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VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE

MELBOURNE

TUESDAY, 13 OCTOBER 2015

(22nd day of hearing)

BEFORE:

THE HONOURABLE M. NEAVE AO - Commissioner

MS P. FAULKNER AO - Deputy Commissioner

MR T. NICHOLSON - Deputy Commissioner

MS DAVIDSON: Good morning, Commissioners. I'm proposing to first outline briefly which witnesses we are going to be hearing from today. Our first witness will be Mr Steven Aos from the Washington State Institute for Public Policy in the United States. He will be addressing the role that that institute plays in the United States. That, strictly speaking, doesn't fall within what we are going to be covering for the rest of the day, which is developing workforce capacity, but Mr Aos was not available tomorrow.

We will then hear from four witnesses: Tracy Beaton, Dr Kim Robinson, Emily Maguire and Ilana Jaffe in relation to developing the capacity of the family violence sector. We will then have a panel of Professor Angela Taft, Professor Kelsey Hegarty and Ilana Jaffe in relation to developing the capacity of the non-family violence workforce to identify and respond to family violence.

After lunch we will hear from four witnesses from the North East Services Connect pilot, Jane Williams, Ren Grayson, Mary Micallef and Cathy Prior. They will talk about how that pilot works and the key worker model and how that might have benefits for the development of the workforce.

Then we will hear from Leanne Beagley from the Department of Health and Human Services, who will talk about the dual diagnosis initiative that has been running in Victoria for some time with the alcohol and drug and mental health workforces and developing the capacity of each of those workforces to understand and do the work of the other workforce. Finally we will have a panel of Belinda Clark and Kate Jenkins in relation to the issue of developing a diverse workforce.

The first witness, Mr Aos, is on videolink. Mr Aos, it's Joanna Davidson from the Royal Commission here. How are you?

MR AOS: I'm just fine, thanks.

MS DAVIDSON: I will first ask that you be sworn.

MR AOS: Okay.

<STEVEN AOS, (via videolink) affirmed and examined:

MS DAVIDSON: Thank you, Mr Aos. Can I ask that you first outline what your role is?

MR AOS: Sure. I'm the Director of the Washington State Institute for Public Policy. The institute that I direct is a legislated (indistinct) of the State Government of Washington State's legislature. We are out on the west coast of the United States. It's not Washington DC. It's Washington State. We like to call it the real Washington, not the other Washington.

We are a state of about 7 million people; I think a little bit larger, but only a little bit, than Victoria. The legislative body that I work for as their director of research is non-partisan research that's guided by an equal number of the Republicans and Democrats in our legislature. We work on projects as directed by the legislature. So the legislature will ask us for what works in juvenile justice or child welfare or education. That's what we then come back with them on things that work and things that don't.

MS DAVIDSON: Can I just get you to clarify the government structure in Washington State. You have an elected legislature.

MR AOS: The way it is in the United States of course it's not a parliamentary system, as you all know probably. So we

have separately elected executive with constitutional separation of powers, just as we do at the national level, and each state has a similar system where the legislative branch of government has certain constitutional powers to pass a budget, to spend money, and the governor is a separately elected official whose job it is - who could veto those bills coming out of the legislature, and the governor runs the executive agencies that the legislature funds.

Then there's of course the third branch of government, a judicial branch of government, that oversees the laws and carries out that. So it's a typical American system of three party branch government. The institute that I direct works in the legislative branch of government and was created by the legislature itself back in 1983, so we are a little over 30 years old at this stage, with a specific desire to have, as I mentioned, non-partisan evidence based research available to the legislature in its deliberations.

MS DAVIDSON: Do you conduct that research yourselves at the institute or do you collect the research from elsewhere and analyse it? How does that work?

MR AOS: Our legislature has asked us to do two kinds of studies, I like to think of them as. In one kind of role we are in the role we have been playing more and more for our legislature. Again what happens during the legislative session is that the members of the legislature will pass a bill. It will say, for example, "Institute for Public Policy, study what works in child welfare. Come up with a list about what works, what doesn't, where are all the best returns on taxpayer investment, and

prepare a report for us for the next session of the legislature." That's the first kind of study that we get.

We have done these reviews about what works in a whole bunch of different areas. When we get that assignment we look far and wide, far outside the borders of Washington State, we even look for research from Australia if it speaks to us in Washington, as many of your studies do, but we look all around the United States looking for the strongest evidence, the most credible research endeavours, whether it is to reduce juvenile crime, we look for programs to reduce juvenile crime with rigorous evaluation methods.

We also like to find rigorous evaluation methods that find that things don't work. If we find something doesn't work outside of our borders and we are doing it inside our borders we then take that evidence and sometimes defund programs that we are currently running when we find out that things don't work.

So the first kind of study we do is I think of our role as an investment adviser. I'm an economist so I use some of this kind of lingo. What we are trying to do is look far and wide where we can best invest Washington taxpayer dollars to get better outcomes as identified by our legislature: more kids to graduate from high school, less crime, less child abuse and neglect, whatever the outcome is, we look for that. That's the first investment adviser role. We are looking all over the world for what's been tried and tested.

The second kind of study that our legislature will ask us to undertake is where we actually go into a program in Washington State and evaluate whether it's

working. Typically what we will do is especially within the last 20 years is we will find out, for example, early childhood education programs look very good based upon studies from around the world, certainly around the rest of the United States, and so that bubbles up near the top of our buy list, if we want to call it that. Then what the legislature directs us to do is to go and actually do an outcome evaluation of our own early childhood education program and see whether we are getting the same kind of results that have been found elsewhere.

So those are the two kinds of studies that we do: outcome evaluations on the ground in Washington and then much more frequently, and especially in the last 10 or 15 years, have been these reviews of evidence of what works and what doesn't from all over the world, really.

MS DAVIDSON: You also not only analyse whether things work but you analyse what the cost benefit is to the state.

MR AOS: Yes. It's a three-step research process that we undertake here. The first is that review about what works. So long before we do anything about economics and cost benefits, it does what I was just mentioning. We look for evidence. Are outcomes improved or not with rigorous methods in getting the outcome the legislature wants us to look at?

Then if we find evidence that something does work we then do the second step, which is a cost benefit analysis where we are really asking the basic question of, "If our taxpayers in Washington State were to fund a program," let's just say in child welfare, child interaction therapy or some program designed to improve the child welfare system, "what would the benefits

relative to dollars of cost be?" So we have to go through and find out first of all what programs cost to implement and then an even trickier part is to figure out what is the net economic value, the monetary value of achieving certain outcomes. So again you do a consistent benefit cost modelling across all outcomes.

What we give our legislature coming back is then a list, much like if you went to your investment adviser and said, "Where can I get the best return on my investment," they probably would come back with 20 different kinds of stocks, bonds and other investments you could do. That's what we do in this case. We come back with 20 or as many topics as we can identify evaluated with a consistent basis so that our legislature can then pick and choose and put together a portfolio of those investments, and those can then find their way into the budget that gets adopted by our legislature.

MS DAVIDSON: How does it work once you provide a report? What are the consequences and what is the sort of feedback mechanism back through government in terms of potentially implementing the advice that you have provided?

MR AOS: Very often during the course of a legislative session - I guess the grey hair that I have up here would indicate I have been through quite a few legislative sessions. This upcoming session would be my 39th annual legislative session. That's a long time to be around this legislature.

When we give a report to our legislature sometimes the evidence sits there and doesn't go any farther. But increasingly our evidence is used by both members of Republicans and Democrats in our legislature to

actually craft how we set up budgets, how we fund our juvenile justice system, just one comes to mind. If you go to the Washington State budget, the budget document that passes our legislature and is signed by the governor usually, there will be explicit references to the list of programs and the legislature is going to fund the programs near the top of the institute's return on investment list in the area of child welfare and children's mental health; in some other areas, adult mental health and adult corrections. The legislature then passes other bills, some of them are budget bills, some of them are policy bills, that direct the agency to fund the programs that are near the top of the institute's list.

In a variety of ways our legislature has been finding ways to take the work that we do - at least some of the work we do, some of our lists about what works and what doesn't - and turn it into actual policy that influence really how taxpayers' money gets spent in our state to try to achieve those outcomes.

MS DAVIDSON: We obviously have a slightly different government system in Australia. From the sounds of it you are saying your reports go to the people who are determining which programs to fund; is that right?

MR AOS: Yes, within our system the legislature's main job is to pass a budget every session.

MS DAVIDSON: If we were to replicate that kind of model in Victoria, it may not be the legislature that we would provide advice to, but it would be the body that would be charged with making those decisions about funding?

MR AOS: Yes. The government that would be in power would be the one - I don't really know much about your process

there politically, let alone the work of the Commission, but I would imagine there could be some policy directives coming from the Commission to the government that would say you could set up something - if you were to base it even in part on what we have been able to do in Washington, you might draw the conclusion that somewhere in the world there's a public entity that has found that there are some pretty good news out there, that there's evidence about things that work, there's evidence about things that don't and they are putting it into place in their public policy systems, and the Commission might tell the government, "This is how you could go about doing it."

COMMISSIONER NEAVE: Let us suppose you have a government mandated program which is being administered by an agency and in the course of doing that there will be many issues of detail which presumably are not covered in the budget specifications or in legislation because you can have something described by a label which will vary according to how it's applied or administered. Do you ever give advice to agencies about those issues? If they are thinking, "This doesn't seem to be working. We can't work out why it's not working. We might want to tweak it or do something," do you provide advice in those circumstances?

MR AOS: We sure do. Of course it's within our system of checks and balances. So within our constitutional system working through the legislature, once the legislature has funded something that's why we get those assignments to go out and evaluate how well in our case the branch is doing it. What we have learned, as people are learning this around the world, it's not enough just to find an evidence based program and say, "Go forth and do it." You actually

have to do it well. You have to implement it with quality assurance, quality control.

This is not a surprise, by the way, to businesses. This is not a surprise to Starbucks, for example. Starbucks know that if they want their stores to go through all the world, as they have, they have to implement their stores with quality control. They have to be able to replicate that business model around the world and into different settings.

That's what we have learned, painfully I might add, in our state. I think when we first started doing this back in the 1990s in the area of juvenile justice we thought, "This evidence based thing works. We will just be able to see it happen." What we learned is exactly what you said, Commissioner; that is, our first go-around we funded those evidence based programs and then we evaluated them and we found out that they weren't working nearly as well as we thought they should.

What we did find out is that when the programs were implemented with quality therapists, for example, the juvenile offender program, they were getting the results. When they were implemented by run of the mill bad therapists they weren't getting the results. On net there was no difference.

So what the legislature learned, this was about the 2002 legislative session, it went back and said to the executive, "If you don't put in place a quality assurance program with the help of the institute by next session all of the funding for those programs will be removed."

So we did do that. We now videotape all therapists that are hired, that interact with families in

the juvenile justice system and elsewhere. This lesson has been learned and it is been put in a variety of systems in our state, not just juvenile justice.

We have subsequently done evaluations of the programs and found out that it is that Starbucks kind of a thing that actually makes sure that the programs work over and over again. Commissioner, you are exactly right. It is not enough just to say, "Here is the thing to do. Go forth and do it." You actually have to follow up and do it well. This should not have become a surprise, but we sort of learned the lesson the hard way.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: Just following on from that, have you had examples where the evidence has said that this particular program should work, you implement that program including with the quality assurance but for some reason it's not working in your local community or with the community? Has that occurred and is there room for adaptation?

MR AOS: On the first point, yes. The classic one was that program that I just mentioned to the Commissioner; that is that we implemented those juvenile justice programs, for example, and found out that they were not working but we at least had the foresight to have an independent review of which therapists were actually doing the program according to the book and which ones were doing something else. That evidence allowed us to then adjust the program and get rid of what wasn't working in the program, basically putting a system in place so that those therapists that were incapable of doing the program were either fired or moved into some other line of work within our social service agency. That's again an operation

thing that you can only get by doing an outcome evaluation later on of that kind of program.

MS DAVIDSON: One of the things that's often said about prevention programs is that it's hard to get them funded by governments because they are long term, they don't have the same immediate outcomes, it doesn't necessarily match with the political cycle. Do you see that the model that you have adopted in the Washington State improves the ability to get those sorts of longer term prevention programs funded?

MR AOS: I think so. You never now for sure because you don't know what the world would be like if the institute hadn't been around working here because that world doesn't exist; the institute is here.

But we have designed our cost benefit models to be long term. If taxpayers spend money today on a program, they spend money on - let's take another topic - our K12 education system, they spend lots of money on that system. We want to know what's going to happen to those students not just in the next year on their test scores, or whether they graduate or move on, but what's their lifetime consequences of doing well in the education system; how much more money are they going to make in the labour market; how much less crime are they going to do in the future because they got higher degrees of education; how are their health care costs going to change.

In all cases we build the model to analyse everything we study, child welfare programs, juvenile justice programs, mental health programs, substance abuse programs, all the things we look at are built with an idea of a consistent model that looks long term into the

future. Our legislature has really come to view those numbers as important, that we don't just focus on the next two years and what the benefits will be in the next two years, but that we actually take a long-term view of the outcomes and the improvements.

Part of the model here is that because of how we get studies directed to us the legislature itself will identify the outcomes that it wants to see improved. It will come back and say, "We want to reduce our crime rate in Washington State. How can we do that, Institute?" We will study ways to reduce the crime rate with adult offenders, rate with juvenile offenders and prevention programs. We will put them all on a common economic footing so that the legislature can select a portfolio of investments.

If prevention was 100 per cent successful then you would just buy all prevention and in one generation you would have no more crime. But no program has ever come close to being 100 per cent successful. All the evidence would indicate that you can reduce crime rates, for example, by a few percentage points, maybe 10 percentage points with a good program. But that means you are going to have adult offenders, you are going to have juvenile offenders.

The trick is to put together a portfolio of investments. Again I'm sounding like a Wall Street stockbroker here. But you want to put together a portfolio of investments and then you want to tie your portfolio of investments to those big picture outcomes.

That's what we do in Washington, by the way. All those programs, including some child welfare programs and

education and criminal justice programs, juvenile justice programs, they go directly into the forecast of our need for prison beds way down the line so that this way we can anticipate how well those programs are going to work and that we don't overbuild our prison system. If we invest in the programs with the taxpayers' money expecting they are going to reduce crime, including child welfare programs that we have, are they going to save prison beds in the future. We want to have that explicitly modeled and do our state prison forecasts so that we don't overbuild the system. Part of the analytical challenge here in your country and your state and my state is how you do the numbers, how you get the numbers, and then how you get the political consensus within our two systems to move the policy ball forward.

COMMISSIONER NEAVE: I have another question. Have you done any look-backs to see whether the effects of your modelling are accurate? Prison beds is an interesting example which is relevant everywhere. You have been operating now for long enough perhaps to be able to say, "We got the prediction of prison beds right or wrong." Have you done that sort of thing?

MR AOS: We do that regularly. Once a year as part of an official process within Washington all the forecasters get together from various agencies and they agree on the assumptions that go into a model; in this case the need for prison beds, what's going to go into our capital budget for prison beds. Many things in the world change. You never know for sure if all those investments are predicting that because all kinds of other policy and non-policy (indistinct) happen.

We don't know for sure, but it looks to us like at this stage - America, as you know, incarcerates a lot of people. Our state, by the way, incarcerates only about half as much. We are only about 50 per cent as punitive as a typical state in the US. Nonetheless, we have about 18,000 people in prison today as I talk. We estimate that without those programs that have been funded over the last 20 years from early childhood education and on up through the adult system that we would have the need for about 2,000 more people in prison today than we currently have. That is holding pretty true to our forecast, it looks like.

We are very cautious in our numbers. When we do these reviews of evidence, going back to the first step in our analysis, we really want to know what would work in Washington on the ground, not what would work in Washington in some university setting done with graduate students. We will typically throw those kinds of studies out because they are not what happens in the real world. If a developer does a program and evaluates the program it might like great. But when it's actually done in the real world, not by the developer but by bureaucrats, the evidence would be that it doesn't work as well. So we take a pretty cautious approach to the effect of these programs. It's an important thing to do because the real world is the real world that we all know about and sometimes things don't work out as well as a textbook or a journal article would indicate.

So we make adjustments to our numbers. The main point is we do it on a consistent basis. The legislature hires me as the director to provide that consistent view

about how we view the world. All of our modelling is done on a consistent basis in terms of what research we accept. Any adjustments we make to them we make to them across all areas. That's the general model that we have done analytically for our legislature.

MS DAVIDSON: You mentioned that the institute is bipartisan. What do you mean by it being a bipartisan institute?

MR AOS: The governance of the institute is bipartisan. Of course we have Republicans and Democrats currently. The party control switches. As in your country of course, the party control switches from election to election sometimes. Currently our state Senate, one of our two legislative branches, is controlled by the Republicans. Our state House of Representatives, the other branch of our legislature, is controlled by the Democrats.

Whichever party is in control in that chamber, let's say the state Senate, that party will control the committee hearing process and set the agenda for that body, have most of the votes to pass bills. But the governance of the institute, whatever party is in charge of the legislature's two houses, in our system there are always an equal number of Republicans and an equal number of Democrats and the co-chairs of the institute are always a Republican and a Democrat. So the whole idea of the institute was set up so that the current majority party would not be the party that would run the institute, for example. It would be truly bipartisan governance. Staff is selected to be non-partisan. There are not partisan political types on the staff.

MS DAVIDSON: How important do you see that as part of the Washington State Institute's model and in terms of its

continuing success, because it's been around for 30-odd years?

MR AOS: Yes. I say it's absolutely critical that it is bipartisan because if it is seen as partisan, if it is seen as being a Republican institute or a Democrat institute or it's an institute that hums to the tune of whatever party is in power at that time, people will think we are cooking the books perhaps or we are letting bias influence how we read the science about what works or what doesn't.

So I think that the bipartisan governance of the institute has allowed it to do the kinds of studies that I mentioned earlier, especially about when we are trying to gather a study and read it we don't read it through Republican eyes or Democratic eyes, we just read it for was there an outcome achieved as a result of this particular policy, and that's really what we focus on.

MS DAVIDSON: Finally, you have done a review in relation to family violence and what works to reduce recidivism by domestic violence offenders. That raised some issues about the Duluth model that you operate in Washington State. How much has that been adopted by the Washington State legislature?

MR AOS: It has not been adopted by the Washington State legislature. We publish many findings. Many of them get adopted and some of them don't. Some of them take several sessions before things begin to happen or the evidence gets used. The Duluth model was put into the statutes of Washington a number of years ago and it continues to be in the statutes. So that will be the model that will be preferred. I don't know the legislative history of how it

got into the statutes, but it is the one that's selected. So it would take a bill of the legislature to overturn (indistinct) of Washington now there is a requirement for that program. So that would actually take an affirmative action by the legislature to overdo it, and that has not happened yet in a session of a Washington legislature.

In America we have baseball. I love baseball. You have some players that are playing in the major Leagues here in the United States from Australia. You can go to the Hall of Fame in baseball if you are maybe 30 or 40 or 50 per cent successful. That means you need only succeed over half the time, but as a hitter you can be in the Hall of Fame in baseball at 30 per cent.

So I played a lot of baseball in my youth, long before the grey hair thing. I know that I try to have that expectation about not everything we do is going to go into legislation. There's lots of things that enter into a political body's decision about what to do. Our evidence is increasingly used, but it's never going to have a 100 per cent batting average. I hope to go to the Hall of Fame, though, with what we have done.

MS DAVIDSON: Thank you, Mr Aos. Unless the Commissioners have any additional questions, perhaps this witness could be excused.

DEPUTY COMMISSIONER FAULKNER: I have one very small one. Just to get an idea of the proportion and the size of your organisation and whether you are constantly needing more money to do the work or does somehow you get guaranteed the funding when the legislature decides to commission you? How big is this organisation? How many studies do you do, that sort of thing?

MR AOS: That's a great question. We are set up in a way that kind of makes it hard to manage, frankly, as the manager of this group. But there are only two positions if you think of it as permanent positions: the director's position and the assistant director. All of the other positions are hired on a project by project basis.

So if the legislature passes one of those bills, when a bill comes to us we say how much it would cost to do a study, to do a study of what works in education, for example. It might cost $US200,000 or something like that.

Then if the legislature passes the bill we will get the $200,000 but it will just last through the duration of the study. So we are currently an institute of about 16 analysts here at the institute, but only two of them are permanent. All of the other 14 is because the legislature has been finding our information useful and ordering projects in the form of legislation along with the money to fund those projects.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MS DAVIDSON: Thank you, Mr Aos, and thank you for attending from the United States. Perhaps this witness could be excused.

COMMISSIONER NEAVE: Yes, thank you very much, Mr Aos. You are excused.

<(THE WITNESS WITHDREW)

MS ELLYARD: Commissioners, the next panel of evidence will focus on developing the specialist family violence workforce. It's a panel of four. I will ask them to come into the witness box and be sworn.

<TRACY DAWN MARIE BEATON, sworn and examined:

<ILANA CLARE JAFFE, affirmed and examined:

<EMILY KATE MAGUIRE, affirmed and examined:

<KIM GRACE ROBINSON, affirmed and examined:

MS ELLYARD: May I ask each of the panel, commencing with you, please, Dr Robinson, to summarise your present role and your professional background.

DR ROBINSON: My present role is a lecturer in social work at Deakin University. My professional background is I now have been a social worker for over 25 years. I have worked in a range of health settings, in women's health and in community health, hospitals, and in more recent years I have focused on working with asylum seekers and refugees.

MS MAGUIRE: My name is Emily Maguire. I'm the CEO of the Domestic Violence Resource Centre Victoria. My professional background has primarily been in preventing violence against women but worked in the response end as well, through statewide public policy and working within bureaucracy as well as working within statutory bodies and community agencies.

MS JAFFE: I currently work for Inner North West Primary Care Partnership on the Identifying and Responding to Family Violence Project. My background is also in social work, and my thesis was in the multiple and complex needs initiative, and I have worked as a social worker in hospital and homelessness as well as in primary health.

MS BEATON: My name is Tracy Beaton. I'm a registered nurse. I'm currently the Chief Practitioner working at the Department of Health and Human Services. I have an extensive clinical background in mental health, including child and adolescent and emergency mental health services.

MS ELLYARD: You have made a statement dated 12 October 2015.

Are the contents of that statement true and correct?

MS BEATON: Yes.

MS ELLYARD: As I indicated to the Commission, the focus of this panel is the specialist family violence workforce. Can I start perhaps with you, please, Dr Robinson. Where did the workforce come from in terms of its history, and how in your assessment does that history continue to influence or not influence how the workforce thinks and operates?

DR ROBINSON: I think a workforce has its roots in a women's movement and feminist movement which was really shaping its very early response to family violence. It predominantly set up voluntary programs. Often those programs were not funded, and they were really about assisting and supporting women to leave situations of family violence and to provide them with advice and support and appropriate networks, perhaps through legal or health channels, in order to support those women and their children.

I think as time progressed my experience in the sort of '80s and '90s was the establishment of small grants, perhaps through community health centres, working with women's health organisations to look at setting up domestic violence outreach programs and to look at liaising with government in establishing women's refuges, and also doing some prevention work in schools and in local communities.

So I think that history has a very important role to play in the establishment of family violence services and informs very much where we are today.

MS ELLYARD: In 1999 you did a study, and I accept that's a

little while ago now, in which you looked at the experiences of women who had encountered and used the family violence system. What were some of the learnings at that time of how the women at that time were experiencing the system?

DR ROBINSON: The study was a relatively small study, but one of the key elements I think from that study was to try and ascertain women from what was then called non-English speaking background, now called CALD, those women's experiences of services across the board. That could have been from early intervention, prevention, refuge services, and to try and gauge from them what their experiences were. I think that has been a very important positioning that we keep women at the centre of that experience of what the services provide to them and how they can gain the insight and support from the provision of care rather than the other way around.

There were a number of recommendations that came out of that paper, and I worked with at the time the domestic violence outreach program and their board of management in the west, Women's Health West, and that was to look at key recommendations. Would you like me to state what they are?

MS ELLYARD: Yes. Were there some things that were positive and some things that were negative, I guess, arising out of those women's experiences?

DR ROBINSON: Yes, I think there were some very positive experiences that women had of the sector - the diversity of the sector, the range of different models, the fact that they were embedded in the communities, that they could seek out the support of supportive GPs, for example,

in community health settings, that they could get access to child-care services who were sympathetic and understanding of their needs, and that there were systems that did provide some degree of information sharing and case management support to enable them to move on with their lives.

There were some concerns that were raised by the women, and in particular the women from CALD backgrounds around the appropriateness of refuge settings and the high security demands of women being in refuge. I think we continue to have that discussion and debate at the moment about whether women can stay in their homes or whether it is they who have to leave their homes and communities with their children and move to an unknown area.

