S&C

SPARK AND CANNON

Telephone:

Adelaide	(08) 8110 8999
Hobart	(03) 6220 3000
Melbourne	(03) 9248 5678
Perth	(08) 6210 9999
Sydney	(02) 9217 0999

TRANSCRIPT
OF PROCEEDINGS

PROTECTING VICTORIA'S VULNERABLE CHILDREN INQUIRY

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

BROADMEADOWS

10.03 AM, THURSDAY, 7 JULY 2011

MR CUMMINS: Ladies and gentlemen, a very warm welcome to Broadmeadows on a cool day. We're very pleased that you are here. I would like to invite Uncle Colin to welcome us.

UNCLE COLIN HUNTER: Well, firstly, I'd like to acknowledge (indistinct) of my ancestors, the Wurundjeri people, and pay my respects to my elders, both past and present (indistinct.) (Balance of welcome unheard.)

MR CUMMINS: We thank you, Uncle Colin, for your dignified welcome and we pay our profound respects to the Wurundjeri people of the Kulin nation and its elders past and present, and I hope future.

UNCLE COLIN HUNTER: Thank you.

MR CUMMINS: Ladies and gentlemen, with that appropriate and significant welcome, the Panel of the Inquiry welcomes you to Broadmeadows. This is a Public Sitting and, as you know, ladies and gentlemen, it's a Public Sitting which means that your presentations here today and what you say are in the public domain and thus can be reported in the media and published on our website. That has the benefit, ladies and gentlemen, of being electronically conveyed to the public at large.

It has a couple of other consequences which I will momentarily touch upon. The first is that it is a Public Sitting and not a court of law. Thus, the traditional protections provided by a court of law, such as the privilege against defamation, do not apply in a Public Sitting. In a court of law, what is said inside the court in the process of court proceedings is protected from defamation. A public hearing like this doesn't have that inbuilt protection. I'm sure none of that will concern any of you in your presentation but I specify it so that you realise this is truly a public meeting and thus what you say is in the public domain. As you know, ladies and gentlemen, the *Children, Youth and Families Act* provides that the identity of persons in the Children's Court process, past or present, must not be revealed and thus any person who has been in the Children's Court process, either as a party, or a child, or even a witness should not be identified. Again, I'm sure you're conscious of that.

The Inquiry, ladies and gentlemen, established by government in January and due to report in November this year, is into systems of child protection and its purpose is to produce positive improvements in the systems for the future. Thus, it is very much a systems-oriented Inquiry and it is very much future-focused. It is quite different to an Inquiry into an individual case or into an individual organisation. Our terms of reference state that we are not to investigate individual cases or individual organisations. That means in turn, ladies and gentlemen, that we don't address the past in terms of allocating liability or allocating blame and we don't investigate past individual cases. Of

course, past individual cases can inform us as data for the future, but we don't investigate them by means of say the Ombudsman would, or a Royal Commission might, or a Child Safety Commissioner might, so you'll no doubt bear that in mind as well and we are really systems-focused and future-focused.

We've had the benefit, ladies and gentlemen, of having Public Sittings in the CBD and metropolitan area and, indeed, regional Victoria and it's been most beneficial to the Inquiry to have those Sittings and we look forward with confidence to the Sittings today and to those who have been good enough with their interest and their commitment and their time to come here to present, so I will go back to the table and then we'll commence with submissions.

The first presentation is the Australian Nursing Federation Victoria branch, Belinda Clark and Maree Burgess. Come forward if you'd be so kind and just take a seat and settle yourselves in. Belinda, take it in whatever order is most suitable to you.

MS CLARK: Thanks very much, firstly, for the opportunity to present today. My name is Belinda Clark and I'm a professional officer with the ANF Vic branch and I, together with Maree Burgess, will be presenting today. Maree Burgess is our ANF Vic branch president, but more to the point, Maree is an experienced maternal and child health nurse who has a lot of experience in providing care to children and families who may be at risk or have been identified at risk. The ANF has made some written submission to the Inquiry and in the limited time today that we have what we thought we might try and do is just focus on some key points.

MR CUMMINS: That would be very helpful. Take it that we are familiar with your written submission, which has been most comprehensive, and that we have all read it, more than once in fact, so take it that we've read that.

MS CLARK: Thank you very much. Our submission identified some key points that we want to highlight today and that is that early intervention is critical and it's also effective in preventing and circumventing the incidence of child abuse and neglect. We also identify that early intervention and timely intervention can be lifesaving and life-changing. We also identify that early intervention is definitely cost-effective and from our specialist perspective that nurses, and particularly maternal and child health nurses, are ideally and uniquely positioned in terms of their educational background to make interventions that will make a real difference in terms of preventing and circumventing child abuse.

I think one of the crucial things to recognise about maternal and child health nurses, and bearing in mind that our submission dealt with a range of different nurses and different domains, we recognise that nurses overall have access and

opportunity to make a real difference, such as school nurses, in midwifery, but the central point in our submission is that maternal and child health nurses really are the cornerstone and are best-positioned to make a real difference. For that reason, we want to signpost that it's the strengths and weaknesses in the core maternal and child health nursing workforce that actually can make a real difference in that maternal and child health nurses are, if you like, the core or the pool of other maternal and child health services or early childhood services that are offered to families.

Maternal and child health nurses, for instance, are supply nurses to the enhanced nursing service, to early parenting services, to the maternal and child health line, so the point is that any investment or any strength in that core workforce is going to have repercussions in terms of the quality and effectiveness of all those other services, so that's why we think it's so crucial to invest and build on the strengths that exist in terms of the maternal and child health workforce because it will have far-reaching benefits for all of those other associated areas of early childhood services and health.

The terms of reference spoke about identifying from our perspective strengths and we want to signpost that we very much believe that the existing strengths in the maternal and child health nursing workforce is their expansive and very extensive educational background, and that's something that we think is very critical and the cornerstone to be able to make quality and timely interventions that will really make a difference. I've brought out copies today and supplied to the Inquiry a survey that the ANF undertook in 2008 and there are just under 500 maternal and child health nurses in Victoria.

MR CUMMINS: Yes, we've got that.

MS CLARK: That identifies those nurses, the maternal and child health nurses speak of what a difference their qualifications make in terms of making a difference. So I think the core point is that we believe that government should look to invest and build on the strengths and enhance the capacity of the existing maternal and child health nursing services and other services that flow from that, such as the MCH line, such as early parenting centres, such as mother and baby units and also the enhanced nursing service and also school nurses to really improve their capacity to make a difference.

Now, how can that happen? I think one of the key things we pointed out is that we would like to see a further strengthening and investment in the core universal service and that is to match the increasing demand, which we've pointed out in terms of the increasing birth notifications. The importance of that is so that the service can make more responsive and timely interventions - and Maree is going to speak to that shortly - but just to say that at the moment there is tension within maternal and child health nursing workloads.

We can have a situation where, for instance, the maternal and child health nurses are restricted largely to staying within the ten key ages and stages visits and there is not enough flexibility or resourcing to move outside and beyond those ten key stages and ages visits which may be needed and which may make a very real difference. So I suppose what we're saying is that we'd like to see further investment in that universal service in a primary prevention role so that the maternal and child health nurses can provide more responsive care. It is maternal and child health nurses that really provide care to families around the core risk factors of child abuse such as social isolation, such as lack of parenting skills, maternal and ill health, postnatal depression, sleep deprivation, breast feeding difficulties, post-traumatic birth, all of these are the known risk factors that may contribute to child abuse and neglect and these are the areas that maternal and child health nurses can make a real difference and do make a real difference and can make more of a difference if the system can become more flexible and become more responsive.

I think it is probably a good time for Maree probably to signpost some of that flexibility which is built in around more scope for drop-in sessions, more scope for out of hours services and increased capability for nurses within the universal service to actually provide home visits, so I might hand over to Maree to actually give a bit of colour and light to that.

MR CUMMINS: Thanks, Belinda. Maree.

MS BURGESS: Yes, thank you. I work at the West Heidelberg Maternal and Child Health Centre, which is certainly identified as one of the high needs centres in Melbourne and I work for Banyule Council. I work with a lower work caseload relative to the other nurses in Banyule and probably relative to some of the other centres across the state, so that figure is 120 new babies over the year. This allows me to have those greater flexibilities that Belinda was mentioning.

So that at West Heidelberg, instead of just ten key ages and stage appointments, we balance it up with open sessions. So during the week there will be an afternoon open session and a morning open session, which means that the parents can just drop in and that means they usually drop in because there's a particular need. It may be, you know, just that chat for a mother that's tired after the birth of a baby; maybe some breast feeding problems; it can be greater than that, there can be family conflict; they might want to sort of seek out some financial support, where to go, advice on those needs; there might be domestic violence issues. I find with those drop-in sessions it gives the parents a good day-to-day basis for accessing the centre. I find with families that things that happen in a family, there are crises that occur on a day-to-day basis and I think it's important that as a front-line service we can have a day-to-day

response to them.

The other flexibilities I work with, as opposed to some of the other centres, are that the parents can always ring in. I'll always take a phone call, so they're not diverted anywhere. If they need to speak to you, then they need to speak to you then and there. I find the families that I work with in West Heidelberg are very receptive to that and they're more than happy for the consultation that we have to be interrupted because they recognise also that if someone needs to ring in, it's probably urgent.

I'm co-located with a child care centre, and this works particularly well, not only for me at times to drop into the child care centre if they have worries about a child, but it also means that for those parents that are working, they can drop in in early morning visits, they can drop in at the end of the day when they're picking up their children - sometimes those are organised visits - and again they can be just drop-in visits, so I think the flexibilities are important.

I highlight these things because this works very well in West Heidelberg, but that we know that families with particular needs and vulnerabilities exist right across every municipality and right across the state of Victoria. Unlike my colleagues working in other centres, they are hamstrung. There is nothing wrong with the ten key ages and stages visits - they are very good - but it does become a rigid way of delivering a maternal and child health service, as opposed to what had been done in the past. That's probably as much as I need to say.

MS CLARK: Thanks very much, so I suppose the key points there are we very much support the ten key ages and stages visits framework, we very much support that, but what Maree has illustrated is that where there is additional hours or additional resourcing built into that, there is also that added flexibility to go beyond those ten key ages and stages and we don't have that in every MCH centre and we think that that would make a real difference.

I think the first message is to invest in the universal service, but to match demand and to increase responsiveness. The second key point is to further invest in the enhanced maternal and child health nursing service. The enhanced maternal and child nursing service is really their core business, to provide care and referral and support and intervention to families who are identified either as being at risk or as needing more intensive care which would, if provided, actually circumvent and prevent incidence of child abuse and neglect.

We have identified in our submission concern that the service at the moment is currently funded in a way which effectively caps funding to services at an arbitrary level, an arbitrary level determined according to income of family

welfare rather than actual need and we think that that funding instrument, which I've outlined in our submission, should be reviewed because we're concerned that it's not sufficient and it doesn't capture pockets of need within the community and it's not really a true and accurate reflection of need.

We also would like to see review of the one-year limit that is currently attached to that funding formula. I think the crucial things about the enhanced nursing service is that it works very much hand in glove with the universal service, and Maree will speak to that in a moment, but our main concern is to see the enhanced nursing service to be able to continue to do its terrific work, but to again recognise that that at the moment is stretched in many areas. When that service, which effectively results in - I understand there is just under 10 hours of maternal and child health nursing care under the universal service, an additional 15 hours of maternal and child health nursing care under the enhanced service, when the funding is capped for that enhanced service, what happens is those families in need go back to the universal service, who then are having to try and fit the required care into their limited resources, so the system is quite squeezed in that regard.

We very much support the enhanced nursing service and we very much believe that it should continue to work in close collaboration and be part of the universal, if you like, part of the internal and child health nursing service. We'd be concerned around potential fragmentation of that service. Just before we speak to those issues, maybe if Maree might like to speak about how those services work together.

MS BURGESS: Sure. Thanks, Belinda. The universal nurse sort of starts with a home visit, it's a fantastic way to engage families, really engaging people on their turf. They invite you into the home so it's a really great way that the relationship starts and usually at a very high need for a family when they've arrived home with a new baby.

The maternal and child health nurse, because we have general nursing and midwifery and qualifications in early childhood development, are certainly well-placed to make those in-home assessments as to how the mother is recovering from the birth, how the baby is faring and certainly at a broader level how the family dynamic is operating, and all this happens in this one-hour home visit, but it certainly works very well.

After that home visit, we invite the families to come in for a series of these key ages and stages appointments and they are closer grouped at the start, there is a two-week visit, a four-week and an eight-week. Over that period of time, you will often see families that you can identify that have particular needs and vulnerabilities that you just know that they are going to need some more intensive support. When the system is working really well with our enhanced

home visiting nurse, we sort of basically get on the phone, have a chat and within that 24 hours, again if the system is working well and the flexibility is there, that enhanced home visiting nurse will be on the doorstep the very next day or that afternoon. That means that you've got an ability to go in and alleviate some of those pressures that often then if you're not responding to them in a timely manner, they will blow up, they will progressively deteriorate. As a mother's health deteriorates, the family's health deteriorates, so we sort of have this swinging and flowing.

The good system working well means we've got this very quick sprinter response from the enhanced nurse. However, when things aren't working well, and to quote at Banyule a month ago, that Child First, who also provide an excellent service, they closed their books and so the high-needs families from West Heidelberg were just not able to access that service. Subsequently then there is this back flow into enhanced, which they then logjam, they can't take on any - and I think as Belinda highlighted - then that comes back to the centre-based nurse who can find with her the expectations and the rigidity around access to the centre, it means that you can't actually offer those families those pressure valve visits, those release valve visits that they so desperately need.

I would also like to see that the relationship of EHV, enhanced nursing, with the mainstream continue because if at any point it was fragmented and moved off to say work with Child Protection, we wouldn't have that timeliness of the response and I think that's where we place the families at greater risk. If we can get in there really quickly, that makes the difference and they go into enhanced for probably six weeks and then back to mainstream, so you're never sort of stigmatising them. They know the nurse, they then become familiar with what the enhanced nurse does and then they move quickly back into the mainstream service.

MS CLARK: And thereby ensure that they continue to engage, which is critical. In addition to the maternal and child health nursing service, our submission also focuses on a range of other services, the school nurses, early parenting centres and we've identified how we believe they can be boosted around issues relating to education and better communication, probably not the scope today to go into and expand on those, but we just wanted to signpost that and to point out that there appear to have already been a number of studies, such as the KPMG study into school nursing which, for instance, made some recommendations to improve and increase the number of school nurses in the schools. What we'd really like to see is those recommendations actually implemented and just to signpost those to the Inquiry.

I suppose, in essence, in concluding we believe that the maternal nurses, and particularly the maternal and child health nursing service, can make a very real

difference and they are critical, they are the cornerstone to making a difference. It's very important that investment occur in the maternal and child health nursing services as a universal service, as a preventative service so that the system's aren't very proactive and not reactive so that the resources are in at the preventative stage rather than at the Child First/Child Protection stage.

We believe that we've outlined how that can be done, but essentially strengthening and boosting the maternal and child health nursing workforce is a very good place to start building on those retention and recruitment measures, building on the strengths, such as the extensive and comprehensive education and qualification requirements of MCH nurses to be a midwife, to be a nurse and also to have done the postgraduate studies, that's critical to us, and also to continue to provide the very important scholarships to maternal and child health or to nurses and midwives wanting to undertake the postgraduate studies, they're very critical to us. Also, to look at initiatives around remuneration and the like that we've outlined in our submission and we signpost those measures just in light of other inquiries occurring at the moment, such as the ECD workforce study and we think they are of critical importance to this particular area. So essentially we believe those changes will boost the system and can be life-changing and lifesaving in many circumstances. Thank you very much.

MR CUMMINS: Belinda and Maree, thank you very much for that. As I said at the outset, the Panel is well-familiar with your report, the 38 pages and your 14 recommendations and the appendices, which were quite substantial, so we came here with the benefit of that, but it's been excellent to have such a good focus by you both on the highlights that you wanted to home in on so that's been I think a most focused, if I may say so, presentation and very helpful. Prof Scott.

PROF SCOTT: Yes, thank you very much for your presentation and the report, which is so useful. The Victorian Maternal and Child Health Service is the envy of the rest of the country and well beyond the shores of this country, as some of us have long known, and this challenge of responding to the most vulnerable families creates a bit of a dilemma for services across Australia where we've seen a shift away from the universal service to be able to resource a very high need subgroup of families, so I guess the challenge in thinking in the Victorian context is how does one keep a strong universal service while really enhance the enhanced maternal and child health service.

I'm wondering if you've got any thoughts about how that could work, and I'm floating an idea which I haven't consulted with my fellow Panel members, but if we were to have an intensive enhanced maternal and child health service where the nurse would engage antenatally in the same way that in the David Olds model of sustained nurse home visiting, say by 20 weeks of

pregnancy, and I'm thinking of very vulnerable subgroups such as young women or women themselves who were former wards of state, or where there is substance misuse, serious mental health problems, et cetera, or very young mothers to engage during pregnancy and to have the possibility of two years of sustained nurse home visiting.

At a system level, how feasible would it be to do that? I mean in South Australia about 12 per cent of all families with a new baby are offered up to two years of sustained nurse home visiting post-birth. From your perspective, thinking about the system as a whole, thinking about cost, workforce, a diminishing and ageing workforce and the risk of shifting resources from the universal primary prevention end, what would be the ANF's response to a proposal such as that?

MS CLARK: If I can start, we agree with all that you've identified there and think that those are very worthwhile. I think our focus, and certainly the focus of our consultation with VAMCHN is that you can effectively achieve both. So the starting point from our perspective is to focus on the universal system as a primary prevention service and to further invest in that service and to, as you quite rightly say, to start antenatally, to start during pregnancy to identify mothers and families at risk in pregnancy and some of our submission deals around that and recommendations around communication. We think that that has to occur and there has to be fairly clear guidelines as to how that should occur and there is already some work being done on that between DEECD. We think that's critical. But rather than when those mums or ideal families are identified during pregnancy, rather than immediately necessarily placing them into an enhanced enhanced, what we think is critical is that those families are identified, that they're linked immediately in for assessment to the universal service and then the universal system can immediately link them into an enhanced nursing service, the enhanced nursing service.

We wholeheartedly agree and support the concept of the home visiting occurring for a more extended period of time according to need and not according to an arbitrary cap and that's critical, as Maree has outlined, to be responsive, to continue to provide that responsive care at the right time that that family needs it and, as Maree has outlined, families can go from a day-to-day in crisis and really needing assistance. We think that if those families can have access to maternal and child health nurses who have that wonderful education underpinning, those nurses can go in there and provide the actual care, referral treatment they need at the right time and thus prevent that family spiralling down or developing chronic behaviours that may lead them into being referred to Child First or Child Protection.

