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TRANSCRIPT

OF PROCEEDINGS

PROTECTING VICTORIA'S VULNERABLE CHILDREN INQUIRY

THE HON P. D. CUMMINS, Chair
PROF D. SCOTT OAM
MR W. SCALES AO

BALLARAT

10.03 AM, WEDNESDAY, 25 MAY 2011

MR CUMMINS: I'm very pleased to invite Auntie Marlene to welcome us to her country. Thank you, auntie.

5 AUNTIE MARLENE GILSON: Good morning distinguished guests, ladies and gentlemen. Hello, my name is Marlene. This is Wathaurung land. As a Wathaurung elder and traditional owner, I would like to welcome you to my country on behalf of my ancestors, elders past and present, welcome to our land. The Wathaurung people are part of the Kulin nation. The creator of the Kulin land 10 and its people is the work of the great ancestor spirit known as Bunjil the eagle, who still watches over the land today. For us, the Aboriginal people, the land has a spiritual connection. It's our mother, Mother Earth. The human spirit is born from our land and returns to it upon death. The land was our supermarket. We may be from different cultures, but we are one people, Australians, and may we walk in 15 unity. I would also like to say thank you for respecting a culture thousands of years old. Thank you, have a good day.

MR CUMMINS: Thank you very much. We're delighted, Auntie Marlene, that you have honoured us by your welcome and we're very glad that you are here. We 20 do all pay deep respects to the traditional custodians of the land upon which we meet, the Wathaurung people of the Kulin nation, and we pay our respects to the elders, past and present, and we look forward to future as well and we pay our respects to elders from other communities as well who may be here today.

25 On behalf of the Panel, I most warmly welcome you here this morning. This is the second of our public sittings. We sat in Geelong last Wednesday and we are here today in Ballarat. We have come first to the regions because we wish to signify the importance of the regions and so we want to be here in the regions first and we'll be sitting in Melbourne and the metropolitan area later.

30

As you know, the Inquiry was announced by the Premier on 31 January this year and we are to report by providing our Report to the Minister by 4 November and she will then table the report in Parliament. Some people have said to us that the nine months is a very short period, but we've had the benefit of a very large number 35 of written submissions to the Inquiry and we would like the benefit of your verbal submissions here today. Some persons have also made written submissions and if they wish to speak in addition to that, of course we'd be very pleased to hear them.

It is a special Inquiry in this sense, that we are retained to inquire into the whole 40 system of child protection in Victoria and our brief is to look at the system and to seek to provide solutions to systemic problems. For that reason, we are not inquiring into individual organisations and we're not inquiring into individual cases. That does not mean for a minute that individual cases are unimportant. On the contrary, we are very conscious indeed of the significance of individual cases and 45 of the difficulty that individual persons often have experienced. We are aware of

that and we respect that and we acknowledge that. But this Inquiry is different from an Inquiry perhaps by the Ombudsman or the by Child Safety Commissioner into individual cases. Many Inquiries look at individual cases or look to the past to allocate liability or blame, and that's a perfectly right, proper and important function, but our function is quite different, it's essentially to look to the future and to look to the system as a whole. For that reason, therefore, we think that the nine months we have been given is an appropriate time. I'm quite sure we could be gainfully occupied for three years examining matters, but I think in the end we'd probably find we're getting more material indicating the same things as we will get, we hope, in this nine months with the benefit of your input. So that's our brief, ladies and gentlemen, to look at the policy and to look at the system as a whole rather than individual cases and to look forward to solutions, not just looking back to problems.

Now, this is a public sitting, as of course you appreciate, and a couple of things flow from that, ladies and gentlemen. That means that anything that you say is permissible to be published, and you might bear in mind that this is not a court of law. As you know, in a court of law, like I sat in for 22 years, what is said in court is privileged from action for defamation, but in a public sitting, which this is not a court of law, there is no privilege against proceedings for defamation and no privilege against self-incrimination, so bear that in mind, ladies and gentlemen. I don't say that in any way to be critical of anyone. On the contrary, I'm saying it in fairness to everyone so that you can bear that in mind, that those privileges in a court do not apply to this public sitting.

There is another special provision. As you know, the Children Youth and Families Act makes special provision that you cannot identify a person who has been the subject of or a witness in Children's Court proceedings, so you must be very careful not to not only name any person, but identify them by any other means, such as referring to the family, or referring to their residential area, or matters which could identify a person who has been in the Children's Court process. That is a very important restriction. The press are well aware of it, they are very familiar with this area and they know not to disseminate that, but the word "publish" means just saying it in a public hearing, including this. So do bear in mind, we want you to tell us your submissions, but make sure you don't identify persons. If you keep it general in that way, that will comply with the provisions of the legislation.

We're very pleased to be here. I think we're very fortunate to have two very distinguished members of the Panel, Prof Dorothy Scott and Mr Bill Scales, highly qualified and experienced persons and so I'll go and sit down and join them and then we'll invite you to come forward. Our first set of submissions is Francis Broekman, Ruth Isbel and Di Allen from Brophy Family and Youth Services and we're very pleased to invite you to come forward and thank you for being here. So if you just take a minute and settle yourselves down and then we'll take it in the order that you would like to present. So, Francis, would you like to commence?

MR BROEKMAN: Yes. Thank you very much for the opportunity to be able to come before you and give our presentation and our submission. If I could just introduce my colleagues. On my furtherest right is Ruth Isbel, who is our client services manager at Brophy, and Diane Allen, who is our team leader for all of our out-of-home care services.

If I could just give a very quick summary of what Brophy is. We're primarily a youth and welfare service with about 70 staff covering the expanses of south west Victoria with locations in Warrnambool, Portland and Hamilton. Collectively, we have about 50 years of experience in the child protection area, or maybe we've just had one year of experience each and treadmilled and repeated that 15 years each, but we have been involved in various sectors in terms of DHS and also not-for-profit organisations. The organisation provides 35 different programs with the youth family and homeless sectors being the primary focus.

Today our submission primarily focuses on our observations and work with adolescents aged between 12 and 18 years of age. We have chosen to do so because we believe that many of the reforms of the Children, Youth and Families Act have in many ways bypassed the plight of adolescents in the out-of-home care system. So we've divided the focus into three parts: reviewing the strengths, weaknesses and possible solutions relating to the adolescent services that intervene early to or divert or stop adolescents from entering the system; then the care of adolescents whilst they're in the system; and then, finally, the transitioning of adolescents out of the system. Then we'd like to finish up with providing a bit of an outline of Brophy's model as the community and youth complex and how that interweaves as an early intervention strategy. So if I could pass you over to Diane Allen to start off.

MR CUMMINS: Thank you. Di.

MS ALLEN: Thank you very much. I'm going to talk about the services that intervene early to divert or stop adolescents from entering the out-of-home care system. The Children, Youth and Families Act and the Every Child Every Chance initiatives have seen have seen significant improvement in the early intervention area with the development of the Child First sites and the introduction of the community-based child protection program which streamlines the entry into family services and strengthens the service system to respond to referrals. This initiative has proven to be very beneficial in south west Victoria where agencies delivering family services have formed an alliance based on agency expertise with Brophy servicing adolescents and their families. Previous programs, such as Family Innovations support program, were developed to allow support to vulnerable families over an extended period of time. However, with the introduction of Child First, the funding for agencies has been limited to periods of a maximum of 110 hours, which we feel inhibits our ability to work in longer term with families in

the family services area.

Early intervention programs, such as Finding Solutions, which aim to divert young people from the child protection system at the point of family crisis and provide mediation have been successful for the young people and their families who have been able to access this program. However, the only referral point for this program is through child protection, which limits access for some families, and due to current funding we have limited capacity, we have two days a week to provide that program in the whole of the south west of Victoria.

In terms of education, we think that adolescents from disadvantaged backgrounds with abuse and neglect and histories and transience struggle in the education system, especially in the transition from primary to high school, and some children who fly under the radar in primary school, once they hit high school are ill-equipped to cope academically and socially in their setting, so that isolates them further from their community. We have early intervention programs, such as Families and Schools Together, school-focused youth services and Youth Connections, they go some way to providing support to vulnerable adolescents. However, there needs to be a streamlining of the system to identify vulnerable young children at the transition point into high school entry and to provide a holistic approach to support them.

In relation to mental health, the Headspace initiative is providing much needed assessment and intervention for adolescents at the risk of mental illness and to link those adolescents into appropriate supports. In our agency, we have an integrated intake service which links young people into programs within our own agency and they get allocated a key worker in the agency to provide management of those young people coming through that Headspace point.

The Kinship Care program is a welcome initiative as it's a much neglected area of the service system. However, adolescent community placements for young people are requested by the department often prior to exploring whether any kinship care options are available. I think this occurs because the child protection system is at times overwhelmed and unable to adequately explore other family options prior to thinking about adolescent community or any other out-of-home care. I think if kinship placements were identified at the point of removal of a child, this would be less stressful on the child and relieve some of the pressure in the out-of-home care system.

Housing is a significant issue for young people. Next year Brophy in Warrnambool will commence a youth Foyer model and provide low cost housing for 16 vulnerable youth. We already have Horizon House, which provides support for people who are in education and training, but clients as young as 14 are presenting at our agency in need of housing and support following family breakdown or conflict and we see a holistic approach to support these young people as being vital

to enable them to transition into adulthood, so they need stable housing, education and training.

Disability is my last point. There is a significant need for appropriate planning for young people who have been in long-term out-of-home care who have intellectual or physical disabilities. Sometimes their orders lapse at the age of 17, but they're not eligible for supported accommodation in disability services until they're 18 and often times these young people go into the homelessness system and they're very vulnerable young people, so we believe there is a significant gap in the service system around disabled young people. I think that's me done.

MR CUMMINS: Does that cover it sufficiently for the moment, Di?

MS ALLEN: Yes, thank you.

MR CUMMINS: Thank you very much. Would you like Ruth to go next or you?

MR BROEKMAN: I'll go next and then Ruth will take over from me.

MR CUMMINS: Yes, thank you, Francis.

MR BROEKMAN: Once it's been decided by DHS that an adolescent needs to enter into the out-of-home care, there are two main paths that one can be involved with. One is them entering into the ACP, or the adolescent community placement program, which is similar to a foster care adolescent program, or into residential care. Whilst there are a number of other peripheral accommodation options, most of those are mainly crisis oriented. So the strength of the adolescent foster care program is that it allows young people to have their individual needs more likely met than if they were in a group care setting. Carers provide a safe and supportive environment and when the match works, the therapeutic impact on young people is quite extraordinary. ACP works well for adolescents who are not streetwise, have the capacity to bond to carers and are not exhibiting complex needs.

However, there are many structural weaknesses in the ACP program which are seriously undermining its ongoing viability. One is that it's based on volunteers and volunteers are able to say no, and they do say no to taking placements, which then makes it very difficult to place young people, particularly when asked by DHS. It has become increasingly difficult to recruit and retain carers, especially to care for adolescents exhibiting very challenging behaviours. Those carers who do become part of the ACP program have increasingly less time to care for adolescents due to work and social commitments. Many of the carers that we have, both dual and single, are in the workforce and hence their availability and capacity to care for adolescents out of school is increasingly comprised.

Most placements are made with scant information about the adolescent, with no

proper assessment having been made on the needs of the adolescent. Hence, inappropriate matches are made and placement transfers are extremely common. The increasingly complex nature of adolescents who need care are burning out carers more quickly than they can be replaced. It's common practice for carers now to take on two placements at any one time. The last point is that there is no real therapeutic care model that underpins the work undertaken by carers and agency staff. The therapeutic care model that has been implemented for children under the age of 12 appears to be having significant results, but there is no equivalent for the adolescent cohort and it could be easily argued that the behaviour management issues in adolescent care are far more demanding on and damaging to placements.

The other accommodation platform upon which out-of-home care is premised is the provision of residential care. The strength of the residential care is that it has a staff 24/7 and hence supervision is provided. It does provide a roof over the heads of a number of young people. Some of the new reforms in developing therapeutic models of care are also really promising and moving in the right direction. The weakness of the resi care system is that care is used primarily to dump children and young people who do not fit any other form of accommodation. Kids in these residential units either exhibit very complex problems, often underpinned by social, emotional, physical learning and acquired disabilities.