MS ELLYARD: Was there anything that arose out of your research, again accepting that it was a while ago, about the skill level of those working in the system and whether there was any uniformity or disparity about the level of training or qualifications?

DR ROBINSON: I think there was an acknowledgment that there was a disparity and that there was different levels of expertise in different settings. So there was possibly a lack of uniformity of training or understanding of the complexity of the systems required when dealing with family violence.

MS ELLYARD: Ms Maguire, may I turn to you, and thinking more in the present day, firstly, would you agree with the analysis that what we presently have as the specialist family violence system traces its roots very much to the women's movement of perhaps the '70s and a very consciously feminist response to family violence?

MS MAGUIRE: Yes, primarily I think that's very much where the roots are. The increasing professionalisation of the sector has meant that there will be new workers coming in who will not necessarily have strong roots, but the kind of structures of organisations who are working with women and children who are victims/survivors of violence, very much I would agree with that.

MS ELLYARD: If we were to try to describe what the specialist family violence system is at present in terms of who works within it, how would you describe the present structure and who is inside it?

MS MAGUIRE: Possibly the best way to describe it is to articulate it in tiers. So there are four tiers, I think, to the family violence specialist service. Firstly, there is the kind of specialist services who directly support women and children. So those are services we might be able to think of them as services who spend 90 plus per cent of their time working directly to mitigate the impacts of violence, to support women to leave or to stay, but to support women's safety, effectively.

The tier down from that are agencies who spend a significant amount of their time in supporting women and children as well as holding perpetrators to account. So that will be - they are agencies like police, courts and specialist court services, legal agencies, child protection, corrections - agencies like that where they spend a significant proportion of their time but it's not the main focus of their work.

The third tier are the more mainstream services and I guess the non-family violence specific support services who still do a significant amount of work with

women and some with children who do experience family violence as well as working with perpetrators simply by virtue of the kind of impacts of family violence and working to support those impacts. So those are things like health care, drug and alcohol, housing, mental health, but as well as agencies like Centrelink, for example, who are seeking to support women's economic security.

Then the fourth tier are general organisations across the state, so effectively anyone who comes into regular daily contact with people who just by virtue of being people will have either experienced or perpetrated family violence.

So if you are thinking about a workforce that's kind of a useful way to think about how you would chunk up, I guess, the specialist and the non-specialist but the necessary skill sets and kind of critical components of what people need to understand and learn.

MS ELLYARD: So the tier one, then, would be what you would describe as the specialist response in the sense of the people whose really entire function is to provide a very immediate response to those experiencing violence?

MS MAGUIRE: Yes .

MS ELLYARD: Is it possible to say how large that workforce is?

MS MAGUIRE: I'm sure we can get that information, but, no, I probably can't, no.

MS ELLYARD: Is there any central body that holds, for example, information about how many people are employed in the specialist response end, what qualifications and experience they have?

MS MAGUIRE: I assume the Department of Health and Human

Services would hold most of that information. There will be community based services who may not have funding through Health and Community Services. There may also be individual workers, social workers and psychologists, who do work somewhat within the specialist family violence sector but as individual practitioners.

But, to the best of my knowledge, there's a lack of consistency and clarity around the core competencies that are required to work in the family violence sector. Primarily what you will find in the specialist sector is that you need a certificate in community development or community services, some will be social work trained, but there are also agencies who are willing to accept, given the history of this work and given there used to be in the '70s a significant focus on ensuring that the women who were working in this space were victims/survivors themselves, which is not so much the case now, but that was very much where it came from. Given that previous history, there are also services who are willing to accept history of work in the sector as the qualification for working. But there is no kind of consistent standard or framework, which is a significant gap.

MS ELLYARD: Ms Jaffe, can I ask you from your observation, picking up that last point about the perhaps disparity between the qualifications or experience that different workers in the specialist services might have, do you have any comments on that?

MS JAFFE: Yes. I would echo that there's a really core grassroots culture and tremendous amount of practice wisdom in the sector, but I guess there's no standardised professional standards for the sector so that

they can also then - they could potentially use as clout for - at better salaries, for example.

I think also part of this is also around funding, that most agencies are not given a lot of funding for training and not funding for backfill. So it's really difficult to send a staff member off for training. If you have a huge demand on your services and a client in crisis, what are you going to choose? Often that's a dilemma that most services, in my understanding, have to negotiate.

MS ELLYARD: Dr Robinson, is it useful to conceive of family violence specialist response as social work, as part of the social work spectrum?

DR ROBINSON: Definitely, yes. I think social work is well placed because of the way in which training occurs, and our education program specifically gives students background in legal, social justice principles. It also gives them a good understanding of policy and practice, research and of course direct service work skills.

MS ELLYARD: Can I turn to you, please, Ms Beaton. In the context of DHHS and in particular child protection a model has been developed to resource its social workers to ensure appropriate standards of professional practice. Could you speak a little, please, about what that model is and how it developed?

MS BEATON: Sure. I think I would just like to start off by saying that social work is one of the desired qualifications that we have for child protection workers, but we also have another couple of categories and it's really around the skill set and the education that means people obviously are able to do things in a

legal - thinking about the legal consequences, developing evidence, working alongside families, understanding child development and so on.

MS ELLYARD: So all child protection workers have to have a degree of some kind; is that correct?

MS BEATON: They have to have a qualification. Not all are degree prepared. We do have some that have diploma in community studies, but the majority are social work trained and there are a number of psychologists, and then there's some other disciplines such as nursing and so on that are able to obviously be part of the workforce in child protection.

MS ELLYARD: I think I interrupted you, but what's the benefit of requiring that degree of higher learning as a precondition to embarking on child protection practice?

MS BEATON: We believe that it's really important that we have a very skilled workforce, largely because of the statutory function associated with child protection and the gravity of the decisions that child protection workers are actually making. So they need to have very clear critical and analytical skills, and an ability to work alongside people, to pull from theoretical constructs and actually work with those actually with families in everyday real situations, they have to be thinking very carefully about what the issues are for those families, what meets a statutory threshold, what doesn't. So it's really important to have a very skilled workforce.

MS ELLYARD: Once they are part of your workforce, how does the Office of Professional Practice work to resource them and keep them appropriately practising?

MS BEATON: There's a number of things that happen in the

department. So there is an introduction to practice, if you like. So beginning practice there is a series of - where new employees are brought into the department, they do some particular work around a case, which includes from the beginning to the end, if you like, so from how it is that you first start to conduct yourself, self-care, thinking about how it is that you work with families right through to a particular application and how you might case manage and work with a family.

We are heavily involved in that in beginning practice, and that's what it's called, beginning practice. That happens over about a five-month period. So people come in, then they will go back out to the divisions and actually work alongside people. There are a number of things that they can't do until they have done specific training. So some of that is around the sexual abuse training, and the Office of Professional Practice are heavily involved in teaching and training that.

We do a number of things which is about supporting front-line practitioners. So we might do complex case reviews. We might be called in to have a look at something. There might be some themes happening in a division and they might want the office to develop some resource and work alongside people to look at that. We do a lot of reflective practice, so where it is that we are trying to critically analyse what it is that's happened. For example, we might put a genogram up, have a look back through the family, how people understand that, is there anything missing, what else could we have looked at, where else might we consider we need to go with this family, what are the options for this family and so on, to

large-scale trainings where we work across the sector.

We, for example, in 2014 started doing a lot of training around family violence but with police and with other experts in the sector, because in fact you are needing to actually work in partnership in order to be able to provide the right type of training and education because it's not - the child protection is one arm, if you like, of the service system that sees people who experience family violence. There are many others.

MS ELLYARD: If best practice in any area of child protection is identified, is it the role of the office to disseminate information about that best practice and resource all of the members of the workforce to adopt those practices?

MS BEATON: Yes, yes, absolutely. The method of that is done in many different ways, whether that's informing policy, whether it's doing individual work, whether it's training, whether it's developing something specific for a particular area. It might be actually building up the capacity. So, really, a large function is building capacity, so working with the other principal practitioners in the divisions and practice leaders about the type of work that they are doing.

MS ELLYARD: Ms Maguire, can I turn to you. You mentioned the increased professionalisation of the workforce. All child protection workers work for one employer, whereas family violence specialists are employed by a variety of different employers around the state. From your point of view, is there presently, and if there isn't could there be some role for, some uniformity of the way in which specialist family violence services are resourced in terms of best practice and training and development?

MS MAGUIRE: In terms of supporting best practice service provision, in terms of funding streams, in terms of kind of articulating a workforce development strategy I think that there is absolutely benefit to some centralisation. That doesn't necessarily need to be government. It could be a statutory body or similar, or it could be led by a community agency. There is a need for a level of standardisation. But I think it's also important to recognise that the ways in which we are talking about workforce development at the moment we are talking about the existing workforce, and we also need to be talking about the pre-service workforce. So we have these two separate workforces, both of whom need to be working to a particular level that is mutually and sharedly agreed, so it doesn't matter where a woman accesses services she is getting the same consistent support and service.

But I think it's important to recognise, and this probably goes to your point a bit, Ilana, that if we are talking about putting standards onto an existing system what that will do is place an additional undue burden on the services who are already trying to meet and struggling and not actually able to meet demand. So if we say that everyone from now on needs to be social worked trained or qualified, whatever that is, I think it is important to consider the realities of that and have a kind of extensive and a longer term strategy for supporting that. But I think in principle it is absolutely necessary.

MS ELLYARD: What about that aspect of the role that exists within child protection of an office that identifies best practice and might have some role in ensuring that people are trained and resourced to understand that best practice

so that there is some uniformity? Is that something you would see benefit in?

MS MAGUIRE: Yes, very much so. Yes, I think supporting practice is the particular key. I think delivering training is one useful function, and I think it is a function - that is something that DVRC has been playing a role in for a number of years now. But training is not the only component of workforce development, and I think ongoing practice support and having a well-resourced system that allows professionals to have that time away from case management and to do that level of support is very useful.

MS ELLYARD: So that then leads to the question of when we think about specialist services what's the particular set of competencies that we are going to be resourcing and how do we set aside the work of a specialist from the work of, for the want of a better word, a generalist? From your perspective, Ms Maguire, what do you identify as the core competencies or things that a specialist responder in that first tier does or needs to have?

MS MAGUIRE: I think there are two things. One, and probably the most obvious, is risk. Specialist family violence services are never going to be able to support every single woman and child who is experiencing violence and nor support every man to change his behaviour who is perpetrating violence. That is just not a realistic expectation of the service, and nor do women always want to go to specialist services. But the focus on managing medium- to high-level risk is the particular and unique role that the specialist service can play.

What we hear and what regional integration

coordinators and services around the state hear is that whilst mainstream or universal, or however we articulate that, whilst those other services do want to be able to identify and respond to that woman who is sitting in front of them, they don't want to be in control of managing that risk. It's too much for them to do, it's not their professional expertise and they have no desire to manage those high-risk cases where women are at risk of being murdered, and there are particular times and contexts within which it is really important to have a specialist family violence response. So the risk component is one, and that is doing very in-depth ongoing risk assessment and safety planning, effectively. That is a very brief way of stating it.

But I think it's also important to recognise that the justification I think for the specialist service is because family violence is an issue that is particular not only to - it is not really an individual issue. Sure, there are some individual components to the justifications for perpetrating violence. But, actually, what specialist family violence services can do is recognise what those individual elements are but they also have an ability to be able to see the broader social context within which that violence is condoned and supported. So they have that kind of dual lens which often other social justice, for want of a better term, issues don't necessarily mandate.

So that's something that specialist family violence services do have and that informs their practice. That's not to say that other services can't build that lens, but actually what's needed is not only for those

individuals to have that lens but for the organisations they are working with, the institutional cultures, to support what is effectively a feminist trauma informed response.

MS ELLYARD: Can I ask you then to what extent do people operating with that specialist family violence level of - with that focus on risk, to what extent in your view do they need to be informed or aware of other aspects of the health or wellbeing of the woman that they might be dealing with who might, in addition to being a victim of family violence, have other co-morbidities, if I can use that term?

MS MAGUIRE: That's imperative. I suppose it's the level to which they need that. I think there are three things that would - there is a need for an understanding of the kind of theoretical frameworks used within - child protection is a particular one, drug and alcohol, and mental health are the three key. So there is a need for an understanding of those issues and how you might be able to respond in an in-the-moment way, not necessarily to provide ongoing therapeutic response.

But it is important for specialist family violence workers to also understand those different systems and the ways that they work and the referral pathways in so that they can work in partnership, in the same way that it is necessary for mental health services to know the referral pathways and some basic information about family violence.

So there is a kind of generalist level of knowledge that family violence organisations and practitioners need around those other issues, but they

don't need the depth of knowledge and understanding that professionals and experts in that field have.

MS ELLYARD: The Commission has received some evidence about the experiences of some victims that they dealt with family violence specialists who didn't have that level of knowledge or understanding of other aspects of the service system. Ms Jaffe, can I ask you from your experience, dealing as you have with women presenting with sometimes complex needs, what your experience of the specialist system has been in that context?

MS JAFFE: I think it's partly also around it's an infrastructure issue. For example, the refuges, predominantly, there are some that aren't but a lot have shared living facilities, and often women and children are in that space, so then when you have a woman with multiple and complex needs, for example with drug and alcohol issues, it can be very difficult to manage her in a shared environment particularly if there is children around. However, echoing what you were saying, these women are still suffering from horrific violence and that we as a system need to be working with them to prioritise their safety. My experience is that often they are landing in homeless services because specialist services do not have the capacity to work with these women, even though they have huge amount of risk.

MS ELLYARD: That's because of the presence of other issues like mental health or drug and alcohol that makes them unsuitable for the present structure?

MS JAFFE: There are some facilities that have independent living units, but I guess it is also about the workforce and the workforce being able to have the skills and

abilities to have that specialist skill level as well as being able to have the generalist knowledge, because particularly when you are managing a residential facility you need to have at the time responsibilities. You can't just be able to refer to a drug and alcohol worker the next day. So they need to have all of those skills. You are working with a person, so obviously really high engagement skills as well.

MS ELLYARD: Dr Robinson, we have been talking about specialist and generalist. Is that binary approach a useful or an unuseful one?

DR ROBINSON: I tend to think it's not terribly useful. I think we need both, so I would agree with what's been said. Just to draw on some UK experience that I have had more recently, you may be aware of the MARACs there, which is the multi-agency risk assessment conferences - bit of a mouthful - with IDVAs, which are independent domestic violence advisers. That's been a very effective system in the UK whereby - it's picked up on some of what you have just identified - it was set up to deal with homicide and very high-end risk situations. It's been extended more broadly with Women's Aid being one of the key bodies to oversee funding for that model. I perhaps would urge the Commissioners to have a look at the model and consider some of the learning from the UK for this Commission.

MS ELLYARD: Ms Beaton, can I turn to you. From the child protection context your staff will often encounter situations of family violence arising in the course of their work. What are your reflections on the extent to which people need to upskill in multiple areas or the extent to which there is a need for a specialist as

opposed to a more universal response?

MS BEATON: I tend to agree that I think that we need to think about it as not one or the other. So certainly - and that depends, I think. So certainly in child protection we have certainly considered how it is that we build the workforce's knowledge and capability around particular areas. So again family violence, we have done a lot of work in the workforce and thinking about things, for example, like cumulative harm, so understanding the impact of repeated instances of violence on children within the context of their family, and thinking also because we don't meet a family that's compartmentalised, so it is not just family violence. There are often multiple factors before people actually meet the threshold for statutory involvement. So we have to be very, very aware of mental health issues, alcohol and drug issues, family violence, sexual exploitation, sexual abuse. So there's a number of areas that we have to continually work with our staff to build their knowledge and expertise.

The thinking has changed over time too. So it's how you keep your workforce contemporary that's also really important - so how you start to think about perpetrator accountability and not just whether mum is a protective parent, but how it is that you actually think about this as a family - if you like, this is a family parenting choice and how you work with perpetrators of violence at the same time as working with the mother.

MS ELLYARD: May I ask each of the panel to comment on whether they think this is a useful or a not useful analogy when we start to think about, again to use the terminology that you are all disavowing, specialist and generalist. If we

take issues of broad public health like, for example, diabetes, the situation is that many, many people with diabetes are managed by their general practitioner, many of them find it then not very often, if at all, necessary to go to see a specialist because there is a higher degree of knowledge within the general GP community about how to manage and treat people with diabetes and only a relatively small percentage might require a specialist response. Is that a useful way for us to think about the kinds of way in which people experiencing family violence might have their needs met by the system? If it is not, please tell me.

MS MAGUIRE: I think broadly speaking it can be. The only level of complexity that is added when you are talking about family violence is that it's not a - I might be showing my poor understanding of diabetes here, but it is not a kind of consistent trajectory that you follow. There are certain things that you can and can't do to keep yourself healthy and safe with diabetes. That's not really the case in the context of family violence.

The level and degree of risk goes like this. It's sometimes based on the particular context. It's sometimes based on what day of the week it is or what time of the year it is, or it is based on whether or not someone has decided to leave or they are pregnant or - there are all those sorts of things.

So what's necessary I think is generally speaking across the board to have those services skilled up to provide that sort of response that you are talking about, but to be able to understand where the peak times of risk are and to be able to recognise and identify that, even if

the woman doesn't look like she is showing up in a moment of crisis, to be able to recognise and understand her language and then refer to a specialist service.

MS ELLYARD: So, to continue the diabetes analogy, that might be about the way in which the GPs are resourced to know when it is time to acknowledge the limit of their expertise and they have to refer to a specialist?

MS MAGUIRE: Yes, I think so.

MS ELLYARD: Can I ask any other members of the panel to reflect on whether it is a useful analogy?

MS JAFFE: I think that it's not really acknowledging that there is often multiple services involved and the service coordination required, and that situation is really difficult and complex and there is not good standards at the moment around service coordination. There are good examples of it, but it's not consistent and not consistent enough for that sort of model, because there's not only the GP and the specialist service often involved. There might be five other services but no-one is really clear of who is taking charge and who is then necessarily defining when the risk is escalated and needs to refer to a specialist service. So I think that's probably another layer of complexity that needs to be added to the analogy.

DR ROBINSON: Yes, I would agree with that. But I also think we could fairly effectively provide training and additional resources. For example, in social work programs we could have a mandatory unit on family violence. We could write that tomorrow and have it in place. That is not rocket science. We can do that. We can do things across allied health, across teachers, early childhood providers. We could introduce that very

quickly.

The research evidence is showing us that survivors of family violence want to be asked about it. They want people to know. They may not feel able to volunteer that information at a particular point, but they want their health providers and others to ask them if they are experiencing violence. I think we can be much more robust in how we can prepare a generalist workforce for that type of role.

DEPUTY COMMISSIONER FAULKNER: On that issue you said "we could do it right now". Why don't you? What is the process that stops social work courses from having a unit on family violence, given the extreme evidence of the pervasiveness of it? Who is not moving? What's happening that is causing it not to be part of generic training?

DR ROBINSON: That's a good question. I think that some courses do have units on it. For example, we do. But it's not seen to be a mandatory element. Maybe that's something we need to take up with professional bodies, with others who do the accreditation - for example, the Australian Association of Social Workers. They accredit the social work program - other allied health bodies. Perhaps that's a role that we need to be more active and prominent about demanding that that's what we require.

DEPUTY COMMISSIONER FAULKNER: Thank you.

COMMISSIONER NEAVE: Can I just ask about that. I'm familiar with legal education, where there are mandatory components and options. So there are mandatory components in the social work course, presumably; is that right?

DR ROBINSON: Yes, that's right.

COMMISSIONER NEAVE: So it would not be difficult to go to the

universities and say, "Any competent social worker has to have a knowledge of family violence, and that must be part of the course"?

DR ROBINSON: That's correct.

COMMISSIONER NEAVE: So presumably you persuade the professional body and the universities; that's how you go about doing it?

DR ROBINSON: Yes.

MS JAFFE: But I think something to add to that is that it's not a professional body in the same way that the legal profession is, and I think that's an issue, and that there is not a requirement, for example, for ongoing CPD points to maintain your professional accreditation. I think if we are talking about benchmarking and having a good code of practice for the sector and a recognised body, then that's something to discuss as well.

DR ROBINSON: Yes. Good point.

MS BEATON: I was just wanting to add to the diabetes analogy because I think one of the things that's very different about diabetes is that it is a socially acceptable thing to talk about and that over time - so the variables are really well understood, and so you do have complex systems actually designed to work around that, and there's a real prevention arm to that because of some of the economic factors and the health outcome factors. So I'm thinking about podiatry, dieticians, schools know when kids have got diabetes, how to recognise the signs and symptoms of hypo- and hyperglycaemia. There's a whole number of things that have happened around diabetes that have been very considered and very deliberate.

I think that it is that sort of process that

could actually build awareness in a much different way so that there is the opportunity for responsiveness in all different sorts of areas. I think it's very important to develop the specialist workforce around the specialist skills that they have and need in order to support women, but there are a whole number of areas that need to be developed so that they can actually support women through early identification, through - in all different sorts of ways. I think that that's actually helpful to think of it in that way because by doing that - you know, we have guidelines about how it is that you work with children with diabetes, with adult type 2 diabetes, all sorts of things around prevention, all sorts of investment around that.

So I think it is a helpful analogy because I think there is a system built around that that is about integration and how you share information. I appreciate the dynamic nature and how things change so quickly in family violence, and just a slight change, one variable, can make significant difference. But I think that we need to explore that .

MS ELLYARD: Ms Maguire, did you want to add to that or to make another comment on - - -

MS MAGUIRE: It was adding to both of those, really. I think what we often do is in these conversations - and I think you are right that we could develop a core competency to sit within a social work degree, but what we could only do is say, "This is what family violence looks like. This is how to recognise it." What we can't do is say, "This is how you assess risk. This is how you do a safety plan," because what we haven't done as a sector, and this is

where the leadership is required, is to articulate what the standardised practices, processes, system is so we can - I mean, that's been one of the biggest barriers, because there are a range of different departments, community agencies - you know, there are a whole lot of different people giving different messages, and risk assessment is a really good articulation of that.

You have a five-minute risk assessment being done by some agencies within the family violence system, you have a really complex, long, common risk - in alignment with DHHS's Common Risk Assessment Framework. But at the moment we haven't had anyone say, "This is in Victoria how we, across those four tiers of the system, assess risk. This is your role."

That's the thing that is missing. So, even if we did a whole lot of advocacy around getting something into a social work degree, it would only be something for individual practitioners. We are very limited in what we are able to do because those statewide system decisions haven't been made.

MS ELLYARD: Is that even true for what you have described as the first tier? Is there that lack of consistency or common understanding even at the level of the specialist responders about how you go about the task of risk assessment?

MS MAGUIRE: I think it is much better at the specialist response because of the Common Risk Assessment Framework and because the government has been pushing that so significantly. But I still think absolutely there are gaps there.

MS ELLYARD: Can I ask about a different issue. Something that

hasn't been identified by anyone yet in terms of whose responsibility it might be to do this is whose responsibility it is to assist the woman in recovery. We have talked about early intervention and we have talked about risk assessment. But is it part of the specialist response to try and help the woman graduate out of the system, or does that responsibility lie elsewhere within tiers 2, 3 and 4 of the response? Perhaps Ms Maguire first and then others.

MS MAGUIRE: I think it's a bit of both. When you are talking about the most commonsense way of understanding where that lies, is with those kind of therapeutic practitioners who have a two- or a five- or a 20-year relationship with a woman and support her, can support those complex needs but can also just support a response around family violence if that's what she wants. For me, those practitioners sit within that third tier of mainstream agencies who do a range of various sorts of intervention.

But I think as it currently stands the specialist family violence service do play a role in that. I don't think that that's necessarily a requirement because of the resource requirements of that, I guess. I think keeping the focus of those specialist services on risk and on a feminist trauma informed approach is probably the best way to understand that. There are other professionals who have the time capacity and their core role is around that long-term therapeutic response.

MS ELLYARD: Do other members of the panel wish to comment on that?

MS JAFFE: Yes. Ongoing mainstream services definitely have a role for ongoing monitoring and support because we know

often when services drop off that that's often when women may return to the relationship. So places like GPs, community health, all the staff there need to be able to be receptive and open for when a woman re-discloses potentially returning to the relationship so they can re-access services. That sort of connection is not there at the moment, and that would be really useful.

MS BEATON: I would certainly like to examine the possibility of what it is that people who experience family violence actually think that they need long term. So I think there is a place for us thinking about what sort of counselling and opportunities there are for women to explore and examine their experience and how it is that they think about how they look after themselves into the future and how they have their families and their relationships and their recovery. If our specialist workforce is about that high risk end alone, then we have to think about the opportunity for the stuff you are talking about which is the prevention. So what happens to a large proportion of people who experience family violence is that a number of them end up developing problems with their mental wellbeing. So there are a number of services that I think are broader that are opportunities for women to feel better and to be able to be much more empowered in looking after themselves and their wellbeing.