So the focus is very much on prevention; boosting the universal service, starting that in pregnancy; getting referral very early; getting the enhanced

nursing service, if necessary, in there during pregnancy; getting referrals set up; even other more intensive supports, such as early parenting centres; even given the waiting times and the like that exist for those services. So rather than waiting for a family who we know that's in need for birth, rather than waiting for that and rather than just suspecting that they may actually become in crisis or, you know, be in more crisis than they already are and then having to wait three months to get into an early parenting centre, start all that happening, very, very early. Maree might want to add to that.

MS BURGESS: Yes, if I could add to that as well. I think it doesn't take much tweaking really for the universal nurse to be able to actually maintain a home visiting model, just adapting those ten key visits. It could be done in a different way and a very interesting example, at the Banyule Community Health Centre the current community midwife is also a maternal and child health nurse, so she actually looks after the women as they're pregnant, particularly high needs families, and then she actually then follows them up after birth and then she continues in her maternal and child health role. It is this lovely fit and she doesn't step much outside those - well, she does, I suppose - it's an extended ten key visits but, you know, it might end up being 10 to 15 hours. For those particularly vulnerable families, that extra time spent in that first year can make a huge difference to the outcome.

MS CLARK: I think just to identify though that for that wonderful system to work, there needs to be the resourcing and there need to be the additional MCH nurses to allow that to happen because when the MCH nurses have a system where they have workload allocated per, say, 150 births, there's no fat in the system to do that, so that's critical. So the answer is there.

PROF SCOTT: Thank you.

MS BURGESS: I think that's probably really relevant actually, that across the state you really do get people, you know, a lot of the rural nurses working under really high caseloads, their birth enrolments can be huge and so they won't have those flexibilities to do those things that we highlighted earlier.

PROF SCOTT: Time is short, so I'll try to be very quick with these questions. One is that given that enhanced maternal and child health nurses and universal maternal and child health nurses are increasingly being asked to work with the most disadvantaged families, and in some cases families with very high complex needs of a level of risk as the same as a child protection caseload, do you see the current standards - and I use that word with some ambivalence because I'm not sure if they're very clear - about the availability of clinical supervision as adequate. I mean in child protection, in non-government agencies people would normally be having or should be having weekly one-to-one clinical supervision in relation to high risk families. It's my

understanding that that's not the case for maternal and child health nurses in enhanced.

MS BURGESS: Well, it's certainly been recognised and across the universal as well as the enhanced service there is supervision provided. The enhanced nurses will have it provided one-on-one and probably once a month. With more difficult cases that will be offered a little bit more frequently, but it certainly is an area of need, yes.

MS CLARK: It is an area of need and, you know, there is two streams of thought. One stream is that maternal and child health nurses are already registered nurses and midwives that have done the postgraduate studies, but we still believe that there is a great deal of merit in better clarifying and better allowing for better mentoring and supervision, and I know that some of our enterprise bargaining agreements for maternal and child health nursing services do have that built in, so there is an actual sliding scale of time allotment. We'd like to see it improved and we'd like to see it included as standard in every enterprise bargaining agreement across Victoria and at the same time the additional support and mentoring and debriefing, if you like, for the enhanced nursing service. I can think of some enterprise bargaining agreements where that is built in, but it needs to be built into all and, yes, we support increased and enhanced mentoring supervision, yes.

PROF SCOTT: Thank you. My last question, if I may, was around that very complex area of making a notification to the statutory child protection service and I think you capture very well the ethical dilemmas in that and the great risk of losing your precious relationship with very fragile families as a result of making a notification and then often those families not being seen as, the level of risk is such that it would deem statutory intervention so there is even less protection available for the child as a result of a notification having been made. That's, of course, a long-standing dilemma.

Do you see any alternative mechanisms - and I'm thinking also about antenatal notifications by midwives as well as following birth notifications by other nurses - do you see any mechanisms such as a process of consultation with the statutory child protection service about the appropriateness of this situation as a formal notification, around whether the risk factors would reach the threshold for a statutory investigation such that you would then only be making notifications in relation to cases where an investigation would be deemed to be necessary? I know this is very difficult, but I'm trying to think of ways of responding to the very serious dilemma you've identified.

MS BURGESS: Yes. I mean just in thinking about that, some of those processes are probably happening. We certainly in Banyule work very closely with the Mercy Maternity, so you are alerted antenatally to some of those very

high needs families. That area could be strengthened and if you're inferring then that we would be involved with protective services at some sort of consultative level that identified those risks, I mean that would only enhance how things - it seems to me your focus is very much now on the antenatal side trying to identify, which is absolutely valid.

PROF SCOTT: They are the same dilemmas postnatally, aren't they?

MS BURGESS: What's that, sorry?

PROF SCOTT: They are exactly the same dilemmas postnatally?

MS BURGESS: They are, yes.

MS CLARK: They are. I think, firstly, on a positive note, I think that the Child First system is broadly - and Maree would probably be able to speak to this better - is broadly aimed to try and achieve what you're speaking to. I think the dilemma that's outlined in our submission is around the worthwhileness, the perceived benefit that will be obtained through engaging.

PROF SCOTT: Thank you.

MS BURGESS: I'll have to think on that.

MR CUMMINS: Mr Scales?

MR SCALES: You made in your submission a number of comments about the expansion of the system to accommodate maternal and child health nurses.

MS CLARK: Yes.

MR SCALES: I just want to talk about how practical that is, given the point you're making about the ageing of the workforce within the sector. Before I do that, can I just clarify a few of the figures. On page 28 you talk about the number of maternal and child health nurse equivalent per birth and the number here is from 120 to 135. What is your ideal number of that ratio?

MS CLARK: Well, certainly around the lower scale and I actually understand that that range actually extends between about 110 and 150. I think we would like to see it very much around 120 at a maximum, but again it also depends on the acuity and the like of the clients and the population and that's a benchmark, it's an arbitrary measure.

Just in terms of the ageing workforce, one of the things about the ageing workforce, the ECG's draft report has come out and, curiously, they define the

ageing workforce as not an issue of concern in MCH nursing. Putting that aside, our understanding is that there is an excellent retention amongst MCH nurses, they have a high level of job satisfaction and that loss of MCH nurses or attrition usually occurs via age-related resignations, so it's achievable through continuing to build on the strength and MCH nursing is an attractive field for nurses to go into and the attractiveness of it are its strengths, that MCH nurses are nurses and midwives and have to do the postgraduate studies. That they do have, as a result, a very good career path, they enjoy independent practice, they are remunerated at a very good comparative level to the public sector so it's very attractive and it is achievable, but again it comes back to recognising that this is a great strength in terms of child - - -

MR SCALES: Yes, I don't think that's in question. I'm just trying to trace through the implications of what's in your recommendations.

MS CLARK: Sure.

MR SCALES: Because it does imply a huge expansion of nursing staff - I'm not arguing against that by the way - but I'm trying to get a sense of what is the scope of that expansion. Before you answer, let me just ask you a couple of specific questions. The actual number of birth increases, which you've sensibly put down, is roughly as I understand it around about 2000 per year. Let's take that ratio of 120. That then means that roughly per 1000 births we need roughly about another eight nurses per thousand. What is the net growth in the number of maternal and child health care nurses in the system at the moment?

MR CUMMINS: If you want to take any of this on notice, Belinda or Maree, you're welcome to because Mr Scales has this rather penetrating way of asking these questions and sometimes it's good to answer, sometimes you might want to say, "We'll put it on notice and send it in."

MS BURGESS: Yes.

MS CLARK: We would need to look into that because we'd need to consult with DEECD and MAV to get you those figures, but I understand that there is around 960 maternal and child health nurses in Victoria at the moment.

MR SCALES: Yes.

MS CLARK: But in terms of your mathematical calculations there, I definitely would need to take that one on notice.

MR SCALES: If you could just get back to the Secretariat because it seems to me that's what implicit in all of your submission is a substantial expansion. It would be helpful to know what that might mean in workforce measures

because it does seem to be quite a large expansion because you're talking about having a universal service in both the secondary schools as well as primary schools and expanding it within primary schools and so on.

MS CLARK: Sorry, you need to clarify in respect of the secondary schooling. What we're suggesting in the secondary schooling is that the KPMG study be implemented, and that is that a nurse be allocated to every secondary school and that's an outstanding about 120 schools and the KPMG report has made that recommendation. In terms of the primary school system, I'd be happy to look into any further details, but it might be worth even clarifying them more specifically.

MR SCALES: It's more about the whole of the submission. I'm not trying to in any way be critical of this, I'm just trying to understand the implications, so if you could go through your submission and look at it in the context of this Inquiry and say what would it mean in terms of the expansion of the workforce, that would be very helpful.

MS CLARK: Sure, we're happy to do that.

MR CUMMINS: We can send you the transcript of these questions so that you've got them and you can work through on that basis.

MS CLARK: That would be good. Thank you very much.

MR CUMMINS: Mr Scales?

MR SCALES: There was only one other relatively minor question. When we're talking about services, particularly within the education system, page 16 now, you are referring to the KPMG report, I accept that.

MS CLARK: Sorry?

MR CUMMINS: Mr Scales said you are referring to the KPMG report.

MR SCALES: Yes, I'm sorry.

MR CUMMINS: It's a bit hard to hear.

MR SCALES: You imply that we shouldn't be necessarily targeting vulnerable schools, and I'm not quite sure why you might imply that. It just seems to be sensible to target vulnerable schools, to have resources put into those vulnerable schools.

MS CLARK: I think again going back to the concept of primary prevention,

we have a concern around limiting preventative services to so-called vulnerable schools and we don't have a great deal of confidence that we can safely say the other 120 schools don't contain children who are vulnerable and we'd like to see those services extended to all of the schools.

MR CUMMINS: That's been most helpful, Belinda and Maree. What we'll do is we'll make a note and, Karen, if you'd be kind enough to make a note to spend the transcript directly to Belinda and Maree so we can get those further inputs.

MS CLARK: Thank you, that would be great.

MR CUMMINS: But the combined submission, being the written and the oral, is most helpful.

MS CLARK: Thank you very much for the opportunity.

MR CUMMINS: We wish you well and we'll hear from you further in writing. Thanks a lot Belinda and Maree. Next, Dr Eren. Doctor, thank you very much for coming forward. We'd be very pleased to hear you.

DR EREN: Good morning. Firstly, I'd love to acknowledge the traditional owners of our land, past and present, and pay my respects. I'd like to acknowledge the organisation, Care With Me, for bringing this Inquiry to my attention and also thank the Inquiry for this opportunity to present.

MR CUMMINS: We're very pleased you're here.

DR EREN: In terms of introducing myself, I'm a post-doctorate research fellow at a children's research institute in Melbourne and my studies are based on post-traumatic stress disorder symptoms in children who have been traumatised. I'm also a provisional psychologist, so I get the opportunity from time to time to work with children and families who are at risk or vulnerable and I also get to work quite intimately with children and families from a culturally and linguistically diverse background as part of the psychology work that I do, and then lastly I also serve on a number of committees at a council level that focus on intercultural and interfaith issues and making sure that the services provided by the council are linguistically, culturally and religiously appropriate.

So today I'm going to be talking to you about the importance of early childhood development and the long lasting effects of this into adulthood. I'm going to be highlighting some of the challenges that a child might face when they are going into out-of-home based care and then I'm going to look at how these challenges might be compounded when a child is from a culturally and

linguistically diverse background, and lastly highlight the importance of maintaining a child's cultural and religious identity in out-of-home care.

MR CUMMINS: That would be most helpful.

DR EREN: So when we look at healthy and secure attachment, what we're really referring to is a reciprocal emotional connection between a child and their primary caregiver and it's something that results as a result of caregiving that is attuned and responsive to a child's physical and emotional needs. Really it's an essential building block of cognitive, social and emotional functioning in a child. It's really critical in terms of developing characteristics such as empathy, the capacity to love, and also the inhibition of aggression which are all related to a child's sense of security and attachment to the world. These attachments begin to develop in childhood, but don't stop there, they continue to evolve into eventual adulthood. What happens when the attachment experience of a child is disrupted is that it really sets the scene for the establishment of further relationships as they develop into the future.

Children who have experienced early problems in their bonding with their primary caregiver, perhaps as a result of neglect, abuse, inconsistent parenting or other significant life stresses or trauma, such as frequent changing of caregivers, illness or the loss of a primary caregiver, these children, when we have a look at the research, they go on to develop a variety of physical, emotional and social problems. When we have a look at what sort of problems these children face in terms of interpersonal relationships, this might include a lack of trust, especially towards authority figures and a resistance to nurturance or guidance; it might include poor social skills; difficulty giving and receiving affection or love; and it might also involve superficial charm and lack of authenticity in interpersonal relationships.

From an emotional functioning perspective, the sort of challenges that these children at risk or vulnerable category might involve things such as a limited capacity for emotional self-reflection; minimal ability to recognise emotion in others and, unfortunately, quite low self-esteem. From a behavioural perspective, the challenges that these children face are things like temper tantrums, minimum self-control, things such as aggression and acting out in order to provoke anger in others. Then lastly, when we have a look at the cognitive and moral development, the challenges that these children face included things such as limited compassion and empathy towards others, difficulty concentrating and attending in the school environment and also might include a lack of understanding of cause and effect. So overall if a child has experienced negative attachment to their primary caregiver, they are likely to develop traumatic internal beliefs about themselves, others and the world. What this really means in terms of the impact upon their ability to maintain attention, interpret information, manage their own behaviour and regulate their

emotions is that they're quite disadvantaged and can be impaired in these areas.

One of my own personal interests in terms of some of the research that I do is having a look at the brain development of children who have been traumatised. When we have a look at the brain development through imaging methods of mistreated and traumatised children, we actually see that these children don't think the way that children who haven't been traumatised think, so they don't remember or approach problem solving in the same way either. The research also highlights that the brain of someone who has experienced trauma during key developmental periods will automatically use the more basic levels of brain processing. So what this really means is that these children are stuck in a fight or flight response and these are the areas of their brain that they are more consistently drawing on for their day-to-day functioning, rather than the more complex areas of thinking that would normally be drawn on for things such as thinking, problem solving and emotional regulation.

As you can see, for a child who has had a disrupted attachment in their childhood, there is a lot of hurdles and challenges that need to be overcome. When these children eventually need to be moved into out-of-home care, these challenges need to be addressed and it's going to be, normally for any child who moves into out-of-home care, it's going to be quite challenging to be able to adapt to the new change and also the challenges, given their situation. But when you're separated from your family and you're also isolated from your traditions and your heritage, it's even more of a challenge. The reason is everything is compounded. There is a lot more change that you need to be able to cope and adapt with.

In terms of fostering a sense of identity and belonging, it's really important for both the individual and overall community wellbeing. When we have a look at social and cultural identity, it's created and maintained through interaction with people belonging to a same or similar background. When we have a look at the research on this front, we can see that the process of developing a sense of cultural and social identity and belonging is quite complex and points to the needs for individuals to maintain their cultural identity as being key to developing a sense of self. I think this is where the importance of organisations such as Care With Me becomes really important whereby such organisations are advocating services that facilitate and foster cultural and religious engagement. I think cultural and religious identity is really important in terms of fostering that sense of belonging.

Now, in terms of a sense of belonging, if a child isn't able to establish that within their family unit, then normally the opportunities perhaps to explore that would be within a cultural context or a religious context and when those opportunities are not available to a child, then they are going to have to pursue other avenues to create that sense of belonging, which is an intrinsic need for

all human beings.

In some of the research that I drew in working with adolescents who have mixed with the wrong crowd, when we begin to work on some of the issues of these adolescents, it becomes very clear that there is a common pattern amongst these adolescents. Whilst the context and the story might be different, the patterns are consistent and they include the notion that often these kids who end up in collaborations with the wrong crowd don't feel they belong to any particular group, don't affiliate with groups that would be more in their best interest, they don't feel their family understands them or they have a very disrupted family dynamics and they feel that by associating with such groups, that they feel important and they feel that they belong. What this means for a child who is going into an out-of-care program is that they're vulnerability is compounded, so they don't have the family to create the sense of belonging and given that there isn't really too many programs that focus on fostering the cultural and religious identity, they also miss out on those avenues as well.

Essentially, when we have a look at it, it's quite a gross summary, but really a child who does come from a background of abuse and neglect has got two pathways moving forward. They either break the cycle of abuse and neglect and start on a new path or unfortunately, in our experience, they continue on that cycle of abuse and neglect and sometimes may become perpetrators themselves. So I think in terms of looking at cost-effective avenues to prevent that from happening, things such as facilitating a sense of self-through maintaining cultural and religious identity becomes quite important.

In summary, in terms of recommendations, I think it's really important to increase Federal Government funding and support for agencies who are at the forefront of the field because as it currently stands there isn't much training out there for agencies and carers in terms of increasing cultural awareness and competence. I think, firstly, such funding will be crucial I think in terms of developing training programs, to help educate current carers who are in the system in terms of developing their own cultural awareness, competence and sensitivity and I think this is really important as perhaps an alternative or as a supplement to the recruitment of culturally diverse carers. Secondly, I think it is really important to channel funds towards developing initiatives that enable the maintenance of cultural heritage and identity, while facilitating belonging within the new community and I think this will no doubt have positive consequences for overall mental health and wellbeing of these children.

MR CUMMINS: Doctor, in the area that you speak of, child development, is inherently most important and your perspective from culture is especially valuable, so thank you very much for that. Prof Scott, would you like to ask Dr Eren any matters?

PROF SCOTT: Yes, if I may, doctor, and please say if these are matters that go beyond what you wish to present to us today.

DR EREN: Sure.

PROF SCOTT: I'm interested in placement prevention and how we might reduce the number of children from culturally and linguistically diverse backgrounds needing to be taken from their family or placed in an out-of-home care situation, notwithstanding the fact that we don't know how many children we're talking about, and we have very little data on the factors which would lead to placement. But if we think that those factors could include situations such as exposure to domestic violence where a mother may feel deeply obliged to remain in an abusive situation and child protection services may see it as necessary to take children from the household to prevent their exposure to that, or if it may be what in the wider community would see as harsh, physical discipline which may be culturally-based or not culturally-based in a family of a CALD background, or the cross-cultural conflict between young adolescents and their parents, just thinking about those types of situations, do you have any ideas or would you like to forward to us in writing any ideas you might have on what would be the culturally appropriate strategies for addressing those situations, including the trauma the children may have sustained in the exposure, particularly the early situations, the domestic violence ones I described, culturally appropriate strategies that could make it safe to leave children within the family where their primary attachments are.

DR EREN: You've made some really valid and important points. I think drawing on my experience in working with those communities, I'd like to highlight that often in families from culturally and linguistically diverse backgrounds things don't get addressed until they get to a point where they cannot be ignored. So such families, perhaps sometimes due to language barriers or difficulty in knowing the resources they need, where are they going to find the resources, is often a problem given some of the barriers that they need to overcome and often in CALD families or communities talking about your problems publicly is very taboo and, unfortunately, it's one of the big barriers that we need to overcome in being able to provide these families with the resources, services and support that they need to address what's happening in the family unit.