Some of the solutions that we think could be viewed or considered by the Panel is that the ACP program needs to be better resourced to be able to provide greater therapeutic care to adolescents and carers. Each program should have a therapeutic care clinician attached to the program or in some form. Volunteer carers remain an important part of the system. However, the system needs to develop the capacity to access a pool of professional carers who can care for those young people with complex needs whilst not being financially disadvantaged by receiving significant reimbursement that can be substituted as a wage. Also, professional carers offer the system an additional type of accommodation and care that addresses the service gap between that that exists between the ACP program and the residential care program. With the increasing number of adolescents not attending school or falling out of school, the ACP programs should have access to educationalists who can utilise accelerated learning techniques, as well as assisting young people to remain or return to the education system.

Finally, to address the number of inappropriate placements into care, whether that be due to the lack of information or no proper needs assessment having been able to be undertaken, the front end of the OH and S system needs an assessment unit specifically for adolescents so that their needs, their wishes and their options can be fully explored prior to a possible placement. I will now pass you over to Ruth.

MR CUMMINS: Thanks, Francis. Ruth.

MS ISBEL: I'm going to talk about transitioning adolescents leaving state care.

Brophy as an organisation has been really lucky that we've been delivering the Office of Housing Young People Leaving Care Housing and Support initiative for about six years and we've also gained funding through the national partnerships agreement and combined that with the money that's come through the placement
5 and support branch as well.

The following are some very short key areas which we believe are the strengths, weaknesses and possible improvements for the outcomes for young people leaving care. So the strength of the model that we've developed is that it is a cross-sector
10 approach which recognises that the needs of young people leaving care are not homogeneous and as such responses need to reflect this.

Our leaving care program sits within the community and youth complex, which Francis will talk a little further about, which has a raft of services tailored for young
15 people. The co-location of services, such as mental health, drug and alcohol, welfare and youth services, health and education and training aims to provide a holistic response to young people and improve access to specialist services. The leaving care program is integrated within this model of service delivery and young people benefit from the improved entry screening and intake processes, referral
20 pathways to specialist services and ongoing care planning.

Another strength is that workers have been able to develop over time strong relationships with child protection and out-of-home care services which has benefit in the majority of cases to enable early referrals, strong young person-centred
25 transition planning based on a comprehensive assessment. Workers are able to support young people over a long period of time because the different areas of funding actually have different eligibility criteria or models, so they're actually able to support young people for up to three years after they leave care with varying degrees of intensity so the young people are able to come back and forward to the
30 services required.

The capacity to engage with young people while they are still in care is a strength as well. This promotes an engagement and relationship approach which focuses on providing young people with the opportunity to develop life skills pre and post
35 leaving care, so engaging with them early while they're still in care is a really key facet of the leaving care program. The access to the brokerage which has come as part of the placement and support initiative has been fantastic. It has provided young people with the opportunity to have their basic, physical, financial and practical needs met. Access to the mentoring program, which again has been
40 through the placement and support-funded dollars, has provided young people with the opportunity to interact with adults in community settings, to promote personal relationships that increase social connectedness and encourage aspirational thinking around vocation and careers, so a focus on the education, employment and training.

45 Some of the weaknesses which we've identified, while I say that it's provided a

really good opportunity for good transition planning, transition planning for young people is often given a low priority and I think that's been indicated by the recent report by the Create Foundation where the actual numbers are quite low for young people having formal transition planning, so the planning is often seen as optional rather than a central issue for young people that are 16 plus.

Sometimes care teams are poorly functioning, so when the care teams around a young person and their family are not functioning well, then the planning can't be of a high, strong quality for their future. Young people are sometimes not given the opportunity to develop life skills through everyday life and activities, and that can be particularly evident in young people exiting residential care. They often have limited access to safe, affordable accommodation options, so that is particularly critical in regional areas, particularly Warrnambool, which has one of the highest rental rates outside of Warrnambool. So safe, affordable accommodation is a really difficult challenge for the workers and the young people as well, and no funding specifically designated to high risk young people leaving care, so all the funding that we have excludes young people who have been in the high risk category while they're in care and I think that's a real weakness that we need to actually put some effort into focusing our attentions on how to provide them with a service that gives them access to the more mainstream services as well.

Some of our solutions, and clearly these are very limited and not highly well-developed here, but development of a variety of accommodation options with a variety of support models for young people leaving care and we've been fortunate enough to have the Foyer model coming on board in Warrnambool, Horizon House. We do have some limited accommodation connected to our Office of Housing funding for leaving care as well and certainly the act says to housing, the key to success in transitioning, situate leaving care services in youth-focused agencies that can provide connections and referrals to a raft of services that are outside of the care and protection system, that are actually moving young people into the community and into the more mainstream services, a stronger priority given to transition planning by child protection and out-of-home care services and a consistent standard of transition planning developed across the state so that there is a standard and everyone is on the same page around what's required in a transition plan for a young person. A stronger focus on education, employment and training through developing partnerships with key players in that sector and training for out-of-home care givers, specifically around the life skills development in daily life, that that is a skill actually assisting young people to pick those skills up.

MR CUMMINS: Thank you, Ruth. We are most impressed by the work you put into this, so thank you very much for that. What we propose to do with all the presentations, commencing with yours, is that they are recorded and we'll be then publishing them at the conclusion of the public sittings so that other people from other areas will have the benefit of accessing them as well, but that's been most helpful the way you've actually divided it up, so that's excellent. Are there

members of the Panel who would like to ask some questions about what has been presented?

MR SCALES: There's a lot, but please.

5

PROF SCOTT: Yes, perhaps if I could start. Thank you for the very helpful description of your programs. You may not be able to answer this on the spot, so perhaps you could follow-up and provide the Inquiry with some further information, but I'm very interested in whether you've been able to do a detailed
10 quantitative analysis of the reasons that young people are coming into care. You talked about family breakdown, but do we understand more about that? I mean to what degree are families struggling with issues around homelessness, or is it domestic violence which is a trigger to the family breakdown or parental mental health issues or parental drug and alcohol issues? Can you look into the group of
15 children and young people you're serving and be more detailed in our understanding because unless we have more detail about that, the potential to prevent young people coming into care will be constrained, so what might be able to be interpreted from any information you may be holding about those reasons about how one could respond in a way that enabled young people to remain in their
20 families. Then if the situation is such that young people can't remain in their families or where that just isn't possible from that young person's perspective, I notice in the submission that very little attention seems to be given to kinship care. How could that be addressed? How could opportunities within the extended family and within the friendship and social network, the web of relationships where young
25 people already have trusting relationships with others, how could one maximise the opportunity for a young person to be in that type of care rather than in foster care with people whom they don't know? You may have a comment about that now, but it may be that there is further information you could provide to us.

30 MR CUMMINS: You're welcome to take it on notice.

PROF SCOTT: Take this on notice.

MR BROEKMAN: We're more than happy to take it on notice and we will present
35 some more information on why young people are in care, going into care and the relationship between the out-of-home care system and kinship care. In relation to that, I would say that I think it's going to be a fantastic adjunct to the front end of out-of-home care in that the Kinship Care program have only just started over just the last couple of years and for us it's only been in existence just for this year, so it's
40 early days, but there certainly will be opportunities for Kinship Care, for the program, to take on a stronger role.

One of the issues that we're facing at the moment is that when child protection decides that a young person needs to come into care, there is no where to place
45 them, apart from in placements, involuntary placements that gives us time and DHS

time to be able to explore the kinship networks. It's a crisis situation at that particular point in time and therefore they need to sort of get the kid out and placed and then it's sort of like, "Now what can we do?" So it would be great if over time, knowing that the kinship care is there, that we're able to intervene earlier through some of our other programs, like Finding Solutions, and be able to link that and to explore the extended families and then be able to place them and support them in that way. But the situation at the moment is that the Kinship Care program is still very much tied specifically to DHS referrals and that's very significant in terms of stopping the flow through the community end.

MR CUMMINS: Right. Mr Scales.

MR SCALES: There are a number of questions I wanted to ask, so Dorothy, if you want to take - - -

PROF SCOTT: Yes, I'd just like to explore it a bit further. It's been a long-standing principle in the field of child welfare that one would first look to the child's or young person's extended family and only when one couldn't find within that web of relationships an appropriate safe place, even for a very short period of time until situations could be further analysed and sorted out and clarified, would you then move to placing a child with a stranger. So I'm still not fully understanding why at that initial crisis situation there cannot be a further exploration in relation to the child's kith and kinship system, rather than assuming that foster care needs to be the response in the crisis. Could you help me understand that a bit better?

MR BROEKMAN: We agree with you, but in practice that doesn't happen.

MS ISBEL: And I think that's around more a resourcing issue. Programs like Finding Solutions are actually doing exactly what you're talking about in terms of diverting from the out-of-home care system, there's a crisis, the young person is about to either come into the out-of-home care system or they've left home and it works really intensely, exploring the family relationships to keep that young person within their family network, whether that be their parents or not. I think it's an incredibly successful program, but it's not well funded, so we have point 5, so we can only work with about three families at one time for a three-month period and that's our role as not being part of child protection. Child protection are doing their work and sometimes we don't have a lot of say over that in a situation as well, so we'll get the referral for out-of-home care and not have much control around the kinship network that's been looked at. But in terms of Finding Solutions, before they enter the child protection system, we can actually do a quite substantial amount of work around exploring their kith and kin networks.

PROF SCOTT: So is it possible, when working with the family to try to keep the family together, you can identify resources within the extended family if that isn't

successful - - -

MS ISBEL: Yes.

5 PROF SCOTT: - - - if that does fall apart and therefore prevent a young person coming into foster care.

MS ALLEN: And that's the whole ethos of the Finding Solutions program.

10 PROF SCOTT: Have you got some data on the number of instances where that has been possible to show - - -

MS ISBEL: We can get that.

15 PROF SCOTT: - - - and again on notice, not now, but what we're looking for is evidence of effectiveness of alternative ways of responding to these family situations.

MS ISBEL: Yes, I think we could get that.

20

MR SCALES: If I could just add to that, I was going to ask you a question about that because it seems to me that the system might also inadvertently or deliberately get in the road of that. For example, we've had some submissions that have come to us and some presentations that say, for example, the rights of the family should
25 be operating very quickly to resolve this, and yet what I'm hearing, I think you say, is you need time for these things to be resolved and if the court system intervenes too quickly and requires too much of a prescriptive timetable for the resolution of these issues, that might not be possible. So to the extent that you think that the system gets in the road of these sort of sensible outcomes, they would be a very
30 helpful addendum to the issues that Dorothy's raising with you. Does that make sense?

MS ALLEN: Yes. Having experience across both the child protection and the not-for-profit sector, my view would be that when children or adolescents are
35 removed from their families at a point of crisis in child protection, often times the child protection system is so overwhelmed that it doesn't have the time and the opportunity to explore extended family in a timely manner and sometimes it is a crisis and they don't have time to find anybody, but sometimes the time lag between a child being removed and the exploration of extended family blows out because of
40 lack of resources within the child protection system to thoroughly investigate kinship options for that child. At the point that we get the referral for an out-of-home care placement, we don't have any, I suppose, any role to ask questions about have they explored extended family first. It's a request to our agency for an out-of-home placement. We either have one or we don't and we
45 accommodate or we can't, so it's not in our realm of I suppose in our jurisdiction to

ask questions of the child protection system to say, "Well, have you done this and have you done that?" and often times we'll take children into care and identify that they've got numerous extended family members after speaking to their carers and our staff, and we work together with child protection then to try and identify an
5 alternative kinship placement for them.

PROF SCOTT: Does that suggest then that the young people themselves may not have been asked about members of their extended family who could provide them with immediate accommodation?

10

MS ALLEN: It's possible, especially younger children. Older adolescents may have been asked about a friend or a neighbour or a relative, but frequently we find children coming into care who can identify relatives or friends and that hasn't been explored.

15

PROF SCOTT: Thank you.

MR SCALES: I want to go through systematically some of the points you raised so let me start where you started with, was some discussions about Child First I
20 think.

MS ISBEL: Yes.

MR SCALES: I was interested in your commentaries around the resourcing and I
25 want to try and separate Child First itself from the agencies that work with and the alliances that work with Child First and the resourcing there. Can you talk about each of those a bit separately. Were you describing the resources available to Child First as a means of assessing the child and/or the family, alternatively the family, before they are then placed with various alliance partners, or were you actually
30 talking about the resources available to the alliance partners?

MS ALLEN: I think that it's both. I think that the Child First sites were set up probably about five years ago in our region, following on from the Innovations projects and there was a certain amount of funding given to each alliance
35 partnership, but it's our experience that it hasn't been reviewed to see what the need has been and whether the call on the service is outstripping the ability to provide the service.