MS JAFFE: I might also just mention there's a lack of focus on the children who are experiencing the violence. Even when they come into my understanding of family violence services, if there is a woman with five children they might not each get a worker, for example. There might be one children's worker for the whole family. I think that

that's a massive gap.

Also if we are looking at preventing violence often those children may then themselves perpetrate or enter into relationships that are violent if they haven't had that ongoing support and counselling particularly around the trauma that they have experienced. I think that's definitely a big gap.

MS ELLYARD: I'm going to come back to the question of gaps in response, but can I invite you, Dr Robinson, first to comment on the issue that the others have commented on.

DR ROBINSON: Sure. I would support what's been said and I do think that remains an enormous gap, actually, that ongoing support and also the bigger question about how we measure outcomes for survivors of abuse. There's been again recently in the UK a study done which has been looking at developing a tool for measuring outcomes for survivors of domestic violence and abuse. It's called the Supporting Survivor Outcomes Tool, and that was developed in consultation with women who had been accessing services and support.

So we do need to think about what models we have in place, how do we mandate that ongoing support for families so that they are not finding themselves on a wheel of exiting services and then coming back in at crisis point again.

MS ELLYARD: Can I turn then to the question that Ms Jaffe has raised and ask you, Ms Maguire, first when we think about what you have identified as that top tier of people within agencies whose primary function is to respond to family violence we are mainly talking about women services responding to female victims of violence; is that correct?

MS MAGUIRE: That's right, yes.

MS ELLYARD: To what extent, as far as you are aware, has there been any focus within the sector on broadening out the response so that it responds not only to women but responds directly to children in their own right rather than as the children of a woman?

MS MAGUIRE: It is something that services do to the best of their ability. As you said, some will have a dedicated worker who has specialist expertise in supporting children within the kind of approach that the agency that they are working for works with in terms that it is feminist trauma informed. But the reality is that in safety planning and in risk assessment the needs of the children are taken into account when we are focusing on the woman, but more longer term support is not something that these agencies have the capacity to provide is the reality. Whether you are talking about one child or five in a family, they are just not funded and resourced to do that.

It is a significant gap and it is very much something that when we are talking about that specialist risk assessment - and we have seen this through the murder of Luke Batty and the coronial inquest that came out - the need for there to be a focus on assessing risk to children and understanding the relationship between risks to children and risks to mothers.

MS ELLYARD: What about specialist responses to other cohorts of victims? The definition of "family violence" is very broad. It encompasses sibling violence, elder abuse. There are other cohorts of victims that don't meet the definition either of a woman or of the children of a woman. To what extent is there presently a specialist

response to those different cohorts in Victoria?

MS MAGUIRE: To be honest, my background is in preventing violence against women and responding to violence against women. You probably will have heard from most of the professionals here who focus on that understanding and that intimate partner violence component of family violence. So I can't really speak to that level of expertise.

DVRCV does run training around elder abuse, around supporting children who are perpetrating violence against their parents, and around responding to the needs of children and babies. But, to the best of my knowledge, it's a gap in terms of the workforce and it's a gap in terms of the needs of the workforce, yes.

MS ELLYARD: Does anyone else on the panel have a comment on the extent to which the workforce ought to, if it doesn't already, respond to those different cohorts of victims and any practical difficulties associated with that?

DR ROBINSON: Again I think it's critical that we do take a sort of intersectional view of this and look at the needs of women with disabilities, for example, LGBTI; that we really do broaden out our understanding of these issues and provide workers, as mentioned, with the skill set to be able to work effectively with those more marginalised communities - refugees, asylum seeking women, again a quite vulnerable group with marginal immigration status. There are a number of different groups that we need to be focusing on more specifically.

MS BEATON: I would just like to make a comment, and it's really just to illustrate some of the thinking that's happened around the child protection operating model.

There's been a real focus on three key areas which have been about safety, stability and development. I think it feeds a little bit into that discussion about do we have a specialist workforce or do we have a generalist workforce. There are many specialist clinicians and counsellors and providers that actually will help people through those issues. So I think that there are workforces out there actually working with children. They might come for different reasons. For example, CASA is a good example where often they are not just working with the child or the victim around sexual abuse but it's around all of those other things that happen as a result of those experiences. So I think it is actually important to understand how it is that we continue to support and build the capacity of the different workforces that people come into contact with.

I think we need both. But it is really important to actually realise that actually often people will choose who their therapist is or who it is that they see, and it's that relationship where the healing and understanding can take place, but it is about how you have a shared understanding of what the issues might be.

MS ELLYARD: Should there be a specialist response to other cohorts of victims? To take the example of risk assessment for women who might be at high risk of being killed by their partners, parents get killed by their children, children get killed by their parents, siblings get killed by their siblings, not very often thankfully but it occurs in certain high risk cases. There presently doesn't appear to be any high level specialist response to anything other than women.

I'm interested in the comments of the panel on why that might be and what might be the implications of trying to develop that specialist response for other cohorts at high risk to perhaps mirror the response that's developed over a number of years to reflect the needs of women.

MS MAGUIRE: I think the reality of the service system that we have now is as a result of demand, basically. Yes, elder abuse does occur. Yes, violence by children towards parents or grandparents or siblings does occur. Yes, child abuse does occur, and that's a separate issue and we have recognised that that's a significant issue and recognised the connections between child abuse and family violence.

But the reality and the reason that the system has grown up around intimate partner violence is because it is just so common and there are so many women who experience it and there are so many men who perpetrate it. That's not to negate the need for a specialist response, but it is also important to recognise that when you are talking about elder abuse and when you are talking about adolescent abuse it's often gendered as well. Adolescents are often male perpetrators and the victim is often the mother. It's not always in the context where there is already family violence, intimate partner violence between the parents in the home, but that's a very regular occurrence. When you are talking about elder abuse, again often the victim is the female. Gender doesn't explain everything in those contexts by any stretch of the imagination, but an approach to a therapeutic or case management way of working that is informed by a gendered

understanding, feminist practice and trauma will enable the skill set that will be able to deal with all of those incidents as one.

MS ELLYARD: Dr Robinson, do you have anything to add on this topic?

DR ROBINSON: I think what you are saying about a trauma informed practice is really critical. We can do better to inform and train and develop the existing workforce. We mentioned earlier that we are talking about working with the existing workforce and providing them with support and assistance to do their current jobs well.

I would also argue that supervision and debriefing to deal with vicarious trauma for that existing workforce is very important. But we also need to be thinking about how do we best prepare the new workforce, the new tranche, the young people who are coming through our universities and our systems to do that work better. I think we need to keep that focus on intersectionality and trauma.

MS ELLYARD: May I turn then to the final topic. Later on today the Commissioners are going to hear from the Victorian Equal Opportunity and Human Rights Commissioner and one of the things that she will say is that she is aware of complaints or concerns raised with her office about whether or not the existing specialist family violence workforce responds appropriately to the needs of victims of CALD backgrounds or victims with disabilities, and a degree of concern expressed that the present workforce isn't equipped appropriately to meet the needs of the diverse society that Victoria is.

Ms Maguire, may I start with you and then invite

others to comment. To what extent does the present workforce get resourced or actively trained to be able to respond to people from all cultural and linguistic backgrounds.

MS MAGUIRE: I think the degree to which the present workforce gets resourced and trained to do any sort of ongoing professional development is limited in reality. The point you raised at the very start is you are faced with a client in trauma who is at risk of being murdered or you are faced with going to a day of PD. Obviously this is what you pick. This is what you are resourced to do.

I'm not speaking on individual cases here by any stretch of the imagination, but I agree that there is a need to better support and skill up workforces to take that intersectional lens, whether it is working with women from Indigenous backgrounds, whether it is working with women from a Somali background or an Italian background or Vietnamese.

The concept of CALD is one that white people have made up to articulate a whole range of diversities of experiences, and picking those apart is necessary and useful. But I think the reality is that there's a justification for why that hasn't happened. It is not an excuse. It needs to happen. But it's a stretched system who haven't been provided with the resources and the materials.

In addition, DVRCV is the only RTO who provides training of this nature. We also provide limited training in this space because there is limited training that's been developed and the focus has been very much in the last few years around skilling up a workforce around

things like risk assessment, that's been the primary push, instead of skilling up a workforce around understanding concepts of intersectionality and different experiences of violence. That's integrated through our current training and I understand it is integrated throughout social work degrees, but I think there are much better ways we can do that.

MS ELLYARD: Would anyone else wish to comment on that issue? Perhaps from the child protection experience, to what extent are there active attempts made, for example, to try to make the child protection workforce reflective of the diversity of the families with which that workforce engages?

MS BEATON: We would consider that as part of risk assessment because in fact family dynamics and understanding the family and context is an essential component of your assessment. So it is actually part of the work, and not in an ordinary way because I don't think the work is ordinary at all, but it should actually be part of the work. So it is important that we continue to support that.

We do that in a number of different ways. For example, in the Office of Professional Practice we have a cultural adviser specifically around issues for Aboriginal and Torres Strait Island people. Part of that of course is to help us to understand diversity and consider those sorts of implications at all different times. So we readily use interpreters and work across systems and with different cultural groups around particular families. You can't work with a family without doing those things.

MS JAFFE: I would just also add it also needs to be built into

the organisational systems. The main thing I would talk about would be supervision, because it's great just to send a worker off to training, but if that's not then incorporated into your day-to-day practice and monitored and critical feedback provided if it is not managed well, then there's no point in training, to be honest. The policies and procedures of organisations and the frameworks of organisations need to incorporate all of those elements.

MS MAGUIRE: One of the things that is useful to focus on as part of these conversations - and I know the Commission will be doing this later - is the diversity of the workforce. The reason that there are mostly women working in this workforce is because women who experience violence are comfortable talking to other women, not talking to men. By the same token, an Aboriginal women would be more comfortable in most cases talking to an Aboriginal woman. The same with a woman with a disability. You want to speak to those workers. So, in terms of a future workforce development strategy, making sure that our workforce is representative of the women who are experiencing violence is essential.

MS ELLYARD: But doesn't one also need to take care to avoid the idea that only a Somali worker could respond to a Somali woman?

MS MAGUIRE: Yes, absolutely. It is again guided by the women's agency and choice and preference.

DR ROBINSON: I would echo that. The supervision is absolutely critical for embedding that change into the quality of the work. We need to look at the issues of salaries as well and improving salaries for workers.

MS JAFFE: Yes, yes.

DR ROBINSON: We have very low paid workers doing this critical work. Why is that so marginalised? So, alongside thinking about skilling up, we also need to raise the status and salaries of workers who are doing this really critical work.

MS ELLYARD: Do the Commissioners have any further questions for the panel?

DEPUTY COMMISSIONER FAULKNER: I wanted to go back to your evidence, Ms Maguire, in relation to the core competencies of the specialist workforce. I believe I heard you to say it was largely around risk management, safety planning for people at medium to high level of risk, and then you added you also do that in seeing the broader context in which society condones violence against women, and they both inform your practice. I don't want to leave it on the table not understanding precisely how is your practice different because you have that broader context that you are considering. It comes up a lot in another area I'm quite familiar with which is faith based organisations who claim that their practice is informed by their faith basis. What changes in doing a risk assessment if you are gender informed?

MS MAGUIRE: The risk assessment tools are there and having a background and understanding of gender and the dynamics of family violence, that's the baseline for everyone. Whether you are talking specialist or whether you are talking a HR manager in a workplace, that's the core understanding.

A useful analogy to draw for me is in the mental health field. We would never expect workers who are

working with people who have mental illnesses to think that depression and anxiety can be resolved by just pulling up your bootstraps and, "Just get out of bed and stop being sad." That's not the approach that's taken to working in mental health.

By the same token if you are working in specialist family violence sectors having an understanding that a woman's gender is one of the things that increases her risk of experiencing violence and being murdered as a human being in this country and this society, that is the kind of theoretical frame that's needed to inform practice. If you don't have that, if there is a disbelief or a distrust or if you are not 100 per cent onboard with the analysis of family violence as something that does affect everyone from all walks of life but is gendered and, yes, there are particular people who experience more severe or more frequent forms of violence, then your practice is not going to be as effective as it could be because the risk assessment tools that we currently have now rely on the judgment of professionals, as they should, but if you don't have the right theoretical framing in your head and an understanding that social norms and attitudes and institutional structures have an impact on the prevalence of violence in society, as all of the research shows, if you don't have that then you are not going to give that woman the agency and autonomy and you are not going to practice in the way that is going to be most useful for her. Does that make sense?

DEPUTY COMMISSIONER FAULKNER: I understand it. I don't know that it is the provenance only of specialist family violence services therefore.

MS MAGUIRE: I would absolutely agree with you. It would be ideal if everyone had that. The point I was trying to make by suggesting that is at the moment that's where, broadly speaking, the bulk of the expertise around that kind of socio-ecological understanding of violence sits, within the specialist family violence services. That's not to say that other agencies don't have it. There are individuals.

But at the moment it sits there now and so that's why those services and that's the kind of one of the justifications for a specialist system. Over the long term I think what we absolutely need to work towards is changing those institutional structures and people's individual practices to make sure that everyone has that lens, and then the family violence system in 20 years might look quite different to what we have now.

But the reality is that concepts around gender are really deeply ingrained in who we are. They are part of how we grow up and they are part of how we view violence. So not only in an individual level but in a cultural institutional level it will take time to move towards that shift. But I would agree with you that we should have it across the board.

DEPUTY COMMISSIONER FAULKNER: Thank you.

DEPUTY COMMISSIONER NICHOLSON: Just to follow up on that question. Under this tiered approach, and to put it perhaps in its most simple form, the core competency of the specialist worker is managing high risk and planning for that, and the core competency for the generalist is assessment of risk; is that a fair summary?

MS MAGUIRE: I think the assessment of risk happens, an ongoing

assessment of risk. Yes, management, you are right, of medium to high risk, I would suggest; not only those high risk cases, it is medium to high risk in that sector. At a universal service level or at that kind of third tier it's not really necessarily an assessment of risk but a recognition of risk factors. If you can recognise what those risk factors are then you have the ability to go on and refer to someone who can do a formalised risk assessment. What we do find I think is that people innately do a risk assessment about, "Is it safe for you to leave the office today," for example. "What support do you need to get home? Can you take public transport?" That is a part of safety planning and risk assessment. But it's not the formalised in-depth risk assessment that we would say would sit at that specialist response level.

MS ELLYARD: If there are no other questions I ask that the panel be excused with our thanks and invite the Commission to take a break and come back at 11.25.

COMMISSIONER NEAVE: Thank you very much indeed.

<(THE WITNESSES WITHDREW)

(Short adjournment.)

MS DAVIDSON: Thank you, Commissioners. I will ask that Professor Taft and Professor Hegarty be sworn.

<ANGELA JOY TAFT, affirmed and examined:

<ILANA CLARE JAFFE, recalled:

<KELSEY LEE HEGARTY, affirmed and examined:

MS DAVIDSON: Thank you. Firstly, I will ask the whole panel. There was a question asked before about the analogy with chronic disease and in terms of dealing with family violence. Do you have any comments in relation to that analogy?

PROFESSOR HEGARTY: I might go first on that. I'm currently writing something where I think that the evidence that we can draw from the chronic disease work is very appropriate to the models and also the evaluations that have been done. The chronic disease model is applied in diabetes, cancer, mental health, and I really think it could be applied to this chronic social condition; the early identification, the idea of assessing risk, the idea of needing a team to be able to solve this wicked problem. Of course family violence isn't a disease, it's a social condition.

Particularly I have been advocating in general practice that the chronic disease item numbers of team care arrangements and GP management plans currently don't include family violence workers and don't really include the idea of domestic violence in that. But I think that it's very clear that we could use those item numbers in the same way that there's a diabetic item number, that we could have a family safety item number. So I think it's an analogy that practitioners will be able to understand.

PROFESSOR TAFT: I would just like to agree with Professor Hegarty in the sense that you start with a universal system and then you filter by triaging or, if you like, assessing severity and then pass on within a system that is well coordinated to a next level of intensity in terms of time and effort put in to supporting that person.

I also really support her idea of actually having a Medicare item, if it were possible. I know this is a state based commission, but I think it would be good to support the idea that in some way universal care services and particularly general practice have time to be able to

devote to this problematic issue and actually do that first level of assessment.

MS DAVIDSON: The next question I would ask is what is the capacity of, shall we call them, non-family violence services. We have already dealt with the issue of family violence services. But what is the capacity of non-family violence services currently in terms of identifying and responding to family violence? I perhaps invite you, Ms Jaffe, to talk first about your project in relation to identifying and responding and what you have discovered in the scoping of that project.

MS JAFFE: The north-west region's PCPs undertook a needs assessment in 2014, and over 200 PCPs responded. From the needs assessment it was very clear that there was not a lot of confidence or capacity in organisations to respond or identify family violence issues. They didn't have policies or procedures in place and they weren't that sure of how to refer even into family violence services.

So when I commenced in my role I met with PCP members and they echoed those issues. I was also speaking to other PCP agencies in other regions. They have also said that these are issues within their regions as well. The main issue is that the organisations don't necessarily see it as part of their scope of practice and that there's not also the time for practitioners to necessarily ask the question and feel resourced to do that.

MS DAVIDSON: What about their knowledge of family violence services and what they do and the availability of those services in their area?

MS JAFFE: There was confusion. They weren't sure which websites, for example, to look up; what phone number to

call; which phone number to call to consult or which number to call for refuge or for case management; and there wasn't like a one-stop shop where they could really understand the system, it seemed, and particularly because services seemed to be divided into regions, so then which service within their region was most appropriate. It wasn't promoted or marketed, I would say, enough to mainstream services.

PROFESSOR TAFT: I will speak strictly to primary health care services in this instance as that's my area of expertise, but I would like to draw on a Cochrane Review, which is a review of trials in the area of primary care settings. We looked to see what the response within the primary care setting was to screening. So screening is asking absolutely every patient that comes in the door whether or not they have violence. At the current moment to date the evidence suggests that in fact the asking within a health care setting increases the amount of identification but in fact there is very little referral. I would argue in the 20 years that I have spent looking at this problem the reason is absolutely at all levels of society. That's to say we know from good evidence that health care providers have the same attitudes and beliefs and understandings as people in the general community do. So if people in the general community don't understand why a woman doesn't just leave as they would themselves, then that's what the health care provider believes.

So if we want to change health care provider practice in fact what I understand is that there has to be something at the larger system that tells them in fact this is a role that they should be providing, that their

own professional organisations then see this as a role that they should be doing, that there is adequate ongoing training, that there are resources and support such as Ms Jaffe was describing. Ms Jaffe was describing the fact that they don't know where to go and what to do. In fact I have had practitioners say to me, "I actually can't ask that question because I actually don't know what to do and it is unethical to do that therefore."

There need to be trained resources supported and linked in with that family violence system in a systematic way where they are familiar. I had the astonishing incident once working with a maternal and child health nurse team and actually introducing them to the family violence support system in the same community health centre in which they were co-located. So that that is possible is an indication of where the system is currently in terms of the level of support provided.

PROFESSOR HEGARTY: I think there's a much greater appetite for this. Of course we have talked about it before, but it's probably the Rosie Batty factor as well as some policies. I think there's capacity, particularly for general practice, to take up some of this work.

The World Health Organization recommends universal services just do a very simple thing of listen, enquire about needs, validate experience, enhance safety and ensure support. When I train general practitioners, and I have been doing it for 20 years, they actually get that. They do understand they have other systems, particularly around suicide, so they understand some of the understanding risk and safety planning.

But if we draw on evidence from the work that we

have done with WEAVE, with GPs, and Angela will talk more about MOVE, but essentially we know that practitioners can have more safety discussions from randomised controlled trials if you train them properly. So we do know we can do it. They do need the systems around, and that includes what I talked about the resourcing. It includes understanding the referrals.

There is actually a system now which I haven't talked about at this Royal Commission before called Health Pathways which are developed by the Primary Health Networks, health care networks, and it's a system and it is made for diabetes and mental health and lots of them.

But currently the Melbourne Primary Health Network is actually doing one on domestic violence. I just got asked last week to advise on it. This is simply where that sort of information is put on, but also through to the local resources. I think that this is a great advance, and that Health Pathways is actually national. So once Melbourne makes that then it will be utilised and can be adapted to areas around the country. Many general practitioners are starting to use that system.

COMMISSIONER NEAVE: So it is a computer - - -

PROFESSOR HEGARTY: Yes, it is an on-line - - -

COMMISSIONER NEAVE: It is an on-line information - - - -

PROFESSOR HEGARTY: It is a health pathway for any condition. Do you know it Ilana?

MS JAFFE: Yes.

PROFESSOR HEGARTY: Some of the conditions that are very popular are diabetes and cancer. Advanced care planning is one of the really important ones. They are just

developing up a domestic violence one. I have had a look at the preliminary. It is actually very, very useful. It has that basic element that the World Health Organization - I was involved in developing up those guidelines, and it really has those elements in it, including developing the local resources. Because the Primary Health Networks are the old Medicare Locals, they do know the local areas, they do know the resources and they can keep that updated.

MS DAVIDSON: Do you have a view on who should be prioritised for building that broader capacity within the system?

PROFESSOR TAFT: Yes. I think if you are actually going to take that chronic disease system that Kelsey mentioned earlier, then I think you would start definitely with the universal primary care system.

MS DAVIDSON: Who do you mean by the universal health care system?

PROFESSOR TAFT: When I use the term "a universal service" I'm talking about GPs and maternal and child health care nurses who see every woman in the community. I have focused on both of these primary care practitioners. I will talk about maternal and child health nurses because they see actually now over 95 per cent of all women with a new baby. If we understand, as we do, that women who are pregnant and have infants under five are at greater risk, it's a risk time, then they have a fantastic capacity to actually identify at an early stage.

General practitioners, which I also work with, see everybody. In a way they have a tremendous capacity. When I did my PhD I looked at their role in terms of working with victims, perpetrators and children. So they see the whole family. There are inherent tensions in

that. But it means they have the capacity to identify perpetrator as well and to actually - particularly adolescents who are experiencing violence, but also to ask questions about the safety of children. So GPs have an even greater role and responsibility, if you like. So they are tremendously important.

MS DAVIDSON: Professor Hegarty, do you have a view about who should be prioritised for funding capacity?

PROFESSOR HEGARTY: I would love to say GPs because I am a GP and I train GPs and I think that they do have a great capacity. But I think I'm going to think about children and evidence. I think that we have clear systematic review evidence that parenting interventions and alcohol and drug prevent child abuse. We don't have the same level of evidence for children witnessing family violence, but we know there's a lot of overlap.

I suspect that three areas that I would like to see prioritised, and I will be interested to see what Ilana has got to say, is the alcohol and drug sector, the parenting general family services sort of sector and the mental health sector. They haven't had consistent training, is my understanding, in family violence. They may have had some training about trauma informed care or even child sexual abuse, some of them, in the mental health spectrum. But I find adult domestic violence they have less training in.

So I really think that those three sectors I would target first. They are certainly further down from prevention. They are further down towards higher risk. But I think those sectors we should be really intervening with.

The other thing is earlier you were talking about healing and recovery. We have good evidence that mental health interventions and systematic type reviews are likely to work, trauma informed cognitive behaviour therapy. I find it difficult to find mental health practitioners who actually have an understanding of trauma informed CBT as well as family violence. That's in the private sector that I'm probably mostly operating. There are certainly some good examples in Victoria of state based who have good trauma informed policies and practices like Northern Area Mental Health Service. You have heard from Sabin Fernbacher about that.

So I'm saying that if we are looking across the spectrum if I was going to prioritise I would go for mental health, alcohol and drug and particularly look at - women's needs are often that they say to us, and I know Angela will agree with this, that they want parenting help. They may be still being unsafe, but often they are wanting to interact better with their children.

MS DAVIDSON: Professor Taft?

PROFESSOR TAFT: I didn't actually finish and I should have. The reason I raised the analogy of the system is that I wasn't saying I would prioritise maternal and child health and GPs over the next services that Kelsey has just mentioned, because that's where women who are already abused, we know that they self medicate and that they have serious mental health issues. I would probably put the abortion services in there because my analysis of the longitudinal women's health study is that women who are abused are pregnant at a younger age, they are pregnant more often, they have more adverse pregnancy outcomes, all

of the outcomes, but particularly unwanted pregnancies and abortions.

So, therefore, you should prioritise not one sector of the system but both of those. I don't have the funding decisions that you may well have to make, but I think that if you start with that triaging, actually shifting people out and then referring them upwards, that's very important.

But I'm agreeing with Kelsey. We are just actually starting to do some work. We have reviewed to see whether there are any alcohol interventions where there is evidence that domestic violence has reduced. There is no such evidence currently. We are hoping and people in Europe are hoping to change that.