So I think, firstly, perhaps education around what is available in terms of support and intervention for different problems is probably going to be a really good starting point and making sure that such information is going to be available perhaps in a language or an approach that is going to be understood by those families who sometimes don't have English as a first language.

PROF SCOTT: Thank you.

MR CUMMINS: Dr Eren, our congratulations on your academic achievements. We wish you well for your work and our thanks for your coming forward.

DR EREN: Thank you very much.

MR CUMMINS: Ms Vicky Chettleburgh. Vicky, thank you very much for coming forward. If you just take a moment and settle in. Thank you also for your written submission and we'd be very pleased to hear you.

MS CHETTLEBURGH: Thank you. I'll start by introducing myself. My name is Vicky Chettleburgh. I have been working in out-of-home care, residential care for six years. During this time, I have been employed with various organisations in different capacities and have been employed in agency work. This has given me the exposure to many different models of care and various placement options for children and young people across nine organisations and more than 20 residential units. Unlike organisations that are making submissions, I do not have the data to draw on; instead, I'll be drawing on my own experiences that I carry in my head and in my heart.

Over the years I have been frustrated at times with the inadequate care that has been provided and advocated for children and young people in many ways with the hope for better outcomes. Today I see the opportunity to focus on how the quality of care can be delivered to a higher standard and improve the outcomes for young people in out-of-home care. When I say out-of-home care, I mean residential care. Like Uncle Bobby at the Public Sitting in Bendigo mentioned, I believe protecting children is everyone's responsibility and I hope that together we can all make a difference to positively impact on the safety and wellbeing of children.

I'm not questioning the decision-making process to remove a child from an environment where they are experiencing abuse or neglect, but I do believe that once removed they need and deserve a higher standard of care than that which is being provided. In my opinion, they are often neglected in other ways whilst in care. In my experience, there is funding for out-of-home care, there is the legislation and there are the best interest principles that all focus on the safety and wellbeing of children, but this is not always reflected in practice. I strongly agree with the comment made by John Bonnice from St Luke's in Bendigo that the current Act provides strong legislative framework and the need is for more accountability to the Act rather than any changes.

I wish to pay particular attention to the current workforce. There is a lack of consistency in relation to conditions, support and training, which appears to differ from one organisation to the next, depending on the organisational

values. As mentioned, residential care workers are often unskilled, inadequately compensated and lack the training and support needed in such a role. Often workers are employed with no experience and not inducted into their roles while left unsupervised to manage challenges they are faced with.

I appreciate that many organisations have mentioned the challenges with recruiting and retention, but I believe these challenges could be overcome with better conditions and support for staff. This is evident where staff receive regular debriefing and supervision, professional development opportunities, are rewarded and recognised for the work they do and are given the support they need. It can differ so much from one place to the next where there is a permanent team or casual staffing; where there are behavioural management plans in place or nothing in place; where there are files and histories of the children or where there are no files; where there are clear and consistent boundaries established or staff are expected to make decisions at their own discretion; where there are age appropriate consequences or none; whether there is structure and routine or not; whether there is a commitment to training and development of staff or where this doesn't exist; where there is regular supervision and meetings or not; and whether workers feel empowered in their roles or decisions are made for them; where there is a culture of promoting transparency and being open to scrutiny or where organisations are dismissive of this. This reflects in the care that is then provided to the children.

Residential care workers need to be inducted into their roles and given training in areas such as behavioural management, trauma and attachment, age-appropriate consequences, developmental stages, mandatory reporting, first-aid, administering medication, crisis management, therapeutic restraints, self-harm, substance use and self-care. Regular supervision is also important due to the nature of the role, but often not available or offered. Debriefing after an incident is also important, but rarely offered to staff involved.

The next point I'd like to talk about is placement and instability for children and young people in out-of-home care. Placements are often decided on availability rather than what is best for the child. This results in a lack of consistency for placements, such as the ratio of staff to children, which is not based on the need, but rather on vacancies. In some cases, this means that due to lack of placement options, children are relocated to other towns or cities in order to be accommodated, which is extremely disruptive for them. I believe there needs to be clearer guidelines and monitoring of contingency placements that vary greatly in duration of time. More effort needs to be made to explore alternative options for these children and place them elsewhere sooner.

Placement instability cannot be reduced without ensuring there are not only placements available, but they deliver the care that is needed within those placements. As mentioned, decisions on placements need to be made

according to the needs of the child, rather than vacancies that exist before stability can be achieved. I do believe that instability can be reduced with the increase of training and support to workers and the resources in place to assist them in their roles. This will reduce the number of placements that break down. Instability exists due to the number of placements, but also due to the number of staff at any given placement.

In relation to young people and carers best informing decisions, there is a lack of opportunity for staff and young people to be involved in the decision-making process and to challenge any decisions that are made. Organisations generally do not encourage or promote avenues for people to speak up, give feedback or suggest how care could be improved. There needs to be more effective and timely response when issues or concerns are raised about the care of a young person or child.

There is legislation that suggests children have the right to have a say and feel heard, but often this is not the case, with decisions made without their consultation or involvement. I feel strongly that residential care needs closer monitoring to ensure the quality and standard of care is adequate and meets the needs of the children and young people. I would like to see something similar to the community visitor's program introduced to residential care. The community visitors program visit disability service organisations where residential care is being provided and report on the quality and standard of care and support that is provided. Implementing a similar program for out-of-home care, resi care, would be helpful for monitoring the services provided, hold organisations more accountable to their funding arrangements and create opportunities to reduce gaps between policy and practice.

The out-of-home care system needs to respond to the needs of children and young people in care within a trauma framework that emotionally links to a sense of belonging if more positive outcomes are to be reached. Children in out-of-home care need a therapeutic environment where they feel connected. This can be supportive and enrich their lives, enabling them to move through developmental stages and overcome issues that have resulted from family breakdowns. There is research that strongly suggests children can heal and recover from the trauma of abuse and neglect providing they experience security, stability and safety that is supported through caring relationships.

MR CUMMINS: Now, Vicky, with the next section, I think it might be best if you simply state Inquiry Question 3.2 or Inquiry Question 3.51, whatever it is, because we've got the questions, and what we'd like is your comments on them. So if you take it just step-by-step, when you get to the next page, I'd just put Inquiry Question 3.2 and then give your answer.

MR SCALES: Although I think, Philip, it actually repeats what's already been

said.

MS CHETTLEBURGH: Yes.

MR SCALES: So I don't think we even need to go through that, do we, Vicky, because you've already covered them off, I think.

MS CHETTLEBURGH: Yes, I've highlighted a couple of points that I was - - -

MR CUMMINS: That's even better.

MS CHETTLEBURGH: But it does cover it.

MR SCALES: Yes, it's very helpful, thanks.

MR CUMMINS: Well, Vicky, that's been very carefully thought and put down so I do commend you on your preparatory work in getting this done, there is a lot of work in this, so thank you very much. Your experience over the six years, not only in that time but in the variety of experience you've had is also very helpful to inform us, so thank you both for the work you've done as well as what you've said. Prof Scott?

PROF SCOTT: Thank you, and I appreciate this and as someone who was a residential careworker in the 1970s, I know where you're coming from on this. Given the diversity of units you've worked in and agencies, you are in a very valuable position to identify the conditions which help them work well and those where they don't work well, even within a similar legislative framework, even funding agreements, et cetera, and I'm just wondering if you could talk a bit about what I've heard some young people say, which is that when a residential care unit is not working well, there is a very understandable - they don't say "understandable" but I do - there is a very understandable tendency of the staff to retreat to the office as a place of physical and emotional safety, to spend a lot of time writing case notes and to call the police for matters which - and of course I'm not hearing both sides of this - but matters that on some occasions might be seen as very minor, on other occasions certainly not minor and the police have an important role to play, of course, in those matters. I'm wondering if you can say whether this resonates with your perception. Have I been hearing a biased perception of young people saying that to me? From your perspective do those dynamics occur and what are the conditions which can change that?

MS CHETTLEBURGH: Firstly, yes, it does happen and it's interesting that you mentioned the police because I made a note at one point to prompt me and I think that in relation to when workers spend a lot of time in the office or call

the police is usually because they're not equipped to better manage the situation or they feel disempowered in their role.

An example that always comes to mind for me is when a young person gets angry and as a result of that might kick a hole in the wall and in some cases the response is to call the police and the young person is charged with property damage. To me, that teaches the young person what's acceptable and not acceptable in society, but it doesn't actually give them any boundaries that are established within the home or any opportunity to I guess explore what lies beneath that behaviour and help them manage their emotions in more productive ways and express themselves differently. I think that the staff are not skilled or supported to manage the situation any differently, so their fight or flight response is to call the police.

Also in relation to being in the office or not being is involved, I think once again comes down to, in my experience, comes down to the team of people and the organisation because it can happen in different organisations, but it can also happen in different units within the one organisation and a place that stands out for me in residential care was a unit that between the team had more than 30 years' experience just in that one unit, which was the only example that I've seen of that, but within that organisation there were other units that were quite different and had a high turnover of staff and would spend time in the office and a lot of things that you mentioned. So I think it really comes down to the staff being equipped and supported to be able to manage such situations and there be a focus on forming relationships with the young people, which is not always the case, but it is evident in some units, I wouldn't say it doesn't exist, but what you're saying is all too common, yes.

PROF SCOTT: Thank you. The second question I had is about your suggestion of a community visitor and what that role may be and in some places in the field of mental health, in prisons, a community visitor has an inspecting-type role, but not a relationship-forming role. In Queensland, where every child in care has the equivalent of a community visitor, there is an attempt to make that more of a significant relationship, but still have its advocacy monitoring role. Would you see any potential in residential care for a community visitor going beyond the monitoring role and the taking any issues back to another organisation and advocating upwards and actually having some sort of role with the young person perhaps around linking them into sports clubs, services or a mentoring role, would that be too much to ask of the one role, be this volunteer or paid? Perhaps you could say a little bit more about how you would envisage a community visitor role, or come back to us with that.

MS CHETTLEBURGH: I hadn't considered what you said in relation to a mentoring role. My suggestion was more I guess one of an investigation - - -

PROF SCOTT: Sure.

MS CHETTLEBURGH: - - - to ensure that our policies and procedures are in place, to ensure that staff aren't sitting in the office, that organisations are offering regular supervision, debrief, that case notes do happen, instant reports do happen, that there are follow-up and generally how things are managed within a unit was more what I was suggesting.

PROF SCOTT: Sure. Would you see that as a paid role or a voluntary role, or maybe you don't have a thought about that, so please feel free to say if that's the case.

MS CHETTLEBURGH: I know from what I've read with disability services, I've never been involved in disability, but from what I've read it's a volunteer role. If you can get volunteers, that's great, but yeah, I'm not sure.

PROF SCOTT: Thank you.

MS CHETTLEBURGH: I just think there's a lack of monitoring.

MR CUMMINS: Yes, quite. Mr Scales?

MR SCALES: Vicky, thanks very much for this. Can you hear me okay?

MS CHETTLEBURGH: Yes.

MR SCALES: This is a very helpful contribution because even though you were somewhat self-deprecating by saying you haven't done the research, this is an important part of the research actually because the fact that you've been involved with nine organisations across 20 residential units is very helpful to us.

Can I ask you, therefore, a couple of questions - and if I'm not making myself clear it's my fault, not yours, because sometimes I use jargon that doesn't mean anything to anybody else except me, so just say, "I don't understand what you're saying," and we'll work it through.

If I can summarise a number of things that you've said one-by-one. You've made a very important point about increasing professionalisation of the sector, the out-of-home care sector - they're my words, not yours. Now, tell me what you mean by that, if I'm right, in terms of the organisations. Do you mean that organisations below a certain size can't do all of the things that you're suggesting? Are you implying that organisations that don't have sort of the critical capability of providing good management are really not capable of

providing the care to young people in the way in which you describe, those sort of things, is that what you're trying to imply with some of this?

MS CHETTLEBURGH: A bit of both. I think that in my experience, like I said, that workers are often unskilled and have never had any experience in the field and for me, I'm not a parent, but for me I think of - like as a parent you're looking up the Yellow Pages and just calling anyone or the White Pages, calling anyone to come in and look after your child. They're really, yes, unskilled, do not have the experience and then are just thrown into roles without any training and support. I do think that that's reflected on organisations because some organisations do recruit differently, do induct differently, do train and support and develop their staff differently - and I'm not sure whether that's, in some cases some organisations are quite new to out-of-home care so I'm not sure if they see it any differently or they feel stretched and feel like they just need to fill gaps and in some cases quite desperate to fill roles and don't really consider the implications of that.

MR SCALES: So of the nine organisations that you've worked for, how many would fit into the category of meeting your model of what constitutes a good organisation to be able to provide care for children in a way you've described and how many wouldn't, I mean roughly.

MS CHETTLEBURGH: Throughout an entire organisation, I'd say one.

MR SCALES: One.

MS CHETTLEBURGH: And then in other organisations I'd say there is examples of different units and different teams of people that have provided that, but I would say it's down to individual people and the individual teams and that might be because some people have experience that can bring that into the role or it might be just based on their own values and morals as an individual. Because there is quite often policies and procedures in place and there is the framework that suggests something quite different, so even without the experience people can come into that role and follow that, if given the induction and resources.

MR SCALES: Can I talk about the one. What distinguishes the one from the rest?

MS CHETTLEBURGH: That it's a therapeutic model of care in a family environment and there is stable carers, it's very relationship-focused and based on trauma and attachment theory.

MR SCALES: Can I then move on to the second thing which I think you were describing, which was the professionalisation of a workforce - again, my

words, not yours - and the sophisticated story here seems to be neither over-professionalising nor under-professionalising. What's your view about what's the right balance here? I mean what is it that a carer in a residential carer unit might need that doesn't go beyond over-education or under-training? Give us a sense of that.

MS CHETTLEBURGH: I think that training can occur in the workplace. I'm not suggesting that there needs to be a minimum qualification for residential care.

MR SCALES: Okay. Good.

MS CHETTLEBURGH: And I can speak for myself, that I came from a retail background and I was given training and support in the role and I was lucky enough to work for an organisation that I received that in the first couple of years, which has sustained me. So I do think that, as I said, there doesn't need to be a minimum qualification, but the training and support in the role needs to begin from day one.

MR SCALES: Would you go to the step that often we're beginning to now see in other professions where people in that profession are required to upgrade their qualifications? I'm not suggesting they should be professional qualifications, but at least upgrading their training or their qualification, is that that's the sort of thing you had in your mind, or not?

MS CHETTLEBURGH: Yes, but I think it needs to be specific to - like I'm not certificate with the certificate IV in protective care - but I would imagine that that's more specific to such a role. I'm currently completing a diploma in community services and I don't think that that would be helpful, as helpful as other training that I've received. So, yes, I do think that what you're saying to skilled staff - - -

MR SCALES: But it's worthy of us at least considering as part of our own considerations?

MS CHETTLEBURGH: Yes, and then I see, you know, minimum requirements, I see a similar challenge in child protection workers where there is a minimum diploma level, minimum two years. It is so difficult to recruit residential care workers now, and there was a minimum period that they needed to study before employed, yes, that would cause some real challenges immediately, so there needs to be something in the role.

MR SCALES: The other two issues that I took out of your submission was that you are actually arguing for an increased level of regulation - my words again, not yours - of the way in which the out-of-home care system works, and

particularly of organisations in the way in which they provide out-of-home care. Now, you gave us some practical examples about how that might happen, but I took out a broader picture I think from your submission. Would I be right, or am I going too far?

MS CHETTLEBURGH: No, I'm not sure what you're implying in relation to broader.

MR SCALES: What I got out of it was a frustration from you about the fact that people were providing out-of-home care, often very good organisations, but they weren't necessarily applying either the regulation or the law in a broader sense and therefore there needed to be a greater scrutiny over those who are providing it. Would that be an accurate description?

MS CHETTLEBURGH: Yes, yes. Because my frustration comes from a place where I've seen it work, I know it can be different and there can be better outcomes and a higher quality and standard of care being provided, so yeah, that's where my frustration comes from.

MR SCALES: Then you also seemed to be implying one last thing, which was that we do need another set of protocols about how we should treat young children and how we should involve them in then much of the decision-making that's going on in their lives in out-of-home care. Again, am I going too far in terms of your own experiences and reflections?

MS CHETTLEBURGH: I'm not necessarily implying that there needs to be different protocol. I think that, firstly, what's in place needs to reflect what happens. As far as best interests principles and Every Child Every Chance and the charter of children's rights, all indicate - and I can't remember the names of other things - but indicates that the children are involved in the decision-making process and do have a say and do have the right to feel heard, but it doesn't happen and very, very rarely have I seen that happen. Those decisions, whether they are in relation to access with their family, whether they're in relation to moving 200 kilometres away, or being placed in foster care, residential care, kinship care, whatever, they're not consulted. That's the reality, they aren't, in my experience, and I do think that there are frameworks in place that suggest that needs to happen, so it's about implementing that. It's not about changing anything for me.

MR SCALES: So the ideas are right, we have to make sure it happens on the ground.

MS CHETTLEBURGH: Yeah, definitely.

MR SCALES: That's really helpful. Thank you very much.

MR CUMMINS: Vicky, we said at the start, thank you for the work you've put into this. Thank you also for your commitment and particularly thank you for your clarity, the clarity of your thought and the clarity of your presentation.

MS CHETTLEBURGH: Thank you. Thanks for the opportunity.

MR CUMMINS: Next, Kerry Crawford, Victorian Aboriginal Child Care Agency. Kerry, are you here? Not yet. Is Judith Gray here from Broadmeadows Uniting Care? Judith, would it be convenient for you to come forward? Thank you very much. Judith, take a seat. We'll just hand these around to ourselves. Judith, please proceed.

MS GRAY: Yes, I work as a partnership facilitator in the City of Hume with the Best Start program, but I'm also representing the program manager for the Communities for Children program in Broadmeadows and what they are is place-base initiatives to focus on prevention, early intervention programs and trying to improve outcomes for communities that are considered to be disadvantaged. I was very keen to present the evaluation results for the first three years of the Communities for Children program, so I've given those reports and I guess the key message for me is the importance of developing a local evidence base about what is working in a disadvantaged community and how we can mobilise the village around families and resource them better. This approach is a community development capacity-building approach and very much looking at the whole of the community and being inclusive of all families who are within that community, so the programs have been designed to be accessed for everyone.