MR SCALES: I mean the reason I ask it is that, as you would expect, a number of
40 people are talking in very positive terms about Child First because they can see this is one of those developments that can help people to sort of in a sense meet the whole need of the family or the child, so that's very sensible, but at the same time they're making not dissimilar points that you're making about the resourcing. I suppose from my point of view I'm trying to peel back the onion a bit more and say,
45 "Well, where's this blockage, you know, what are we talking about here?" Is it the

concept of Child First that somehow the governance framework hasn't been set up correctly, or is it that we're putting our resource in the wrong spot, or is it really what we're now seeing is an identification of a problem which was already there, that is, the lack of resources which are available to those organisations which are meeting the needs of Child First, so it's trying to - again, as Philip said, we don't need for you to have an answer on that today - but if you have a view that would be sort of helpful to begin to guide certainly me anyway where I should direct my thinking.

MS ISBEL: And certainly I'd say, just concurring with Di, but the actual family services area I think is where the resource is reasonably poor.

MR SCALES: So again, without putting words in your mouth, the assessment seems to be going okay.

MS ISBEL: Yes.

MS ALLEN: Yes.

MR SCALES: But then it's the lack of available resources - - -

MS ALLEN: Yes, yes.

MR SCALES: - - - to be able to have the family or the child's needs met via the alliance partners appropriate.

MS ALLEN: Yes.

MS ISBEL: And particularly the long-term, the families that have the more chronic ingrained issues with support for over a long period of time, which originally we thought we were going to be able to do through Innovations, but that changed and we've now got throughput pressures, so families start recycling because they haven't got that intense support and we don't have the capacity to do it.

MR SCALES: Can I ask you a bit about education and I just want to move through them as you've described them. This issue about the ability to move between stages of education is really interesting so I wanted to explore that just for a moment. Before I do that, I want to get your sense about the extent to which in effectively the sort of broader Grampians region there is a different set of issues around meeting the educational needs than what you might find in sort of downtown Melbourne. Should we be thinking about this differently than we might think about it in other geographic regions, this educational problem I mean.

MS ALLEN: I think that the tyranny of distance, certainly in south west Victoria,

brings its own issues to children in education, and especially for education for children in out-of-home care. I've got an example of a young man that was just living on the border, between South Australia and Victoria, and he was put into out-of-home care, but it's very difficult to access schooling. So moving children from one part of the region to another and starting again with community and linking them into education is difficult.

MR BROEKMAN: May I add to that that from a rural perspective it's more difficult. There are not the same number of options open to young people, particularly if their behaviour is not seen by the school as being really helpful to the school. There are very few options to take them out and place them in another. The schools already know these kids and therefore won't support them and there's very few alternative education settings within rural areas, due to the lack of numbers, to be able to afford or create those opportunities.

MR SCALES: That leads me into I guess the second set of issues that I'm interested in your view about. It seems to me now that the information, the evidence that seems to be coming through from the Inquiry so far is that there is almost an inexplicable link between the out-of-home care need of the child and the educational need of the child. What we seem to be getting is two sets of imperatives bouncing up against each other, this great need for just good shelter for the child and make sure that they're well cared for, and then this interaction with the education system, and when they are disjointed, that is, the child goes from various placement, they then go to various schools with all of the resultant added trauma. Now, that leads to at least a potential sort of discussion about how we think about the interaction between those two when we're making decisions about either schooling or out-of-home care and I'm wondering whether you've thought about that and whether there are issues there that you might sort of guide us in. I mean, for example, when you've been in discussion with DHS about a placement for out-of-home care, has there also been a discussion about how there can be the minimum level of disruption around a child's education during that process.

MS ALLEN: That's always a discussion we've had.

MS ISBEL: It's always a discussion and it's certainly a very agonising discussion at times because being in a rural area we have very limited placements in areas like Portland or Hamilton or Cobden, the smaller areas, and you may have a young person who's actually attending an SDS at Cobden, but we can't find a placement close to home so we have to find a placement that's maybe an hour and a half or an hour's drive away, so we do try to transport that young person back and forth, but that has its own issues as well. So it's a really strong dilemma and challenge in the rural areas around schooling because we do have to disrupt their schooling because we can't find the placements.

Some of our ideas around trying to recruit more carers, and we're currently in the

progress of a strategy, is around trying to connect with school communities so that the school community takes some ownership and responsibility of their children and young people that are in their zone so that we can find carers that if there is a young person that needs to stay at that school - sometimes moving school is a good idea, sometimes it's not - that the school community will take some responsibility around finding a home for that young person, and they would be accredited carers, so that's sort of one of our strategies currently, to address two issues, which is the need to move kids continually, as well as our lack of carers as well.

MS ISBEL: And I think it goes a bit broader than that too in terms of disconnect from not just schooling, but sporting clubs and community infrastructure that a young person may have had in one small town say, and then having to be placed an hour and a half away, you know, can't access the training sessions, can't access the footy, can't access the mates and all of those things that go with that.

MR SCALES: You talked about this issue about moving between different stages of education for a child that might be in out-of-home care. Do you have any view about whether there needs to be different programs for that? Is that what you're suggesting, that there is sort of a special need as a child goes either from primary to secondary, secondary maybe to tertiary, whether it's FET, or something else. Is that what you had in mind when you were talking about that?

MS ALLEN: I think it's also about acknowledging that some of the children that have come from very disadvantaged backgrounds who have lacked the skills of the basic reading, writing and maths have managed to struggle through primary and been put up in classes when their skills may not have been to the level that they should have, but coming from a very small rural primary school to a very big high school, say in central Warrnambool, has some significant challenges for these young people because they're behind academically, they struggle socially because of their disadvantaged backgrounds and just to shore up more support and put more resources into the transition for those young people at that point of entry into high school I think is crucial. Some schools are much better at it than others, but I think it needs a systemic, planned approach to identifying those kids in primary school that may struggle, and I'm sure primary schools can have the ability to do that and work maybe across the two levels at the point of transition to make sure that those kids do settle well into high school and can achieve as much as their abilities allow.

MR BROEKMAN: One other thing in regards to that is that if we're able to have access to an educationalist that's working with the kids that are in the out-of-home care, we're able to give some continuity and consistency of educational support to them if they do go to different schools. What we do find is that it's very difficult (a) to find an assessment, an educational assessment of these young people, to be able to then utilise some of the best qualities that they do have and then add and build on that to be able to create better educational outcomes for them. They're so far behind because of the trauma, and you all know about the theories around the

capacity to learn, the lack of capacity to learn when traumatised, that we don't integrate that therapy, dealing with trauma, and then also working with the learning environment as well. So a lot of those kids just fall out and a number of the kids have fallen out of the system, so we're wanting to support them with an educational focus, not just to say that TAFE can do it, or this school can do it, or that school because it's just going to continue to be a carte blanche and a dog's breakfast. That's why we're sort of saying that if ACP programs either have access to or do have an educationalist so that they can work with these kids directly and support them, know them, they can also then be a key worker that can link them to the schools and other educational opportunities.

MR SCALES: Thank you. I want to move on then to - we've talked about kinship care, so that's been terrific. I want to talk then about your comment about adolescents, in particular, and in particular I think you raised the question of therapeutic care, models for adolescents. I'd be interested to know what you had in mind in terms of what the therapeutic care model for adolescents might look like and how different it might be for those young children that are the not adolescents. What would we be looking at there?

MS ALLEN: Our idea around a therapeutic model for adolescents is more about having a team of workers, including a mental health or a clinician, a psychologist attached to the program staff that can work with both the carers, the young person and our staff to manage the behaviour and to actually work on a model that's around building capacity, building skills and addressing past trauma. So it's not necessarily that they're available 24 hours or that model, but somewhere that can skill-up staff and the carers to actually work with that young person in a much more therapeutic way. Rather than at the moment our placement staff aren't experts on every form of disability or issue, so for them to be able to be on top of those issues and support the young person and support the carers to be able to manage those behaviours is actually quite difficult and they're not trained in that area, so to actually build the skill base of the people around the placement is our idea of a model that's more therapeutic than what we have now.

MR SCALES: Thank you, that's helpful. You also talked about the access to the brokerage to I think you said the reallocation and support funding. I don't think I'm familiar with that. Do you know if we've looked at that, Dorothy?

PROF SCOTT: It would be good to hear a little more about that, how it can be flexibly used.

MS ISBEL: That's for the live-in care?

MR SCALES: Yes, that's right.

MS ISBEL: The placement support live-in care?

MR SCALES: Yes, please, yes.

MS ISBEL: Yes, the region has quite a large amount of brokerage and that brokerage is - the target is mainly young people who have exited state care, but you can also apply for brokerage for young people who are still in care.

MR SCALES: So you apply to DHS for that brokerage?

MS ISBEL: The agencies, there's two agencies, ourselves and Barwon Youth, who is in Geelong, and we manage that brokerage in partnership with the department and it's mainly about assisting them with their physical and financial needs to leave care in a really planned way. So we put in money around - it could be rent, assisting them with rentals over a period of time, so accessing accommodation; it can be furnishings for a house, we all know young people leave care with very little of their own belongings and TLUP - and don't ask me what that stands for - but TLUP, which you apply to the Commonwealth for, is only about $1000. So this brokerage can actually assist them to furnish a house, it can support them. It's really flexible. It can support them with a car, if that means they're going to get a job; it will support them if they're going on to further education. It's incredibly flexible in terms of what we can use it for.

MR SCALES: This may be an oversimplification, but are you given a resource pool that you can use in those circumstances?

MS ISBEL: Yes.

MR SCALES: It would be helpful to know a bit more about that, I might say, about how that operates in practice, we'd be very interested.

MS ISBEL: And we, as an organisation, can sign off anything under 500, but it needs to go to a funding panel - - -

MR SCALES: Sensible.

MS ISBEL: - - - if there's anything over that.

MR SCALES: Okay. Well, a bit more information on that would be practical, about how that applies in practice would be very helpful. I think just finally from me, Philip, I think, Francis, you said that you were going to just talk about the principles of sort of Brophy that drives you, but I didn't hear - maybe we cut you off and didn't give you enough time to talk about that. Did you want to make a comment about that?

MR CUMMINS: We're going to ask you to sum up at the end.

MR BROEKMAN: I could sum up?

MR CUMMINS: Yes.

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MR BROEKMAN: Thanks Bill. One of the issues that we've always sort of struggled with is the siloed effect that we are all in, whether it's education, employment, out-of-home care, mental health, drug and alcohol and juvenile justice and we find that any of those young people in those particular areas are siloed in
10 that we were really concerned that we weren't able to mainstream a link in other sectors to be able to provide a more holistic approach. So the board decided that we needed to then look at some sort of way in which we could do that and we developed what we now call is the community and youth complex which is based in Warrnambool and it has a number of co-located agencies and a number of
15 service partnerships with various sectors and it is a graded care system and by saying that we have an integrated intake system so that any young person, whether they have drug and alcohol, mental health, whatever issues, it could be out-of-home care, it could be juvenile justice, are intaked, able to be assessed more fully, obviously depending on whether it needs to be done or not, and we're able to then
20 link them to the services that they need and we're able to track that.

In that we saw that it was just not around the service area, we needed to intervene more earlier, so within the same building, it's a three-storey building, we've been able to develop youth enterprise community activity programs on our ground floor,
25 so we have a youth retail and a coffee shop and a music area so we're able to include young people from all different walks of life, you know, whatever they're involved with, referrals can be made from other programs for them to be involved in just youth stuff and learn skills, life skills. But then we also have, through Headspace, we have a health service, so we have a sexual health nurse that we have
30 on board, a couple of GPs and two psychologists that we can actually access. So we're getting a lot of young people that are coming just off the street, accessing the health services, and then saying, "Oh, by the way, I also something else in relation to X or Y and my family," or whatever, so we're able to intervene more early with that.

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Also, we're able to provide I think a stronger or better quality service to juvenile justice kids and to also out-of-home care because each one of those young people can be referred back to the health service in which a mental health care plan can be achieved and also then other services that are mainstream, more mainstreamed to be
40 able to access, whether that be universal, maternal health or whatever, we do have access to that. So it took us quite a while, it took us 10 years to build and to fundraise and create and we just think that it's - particularly in rural areas where we have point 2 of this and point 1 of that and point 3 of that, that we're able to then draw that together and provide a more holistic care approach.

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MR CUMMINS: Francis, that's terrific. Francis, Di and Ruth thank you very much for your presentation, it's been most helpful and we look forward to some further input along the lines we've discussed, but we very warmly wish you well with your work.

MR BROEKMAN: Thank you.