But certainly that's another opportunity therefore not only to actually reach the victim but also to reach those who are perpetrating and see if they need or would actually accept responsibility and some help. So that's in mental health and alcohol and drugs. You are going to get both perpetrators and victims self-medicating, perpetrators using it as an excuse in a way.

Those with mental health issues, we know that there are a significant proportion of perpetrators who have mental health problems. It would be really good to actually get them at an earlier period and try and get them into dual services.

But the advantage of the universal system is that you can then look at the whole population. You are already filtering right down here those who actually get to those services, and certainly in alcohol and drugs and

mental health you are already filtering out quite a few people who probably could be helped at an earlier stage. That's why I'm saying I don't know where I would prioritise. Both of those parts of the system are really important.

MS DAVIDSON: Ms Jaffe, do you have a view?

MS JAFFE: I completely support both of what you have said. The only other additional comment would be around the integration of all of that. There is an assumption that then all those systems would work together and then solve the issue, which is not happening. There's a lot of discussion around should we have hubs, should we have co-located services, where does specialist sit, where does generalist sit. I think it really needs to look at service coordination, how we are going to be client centred and respond and provide support to the client so their needs are met. Often the client is actually not complex. It's often the system that's complex and how they are trying to engage with the system. The system is funded in all disparate ways and it is not funded in a way that's cohesive to get their supports met.

COMMISSIONER NEAVE: Do you have any suggestions as to how you might do that? Just for the moment let's just talk about within the health system, because of course there are all the other add-ons. But what would be your mechanism for ensuring better coordination, particularly in light of Professor Taft's comment before about the maternal and child health nurse in the same service not talking to the people in the other area?

PROFESSOR TAFT: I can use actually the trial that we have just finished and published called the MOVE trial, which was

working with eight maternal and child health nurse teams which we then had four intervention teams and four comparison teams. The reason I raise that is that we drew on a very successful model that Kelsey and my colleague, Gene Feder, who is Professor of General Practice Research at Bristol University, conducted in the UK in general practice. Basically what that did was to make formal links and MOUs between the primary care service and the formal family violence service.

What we did again was to build on that model and to bring family violence services into maternal and child health, introduce them so they got to know each other. It allowed the family violence service to say what they did, what their processes were and if you referred what would then happen. We are just about to start in general practice tonight in fact with the Indian community with bilingual doctors.

The idea is that then the family violence worker is co-training, and the co-training, which is what Professor Feder did in the UK and we are doing in Melbourne, is actually to say, "Okay, go along to training. You have GP training, clinical training and you have the family violence worker there to say, 'This is who I am. This is what my service does.'" Then they have an ongoing role in supporting a group of practices or teams of maternal and child health nurses. In fact when we did that trial the randomisation meant that three teams had the support of one worker and one team had the support of one worker. The team that had the one-to-one support of one worker was the best in that trial. They did the best; that's to say they identified more women, they referred

more women, although the referrals were still low.

PROFESSOR HEGARTY: Can I add something here. The analogy I again would say is alcohol and drug and mental health used to be very disparate. The dual diagnosis movement, of course there's parts of it that aren't successful. I have been talking about triple diagnosis. But again it's not a diagnosis. But these are different disciplines. We just heard about the sort of paradigms that the family violence sector has. I think there really needs to be a putting them together in one room. Certainly many of the ANROWS projects are about breaking down those silos and so I think we will look to those results. We are doing one on mental health and sexual assault. I think that might help us.

If we look at evidence, though, we tried to as part of the World Health Organization look at whether this idea in sexual assault of a one-stop shop versus a not - we couldn't find enough evidence to be able to recommend whether it was better or not. That doesn't mean that it's not better, but we really couldn't find where people are comparing integrated models. We think co-location is an important thing, but that's a lot of infrastructure to try and get that to happen. So I think some of these protocols, standard referrals, ways of working, getting people together, peer support, co-training, all those sorts of things we know may help.

PROFESSOR TAFT: Can I add one more thing, too. I know I spoke about this to Counsel Assisting, and that is to say there are 101 models of the enhanced maternal and child health nurse currently in Victoria and that needs reform, and I understand that the department is aware of that. But

there could be potentially also secondary referral within maternal and child health; that's to say the universal nurses can do the initial assessment and identification of victims and their children, but pass them on to those who have more time within the system, that's the enhanced nurse.

Then for further support I know there is a very interesting experiment going on in the Eastern Domestic Violence system where in fact they are inviting in the Community Legal Centre. So there are models potentially. But I believe that for a primary care practitioner to feel that they have the confidence and are supported in asking that question they need to know who the services are and what backs them up. They may have not either the time or the interest and they certainly don't have the specialist knowledge to support the victim in more depth. But if they feel that they have the back up and support, the secondary consultation or for debriefing or for preparation, if they know somebody with a particular problem is coming in because they have an ongoing relationship, then I think they are going to be more willing to take this as part of their professional behaviours and are more likely, which is what we saw in the trial, then to take on this task of actually asking difficult questions and following it up.

DEPUTY COMMISSIONER FAULKNER: I think it was Professor Hegarty or all of you have really agreed to say that bringing people together in some face-to-face co-training, coordinated way seems to work and that therefore we can think about the glorious co-location thing, but you can do it in other ways. I think that was the evidence of all of

you.

I still think there is an element there that needs defining which is what is the thing that drives that coordination. I noticed you mentioned pathways and the PHNs. We have someone here from the PCPs. We have a variety of organisations that aim to coordinate primary health care with, in your case, community services in particular. What's needed to facilitate that cooperation if it is not a co-location?

PROFESSOR HEGARTY: I think there are models where the Primary Care Partnerships have worked very well, particularly sometimes around a particular condition or a particular area. It would have to be that some GPs are not engaged with Primary Care Partnerships, even though the Medicare Locals, the previous primary care networks, used to be involved in those.

The question that you had before to someone was, "Why can't we get social work training into undergraduate social work?" We have been campaigning for 25 years for training, for co-training. Until it becomes mandatory in some way for these group of practitioners - and then the vehicle might be a Primary Health Network, it might be Primary Care Partnership. There are examples where you need that regional coordination, more than the regional coordinators for family violence at the moment, in the health system. That could be at a regional hospital level. It could be I think at a Primary Health Network.

There have been good examples of immunisation in Aboriginal, Indigenous, Torres Strait Islander, in those Medicare Locals previously where that has had outcomes. You definitely need an infrastructure of an organisation

to be able to enact this. But for actually something like training - and we have talked at length before I know at the Royal Commission that training is not enough; that we need these systems in place.

We need AHPRA to step up and say that we need child safeguarding. I just don't see how we are going to get it otherwise. It is in the curriculum for training of GPs. I'm less aware about the nurses. But until we get it at a level that is as obvious as diabetes and mental health and asthma - and I think the only way to do that is to try to get it as mandatory to safeguard our children.

COMMISSIONER NEAVE: Just as a matter of interest are there any models in universities of training social workers and doctors, medical students together, for example? That would be quite useful in terms of getting people acclimatised to the thought that medicine has social aspects, I know that's in the medical course now, and the social workers to think of some of the other issues.

PROFESSOR HEGARTY: Interprofessional training has certainly been trialled and attempted in various ways. Often the bureaucracy of the universities get in the way. But I think there's certainly been a push. But I think every inquest I have ever seen has recommended training in this area in the last 10 years, or interprofessional training. But that's never been enacted because there's no teeth to it.

PROFESSOR TAFT: Can I just add that I don't think it's enough. Screening was made mandatory in this state by the Victorian government, that is to say screening within maternal and child health nursing. When we looked at it as it was before we commenced the MOVE trial it was around

the same percentage, that's to say it was screening about 25 per cent of women, which is the same as the systematic review worldwide looking at screening of one kind or another. Mandatory is very important, but you actually need to find a way of supporting and resourcing professionals in an ongoing way.

I think it needs to come at government level, at professional level so that whether it's the AMA or the nursing or the midwifery council saying, "This is a core part of your work, we think it's part of your professional role and you should be doing it," and then the training is ongoing, systematic and for very busy health professionals on-line as well, it needs to be, and all the resources are as well and they are made aware of it.

Our aim in the MOVE study was sustainability of health professional change. When we went back two years later the professional change had gone up in both groups. In the comparison intervention arms they were both screening more. So I would say there's a time element here, but in fact in terms of doing the safety or reporting that they were doing the safety planning in the intervention where we provided nurses more with responses to what they felt they would need in order to do this job better, they were doing it better.

So I'm saying that it's not just mandatory. It's not just waiting over time, but that time helps. If you do get that message, "This is your professional duty of care to do this," and then you provide those professionals with what they need in an ongoing way, then you are more likely to get a sustained behaviour change, which is what I think we should all be working towards.

MS DAVIDSON: You have talked about having a systems approach. I think in the MOVE project you actually developed a tool that was used to assist in screening. Can I ask you to talk about that?

PROFESSOR TAFT: We had a process where we worked with nurses about what their issues were and we had a theory around sustainability. But when we were working together in the developmental part of this project we brought evidence that was growing out in the field that both professionals and women, if it were possible, preferred a non-direct method of being asked. That's to say that if you had a tool that women could fill out themselves, so a self-completion tool where women could fill it out, the nurses said, "That would be good for us because if we weren't having to ask directly out of the blue like that and women weren't having to respond" - women are used to coming into our offices, sitting down and filling out forms. So it's a context in which this kind of thing is going to work.

So they would invite women to sit down and fill out a form where in fact nurses were telling us, "We want to talk about maternal health and not just about the baby. We realise that mothers play an enormously important role." So we were asking about breast pain, back pain, common indicators of maternal ill health after giving birth. Then it asked exactly the same questions that were asked in the CRAF training. But it was for a woman to actually indicate whether or not she was being abused.

What that meant from our point of view in our evaluation was that women could decide whether today was the day that they were ready - because women are all on a

journey and some women aren't anywhere need understanding what's happening to them, some of them are concerned about it and don't know what to do, and some absolutely know what's happening - but they could decide, "Today is the day I'm going to disclose. I trust this nurse enough and I'm going to tick."

Then what the nurses said to us the way that made them feel comfortable, they didn't have to ask that confronting question that many professionals feel difficult with, they were given permission by the client and then they would take the conversation from there. So what we found was that women and nurses preferred it. Two years later 80 per cent of all nurses in our intervention arm were still using the tool. We made it available to the intervention teams as well, and 40 per cent of them were using it.

So in this context, in maternal and child health, it worked. So in other contexts perhaps - and I'm doing a lot of work with Marie Stopes myself - I think in the abortion services that would be a very good method of doing it as well because women come in, fill out a lot of forms and you could do a similar mechanism if people in those services felt that they had the information and back-up as well.

MS DAVIDSON: The Commission has received quite a few submissions that advocate for expanding the CRAF training. What is your view about the CRAF training, and is that an appropriate response and is it a sufficient response?

MS JAFFE: I will talk about what we are talking about, the level 1 CRAF training, which is predominantly awareness raising. I believe that it needs to incorporate some

basic safety planning, predominantly because often a woman will disclose or will unpack with whichever health professional she lands that she is experiencing family violence but may not be ready to uptake services. From speaking to services, that can take anywhere from weeks to months for her to potentially make that decision, to even make that phone call. In that instance no-one is safety planning with her. I think that because this professional has the skills to engage and has obviously been able to provide a safe space for her to disclose, by osmosis they should be able to safety plan with her in that instance.

I also think that there needs to be a degree of risk assessment as well because if it is high risk they need to know to call police. They should have capacity to do that. I guess part of this is also around time. My understanding is a lot of health professionals don't want to ask this because they don't feel they have permission to spend that amount of time. So I think a lot of that comes from organisational systems to support practitioners to say, "I'm going to push back all my other patients and this is something that I'm going to prioritise and that I have the skills to do that."

PROFESSOR HEGARTY: But I think we can also teach them to understand risk to some level, and they have to understand risk because they have to work out who is higher risk and who needs the specialist response. That doesn't mean they will always get it right. I have taught it and I have also taught a very limited safety plan around, "Have you ever thought about where you would go, how you would get out of the house if things were escalating? Things sometimes do escalate. What is your own opinion about

your current safety?" There's a fairly standard way that practitioners respond to.

It doesn't have to take a whole lot of time because the joy in general practice is often you can get someone back, and in maternal and child health nurses the same. It's not a one-off. It's different obviously in emergency departments.

The common risk assessment, I don't even like the term because "risk assessment" doesn't say "management" as well. I think that we get caught up with risk to the exclusion of actually listening sometimes to what women are saying is their greatest need. So that's why I like thinking about understanding risk. I liked how Emily Maguire talked about it before where she was saying it's about understanding risk and planning for safety and, if it is complex, getting them to someone who is a specialist in that. I'm not treating heart attacks. I get them to the cardiologist. But the current CRAF training has not obviously been informed enough by universal services because you cannot just identify and refer everybody, which is sort of what the level 1 - the basic CRAF training.

I think that the four tiers that Ms Maguire articulated before are very clear and they do need different things. So that element of the CRAF training is actually really good. I just think that they perhaps have got parts of the universal service wrong.

PROFESSOR TAFT: Can I just add to that, and I would agree with both my colleagues here. One of the things that I have always found problematic about CRAF training is that it is one-off. I think I couldn't emphasise more how the

feedback that I have had from nurses and doctors is that the training has to be regular and ongoing. So there has to be continuing professional development and it does beg the question of where the training is started, and I won't cover that.

But the other thing I want to say is that both GPs and maternal and child health nurses and people in the universal system, they see women in really serious situations. Because women are afraid, because they are on a journey, and they could be anywhere on that journey, anywhere at any stage of change, sometimes they don't - and we know the evidence is they don't - want to be referred. So in fact there is not a choice. I have spoken to nurses with guys out the front with a rifle over their knee in serious cases. They need to know how to manage serious cases, and they need to know how to manage when the woman doesn't want to leave them because she trusts that person. She knows that person. She has an ongoing relationship. She is not yet ready to move on.

So in fact some great work that Kelsey has done about some sort of brief training about how to sit with motivational interviewing in order to give a woman - to bring a woman along to feel confident enough to take another step and go off to specialists is also very important. I think that CRAF training needs to be ongoing and developed with the idea in mind, and this is where both of us found that in the current training there wasn't a good understanding about stages of change, about sitting with where women are at. We had a lot of nurses in a prior study that I undertook indeed with Kelsey called Mosaic where the biggest thing that the nurses came back

with was they weren't happy to sit with women who wouldn't take their advice about leaving. So they weren't comfortable with sitting with the problem. That kind of training and the need for that is abundantly clear in the work that both GPs and maternal and child health nurses do.

PROFESSOR HEGARTY: We are doing some work obviously with early identification of perpetrators in general practice and the lack of evidence in that area. But I think this focus for any risk assessment and management or understanding a first-line response and where you would go needs to be for women and men and children, and so developing up ways of talking to children as well, and obviously the safety and confidentiality and all those things. But we currently don't have a statewide approach to early intervention with men who use violence and children exposed.

COMMISSIONER NEAVE: I was just wondering whether there is any mechanism for identifying a perpetrator. You might do it through some of the things that the woman says, but if you only see the perpetrator - - -

PROFESSOR HEGARTY: The little amount of information that we do know is that they often present very similarly to the women. So they present with mental health issues, alcohol and drug issues, chronic pain. Sometimes their partner has said, "You go along to the doctor or else I'm leaving." It's obviously not a high risk situation when they do that. Sometimes they come in saying they have anger problems. We have only a small amount of evidence around that, but that's that.

In fact what you use is very similar techniques to what you would utilise with the women. Where is this

man at with where he is recognising that what he's doing is damaging or not? Is he actually recognising that what he is doing is abusive? Does he have any motivation to change? It's using some similar techniques.

None of that has been trialled in randomised controlled trials. We are going to do that soon if we can get the funding. But it's a response that people have used with men who drink too much or men who do a whole range of other things. So I think the principles are there. We just don't have any current randomised controlled trials.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: The other issue that's been raised is assisting with recovery, not just getting women and children safe but assisting with recovery. What is your view about incorporating some of that within what those universal and specialist non-family violence services might be able to do?

PROFESSOR TAFT: I was going to say that really in terms of the evidence that I have seen or we have both seen I think in the United States around trauma informed care that that's certainly, as far as I can see at the moment, the best evidence based approach to women and children. In terms of what's going to help perpetrators, I don't think there's good evidence yet. There was some evidence in America by a guy called Ed Gondolf when I looked at it many years ago. Of the people who stayed in the men's behaviour change groups, and they were always looking to find out from partners as well whether women were feeling more safe or that their lives had improved in any way, for 80 per cent of the women of the people who stayed in that

training they did say that they felt better about it.

So there's limited evidence. I think it's very important, the emphasis that Kelsey has been giving on children and on parenting. We both were recognising that some time ago, that women were asking for parenting support because it really mattered to them.

I think that of the little work that I have done with perpetrators many years ago and with No to Violence what I understood from the men who ran the behaviour change groups was that when you said to the men, "Do you want your sons and your daughters to have a similar experience to you," that was the point at which they were motivated to make change. So that kind of motivation can often be for women when they decide to go and for perpetrators when they decide to take some action. So there is some limited evidence.

In terms of whether it is appropriate in the universal service, certainly from a maternal and child health service I don't think that's an appropriate role for them. However, the role of the enhanced nurse, which has yet to be developed and made consistent in Victoria, there may be some role for that nurse to work with therapeutic services.

PROFESSOR HEGARTY: I think there are two keys to it. One is the relationship. Sometimes that has to be me because I can't find an accessible, affordable mental health practitioner who is trauma informed. Hardly any of them bulk bill. To get them into the state based services - you know. So I see women week after week. Really what I'm doing is doing holistic women centred care to the level of my ability. But there are other GPs who

do a lot of this work as well.

I draw on an intervention developed by the Canadians. The Canadians and the New Zealanders do clever things, don't they. They have developed one thing called "I heal". It's just a dimensional thing to it. So really you are looking at physical and mental health. Safety is one aspect, but also housing and finance. I find I can't work with someone if they haven't got stable housing. I can't work with someone if they have zilcho money to be able to afford shoes for the kids or whatever. I do work with them, but I find it hard to work on their healing and their mental health when their physical safety and physical surroundings are so bad.

So connecting to financial services, to parenting services, all those things I think we need a very holistic idea of integrated care. That's hard to do, I know, but I think that we need to draw those in. So the healing happens through, I think, trusting ongoing relationship where you look clearly.

As I said before, we have evidence that cognitive behaviour therapy trauma informed does actually work for women who have left the relationship and who have a diagnosis of post-traumatic stress disorder. But that seems to be a no-brainer. If you actually give people treatment for their condition, they improve. It's finding that sort of care that I struggle with.

PROFESSOR TAFT: I was going to add we are just starting this trial that we are starting tonight, it's only a pilot, but the idea is that there is a partnership between bilingual GPs and bilingual advocates, and the idea behind it is that there is this ongoing relationship between the health

care practitioner and the advocate and the case worker advocate. Kelsey was describing about not being able to provide care if that person is homeless. In this case we will be particularly looking at immigration status and visas and things being very uncertain there. That's the role of the case worker advocate, but there would be an ongoing discussion and feeding back to the GP about where it is at and supporting her or him and the work that they are doing by providing those extra supports to the patient. We don't know whether that's going to work, but that's what we are going to try and see how it works. But it's certainly worked in Gene's trial in England.

MS DAVIDSON: Professor Taft, you mentioned the possibility of some on-line training. I think, Professor Hegarty, you are working on a self-assessment on-line tool. Where do you see this sort of technology as potentially assisting and building the capacity of a broader workforce to identify and respond to family violence?

PROFESSOR HEGARTY: There's not a lot, but there is on-line training in this area. The Commonwealth has funded DV Alert and just enhanced that by 14 million going to be given to expand DV Alert, which is a training program for health practitioners that I don't think many health practitioners know even exist. So I presume that part of it is training, and that's supposed to be for police, social work and emergency department. I know they are going to work with the College of GPs and the Commission has certainly heard me talk about the College of GP program of education in this area.

So the training is there that people could access. The problem is getting them to access it and

getting them to do it. As I have said, unless we decided somehow to enact legislation that made - not legislation, but made it that it was mandatory training.

The tool is a different thing. So the tool is an on-line healthy relationship tool and decision aid. It does some of the motivational interviewing I just talked about on-line. So it's like e-mental health and it's the beginnings of us trying to develop up e-family violence. It's currently being trialled with 400 women. We are at the six-month outcomes. Essentially we advertise for women who are afraid of their partner or who feel that their relationship is unhealthy. They go on-line. They self-reflect. They self-manage. It is similar to other on-line things for any other chronic diseases, actually.

So we are hoping that will particularly work where a practitioner mightn't really want to do some more of that motivational interviewing or the work or they don't feel capable. There's a lot of younger practitioners using apps and things to give to patients. So that's one avenue for it. We also see it as being involved in the 1800 Respect perhaps or DVRCV's on-line materials for women. We are also wanting to develop one for men who use violence. So I think the on-line space can either work with the practitioners or it can actually work as an alternative in an on-line hub for a response.

But the evidence for this in e-mental health is growing. So I see no reason why it couldn't work here. We haven't got chat rooms and therapeutic delivery by a practitioner, but certainly for young people this is the direction to go.

PROFESSOR TAFT: Can I just add to that. One of the things

that always occurs to me, because I'm very happy to be part of this team, is that women are often isolated. Not everybody goes to professional services, we know that. Therefore to have something for isolated rural women, in particular I think women with disabilities, because we know they are at greater risk, that having that potential is very important.

I would just like to add in terms of training that health care professionals are very busy and getting them to make time to go to training is difficult. Having on-line resources and training available is a very important option because often they will do it in their own time, in the evening when they go home or in their car on the way home. I can't say they are more likely, but there is the capacity to listen to it.

So I think it's very, very important. But I really, really echo Kelsey's point that, unless this training is made mandatory and made a part of professional training for any primary health care professional in particular, but also in those other areas we talked about, mental health, drug and alcohol and abortion services points - it should be because there's going to be a significant proportion of the people that they see whose problems they are trying to fix whose underlying problem they are not addressing. So my view would be and my recommendation would be that training in family violence would be mandatory for those people and that there would be ongoing on-line support for them to be able to access it in an ongoing way, as many of them have asked for.

MS DAVIDSON: You have identified the need for the back-up support, the family violence services. Ms Jaffe, you

identified in your scoping work practitioners may not even have known who the family violence services were or what they did. What do you see as being improvements in that sort of service system to help support the work of universal and specialist non-family violence services?

MS JAFFE: My experience of managing co-locations is that you have to have good standards of the worker. The worker needs to be very senior and the systems need to be in place to support the integration of that worker into the team, and then the referral back into the specialist service, as well as the coordination with other auxiliary services. It also needs to be funded. It shouldn't be coming out of current EFT.

I do think there is a space for that, to have specialist services located in universal services to support the universal services to do the work and to act as a consult, and then to help them make assessments if they do need to be referred on to specialist services.

Then also you get that integration of cross-referring, so having women and specialist services being able to have a better pathway into health services because of that shared relationship. It's multifaceted in how you make sure that those systems and mechanisms work. What we don't have at the moment is good standards for how to manage a co-location, because then you get an instance like what you discussed where they are not talking to each other in the same building. So we need to also come up with standards around the level of seniority of the worker and the years of experience, how the management team work together and work collaboratively, and how the teams are integrated within each other, and then also what sort of

ongoing professional development is delivered for both teams so that they are able to cross-refer.

MS DAVIDSON: Professor Hegarty or Professor Taft, do you have any views on what needs to happen with the family violence sector in order to support the work of those - - -

PROFESSOR HEGARTY: Yes, and I'm really going to talk about general practice. You can't have co-location with general practice. There's too many of them. But certainly the idea of an outreach worker that managed an area - not the overworked outreach services that currently exist. I'm clearly saying we need more specialist family violence services that we can interact with. They need to be funded better. They need to have standards and the training as discussed earlier. I think that that would be such a good thing to happen. The same as there might be a diabetes educator that services a whole set of general practices, you could have a family violence advocate, and Angela will talk more about that.

The second thing is you need these on-line things. So I can search the Australian Psychological Association and I can find psychologists in the area and what they are specialising in. It's almost impenetrable, some of the family violence services. Mental health services are similar sometimes. So I think that we need a clear on-line way that we can get to see who are the services, where are they in our areas. Currently that's not available.

I think the Health Pathways model, because it is a centralised model for all health pathways, I think could be a really - I can send you more links to that, yes.

PROFESSOR TAFT: I don't have a lot to add to that except that

I would say that I would echo what Kelsey said. One of the common things when I went to interview GPs was they would say, "Yes, but it takes forever to get into a family violence service. It just takes too long. Therefore I have to sit with the problem." I am echoing that I actually think that it needs greatly increasing.

Because I have a particular interest in migrant and refugee communities, I think also that we need to make sure that we reflect the diversity of families that we have here and make sure that we have multicultural family violence services sufficiently able to respond to the level of need that is increasingly becoming apparent.