I'd like to just read out the press release from the evaluation report:

> *Seven Years of Working on Improvements For the Community, a Good News Story For Hume. The press release provides details of the results of the Broadmeadows Communities for Children site evaluation 2005 to 2009. The report will be launched on 20 August in 2010 by the Honourable Maria Vamvakinou MP, Federal Member for Calwell. It demonstrates a major increase in the focus on the early years by 20 partner agencies and mobilisation of resources, including Hume City Council, Dianella Community Health, primary schools, non-government agencies and local community organisations in Broadmeadows.*
>
> *In addition, over 20 per cent of the projects reported have had an impact more broadly across the City of Hume. The results are presented in the report written jointly by Broadmeadows Uniting Care and the Centre For Community Child Health at the Royal*

Children's Hospital. It joins up data and actions from the Australian Government Communities for Children program and the Victorian Government Best Start program in Hume. Over 28 agencies in the Hume early years partnership collected the data for this report, demonstrating a whole of community effort and commitment to ongoing review and reflection.

So in terms of summarising the results from 2005 to 2009, the site developed the following outcome-based evaluation methodology, working across 35 projects and five strategies targeted at a child, a parent and community level. It is these multi-layered approaches which are known in the literature to improve health, wellbeing, development and learning outcomes for children at a community level. Results were informed by qualitative and quantitative data, with all projects following the same evaluation process. Projects were spread across the 28 partner agencies, including large and small community organisations, schools and multicultural agencies as well.

High levels of parent and professional engagement were evident in the Broadmeadows Communities for Children site. Over 800 parents participated in surveys from a range of cultural groups, 198 professionals wrote journal notes about the impact of the programs and the partnership agencies. School principals collected data on access to early years programs before school entry. A quote from the program manager of Communities for Children, Colleen Turner:

More early years programs have been provided in Hume and these programs have been designed and planned with local community needs in mind. Programs that have been particularly successful are those making use of local expertise and building on the strengths and resources within the local community, often using bilingual facilitators.

Both parents and children report more social contact over a three-year time span before their child started school. This is a key factor influencing school readiness as it improves a child's social, emotional, development and early literacy skills. Parents with young children also report that they felt more supported by their community and took on board strategies to support their children's learning in the home.

Many parents have been offered support and welcome in the programs than was previously the case and now they have an ongoing relationship with workers and other parents. Community leaders and parents are involved and many have found pathways to employment through the programs. These benefits are for those living and working in the Communities for Children site and there is evidence of the spread of this across other activities in the City of

Hume.

A key enabler of the results has been the processes put in place with a formal community partnership. The Hume early years partnership has facilitated shared leadership across the sectors, including sharing in community engagement, pooling of knowledge and expertise and joint planning and resourcing of programs. Many programs have been embedded into the service system for the long-term and new innovative projects are being set up annually. High levels of community engagement and linkages have supported increased universal access to early years programs and more targetted activities for those with more complex needs. Communities for Children projects that have an impact more broadly across the City of Hume have been the Aboriginal partnership work, the Hume playgroup coordination and the parent/child Mother Goose program.

The site has used the Australian Early Development Index to inform decisions about the allocation of funds and project priorities, the 2009 AEDI results in Hume, so mixed results since the world economic crisis which have been keenly felt in the Broadmeadows area. Children in Broadmeadows and surrounding suburbs are twice the national level of developmental vulnerability upon school entry with results providing strong momentum for action.

Prof Frank Oberklaid said in the foreword of the evaluation report:

> *Progressive communities are those that are constantly reviewing how services are provided to children and families. Communities for Children program requires services to engage with communities in order to respond to demonstrated needs and circumstances.*

The report details the efforts of the Hume early years partnership in doing this over the past four years. A quote from the Hon Maria Vamvakinou MP in the response to the report:

> *Increasing knowledge about services by parents has led to increase in access, to maternal and child health and playgroups. Playgroups saw the highest increase in accessibility over a three-year period. The expansion of playgroups and the community hub models is the focus of many agencies in Hume. Most partners in the Hume early years partnership support and host playgroups.*

Then I've provided some additional information with the press release looking at the outcome measures for the Communities for Children program and basically showing how all of the partners have been committed to working on

those outcomes. They were involved in developing them with the staff in order to get that buy-in and commitment from everyone towards those outcomes.

MR CUMMINS: Yes, thank you, we have that.

MS GRAY: And just to draw your attention I guess to the enormous number of parents who were so willing to complete surveys and staff, you know, if we use playgroups as an example, the question is always asked, "Does this mean we might be able to keep having this program," when parents are asked to fill out evaluation forms and comments.

MR CUMMINS: Yes, that's most positive.

MS GRAY: So I was very keen to summarise the fact that early intervention and prevention programs are showing promise in the City of Hume and that idea of getting the village working well to support all families and in that way families with more complex needs can be connected into that village much more effectively.

MR CUMMINS: Thank you. That's very helpful, Judith. Prof Scott?

PROF SCOTT: Thank you, yes, it's very interesting and very encouraging and relates so much to our prevention and early intervention terms of reference. I'd like to ask you about the very last group of families you mentioned, those with multiple and complex needs, because initiatives both in Australia and elsewhere, such as Communities for Children, Sure Start and some of the earlier US programs have had good gains with what one might call disadvantaged families. In most circumstances, they haven't been as successful, and this isn't necessarily a criticism of them, but the challenge of reaching the desperate families - desperate, not just deprived or disadvantaged.

MS GRAY: Yes.

PROF SCOTT: So where there really are multiple and complex needs, and we're talking about families where there is domestic violence on the edge of homelessness, where there might be parental mental illness or substance misuse, under what conditions can initiatives such as this - and I'm aware of Communities for Children plus, which is trying to address this from the Commonwealth perspective - under what conditions can an initiative such as this be a successful platform for dealing with the most vulnerable families on the edge of a child being placed and whether that's even a realistic expectation, so I'm really asking your assessment of the degree to which a primary and secondary prevention platform can actually meet the needs of families who are much more disadvantaged than the population that it's perhaps intended to serve.

MS GRAY: Well, I guess this is the new phase of the Communities for Children funding, to focus more towards a secondary end of the service system. I haven't mobilised a lot of work in the universal services, so I wouldn't like to comment at this stage, given our evaluation report was over the previous four years, but just to say that the theme I guess that's occurring is that the secondary and tertiary services have been overwhelmed because there have been so many parents who have been linked into the service system and so we've found as a result of a lot of community engagement, very large numbers of parents being linked into preschool, for example, that the system is really struggling now to meet the needs at the secondary and tertiary level and so I guess that's going to be a real challenge. The sense of overload is great.

Some of the secondary and tertiary services are looking at working in the community hubs and working in playgroups so that they have a presence in those universal spaces and families can get to know the agencies or the skills of the staff member, but this usually leads to lots of referrals. So it's working very well as a pathway and a linking system, but it's got lots of challenges in terms of the issues that you raise. My only comment about that in terms of sustainability is that we have trained a lot of community, bilingual community workers and I think in the long-term these workers and parents are in the community for the long haul for the whole of their children's life so these parents are often still there when there are very complex families in very desperate situations, as you say. Maybe they're at the school or at the venue where some of those parents are and so that's all I'd say, that our community village people, if I use that term, are going to be there regardless of services coming and going or programs coming and going.

PROF SCOTT: Is it just more resources or are different models and ways of working required to reach - - -

MS GRAY: I think it's early days for us - - -

PROF SCOTT: It's too early for you to say.

MS GRAY: - - - in terms of, you know, that's very much the questions we're asking.

PROF SCOTT: If you have any additional data which might demonstrate how it's been possible to engage children and families who were previously unengaged or disengaged from the universal children's services, that would be very helpful to us.

MS GRAY: Well, I guess that's a huge part of what the results - they're talking to, you know, the increase in preschool participation has been very

positive and that's been helped by the fee relief from the State Government for kindergarten, but many of those children have challenges in kindergarten and the question is again, is the system able to support them well enough to maintain their regular attendance.

PROF SCOTT: Yes, thank you.

MR CUMMINS: Mr Scales?

MR SCALES: Just a couple of simple questions. This is a Commonwealth-funded program?

MS GRAY: The Communities for Children program?

MR SCALES: Yes.

MS GRAY: It's built on the State Government Best Start program, which funds the partnership structure, which is the sort of decision-making group who allocate resources and jointly plan together.

MR SCALES: I just wanted to talk about that. On page 13 of this larger report, the Communities for Children, the final local evaluation report, it talks about Uniting Care being a lead agency.

MS GRAY: Yes.

MR SCALES: Then it talks about you operating in consortia with a number of other organisations.

MS GRAY: Yes.

MR SCALES: Can you give me a sense of how that works and how that then relates to the other organisations that are part of the whole program?

MS GRAY: So there is a broader partnership of 28 and they represent the health, education, community services, early intervention sectors and then also community members and we have parent representatives, a parent advisory group that also links into the partnership membership. In terms of the consortia, they provide the final signoff to the allocation of the funds and the acquittal of the funding of the program and, yes, the final signoff to how it's being run.

MR SCALES: So that the 20-plus organisations put in an application for funding, is that the way it works, and then the consortia decides?

MS GRAY: No, the consortia put in the application for funding for the overall program and then there is approximately $500,000 a year that is allocated through the partnership and the programs are developed and designed by them and there is a voting on priority setting in order to finetune.

MR SCALES: So is there a board?

MS GRAY: The consortia is the - - -

MR SCALES: The consortia is the board?

MS GRAY: Well, then there is an executive of the partnership, which has just finalised its terms of reference and reviewed a partnership agreement, so the partnership agreement has just been renewed and signed by all the partners. I didn't mention the executive structure of the partnership and they're there to again assist with strategic planning and advocacy.

MR SCALES: Thank you very much.

MR CUMMINS: Judith, thank you very much for bringing this forward to us. We're most obliged to you, both for your verbal submission and for the material.

MS GRAY: Thank you.

MR CUMMINS: Ladies and gentlemen, we've been going just on two hours, so we'll take a 10-minute break. Can I say to Marilyn and Josh from the Centre for Excellence, would it be convenient to you if we asked you to come forward after the break? You don't need to reply now, have a think of it over the break, and we'll see everyone in 10 minutes.

ADJOURNED **[11.57 pm]**

RESUMED **[12.09 pm]**

MR CUMMINS: Ladies and gentlemen, if it's convenient, we'll resume. What we're going to do is have the benefit of hearing from Kerry Crawford, then we're going to have a private hearing and then continue after lunch with the schedule as scheduled after lunch, so we'll have Kerry Crawford now and then go into a private hearing and then commence with the after lunch speakers then. Kerry, thanks for coming forward.

MS CRAWFORD: Good afternoon.

MR CUMMINS: Good afternoon and good to see you.

MS CRAWFORD: Good to see you again.

MR CUMMINS: You just settle in there for a moment and just take a moment to settle down and we'd be very pleased then to have the benefit of hearing you. We've had the benefit of the written submission, so you can take it that we are familiar with it and whatever you'd like to do to speak of in terms of focusing or emphasis, you're very welcome to do so.

MS CRAWFORD: Thank you, and I'm going to read from this transcript, just so my nerves don't get the better of me, if that's okay.

MR CUMMINS: You're most welcome.

MS CRAWFORD: Thanks. Is it okay if I start now?

MR CUMMINS: Please do.

MS CRAWFORD: I begin today by acknowledging that we meet on the land of the Wurundjeri people and pay my respects to Aboriginal elders, past and present. As you are all aware, VACCA submitted a written response to the Inquiry and today what we're going to do is just add to the submission in the area of Child First by again discussing the concept of an Aboriginal Child First service.

When Child First was introduced in Victoria, at that time there were no Aboriginal specific resources allocated within the Child First for Aboriginal business and this was despite a strong advocacy from VACCA around that component. Therefore, Child First was set up as a mainstream service that would deliver assessment, intake assessment and referral for all families, including Aboriginal families. In terms of Aboriginal involvement, that concept was to come later from mainstream alliance members, but in that sense there were no Aboriginal decision-making processes within it. So in the north and west region the mainstream CSOs contributed to the Aboriginal component of Child First by having portions of their budget shaved off so that the creation of the Aboriginal liaison worker position would then address the consultation part of working with Aboriginal families within this sector. These positions were to be available across the mainstream Child First catchments, and again to provide the cultural input via consultation as referrals from Child Protection came through that related to Aboriginal families.

The effectiveness of these positions are dependent on two main factors: firstly, on the goodwill of the mainstream orgs financially contributing parts of their budget back into DHS, to DHS then fund VACCA directly and add targets to that funding of 2.66 EFT with a target of 3500 hours. Secondly, Child First

staff obviously would need to have an understanding and appreciation of the expertise of Aboriginal colleagues and take the opportunity to consult with the ALWs, but this wasn't a mandated process.

Anecdotally, our Aboriginal and liaison staff describe how they have made a difference to Child First service delivery, however, ACSASS service reports limit a difference to the number of Aboriginal children referred to Child Protection since the introduction of Child First. So on a broader scale that also means there has been no impact on the number of reports or re-reports via the Child First process.

Today what we wanted to propose - and I guess it's a revisit of that earlier conversation - is an Aboriginal Child First service for the north and west region of Victoria and we want to move from a process where the first port of call is through a mainstream organisation for Child First and its central to Child First service delivery and the Aboriginal liaison worker is really on the periphery of that, so it's post-intake, often post-assessment and starts to come in at the allocation process and in a consultancy role to Aboriginal Child First - let me start again, sorry, because I'm reading this and making it up as I go as well.

Child First is central to Child First service delivery and the Aboriginal liaison worker is on the periphery and in a consultancy role to Aboriginal Child First having a central decision-making role within Aboriginal families. So our proposal is built on three principles: firstly, self-determination, and that's the commitment to decisions about Aboriginal people being made by Aboriginal people and obviously delivered by Aboriginal organisations; the principle of Aboriginal services first, that is, wherever possible services for Aboriginal people are delivered by Aboriginal organisations; and self-management, which is Aboriginal services are responsible for service delivery to Aboriginal families and thereby understand the issues and can target better responses and can advocate for solutions. The Panel has been furnished today with the current model of Child First and the proposed model of Aboriginal Child First, so it's more for if you wanted to ask any questions later or to take away and consider.

MR CUMMINS: Thank you very much.

MS CRAWFORD: If we have a look at the flow charts, the current process is that the mainstream Child First sits in the centre, which is this one here.

MR CUMMINS: Yes, we've got it.

MS CRAWFORD: So what happens is, the referrals to Child First come through a number of pathways. So they can come through Child Protection, which is the main referrer, and then they can come through other processes as

well, and that's usually by a non-Aboriginal service referrer, Child Protection and so forth. So by that time you've already had one handling by a non-Aboriginal person about a non-Aboriginal case, it comes into a mainstream Child First and usually at that point it's a non-Aboriginal intake worker that then has a discussion about what this case means. At some point within that there is an expectation that consultation occurs with the ALW and at that point a decision is made what type of service delivery may benefit this family, or if the family wants an Aboriginal service, so at that point the family is given a choice, do you want Aboriginal or mainstream, which is a kind of a little bit different to mainstream because mainstream just gets mainstream, so there is a difference there already to start with.

Within that as well, the consultation with the ALW doesn't necessarily mean the case automatically goes to an Aboriginal family support service. It may be that the question is asked whether the family wants mainstream or an Aboriginal specific service, then they may come to the ALW, may consult and it may be that within that capacity, it may be decided at some point that there may not be an Aboriginal service provider available, so then even though the discussion has been had with the client, it may then go back to the client and say, "Well, actually there's not Aboriginal services available, blah, blah, blah," so there's all this kind of cumbersome handling of an initial process that really is all about service delivery for a particular person, so in that sense while the concept initially obviously looks great, as we flesh it out over the years what's come up is if we were to look at an Aboriginal Child First concept at the centre, these conversations first-hand about Aboriginal clients are had with Aboriginal people within an Aboriginal organisation where the decision from the seamless process is initial capacity, not only from our own family services, but then the outer Aboriginal service sector as well before it even gets to the potential of a mainstream. Does that make sense - - -

MR CUMMINS: It does.

MS CRAWFORD: - - - or have I flown through that really quickly and lost everyone. As you know, I speak really fast. You've had this experience before. I guess that's our proposal and we see it also in line with the new move forward - and VACCA can only continue to move forward on this platform and I guess it's an evolution of Child First - it's not to replace the existing Child First, it's actually as an additional service provision and a seamless service provision for Aboriginal people. Moreover, what it does actually fall in line with is the one DHS proposal. So rather than having people going through multiple doors for one service, they're coming to a one-stop shop, so it's the first port of call for Aboriginal people, rather than being handled numerous times before we actually get a decision about the service this family is obviously going to receive.

Within that, too, the service sector that sits behind VACCA, so the suite of services that are available, also meet the need of this initial intake, so we do provide family service support, we do provide a family violence program, we do have other high order services that are available that are a direct child protection referral, but obviously moving down the track we can look at that differently as well, so there is this suite of services that sit behind this Child First concept that is immediately available for consideration for access and allocation for families. Then the negotiation where that capacity isn't available is actually negotiated by Aboriginal people or, in actual fact, the Aboriginal organisation as a clear and genuine partner within the service sector for the broader orgs because we know that there is a bulk of family support dollars for Aboriginal people that sit in mainstream. Mainstream are clearly our partners, but we need to be equal partners on this platform that are negotiating for best outcomes for families.

MR CUMMINS: Thank you, Kerry. Gabrielle, would you like to add anything to that?

MS BURKE: So we've also provided the flow charts.

MR CUMMINS: Yes, we've got that.

MS BURKE: And gone through the current approach and the new approach, so the question that we ask is will an Aboriginal Child First make a difference? We think the Child First for Aboriginal families is more likely to be more effective when delivered by an Aboriginal organisation. Aboriginal organisations understand the Aboriginal children and families they work with, know about other Aboriginal organisations and services that could deliver a range of services to families and consider culturally appropriate ways of engaging and assessing families.

The strength of the Aboriginal approach is highlighted in the case example included in our written response and also in the presentation by our Aboriginal liaison worker when you visited VACCA. Strengthening Aboriginal organisations in the area of early intervention will also assist with Aboriginal workforce development, it will also allow for Aboriginal organisations to build their reputations and profiles within Aboriginal communities. In the north and west this can enhance the relationship between VACCA and the Aboriginal families that provide services for and may contribute to them accessing services more quickly earlier.

For VACCA, our goal is for every Aboriginal community to be strong in culture, value their children and recognise the importance of the whole community in raising children and keeping families together. An Aboriginal Child First is consistent with this goal. While we focused on Aboriginal Child

First, we are acutely aware of seeing our service system for vulnerable children holistically. The effectiveness of an Aboriginal Child First service will depend on the range and availability of Aboriginal family services that underpin it.

Aboriginal families comprise 6.3 per cent of families attending family support services. In the north and east area, just over one-third of these families receive an Aboriginal family service. An Aboriginal Child First service that must refer around two in every three Aboriginal families to mainstream family services may be compromised in terms of achieving its potential and we would refer you to our written response in the area of family service development. In summary, we propose an Aboriginal Child First intake assessment and referral service for the north and west region of Victoria as a significant part of the way forward in delivering more effective early intervention services for Aboriginal children and families.