MR CUMMINS: We'd now invite Marlene Butler and Jeneice Robertson of Child and Family Services to come forward. Marlene and Jeneice just take a moment and settle yourselves in conveniently. Marlene and Jeneice are from Child and Family Services and we very warmly welcome Kevin Zibell as well, the chair. We're very pleased to see you hear, Kevin. We've had the benefit, Marlene and Jeneice, of studying the written material, so assume that we are familiar with that and we're very pleased to hear you in the way that you'd find most convenient to proceed.

MS BUTLER: Thank you. Can you hear us?

MR CUMMINS: Yes.

MS BUTLER: I'm Marlene Butler and I'm the manager of Family and Early Childhood Services at CAFS. Do you want to introduce yourself?

MS ROBERTSON: And Jeneice Robertson. I coordinate kinship, adoption and permanent care, thank you.

MR CUMMINS: Right. So, Marlene, would you prefer to proceed, or what's the best way?

MS BUTLER: Yes, I'll start off. Just broadly, CAFS is quite an old organisation, nearly 150-years-old. It used to be an orphanage for children, so we've been in the business of out-of-home care and community support for a long time. We've got four regional offices, ranging from Bacchus Marsh up to Ararat and our main office in Ballarat. We also have an early childhood parenting centre in Ballarat and probably about 170 staff and nearly 200 volunteers.

I manage Family Services, Child First and Early Childhood Parenting Services. In relation to my verbal submission, I'm just going to make some kind of broad comments and a couple of points. I won't reiterate what we've already provided in written form, but really just make a couple more comments and hand over to Jeneice.

MR CUMMINS: Sure. That would be helpful.

MS BUTLER: I've been working in the area of family services for probably about 14 years and so I've seen the progress of family services from what used to be

called Family Support and then it had a phase called Innovations program and, more lately, Family Services and Child First, so I've watched the transitions over the years. I guess my comments are about the legislative change a bit over five years ago and the sector's involvement in those changes and discussions with the Department of Human Services about the proposed legislative changes and some of the key aspects of that.

I remember a sense of excitement and a sense of enthusiasm about the principles underlying those changes and particularly about this idea that seemed so obvious and yet so revolutionary that child wellbeing and safety is everybody's business and it was like everybody was going, "Yes," you know, if only we could generate that idea in the community and get it taken up in a real way, so there was a lot of support for the changes. I have to say though that I think in the sector I feel that there is a great deal of disappointment about the change. I think there is a lot of, certainly in family services, practitioners, I see a lot of cynicism and sometimes a bit of despair actually about the difference between the excitement and the energy and the enthusiasm we had and the realities that face us every day. I think in the written submission we've detailed a lot of what we think is a failure of implementation. As our colleagues from the south west were talking too about the lack of resourcing, I think we've got a lot to say about a lack of resourcing, but I think there were some difficulties too in the implementation in terms of some of the theoretical constructs and some of the language that was used to sell the ideas. In particular, I want to talk about just briefly the best interests of the child as a term and cumulative harm as a notion, as well as this idea that the service system should be geared towards what was called earlier intervention, so I might just start with that one.

MR CUMMINS: Certainly. That would be most helpful.

MS BUTLER: The term "earlier intervention" we thought at the time that the changes were about to take place would gear the system towards preventive work. What we find is that earlier invention actually means earlier than child protection. So, in fact, what it has been used to do is to limit the opportunity for us to engage with families that are in difficulties that need support by prioritising those most at risk and most at need, so in fact there is no such thing as early intervention any more.

When I first worked in family services four years ago, it was fantastic. Family support workers would do very innovative things. They would work with families who had basic parenting problems or difficulties getting a child to school and they would work with riskier situations as well, but it was very diverse, and they could work with families on a long-term basis if they needed to because it wasn't restricted. That's no longer the case, so in that sense early intervention doesn't work any more.

Child First now can only prioritise those who are at the very pointy end who are either just about to be removed by child protection if something isn't done, or they're very much on that trajectory and pretty advanced. So these are families, these are not ordinary families, who are having a lot of problems, and I think this isn't well-understood. These are very special families; they are families that are very similar to those in child protection; they are families that are very similar to those in out-of-home care as well and they are not just people with a few issues. They have clinical presentations. We know that from our own work and from our research that they have very profound and advanced detachment problems and they have multiple often cross-generational issues, multiple issues impacting them too that are well known.

Dorothy, your question earlier about what are the issues affecting families and adolescents coming into care, we know from the research that they are mental health, drug and alcohol and family violence. They are the three key presenting factors to family services, as they are for out-of-home care and child protection, so those three issues are very significant, but added to that is intergenerational stuff and very profound problems of attachment.

We also see a lot of intellectual disability and profound learning problems in our population, so these are very, very difficult people to work with and very difficult to make an impact with and to produce change. So what happens to everybody else that rings up Child First, we say, "Sorry, we actually can't help you." We try to refer to a range of other agencies, but often that's very difficult because they don't have capacity either, so in fact I think we've done away with a whole secondary service system and Child First Family Service is called secondary, but I think it's really bordering on the edges of the tertiary system and really we're not particularly a preventive system at all any more, so that's the first thing that I wanted to talk about in terms of that term "earlier intervention", it was sold to us and I think we've been very disappointed with the end results that we're now faced with.

The second point I wanted to make was about the best interests of the child. I was reading an article by Patricia Ainsworth and Frank Hansen in Children Australia recently and they made this point, and I just want to mention it because I thought it was a really good point. There's no consensus about what this construct "the best interests of the child" actually means, either in law or in social science, and in practice we find it's almost meaningless. So what that means is that we are often working in situations or with families where we're absolutely appalled that the state that the family has come to by the time we get them and how could decisions have been made in the best interests of children for this combination of issues to be presented to us?

MR CUMMINS: Do you mean that it's not really looked at and it's in the best interests of others, such as the parents, et cetera, or do you mean that the term is really content-free?

MS BUTLER: I think it is content-free because it is very loose and nobody actually understands or agrees as to what it means and so we find ourselves making decisions, or participating in decisions, or participating in the results of decisions that we profoundly disagree with in terms of what we would consider the best interests of the child. What that does is lead to a level of powerlessness I think in the service system, and I spoke about the cynicism of workers and I think it does lead to cynicism because we see things happen all the time that we think are absolutely not in the best interests of children, but when there is no consensus about what that term even means, it's very difficult to have an impact or even to have an argument, to put a case forward very successfully.

The term "cumulative harm" is even more problematic. There is no demonstrated case practice around cumulative harm. To my knowledge, there aren't any cases that have succeeded in getting through the courts - I could be wrong, there might be one - but the last thing I heard there hasn't been any. We, in the early days after the implementation of the legislation, were very excited, I have to say, about this notion - and it was one of those "yes" moments again - because "cumulative harm", I mean, you know, there are so many families where this is an issue and we were so delighted to see that that was recognised in the legislation and so bitterly disappointed in the reality that we cannot get an argument about cumulative harm. I have to say probably we've almost stopped trying, sadly, because what's the point? You just never get anywhere.

MR CUMMINS: Well, I mean you can understand how the "best interests" might be a sort of Rorscharch test where people just project on to it what they think rather than what's there, but you would think that "cumulative harm" would not be a concept that would be hard to grasp, so what's gone wrong?

MS BUTLER: I think the cases that have been brought forward by child protection have been so difficult to prove in court. I think the hold up is with the legal system and how well they interpret this term or are prepared to permit evidence towards proving a case of cumulative harm. It seems extraordinarily difficult and we have families with multiple children that have been removed; many, many episodes of child protection involvement and family services and they bounce between our systems where the next child is born, the same issues exist, the same interventions that have been tried before are tried again, maybe some tweaking, with no results. Nobody knows what to do, can't seem to have that taken any further and child protection needs to be pretty confident before they'll even mount a case of cumulative harm because it is so resource intensive, preparing a case, getting it to court, putting it forward, getting what seems to be an extraordinary amount of evidence together that still isn't convincing. I would say there's probably not one case in family services that doesn't have evidence, significant evidence of cumulative harm, but whether it's something that anybody can or is now able to do anything about remains to be seen, but it's not looking

good.

Just moving on, we did in our written submission talk in question 1.1.3 in terms of cost-effective strategies, investing more in early childhood services and investing in research in family services about what works, but I just wanted to highlight, in terms of early years services, the plight of families with learning problems, parents with learning difficulties and intellectual disabilities.

We've been doing some work in this area and we think the Grampians region certainly has a high proportion of parents that have disabilities and learning problems. I'd have to say that we're pretty appalled that there are so few services available for parents with learning problems. Family Services is ill-equipped to work with these families very successfully. One home visit a week really doesn't do it. They need long-term support and when they have young children they need support until their children are at least four-years-old and able to get into a good kindergarten. They are a very high needs group who tend to be invisible in the community and we find that there's very little either international or Australian research about this group. They seem to be almost completely ignored and they certainly are overrepresented in child protection and they're overrepresented in our family services system, and I imagine they're pretty well overrepresented in out-of-home care and I think our colleagues earlier were talking about young people with disabilities too, but we're finding that parents with learning problems can't retain information and often become in dire straits with child protection because it's not that they don't love their children, and they're typically not abusive, but they are very neglectful and that is because they don't actually understand the developmental needs of their children, and without that long-term support their children actually become very delayed and develop environmentally-based learning problems and disabilities themselves too, so they are a very special needs group that I just wanted to highlight that our system is not serving very well at all.

MR CUMMINS: Yes.

MS BUTLER: Just briefly, on question 1.1.5 on the benefits and features of the public health model, we like this idea because targeting and highlighting the underlying determinance of child abuse and neglect could lead to a greater emphasis on prevention and I think throughout our written submission we've again highlighted this need for certainly more early intervention and preventive services because that's just not very prevalent at all and perhaps a public health model would assist people to understand the need to intervene in a much more effective and early manner.

Lastly, I wanted to touch on question 2.3 about early identification and intervention. We've talked about in 2.3 under Immediate Priority, "Intake services overwhelmed by increase in demand resulting in transfer of risk from child protection to Child First and so on." We have about three EFT in Child First. At

any one time we have between 40 and 60 cases in assessment and we have families that are on hold after they have been assessed for up to six months because we can't allocate them into family services because there isn't capacity for allocation.

5 We have, in what we call holding, up to 25 cases at a time so all in all we'd be holding anything between 60 to 85 cases with three EFT. Now, our colleagues were talking about the real hold up in service delivery being more at the family services end. We would have to say that it's probably both, that there is a lack of resources at the Child First end. We are really struggling to deal with that level of 10 demand and also we don't have enough capacity in family services to transfer cases through once they've been assessed. There is a real throughput problem there too, and as our prior colleagues were talking about as well, the problem there is complex cases with high needs and needing long-term support, so you've got a bottleneck at that end and then you've got a lot of demand coming through Child 15 First as well, which is very difficult for us to manage.

We've provided some written evidence about this. What we have in our agency is a fortnightly meeting between out-of-home care family services, Child First and some of our other programs to talk about what we call hot cases and they might be 20 cases where we might all be working with a family, or there might be a big issue of risk that we're concerned about, how we will manage it, or we might be really worried that we're having a breakdown in communication with some services or with Child First and it might end up in a bunfight, something like that, so any of those come into the category of hot cases.

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I've provided say the last few months' worth of hot cases from Child First just to give you a sense that - identifying information has been taken out - but it's summary information about the sorts of referrals that we're getting and holding, the sorts of referrals that we think are very risky, the details about some of those family 30 issues and some of the dilemmas that we have in terms of making decisions or progressing what we think is a reasonable decision for some of these cases, so you might be able to have a look through some of those just to get a sense of what the work at the coalface is actually like.

35 MR CUMMINS: Thank you, Marlene. Terrific. Jeneice.

MS ROBERTSON: Thank you. Now, I need to take you on a totally different path, right down to the end where permanent care comes into being where the children who we receive referrals for have been determined that they cannot return 40 to their parents, that there is no kinship option. That is where we're at now.

I'd like to refer to just question 3, 3.5, 3.5.1, 5.2, 5.3 and 5.6 and explain some of the issues we're having in relation to, one, access conditions. Constant contest reviews that are eroding the stability of children's lives in the court system and 45 maybe the interpretation of the new act which you alluded to because I think some

of our magistrates and some of our solicitors look at the new act and see a totally different meaning to, as you say, the best interests of the children or the cumulative harm so, if you don't mind, I'll just read from here.