I would like to add one more thing in terms of the system. One of the previous studies we did was around peer support particularly for mothers experiencing violence. The way that model worked - it was a model called Mosaic - was community women were recruited for their particular qualities of non-judgmental, empathetic women, but they were given particular training and support and coordination by a very experienced senior coordinator.

We had to test it in terms of the funding that we had at a regional level. I think they could be in every local government. I say that because when I went to talk to the maternal and child health nurse team, even the enhanced nurse, the way enhanced nurses were funded at the time, said, "Oh my God, I'm only funded to do six additional visits with each family and that's not enough. How wonderful it would be to have a volunteer who was given some funding for her travel who could actually follow up and we had that person available to support the mother for a year." Amongst the women that we supported

there was at the end of the year less abuse and less depression.

So I'm saying that part of that system can be the professional system, but I recognise that we are probably never going to be able to fund it to the level that we need and we should think about and consider whether a volunteer system supported by some limited funding plus a professional coordinator mightn't be an additional resource. It's been tried also by I think the children. Cathy Humphreys tried it with the child protection Services. So it's a model worth thinking about as a support to that system.

MS DAVIDSON: These are family mentoring kind of models, are they?

PROFESSOR TAFT: Yes. It was mother to mother. It drew on an American trial called the Madres Project where it was mother to mother peer support. Those women needed to have a whole lot of safety mechanisms. We gave them mobile phones so they didn't use their own. We gave them professional support. They had a regular six to eight weeks - they all came together and shared the strategies they were using and responded to training, so some ongoing training. But it was, I believe, a useful model to look at.

MS DAVIDSON: In terms of implementing some system, how important is it? We heard from the New Zealanders in relation to implementing the Violence Intervention Program about evaluating as you go along. They had trialled it for quite some time in a system of sites before it was rolled out across New Zealand. How important is it to monitor and evaluate what you are doing and assess what

the outcomes are?

PROFESSOR TAFT: Absolutely critical. Screening, which is one of the kind of reflex actions of government to say, "We will put in screening," people think self-evidently it's going to work. There is a great level of evidence that it doesn't. The only way we are going to know whether we are being effective or not is to actually put in good data systems and make sure that they are consistent and trained. I know that the government is looking at that within maternal and child health. But we do need a way of monitoring and evaluating.

The truth is with maternal and child health that we also need - and there is a system that they use to monitor what the outcomes are for women. We need to know if they are safer. We need to know if they are comfortable with it. We did an initial survey with 10,000 women. With contemporary women you (indistinct) so we got a 26 per cent response rate. But even then the level of violence amongst those women was I think significantly high.

But I think that within the maternal and child health nurse system they regularly send out surveys asking their clients what they think. So I think we need to monitor and see whether professionals are doing what we have trained them for and what we have asked them to do, and then we need to see whether it's making a difference to the women. That's bottom line; that's what we are trying to do within this system. So good data and good evaluation and monitoring, and ongoing monitoring is essential.

I would like to say one thing about the way the

New South Wales government are going about because I have a problem with that. New South Wales, in terms of their health care system, they have a month. So November is screening - is evaluation month. So everybody knows that November is evaluation month, and so they all do better, I believe. They have just released something where they have looked at it over a year and the screening rates are 35 per cent if you look at it over a year. So it has actually got to be systematic, ongoing monitoring, not a one-off effort.

PROFESSOR HEGARTY: Can I add three quick points. It needs to be at all levels. So it needs to be quality assurance, it needs to be evaluation. We need proper research as well. We are going to put a research excellence centre, the NHMRC - you know, we need it at all levels.

The second point is the New Zealanders have a lot of online audit tools and a lot of material, and they have been doing it for a long time. You need all of those easily available for people to be able to look at and use.

The third is the point that Dr Robinson made earlier about how we need to talk to women about their outcomes. There's also a UK group talking to children about what outcomes they want to see from things. I just think we need to concentrate on that.

MS DAVIDSON: Finally, the Commission heard about the Violence Intervention Program in hospitals in New Zealand, which combines child abuse and intimate partner violence. In their evidence they talked previously that the programs that have been rolled out for developing the capacity of the health sector needed to be understood in the context of the national "It's Not Ok" campaign.

We heard quite a bit more about that campaign yesterday, which included messages that it's not okay to use violence, it used a lot of messages directed particularly to men that it was okay to ask for help, but also to women that it was okay to ask for help, and finally the idea of building the sort of capacity of the community to provide that help, including either to help victims or to influence perpetrators. It was supported by some resources about how to provide help, including the idea of not sweeping it under the carpet and not swooping in and saving the day.

They identified in relation to their Violence Intervention Program that that was a critical part to supporting the role of the health sector. Would you agree with that kind of approach, that the Commission shouldn't be examining how you develop the capacity of the workforce in isolation from other areas of perhaps reform and public awareness campaigns?

PROFESSOR HEGARTY: Yes.

PROFESSOR TAFT: Yes.

MS JAFFE: Yes.

PROFESSOR HEGARTY: Because what we have seen this last year, where basically there's been an awareness campaign through the death of Luke Batty, has had the most immense effect on every practitioner I meet. As to validating why I have researched it for the last 20 - they sort of suddenly get it. So of course it would be enormously helpful. My understanding is the Commonwealth government has put 30 million aside for some sort of social campaign, I think.

PROFESSOR TAFT: Can I just add one of the things - I think

I made the point when I first started, which is that health care professionals have the same beliefs that community attitudes have. I know that there's been a monitoring by our Federal government of community attitudes and by VicHealth, and you can see that people now actually are understanding that violence is more than physical, et cetera, et cetera. So I think I'm just saying "yes", basically.

MS DAVIDSON: So if I just summarise some of the messages for the Commission that's come out of your evidence, it's not about one-off training; there's a need for a systems approach; building capacity in those universal and specialist services isn't a project that's done in isolation from the other parts of the system and reform that the Commission is looking at; and the importance of data outcomes, monitoring and evaluation. Is there anything else that you would emphasise to the Commission?

PROFESSOR HEGARTY: Listening to children and responding to children.

PROFESSOR TAFT: Actually I would say the whole family. I would say victim, perpetrator and children - I think to have that approach. I think we are only just beginning to understand how we might intervene with men, and, let's face it, they are the issue for the large part, not only. So offering men who abuse - for those that are willing to accept it - some hope and some therapy, management, something, is an important part of it as well. So there's the whole family - a whole family approach, a cultural diversity approach, and the system that - that idea of the system of being universal at base and then filtering up and that there are specific services that those specialist

services that have a very important role to play and recognising that and supporting it.

MS JAFFE: I just support exactly what you both said.

MS DAVIDSON: Do the Commissioners have any additional questions?

COMMISSIONER NEAVE: No, we don't.

MS DAVIDSON: I would ask that the witnesses be excused and we will resume at 1.30.

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

<(THE WITNESSES WITHDREW)

LUNCHEON ADJOURNMENT

UPON RESUMING AT 1.30 PM:

MS DAVIDSON: Commissioners, I would ask that the panel be sworn.

<KATHRYN PRIOR, affirmed and examined:

<MARY-ANNE MICALLEF, affirmed and examined:

<REN GRAYSON, affirmed and examined:

<JANE WILLIAMS, affirmed and examined:

MS DAVIDSON: Perhaps I could get you to start, Jane, and tell the Commission just an overview of the Services Connect model that is currently being piloted in the north-east region and what your role is within that model.

MS WILLIAMS: I'm the Partnerships Manager for North East Services Connect. Services Connect was initially developed as an internal service or an internal program within the Department of Health and Human Services. It was designed internally to bring together child protection, youth justice, disability services and housing services, and kind of bridged the gap between the internal programs and externally.

Now that it's in the community, North East Services Connect, there are eight partnerships. Services Connect partnerships all across Victoria at the moment. It was a competitive process, and North East Services Connect has 15 primary partners. Each Services Connect partnership operates slightly differently, as per their submission that they put in.

Our Services Connect model runs as a co-located model. So we have 15, as I said, agencies that are primary partners and external secondary partners as well that refer into our program. Our 15 key workers have been relocated from all of their home agencies. So that

includes services such as - we have got disability programs, youth programs, mental health, drug and alcohol, family violence, family services across the board. We are all located in one hub in Heidelberg, and we work across the Services Connect platform.

MS DAVIDSON: Could I turn to you, Ren, and ask you to identify what your role is within the Services Connect and what your role is back in your home agency.

MX GRAYSON: Yes. I'm from YSAS, which is the Youth Support and Advocacy Service. So I'm a qualified youth worker. All the workers from different partner agencies bring their own specialty. So I specialise in working with young people. So my role is a key worker. So I'm a key worker for North East Services Connect. So I work with a broad range of clients now, not just young people. My role with YSAS is around early intervention and diversion for crime. So I'm not sort of doing that work for North East Services Connect. I'm doing all client work, so working with adults, working with families, sort of any issues that come up. It's been a nice change and a challenge. That's my role.

MS DAVIDSON: How many days do you work at Services Connect and how many back at YSAS?

MX GRAYSON: Good question. I'm doing 0.5, so I split my time between YSAS and North East Services Connect. I think some workers are doing full time. That's is just sort of what my home agency has done. It has been quite good, though, working both the roles as well. I can still have time with my home agency, and then build rapport and things in North East Services Connect. So I feel quite connected to both the programs now, which is a really nice

feeling.

MS DAVIDSON: Can I move to you, Mary. What's your role within the Services Connect?

MS MICALLEF: I'm a key worker with Services Connect. My home agency is northern family violence at Berry Street.

MS DAVIDSON: In terms of your background, what is your background?

MS MICALLEF: I'm a social worker, and I have worked in the field of family violence and sexual assault for more than 20 years.

MS DAVIDSON: How many days are you spending at Services Connect and how many at Berry Street?

MS MICALLEF: I'm doing one day a fortnight back at the home agency.

MS DAVIDSON: Can I turn to you, Kathy. What's your role with Services Connect?

MS PRIOR: I'm the Deputy Director for Berry Street in the north, and we are the co-leads with CPS of the Services Connect partnership in the north-east. So I have kind of an executive function sitting within the partnership. I also happen to have an executive function over our family violence team at Berry Street.

MS DAVIDSON: Can I get one or more of you to explain what the key worker model means in terms of how you deliver services to clients?

MX GRAYSON: My understanding and how we are sort of using it in North East Services Connect is the key worker is the worker for - it could be a single client, it could be a family. You could be working with a family but having sort of different goals. So it's basically around what the client works. So not telling them what you think;

it's sort of about what they choose to work on. So it's a very client-centred, client-driven service. So it's around their presenting sort of needs and what they want to actually work on.

So it's been really cool working in that model around achieving goals that clients want to do, not just doing things that you have to do for assessments and things like that. I found it a really successful way and a really empowering way to work with clients. We are seeing a lot of really good results, and we are getting a lot of positive feedback from clients around feeling - a lot of it is just giving them a really good service provision as well, I think, like building that rapport.

Sometimes we do a bit of the managing other services as well, so it might be around organising care team meetings or just figuring out what's actually going on for a client or - like linking them in with other services that might be specialists in that area.

DEPUTY COMMISSIONER FAULKNER: Can I just clarify. How does a client get to you? Are you just taking them as an intake in random order, or is someone matching someone to you or?

MS WILLIAMS: Each different Services Connect partnership has a different way of doing intake. The way that we do our intake is we have our own intake function. So our key workers are all on a duty system. So someone can refer themselves via our website or via calling our phone number and make a referral for themselves.

Our primary partners, for the 15 agencies that have re-aligned a key worker, can make referrals to us as well; or external partnerships, so external partners or external people, so GPs or schools or anybody, can refer

into us as well.

DEPUTY COMMISSIONER FAULKNER: How does Ren get the particular person that they get?

MS WILLIAMS: It's random. The idea is that, although Ren's specialty might be young people, Ren might get a drug and alcohol client, and then the onus would be on Ren to speak to the specialist drug and alcohol worker in our partnership and consult with them around what would be the best method of working with that particular client.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MS DAVIDSON: We previously heard from a couple of other Services Connect pilots that the key worker model effectively means that as a key worker you no longer work solely within your specialty; you effectively lose that specialty and you are expected to develop the ability to work across all of those areas and specialties that your Services Connect encompasses. Is that a fair reflection, do you think, of the model?

MS WILLIAMS: I don't think you lose your specialty. I think you keep your specialty and you use that specialty to upskill the other key workers within our partnership. That's definitely the way that we would view it in North East Services Connect. So it wouldn't be that - if Ren's specialty is young people, then people would call on them to use their knowledge and then it would in turn increase the capacity for them to work with young people in the future if they were to get that kind of a client next time in the random allocation process. So I don't think they necessarily lose it. I think that they gain additional skills on top of that.

MS DAVIDSON: But there is not the expectation that Ren will

just deal with young people or that Mary will just deal with family violence clients?

MS WILLIAMS: No, that's not the way that we do it.

MX GRAYSON: I think the point is to get different clients with different issues, which as a worker can be a little bit scary. You might get a client with lots of different issues that you might not have heaps of knowledge in. But we all have a base skill set, like I'm a trained youth worker, Mary is a trained social worker, we have very similar skills but it's just sort of where your knowledge sits. So it's about having access to other workers that might have a wealth of knowledge in that area and getting some support.

We do joint first visits, so being able to go out with - if your client, say, has a disability, being able to go out and get support from a worker from a disability background so you can best support that client. We are not saying we specialise in everything. We are saying that we are going to do the best that we can with all the knowledge we have to get the best service for that client or that family. I just think the wealth of knowledge that we have from all the 15 different services, like, if you can't find it there, like, you know, somebody always knows the answer, which is really cool.

MS MICALLEF: It is an amazing way to enhance your skills.

MS DAVIDSON: In terms of your own experience, Mary, how do you see that working in the Services Connect model has enhanced your skills?

MS MICALLEF: For me, it's - the way I describe it is that I'm getting on the inside of the other services, so that you are not knocking on the door all the time. You are

getting inside and learning a lot more about how the particular service systems work and how you can impact and create networks and move things along. It's just an amazing opportunity in that sense. So, if it's an amazing opportunity for me, that relates to the people I work with.

MS DAVIDSON: What then does it mean for your home agency and your work and your home agency?

MS MICALLEF: I take that knowledge to my home agency and enhance - it's sort of creating a new partnership in a way of, you know, when these things are happening we can transfer, and it's a two-way process.

MS DAVIDSON: Does that improve your ability to refer to other services when you need to refer, do you think?

MS MICALLEF: Yes, I do, yes, because there are points when we - if it is high-end crisis work, that's not what we are going to do. So when we have the connections we make those referral paths easier.

MX GRAYSON: I think it's just about knowing some of the other options that are out there. In the sector it's sort of all about who you know and even knowing about a program or a service. You can't know everything. So it's been really good to just have those connections about a cool program. I find myself at my home agency now being able to offer more information or a referral for - because we only work with young people, so being able to offer referrals for parents so that they get adequate service as well, and it's things like that, just sort of I think giving our team a bit more capacity as well to do what we can with the people in the community that we are working with.

MS PRIOR: One of the other things, and the north-east partnership in particular in the early stages and to this day accepted referrals without any kind of eligibility, and Services Connect, that is the model. It shouldn't be about meeting eligibility and threshold criteria. But in the early days in particular it was just, "Flick the referral in. We will have a look at it and see what we can do." I think that's the beauty of - wanting to get a service or a service type in a different model has actually created greater throughput in some respects because they don't have the eligibility criteria necessarily in place.

MS DAVIDSON: Can you tell us about the eligibility criteria that apply within the various services and how that impacts upon clients and their ability to obtain a service?

MS WILLIAMS: Do you mean eligibility criteria for - - -

MS DAVIDSON: Not for Services Connect but the way that it works in other areas - - -

MS WILLIAMS: I think the difference would be that we don't screen people out. We screen people in. I think some of the barriers to accessing services is the way that other services are funded is it's a particular type of client that they need to see. So they need to see women or they need to see families or they need to see men, or they see all of the above or none of the above, whereas we don't have those criteria.

I think that sometimes people will - referrers will maybe add things to referrals to get people into a service type, so maybe make things bigger than they are because that's what the specific referral criteria may be,

that they have to be in crisis or that they have to be over 18 but under 21. There's all those kinds of parameters that make it really difficult; whereas we have tried to break that down and have none of them where possible. I think our only criteria is the clients can't be at immediate risk of crisis, because there's obviously specialist services to manage that and we are not it, or if housing is their primary and only issue, which is hardly ever the case, then we don't have access to housing. But we could definitely support people while their housing application is in progress, and that's when we tend to find that there is a multitude of other issues surrounding the housing as well.

COMMISSIONER NEAVE: Can I just sort of tease that out a bit. So I present. I'm a 17-year-old drug-using, pregnant young woman who has a problem with family violence, but it's not sort of an immediate crisis - perhaps it should be in those circumstances. So I present. I'm randomly assigned to a Services Connect - one of your key workers, who will then help find the services that I need or provide them themselves?

MS WILLIAMS: They would provide as much support as they could within the context of what we are able to do. So the idea would be that we would provide - being able to consult with the other - with the drug and alcohol specialists, with the family services because of the pregnancy - you know, with the relevant other key workers. The idea would be that we would provide as much support to that person so that they would only have that one point of contact so that there wouldn't need to be a drug and alcohol worker and somebody for the family services, somebody for the

family violence, that there could be one person that could be that provider for that young person.

MS PRIOR: And help navigate the system, I think, as well.

MS WILLIAMS: That's right, and make referrals where appropriate if they are not getting proper antenatal care or postnatal care hasn't been set up for after the baby - all of those kinds of things would be explored, and we would use the tools that we use, the key workers use. So the initial needs identification would go through and work out exactly what it is that this young person wants to deal with, because that's the other thing, that you may present - I may see all of those issues as issues for you, but you may only want to work on the fact that you have drug and alcohol issues. You might not want to look at any of those other factors. We would work on the issues that you wanted to work on, not the issues that we may identify. We might have some discrete conversations around the other things that might be going on for you, but we wouldn't necessarily push that if that wasn't what you wanted to work on at that particular point in time.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: Can I ask you, perhaps, Ren, as a person from a service system or a specialist family violence service, how has working in the Services Connect model that includes a family violence specialist helped you deal with family violence cases, and have you yourself had to deal with cases involving family violence?

MX GRAYSON: Yes. Like I was saying before, I come from a youth background and from one of those services that we have a very strict eligibility, like 10 to 17 have to get a referral from the police, that sort of work, and they

are our only client. Like I said before, it's been a challenge but it's been really interesting working in this model and having different clients, from adults to families, and where I would previously have said that I probably wouldn't have felt that confident around working with family violence because I didn't have the specialised kind of skills and things like that that I would have felt adequate to be able to give them the best service I could.

But I think working in Services Connect we have done the CRAF training, I have the ability to talk to specialised family violence workers, I have done home visits with Mary and things like that to get advice on how to do IVOs and things like that for clients. So now I don't see it from a worker's perspective as being really scary and being that I can't work with that.

On my case load now I have quite a few families that have a family violence history or presently, and I feel quite competent to be able to at least access good referrals, have knowledge around IVOs, safety risk sort of stuff. So I'm not saying I'm a specialist worker by any means, but I feel competent and confident to be able to work in this area, whereas previously I wouldn't have said that. That's been my experience.

MS DAVIDSON: You, Mary, as a specialist family violence worker, how has it enhanced your skills to work in other areas like alcohol and drugs, and mental health? We have heard that family violence and those three often co-occur. How has this model helped you work with those sorts of problems?

MS MICALLEF: That's exactly spot on, that when there's family

violence there's often many other complex issues, and having those workers right there to work with and consult and support you has been an amazing experience. As I said before, it means that my practice skills are higher because I'm more confident and I have that support. So I bring that to the people that I'm working with. I just feel like it just really works, absolutely.

MS DAVIDSON: The Outcomes Star - you talk about a client-focused or client-driven model. What do you mean by being client driven, and how does this differ from perhaps the work that you would have done previously?

MX GRAYSON: I think it's been really interesting, this model, because I think a lot of workers would have previously said, "We are very client driven, very client focused," but then in this model you are like, "Actually, I wasn't as best as I could be." So I think the Outcomes Star has been a really cool tool to use. So it sort of goes through different parts of a person's life with them and you get to rate sort of how things are going, like whether it's around money management or whether it's around drug and alcohol, or things like that. So it's sort of like that holistic model, and - yes, like getting the client to score what they think of their life, and then a lot of the time I use that as a bit of a plan afterwards. It's not like one of those scales where it all looks really negative. It actually is quite a nice experience to do the Star, I found, with clients.

Like Jane was saying, it is just about the goals that they are presenting with. We are not coming in saying, "You need to do a drug and alcohol stay and this and that." It's sort of like, "Okay, you want help with

employment. That's what we are going to do." But I think it's that rich sort of stuff around building rapport with clients that opens up the door for other things. Like, some of the clients that I have worked with might have only said, "I want to get my child into child care," but then all these other sort of things have come up as well because we are not that scary and we just want to help and it's about them, not about us. So I think that model has been really positive.

MS DAVIDSON: Are you saying that the client-driven model assists in building a trusting relationship or they get a good experience?

MX GRAYSON: Yes, I think so. We have a different way of looking at re-referrals as well, which I think is quite different in the service sector. Like, say, at my other position, if we got a re-referral it's kind of like, oh, no, you didn't do your job that well. Here, it's kind of like you did your job really well and they want to work with you again on new goals. So it is sort of like a positive thing. So they can re-refer into service.

It is about capacity building and empowerment for them so that they can achieve their goals. But we are not just sort of working with them and then saying goodbye and that's it. The option is still there to come back if things change in their life or if they come up with new goals. I think that's been a really positive impact as well. But, yes, I think it is about building that trusting relationship and things, yes.

MS MICALLEF: In terms of family violence, women will often present with other issues, and because of that space to build that trust and work just where they are it opens up

the space to explore further. So sometimes workers will come to me and - "I have a feeling something else is going on here", so we can unpack and work with what it is they are thinking about and ways to introduce that that aren't threatening to the woman and then can start that work.

MS DAVIDSON: Does that mean then - I suppose this question is to you, Mary - that women might be more willing to disclose family violence in a way that they - possibly before they might have then decided to access a specialist - go directly to a specialist family violence service?

MS MICALLEF: It can be a much safer place to be in and to talk about, because we are working from where they are, and that is part of the work in - when I'm talking with the other key workers around intervention orders, it's about how that would work to enhance their safety, will it be safe, what are their options, which ways do orders work and how can they use that or not use that, what would be another way. So it's bringing in their options rather than often what happens is at the crisis end of things when the police come in and then things happen and it skews from there.

And the safety of it not being called a family violence service. So if they are starting to explore, they are doing this work about something else, and that's a safer option for them than if they tried to present at a family violence service because of what their partner might make of that.

MS WILLIAMS: Yes, I think some of the feedback is that not having the stigma attached to a specific type of service, so not showing up where people know you are at the drug

and alcohol service, or they know you are seeking family violence. You could be there for any number of issues, and I think that's one of the benefits of having everybody under the one roof. You could be there for any number of reasons and no-one has to be any the wiser as to what it is that you are particularly seeking through us.

MS PRIOR: It also means that you don't necessarily need a crisis to have occurred in order to access the service.

DEPUTY COMMISSIONER FAULKNER: It seems to me this is a very brave new world where there is no admission criteria, and I suppose I'm interested in the other end, which is the discharge or the finishing-up work. How do you actually get a flow-through of people? Do people say, "I have achieved my goal and I'm going now"? What happens?

MS WILLIAMS: That's our aim. Our aim is to have smart goals - so really short, easily identifiable, easily achievable goals - with each client, and, as Ren was saying, about capacity building them to go forward and support them to achieve those goals and maybe to go away and practise some of those skills; then if they have more needs in the future, then to refer themselves back in again. So like Ren was saying, we think that a re-referral is actually a good thing because it means they have gone away, they have tried something, and the idea would be that even if they received a slightly longer period of involvement in the first instance, that each time that they came back it would be - there would be less and less need for a duration of time. So the duration of time should lessen each time that they come in contact with our service.

DEPUTY COMMISSIONER FAULKNER: Just while I have the floor, is there anything that you have been very surprised by in

terms of what clients want compared with what you might have expected?

MS WILLIAMS: I think the biggest thing for us that we have noticed is that the referred issues, so the issues that the referrer may put on the form, are very rarely the issues that the client will identify when we go out and meet with them. So I think the nature of how people do referrals is to put as much information as possible and make things seem as severe or extreme as they can to get it across the line, and then we might go out to the client - we might think that there's this really great big issue based on the referral, and we go out and speak with the client and it is actually really easily resolved. So their referred issues are not necessarily the same as the actual issues, is what we've found.