MR CUMMINS: Thank you very much. Our visit to VACCA was most helpful and informative and, if we may say so, most impressive. It was excellent. Prof Scott, any questions for Kerry or Gabrielle?

PROF SCOTT: Yes, I'm trying to absorb it, so I apologise if I haven't understood it well. I accept some of those advantages of the model being proposed. Could I just ask a few things about the proposed model. One would be whether there was the capacity across the state to operate such a model, or would you be proposing that this be piloted in one particular region and then there be a longer term process of scaling that up or rolling that out, depending on the success in the pilot phase. So I guess the first question, if I could just leave you with that, is the readiness and the capacity to do this across all the regions of the state.

MS CRAWFORD: I think that's interesting. In my sense, the reason it's been developed is because from the concept and it has been a concept that's quickly become now obviously being presented to the Panel, so that wasn't expected, but beyond that the original concept was regional because the office that I sit in and the areas that the ALW covers which sits in the team that I manage is across four catchments, so one region. So the original concept is really about that region.

PROF SCOTT: So would you see this as starting in one region, being rigorously evaluated and then a process of it being extended on the basis of that? Is that the sort of process of implementation?

MS CRAWFORD: Well, I think there is potential for that, Dorothy, but if we're talking about a business investment as well, so beyond just the capacity of the org to deliver the service, there also needs to be a business investment behind that and what that really means for me is when we look at when Child

First was first established, we were as a state quite happy to fund organisations for the same process, but we funded that in very much a funding and mainstream process and it was a new concept and Child First has rolled out. So it's not so much about capacity building, the service systems underpinning it, we will really need to consider what that looks like going forward, so we don't want to jump into it, but in terms of being able to manage a Child First site and use it within the same concept as what the other Child Firsts operate, absolutely, but it is regional. I guess in terms of rolling out a pilot, if that's one way to get it launched, I guess that would be practicable.

MS BURKE: And I think that we would perhaps feel that we were not in the best position to comment on the readiness of other regions to pick up an Aboriginal Child First, that really some of those other regions would be in a better position to comment on their readiness, but we here in the north and west region that we can say that we are ready.

PROF SCOTT: Good, thank you. My next question was on the first page where you have the current process and the difficulties with that.

MR CUMMINS: The flowchart.

PROF SCOTT: The flowchart, yes. If we go to the bottom, the purple on the left-hand side and the palish blue on the right-hand side, if you say that if no family service is available under the current system Child First "holds" the family with minimal phone contact and the difficulty in the current model is that that diminishes the opportunity for Aboriginal families to have access to other services while waiting for family service availability. In the current model, is there no way that that can happen, that families can access other, including Aboriginal-specific services, while waiting for a family service?

MS CRAWFORD: Yes, so what that means is they're actively held and they have minimal service provisions, so normally that may be phone calls, that may be done in conjunction with the ALW, but it's absolute minimal because a service can't be provided, but I guess that's what actually brought about the conversation about our own Child First because there hadn't been any process really that had been bedded down about active holding. So we've now decided to actually say, well, the ALW needs to be actively holding these cases so there is direct Aboriginal involvement, which then led to the conversation about Child First. That shift is only quite current so it's interesting that you've picked up on that, Dorothy, yes.

PROF SCOTT: The third point, and this is a sensitive one and I assume the opinion that most Aboriginal families would prefer a service from an Aboriginal-specific agency. In the proposed model where Aboriginal child and family referred to Aboriginal Child First right upfront, how might that work for

families who are anxious about confidentiality who may not prefer an Aboriginal specific service and those complex family situations where you might have one parent of indigenous descent and the other not - these are always going to be complex and sensitive matters - but under your proposed model how might those issues be grappled with?

MS CRAWFORD: So it's not a sensitive question, it's a very sensible question and a very common question. I guess it's the way that we've set up our service provision within this sector over history and that is that there has very rarely been a choice for Aboriginal people but to go to mainstream first, so VACCA as an organisation is a lead in that. It's just over three decades young, so we're only as a sector starting to get our head around that Aboriginal orgs can also be part of the platform of the sector and not a secondary service, so it is a very interesting question and it's about us shifting the way that we view this.

Now, a very sophisticated way that this was put to me to respond to - so it's not my response but I'm going to plagiarise it - is that we don't build a service sector around the minority, we build a service sector around the majority. So the minority of Aboriginal people may not want to go to an Aboriginal direct service, but we wouldn't build a service around that one person out of ten. That was really profound for me - so I don't own that, I'm actually saying something else - but I'd like to own that.

The other thought in that too is that again I go back to my earlier conversation, that we often don't think that in mainstream, we don't see sort of mainstream people saying, "But can I have an Aboriginal service." That's not thought of because there is a multitude of mainstream services that they can access. Now, we need to start to think about that in our Aboriginal space, but it doesn't stop people from asking for mainstream if they're not happy.

The non-Aboriginal parent versus the Aboriginal parent, at some point in time that child, who is the focus, has an absolute fundamental right to understand their own identity. So this process of allowing to bring people along to navigate that complex issue - and it's only a pathology because of where we are 200 years down the track, Aboriginality isn't a problem - so it's about navigating that and bringing that to your new platform as well and in the other sense of the process, which was something else you brought up that could also be seen as an issue, which I also haven't answered yet.

PROF SCOTT: It was around confidentiality, the sensitivity of some of these issues.

MS CRAWFORD: That's exactly right. So obviously with Aboriginal connections it's really not six degrees and often it can be 0.1 degrees of

separation, so within services that have been living and surviving and quite resilient within this sector for a number of years, we've learnt what that means and we are also bound by exactly the same legislative processes as any other org that delivers these services, but I guess we're also heightened and sensitive to that because it is our business and we need to be very, very mindful of that. But, again, if people choose to self-select out of a service, that's their choice, but that's the minority and, historically, people haven't had the choice, so why not sort of bring it out and promote that, is my sense.

MS BURKE: If I can just add to that, I think that our services that exist at the moment, our foster care services and our existing family support services, face that question, not frequently, but they do face that question and they've learnt that that's a complex question, not a simple question. So it's not a matter of going to a family and saying, "Do you want Aboriginal or not," it's actually a matter of talking it through with that family, reassuring them about issues of confidentiality, and I suppose that's what I was referring to when I talked about the importance of Aboriginal organisations being able to build their reputation with their own community. If we continue to fund mainstream but we don't fund Aboriginal organisations to build up in the preventive area then that reputation will constantly be under the kind of guise that you've alluded to, so I think it's a complex question. Our workers would not go in and say to a family, "Do you want Aboriginal or not," but certainly if a family was expressing concern, they would discuss that through with them and if there was not a way around it, they would arrange a referral to a mainstream service and that would happen at VACCA on some occasions now today, even without a new Aboriginal Child First.

MS CRAWFORD: Just in addition to that as well, if that's okay, I know we're pressed for time, that question is often asked by a mainstream person. With all value to our mainstream colleagues, and people are in this business with absolute genuine intent, but the majority of this workforce, our mainstream colleagues, also struggle with what that looks like and how you ask that question and are frightened to ask the Aboriginal question, like in some way it's offensive. So even to this day we can say that completely without malice, but that's the fact, and it doesn't need to be offensive to be asked, but people struggle with it because the first port of call is mainstream and they've got to navigate that conversation, which then can be halted conversation and make the other person feel uneasy about what this service looks like. So there is all those dilemmas that a family that we know or we have an alike with or a communication style that's culturally relevant, the first port, those halted and difficult conversations aren't going to be difficult relating to culture, they're going to be difficult about the issues, which is a different place to come from. Abuse is abuse. Culture is culture. So, yeah, I think we navigate it differently.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales?

MR SCALES: Thank you very much. This is very interesting. It's interesting because when I read through the larger submission from VACCA, one of the questions that I had in my mind, because you did highlight it to some extent there as well, so thanks for elaborating on this. Can you help me to understand what the governance structure would look like.

MS CRAWFORD: So where the team would sit?

MR SCALES: No.

MS CRAWFORD: Or being part of the alliance?

MR SCALES: Well, yes, all of that. Who would be the lead agency? What would the alliance look like, those sorts of questions, help me with that.

MS CRAWFORD: Interestingly, because again this conversation has taken off rapidly, so thanks Bill, the team itself obviously would sit, I believe, still where we are now because we already have the foundations of that, so that's the domestic view. So the Child First team itself would sit within East Brunswick VACCA and the ALWs would be part of that.

MR SCALES: So VACCA would be the lead agency under this model?

MS CRAWFORD: So VACCA would be the lead, yeah, and we're already part of the alliance and obviously, you know, see ourselves as a respected partner in that and - - -

MR SCALES: But this one is a bit - do you mind if we have an interaction on this one as we're going through it?

MS CRAWFORD: Yes.

MR SCALES: But I think what you're describing is something a bit different from the alliance, isn't it, because you're saying that this alliance is really an alliance of all Aboriginal organisations, isn't it?

MS CRAWFORD: No, I would see us still critically a part of the existing alliance because our Child First relationship with the broader alliance is absolutely critical to the success of this Child First because we are critical partners and critical colleagues in this whole - because we're still going to be, and our Aboriginal people are still going to be using mainstream services within the existing Child First alliances, so they are critical, so it's a complete

inclusive model, not an exclusive model. It's really just extracting a team and an intake service that's Aboriginal only.

The alliance process, I agree with you, Bill, is something further to be navigated and fleshed out because does it mean that we are an extra alliance and a stand-alone alliance that the other alliances come and meet with, or do we create a hybrid model of VACCA still sitting on the existing alliance, which is a critical part to our success and our ongoing relationship within this sector holistically, so that is for further conversation and consideration, I do believe.

MR SCALES: I mean they're the things I think that need to be teased out because at one level I think this is very attractive, but at the same time as there are sometimes differences between organisations within mainstream alliances, there can sometimes, I would imagine, be differences even within Aboriginal organisations within a similar alliance, so the way by which something like this might come together that in fact enables the availability of Aboriginal services across the board when a particular individual presents, in whichever way that might occur, doesn't seem to be a trivial question around this model.

MS CRAWFORD: No, that's right.

MR SCALES: So it might be worthwhile just trying to tease that out so that certainly I might be able to understand it in a bit more detail. I mean we would hate to have a situation where people might see that any one leader of an alliance might be seen to be biasing services in favour of one organisation over another when we've tried to make sure that the way Child First works doesn't do that or that there's no claims about that, it's completely transparent about how that all operates. I think we would want to try and achieve the same thing within an Aboriginal indigenous Child First approach as well, so if you've got any help to us in that regard that would be of considerable help to me anyway.

MR CUMMINS: Kerry, do that as a follow-up, even a schematic, just think about it a bit and perhaps send it into us because the matter that Mr Scales has raised is quite a complex one I think and it might be best to just perhaps sit down and do a bit of work on it and then send it into us, which we'd appreciate.

MS CRAWFORD: Yes, absolutely, and again it's about an additional service to the existing alliance, it's not an exclusionary service.

MR CUMMINS: We understand that.

MS CRAWFORD: So we would be drawing heavily on our partners because it has come up as a question and we need to navigate that and come up with a really good model.

MR CUMMINS: Well, in the end the answer mightn't be that complex, but I think it's worth just working it through a bit.

MS CRAWFORD: Yeah, definitely.

MR CUMMINS: Often when you work through a complexity it becomes simple in the end, but send it into us, I think it would be very helpful.

MS CRAWFORD: Thank you.

MR CUMMINS: Well, Kerry and Gabrielle, thank you so much for coming forward. We're very pleased to see you.

MS CRAWFORD: Thank you for your time.

MR CUMMINS: Ladies and gentlemen, we're going to move into a private session now and we'll resume at half past 1, so I hope you can all go and warm up a bit with a cup of coffee and we'll resume at half past 1 and thank you for being here this morning.

ADJOURNED **[12.37 pm]**

RESUMED **[1.37 pm]**

MR CUMMINS: Well, ladies and gentlemen, welcome back to this afternoon's session. I'm sorry we're a bit late. We only had I think it was a 12-minute lunch because we'd had a private session, so we're resumed and I'm sorry we're a little bit late. Associate Professor, we'd be very pleased to hear you. Associate Professor Laidler, thank you so much for coming forward. We've had the benefit of your written submission and we'd be very pleased to hear what you'd like to say.

ASSOCIATE PROF LAIDLER: The written submission doesn't go into a lot of detail, it was essentially just to stake a claim and so we thought that some work we were doing with the Mental Health Reform Council paralleled at least and probably directly intersects with the interests of this committee. I'm talking only about the mental health service system as it relates to vulnerable children and adolescents I think and their families.

MR CUMMINS: Yes.

ASSOCIATE PROF LAIDLER: The Mental Health Reform Council exists to oversee the implementation of a whole of government strategy called Because Mental Health Matters that was published about three years ago. We've got a twofold role, one is to oversee the Department of Health's implementation of

that strategy; and secondly, to advocate for the changes that are in the strategy. Your officers can look it up, it's got eight key points and all that sort of thing. If I were to summarise it, essentially I think it responds to consumers' experience of the mental health service system, which is that they can't get timely access to services, and even when they find a way of getting into services, the service system isn't integrated for them; that's generally true across the mental health system, so the strategy proposes a few key approaches that mental health services should take on to address those problems.

One of them is clearly early intervention. The evidence all says that if you can intervene early in an episode, early in the illness, early in life you have some chance of - well, there is a dispute between clinicians about whether you can influence the course of the disease - but there is certainly no dispute about the fact that you can stop the social defragmentation that often ends up being the major disadvantage that mental health problems cause, so it's focused on a strategy of early intervention and using a philosophy of treatment that assumes people can and do recover from mental illness. That we tend to see the people for whom mental health problems are persistent in our community, but in fact 80 or 90 per cent of people who have even quite serious mental illnesses do get better and we know there are things that you can do that make it easier or more difficult for people to get better, they relate mainly to social support. The three big ticket items are housing, if you can make sure that the people are housed; the second set of issues are related to either educational pathways or job pathways, if you can steer people back into productive engagement in the ordinary sorts of structures we have in our society you do better; and the third set of things relate to familial and social reintegration, if you can give people opportunities to resocialise, in fact they do a lot better. That's a summary of the strategy. I don't want to bore you with it. As I say, it's well laid out.

In that context, the council's attention has turned specifically to children and young people's services because the sort of patchwork approach to service provision that I described as characterising the whole system to some extent characterises the service system for children and young people even more. I'll focus just at the moment on the needs of kids between zero and 12. At the moment, we lump together in the mental health service system a whole range of kids who have everything from autism spectrum disorder, epileptic-type disorders, behaviour disturbance, developmental delay, learning difficulty and a few kids, maybe about 200 kids in the state each year, who have genuine childhood psychosis. Most of these kids don't have problems that we would normally call mental health problems, they're actually problems, whatever their aetiology, problems that are better serviced by learning interventions rather than medical interventions. You have to get the medical stuff right. If a kid does have autism spectrum disorder associated with epilepsy, you know, you need to treat that, but that having been treated, what you actually need to address are the learning needs that those problems create for the kid.

So we've got this whole of kids and the mob I left out there - and the mob you're most interested in, and I shouldn't have done that, I'm sorry - and a good number of kids, I mean you'll do better ascertaining the number than others I think because you've got a lot more information available to you, but there's somewhere around the order of seven to ten thousands kids each year where we identify neglect and abuse to the extent that it would almost certainly cause trauma for those kids and those kids would all in one way or another be affected by what in adults we'd call post-traumatic stress disorder. Again, you're Inquiry as a whole I think will get more information about that. That's the pool of people the children's mental health service system has to deal with and then the service system is fragmented and all over the place.

We provide some of the services to those highly vulnerable children I just spoke about through the Children's Court Psychology Clinic, we provide some services to some of those children through the child and adolescent mental health service, and specifically a program that's still being run as a pilot within there called Take Two, we provide some of the services to those children through the maternal and child health system, we provide some of it through the CAMHS system, some of it through the school support system. The services that we then provide are over-focused on assessment - and it's going to get worse, the Federal Government has just announced its intention to provide universal assessment for kids of three-years-old in our community, so we're going to identify even more kids for whom we don't have a service system and treatment remains the problem.

I do all that, if you don't mind, by way of background, so it's that that the council is concerned about. Within that, it's very particularly concerned about those seven to ten thousand kids who we know already are at risk. Whatever about early intervention with the rest of the kids in that complex service system, there is a certain subset of those kids who we know are highly at risk because they've come into contact with child protection and the justice system. My view is that they deserve the same specialist attention that we give to adults for whom that happens.

In the mid-1990s the state set up the Victorian Institute of Forensic Mental Health when it became obvious to everyone - Forensicare - when it became obvious to everyone that the prison population was essentially now a population of people who had had or continued to have serious mental health problems. The reasons for that, people will dispute, but it certainly was tied up with the deinstitutionalisation that went on through the 1980s and it also I think came from a greater awareness of the people that the courts were actually seeing.

On a philosophy that said these people have already been identified as being

risks and at risk, the decision was taken to set up a specialist service that might be able to provide them with a level of service in some ways better than we provide in the general community because that was seen as the best way of reducing risk and I would argue that that's been remarkably successful and it's certainly a model that's been followed around the rest of Australia for how we deal with the specific mental health needs of people who have come into contact with the criminal justice system because of their mental health needs. I want to argue we should do the same thing for kids and for adolescents essentially.

I think either the remit of the Victorian Institute of Victorian Forensic Health should be extended - there is actually nothing in the Act that prevents them doing this at the moment - but they don't get the money for it, essentially. I think what we have there is a centre of international excellence where if the skills weren't already there to deal with children who come into contact with the courts and the justice system, they would easily acquire them, it would be an attractive place to work because of the link between the service system and the university and all that sort of thing, or if we don't extend the remit of that institution, I think we should set up something equivalent.

I think the truth that every practitioner in this field knows is that kids who start off identified as being the victims of abuse and neglect when toddlers are seen at various stages through the child protection system, the juvenile justice system and the adult justice system such that if you go down to Fulham Prison you can meet people who can tell you about their journey through that, and it's not determinous, it's not as if every child who starts off in the child protection system ends up in Fulham Prison, or vice versa, everyone who gets to prison started off in the child protection system, but there is this consistent stream of people whose life journey takes them in that way and because we don't intervene early, we actually make problems for them and for our community all along the pathway. These are the people that end up being significant consumers of the health and welfare system right through that passage.

I think the fact that people have contact with the courts also gives us a scope for intervention that we don't have in the general community. That once somebody has come to the attention of a court and an order is made about them, I think already the community has said, "We have got a right to intervene here in a way more significant than we allow generally in the community." That's the basic proposition. That we need a service system for children specifically who are in contact with the court system, for adolescents who meet the juvenile justice system that parallels and is as extensive and as highly specialised as that that we currently afford to adults.

MR CUMMINS: Thank you very much. That's very well focused, if I may say so, associate professor. Prof Scott.