The difficulties faced by us and other permanent care teams - and most permanent care teams are quite small teams - we've got a 2.5 EFT that covers an absolutely enormous region; however, these are the difficulties that we all tend to face, incredible amounts of access for children with their family. There are at least nine cases at present in this region where children are having several access periods per week, have been out of the care of their parents for a number of years with the non-reunification case plan, and even with professional opinions supporting an access reduction, magistrates disregard these views and they're constantly upholding a parents' rights above the rights of the child. Invariably, children are removed from school to be able to attend these access times and kids can't get on with their lives, there is no normality for them. Life is so different when you have a worker, when you have constant access times with parents and then you go back to your permanent care family or your long-term foster care family and try to get on with living.

There are well over a hundred cases in this region within my program where children have been placed in a permanent care placement with an access plan that's workable, we're saying four to six times per year. We've had a really high success rate and these children go on to develop and achieve, while still having an identity base connection with their parents, and I think that's where the issue is. I don't believe that magistrates and maybe some solicitors understand the difference between an identity-based relationship and an attachment-based relationship, and when a child has been put on a non-reunification case or plan and they are to move away from their parents because there is no other alternative, we need to be able to encourage the parents to let go and not encourage them to hang on with more and more access in the hope of building up that relationship with their child, which is going to be damaging.

At present, workers feel as though they are part of the abusive system that insists that traumatised children continue to be forced against their will to have weekly access with those parents that have abused and neglected them in the past. Even after many court hearings and case plan meetings, parents have the opportunity to further extend their children's length of temporary care in the foster care system with numerous requests for reviews, contests re decisions, dispute resolution conferences, et cetera, and these can take over a year to come to some form of a resolution. Once again, this impacts on these kids, whose lives are put on hold as they await the fate that's determined for them. Their wishes are often the very last to be heard and even then there have been instances where these have been totally dismissed by magistrates and the parents' solicitors have refused to acknowledge the voice of that child. We feel as though we're condoning these children to be further traumatised by the system that's supposed to be protecting them.

Possible solutions. Well, I don't know. It's very difficult. I suppose I'm saying that we want magistrates and solicitors to be aware of the importance for vulnerable children to have an appropriate family in which they can grow up in. They need a chance to attach and at the very least an opportunity to be loved in a secure and nurturing environment. We all know that and it's wondered that magistrates and solicitors realise that there really was a good reason why these children were removed in the first place and there's a good reason why it's a non-reunification case plan.

I believe that there's some confusion in relation to the new act which is supportive of a child having a relationship with the birth parents and I'm wondering if that's being interpreted, as I said before, as being an attachment relationship when in actual fact it needs to be an identity relationship. A greater knowledge of early childhood development and brain development and the negative results of trauma on these areas in young children in the system might make our decision-makers more aware of the damage that they're incurring on these kids, who deserve all that other children do. If the birth family can't attain this in a timely manner, we should not be letting these kids drift in that system. We should be able to find their parents, and they're out there, I have people there who I'm training constantly desperately wanting to have a family and these are people who have had to jump hurdles and hoops to get to the stage of becoming an applicant for permanent care. We have children that we could match them with, but we wouldn't even think of trying to do that unless all of these court issues have been resolved, until the access has been resolved and (indistinct) too that there are no kinship placements for these children and those are the things that have to happen before we can even attempt to place these kiddies in permanent care. So we have got a pathway to go, but it's not being expanded on, it's not being looked at as though this is a really beneficial path for these kiddies.

Serious consideration probably needs to be given to changing a system that frees up children for permanent placements, as in England or America, so the parents after this point are not able to continually appeal and contest these decisions. We'll need an order that frees up children for permanent care that provides them with greater security regarding their future and alleviates the issues of children's lives being put on hold for a number of years while these contests and appeals continue.

Just moving down to the reference question number 3.5.2. Permanent care programs offer ongoing support until the child is 18 years of age. At the initial stage of placement, carers are able to telephone the permanent care workers 24 hours a day. We can do that. We are a small team, we have small numbers coming through, we can do that. These workers know their cases. They're able to provide valuable and effective support and it's believed that this is a real strength to our program as strong relationships and trust develops between the carers and their workers, often ensuring that small problems do not become large ones as the

placement progresses.

Since 1995, when the permanent care program began in this region, 4.62 per cent of placements have broken down after a permanent care order had been made. There are over 106 placements that have continued to provide loving, quality care to children outside the welfare system - and isn't that our goal - get them out of this system that they're in and let them live as normal kids do.

We believe the low breakdown of placements is reflective of the success of our program in providing long-term security and stability for children who can't be returned to their parents. Permanent care is a successful program in providing that stability, enabling these kids to have a normal family life and build up secure and lifelong relationships but still know their parents, still know their biological family, but in a much more limited capacity. Currently, the program provides after-care support to 24 children in permanent care families and with 18 of these children issues revolve around access, but we're there as workers to support these, to work through those issues with the carers and with the birth parents, so there is an open door policy there for everyone to be able to work through it together.

After-care support enables the program to provide support as required to resolve all of those issues, as I mentioned. This support has been so successful across all the regions and it's clear that there are very few breakdowns in a permanent care placement, as opposed to foster care conversions to permanent care, which is once again a totally different issue. There is a disparity of service for those permanent care placements made that do not come under the umbrella of adoption and permanent care teams; foster care conversions, when children have been placed for over two years in a foster care placement and it automatically converts to a permanent care order.

To correct the disparity in the system, because those kiddies that come into a foster care conversion placement, do not get post-legal support and you can understand there are no workers in there working those cases. There is no-one there for those carers to fall back on, so once the kiddies get to adolescence and the issues become so horrific that the carers throw their hands in the air and walk away, that doesn't seem to happen within the normal permanent care program, so I think that that is something that could perhaps be looked at.

Maybe the solution would be - and I'm pushing my own program here because I am very passionate about it - however, I believe that if all applications, including conversions to foster care, came through the permanent care program, they would be assessed as to the right match, they would be looked at on their merit and there would not be an automatic assumption that a permanent care order would be the most appropriate order. While it is likely there might be recommendations for some cases to remain with DHS involvement as higher levels of support might be needed to maintain the placement, for those that were suitable for permanent care

there at least would be the opportunity for after-care support to occur and then I'm sure those placements would move on, as our permanent care ones have.

In relation to reference 3.5.3, and I'm going to talk a bit about access, which I alluded to earlier.

MR CUMMINS: I've been through your one on access and 3.5.6 on current legislation, so we've got the document, there is four pages on that here.

MS ROBERTSON: Yes.

MR CUMMINS: Can you just tell us orally what you think are really the key points because you're obviously very knowledgeable in the area. I mean we can read this material. Tell us the key points.

MS ROBERTSON: Okay, for access?

MR CUMMINS: Yes, and then on 3.5.6 as well.

MS ROBERTSON: All right. Fine.

MR CUMMINS: Check your notes if you want to, we'll read them, but just give us the bull's-eyes.

MS ROBERTSON: Okay. Well, currently there are 49 kiddies in the program with various levels of involvement with access. Most of these successful ones, their access levels are four to six times a year. What we're struggling with is when access conditions come in from a magistrate wishing for 12 access periods per year, or maybe even more. It just really breaks down the possibility for that child who has been removed from its parent to be able to build a relationship with the parent who has taken it on. Once again, if we're having too much access, we're finding that parents, birth parents, are really trying very hard to hang on to that birth parenting legal responsibility and, in actual fact, we're setting them up for failure because the kids are not going to go back home, so we need to differentiate and if we could possibly get more guardianship orders occurring instead of, as it is at the moment, custody orders coming through, then that would resolve that issue. That's it in a nutshell.

MR CUMMINS: Yes, and I've got your dot points here, which I think is very helpful. Now, what about your permanent care, your current legislation, 3.5.6, give us the essence of that because we'll go to the detail in the room, but just give us the essence.

MS ROBERTSON: Okay. The essence of that is we were under the impression with this new act that came in that children would come through the system at a

much earlier age. After they've been out of care of their parents for a particular period of time, they would be able then to be looked at on a non-reunification case plan and move forward. This is not happening because of the delays in the contests, the reviews, et cetera. As I've mentioned before, it just seems to be prolonging the whole process, so the kiddies that are coming on are no longer two, three years of age. They've been out-of-home care for probably five years and they're still at the age of seven, eight, they're going to school and they're still in no man's land.

MR CUMMINS: All right. That's very clear. Would members of the Panel like to ask Marlene or Jeneice some questions?

PROF SCOTT: Yes, I'd like to start, Jeneice, with a question to you and then Marlene, if I may. Staying around that issue of permanent care, what you've given us is valuable, but I understand that you may have actually more valuable data - and I keep saying this - that it's good to have descriptions of programs and general principles and general comments. What is of great value to us is to have fine-grained analysis. Might it be possible to look back over the permanent care program over a number of years and to extract from that - again, not identifying cases - but the ages at which children were placed in permanent care, the access conditions that were on those orders, whether they were conversions from foster care or non-conversion permanent case placements and how that may relate to the breakdown of a placement, et cetera, et cetera; that is, we need hard evidence on what is working in permanent care and what is failing in permanent care if there is to be a convincing argument to support the recommendations that you've made verbally and in written form. So if I could ask for much greater data mining on the agency records which you have.

MS ROBERTSON: Yes, certainly.

PROF SCOTT: Marlene, in relation to the reasons for family breakdown, I think, yes, we do know of the common issues of parental substance misuse, domestic violence, parental mental health problems and to a numerically less extent parental intellectual disability, notwithstanding the resource requirements in relation to that latter group of families. But in identifying those as contributing factors, (indistinct) region if any examples are there of the services that exist specifically for those problems, non-child focused services traditionally, our common drugs, domestic violence, adult mental health, intellectual disability. What examples might there be, if any, of those services having had their capacity built to respond to the needs of their adult clients as parents and to deliver a service which is more holistic and more sensitive to the needs of those children. My argument obviously is if we can build the capacity of those adult specialist services to respond in a child and family-centred way, can we actually prevent families coming into Child First and the child protection system?

MS BUTLER: Well, that goes back to my point about the original excitement about the notion that child welfare and safety is everybody's business because, clearly, child protection and family services system can't attend to the welfare and safety of all children and it requires the other parts of the service system to attend to that equally and that was the original idea.

PROF SCOTT: Sure.

MS BUTLER: And that's what would work but - - -

PROF SCOTT: So is there one example - - -

MS BUTLER: No, there isn't.

PROF SCOTT: Not in any of those sectors in the whole of this region, there is not one example of one of those types of services responding effectively to the needs of the adult clients as parents and the needs of those children, not across intellectual disability, family violence, alcohol and drug, mental health?

MS BUTLER: Probably not in a holistic way, and I would agree with our colleagues from Brophy earlier in saying that the service system is very siloed and part of the work of the alliance is to try and break down those silos and invite, encourage, train, do whatever we can to inculcate this notion that everybody else is responsible as well and if we work together we can have a better outcome for children.

There are some initiatives in the mental health sector, as well as in the drug and alcohol sector, to kind of attempt to begin taking on board this notion, but there is no example I can think of of practice that is successful in terms of being holistic and really child-focused and working in partnership with us to do that. Family violence services potentially more so, particularly some of the services that are federally-funded to take more of a family relationship focus that do attempt to be a bit more holistic and, as I say, in our agency we do get together on a fortnightly basis to talk about shared cases or raise ideas about interventions that we might do, even jointly. But, yes, I'm sorry to say that - and I do know most of the service networks in our catchment - and I can't particularly talk with any confidence about anything that I would regard as holistic.

PROF SCOTT: So is it resources or is it skills or is it both because in some of those sectors, like drug and alcohol and adult mental health, at the policy level the rhetoric is there about the child of their adult clients, so why is it do you think that in this region, which may be similar to other regions, I suspect, that we don't see that actually in a real delivery of service when the rhetoric is there in a policy overarching sense.

MS BUTLER: I think a lot of it is about resourcing and I think our services are generally so under-resourced that they're very busy gatekeeping, and I'll give you an example.

5 We have a program for parents with learning problems called Growing Together that we've mentioned a little bit I think in our submission. We did a very rigorous piece of research with the University of Ballarat to demonstrate in statistical ways its effectiveness and we did demonstrate its effectiveness and at the end of the project we got the departments together that we thought should be involved because
10 it's everybody's business, so that was disability, child protection and Department of Education and Early Childhood because we were working with parents who have young children.

None of those departments really took on board the idea that it was their business at
15 all. Disability tends to regard the issue as a problem of child protection, child protection doesn't particularly own the issue because they're not in child protection yet, and Department of Education and Early Childhood probably took on board the issue that it is their business more and they gave us some funding for one year, that's it. The funding for that program is now finished. Do you know what I mean,
20 it's like we think that these departments should be working together. That there should be a combined and joint and very serious focus on the needs of these families, and yet there is a lack of resourcing and I think that leads to a bit of buck passing and gatekeeping about who is actually responsible.