MX GRAYSON: I think going on from that, it cuts down that having to tell your story so many times. We are not asking someone that they have to give us their whole history. They sort of can present with how they want to present, like, for example, the 17-year-old that's pregnant and using drugs, as you mentioned, like, they might be around "I want help with employment" or things like that. So it might be a bit of a surprise what they actually want to work on, and the client might be a bit surprised that you are not saying, "You need to do this, this and this as well." So I think it just opens up a bit of a different working style, which has been really cool.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MS MICALLEF: It opens up the work with the men. My first client was a perpetrator who had just separated, had the intervention order against him, and a lot of my work with

him was about - and he had already done behaviour change work but about tapping into what triggers you and controlling that and understanding the intervention order, and one of my last sessions with him, his mum was there, and he said to her, "But it doesn't matter if she contacts me. I'm the one that has to not contact her or answer the phone because I'm the one with the order." Having him understand that was a huge shift. So it expands what we can do in the things we were listening to before around the work with men and what can be possible.

MS DAVIDSON: Just picking up on that point, in terms of how the Services Connect model might contribute or fill gaps, service gaps, in relation to family violence, can I first get you to address, perhaps Kathy and Mary, how you might see the Services Connect model provides an opportunity to provide a service to men that might not currently exist?

MS PRIOR: Building on the conversation just now, when the department were putting out the Services Connect model and talking about the tender they used the language of families quite a lot, and different Services Connect pilots have different clients coming through based on either the partnership or the demographics of the area they are working in. I think a surprise for our partnership was the number of single men actually being referred, which is an opportunity to actually think then about through a family violence lens what work could actually be done in that space in working with men.

I don't think the Services Connect model has really explored that in a huge way. There's been lots of conversations around how can Services Connect models work with women and children, again probably because that's in

some respects an easier client to tap into, a client cohort, because they are the ones that the service system are predominantly working with specifically in that family violence space.

But there's definitely opportunity. Because of the referrals coming in, it's a catch-all in a lot of ways. So you have clients that are coming in who may have had experiences of family violence throughout their life, who might be perpetrators of family violence, who might be in family cohorts, who might not be, who might be in crisis, who might not be; so that continuum of care around when family violence might be happening and what the peaks and troughs are. It may happen while Services Connect are working with them or it might not. It just kind of depends.

I think working from the same risk assessments, through using the CRAF, there will be the assessments that will be happening, and having Mary in the space as well as a specialist conversations can happen within the team if they have niggles or are a bit worried and want to maybe start exploring whether safety planning is required for a woman and her children. So I think there is opportunity to do some of that work with men and creating greater safety.

MS DAVIDSON: Turning to women and children who might be experiencing family violence, how do you see particularly the Services Connect model fitting with the services that are provided by specialist family violence services? Is one taking over the other? Are they working in a complementary way or?

MS PRIOR: They can't take over. There is too much work, for a

start. The demand is ridiculous, really. I think the other aspect to it is the continuum of the experience of family violence. So, whilst we have the pointy end occurring and the specialist family violence services might be working that pointy end, they are also working with women and children throughout the continuum of their experiences of family violence. That might last a year or so or longer. Women might dip in and out based on what's happening for them.

So I think there's capacity to think about different ways that we could be working with women and children and men. Like I said, the demand is so great I think we need to be thinking more creatively around how we actually are influencing the prevalence of family violence in our community anyway.

MS MICALLEF: So the family violence service, they have the capacity - they have the connections with the police. So those women at extreme high risk, that's where they should be sitting, with the family violence service. Then there's a whole range of families underneath that. So sometimes it can be women, and, as I said before, they might come in for something else but they were just dipping their toe in wanting to start to explore, and they won't even be able to say it out loud, and they talk very quietly and when you start to unpack that it is violence, "Oh, no, but I could never leave."

But, if you have the time to unpack that and work through, you can work on a safety plan and they can leave in a safe manner that's not in crisis, and we can link in with Centrelink to get them an income so they can save towards getting a private rental, if that's what they need

to do, because not all women are safe to stay in their homes or would be able to afford to stay in their homes. So there is a great capacity for us to do that very early intervention work that will lead to down the track maybe when a separation happens that things are in a much safer and more supported way.

There are a lot of women who will have a lot of autonomy once the initial thing around separation or intervention orders has - once that extreme unsafe time occurs, where we can do the work with them, and it might be piece work where they might now need to do the Family Court. So I can tap into Berry Street services and make an appointment and go to the appointment with the woman where we do a Skype legal appointment with the Women's Legal Service and they can get the information they need from a legal point of view to start to make informed decisions about how they are going to run that part.

Then when that's done they - that bit of the work's done, and then they might come back months later because then something else is occurring. So there's that potential for that in-and-out work that we carry much more than I think with the L17s coming in the door at the moment, that the family violence service has the capacity to do.

MS PRIOR: I guess the other thing that is key is Berry Street is the entry point for the police referrals in the north, so the seven LGAs in the north and in Grampians. That's an involuntary. Most of the time a woman doesn't necessarily say, "Yes, I want police to come around and I want to be referred to a service and I will uptake that service." Some women will. But in the broad spectrum of

things it's not necessarily a voluntary. It's been triggered by a crisis and not necessarily their doing, calling the police or getting the police involved. So there is a difference between the involuntary service access and voluntary, which, again, we need to be thinking about women's own self-determination and carriage in that as well.

MS DAVIDSON: In terms of the clients that you have, how complex are they relative to your clients at your home agency? Are you dealing with a similar cohort, or are you dealing with less complex clients or more complex?

MX GRAYSON: For me personally, it feels I'm dealing with a lot more complex clients. Young people bring their own complexity, but because I'm doing a single sort of type of work I know what I'm doing and it looks a bit similar. But this sort of work is quite a lot more complex because you could have housing, you could have Centrelink or mental health issues and things like that. So for me some of the referrals seem a bit more complex but not overwhelming because of the way we sort of work and the knowledge we have. So I think, yes, it looks quite different to me, the work I'm doing.

MS WILLIAMS: I think because of the way that the work is structured - so we have three levels of support. We have self-support, we have guided support and we have managed support. In that, the self-support tier, if you like, is up to about six hours of support per individual, per family, whatever that looks like. So that might be at the lower level of the threshold. So they might just want an individual, they might just want some information on something. They might want one person to come and support

them at court around a certain issue. They might just want a brief intervention.

Then we have the next level is the guided support. So that's around about 30 hours notionally per intervention. That could look something slightly more extensive.

Then we have a managed support level, which is up to 60 hours. So that could be over a - that's in any amount of time. So it could be 60 hours in a month if it is a really kind of complex, high-need situation or it could be 60 hours spread out over six months, depending on the need of the client at any particular time.

So in saying that we do cater for - the majority of our work is supposed to be down the self-support end. But, given that this is a test, that's - we're still - it's only a two-year testing period, so it winds up in October next year. So we are testing whether or not that is actually what our client demographic will look like, and at the moment it kind of - it varies between the self-support and the guided support, and then we have some managed support cases as well. So we do have the spectrum.

MS DAVIDSON: Where do your referrals come from?

MS WILLIAMS: They can be self-referred, they can be referred from the primary partnering agencies that have the re-aligned key workers or they can be referred from general community. At the moment we are seeing a lot of self-referrals. So I think they may have originally been referred from another partnering agency or from the community, and then they refer themselves back in.

We have also, unsurprisingly, had a lot of

referrals from housing services. But we are seeing family violence, we are seeing drug and alcohol. It does cover the spectrum. From schools. From - GPs have made referrals. Dermatologists have made referrals. It is a strange profile at this point in time.

MS DAVIDSON: Is there a waiting list for the service?

MS WILLIAMS: Not at the moment. We don't run a waiting list at this point in time. We haven't had to because we have been fairly new and trying to generate referrals and that kind of thing. At this stage we try to offer everybody at least a self-support session or approach, if you like. So hopefully we will be able to - within our intake duty system the idea would be that if somebody - if we were full - if we were at capacity for the guided and managed support, then we would at least be able to within that intake system offer someone a short five hours worth of support, and if they needed something more extensive then we could at least provide them something in the meantime while they are waiting for the next level of support.

DEPUTY COMMISSIONER FAULKNER: I still don't understand the initial screen that was there about emergencies. So you obviously don't take some people because you can't cater for them.

MS WILLIAMS: Yes.

DEPUTY COMMISSIONER FAULKNER: Who are they?

MS WILLIAMS: So people that the - for example - the example that I give when I'm explaining is if, hypothetically, somebody is in need of a CAT team and a crisis assessment response for mental health, then that wouldn't be an appropriate referral to us. It would be more appropriate for them to get the crisis response, have that treatment,

if you like, and then to refer to us after that. The same with family violence. If they are presenting and they are at significant risk and they have lots of the key indicators for a high-risk family violence case, it would be more appropriate for that to sit within the specialist service.

MS MICALLEF: Which could include refuge.

DEPUTY COMMISSIONER FAULKNER: Yes. Thank you.

MS DAVIDSON: I think, Ren, you mentioned a client who might have wanted assistance with employment, for example. The Outcomes Star doesn't - it tends to be, I suppose, quite welfare focused. But you have mentioned that a client might want to work on employment. How do you pick up those issues where a client actually doesn't just want assistance finding housing or getting a Centrelink benefit but actually wants to become self-sufficient? Where does that fall within the capacity for Services Connect?

MX GRAYSON: It definitely falls in our capacity to help with those sort of things. The Outcomes Star tool is quite a holistic tool. So it covers lots of different sections of someone's life, not just housing or not just one thing. Our work can vary quite a lot and it might involve as a worker having to find some information for them. It might be around they want support with writing a resume and linking in with a job agency and things like that. So that would be our role to help with that. All of it is an empowering model, so giving a client the tools to be able to do it themselves as well. It's not just us sitting there writing their resume for them.

I think we have capacity to do lots of different work. It's quite interesting what a client might want

help with. They might just want someone to sit with them while they are doing a financial counselling appointment and take notes because they can't remember everything. There's lots of different sort of ways that we can work that is that really practical, rich rapport-building type of work, I think, or it could be around linking in with the right services for them. Even as a worker it's quite hard to know all the services and things like that. So as a person in the community it can be overwhelming. So it might just be being able to guide them in the right way.

MS MICALLEF: I'm doing some work with a CALD woman at the moment, and my role is advocacy with the Coroner's Court about an outcome - the outcome in the Coroner's Court had - over the death of her husband. So that's how varied the work is.

MS DAVIDSON: Who has legal responsibility for the work and the workers?

MS WILLIAMS: The way that our business rules are structured are that the human relations and all of that kind of - that aspect of each of the key workers still sits with their employing agency. So each of the re-aligned key workers is still employed, and all of the provisions that sit underneath that sit with their home agency as they would be if they were staying at their home agency, and we are responsible - the Services Connect - so our leadership team are responsible for the operational management of the key workers; so in terms of the duty of care, making sure that they come back after home visits and that their wellbeing is looked after as well. Supervision, yes, absolutely. So the key workers will get operational supervision from us as Services Connect, so we

have a practice leader and a team leader. So the key workers will get their case management supervision from us, but they will also get supervision within their home agency and professional development opportunities in both areas, so that they still remain connected to their home agency and that they also have supervision around the important day-to-day work that they are doing as well.

MX GRAYSON: We are sort of implementing group supervision type reflective practice space, because there's so many workers with such a wealth of knowledge and you just want to sit there and pick their brains. So we are running different sessions around - like this week I'm presenting around alcohol and drugs, and next week it might be around family sessions and things like that. So we are sort of utilising the expertise that people bring and sharing that in a team where you can actually ask questions or get practical advice or do a role play or whatever it is; so around that capacity building and things like that. So I think that's a really cool opportunity to use the knowledge that we have.

MS WILLIAMS: One of the advantages of the co-located model is that there is a kind of unique opportunity for organic consultation to occur where it wouldn't ordinarily. People might overhear a conversation that's going on around a particular topic and might be able to chip in from some experience that they have had in the sector, and having 15 different workers with 100 years of experience probably between them coming from all different sectors of the - all different areas of the sector means that there is so many organic conversations and so much opportunity for learning that just wouldn't occur if they weren't all

situated in the same place at the same time.

MS DAVIDSON: How is Services Connect funded?

MS WILLIAMS: At the moment it's funded in terms of the re-aligned key worker is still funded from the position that would have been re-aligned from, and it was a two-year pilot that started I think in October 2014 and finishes in October 2016 that - this pilot or testing period to work out what it is about this model that might work, might not work. So there was an element of funding that was attached to each of the testing or each of the pilot programs, but I think going forward there is no plan at this stage that I'm aware of.

MS PRIOR: There's a lot of goodwill. Agencies are re-aligning workers. So there's a lot of in kind - not in kind. It's probably not the right word, but extra funding that's come with the staff being re-aligned into the program and then whatever else they have access to within their home agencies as well.

MS DAVIDSON: Who is funding the physical building?

MS WILLIAMS: Facilities and stuff like that all came out of the initial budget for each of the pilot programs. Each of the different Services Connect pilots, some of them are not co-located, so they would have spent their money on other testing features of their particular pilot, whereas some of our funding was obviously set aside for the purposes of rent and for utilities and those kinds of things so we could operate the way that we do. The same - we did get funding from the Department of Health and Human Services for things like cars and for laptops. What are they called? Not laptops. The smaller, more functional laptops that they can take out and take to the home visits

with them, so it can be very outreached based. We can meet clients well and truly where they are at, whether that be in their home or in a park, if that's where they are more comfortable, at a cafe, wherever they need to go. So key workers have access to their devices when they are out and about so they can do the Outcomes Star in a person's lounge room if that's what's appropriate for them at that particular point in time.

MS DAVIDSON: Is there an evaluation process for Services Connect?

MS WILLIAMS: Yes. The department, as part of the whole project or testing period, have - they are undertaking the evaluation, which is due to start - the client component of the evaluation is due to start at the end of October.

MS PRIOR: Different sites are doing their own evaluation or research as well and gathering data.

MS DAVIDSON: Pending an evaluation, what do you see as some of the key features of the way that you have established the Services Connect model in the north-east? What do you think are some of the key features for it working well?

MS WILLIAMS: I would say that the component from north-east that is working really well is the co-location and the ability for the key workers to be in the same place at the same time, to undertake similar training - the same training, to undertake similar professional development opportunities, to be able to learn from each other and to be able to not just work the cases that may be considered their specialty. So being able to have cases randomly allocated to them and then having to go out and make those connections and have those relationships and build on the foundation that they have got I think is one of the really

unique features that Services Connect in the north-east has.

It's the thing that expediates the process of information giving, and therefore I feel like it expediates the client's experience with us in terms of if Ren had to, hypothetically, ring a housing service, there might be two days worth of ringing backwards and forwards and playing phone tag, whereas Ren can turn to the key worker next to them, ask them which form it is, ask the housing worker what would be the best thing to do in this situation and then speak to the client within the next 10 minutes. So you can cut down two days worth of work by having the conversation with the person next to you.

MX GRAYSON: From a worker's perspective, I think it just cuts down a lot of that red tape. A lot of different service sectors talk in a lot of jargon and acronyms and things like that. If you don't work in that sector it's quite hard to know how to do a referral and what they are actually talking about.

At the end of the day we are all just trying to give our clients the best service they can and access to the best programs and things that we can. So I think it just cuts down the barriers. Like, you don't have to go back to your desk and Google furiously for different programs and stuff. You can access some of the best things we have in this state from our program.

At the end of the day it's just a good service for our clients is really what we are all trying to achieve. We are all helping each other out. People sit with you for 45 minutes and go through a referral with you or people will give you all their cheat sheets on how to

get disability funding or things like that. It's just been really helpful as a worker.

MS MICALLEF: Or even the simplicity of knowing exactly what the person's title is that you need to speak to for the issue you have, rather than going through and going da, da, da, da, da, you know. It can be just so short and sharp to get in the door.

MS DAVIDSON: What would you say to the criticism that Services Connect is all very well but there's no services to connect?

MX GRAYSON: I just think it's funny because there are so many services. Like I was saying, as a worker it is so hard to navigate the system, let alone being someone in the community just trying to access some support. Like what we were saying, we could come up working with lots of different things or different issues that you might not have thought of. I'm constantly learning every day. So I think it's quite funny.

MS MICALLEF: They are there. That's what I was talking about before. We are not knocking on the door. We are going inside the door. That's the beauty of it, that we are working from the inside of the system that already exists.

MS WILLIAMS: I think originally the Services Connect model was a lot more structured around case coordination and care team coordination. So I think initially the idea was that the key workers would predominantly be around coordinating the services that might be involved with the client. That is one of the things that we can do and we will do. If a client comes to us and they have lots of services that are already involved with them and they are already working really well with those services and they are quite happy

with the people that are involved and those people need to remain involved with that client, then one of the roles that we can play is that kind of coordination role.

But I think on top of that, which is important and which is coming organically from the work that we are doing, is that we can do a lot of that case work, we can do a lot of that brief intervention, that single session work, the empowerment and the capacity building for clients, and I think that some people may not understand that that's a fundamental part of what we do, not just the coordination of services that may be involved. That's only one element of what it is that we do.

MS PRIOR: I think it's been tricky, though, in the life of Services Connect in that the language has changed throughout its time. So the understanding of the Services Connect pilot sites, therefore, has been quite challenging for the sector in terms of knowing what they can do, because there's also the diversity across each of the eight sites and also the difference between the internal DHHS Services Connect pilots as well. So that has been I think quite a challenge in terms of the language that's been used and the fact that we have had change of government as well overseeing them.

DEPUTY COMMISSIONER FAULKNER: Can I just check, then. I'm one of the persons who has heard over and over that there are no services to connect, and particularly housing, mental health services in particular. So are you saying that somehow you have broken the code for getting into those things? It's an interesting concept. Can you fast-track a person to get a mental health place, or can you fast-track a person into housing?

MS WILLIAMS: No, absolutely not. I think that's one of the things that we would say: "We don't have access to housing. But what we can do is support you with whatever else might be going on for you while you are on the waiting list for housing", "While you are on the waiting list for a specialist mental health service we might be able to support you to go to your GP, get a better mental health plan", "You might be on your waiting list for housing, but you might also want to have your children enrolled in schools."

It is by no means the panacea. We do not have access to housing, we do not have access to mental health services that are at capacity. But what we can do is use the mental health re-aligned worker in our partnership to do some of that initial work that - maybe link them into a support group while they are waiting for more extensive services.

So, no, we don't have access to services that don't exist, but we can provide support across a number of areas while you are waiting for your housing need, and sometimes what we find is if you can just address some of those needs then - obviously the need for housing is paramount. If you don't have somewhere to live, that's problematic. But if we can address some of the other things at the same time then it lessens the client's anxiety at least, so that they have some of their other needs addressed and they feel like they have someone to support them through that time as well.

MS DAVIDSON: I have no further questions, unless the Commission has - - -

DEPUTY COMMISSIONER NICHOLSON: Thank you. Just a question

about governance. Services Connect isn't incorporated, is it? Is it an incorporated entity?

MS WILLIAMS: No.

DEPUTY COMMISSIONER NICHOLSON: Who exercises governance over budget, et cetera?

MS WILLIAMS: For North East Services Connect we have a co-lead. So CPS, Children's Protection Society, is the funds holder, and that exercises the governance over the financial arrangements, and Berry Street is the other co-lead in terms of the governance overall as to how we do it. We have an executive leadership group, and then we have a senior operations group, and then we have other management groups that sit underneath that.

DEPUTY COMMISSIONER NICHOLSON: So if Services Connect were to continue after the first two years is it intended that they become separately incorporated?

MS WILLIAMS: I would have no idea the answer to that question.

MS PRIOR: I don't imagine in its current iteration.

DEPUTY COMMISSIONER NICHOLSON: What is your view about that? Should it be separately incorporated?

MS WILLIAMS: Not if it is working the way that it is. Part of the beauty of what it does is that it brings people together. So if it was to sit separately it wouldn't necessarily have the elements of coordination and cooperation that is kind of fundamental to the way that it's working and to it - in its current form.

DEPUTY COMMISSIONER NICHOLSON: Under this form of governance, if there was a case of negligence on behalf of one of the key workers, who is responsible for it? The home agency or the - well, Service Connect isn't incorporated. So is it Berry Street, is it?

MS PRIOR: The Children's Protection Society and Berry Street are co-leads, but in terms of the responsibility of the staff persons it's with their home agency.

DEPUTY COMMISSIONER NICHOLSON: So if they were seen to be negligent it would be the home agency, would it?

MS PRIOR: Yes.

DEPUTY COMMISSIONER NICHOLSON: Yet the home agency doesn't direct the work.

MS PRIOR: Sorry, say that again. In terms of their day-to-day practice?

DEPUTY COMMISSIONER NICHOLSON: My understanding is that it is Service Connect personnel that direct the key worker, not the home agency.

MS WILLIAMS: In terms of their day-to-day operations, yes, correct.

DEPUTY COMMISSIONER NICHOLSON: And yet the home agency ultimately has legal responsibility?

MS PRIOR: Yes, ultimately. We would probably need to double-check that and get back to you on notice, if that's information you would like to get a bit more detail.

DEPUTY COMMISSIONER NICHOLSON: I would have thought that would be important for the boards of the home agencies to understand.

MS PRIOR: Yes.

DEPUTY COMMISSIONER NICHOLSON: Thank you.

MS DAVIDSON: Just one final question. The name "Services Connect", given its history within DHHS, is that still a non- - what is your view about using it as a name for the community services?

MS WILLIAMS: I think the name "Services Connect" is inherently confusing because of the nature of the internal Services

Connect and external Services Connect is - each individual pilot is run differently, and we also operate differently than the way internal Services Connect did. So I think that for clients that may cross both the internal Services Connect and the external, it's very confusing for them as to who it is they are dealing with at any given time, especially if they are just receiving a phone call and their message or something like that. So I think a name change would be advisable, if nothing else, just to clarify some of that for clients.

MS DAVIDSON: Is that because Services Connect also in the internal model could connect organisations like Child Protection, for example?

MS WILLIAMS: Yes, there is the understanding that Child Protection was involved in the internal Services Connect to some extent as well. So sometimes there is an assumption from clients that if we are doing the same thing they may not want to engage with us for that purpose, yes.

DEPUTY COMMISSIONER NICHOLSON: I had one final question. We have been talking today about workers' development and competencies, et cetera. You have reported that through this process the key workers develop - really enhance their skills. My query is: are those advanced skills or competencies formally recognised in any way, and are they reflected in higher remuneration?

MS WILLIAMS: The remuneration sits with their home agencies. So whatever the key worker's base rate or whatever the key worker was being paid at their home agency is continued across into their re-aligned position. So that sits with their home agencies.

Insofar as formal recognition, all of the training and official professional developments are recognised by the home agency and they get the certificates, and that can sit on their personnel file with their home agency.

MS PRIOR: But they are not formal qualifications.

MS WILLIAMS: But they are not formal qualifications.

DEPUTY COMMISSIONER NICHOLSON: They are not certified and they are not reflected in - - -

MS WILLIAMS: It is not a certified qualification, no.

MS DAVIDSON: If there are no further questions, perhaps the panel could be excused and we could take a break until 2.45.

COMMISSIONER NEAVE: Thank you very much indeed.

<(THE WITNESSES WITHDREW)

(Short adjournment.)

MR MOSHINSKY: Commissioners, the next witness is Ms Beagley. If she could please be sworn in.

<LEANNE BEAGLEY, sworn and examined:

MR MOSHINSKY: Ms Beagley, have you prepared a witness statement for the Commission?

MS BEAGLEY: Yes, I have.

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

MS BEAGLEY: Yes, they are.

MR MOSHINSKY: Could you please outline for the Commission what your current position is and just give an overview of your personal and professional background?

MS BEAGLEY: Okay. I was originally trained as an occupational therapist and a family therapist in the '80s and '90s, and I worked for many years as a family therapist in

adolescent mental health in the clinical mental health settings, and subsequently moved into the department six years ago and have had various roles in the mental health and drugs area within the Department of Health and Human Services. I'm currently the director for mental health and drugs for the department.

MR MOSHINSKY: Thank you. We have called you to give evidence today about the Dual Diagnosis Initiative. Just to explain, the purpose of calling this evidence is really as a case study which can be relevant to illustrate how workforces skilled in one area might be upskilled in another area. Could you please explain to the Commission sort of at the overview level what the Dual Diagnosis Initiative is?

MS BEAGLEY: Thank you, yes. The Dual Diagnosis is a long-term program of system reform and workforce development that has been undertaken under the leadership of the Department of Health and Human Services in its various forms over the last 15 years. So there was a recognition in the late '90s that, and an emerging concern about, the number of people who were unable to access mental health services because they were presenting with addictions and vice versa, that people who were presenting to drug and alcohol services also brought with them mental health issues.