PROF SCOTT: Thanks Terry. Dorothy, if you remember. There are two things I'd like to ask about, one is following on from what you've said and the other is about the children who have a parent with a serious mental illness, and I'm not wanting to assume that all of those children by definition should be defined as very vulnerable or child protection.

ASSOCIATE PROF LAIDLER: Nor do I want to pathologise kids for their parents' problems.

PROF SCOTT: Yes, sure but if I can come to start with, about the children in the role of client or patient, and I think it would be very interesting for us to hear about the outcomes of the 5 August planned meeting. We think of children as having multiple needs that need to be assessed and acted upon, but assessed if, say, the Children's Court is to be decided in its decision-making and case planning flowing from that and children, we've been informed, and many of us would agree, have physical needs and need a paediatric assessment, as well as looking at their mental health needs. If the role of the Victorian Institute of Forensic Mental Health were to be enlarged to deal with the mental health needs say of children from nought to 12, would you see that as a duplication in relation to their broader health needs and also sight and hearing, the broad physical needs of the child being able to be assessed comprehensively? So I guess the roles and responsibilities of the Children's Court Clinic as currently constituted, Forensicare in its capacity and then what we already have is a paediatric forensic service in this state, which performs probably a fairly narrow role at the moment, but would that potentially have the capacity to perform this broader role?

ASSOCIATE PROF LAIDLER: I'd point to the Forensicare model again, and Justice Cummins would be - Mr Cummins, I'm not sure what to call you now - - -

MR CUMMINS: Mr Cummins now.

ASSOCIATE PROF LAIDLER: - - - would have had the experience of this. Forensicare does a lot of that, it will do the assessment that assists the court. The courts tend to value it because it's independent and it's not partial to the claims that are being put by either party in the situation and then when orders are made the Victorian Institute of Forensic Mental Health provides the treatment to the people that the treatment is ordered for.

Victoria's never had a Stalinist model for service provision, you know, you can contrast it in other states where someone makes a decision in Macquarie Street and a nurse's position description is changed in orange, or something like that. It's always been a system of multiple players and I think there's a lot of strength

in that because then you get local initiative encouraged, different approaches encouraged. The downside of that approach is that no-one pulls that system together at the moment generally and for these kids who are highly in need, no-one pulls it together.

I'm not proposing the sort of model where this mob would have to do every component of the service system, but it's got to be someone's responsibility to say, "Here is the whole smack of assessment and treatment services that this child within their family needs and it's our responsibility, we'll take it as our job to assemble those resources in the way that's necessary to make sure that they receive that integrated package of service." I'd have no problem with that including medical assessment, but I mean there is no-one, for example, in Forensicare at the moment who could do a paediatric assessment, but there is plenty of good paediatricians around and if number one on the check list of the responsible organisation was, "Get the paediatric assessment done," I'm sure it would be done. I'm not proposing a one agency does everything sort of model, but I'm saying that one - well, I think I'm saying agency or one entity in some way or another has to say, "This kid is our responsibility and we will get together the assessment and the treatment services that they need because we already know that they're at risk."

PROF SCOTT: Thank you. My second question is about children of parents with a mental illness, and with the exception around the post-partum period where I think Victoria probably has some of the best services which can take on board both the needs of the infant and the mother, to be a mother in the post-partum psychiatric condition, when we think more broadly about parents struggling sometimes, and not always struggling, but to raise children with periodic or chronic serious mental illness, we've got some nice policies in this state, both in alcohol, other drugs and in adult mental health about being child sensitive and family-centred.

There seems to be a big gap between the policy and what happens on the ground, so from the perspective of the Victorian Mental Health Reform Council, do you have any views on what would be necessary to help our adult mental health services be more responsive to the needs of the children and the needs of their parents as parents, not just as adult clients in an adult mental health service, which would reduce the vulnerability of those children and potentially prevent them becoming involved with the child protection system, in which they are over-represented.

ASSOCIATE PROF LAIDLER: It's a bit of a circuitous answer - no, it's not really. I think there is some sense in which the focus of the service system actually has to shift from the families, where it tends to be focused at the moment, to the children who have been damaged, and I don't mind saying that because all good mental health practice will treat those children in their

families, in their homes, in their communities to the extent possible. But it seems to me that at the moment we put a lot of resource into treating families, some of these families bring into the family situation a history of three or four generations of similar problems and I don't know that we could say that we get measured effective outcomes for that concentration of resources. I wonder if we did shift the focus to saying, you know, can we address the specific needs of this child within that family rather than that broader concept of treating the family, if we wouldn't get further. That's a bit ideologically contentious, I understand, but at some stage I think you've got to stop banging your head against a wall.

The treatment system we're using now does not deliver services to the children who need it and I think you've got to be honest and say that and then say, "Well, can we revamp that in some way so that it does?" Maybe we can, but I suspect that if we had a very direct focus on treating the specific needs of the children and then embracing the family in the way that's necessary to provide that treatment, we might in fact do better.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales?

MR SCALES: No, I think Dorothy has covered the questions.

MR CUMMINS: Associate professor, thank you very much and you got it right, I as a judge often said how valuable the work of Forensicare was, and as a retired judge I still say it. Thank you very much.

ASSOCIATE PROF LAIDLER: The kids deserve it too.

MR CUMMINS: Father Joe Caddy and Ms Sheree Limbrick. Welcome to you both. Just take a seat and settle yourselves down. Thank you very much for your written submission, which we've read with care more than once. It's a very valuable submission, very articulate, very well-thought through, if I may say so. I congratulate you most warmly on it.

FATHER CADDY: Thank you, Justice Cummins and Prof Scott and Mr Scales. I notice the gum leaves down there, too. I think that's very appropriate in NAIDOC week especially, so we'd like to acknowledge the traditional owners and pay our respects to their ancestors, past and present.

MR CUMMINS: Very good. Well, Father, take it thus that we are familiar with the contents and you take us to the points you'd like to emphasise.

FATHER CADDY: Thank you very much for the opportunity, as I said.

Since we've written the submission, another issue has come up that I'd just like to speak to briefly and then I'll ask Sheree, who is our director of community services, to speak to the major content of the program.

MR CUMMINS: Certainly.

FATHER CADDY: The issue that's really come to our attention over the last month or two is the issue of the youth justice system, which we know it isn't specifically mentioned in the terms of reference for the Inquiry. I just would point out that Victoria has a youth justice system that has really some quite admirable features; for example, the dual track system is unique in Australia, allowing judges the discretion to impose youth justice orders rather than adult corrections orders to young people convicted of an offence, young people between the ages of 18 and 21.

I think another excellent characteristic of the Victorian youth justice system is that historically it's had far lower rates of incarceration than other jurisdictions and it seems better able to manage and reform young offenders in community and family settings, but there are some groups that are really over-represented in the custody and youth justice, and our observation suggests that young people who are in the state protection and care system are one of those groups; in fact, the Department of Human Services did a snapshot survey in 2009 and found that of 155 boys and nine girls in custody in the youth justice system, 30 per cent of them had been either currently or had previous contact of the state protection care system. It's a very high representation. I think it's fair to conclude then that matters relating to youth justice are highly relevant to an Inquiry into protecting Victoria's vulnerable children.

The particular concern that CatholicCare has relates to a current proposal of the State Government to require judges to impose minimum sentences of two years in custody for children aged 16 and 17 convicted of offences either intentionally or recklessly causing injury, that's with gross violence and there is going to be exceptional circumstances, but none of that is defined. I think the notion of what is effectively mandatory sentencing is inconsistent with the current requirement for judges, when imposing a sentence on a young person, to have regard to the following matters: the need to strengthen and preserve the relationship between the child and the child's family; the desirability of allowing the child to live at home and the desirability of allowing the education, training or employment of the child to continue without interruption or disturbance; the need to minimise the stigma to the child resulting from a court determination; the suitability of the sentence to the child and, if appropriate, the need to ensure that the child is aware that he or she must bear a responsibility for any action by him or her against the law and, if appropriate, the need to protect the community or any person from the violent or wrongful acts of the child.

All these matters have to be considered in sentencing and they're detailed in section 362 of the *Children, Youth and Families Act* 2005. In our view, the Act requires judges to consider all of these matters for good reason. The 2009 DHS snapshot survey that I quoted from earlier also disclosed that of the children in youth justice custody, 26 per cent presented with mental health issues, 27 per cent with issues concerning their intellectual functioning and 24 per cent had a history of self-harm or suicide ideation. In that context, judges have to have maximum discretion in sentencing young people with such complex backgrounds and needs. The principal purpose of sentencing for children such as these ones has to be about their rehabilitation and their proper development. To impose a requirement for minimum sentences effectively disallows sentencing judges to take into account the very important considerations currently required in the Act and I think that really does reduce the capacity of the court to sentence in the best interests of the child and his or her prospects for rehabilitation and development.

We just wanted to make that point in addition to our written submission because we feel that the issue is very important and we just make some supplementary recommendations around that: that we'd urge this Inquiry to recommend the State Government to rethink and to abandon the intention to remove judicial discretion in the sentencing of children convicted of any offence and we also think that the youth justice system could be improved greatly if in any review of the Child's Safety Commissioner, that the Commissioner was given a role also of monitoring that system, the youth justice system, and it would also be I think greatly improved we think if there was the sort of community or independent visitor's scheme such as exists in the correction system, in aged care and in the mental health and disability care systems through the Office of the Public Advocate, if those sort of things could be introduced into the youth justice system, so that's new material which we hadn't brought here before but which we felt was important to place before the Inquiry.

MR CUMMINS: Thank you very much. We'll place that together with your May 2011 submission.

FATHER CADDY: Thank you. I'll hand over to Sheree.

MS LIMBRICK: Thank you. You have got our written submission, I just really wanted to highlight four key areas where we think our practice and experience brings perhaps some possibilities for exploration for the Panel. Firstly, focusing on strengthening parenting support, skill development and capacity building. The two suggestions principally that we made in our written submission were around considering the applicability of family dispute resolution and models such as the parenting orders program into more of a

child protection and care system. As long-term providers of family dispute resolution programs we can see that there is a much broader contribution that these programs and the skills of the staff within those programs could potentially bring to the protection and care system. We also feel the same around parenting orders.

One of the concerns with the child protection system really for a period of time has been the lack of an in-depth assessment of parents' capacity to parent so we think, as there should be, there has been an emphasis on the risk of the child remaining in the home, but sometimes that's at the lack of them looking at, "Well, what do we actually need to do to support the parents to retain the children in their care? What skills can they acquire?" So we're suggesting, firstly, that perhaps through Family Services or Child First, a stronger emphasis on skill development and parenting programs could see that gap being filled and that the applicability, as I said before, of our models such as Our Kids, which is CatholicCare's parenting orders program, but there are many others delivered through federally-funded parenting orders programs and the cooperative parenting programs in rural areas, the skills and expertise of these staff could easily be transferred and really with some just minor design modification to the programs we think could easily be applied to some families coming into the protection and care system.

Similar for family dispute resolution, I think the one thing around the family dispute resolution model that we'd like to highlight is the really strong emphasis and commitment on child inclusive practice, so very clearly putting the child at the centre of the family's focus and the concerns for the family and having the voice of the child presented to the parents time and time again proves to shift pretty entrenched behaviours in our experience when we're talking about sort of post-separation counselling in that sort of context and we think the same principles could be applied in the protection and care system in some families.

The second area is around family support and I think just pretty succinctly, our contention around family support is working with families as early as possible proves to be the best solution and we're in a bit of a dilemma in terms of how family support has shifted with Child First and it being sort of a bit of quasi-child protection, it means that we're not necessarily working in family support in such a preventative frame that we have been in the past. The second point around family support is the longevity of the case support that can be offered. The longer that case managers can be consistent and work alongside of family, the better outcomes that we get for some of the more entrenched family behaviours and intergenerational issues that we see.

The third area to highlight for us was again drawing on our experience with our alcohol and other drug family program, the Mirror of the Cross. Similar to

what was discussed earlier in terms of focusing on the needs of the child as central to the family where the family or the client presenting to the service may very well be the adult, I think the Mirror of the Cross model really does highlight how we can work together and focus on supporting family members, all family members of the alcohol and other drug-affected client, whether they be a child or an adult, but really we see some of the blocks in terms of the system are really around the system not really being geared up to view the child as central, the staff don't necessarily have the skills, they would see themselves as working very much with an adult and not necessarily understanding or having a jurisdiction as such with the child. So we really think that that system, alcohol and drug is our experience, but other systems equally, mental health and disability services really need to take a shift and a more holistic approach to focusing on the needs of any child accompanying an adult into a service.

Lastly, the sort of fourth area we wanted to bring to your attention particularly was our experience with new and emerging cultural groups. CatholicCare is a provider under the Department of Immigration citizenship settlement grants program and we work extensively with communities in the western and south-eastern parts of Melbourne and we're really concerned about the intergenerational transition of the trauma that the parents have perhaps undergone when they've journeyed from wherever they've journeyed from overseas to be accepted under the humanitarian and refugee program here and how that's having an impact on children and adolescents in their communities.

We think that an increased linkage between our universal services available to everyone, so child protection, family services, housing, schools and the specialist services, such as our own funded through DIOC, would serve to prevent this particular population of vulnerable families being increasingly represented in the child protection system and we just point - we didn't necessarily put this in the submission - but we'd point to one initiative that we're a partner with which is led by Foundation House, which is their family strengthening strategy, which is currently philanthropically-funded in Dandenong, Werribee and inner Melbourne working with Sudanese, Afghan and Burmese communities with that very intention in mind, bringing the family support services to work with community leaders in the cultural groups to bridge the divide between the universal and specialist services.

MR CUMMINS: It's very good that you isolate those points for the purposes of focusing it and to take it in the context of your larger submission, so thank you, Sheree. Prof Scott?

PROF SCOTT: Thank you. There is so much in this submission, it's very valuable and very broad. I'd like to just focus on two areas, one is the very last area you raised and the other is one that's in your written report about

permanent care and adoption. So around the new and emerging cultural groups, it would be very helpful to the Inquiry if we could receive some information about the model that you're pioneering with Foundation House because how one works with communities leaders in those three and other communities to deal also not just with the intergenerational trauma dimension, but the at times tension between child-rearing practices which may be perceived by the wider Australian community to not be acceptable, so if you could perhaps give us some information on that and if you had any thoughts on how federally-funded refugee re-settlement services might be able to be child and family-centred around those issues of those cross-cultural tensions and increasing accessibility to universal services we'd find that very helpful, so that's more of a request, if you could come back to us.

FATHER CADDY: Can I add one other program that we're running is the African Dads and Kids and that really does pick up that last aspect of what you're talking about, the cultural differences, but we've operated that for a number of years now - I think this is the third year, in conjunction with Victoria Police and some other community partners - we lead that, and take the African dads away with their children and it's highly structured, but it's in an informal setting, it's in a camp type of setting, but then quite structured within that and the feedback from that has been tremendous and I think it's had a real - well, a very good impact on some of those families so we're happy to get some details of that program and some of the evaluation material back to you on that.

PROF SCOTT: Thank you. That would be very helpful. My second point was about permanent care and about adoption and I note that in your written submission you talk about a couple of issues here. One is that there are many children who under the Act are eligible for a permanent care order, or to be eligible to be considered by the Children's Court for a permanent care order, but they are not being considered for that order and they have been in their placements for many years, in some instances, and family reunification would not appear to be the case plan.

Then you talk about the problematic level of contact or access with parents when a permanent care order is made which may make it very difficult for the child to develop the deep attachment to the permanent care family, which psychologically is intended to be now the primary figures of attachment for a child who has been in care for many years and been unable to return home. So I wonder if you could talk more about your agency's long experience in this area and where you see the change having to occur.

The second thing I'd like to ask, because so few people have addressed this, is what is the place for adoption for children who have been in out-of-home care for considerable time where reunification has failed or is too dangerous to contemplate and where you may not have parental consent, so again your

agency is one of the few that has traditionally provided an adoption service for children who have been in care, and we've had very little input about that, about attitudes to making use of the current law in relation to a dispensation of parental consent to adoption. Now, there is a lot in that question, but if you could just say a little bit more about permanent care and adoption in relation to how you see the needs of children.

MS LIMBRICK: We're just arguing over who should answer.

FATHER CADDY: We're scrambling over that one.

PROF SCOTT: Do you want the pages?

FATHER CADDY: No, we've got them here.

MS LIMBRICK: In terms of the - I'll take one point first - so the issue in terms of access for the birth family to the permanent carers, I think as we've sort of said in there, there tends to be, in our opinion, a practice of providing the birth parents with sort of preferential treatment necessarily over the best interests of the child, in our opinion. So where we would say the best interests of the child would be, to obviously keep their identity and understand what's happened for them in their birth family, but the need for them to very clearly move on and form attachments with their permanent care family. That there tends to be too many times a focus on continuing to provide sort of up to weekly contact with the birth family that goes against the sort of forming of the attachment, particularly when we're talking about lots of distance and things like that.

FATHER CADDY: And that's when there is no real prospect of reunification and that's already been established.

MS LIMBRICK: Yes, so there's been a long, long process to get them to permanent care and sometimes those parents may not have actually had contact along the way, but then there is still court-ordered contact beyond the permanent care order which in some cases in our opinion then impacts negatively on the child then staying with that permanent care family and forming the attachments. Our permanent carers are very aware of staying in touch with birth families and providing the child with their identity, information and understanding that, but this sort of active ongoing toing and froing in some cases does impact negatively on the children.

PROF SCOTT: Could I just ask at that point, I think in the written submission you see this as the Children's Court still tends in general to see the parents as primary carers.

MS LIMBRICK: Yes.

PROF SCOTT: Do you think that that's the main reason? Do you also think that there is a bit of dispositional bargaining that goes on before it comes before the magistrate so that, in fact, in order to secure a permanent care order without a contest you have the department coming to an agreement about a frequency of contact which is, in fact, not really believed to be in the child's interests. Is that a factor?

MS LIMBRICK: Yes, I think that is in some cases. Yes, absolutely.

PROF SCOTT: Sorry, I think you were going on to adoption, perhaps.

FATHER CADDY: I've forgotten the question.

PROF SCOTT: Sorry, I asked too many. The other one was about adoption and the place of adoption for children who have been in care for many years or for a significant period of time, it seems to have very little place in the Victorian system. That's not how it is in many other jurisdictions. Given your agency's specialisation in this, particularly in the past - it is probably doing very little now I imagine in adoption, in special needs adoption - what are your views on exercising a process around dispensation of parental consent to adoption, around the place of adoption in the spectrum of options for these children?

FATHER CADDY: Well, I think we've had some very good outcomes in adoptions. Where there is cooperation with parents, with birth parents, so that certainly does help the situation, but I also recognise that in many cases a decision has to be made and I think the longer that is delayed, when it does become pretty well inevitable that the child is not going to be reunited with its birth family then the longer it takes to make that decision, the less beneficial the outcomes can be. So there is always going to be some limitation as to how beneficial an adoption without parental consent will be, but the longer that that is left to go I think the less beneficial are the likely outcomes.