25 PROF SCOTT: Could we have a copy of that study and that will be very helpful to us.

MS BUTLER: Sure, yes.

30 PROF SCOTT: Thank you.

MR CUMMINS: Thank you.

MR SCALES: Philip, I think we've covered most of the things in the discussion.

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MR CUMMINS: All right. Well, Marlene, Jeneice and Kevin too, thank you so much for coming forward. We value your work very much and we wish you well. Ladies and gentlemen, we'll take a 10-minute break and we'll resume in 10 minutes' time. Thank you.

40

ADJOURNED **[11.46 am]**

RESUMED **[11.57 am]**

45 MR CUMMINS: Ladies and gentlemen, I'm pleased to invite forward Karen

Glennen from Colac Area Health and Wendy Bunston from the Royal Children's Hospital. If you'd kindly come forward, Karen and Wendy, we'd be very pleased to hear from you. Just settle yourselves down and when you're ready, it might be helpful, Karen, if we commence with you first and then ask Wendy second.

5

MS GLENNEN: Yes, no problems. So I'm Karen Glennen from the Barwon South West Children's Resource program. It's not a direct service delivery role, it's a networking and resourcing role that works across the entire Barwon south west region and it's funded out of homelessness, so I come from a little bit of a different

10 sort of area to a lot of the presenters that I've seen this morning. During my wanderings around the region I was just trying to pick people's ears around what they were seeing as some of the issues and things that were going on between the system, so I come from that sort of area and also having worked with Wendy on a couple of projects at various stages and in different states so she'll talk about those

15 a little bit later.

I suppose just starting off, I just wanted to perhaps reiterate some of the issues that were raised by - I'm sorry, I missed the introductions of the people who were on just previous - - -

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MR CUMMINS: Marlene and Jeneice.

MS GLENNEN: I got lost. They talked a lot about disability and the need - and so I don't want to go over all that again - but certainly to reiterate in rural areas

25 disability and access to services is a huge, huge issue and those parenting issues that come with that and the number of young people that are living with intellectual disabilities within the community and living normal lives and having children is causing huge impost on some of the sectors that aren't normally associated with working with that cohort, so there is a whole range of issues around appropriate

30 training and stuff with that.

The others that I also wanted to just reiterate as well was the issue of the holding and capacity, huge, huge numbers in terms of Child First. Speaking with each intake across our region, large, large numbers and also the understandings of

35 magistrates and solicitors with their dealings around children's issues, you know, training in that sort of area, which has also been talked about. I suppose the biggest one is that much more consideration needs to be taken around that issue of the cumulative harm. That it's not the episodic sorts of incidents that we should be looking at, but it still tends in some areas to rely much more on that and so that

40 whole thing of cumulative harm and what's going on for families is really being sort of overlooked.

The other thing, too, that I wanted to talk about, Dorothy you asked the question just before the break there about systems and how they work together and an

45 example of a good system. I think all of those things that they talked about, like the

service sector is very siloed and there is lots of rhetoric and there's lots of talk and there's lots of, you know, "We should all be working together," but it doesn't actually happen. Agencies and sectors are still very much focused on what their funding streams are, who their core clientele is and all of that sort of stuff, so that thing of, you know, yes, there might be some really, really good little examples out there, but they're not sort of across the board and a lot of that comes down to worker goodwill or agency goodwill in sharing and being creative with what they've got and bending parameters. I think it does come back to what you asked, is it skills or resources? It's absolutely both and skilling up workers is really hugely important, but then having the resources for them to be able to commit to doing long distances out in the country or whatever is also really important.

Just I suppose in terms of the headings and sort of the key themes that people talked to me about was very much about communication. That there is not really, really good communication across sectors. That there are lots of assumptions about who does what and what happens with families and what professionals think is happening out there and who is responsible within that. Sometimes that can get very, very blurred, especially when there are large numbers of agencies or sectors involved with very different emphasis. Who leads that sort of thing? So people talked often about that lead practitioner sort of role, someone that actually comes in and takes hold of those really hugely chaotic sorts of situations where there can be perhaps 10 or 11 or even more services that are actually working with families for periods of time, so they talked a lot about that sort of - - -

MR SCALES: Who are the "they"?

MS GLENNEN: These are workers across quite a number of sectors, across housing sector. The education sector talked about that too. They find that they're being really sort of lost within making referrals. My role works with homelessness and family violence predominantly, but the other part of it is about making partnerships and relationships with other sectors that intersect with others - - -

MR SCALES: So you're picking up these from workers in each of those fields?

MS GLENNEN: Across, yes. These are the broad sorts of - - -

MR SCALES: Let me try and understand that. So that means primary/secondary school teachers?

MS GLENNEN: Yes.

MR SCALES: Private and public?

MS GLENNEN: Both, from both sectors.

MR SCALES: Okay. Nurses?

MS GLENNEN: Nurses, I haven't had a chance to talk to so many nurses. I've talked to community nurses that have been situated alongside Child First and family services, but they're much more in that sort of thinking of the Child First, child protection - - -

MR SCALES: So workers within community sector organisations?

MS GLENNEN: Yes, a lot of them were.

MR SCALES: And how have you collected this information?

MS GLENNEN: Just by word of mouth, by talking, by visits, agency visits. That's my role, it's about going around, you know, talking with agencies, providing training or taking resources, so it's a networking sort of role. It's not a service delivery role.

MR SCALES: Okay, thanks.

MS GLENNEN: The other thing that they talked a lot about, and it goes back to communication, is tracking families. That families can leave areas, especially rural areas, and be lost and no-one sort of knows where they end up and what happens, so getting more immediate information from potentially child protection or Child First or whatever agency is working with them. They talk a lot about the waiting list and how families can be bounced around different waiting lists, so there could be waiting lists for obviously housing, and referrals can be made potentially to Child First and then a report on to child protection, and in each of those there are in rural areas quite long waiting lists, up to two months and more for Child First in some areas. So workers in housing can be working with quite transient families that are then sitting on quite long waiting lists and no-one is really keeping a good hold around those families. Then when they move on to potentially child protection, no investigation has been taken up, nobody is then notifying back that, "Well, we're not going to be working with this family," so there is sort of this void of responsibility in some cases.

They talked about assessments, Child First having a central intake, housing have central intake, mental health having central intakes. There's lots of central intakes that are happening, but in some of those other central intakes, like housing or mental health, are they really also doing assessments around the needs of the children of those people, so what's happening there? I'm trying to go quickly to get through this.

MR CUMMINS: No, that's fine.

MS GLENNEN: So early intervention, they talked about often seeing a need for a role that sits between the maternal and child health role and a Child First role, so it could be a role that is much more a family coaching or a family, you know, some sort of role that walks alongside those families in those vulnerable times and is able to provide whatever support that they're going to need within that and they talked a lot about too, especially in rural areas - and I suppose I come from a rural area so I'm talking about that - food, security and transport as being huge issues that they're seeing much, much more of and they're things that are really neglected. We often think about housing and other things, but we're not so much concerned about the transport and food security, which really adds to stability within housing. They talked about more support for kinship care sorts of arrangements. That many children are looked after in really informal sorts of relationships because they don't want to get caught up in the bureaucracy of what it potentially means in terms of ongoing kinship care.

Talking with child protection workers, they talked a lot about admin support for them, so something that would allow them to go out and do more of that networking sort of role, being much more a part of a service continuum rather than being the child protection sort of gatekeepers of all things that are statutory around children. One of the things that came up was perhaps potentially a thing of looking at portfolios of responsibility, even within child protection, so that all workers aren't expected to be doing court, investigation, support. That perhaps that might free up more opportunity for more networking, more working with other sectors if they were freed up a little bit more. Obviously the integrated sort of service model where all of those support services can be put together to work really closely and collaboratively, but with the focus that it's not we're housing, we do the housing thing, we're adult-focused; it's everybody has to come to that one understanding that we work for the most vulnerable within this and start with the children's needs first.

MR CUMMINS: That's very helpful, Karen. You've collected a number of clusters there and themes from your work moving around and it's very helpful to have that come through, so thank you for that.

PROF SCOTT: Could I ask a question?

MR CUMMINS: Yes.

PROF SCOTT: Specifically around the homelessness sector, that's an area that at a federal level over the last three to four years has received a lot of attention and of course there are two groups particularly within the homelessness population that bear on our terms of reference, it's young people exiting from care into homelessness services, which we heard a bit about earlier, about the leading care strategies; but the other, of course, are predominantly women leaving domestic violence situations with young dependent children coming into specialist

homelessness services.

Have you seen over the last three years a change in the capacity of specialist homelessness services which once upon a time didn't even count the children, officially count the children who came in with their mothers or their fathers in some instances. Have you seen a change in their capacity to be more child and family-centred in the way they work, notwithstanding that it's often for a relatively short period of time and that it's a stressed and underpaid workforce in those specialist homelessness services? Have we seen an improvement and can we build on any such improvement that may have occurred?

MS GLENNEN: There has been a huge improvement from that - not even counting children - to, yes, there is an understanding of children's needs and certainly children's needs are I think thought about it in a much more thoughtful way, but we've got huge, huge strides to go still.

The homelessness service sector has undertaken an accreditation system and one of the standards within the accreditation was around working with children, so that did actually ask agencies, "What do you do around working with children?" Now, it still seems that the majority of the work is still very much about the material aid and about providing and thinking that providing the house is going to solve all of the issues around that family dynamic and what's going on. Some agencies do it beautifully and they take huge leaps into areas where perhaps you think, "Is this nearly a family support role that you're undertaking in this situation," and where does that sit, so there is that line that the homelessness sector is trying to tread around how do we think about children in a way that's really respectful of their developmental stages and the trauma and everything that they're experiencing on top of the family trauma that's going on but, yeah, we've got a long way to go and that's ongoing education, training and skilling of the workforce again.

PROF SCOTT: It would be helpful if we could be linked to the information about the accreditation of specialist homelessness service. Perhaps accreditation is one mechanism or tool for assisting the change in the focus of such services so that they're more child focused, so thank you.

MR CUMMINS: Excellent. Wendy.

MS BUNSTON: I manage a program called Addressing Family Violence programs at the Children's Hospital Integrated Mental Health program which has, ironically, been funded largely by philanthropy, as opposed to any government funding, and our connection really comes from the work around doing some training and support to refuges around supporting mothers who have infants affected by family violence.

We conducted a pilot program in Tasmania in five women shelters where we ran

infant mother groups with the staff and in two of those refuges, and that was in 2008, they've continued to run those groups. So I guess it's building on what Karen is saying around if people feel they have the confidence to do this work, then they will go on and do this work because most people in this sector are very passionate and very committed to the welfare of children. So I guess what I wanted to share was not so much a view of what the Children's Hospital or the mental health services thinks about things, but my sort of journey as a professional over 22 years in this area and thinking about the rich resource we have around relationships of professionals with professionals and professionals with families. So this concept of thinking around, as a contingent care giving community, as professionals we do an enormous amount of good parenting for very at risk and damaged families.

Some families have experienced intergenerational transmission of violence so their capacity to impart very good and healthy parenting skills to their children is impaired. Some parents are highly traumatised for what's happening for them and are not in a position to be available to the infants and to their children, and particularly in areas like police going to domestic violence situations, refuges where there has immediately been a crisis of some description - infants are highly disregulated at that time and we know that for infants disregulation in that first 12 months of life is incredibly unhealthy for their neural development, so if they stay at that disregulated state for an ongoing period of time we know, the evidence is there, that it will do some lasting damage.

We have a care giving contingent community of professionals who can actually come in and do some very powerful work on the ground at the time it's happening whilst parents recuperate, whilst parents are able to do their own healing. So I guess it's that stuff of in the refuge work very much about wanting to support workers on the ground with really simple things around being able to actually acknowledge the presence of the infant or the toddler, being able to talk to the infant and toddler and recognise that they have needs, traumatic needs that are very separate to their parents. Whilst I think we have this view that still probably comes from an old age sense of the children are the property of their parents, the children are the property of this community and some parents are unable, unwilling, or whatever to do that at the time when infants most need them. We have living, breathing people like ourselves who are in their proximity that can do some fabulous work and I think that's what we've seen on the ground.

We've continued to do some work with a local refuge, so I'm based at Sunshine. We have Women's Macaulay Services - women's and children's services, they were able to get some funding and we had two mental health workers that were working in the unit with them for six months and it made a huge difference to how they worked with infants and children, how comfortable they felt in doing that work, in thinking about what they could do at a time when perhaps the mother couldn't do that work and just the shifted name for our workers as mental health clinicians, so again that idea of having people together, learning from one another.