It's understood and generally accepted that about 40 per cent or more of people who have a mental illness diagnosis may also have a drug and alcohol or an addiction problem as well. So there was raising concern in the service delivery community about the challenges for this particular group in accessing services when in fact the impact of having a diagnosis of an addiction and a

diagnosis of a mental illness together created more concerns and impacts and poorer outcomes - higher rates of suicide and incarceration and social alienation and social problems with families and so on. So it was a group who actually were more complex and more in need of treatment, but because they were presenting with a diagnosis of addiction or a diagnosis of mental illness together that they were somehow not able to access the mainstream service system.

So in the early 2000s four teams were - well, actually one team was piloted and set up at North West Mental Health. That team was called SUMITT, and it was about - it was within the clinical mental health setting - generating some best practice and generating some training and education across the regular mental health service system to understand the role that drug and addictions was playing with the mental health clients that were accessing services and - - -

MR MOSHINSKY: If could I interrupt you at that point before you go on further about that first team. Could you just outline the three sort of basic groups of service that there are? You have referred to the clinical mental health services. What are the three?

MS BEAGLEY: So there are three areas of service delivery that I look after. Of course there's lots of mental health services delivered by private providers, and alcohol and drug services delivered by private providers. But in terms what is funded and with whom I am working in my current role is the clinical mental health sector. The clinical mental health sector is funded through the hospital system. It delivered care to about 65,000 people

over the last year - that's bed based and community based and crisis based services - and has a workforce of about 5,000 people and is funded by the state government to the tune of about $1.2 billion.

Then the second sector is the mental health community support services, which are generally non-government services, who deliver care to adults with severe and persistent mental illness and associated disability, and provide ongoing support and care to that group. In 2014/15 that group of services saw about 12,000 adults with severe and persistent mental illness, and they had a staffing cohort of around 1,300 staff, and the government spends $126 million on that sector.

Then the third sector is the alcohol and drug treatment sector. Again, that sector is delivered through a range of service providers, including standalone, non-government providers, like Odyssey House, and then also through some hospital services there is a range of withdrawal and rehabilitation services and outpatient treatment services provided through some hospitals. That group of services saw about 27,000 people in 2014/15, has a workforce of about 1,400 staff, and there is about $147 million in treatment services. I also have a figure for prevention, which is about $33 million worth of programs related to prevention in alcohol and drugs.

MR MOSHINSKY: Going back, the pilot unit was located within the clinical mental health part of that structure?

MS BEAGLEY: That's right. That's the part of the system that deals with people the most acutely unwell and are seriously ill. That's the psychiatry component, I guess, of the service system. It was the concern about people

with addictions and intoxication accessing mental health services that originally people who were - particularly clinical leaders who were concerned about providing care began to raise some proposals for changing the system.

MR MOSHINSKY: Then what happened next after that initial pilot?

MS BEAGLEY: The department then, following a - the department then worked across the drug and mental health areas, which are now combined in the department but at the time were not, to fund four teams and extend those teams to have outposts or like a hub and a spoke model, I guess, in the rural areas to ensure that there were workers in rural areas linked to a base team. So four teams were then funded, again in the clinical mental health setting, but with an expanded role to support the delivery of care by the regular clinical mental health system and the non-government system, and to make links and appropriate referral pathways and connections with the alcohol and drugs system.

Those services were not expected to see clients as specialists. They were expected to create the environment where people presenting with both mental illness and drug and alcohol problems were appropriately supported, came into the system where they were appropriately cared for.

MR MOSHINSKY: Then after the period when there were the four teams, was there a further phase of the rollout?

MS BEAGLEY: Yes. So there has been - programs been extended over time. So remember we are still in the early 2000s here. The program has been extended over time to ensure that different parts of the clinical sector, the

residential rehab program, housing services, Aboriginal services and youth services delivering both mental health and drug and alcohol care were appropriately skilled to do so.

The first evaluation was undertaken by Turning Point in 2004, a result of which was that an education and training unit was funded to extend the more formalised training and create some links with the broader tertiary sector and the statewide cluster training that's provided through the department.

There was also an introduction of reciprocal rotations model, which was where services would be - individual providers or individual - the drug and alcohol workers or mental health workers were offered the opportunity to rotate into the other service system, work as part of the other service system and have on-the-job, if you like, training and placement.

The third component was to strengthen addiction psychiatrist programs so that psychiatrists who were trained primarily obviously in mental illness and mental health treatment were also provided with additional support to understand the role of addiction both in assessment and in treatment models, because in the clinical sector the psychiatrists are the clinical leaders and set the standards of care.

There was also at that time - I'm jumping in here, but also at that time a broad key direction policy was developed by the department, in consultation with a then ministerial advisory council, to broaden the policy framework and underline to both the mental health and the alcohol and drug service systems, all three areas, that

dual diagnosis in people living both with mental illness and with an addiction were core business for both sectors, that there was a requirement that services would work in an informed way, that they would deliver and develop services that referenced both and understood the complexity that people brought with them when they brought both diagnoses.

The department entered into an agreement with the Commonwealth, a partnership agreement, in 2009. It was a homelessness partnership agreement, but a component of it was some funding to outpost youth dual diagnosis clinicians into homelessness services to join up the connection between drug and alcohol, mental illness and homelessness, and to provide some on-the-ground support for and education and secondary consultation to homelessness providers around that.

There was a further extensive evaluation then undertaken in 2010, which was to - it was 10 years into the initiative at that stage. Out of that evaluation a range of other developments have evolved.

I guess the point to make about this program has been that it's been developed over a long time. It's been evaluated every five years so far. It's been responsive. The service delivery, the funding models and the levers that are used to deliver change have been responsive to the evaluations, I guess, and to what we are learning as we go. It would be fair to say that the evaluation in 2010 confirmed that the work that had been undertaken the previous decade had really changed the way that people were assessing and identifying mental illness behind an addiction and the role that an addiction might be playing

in a mental health condition.

There was a second stage, which is obviously that, once you have made an assessment and a needs assessment and understand what's going on, you also need to be able to then plan treatment, and that references both sets of complexities, and often these people have other complexities, as I said before, as well - homelessness and social isolation and various other challenging situations, including family violence.

MR MOSHINSKY: By 2010 had the Dual Diagnosis Initiative been rolled out to all three of the sectors that you referred to earlier?

MS BEAGLEY: Yes, it had. So the investment was sitting in the clinical sector, which - the workforce in the clinical sector are highly qualified occupational therapists, psychologists, social workers and nurses along with the medical teams. Those dual diagnosis teams had been functioning for some time. They had the rural counterparts who worked as part of the team, and they had a range of services or catchments that they were obliged to provide services to, support and secondary consultation and training to, and catchments where they were working across the partnerships and across the silos between the non-government mental health services and the drug and alcohol services.

MR MOSHINSKY: Is the way the program works that the workers in one specialty, be it mental health or alcohol and drugs, are able to provide treatment for sort of both needs, or is there still referral to the other service?

MS BEAGLEY: It absolutely needs to be capacity to refer to the other service. What we were originally wanting to see as

a service sector was that, if somebody presented, we were not screening people out, if you like, on the basis of their diagnosis, say, from a mental health service, on the basis of their diagnosis of an addiction or their intoxication at the time that they presented for an assessment. So the important bit was the open door, and we began to talk about it being no wrong door, that there was no wrong door for people to walk into if they had a mix of issues that included mental illness and drug and alcohol problems.

So as part of the needs assessment and the clinical assessments of risk and illnesses and the addictions that there may be a particular time when someone perhaps in a mental health service needs a period of withdrawal or needs a period of rehabilitation, in which case they would be referred for those particular treatments, specialist treatments, in alcohol and drug service system, but we would be expecting that all of our - after the investment and the program of workforce development that has been going on for many years, that both sets of services would be able to recognise and treat at least initially both diagnoses.

MR MOSHINSKY: The education and training unit that was set up for a period, ultimately what's happened with that?

MS BEAGLEY: Ultimately we have been seeking in the last five years through our workforce development programs and general service development and service improvement programs, and descriptions of our service expectations, that it is an expectation of every mental health service that it is capable of delivering care to people with addictions and mental illnesses, and that every drug and

alcohol service is capable of understanding, recognising and dealing with people with mental health problems.

So over time the capability of working across both of those has become an expectation in the service delivery. It's an expectation of services when they tender to deliver new and expanded programs, and it's an expectation that the workforce is capable. Many of the programs for providing additional input, if you are in one of those streams, is through the regular training environment now. So we didn't see the need to continue to fund a separate workforce training unit because services were either developing their own capabilities and core competencies or they were being represented through the TAFE and higher education areas.

MR MOSHINSKY: Can I ask you to reflect on what some of the keys to the success of the program have been? From what you have said and from the evaluations, it appears to have been very successful. What are some of the key reasons why it's had that success?

MS BEAGLEY: Thank you. I think the original program was about providing workers with particular capability and understanding who were part of the core team - to push the core team to change their practices, to challenge their views about what was possible and to give them some tools for - so right from the telephone call and the first assessment in an emergency department or in someone's home when they are in crisis, to move away from saying, "I can't do an assessment. The person is intoxicated," to, "No, we can do an assessment and we do need to build some engagement and we do need to understand what's happening with this person now" - very basic walking

alongside people and creating - perhaps not unlike the previous panel, who were speaking about working alongside each other and learning from each other along that way.

So having experts who then continue to skill themselves up in the complexity that is a dual diagnosis has been really important. Groups of people have become specialists in the area and they have become advisers and champions for this work. So that's the first part.

The second part was that the three sectors were all working with very complex people and knew that most of the people they were seeing had real challenges across both sets of issues. So providing them with a framework was both important and probably a bit of a relief because it was providing them with a way forward to deal with some real complexity and concern, and eagerness to do the right thing and to provide clients with the very best care, which wasn't possible before.

I guess the third element was that as the system has evolved, and as we have recognised milestones along the way in delivering the program of care and change I guess and reform across the system, we have been able to be fairly agile about where we focus funding and how we embed it into practice and require services to move from learning into core business, and that's been a really important process, including providing policy, frameworks that oblige services to work in this way.

MR MOSHINSKY: One of the things you mentioned briefly was champions. Could I invite you to expand on that and the role of champions in this type of project?

MS BEAGLEY: I guess that people who are working in the human services field or in any endeavour are keen to do the very

best, and there has been a range of leaders in the sector in each of the sectors that I have spoken about, so in the drug and alcohol sector and in the non-government sector and in the clinical sector, who have taken these issues around complexity and the dual diagnosis program, have developed some research, have developed service models and tools, have attempted to engage and pull down the silos for referrals and so on, and provided additional training and support so that the impetus is not lost and the motivation is not lost to continue to change and grow.

I guess the department has been in a position to support some of that leadership from the sector. It is a devolved governance structure that I look after, so the government doesn't deliver these services. They are funded and managed as a system manager by the department. But there's been some real flexibility in being able to apply funding models and respond to innovation in an area that's been really very challenging for the service system.

MR MOSHINSKY: Were there any challenges that you experienced along the way with the Dual Diagnosis Initiative?

MS BEAGLEY: Yes.

MR MOSHINSKY: Would you be able to refer to some of those?

MS BEAGLEY: There's been some innovations that have been trialled and not worked as well as we thought they would. One of those was the reciprocal rotations, which was the idea where someone from one sector would work in another sector and then come back and bring the expertise back into the group. That didn't work as well as we would have liked or imagined that it would. Partly that was because people saw how other sectors worked and stayed, applied

for jobs and stayed. Partly it was because people were anxious about moving, so we didn't have a big uptake of that. So we ceased those reciprocal rotations and used that funding for other components of the program. That's an example.

I guess the other challenge is to work across silos when we fund and deliver services in silos. So it's a real challenge to pull those down. That required some real targeted leadership, and probably the education training unit in its time provided some excellent support in providing services - education services that targeted each particular area. Rather than a universal program applied to everybody, there was targeted, "What does the alcohol and drug sector need to know about mental health, and what does the mental health sector need to know about alcohol and drugs," and targeted training.

MR MOSHINSKY: Were there cultural barriers between the sectors that were a challenge for the program?

MS BEAGLEY: Yes, there were service and cultural barriers, I would say. So the drug and alcohol sector is a sector that understands the benefit in building engagement with individual clients so that they are able to - so that the sector can respond quickly when someone is motivated for changes or that they can come back - a sort of "easy out, easy back" kind of program of engagement with clients.

The mental health sector has been less able to do that because of the service system model where there's been a sort of intensive drive for assessment and treatment and discharge, and it's a very high - people aren't, I'm sure, very aware of the sort of high demand in the clinical mental health sector in particular and in the

non-government sector. So it's been a very different model.

However, both service sectors have been engaging with the idea of recovery as a key treatment aim. But recovery has had a particular set of issues and cultural issues in alcohol and drug services which have been more focused on harm reduction, reducing harm and limiting harm. The mental health sector has been more focused on recovery journeys and supporting people to achieve what they want to achieve.

There are cultural differences in how they get played out, how you provide treatment and how you respond to when people have made commitments, for example, in their alcohol and drug plan that are hard for them to live with and how that impacts on their capacity to, for example, keep appointments and so on. The different ways that the service systems have developed have meant that understanding the needs of someone with a dual diagnosis has had impact on both sectors in how they deliver care.

MR MOSHINSKY: Looking back on the program now, are there things that perhaps you would have done differently if you had your time again or not?

MS BEAGLEY: I think that reviewing is a good thing, and I think there are always ways that you can develop the program. We are keen to see it develop in response to - always to emerging understanding of what people's needs are and what helps them and what doesn't help them. There are some real challenges in understanding what is the clinical research and evidence for treating addictions when they are matched with mental health problems. If we had it again that would be an arm that I would be

interesting in seeing, is the development of some more research and evidence building of what is helpful when people are in that dual diagnosis framework.

Having said that, there is quite a lot of research that's been undertaken, which I have referenced, by some researchers in the United States, Minkoff and Cline, who talk quite a lot about the fact that what we are looking at here is complexity, people with complexity and people who need very careful, thoughtful assessment and treatment planning that addresses all aspects. All of those things are challenges that every sector faces, in fact, not just the mental health and drug treatment sector.

MR MOSHINSKY: I just want to briefly then ask you about family violence. I appreciate that's not your area of responsibility or expertise, but I just want to invite you if you have any comments on the potential for rolling out a similar model to include family violence capability, the capability to deal with family violence issues both with people who are experiencing family violence or using family violence, using violence against family members. Do you have any observations about the potential to adopt a similar framework?

MS BEAGLEY: What's a standout in the Dual Diagnosis Initiative was that it recognised that all parts of the system needed particularly targeted programs of work development and that it wasn't about one sector needed to know more about it than the other sector, that it was about - that it was everybody's business. So the drug treatment services needed to understand mental health programs and deliver mental health informed drug treatment, and likewise mental

health.

So in terms of a key learning - it's not my area of expertise, family violence, but the mental health and drug sectors are absolutely in the forefront of needing to understand and work better with people who are victims or perpetrators of family violence, and I would see that being an obligation back through with the family violence organisations as well in terms of their understanding of the impact of the addictions and the mental health issues that are either a part of the family violence or a sequelae to them to family violence issues.

It's not just about referral, I guess is what I'm saying. It's not just about knowing who to refer to and when. It's also about being able to change practice in your own business in order to deliver an integrated service to somebody who has a range of those issues.

MR MOSHINSKY: I take it from what you are saying you see potential for the application of this approach to include family violence sort of capability?

MS BEAGLEY: Absolutely, yes.

MR MOSHINSKY: Are there any observations you would make to the Commission about perhaps important things to keep in mind based on the experience with the Dual Diagnosis Initiative if one were contemplating adopting the same type of approach to include family violence capability?

MS BEAGLEY: I think that there needs to be a recognition that, if you are wanting to create reform or workforce development, each sector is involved in that planning and the review and the monitoring of that, that it's not imposed on one or other sector; that the government takes clear leadership about what's expected, like in the way

that we were able to do with the key directions work, which was to say to services, "This is an obligation and expectation of how you deliver services," and there was then some leverage applied through the contracting mechanisms to ensure that services were signing up to dual diagnosis frameworks.

So I guess that would be something that I would advise: if there was a broad workforce framework, that there would be government leadership, that there would be monitoring and ongoing support, that there would be some different approaches according to what the cultural needs were of the organisation and that they would be sufficiently agile to evolve or develop over time in response to evaluations and the effectiveness of those programs.

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

COMMISSIONER NEAVE: I just wanted to ask whether you had reflected on the possibility of putting family violence in there with your dual diagnosis, because one way to approach this is to say this is a very useful model which we could apply to family violence and, say, drugs, alcohol and mental illness. Another way to look at it would be to say we really need family violence in there in the mix of what's already there. I wondered if you had reflected on that.

MS BEAGLEY: We had certainly reflected on that and also in a broader way on how we might build the discourse of trauma into the work that people are doing so that they are not asking, "What's wrong with you"; they are asking, "What happened to you?" That includes that sort of crossover of

child sexual assault and people living with long-term trauma who are presenting to mental health services and drug and alcohol services in particular. So we have certainly been thinking about ways to expand that.

MR MOSHINSKY: If there are no further questions, could Ms Beagley please be excused. Thanks.

COMMISSIONER NEAVE: Thank you very much, Ms Beagley.

<(THE WITNESS WITHDREW)

MS ELLYARD: The final panel is Commissioner Clark and Commissioner Jenkins. I will ask them both to come into the witness box and be sworn.

<BELINDA ROSE CLARK, sworn and examined:

<KATE MICHELLE JENKINS, sworn and examined:

MS ELLYARD: May I start with you, Commissioner Jenkins. Could you summarise, please, your present role and responsibilities and your professional background?

COMMISSIONER JENKINS: I'm currently the Victorian Equal Opportunity and Human Rights Commissioner. I have roles and functions under three pieces of legislation - the Victorian Equal Opportunity Act, the Racial and Religious Tolerance Act and the Charter of Human Rights and Responsibilities - and I have been in this role for two years. Prior to that I was an employment lawyer specialising in the area of equal opportunity and human rights.

MS ELLYARD: Commissioner Clark, can I ask you the same question: your present role and what it involves and your professional background?

COMMISSIONER CLARK: My current role is the Commissioner for the Victorian Public Sector Commission, a role which I have held since April 2014. That role primarily is

defined under the Public Administration Act, which requires the Commission to advocate and maintain for the integrity and professionalism of the public sector, and also contribute to the efficiency and effectiveness of the public sector.

Prior to this role I held various public sector roles in New Zealand over a long period of time. I was Secretary of Justice for 10 years, and then after that I was the Chief Executive of the Tertiary Education Commission, which is a funding body, and I have had some time in private legal practice as well.

MS ELLYARD: You have made a statement to the Commission that's dated 9 October 2015. Are the contents of that statement true and correct?

COMMISSIONER CLARK: Yes, they are.

MS ELLYARD: The focus of this afternoon's session is on workforce diversity. Perhaps I could start firstly with you, Commissioner Jenkins. Why is diversity a good thing? Is it an end in itself or is it a means to an end?

COMMISSIONER JENKINS: Most organisations that are really moving towards the idea of better workforce diversity are doing it for a good reason, although in some ways lots of people will say it's just the right thing to do in terms of a community. But the primary reasons that are the drivers for a better workforce diversity are to better meet the needs of the customers or clients, to attract from a broader pool of talent, to get better governance or organisational skills, and then the last one is to meet the legal obligations not to discriminate, so to make sure you are not excluding, either directly or indirectly, diverse workers.

MS ELLYARD: From your observation or the work of the Commission, what is it that leads there to be an absence of diversity? Why does diversity not naturally occur in a diverse community?

COMMISSIONER JENKINS: We have a long history and the ways a lot of our organisations have evolved over time have been based on a sort of single way of operating, often described as hetro-male operations. That's a broad generalisation, though. Different industries have attracted different workforces. So it really varies across the community and the different workforces.

The point we are at in time, though, is to realise that that history means that without some change, some disruptive initiatives, we will continue to get lack of diversity in some workforces, and the recognition now is that that means you miss out on a whole lot of benefits and sometimes you are causing harm.

MS ELLYARD: Can I turn to you, Commissioner Clark. Is ensuring the diversity of the Public Service part of your function?

COMMISSIONER CLARK: Not in a specific sense, but there are several sort of roles and functions that we have in the Commission that touch on it from different angles. One is from the human rights angle in that one of the values of the public sector is to uphold the human rights charter, and one of those is freedom from discrimination and equal opportunity.

We have also got a role in collecting data which gives you a picture of the workforce composition and how that is at any given time. So that's sort of a monitoring role. We've also got a role in assisting departments and

agencies with issues around capability dependent on our resources. So there are several sort of aspects to it.

Another thing I should mention is one of the public sector values is responsiveness. We want a public sector that's responsive. So diversity is quite important here so that when the clients of government services have different and diverse needs that public sector is actually able to respond in an appropriate way to those sectors.

MS ELLYARD: So when we speak about diversity, and perhaps I will invite each of you to speak about this, are we referring to the diversity of the person delivering the service or are we referring to the service being delivered in a way that takes into account the diversity of the service recipients?

COMMISSIONER JENKINS: If I go back to your first question, it strikes me that in the family violence sector the business case for diversity is the ability to deliver better services to our diverse community. So that means more tailored approaches, more approachable, improved communication, better understanding of different cultures and different experiences.

That can work both ways. So, in terms of looking at delivering that service to a diverse customer base, the two ways that are really obvious is, one, you would upskill the current workforce no matter what their background to be more capable of responding to whatever the needs of the client are; and, two, naturally a more diverse workforce would be able to bring those extra skills without having to necessarily train someone on what the lived experience would be like.

So in my view the aim would be sort of a twofold

approach: one, if you want a more diverse workforce you would need to look at recruitment/retention; but, two, that skill development, so skills and training for the current workforce.

MS ELLYARD: Commissioner Clark, from your perspective, you have said you don't look at diversity specifically, but is part of the concern of the Public Service to be reflective of the community or merely to serve the community in ways that the community requires?

COMMISSIONER CLARK: I think I would probably see those two things as quite closely connected. In order to be responsive there at the very least would need to be evident in the wider public sector the experiences and perspectives from a diverse range of groups. So I think it's on two levels. You would like to have a public sector that's as reflective of the community it is serving as possible. It's both business sense, as Commissioner Jenkins said, but it also comes under the equity issues.

Then I think you should also try to complement numbers of people from different groups with an overall general capability whereby people are able to move in communities that may be different to their own or they are able to give policy advice which can reflect and incorporate those perspectives. So you sort of want both, I think - both the makeup or composition to be similarly reflective, but in addition for public servants in general to be skilled at dealing with and engaging meaningfully with a whole diverse range of stakeholders.

MS ELLYARD: You mentioned that part of your function is to collect data. What's the workforce about which you are collecting data? How large is it and where is it?

COMMISSIONER CLARK: It's very large. It's the whole public sector workforce as defined under the Act, which is about 270,000 people. I have to say there's some limitations to that data, which we are currently looking at, particularly from a diversity point of view. It's a very devolved system in Victoria. So agencies collect their own data, and we collect that and report on that at a metadata basis.

One of the issues is that our system takes payroll data, and that will cover age, gender and Aboriginal status, but it won't cover a lot of other information that actually agencies are collecting quite often around ethnic origins, different language groups and so on. So to some extent we are missing some of the richness of the data, and we have been conscious of that for a while and are looking at ways to improve that.

The workforce data collection is the data that we get from organisations' payrolls. So that's one stream. We also have another stream of data, which we get from the People Matter Survey. That is optional as opposed to the workforce data, which everyone supplies to us. That is usually done annually. We have about a 33 per cent participation rate. One of the problems with the data is shown up by the fact that the two different sets compared sometimes will give quite different answers. I think it's the workforce data says something like we have a 0.4 per cent Aboriginal workforce, whereas the People Matter data it's one per cent, because they are quite different cohorts. So there are things we could do to improve that data collection which would help us have a better picture of what actually is the amount of diversity

in the public sector workforce.

MS ELLYARD: The Commission has heard a fair bit of evidence about the fact that many front-line services involved with family violence are paid for by government but they are not government employees; they are employees of non-governmental agencies who have entered into contractual arrangements. Do you have any responsibilities or powers in relation to that workforce - government paid but not government employed?

COMMISSIONER CLARK: No, we don't. So that would require legislative change to obtain that data from, say, local government or NGOs.

MS ELLYARD: If it were to be thought that there was a need to try and conduct some overall measurement of the nature of the family violence workforce and their attributes, whether for diversity reasons or otherwise, with an appropriate legislative change, what else might be required in terms of resourcing to enable your organisation to add that task to what it already does?

COMMISSIONER CLARK: The advice I have is that it's relatively doable. It's not a big expense. It would obviously be some resource implications - if we were collecting a lot more data, then we would need a certain number of analysts. But I don't think the changes are insuperable from an IT point of view. You are probably just talking about person hours and analyst hours, and potentially some other people involved in training as to what we would need in terms of consistent datasets and so on.