PROF SCOTT: Would you have data on the breakdown of your adoption placements for older children? I'm only talking about the in-care population.

MS LIMBRICK: Yes, we can get it. I don't have it at hand, but I can get it, yes.

PROF SCOTT: That would be helpful to us, I think.

FATHER CADDY: Yes, the numbers are not great.

PROF SCOTT: No, I appreciate that.

FATHER CADDY: They are not very high.

MS LIMBRICK: They're not high at all.

PROF SCOTT: Yes.

FATHER CADDY: So it is difficult to draw too much of a line from it.

PROF SCOTT: Thank you.

FATHER CADDY: The other area is that the whole post-adoption support thing for families is just so under-resourced that it makes this option extremely unviable and we have to really raise all our money to do that. I think if you had non-compliant parents, you would really want even more in there to bring them around over time, so that just is a severe constraint because when we work with a family who has adopted a child, we're with the child, we're with that family and we're with the relinquishing family pretty well for life and we feel a moral responsibility to do that, but there isn't enough recognition of the cost of doing that in the system.

PROF SCOTT: Yes, I noted that in your submission. Thank you.

MR CUMMINS: Mr Scales.

MR SCALES: Thank you very much, Father Caddy, for these submissions, it's very helpful. An issue that has begun to emerge quite strongly throughout this review is the question of leaving care and you make mention of it here obliquely I think to some extent and you talk about a specialised team and a specialised program for young people leaving care - I'm talking about page 15 now.

FATHER CADDY: Yes.

MR SCALES: Do you have a view about what that team might look like, how it might be governed and what the program might look like in relation to leaving care?

MS LIMBRICK: I'll tackle that in two ways. One is that we proposed there the notion of some sort of program, which I'll come to in a minute, but actually I think fundamentally in our philosophy there is a question about preparing children to leave care from the day they come into care, rather than thinking of it as an add-on at the end or a chronological, you hit 16 all of a sudden, we need to start thinking about leaving care, so I think we sort of probably gain

obliquely alluded to that, but I'd definitely call for the case planning system to be thinking about those issues literally from the day the child comes into care and that may be transitioning to adoption, or whatever it is, or it could be transitioning to independence or family reunification.

In terms of the sort of specialist model for children or adolescents, I suppose, 16 to 18, in terms of the skill set, we were thinking very much around a multidisciplinary team that can prepare and look at integration into housing, employment support, continuing mental health input and I think fundamentally, which probably wasn't written in here, but a recognition that a lot of the young people who do leave care, we may have spent time working with them while they've been in care to build some protective behaviours around what might be happening in the family, but a lot of kids leave care and go back to their family and are they very well prepared to actually protect themselves as a young adult I think is another issue, so it's not necessarily a specialist skill set, but it's more about thinking how do we help children prepare to have a different relationship with their parents once the state leaves their lives - so that's sort of a hotchpotch answer - but that would be the thing, I think the key issue is obviously for kids leaving care. Some of it is about the skills and the workers who can follow with them and continue a relationship that's been formed in the care environment, but some of it is actually about access to physical things like housing stock that just doesn't exist. Where do some of these kids actually go and we exit them into homelessness because the homelessness system is stretched as it is. So some of it might even be about a specialist housing response to how we support children to find a placement and then build the skills they need to pay rent and budget and do all those sorts of things.

MR SCALES: Thank you, that's helpful. On page 16 you talk about the incidence of alcohol and drug misuse and you make a point that's been made to us by others about how alcohol, in particular, is a key contributor to violence and abuse and you give the appropriate references. You also go on and I think focus on the fact that from your perspective dealing with the individuals that are associated with alcohol and drug dependence is important.

I want to draw you out about whether you believe there are more systemic solutions that should be considered by this Inquiry. For example, would you go as far as suggesting that there ought to be some elements of advertising, planning, regulation around licensing laws that might be particular to this issue, given the point you make, the quite appropriate point you make about the ubiquitous effect that alcohol has on the sorts of things which this Inquiry is addressing.

FATHER CADDY: That's not something I have given a great deal of thought to and in this context.

MR SCALES: You might want to take it on notice. I accept that that's not what you've written - and I'm not wanting to put words in your mouth either - but it does seem to me that we're looking at systemic questions as well as whether there might be individual programs that might be able to assist the individuals.

FATHER CADDY: I definitely think that there is a cultural issue here and it's across the whole culture. We have very much a drug and alcohol-centred culture and it's not surprising that more vulnerable families are going to be adversely affected by that, so I think that in any building up of the place of family and the centrality of children, then anything that could also reduce the centrality of alcohol as part of that would be beneficial socially.

MR SCALES: I mean I partly put this in the context that's been put to us and that is that we should be thinking about addressing the child protection and vulnerable children and families within a broader framework of primary, secondary, tertiary support and if we are going to take that much broader approach, it does seem to me that we have to go way beyond programmatic solutions to some of these fundamental questions. You may want to just take that on notice. I'm not asking that you should come back unless you feel compelled to do so, but it's a question.

FATHER CADDY: I think in that broader social context there is a whole range of issues that could then be roped in, including income security for families.

MR SCALES: Yes, and you make some reference to that in your submission. Could I raise one other question, and this is a slightly broader question. From my observation of your submission, your submission, the way I've read it, is one of the more conservative of the submissions. It tends to be a submission which, if I can sort of paraphrase some of the things you've raised, are really about improving the existing system rather than reforming the existing system. If that's your view, that's fine, and it would be helpful to tease that out because we're getting other submissions and other contributions which are much more radical, they are much more radical. They are radical to the extent that they're redefining responsibilities, they are redefining roles, they are redefining governance arrangements - I know I can go on - yours doesn't do that and I'm just wondering why.

FATHER CADDY: I guess that we have written this out of our own experience as part of that system, so we've seen the shortfalls in it and areas where it could go a lot further, so in a sense to that extent we're saying, "Well, this system probably hasn't been satisfactorily tested. If it's under-resourced, it doesn't go far enough, it doesn't make the leaps and reach into mental health sufficiently, into drug and alcohol sufficiently, then there is a lot of areas that

haven't been tested yet.

MR SCALES: Sure.

FATHER CADDY: But I mean I also wouldn't be opposed to a radical rethink of any ideas that have come up as well, so I don't think we would be opposed to it.

MR SCALES: I don't mean to diminish what you've written.

MS LIMBRICK: No.

FATHER CADDY: No.

MR SCALES: Please understand that, and I'm not suggesting that for even half a nanosecond and I hope you don't interpret it in that way.

FATHER CADDY: No, I understand what you're saying but, yes, I guess we've taken an incrementalist approach from what we've got, so I suppose we've seen babies thrown out with bath water before, too.

MR SCALES: And we're conscious of that and Dorothy keeps reminding us that we have to be very careful about not creating unintended consequences of change, so I understand that, but I was just trying to understand more why it was that you wrote it in this particular way and in this particular style.

FATHER CADDY: Thanks for that observation.

MR SCALES: So I'm interpreting that to say that you just believe that, not that you don't think some radical change is necessary, but you're cautious of radical change because of unintended consequences?

FATHER CADDY: Yes, we're cautious of it, but not totally against that if it could be shown to be effective and that that's the way to go, so yes.

MR CUMMINS: Could I, in conclusion, take you to page 19 of your May submission. In the middle of the page you will see a heading 3.3.3 and it is the sentence above that, I'd just like to ask you a question about it. You refer to the long-term ambiguity with respect to the legislation decisions that too often does not focus on the welfare and interests of a child being paramount. Now, you've picked up a number of things in this section. One is the inadequate taking into account of cumulative harm, and you've spelt that out very clearly if I may say so. You've also referred to the matter of the repeated failures and incapacity of parents and when that is demonstrated. You said that the

Children's Court has a proclivity towards giving birth parents an opportunity to care for their own children - in other words, it's too slow to take the next step, as I understand your submission. Do you want to say anything more perhaps about the culture of the Children's Court in those regards? There are other aspects - for example, Prof Scott a few moments ago touched upon dispositional bargaining and things like that - but looking at the Children's Court perhaps as a whole, picking up what you've talked about as the long-term ambiguity, do you want to say any more about perhaps how that should be progressed, even if I may say it, Mr Scales, in an incremental way?

FATHER CADDY: I will let you read some more about this, but one area that I think would be interesting in this regard is the use of some of the alternative dispute resolutions that we've talked about in the submission.

MR CUMMINS: Yes, you go on and spell those out.

FATHER CADDY: The parenting orders program, for example, works with couples who have been through court, they've had intervention orders, they've had all sorts of stuff continually failing to get a workable family order. When we work with those families and we put the child right in the centre and they start to see - they can usually come around as parents to say, "This is better. We're working now jointly - we might hate each other's guts - but we're working a joint project for our kid who needs a mum and a dad." Those alternative dispute resolutions can lead to outcomes that the courts, which are much more adversarial, can never get to and we believe that if those sort of mechanisms could be brought even more - and they are there to some extent in the Children's Court - but if the child could be put right in the centre of that alternative dispute resolution setting, we think that would have better outcomes and that's why we have talked about some of those other programs.

MR CUMMINS: Yes, I think that's a theme which is emerging more and more forcefully as we get further into the Inquiry. Thank you both very much indeed. Our good wishes for your continuing work.

FATHER CADDY: And thanks for the opportunity to speak to you.

MR CUMMINS: It's a pleasure. Thank you Sheree and thank you Father Caddy. Next, Ms Nicola Cowling and Mr Patrick Griffiths. Thank you both very much for your written submission of Anex, which we have read, so assume that we're familiar with it and we'd be very pleased to hear what either further matters you'd like to put, or perhaps focusing on what you've written, what emphasis you'd like to put upon things.

DR GRIFFITHS: Thank you very much. My name is Dr Patrick Griffiths.

MS COWLING: Nicola Cowling.

DR GRIFFITHS: We work with an organisation called Anex, which is the peak body nationally for needle and syringe programs across Australia and our chief patron is an emeritus professor, Gus Nossal, and another patron is Michael Kirby, so we sort of match there a little bit. Thank you for having us here today. I'd like to apologise, our chief executive officer, John Ryan, is unable to attend in person. He has a meeting with Minister Wooldridge this afternoon pertaining to some of these matters which we'll also raise here.

MR CUMMINS: Certainly.

DR GRIFFITHS: Nicola will speak on a number of issues, I'll focus on two primarily. As you would know, drug dependence, illicit drug dependence, really can very often compromise a person's capacities in tons of areas of life, of which parenting is clearly one.

The Victorian Child Death Review 2009 find that parental substance use - - -

MR CUMMINS: Just sit back a little bit.

PROF SCOTT: Yes, you're too close.

MR CUMMINS: We can hear you. We're just getting a bit of reverberation.

PROF SCOTT: It works better when it's sort of at a distance of about 12 inches.

DR GRIFFITHS: You can see how often I've done this.

MR CUMMINS: That's it.

MR SCALES: Perfect.

DR GRIFFITHS: The Child Death Review found that obviously substance use and family violence were pretty much equal in terms of risk factors for children's death. One of the problems with people with drug, illicit drug addictions is that many very good services, NGO and government services that are out there for people say in the area of parenting, they're not necessarily accessed by people with illicit drug problems because of fear that they're going to lose children, et cetera.

A couple of the areas that people with illicit drug problems do access - I know I'm speaking about injecting here - obviously regularly is the needle and syringe programs and/or pharmacotherapy. I think the point that we would like

to make today is that in both the needle and syringe program area and in pharmacotherapy, but in particular needle and syringe programs, there is probably ways that we can rethink and be a bit more imaginative about how those services, which are frequented by men and women, you know, parents, future and current parents, how they can be better equipped, these NSP services, to assist in the whole area of improving welfare of children, so I'll speak about pharmacotherapy and the needle and syringe programs.

MR CUMMINS: Yes.

DR GRIFFITHS: As we know, pharmacotherapy is one of the most important parts about that, whether that's methadone, Suboxone or buprenorphine, stabilises people's lives or it can help stabilise people's lives. Obviously the more stable your life is, the better position you are to hold down work, which obviously pertains to your parenting capacity, but also other areas that would influence the vulnerability of children as well. The pharmacotherapy system in Victoria is an area that we've been concerned about and advocated on for a number of years. Is the Panel aware of the review, the pharmacotherapy review which was released by the Minister on 21 June?

MR CUMMINS: Yes. I haven't read it, but we're aware of it.

DR GRIFFITHS: Yes, so I think that I would probably just suggest that that has the details of where the problems lay and how they could be improved which would have, you know, implications for the area you're looking at, would be well worth to have a look at.

One of the interesting signs of sort of a weakness that we've got in our pharmacotherapy system is that in 2009, when you include methadone, Suboxone or buprenorphine, 58 per cent of clients who attended needle syringe programs to receive sterile needles - and this is according to the Annual National Survey of Needle Syringe Programs - 58 per cent of those people were currently on pharmacotherapy. So what that indicates is that the system is there, but a great number of the clients who are trying to stabilise their lives are also continuing to inject illicit drugs, so that tells us that the program isn't functioning anywhere near as well as it could.

As of mid-last year when I received the data from the department, there were 21,000 Victorians, 21,100, something like that, Victorians who had been prescribed to go on to pharmacotherapy. Once you are prescribed, a permit is issued for you, so there was a permit for 21,000 people, but in terms of those people who are regularly then receiving their pharmacotherapy, for example their methadone, there is only about 13,000, so you can see that there is a missing 8000 people who, for a variety of reasons, are sort of slipping off the system. A contributing factor to why people may not be continuing their

pharmacotherapy is obviously the cost involved. Nicola, would you just like to - - -

MR CUMMINS: Nicola?

MS COWLING: Yep, just in terms of costs of pharmacotherapy?

DR GRIFFITHS: Yeah.

MS COWLING: One of the main reasons that I wanted to come along today was that I inherited a project with Anex which was all about educating people working with drug-using parents or drug-using parents to be and one of the things that came up again and again in terms of pharmacotherapy was how important it is, particularly for the pregnant mother, to be maintained during that pregnancy for the health of herself, but far more importantly, for the health of her unborn child.

One of the other things that came up in the training that we delivered, this was in collaboration with the women's alcohol and drug service from Royal Women's Hospital, was that when women are pregnant, as you can imagine, you've got a much greater distribution of blood all of a sudden as with your growing belly and your growing infant and so women are therefore required to increase their dose of pharmacotherapy. In doing so, this means that you're going to be required to be on that program for a heck of a lot longer than is perhaps anticipated and, as you can imagine, a lot of people are very reluctant about going on pharmacotherapy in the first place, but even more so about being on it for a long-term.

The guidelines for reducing pharmacotherapy are, and rightly so, quite conservative so it would not be uncommon for a woman to start on perhaps 60 milligrams of methadone and find herself creeping right up to 200 milligrams of methadone by the time she's full term, which means that it's going to take her at least a year to reduce off that methadone afterwards.

One of the big issues that came up with the participants in the training that we delivered around Victoria was that a lot of women really struggled with the financial costs of pharmacotherapy, and I appreciate that for those of us who are outside the drug and alcohol sector it can seem incongruent that somebody can perhaps have $200 a day to spend on heroin and then are grappling to spend $35 a week on pharmacotherapy, but of course one of the greatest aspects of pharmacotherapy is that it's allowing people to maybe move away from a life of criminal activity. Therefore, if you're not engaging in crime, in sex work, whatever the case may be, your finances are going to be heavily reduced. So we put together a very rough example, say if it was a single woman who was still pregnant, she'd be looking at receiving I think it is $474 a

fortnight.

PROF SCOTT: Sorry, could you say how much that would be?

MS COWLING: $474 a fortnight, if you're on a health care card, but we've given the example, assume this woman does have a child in her care, then it goes up to $514 per fortnight. If you're looking at additional costs, in my experience working in the drug and alcohol sector, in the sector of people experiencing social and economic disadvantage, very, very difficult to find accommodation. As the previous speaker has mentioned, it's so hard to find housing, this is across the nation, and Victoria is no different, there is just very limited housing stock and very limited appropriate housing, so it's not uncommon for somebody to end up in a rooming house accommodation.

The average cost, in my experience, is about $160 a week, so if you consider someone is earning $514 on government payments, they are paying $160 a week for rent and then you add $35 per week for pharmacotherapy, that leaves roughly $60 for that woman to spend on transport, food and other provisions for herself and her child. It's not very much money I'm afraid and one of the things that came up again and again was things like basic nutrition. It's so much cheaper and more accessible for families, particularly families that perhaps haven't had positive role modelling, to buy cheap, crappy food instead of good, nutritious food, so all of these sorts of factors came up when we were talking about costs, but pharmacotherapy was a big one because it was so essential to helping the parents, particularly the mother, maintain some normalcy in her life and I guess stability as well, so I think in that regard pharmacotherapy was definitely identified as a big issue in this sector, and I think not just the drug and alcohol sector, I think across the social welfare sector, but for illicit drug-using parents, particularly with opioids, of course.

DR GRIFFITHS: So we would like to put to the Panel today that we're of the view that pharmacotherapy in an ideal situation should be able to be provided free to people, obviously subject to means testing, but if that was not possible - and I've read that review which I mentioned last week and that suggestion is in that review and it's already been rejected, so that's not likely to get up - but perhaps specifically there is a case to argue for women who have recently given birth for a period of five or 12 months or a couple of years to have free pharmacotherapy or at least subsidised pharmacotherapy because, as Nicola said, if you're on a program, by the time you've given birth, you're on a very high dose level, it's going to take a lot longer to get off and removing any barrier to continuing pharmacotherapy in the early stages of motherhood would be excellent and that's quite possibly a recommendation that won't break the bank, so to speak.

MR CUMMINS: We follow that, that's obviously a critical time and it's a

more targeted matter than the ideal solution.

MS COWLING: Yes. If I might interject, Patrick, sorry. I did come across one service who wished to remain nameless, who was a specialist midwifery service and they were actually funding themselves the cost of their clients' pharmacotherapy throughout the pregnancy and I think, if I'm remembering rightly, six months postnatally and they were finding that they had great success with that and it was all done within the hospital system. They said it was actually lovely in other ways because it was allowing for ongoing contact with the hospital, they were more inclined to check in in terms of postnatal care and they were also finding that it was creating a little bit of social networking, like an informal mother's group for those women and that was one big issue that came up time and time again in the training that we did. So many of these women felt that they were very socially isolated and those that were trying to do well, those that perhaps did have the protective factors in place to still be caring for their children, found that there were no suitable supports for them insomuch as mainstream services, they really didn't feel comfortable accessing mainstream services and it could be something as simple as offering a mother's group for drug-using parents. I know this is something that Moreland Hall has done previously, but my understanding is that that group is no longer in operation and these sorts of groups have only ever been done ad hoc, very sporadically and very much the funding is often limited, but a little bit of creative financing done within organisations.