I certainly have always throughout my career, I worked in child protection for some period of time and then I've worked in mental health for the last 16 years. I incredibly respect the pressures that child protection services are under and I think if a mental health team actually lived in the same offices that child protection workers lived in, could be there as a ready access for support for immediate work with families, for supervision, I think it would make a huge difference to raising the skill set of those child protection workers; raising their confidence, often they're quite new workers that have come in and are dealing with really the hardest cases and if you had access to a range of professionals who are very skilled in what they do and you felt supported in the work that you do, I think your skill set is going to come up quite rapidly. So I think it is that thing about being able to work collaboratively, thinking about some of those systems that traditionally have been a little bit insular, how we actually work collaboratively with one another and learn off one another and how we actually enable people on the ground to feel confident to actually engage with infants and children who are in a highly perilous situation psychologically and neurologically to do immediate relational repair work then and there on the ground, so some of that is skills building but I think a lot of - you were talking about data mining before and I was thinking, okay, when I think of my 22 years in this career, structurally we're always going to have problems; structurally it's always going to reflect to some degree our community's ability to tolerate and think about certain parts of self that are too difficult, so people don't like hearing about Darcy being thrown off the bridge, they put barriers up. That's how they respond to it. Don't go in and think about, "Well, maybe my next-door neighbour, maybe somebody in my family," maybe it's actually something that we all need to face as a community. It's easier to split it off and say, "Let's build barriers on the bridge." Maybe the money that built the barriers could have actually been put into some other things that are around actually enabling us as a community to speak about the unspeakable.

We've got a team of some fantastic services and professionals out there that often feel a little bit out of their depth. For young workers, for workers that haven't done a lot of work with infants and children it can be very nerve-wracking, it's like, "Am I doing the right thing? Am I assisting this child?" Being able to engage with an infant who is depressed, engage with an infant who is traumatised, who basically has shutdown and disassociated to cope with the overwhelming mass of what's happened to them, to have a living, breathing responsive adult in their proximity who talks to them, who actually brings them back alive, who actually manages their regulative states is a very powerful thing to do, more powerful than, "Let's make sure we've got the doctor's appointment happening," or "let's make sure we've got this happening or that happening." These are incredibly psychologically important and very reparative things that we can do then and there at the time to assist children who are going to go through this pathway to have access to professionals who actually are very responsive to them and can actually think about what's the psychological first-aid I need to be doing with this infant and child, as much as

thinking about are they hungry, are they cold, do they need somewhere to sleep? Those things alongside are incredibly important and I think the scientific evidence now is so overwhelming, we can't ignore it.

5 There is some amazing research that's been done. I was at the infant mental health conference in Perth a couple of weeks ago and a lady called Karlen Lyons-Ruth, and it's the Harbour Family Pathways project, have done some amazing work that has demonstrated that in the first 12 months of life those children that have care-giving experiences where the parent or - yeah, I'll say the parent is
10 withholding - so more on that neglect spectrum, are six to nine times more likely by the age of 20 to have developed borderline personality disorder or have higher rates of suicidality, so what we're getting now is what happens in those first 12 months, 24 months, 36 months of life will show itself in adulthood.

15 In my work, I work with infants and mothers and infants and fathers, men who have been through men's behaviour change programs and their infants and toddlers, I work with children and I work with adolescents in our adolescent inpatient unit and I see the difference in how much work you can rapidly do at that infancy age to what happens by the time they're adolescents. Whilst I absolutely commend Pat
20 McGorry in getting all that focus on young people, there's a whole world there that happens exceedingly quickly and lays down very solid templates for what's going to happen for the rest of someone's life much earlier than needs to be attended to and I hope that we're smart enough to not wait years and years before we suddenly discover infants.
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MR CUMMINS: Very insightful.

MS BUNSTON: Was that quick enough?

30 MR CUMMINS: It was terrific Wendy.

MS BUNSTON: There you go.

MR CUMMINS: Dorothy?
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PROF SCOTT: Yes, very interesting. Thanks, Wendy. I'd just like to float an idea with you. I don't think we may get to a stage where we have a whole mental health team inside a child protection unit, but I certainly in another state have seen a model that I'd like you to comment on where a mentor health liaison nurse was
40 located within a statutory child protection centre/service/unit and her job was to do a number of things. One was to help child protection workers have a better appreciation of adult mental health issues, but it was also to help her mental health colleagues in another service to create the door so it was open for those parents to be able to get assistance from adult mental health service.
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MS BUNSTON: Sure.

PROF SCOTT: Do you have any comment on those sorts of models because, of course, this goes beyond adult mental health, to all of those issues we've been talking about, including intellectual disability, including alcohol and other drugs. That one is a particularly important one, the AOD sector.

MS BUNSTON: I think we're sharing the same clients.

PROF SCOTT: Yes.

MS BUNSTON: So I think that what happens is that you go through different services and often mental health - often we get them later than a lot of other services. So in some ways it's this sense that mental health, or CAMS, the child (indistinct) sort of is on the cutting edge of that work. I often think they've been through a whole lot of other service systems before they get to mental health.

The level of training that mental health practitioners get compared to other sectors is reasonably high, so there actually has been quite a process you get to to be able to work in a mental health service. We have high levels of professional development, so there's a real emphasis on professional development for the rest of your career of achieving higher qualifications, doing more work to really become specialised in this area.

What would be really nice, if all of that specialist knowledge and expertise worked in the reality of day-to-day lives of community agencies that are not as well funded, that maybe do not have people as well-qualified and that there can be a sharing of skill sets amongst those two services or three services or four services, so I certainly think having worked in child protection, having worked in non-government, having worked in mental health, that each of those different sectors pick up the same sort of client group. Sometimes we need some of those clients to be accessing mental health sooner than we should be, but it's because we're not communicating together, because we're not talking together and I think there's some anxiety around - I mean I think it's a tough gig working in a refuge. I do not know whether I'd be able to do what refuge workers do. I think it's an extraordinarily confronting and difficult job and we've worked with workers that have been there 20 years and have just been amazing. They're our unsung heros. They just have done amazing work, don't get paid half as well as we do and they're not really supported, they're not recognised or respected for I think the work that they do do. So I think it really is around - it's probably paralleling the families that we work with that are often seen as not as good as other families in the community, or they're the difficult families, or the problematic families, or the bad families, you know, that the media comes across and they go on those TV shows. The same thing I think can happen for the service providers that work in those sectors where child protection workers are always given a canning. It's a really tough job, child

protection.

MR CUMMINS: Absolutely.

MS BUNSTON: It's a tough system. You can work incredibly hard, get to the courts and then have things overturned. It's tough. But in the public sort of eye, they're the ones that you blame for it all. Talking about "it's everybody's business, it's everybody's responsibility" is words, it's not action. I think we do have to begin to sort of think about how do we work more collaboratively together to open those doors, how do we get people fast-tracked to get access to services when they need them rather than, "They don't turn up for three appointments, so they're off our books." Some of those families are not going to turn up for appointments and the onus is on us to actually work a little bit harder to engage them or thinking more creatively about how we engage them.

Good parenting is the capacity to actually think creatively and flexibly about how do I manage this without being overwhelmed and beginning to make my child into a bad child. Good service provision is the same capacity. How do we actually manage difficult families that have been through horrific things and do that with compassion and do that with integrity and stop demonising them and actually understand that this is a traumatic reaction to something that's happened to them probably at a very early age, probably pre-verbally and they're acting out stuff that they're not even conscious of doing. So I think there is the capacity as service systems to actually think more realistically about how we actually respect what everyone else does and actually provide better support to what everyone else does. There is a whole heap of stuff I don't know how to do and I would be scared bejeebers to do. Like even being a secondary schoolteacher, I don't think I could do, you know. Let's respect what people can do. Let's honour that and let's work collaboratively together.

MR CUMMINS: Bill?

MR SCALES: Is your prime argument that for all of the professionals who work in the field, there ought to be a form of qualification that qualifies them to work with children in crisis or families in need. Is that the essence of your - - -

MS BUNSTON: No, it's not. The essence of I guess what I'm trying to say is that that idea of silos, it's a physical reality because we have physical buildings and we have physical distinctions between budgets and all that, so we have physical silos, also mental silos in the mind of professionals, so we deem that what we do maybe is better or different or not as good or whatever and I think what I see - - -

MR CUMMINS: But separate from.

MS BUNSTON: Yeah, and when I go and work in refuges, I am just astounded by

the things that refuge workers do. I'm in awe of what some of those workers do because I just don't know whether I could do it and I think it's being able to create opportunities for people to come together and work together because I think when we start to demonise a split-off is when we actually keep it.

MR SCALES: I suppose I'm trying to understand how you see that then working because I thought what you were trying to describe was you can break down the silos by having the professionals understand the skill of other professionals - - -

MS BUNSTON: And I think sometimes that happens when you actually have an opportunity to walk in their shoes and that might be that you have some mental health professionals actually do some work in a refuge, do some work in child protection, child protection having an opportunity to do some things in other services.

MR SCALES: Yes, but I suppose we have to systematise this. We're being asked to look at the whole of the system.

MS BUNSTON: Yep.

MR SCALES: That, unfortunately, means that we have to actually think about what are the practical programs that we might put in place to make your idea about breaking down silos work and in a way we have to move across what might be essentially just good intentions and either regulate, accredit people so that they can do exactly as you're doing. So what I'm trying to get to the heart of is how do you see this actually applying in practice because most people will sign on to the idea that all of these professionals that you quite rightly say are doing outstanding work need to both understand each other's work and know how to work together, so how would you turn that into a system outcome?

MS BUNSTON: I think some of my most useful working experience has been - when I first started in mental health I was employed to set up an outpost clinic at Melton Community Health Centre and at that time they had CASA workers there, they had drug and alcohol workers there, there was a range of different professionals who would come in and spend time in that centre and would go down to Melton. One of the ideas they had was that they would develop a family therapy team that consisted of workers from those different services. I think that worked really well because you had people across different sectors being able to be involved in assessments and family work and you could pick up on lots of things that maybe I would miss because I come from a particular perspective. I also think it built connections, it built relationships between other services. That sort of went to the wayside because of money constraints, you know, there was amalgamations, all that sort of stuff. So often I think what we probably - everyone in this room experiences, you have times when you see things working incredibly well and then the system will manage to come in and, for whatever reason, crush it or things will

happen, but it's usually worked really well because you've built relationships.

MR SCALES: Although we did hear this morning from the Brophy Family Youth Services that they've combined the built environment, a building, with the bringing together of a range of family and youth services in a way which gives them the ability to operate more effectively on behalf of children and young people. Is that what you're really describing?

MS BUNSTON: I remember hearing about a program in America, and I'm not sure what state where it was this one-stop shop for family violence where they actually had a range of different workers that worked in the same building so a family wouldn't have to go from here, to here, to here, to here and there was communication between those professionals. So I think it's the same thing, it's relationships that cause trauma and violence and places children in vulnerable positions and it will be relationships that heal and support children from those positions. Sometimes we will enable the families to do that, sometimes we as a service system may need to do that for some of those children as they make their way through. It's the same with foster care workers aren't highly supported, aren't highly paid, aren't highly valued.

MR SCALES: Let me then put it in the context of this broader rural and regional area where we heard this morning that it's actually quite difficult to do that for all of the reasons that you'd be familiar with. How might we think about that in a rural and regional setting?

MS BUNSTON: Well, strangely enough, I've just come back from a consult that I did up in Traralgon and what was really interesting was I did a consult to the perinatal team, I did a consult to the CAMS team and then I did a consult to another team that was school based and my question to all of them afterwards was, "Why don't you meet as a group?" The themes that were coming up in that consult was the same for everybody and it was a bit like, "Oh, well, we don't really meet as a team because we've got this program and we've got these programs," and it was for me, "I think if you met as a team then you've actually got a critical mass, for a start," because it's actually really difficult work for perinatal workers in the rural sector to just manage the emotionality of this work, let alone just the physicality of the work. It was a very simple thing, "I think you should meet as the three groups together." That's simple. That's not rocket science stuff. That's just like, "If you guys met together, you're actually talking about some of the same issues, you've got some of the same struggles and you've built yourself a support network," which is what isolated families need, they need a support network. They're probably not trusting of a lot of people and I think even service providers aren't trusting of each other, but I think that's what we're aspiring to do.