MS ELLYARD: Can I turn back to you, Commissioner Jenkins, but perhaps invite your comment as well, Commissioner Clark. You mentioned, Commissioner Jenkins, that there are

certain entrenched positions that mean that positive change or positive attempts to change need to occur if diversity in workforces is to be increased. What are some of the ways in which that can occur?

COMMISSIONER JENKINS: If I think about the particular challenge facing this Commission, certainly the workforce - so you are saying the data is not being collected. It's also a very sort of underresourced sector and the idea, I know you will be thinking - the idea of these organisations thinking that they have to collect and report on something else would add to already stretched services.

So my sense about what could be done with the influence of government is to ask for more diversity, perhaps look at mechanisms to report but also from within government to support a workforce diversity strategy. I don't think these disparate organisations would have the skills or capability to do that. A central government agency perhaps within DPC, the Women and Equality Unit, for example, with the right skills and funding could put together sort of a workforce strategy that would look at things like recruitment/retention. It would particularly audit the composition of the workforce. It would then look at the barriers. So those are the things that really is the starting to understand why particular people are attracted to workforces and particular people are not surviving, looking at upskilling.

So my thinking in what it would involve is it would involve understanding the composition, understanding the barriers, and then developing a strategy that would be usually about recruitment but then retention and what are

the workplace cultures that you need to keep people.

So within large organisations that is how it is done. It's no longer seen as a policy, you know, "We are going to say what we are going to do. We are going to do a bit of training. Everyone is going to run through a day of training once every three years, and we are going to have some complaints procedures so people can come and complain." That hasn't achieved the change.

So now it's sort of really going off the back of a lot of the VicHealth thinking about primary prevention. It is what are the multiple mutually reinforcing steps that you need to put in place, but in the family violence sector I think if you want to achieve that change government could both require it but also would need to provide the expertise and resource.

MS ELLYARD: This analysis is assuming that there is an absence of diversity at the moment in the specialist workforce. From your perspective at the Commission, do you have any view on whether there is at least a perception that there is a lack of diversity?

COMMISSIONER JENKINS: You talked before about have you got a role - I think you asked Commissioner Clark - in diversity. We do have statutory roles to improve or achieve substantive equality and human rights; so coming from that perspective. We haven't done a targeted piece of work in the family violence workforce sector. What I know is really what I have heard from following this Royal Commission, and I do hear anecdotally, particularly from women with disabilities and women in CALD communities, that they don't feel the response perhaps is tailored to their needs.

The work I have done sort of related to the gender equality issues that come out in the family violence area are more at the large organisation end of scale that's often working on gender equality across different settings but particularly across workforces.

MS ELLYARD: Commissioner Clark, did you have any perspective from your point of view to the extent that a particular part of the department or part of the sector might wish to increase the representation of people from different backgrounds, for example, the ways in which that might be done and the role that your organisation has in resourcing or supporting that work?

COMMISSIONER CLARK: There is no sort of sector-wide program or set of policies. So I know of some individual initiatives and programs that are undertaken. We at the VPC, for example, have a graduate recruitment program. We have a separate pathway for Aboriginal recruits in that, and we are also just establishing a unit to look at Aboriginal appointment across the whole public sector. Then you have the Koori employment initiatives in the Department of Justice, which are pretty well developed and have a very good reputation. Then DHHS has got a specific program around people with disabilities, and there would be others as well. But there is no sort of overarching program or policy.

As I said, we have quite a devolved system here where responsibilities are at the departmental or agency level. So we could undoubtedly have a role to play within that devolved system, though. I think there's a couple of areas in which we could contribute.

Can I just go back to data for a moment, just

picking up something that was said before. We talked before about technical barriers to data, sort of IT systems and data integrity and so on. That's one issue. There is another issue which we became aware of when we were looking at how we could improve our own response rates to the data that we collect, and that is people not wanting to declare. So, in addition to actually making sure the technological and capital requirements were there, we would need I think to have an engagement with the different communities to gain their trust, because I'm not sure as to why they would want to give us that data in the first place.

MS ELLYARD: Why someone would wish to disclose on a People Matter form that they have a disability or that they identify as a particular sexuality or whatever it might be?

COMMISSIONER CLARK: That's right, yes. I think there is some ground that would have to be made up there. So there is the technical issues, but there is other sort of trust and confidence issues.

Then moving to what could be done, I think we could work with departments to - on a number of levels we could design - co-design with departments strategies for what they want if they were going to target a particular workforce, whether it was court staff or teachers or whatever.

We could certainly assist also in research for what's best practice. We could look at other jurisdictions or places perhaps where they have been successful or more successful in having a diverse workforce and look at how they did that. So there's those

sorts of contributions that can be made, given the fact we are quite a small organisation.

MS ELLYARD: Can I turn back to you, Commissioner Jenkins. One of the issues perhaps raised in the family violence workforce is the gendered nature or the perception that certain kinds of work within family violence response needs to be done by people of a particular gender, most particularly that women need to be the ones responding to female victims. There are of course provisions under the Equal Opportunity Act that make it permissible for organisations to select on the basis of particular attributes. But I wonder what reflections you have on the extent to which it is appropriate perhaps in the mid- to long term to continue with assumptions about particular kinds of work being gendered in a particular way?

COMMISSIONER JENKINS: There traditionally have been exemptions sought to allow family violence service providers to employ only women that have been granted. I think most recently there was one, Georgina Martina. That was in 2012. That really accepted the contention that there was a risk to people's safety and security, or at least a sense of that, the service provision. So an exemption was granted to allow all male workforces in a women's refuge.

In terms of considering about the question of gender - so I agree. Because of the research on the gendered nature and the suggestion that it's gender inequality that's causing these issues, the question would really start in terms of service provision with a focus on the safety and security of the clients and the customers.

That doesn't mean that every client would require that. But on the research at the moment it seems to

suggest that a lot of women are very fearful even having in their sort of safe place a man. That doesn't remove the possibility of men working in a whole range of areas, including primary prevention and more broadly.

So it doesn't exclude non-violent supportive men being involved with the sector. But at the moment, just based on the research, you would want to be satisfied that the clients would not have fears and that it doesn't reverse the good momentum we are getting from exposing this issue and having women come forward, that women start feeling reluctant to come forward.

So, again, using the human rights approach, we would say right to life, right to protection from cruel, inhumane and degrading treatment, and right to families and children, you would put that first, and if you were satisfied that there would be no concern then there's no reason why you wouldn't open it to a broader workforce. But, whilst it's not my area of expertise, it seems like that is one of the attributes that has been recognised as one of the attributes in the context of the harm suffered - - -

MS ELLYARD: Do you mean that so long as it could be identified that it was important, if not crucial, to the service recipient receiving a service and being willing to access it that they be able to get it from a woman, it would continue to be appropriate to limit the workforce to women?

COMMISSIONER JENKINS: Yes, that's simply right. The special measures provisions under the Equal Opportunity Act really are about achieving substantive equality for a group, and the view has been to date at least that the equality of

the group is looking at the women who are using the service and there has been evidence produced saying that they are more likely to come forward and are more assisted by women. So that's been the basis of the exemptions to date.

MS ELLYARD: How does that sit with the experiences in other sectors that there's been some historical truisms, I suppose, about certain sectors being male and certain sectors being female and a general view that over time those kinds of perceptions are not appropriate or cease to be appropriate? Can you see a time at which it might be possible to not need to conceive of family violence responses as being gendered, women for women and men for men?

COMMISSIONER JENKINS: I hope for a time when that's not - I know this Royal Commission is about trying to eliminate family violence. So I hope that more broadly the gendered nature of it would not keep coming up. I also hope and am working very hard for a more gender equal community generally.

As a general comment, looking at the workforce more broadly, part of the inequality that we experience is women tend to be in caring professions that are at lower pay rate and men tend to dominant sort of engineering, merchant banking. So in terms of just a pure financial basis I think it would help our whole community if more men were attracted to caring professions and public service and more women got opportunities in some of those higher paid professions. We will know we have reached equality then.

So I see in future that might be the case.

Certainly even now there's certainly opportunities for men to be involved with this sector. But I understand from what I'm told that in some services the thought of that creates fear in the minds of the victims.

MS ELLYARD: What about victims who have another attribute that might be protected under the Act, whether they have a disability, they are from a non-English speaking background, they identify as gay or lesbian or transsexual? To what extent should there be an expectation that each particular cohort gets a specialist response that meets not only their gender status but also the other particular features that might in their minds be contributing to their victim status?

COMMISSIONER JENKINS: Part of my response to that is I think there is a role for both mainstream services and, based on specific additional barriers by certain groups, some specialist services. So my belief is there should be mainstream services that are equipped to be responsive to whatever the needs are in whatever the location.

I think over time we have seen that some of the specialist services can give additional assistance and you can build that specific expertise. So I think there's a need for both: the mainstream service to be more skilled at serving a diverse community and then specialist services, like in anything else, where if it would assist you you use a specialist service.

MS ELLYARD: Can I ask you about a different topic. One of the big issues that this Commission is going to grapple with is the question of how community attitudes can be shifted about family violence and about violence more generally. From the work that the Commission does on community

attitudes in relation to a whole range of things, whether it be sexuality or race or gender, are there any learnings or insights that you could offer the Commission about what works, things to avoid, a philosophy that might guide attitudinal change about such significant issues?

COMMISSIONER JENKINS: In the time that I have been at the Commission for two years - I was a lawyer for 20 years trying to help organisations get better at equal opportunity and, sadly, the progress was not nearly as fast as I had hoped in that period. A lot of the work we are now doing is really changing our frame of thinking, not referencing the laws as they are written which really are focused on setting some rules and then requiring basically the victims to enforce the laws; so in essence to require the bravery of a person to determine the whole system's work. So that has been, though, with well intentioned - we set the policies, we tell everyone how to behave and then we expect people to complain if something goes wrong and at their own peril, really. That was how we were thinking.

In terms of the new thinking, which at the Commission is very informed by some of the VicHealth thinking, we are recognising that you need to stop thinking about how your organisation looks in terms of reputation. If you believe there are benefits of a diverse workforce then you recognise the drivers behind inequality, whether it is gender or otherwise. So if I look at gender inequality and then you realise that that is not something that just comes from one manager or one organisation, that you recognise that there is a multi-layer, there are individuals, there are teams, there

are managers, there are organisations and there are community attitudes, schools that are all feeding that community attitude, and we know the community attitudes on violence against women, particularly in younger people, are alarming and surprising, I think.

So the work at the Commission we are doing is saying, "We do want to change everybody, but we can't. So what are the key settings for change?" So the work we are doing - while we haven't pinned these down - the key settings are workplaces for us, sport, media and schools, really. Those are places that we feel that they are key places for change. A lot of the work we are doing - so we have the male champions for change group. That group in Victoria has the AFL CEO, the head of Australia Post, head of the Public Service, a whole range of sectors. They are working within their organisations but also we have asked them to consider how they can influence community attitudes more broadly.

So I guess our experience has been that, whilst individually they don't think they can change community attitudes, actually those four places really do and can change what the norm is and what's viewed as acceptable. So giving a really simple example, because I was just this morning at Australia Post's launch of their gender action plan, they sponsor the Stawell Gift. Up until this year the Stawell Gift paid $60,000 for the male winner and $6,000 for the woman. So Australia Post has gone in and said, "No, they should be the same." It might seem a long way from what we are talking about today, but it tells you how women and men have been valued. So the sense for us is that those organisations need to look internally but

also need to look externally.

MS ELLYARD: Commissioner Clark, can I turn to you. You indicated that part of your role is to uphold the integrity of the Public Service. From your perspective are there large pieces of work that you have had to do on identifying or shifting attitudes or upskilling a large workforce in a particular way from which you would draw any conclusions about how you engage in the large-scale work of changing people's expectations or attitudes about something?

COMMISSIONER CLARK: I wouldn't say large-scale, but we are actually thinking about this type of problem in another context which might have some relevance, and that's around integrity issues. What we have found is that, given there's been quite a few integrity breaches in the Victorian public sector recently and we are quite often involved in reviewing some of those organisations or instances, knowledge of the principles and the codes of conduct is quite high. So it is not a problem of promulgation or understanding of the issues. There's something else going on which is some gap between understanding what the code of conduct is and what the values are, but somehow thinking it doesn't apply to oneself or in a particular situation.

I have to say we don't know the answer to this problem, but we have been thinking about it and thinking can we look a bit more innovatively than we have been. We have sort of been concentrating on giving edicts, if you like. We are statutorily required to do that, but that's not getting us where we need to get, and do we need to look at some other disciplines like behavioural insights

or something to see how does someone absorb an idea rather than just read it and think it doesn't apply?

So I'm just listening to the conversation thinking something perhaps could come out of that as well. DPC actually have a unit at the moment dedicated to progressing work on behavioural insights, I think more aimed at this stage at the policy settings. But you could apply it to any sort of major program of change or reform. This might be an ideal subject of it. You were saying how could we assist in this. I was thinking you would have to engage, first of all, with the communities that you wanted to be responsive to to understand their framework and the prism through which they see things, and then sort of a lot of translating work sometimes going on or bringing people together to then sort of co-design something that is responsive to the group.

I said before that sometimes there's a barrier to - sorry, I'm just diverging on to another point here, but sometimes there's a problem getting people to declare an aspect of diversity because they are worried about what's going to happen to it and their privacy and are they compromised or going to be under pressure in some way.

But I think there's another challenge as well which is how do we engage some communities in wanting to be in the Public Service and wanting to be in these helping and caring professions. From my point of view, I don't think we have grappled with that either. So we are not somehow making it accessible enough or attractive enough that we are attracting people in. So what's the recruitment challenge? How do we bring people in? Once they are in, is it a safe place for them? Are the

supports there? Is the induction right? Is there career development and planning? Are there leaders skilled at leading a diverse workforce? There are quite a few different aspects to it. Again I think we will have to be more wide-ranging in looking at tools to address this, because these are fundamental changes in the way we have been organising ourselves.

COMMISSIONER NEAVE: Can I have a follow-up question on that. It's always struck me that we don't take advantage in Australia or in Victoria very much of the fact that we have a large number of people in our community who are bilingual and who have competence in more than one culture. I do wonder whether that might be something that could be taken up within the Public Service because there are enormous benefits for the community as a whole to have people with a range of ethnicities and language skills and so on, and yet somehow that doesn't seem to be weighted, as far as I can observe, terribly favourably. I don't know whether you have given any consideration to that issue.

COMMISSIONER CLARK: From memory I think in the People Matter Survey 21 per cent of the respondents had come from a background where English wasn't the main language spoken. That's quite a small sample, I grant you. But it looks like there's a reasonable number of people with diverse linguistic backgrounds. But it doesn't answer your point about are we then utilising that. It looks at first blush like there is no sort of access problem, but I don't think we are optimising that experience.

COMMISSIONER NEAVE: The New Zealand experience is people with a Maori background seem to be much more prominent in

public life. It's just an observation; I may be quite wrong. I just wonder why we are not capitalising on what I see as an enormous advantage.

COMMISSIONER CLARK: If I could speak to the New Zealand experience. That came about I think from very conscious efforts that were quite controversial at the time they were mooted that have become the norm, so people forget. But there was a lot of debate about whether there should be quotas, for example, whether there be quotas by another name. The fact that Maori is an official language helps because it has enabled the public sector to make that - it's not mandatory to learn it, but a lot more people have the opportunity to learn it and there's provision and encouragement. So all of these things have contributed, as you say, to a situation today which is healthy compared to, say, 20 years ago.

MS ELLYARD: Commissioner Jenkins, can I ask you another question about diversity, thinking about the workforce becoming more representative of people from non-English speaking or culturally diverse backgrounds. We had some evidence earlier today about the historical context in which the family violence workforce arose. That context, it was agreed, was the feminist women's rights movement which began in the '70s and '80s to try and mount a response to the family violence that women were experiencing. It might be thought that that historical context might continue to influence the way in which the role is perceived and the kind of people who might think, "That's a job I can do." I wonder whether you have any reflections on whether you think that's right and how, from your observation, it's possible to start to encourage

people who don't look like the workforce has always looked to think of it as a workforce that might suit them.

COMMISSIONER JENKINS: That challenge exists in a lot of workforces. So it happens in reverse as well in male dominated workforces and the challenge to get women in. So the practice has been to sort of try and get one or maybe do a Noah's Ark and get a couple of each in. The reality is, particularly when you talk to some of the people, it's hard work to be the only one.

So some of the more radical thinking now where you are looking at getting a diverse workforce is to look at recruiting five people, not one, and don't sort of make the one person feel like the whole weight of the world is on their shoulders.

I think that we are at a moment in time where I think the understanding certainly of the people in the sector are very driven by meeting the needs of clients. If the finding is certain clients are not coming to those services, I would expect there would be an openness to look at what are the capabilities in a current modern workforce that we need. So in the past I suspect there wasn't a rush for people to join the workforce; in those 70 stories that I hear are really very much women taking on something that others weren't prepared to.

But when I listen to this conversation if the view is to meet the needs of the clients we need different skills and we need experience in different cultures, different languages, then that should start being part of the capability set that we are recruiting for and we are vocally talking about.

I think the other challenge in any workforce

that's now well known about is something called homophily, which is that idea that you will naturally think the person who looks like you and sounds like you, you will see them as the more talented one because you are naturally attracted to someone like you. If there is better transparency about - this would be part of a recruitment strategy - what are the capabilities that we need and be more targeted towards different backgrounds or different experiences, then I think you would get more people applying and more people being successful in getting roles. If the workforce looks one way then it will require, as you said in New Zealand, a really focused attention to change that course. It's not going to inevitably happen.

MS ELLYARD: Just on that issue, and I think we have spoken about this perhaps to some extent already, when we think about making the workforce more diverse so as to respond to the needs of clients, at the moment the family violence workforce does respond to women from culturally and linguistically diverse backgrounds to some extent and it partly does that through the existence of a particular multicultural agency which creates - and this isn't a criticism - the services and the multicultural service. Can I invite you to speak a bit more about whether in making the workforce more diverse you run the risk of compartmentalising so that there's people from non-English speaking backgrounds who work for non-English speaking background clients and the services that already existed that respond to the so-called traditional client base.

COMMISSIONER JENKINS: I don't necessarily think that naturally follows, that if you had an Indian worker they would have

to always be dealing with an Indian client. I don't think that's necessarily desirable or what you would be aiming for. But over time I think that if people get more accustomed to coming to agencies - if I circle back.

I talked about meeting the needs of clients. But I also do think in the war for talent, good people, it is illogical that we are not trying to grab people from across the community, and I also think a diverse workforce by and large creates more innovation, has better governance. So if you put all those together it is not true in diverse workforces that it all gets segmented in that way. If there is a temptation for that, then organisations need to understand if you are a mainstream organisation you are providing the service more broadly but you can tailor as you need to.

MS ELLYARD: You mentioned earlier the imposition that would be placed on a number of quite small agencies if they were required to start reporting or acting actively on diversity issues when they are already so stretched and the Commission has heard relatively underfunded. What would you see as being the role of government in resourcing or supporting any diversity initiative in the family violence space?

COMMISSIONER JENKINS: I think that's crucial. Personally I think, whilst it's a very spread out sector, the issues that we are talking about by and large are similar in a single sector and that government would not just be providing money but in fact expertise. If you could have a central spot within government that would actually develop the strategies, provide the tools, guidelines and really give the support, perhaps skills and training, that

will be a very efficient way to assist the sector and also a supportive way because if the reality is we are going to get better outcomes then it would be a great investment.

So just thinking about this would be the idea of a central point in government that develops a broad workforce diversity strategy, perhaps even broader than this sector, but certainly tailored to this sector to provide the support, and then organisations need to access that support. So that's how I would see it, which is both resources but it's also the expertise.

MS ELLYARD: Did the Commissioners have any questions?

COMMISSIONER NEAVE: Would your organisation be a suitable one to do that task? It's a bit out of the mainstream for the sorts of things that you have done in the past.

COMMISSIONER JENKINS: I haven't given that thought, but certainly in terms of some of the skills and expertise the Commission might know we are doing a project at the moment that we have been engaged in from police. So Victoria Police have engaged us to do really a three-year project, but a one-year project to really come up for them with an action plan that involved research on the drivers, the barriers. So probably a similar piece of work. That work will come up with a very clear strategy that they are to implement. So I guess thinking while I'm talking we would have the skills and expertise. We would, as would any government agency, need the funding. But we would definitely, and I think it would fall within our statutory remit to do that.

COMMISSIONER NEAVE: A follow-up question. Are there any examples of service contracts where the government has required that there be some attempt to, for example, make

your workforce more bilingual or more bicultural? Most of the services that are specialist family violence services are funded through contracts to provide particular services. Do you see any difficulty in saying, "Well, we will fund you, but we will fund you on the basis that you hire some people to do this work with that set of skills"?

COMMISSIONER JENKINS: Off the top of my head, I don't know. But it seems completely logical that government could set those specifications in its contract as it does with any other contract that it engages. I know that government has traditionally set requirements for corporates about their equitable briefing of barristers, which is interesting. That had incredible success of immediately changing, partly because it was a requirement, partly because then organisations need to record. It drew attention to something that perhaps they unintentionally were doing. From my background I know that. It affected me in my professional career. I don't see why government couldn't do it, and perhaps they already do. But I guess my concern about this sector is that you also provide some support behind what that looks like.

COMMISSIONER NEAVE: Thank you.

DEPUTY COMMISSIONER FAULKNER: I think your earlier evidence said that the specialist family violence sector has an exemption under the Victorian legislation.

COMMISSIONER JENKINS: So the way the laws work now - it used to be the legislation meant that you could go and apply for an exemption. So lots of the family violence and lots of services that dealt with sexual assault would apply for an exemption to let them discriminate.

In the 2010 amendments there was introduced a

particular provision that also exists under the Sex Discrimination Act which is about special measures. So it's a provision that says if you are taking an action to rectify sort of substantive inequality, provided you meet a few criteria, and one of them is that it would help and it is proportionate and it is reasonable in the circumstances, that you can discriminate on that particular basis.

So what's happened in practice is some of these services can just justify that discriminating in - so examples might be family violence. The Women's Family Violence Legal Service can use that exception. So the law has worked to say, "Rather than have you all run off to VCAT and get an exception, we recognise that if there is substantive inequality and you are trying to fix it, you are not trying to do anything more than that, and it is proportionate and it's reasonably likely to help fix the problem," you don't have to come to us; the law will allow you to do that.

DEPUTY COMMISSIONER FAULKNER: Have there been examples of organisations - I think about the police, for example. You were talking earlier that women would prefer to go to a family violence service that is gendered in its staffing. I think women possibly prefer to see policewomen as well. Is there any history of that sort of action?

COMMISSIONER JENKINS: Yes, very common. So lots of the exceptions have been used. There's also requests to see the same sex of doctor for particular religious reasons. So there have been those. They are usually granted. I can provide to the Commission some evidence on the

exemptions that have been granted and the rationale given on why it believes it is justified.

COMMISSIONER NEAVE: One of the issues that's arisen in that context has related to the policy of some refuges to say that boys over the age of 12 can't be admitted, and also one of the issues that's been raised with us is that sometimes transgender people have not been admitted to refuges because they have not been women. I don't know whether you have had to grapple with any of those issues. They are very complex issues. I wondered whether you had any views to express on either of those.

COMMISSIONER JENKINS: I would want to consider those, but those are genuine concerns. Particularly I know transgender people have struggled in this area and the preconceived views on what they are entitled to. Similarly with the older boys. In terms of how the law works, certainly the Human Rights Charter and also the Equal Opportunity Act, it is quite often a balancing act in determining what's the line in terms of what are the rights of the people there versus - so prima facie to exclude a boy over 12 might be discrimination. Would a special measures provision apply? Maybe not. So you would go through some thinking. That organisation would really need to get clarity on that before they took that position. If they did, then I guess you would hope that there's proper and appropriate services available to them. But that makes it difficult if they are trying to be with their mother, for example.

COMMISSIONER NEAVE: The difficulty with the special measures provision is that it doesn't really give you much guidance in those sorts of situations because you are balancing

competing considerations.

COMMISSIONER JENKINS: That's right. I'm happy to think through those two questions, but that's the sort of questions that come to the Commission where we would think that through and talk that through without them needing to go for external legal advice and give our view on where that type of situation would fit. But that is very much the challenge. I listen to that and I can see completely the harm that could be caused on both sides with those scenarios.

COMMISSIONER NEAVE: Thank you.

MS ELLYARD: If there are no further questions I ask that the Commissioners be excused with our thanks and note that's the end of the evidence today.

COMMISSIONER NEAVE: Thank you very much indeed.

<(THE WITNESSES WITHDREW)

ADJOURNED UNTIL WEDNESDAY, 14 OCTOBER 2015 AT 9.30 AM