MS ROBERTSON: I think one of the other things too that we really need to look at in terms of a rural context is perhaps more effective use of perhaps some of the

new technologies that are out there, and whatever that means. Because I'm situated at Colac Area Health, which is an acute hospital setting aged care and all the community services, you can be born in that hospital and go through every conceivable issue that you could think of and come out the other end at old age. So I mean it's a truly integrated - and it works fantastically in Colac and surrounds - but we then have the issue of how do we service Lismore, and I'm sure that the Brophy people would also say, "How do you then think about the Castertons and way over those really, really remote areas." It's difficult. It's difficult for workers to get there. So it's like I don't know that technology is always going to be the answer, but in terms of even bringing workers together for those sorts of consult things, that's potentially a way that we can support workers more, you know, provide training. For someone from Portland to go to Melbourne for a one-day training is actually nearly a three-day commitment and a lot of them are part-time workers. It just doesn't happen, so we've got to be - - -

MS BUNSTON: And us city folk could be a little bit more mindful about rural cousins in terms of, like I know at the Children's Hospital - not that I'm talking on behalf of the Children's Hospital - but I know that we have lots of fantastic training, we have lots of international speakers. There's nothing stopping us from having those presentations video-conferenced. We did a forum last year and we had Northern Territory in watching the forum, we had Mildura, so we had about four. We put out a flyer to people saying, "If you would like to video-conference - - -"

MS ROBERTSON: South Australia.

MS BUNSTON: South Australia, that's right, "then you'd be welcome to." So we had 220 people in the audience and then we had another few hundred watching us from other places. I've been supervising some groups from Sunshine on Skype, over in the peninsula and in Geelong, so I think there is opportunity - it's not as brilliant as being face-to-face, but it's the next best thing. So I think you're absolutely right and that's something I asked this consult in Traralgon, "Do you use Skype?" and they said, "No, we haven't got the facilities for that yet."

MR CUMMINS: Good on you. Anything else?

MR SCALES: No, that's fine.

MR CUMMINS: Sharon and Wendy, thank you so much and speaking from the head and the heart, thank you. Terrific. Next I'd like to invite Mr Paul Auchettl to come forward, if he would like to. Just take a seat, Paul, and settle yourself down. Were you here at the very start of this morning?

MR AUCHETTL: No, sorry.

MR CUMMINS: That's quite all right. What area would you like to talk about,

Paul?

MR AUCHETTL: I'm a carer, so foster care is the area.

5 MR CUMMINS: Yes, we'd be very pleased to hear you speak on it.

MR AUCHETTL: And, sorry, I didn't realise that disabilities is included. I just didn't catch that in the material.

10 MR CUMMINS: Right. Well, the main thing is don't refer to anyone by name or identify anyone who has been through the child protection system. I'm sure you understand that.

MR AUCHETTL: Yes, I've had a flyer about defamation.

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MR CUMMINS: Good on you. Well, if you just tell us what you'd like to say.

MR AUCHETTL: My name is Paul Auchettl. My wife, Cathy, and I have been doing foster care for 17 years. We take sibling groups and we used to do what they
20 called reception sibling care and now we've moved into more mid to long-term care. We haven't had a holiday this century, I know that sounds funny, but we saved up last year and went to Queensland and got caught in the floods with the kids, so when we came back I'm determined to have another holiday because their view of the world is that it's very risky out there, so we've got to plan something
25 better.

As the kids grow up they become quite aware of lots of issues and I think this country is full of paradoxes. It's like little children are sacred, bring in the army and when my ten-year-old was talking to us about this she said, "Well, that's good.
30 Maybe some of the kids will grow up and become defence force personnel," and I just think it's an example of how we get it wrong and we tend to push a lot of resources towards something and they make it all the way until the child and then it seems to fall away.

35 I'd like to focus on long-term foster care or midterm because I feel that they're the group that suffer the most when it comes to gaining support and they've had to endure that trauma of loss and grief and after a while they develop an attitude that, "It must be my fault," so a lot of the care is in getting their self-esteem up. I feel that the most important thing that we can do is to assist them very early on at
40 primary school level because it's at that level that they can't focus, they can't concentrate, they tend to crash, slip behind everybody else, they then become accustomed to that and the support that's required to get them out in my mind doesn't require a lot of money or a specialist skill because what we've noticed in classrooms is that children respond one-to-one, that within the classroom setting
45 they cannot function properly in that group setting, they just don't feel - they don't

have that sense of belonging, that's been almost stolen from them and even though it wasn't their mistake that brought them into this out-of-home care situation, they seem to inherit the blame, they seem to, in their low self-esteem, start making mistakes, even though initially that big one wasn't their mistake, but for some reason the trouble with care is that we can't stop children inheriting mistake-making practices.

The biggest hurdle I've found is getting human services to talk to the Education Department about this vulnerable group. For four years I've been working with one child meeting four or five times a year with a range of people who help us put applications to student services so that we can gain an aide in the classroom, which lots of people do these days and I've just heard that they've added autism to that range of conditions that can gain you support in a classroom. I'm talking about a teacher aide. But for some reason children in care are missing out. I don't understand it properly. I wish there were some people here today that do talk about this problem between education and human services. For some reason we can't mention trauma prior to school age because for some reason that discounts them from gaining support and I and a few of us have called this system a house of cards, it's going to collapse on children as they get older. We're asked to help them fit the category, rather than identify their actual need.

So if we put in a submission and we can have extreme behaviour, hurting animals, if there is all this squeaky wheel stuff then you're more likely to get your funding. But if that is not a true reflection of your child then later on, when you need to start the whole process again, it's very difficult because they carry a diagnosis that was a bit of a set-up to get a little bit of support in the school and I find that whole system like a house of cards. It will collapse on them later.

There also seems to be an extraordinary - primary schools seem to be encouraging success. They are trying to instill success in children so that we now have graduation at grade 6. Children who are not ready for secondary level studies are being pushed up and I find that a large group of those children going up are children who are out of home and have been for some time. They face little chance of making that success real. It comes down on them very quickly at secondary level and they fall out and I find that awful.

The solutions, because children respond very well one-to-one, these children, I don't see the problem with human services and education being able to get together and critically keep someone with them in the classroom so that they can keep up with the pack. To me, everybody talks about education being the answer, yet we seem to just watch these children slip from a very early stage. Once we get to the high end, which is the expensive, late adolescent services, they are costing a fortune and I'm not talking about paying out big money, I'm talking about particular support and I understand that it's different from the way aides work at the moment with children because that's likely to be ongoing, forever maybe in the education

system for that child, that they may have a disability that they may not grow out of, I'm talking about children growing out of this, so we need to be able to get them to catch up to the class and then we need to be able to support them to work within a class. I feel that will go a long way to limiting the damage that we see with youth services, youth homelessness, offending and - - -

MR CUMMINS: All right. We've got that point.

MR AUCHETTL: Yes, if I could move on to another area.

MR SCALES: Yes, the only thing I add to that is that one of the groups we had here this morning before you arrived actually made a very similar point about education, so I think you made the point that there was nobody here today who had raised it.

MR AUCHETTL: I am aware of people that could be here.

MR SCALES: There was quite an interesting and I think an illuminating discussion about this need for how we might think about education in the context of the children we're now talking about.

MR AUCHETTL: Yes.

PROF SCOTT: Could I ask a question about that before we move on. Children in care are meant to have an individualised education plan. In your opinion as a carer, how well do you think that works? Are children in your care and others you know of, is there an individualised education plan? Is that plan actually implemented? Could you comment on that as a mechanism.

MR AUCHETTL: I've seen a lot of the plans. I've been involved, and I am involved in some now. When I tackle the Education Department about the plan, because they say they've been asked by human services to monitor out-of-home children. That's all they're asked to do. The plan at the moment is to try and attract support and to keep an eye on them. It's not enough. We're monitoring. We're watching, you know. We almost understand the problems, but we're not doing anything. Everybody, in my case, is aware that we have been unsuccessful for years in trying to attract funding and something in the system which has been chronic is that it's apologetic. It just says, "I'm sorry."

There is an enormous amount of pressure falling on carers. I think there is a lost art, and that is advocating, and now we are finding that carers are having to advocate strongly, not just into the community and into education, but also back at protective services and the non-government agencies. I feel that sometimes workers have it in their job description to do this but they don't and in the end it falls on to the carers and I think they are already overwhelmed with very high

expectations.

Where we have young children trying to overcome this trauma of loss and grief, it's very difficult because it's like a specialised service is needed. However, we've found over the years that if you provide a family that gives them the sense of belonging and they start to share in some joyful experiences, that they do recover. Children are amazingly resilient so if we get it right, they become very colourful characters as though grow up and if we can somehow invest in making children set the bar a bit higher, gain tertiary level education, I believe these are going to be the colourful characters that we need to bring back this empathy that seems to have totally disappeared and if little children are sacred, we should be able to identify what it is and nurture that.

They give us great insights. When they're settled and comfortable, they tell us the truth and as adults I find we are always skirting around the issues. It's too hard to be deadly honest with children because the world is so mixed up that it's almost painful to think, "You're going to have to cope with this," and children who are living in out-of-home care, even if your facility is fantastic, they prefer to be home which is disruptive, chaotic, violent, or could be. For some reason they thank you and they go back to this with this hope - hope seems to cause pain - hope that they're going to go back and fix things. They have these dreams that get shattered so quickly.

I don't know about services any more. We used to work in reunification, so children would come to us from the police sometimes and then very carefully you can plot a path back to home. If you don't get them back home early on, that protracted time of care puts them at risk of being separated as siblings and I find it awful that children often leave care with more problems than they came in and separating siblings and leaving them alone in the classroom are two of the biggest factors I know that influence the way children are going to come out the other end.

MR SCALES: Can I ask you just one last question on the education story just for a moment?

MR AUCHETTL: Yes.

MR SCALES: Are you saying from your experience that the method of teaching young children in primary school current, you know, for most children, doesn't actually meet - the method of teaching I'm talking about, not school per se but the method of teaching - doesn't meet the needs of the children that you've had in your care to enable them to get an appropriate primary education? Is that what you're saying?

MR AUCHETTL: Yes, I'd be saying that because, to be fair, teachers are saying that they are being required to do so much now that when one child is different,

they struggle. The other thing I've heard is that teachers will say that, "It's good how when I spend all this time with your child, that they open up and come good, but I have to keep weighing that up against the class."

5 MR SCALES: So it's a pedagogical question. That's helpful, thank you.

MR AUCHETTL: My last point is just about this family community issues because in mid to long-term foster care I think children get an idea that their family is much bigger than their foster family and their biological family and they reach
10 out to the community, quite awkwardly, but they try to find where they belong and if they are successful then I think this is the beginning of colourful characters. We must start investing in children becoming part of our community from a young age and I believe in martial arts, ballet, dancing, all these after-school curriculum activities. The burden is on foster carers to just do it, and the average foster care
15 payment is less than $20 a day per child. I think that the room for one more program or mentality was very good, but when it comes to sibling groups, we need to perhaps think about how we see carers of sibling groups and see them as hopefully professional carers or not volunteers, but be given a better reimbursement so that they can either explore these issues, like after-school curriculum that start to
20 tie children to the community.

Finally, I've always wondered why we can't provide them with some like super component of the package that the department has, whether it's 7 per cent or 5 per cent of however much money you are spending on them, why are we not
25 putting that aside for the goal to gain tertiary skills? Why can't we have some focus towards if education can be an answer for them, put them on support early and plan for if they can make it later. If they make it to the end of secondary level, let's do what we can to get them into tertiary because we are missing a valuable resource. These children are so honest and if they survive with their resilience then they'll
30 become something that we need to go forward.

I know that it's a double-edged sword because we see that when they're young the resilience that they're developing can be good in the sense that they can quickly move on from a painful experience, but they can also have trouble going back to
35 apologise to someone who they've hurt, they've moved on too quickly. I don't think it's too scientific how we're going to approach these children. There seems to be a fear of making mistakes, so we're not jumping in with children, especially after it's settled a little bit and their families have moved aside, they're still involved in their lives, but children are carrying something in their head that stops them from being
40 able to focus every day on what they need to do just to keep up with other students.

MR CUMMINS: That's been most thoughtful and very constructive too, so thank you for coming forward and thank you and your wife for being here today. We'll take on board what you've said, Paul, and we'd like to thank everyone for being
45 here today. It's most important that we have the benefit of hearing your

contribution. As I said, it's recorded and we study it further, so our thanks go to all of you and, in particular, to those who have helped organise it and the officers who have helped us, so we're most obliged to you all and we'll now conclude the public sitting.

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INQUIRY ADJOURNED AT 12.57 PM ACCORDINGLY