DR GRIFFITHS: So there is an example where that recommendation is actually being applied on a small-scale under the radar almost unofficially within a service, they're actually moving some monies around and things like that, but it's been having some success so perhaps that's something that the government could look at doing, easing - as Mark Latham would say, what was it, ease or squeeze or something once upon a time - so that's been potentially a moderate recommendation that at least the government may consider.

I think probably one of the key messages, which was again in the report last week, was that we're really not going to be able to utilise the potentiality of pharmacotherapy to help people with parenting until the system is actually fundamentally fixed. There is a huge shortage of prescribing doctors and they're actually declining, they're getting older and there is obviously also a shortage of prescribed pharmacists who dispense. Given that that's so fundamental to enabling people affected by drugs to perform duties as parents, we really I think need to be factoring this into the consideration of your Inquiry.

One of the other things too, sticking to pharmacotherapy, I mentioned before that there's about 8000 people who are not picking up their prescription, for example, the methadone or the Suboxone. We know the gender of people who

are in the 21,000, people who have a permit, people who have a prescription written for them. You can get their names and their gender, all that sort of stuff, but of that 8000, we know nothing. I tried to get it last year actually because I thought are the vulnerabilities for women - because the pressures upon maintaining a pharmacotherapy program, there will be some differences between men and women, and particularly related to parenting, costs, et cetera - we don't have any data on that gender breakdown and I think that that is a bit of a flaw and if we do want to maximise the potential of pharmacotherapy towards improving the welfare of children, we need to be right over what are the factors that are making people drop out. We don't know that.

The other thing too I think is important is that there is a big gender imbalance when you look at the doctors who are prescribing pharmacotherapy and also the pharmacists who are dispensing it. There is a shortage overall, but there is far more men than women and I think it would be fair to assume that it would probably be a step forward for women and pharmacotherapy if we had more female doctors, so that's a structural weakness in our pharmacotherapy system that I'd like to bring to your attention.

Now, in relation to needle syringe programs, I'm certain the Panel is aware that the vast bulk of those programs in Victoria receive no specific funding. About 90 per cent of the needle syringe programs are unfunded. They get no funding from the government to actually perform that task; it's actually a duty that they do out of their salary in other areas. That really means that without those specialist staff, the potential for those services to act as referrals towards other welfare services, other health services is diminished and the people in these secondaries often lack awareness of illicit drug issues and so it compromises their ability to interact with clients to build rapport and that rapport is essential. As I said before, a lot of these people aren't accessing family services, are they?

MS COWLING: The feedback that we got from the training, and in my experience working in the drug and control sector, illicit drug users in particular, but I would argue this is the case for people that have problematic alcohol use, although this is something perhaps, what's the word, better hidden, it can be a hidden population, but our experience has been that often these parents, mothers in particular, are very reluctant to engage in services and you will be well familiar with the reasons.

Injecting drug users and illicit drug users are very poorly represented in antenatal care for a number of reasons, partly it can be simply because of the physiological changes of their drug use means that they're menstrual cycles may have changed and there is often an assumption that you simply can't fall pregnant. I've often worked with women that do not discover they're pregnant until five or six months along in the pregnancy.

The most common factor though, of course, is the fear of Child Protection or Child First involvement and this can be because, as the previous speakers alluded to, there is a lot of intergenerational involvement with drug use and Child Protection and the vast majority of parents I worked with had been in foster care themselves and I think this is an increasing issue and I'm sure it's something that you're hearing plenty about. So because of this involvement and because of the involvement of friends and peers and because of perhaps previous involvement with Child Protection as parents themselves, there is a great reluctance to engage in antenatal services because that is equated with Child Protection and this, of course, is putting the parents and the child at much greater risks.

What we are really advocating for and what we we're starting to work towards with this project, which I'll explain a little bit more in a moment, is the potential for needle and syringe program workers and alcohol and other drug workers to act as a conduit to antenatal services to support and advocate for these women and these parents and to help them recognise that rather than it being a path to Child Protection involvement, this involvement could actually be a protective factor.

I think it's important for me to clarify too, I think sometimes the harm reduction sector is criticised in mainstream community for being soft on drugs or for always siding with the parents. Of course this is not our stance at all, we recognise the importance of protecting the children and of course there are going to be cases where simply the parents are not able to care for their children. But in saying that, drug use in and of itself does not mean that somebody is not fit or able to parent and I have met personally many illicit drug users who have done a tremendous job parenting. In saying that, they often had many protective factors. It is where you have the additional factors of homelessness or inappropriate or transient housing, mental health issues, domestic violence, history of emotional, physical or sexual abuse, all of these other factors which I'm sure you're very familiar with.

What we would like to see is that, particularly with NSP workers because they're dealing with a very vulnerable group, they have that rapport already I suppose to help break down some of these fears and barriers and so they are in a very good position to help build up a relationship with antenatal services and to maybe help the parents to see this as a harm reduction measure in itself. Often women would say to me, "I don't want to go along to the Royal Women's or to the Mercy," or whatever the case may be "because they're going to take my children away from me, that's what's going to happen." Really what we need to be telling these women is, "If you don't go along to these appointments, you're actually increasing your risk of Child Protection involvement," and helping them to have a better understanding of not just Child Protection, but of

course Child First, I think that is really important too because, as you can imagine, they're put in the same basket.

Most women I work with would say, "What's the difference?" and, of course, some women have had involvement with Child First that's immediately led to involvement with Child Protection, and that will happen. But the truth of the matter is, as we all know, if they're not fit to be parents, if they're not able, if they're struggling, this is going to happen anyway. Better for them to recognise that the more involvement and more support they can have with these services, the better the chances of maintaining the family unit.

Our thinking is also if we can up-skill needle and syringe program workers and drug and alcohol workers to have a better understanding of what antenatal care involves, what perinatal, postnatal services are available, what family support services are available and so on, they can help this very vulnerable group to better navigate these services, and where there are other protective factors in place, they can also help to identify and address these protective factors. But where there is the potential for this family unit to function, this sort of education, this sort of support for that sector would hopefully diminish the need for involvement with government services such as Child First and Child Protection or even limit the involvement so it would be more of a protective involvement.

I think it's important to help women to realise that Child First or Child Protection can actually be of great benefit for them as well because it can help fast-track them into other services that can benefit their potential to be a good parent, so we think that's a really, really integral direction. What we'd ideally like to see is perhaps funded positions for parent support workers within the AOD and NSP sector because drug and alcohol issues are such a significant contributing factor to child protection cases. I think we need to diversify the way we address this and be as holistic as possible.

The other thing that came up from the - and feel free to stop me because I might ramble - but the other thing that came up when we were doing the training, and I must point out the training was attended by a diverse group of people across Victoria, we had midwives, nurses, perinatal, emotional health specialists, counsellors, youth workers, NSP workers, AOD workers, doctors, psychologists and social workers and a few others who are escaping me, child care workers and so on.

Unfortunately, despite pitching to Child First and Child Protection, we only had I think three people able to come along to the 12 sessions that we ran across the state and they were fantastic and their contribution was really well-received by everyone in the group, but what they were saying to us and what people working in affiliation with these services were saying, they don't

have the time to access training and the training that they receive in drug and alcohol is extraordinarily limited.

After I finished the training, I've had correspondence with two staff members from different child protection services both saying, "We really enjoyed the training. We really need more of this because we just don't get enough," and I think sometimes the AOD sector perhaps gives the child protection sector a bit of a hard wrap and vice versa and we would like to see much greater integration and collaboration between these two sectors because they really don't understand how each other works.

In an ideal world what I would like to see is for collaborative training, bringing these services together so they have a better appreciation of what each other does and they start to use a common language and start to recognise that everybody is interested in the best interests of the family unit, but also very much interested in the best interests of the child. So we think that we would really like to advocate for improved drug and alcohol training for Child Protection, Child First and also Family Services, who are very involved as well, but by the same token the AOD sector and the NSP sector, they need to have similar training in Child Protection, Child First, Family Services, antenatal services and so on because - I hate to use this term - but we do very much operate in silos in the health and social welfare sector and it's to the detriment of the client group.

DR GRIFFITHS: I'd just like perhaps to elaborate slightly on one of the points that Nicola made - and I know we're probably over time. Within the state, although most of these services are secondaries, are unfunded, they're emergency departments, as you know, there are a number of stand-alone specialist services in Collingwood, Richmond, Dandenong, Footscray that once upon a time were just set up as needle syringe programs but which now which have a range of services in there. If you ever get the time, pop into the Johnston Street service. People can come in, they can sit down, they can read, they can have breakfast, they can have a coffee, there is financial advice they can get, there's some mental health is being integrated now, there are doctors, a whole range of things, but those services do not have people there who are skilled in parenting-related issues. Even though hard to reach population, injecting drug users who are running away, avoiding a whole range of other services, they go there for a cup of coffee, some needles, this and that, safe injecting advice, so they're gathering in these places, but imagine the potential if we just put some parenting-related skill sets in there. I mean the trick is to find these people. They go there. So that again would just be quite a simple, probably not very expensive, structural shift and evolution that could be done and implemented quite quickly. People go there for the doctor, there are doctors there, but I don't think the kids, who sometimes go with them, are going to the doctor, so there is potentiality there on those specific stand-alone

sites.

MR CUMMINS: I think that's a very good point to finish on because it's actually been a very extensive submission and a very thoughtful one and I think it's a very good practical end point.

PROF SCOTT: Just a request, that it would be very helpful for us to have a copy of the 2007 survey that you conducted which you referred to at the top of page 11.

MS COWLING: Yes.

PROF SCOTT: And just to say that it's really marvellous to have a submission from the alcohol and other drugs sector; it's very, very helpful. Thank you.

MR CUMMINS: Mr Scales?

MR SCALES: Nothing, thank you.

MR CUMMINS: Thank you both very much.

MS COWLING: Could I squeeze in one quick point, just something which I came across which I thought was fascinating, and you may well be familiar with this, but when I've spoken about it in this sector people have been interested. In the UK, and apparently there has been a pilot case of a similar program in Adelaide, there is a possibility for drug-using mothers to be placed in foster care with their child and I think this is an interesting program to look at. So such placements, they're looking to maintain the family unit, where appropriate of course, it is allowing the foster parents and affiliated family services the opportunity to monitor and also positively influence the mother's parenting, it's offering support, respite, positive role modelling, which is a big issue, positive role modelling, I'd love to see an Adopt An Auntie or Adopt A Grandma program, things like this, in addition to providing the mothers with the skills, the knowledge and the confidence that she needs for effective parenting.

I had a child a year ago and it made me realise, I've got a lot of bloody protective factors in my favour and I still found it awfully challenging. When you look at all of the factors that some of these vulnerable families are facing, it's no wonder that things fall apart, so I think we need to be as holistic as possible and I thought that was a nice initiative, so thank you for letting me go on.

MR CUMMINS: Thanks Nicola. Thanks Patrick.

MR GRIFFITHS: Thanks very much.

MR CUMMINS: Mr Youssif Assafiri. Come forward, Youssif. Take a seat. We'd be pleased to hear what you have to say.

MR ASSAFIRI: Well, basically I've been working with Care With Me for the last 12 months and I have basically wanted to basically emphasise the importance of some of the work that Care With Me does for children with cultural and linguistic diversity.

MR CUMMINS: Yes.

MR ASSAFIRI: If you don't mind, I'd just like to tell my story for you guys, I hope it's not too heartwarming or not too boring.

MR CUMMINS: You're welcome to read it.

MR ASSAFIRI: I'd just like to first of all say thank you for giving me the opportunity to tell this story and I apologise to my, who I would say is a colleague/friend, Mohamed Elmasri, from the Care With Me program who was unable to make it, so I'll just state that first, but anyways, I'll go ahead.

I'll start off by saying good afternoon, my name is Youssif. I am a young man with cerebral palsy and the reason why I mention this is because all my life I have been through many challenges and it has taught me how to overcome adversity when faced with challenges that life may present to an individual. Although everybody's life is different, the one thing I have learned is the importance of establishing a connection with either an individual or a small community. I have gained this knowledge by educating myself about the importance of making connections with someone and I am here today trying to connect with you by telling you my story and how it has impacted on me and my peers. Also, I want to make recommendations to all multicultural families and how it would benefit the community.

From a tender age of six-years-old I experienced my first moment of foster care. However, I had my siblings to help me ease my separation from my parents. A year later, I felt after all the court hearings, I moved back and forwards between my parents until I was 10-years-old, which then I was moved to full-time care under DHS, but this time I was on my own. I remember my first night, coming from a family of seven other siblings who ate dinner every night together and now I was sitting there all alone, eating by myself, wondering what I had done and why this was happening to me. So afterwards I prayed to God and cried myself to sleep, hoping that this was just a dream and when I woke up, nothing had changed.

I finally got used to being away from my family because I had no choice. After moving around for a period of six months and having minimal contact with my family and changing schools and losing friends, I felt like my life was cursed. Then I met my foster mother and father who gave me new life and a sense of a new family, but I knew they weren't my real family.

A couple of years later, my mother passed away when I was twelve-years-old. This had an impact on my family even more because before she passed away I knew where my siblings were. Now my immediate family had no choice but to live interstate with other relatives. Therefore, there was less contact with my siblings to establish family relationships. Four years later, I had major surgery. Thank God I had my foster parents, who helped me learn how to walk again and help me get back on my feet. They were like a blessing to me. Unfortunately, I knew that once I was 18 I had to be on my own because the law considered me to be an adult and yet compared to everybody else I knew who had the luxury of being able to have a home, unlike me at my age.

As I grew up, I suddenly began to realise I had no sense of identity. It was like I knew what I was, but I wasn't that, if that makes sense. I couldn't connect with certain people from my community because this was unusual and looked down upon from some people, so I felt outcast until I met my brother-in-law. I am now 29-years-old and at this time I work with people from many communities and I have witnessed similarities which I have gone through myself. This made me think that there was a problem with our current system and I wanted to do something about it, but I didn't know how.

Then I found a small organisation called Care With Me. I have been working with them for the past year telling my story and I only wish they had been around to help me and my family. As I am here today telling you my story on behalf of children of many multicultural families that are in need of support services like Care With Me, I believe had there been an organisation during my time of growing up which provided services to help harmonise and educate cultural differences among multicultural families and the sector, which through the sector is governed by laws and policies has recognised the importance of this, still there are children losing their identities, just like me.

The recommendation I would like to highlight is that there needs to be a need for more organisations like Care With Me to be better supported or established because I have experienced first-hand what it's like to have your identity taken away from you at a very young age and the long-term effects it's had on me throughout my life. By this I mean education, relationships and even finding a place to live. I just currently found, I believe, a long-term solution. I'm now 29, I believe I've finally found that place and hopefully I'm there for a long time because most of my life I've been unstable and just been moving around

from place to place, I've been all over Australia - not all over Australia - but many places in Australia and I just think that that's part of the long-term effect that it has on that.

I just want to continue a little bit more about my recommendation. You see obviously you guys can see the importance and the effect that it has and the magnitude of it; it is enormous. If only we had an organisation like Care With Me who deal with cultural and linguistic diversity then maybe my family could have been saved from separations and the irreplaceable time of not being able to spend time with my siblings and the long-term effects of that. People recognise drugs and alcohol and all the sort of other stuff that people want to use to say that these people have issues, but there is another issue at hand that people don't recognise a lot and that's obviously cultural and linguistic diversity.

The opportunity was missed and it could have provided my family with - how they could have helped my family was what I believe is that prevention is better than cure, so to have an organisation like Care With Me who had have stepped in before things got escalated or the department got involved, things could have been harmonised between the two cultures, between the Middle Eastern culture and the Australian western culture. The reason why I categorise it like this isn't because I'm not Australian. I was born in Australia, I am an Australian and I'm very proud of it. However, I've worked with many men from that region and the one thing I find common is that when they come from a country like Lebanon, for example, they have a status. They are usually a doctor or a police officer and then they come to Australia and they have to start all over again and they lose their status and so what they try to do is impose their beliefs and customs on their children.

Now, in terms of the child, how the child perceives things, the child gets caught into a rift and doesn't understand why this is happening. Often what happens is there's a clash because the child wants to live his freedom of life and the parent wants to impose their customs and beliefs, so that's what I wanted to recommend today. The reason why I made those recommendations is because not only does it benefit children, but it also benefits the community. This would help children by building their resilience and saving the community from extra burden of providing additional support. This would also educate our community in harmonising and understanding our differences.

I believe that education should be free to all and I was one of the lucky ones. I had good foster parents, I had very good people around me to guide me through life, to give me my head on my shoulders and I feel like I was kind of blessed now when I look back at it. But since then I have worked with many, many kids similar to me and they don't have that opportunity. There is simply not enough foster carers today in Australia to accommodate the children today

in foster care or in residential care.

One of the solutions or one of the recommendations I was going to emphasise is that we need more organisations to help these kids before they get to that stage, before they get into resi care. I've worked in resi care, I've been through resi care and I've actually worked in there for almost two years and I find that the children, no matter even if you've been in resi care, they look at you as you're against us, they don't really want to connect with you because they have no sense of family. They don't feel like they belong anywhere. It's a rotating shift.

If you look at most common households in Australia, most families, they don't have rotating shifts. They have two people, which are parents, who conduct the home of those children. They don't have that. They miss out on that. They have to go to maybe multiple places on Christmas Eve or maybe go nowhere on Christmas Eve and they can't have their siblings around.

I use my story to educate people that there is a problem and that something needs to be done, so I just hope that I'm trying to connect with you and hopefully you guys can shed a little bit of light towards the government that this is a problem and maybe possibly something needs to be done about it to help lessen DHS's workload. I've also been studying community service welfare in NMIT for Preston TAFE and my understanding of it is that there is a lack of people who are qualified in the sector and because the turnover is so quick and there is a high demand in welfare sector workers. Basically there is a shortage of people with those skills and I believe that this is something that isn't very much looked at. I mean we are taught things about culture and the importance of culture and the difference between culture and religion, but we don't really understand the impact it has on people and the significance it has on people's lives. I know certainly for me it was to the point where if I wanted to traditionally meet a girl from my same cultural background, I had no knowledge of that. I didn't know how to do that so I often just left it alone and didn't go there and I missed out on that opportunity.

I want kids in care to have the fullest potential like I did. It wasn't perfect, but it was better than most and I'm grateful for that. I really am. I mean I don't know if it was the system, I wouldn't say it particularly was, but I believe it is because of good people and we need good people and these organisations, these small organisations who deal with those cultural issues that DHS can't understand because everybody's different, not everybody understands the Asian culture or the Middle Eastern culture, it's just too much knowledge, but if you harness or zone in on one particular culture and understand that culture and then work with that particular culture you're more likely to connect with that particular group because you understand how they are thinking and I think that to me, if you remember my story from the beginning of the importance of

connection.

A lot of kids I find go into care, a lot of them are good kids, very good kids and they have no issues. By the time they leave resi care, they have many more complex issues because they've been exposed to sexualised behaviour, they've been exposed to violence, gang-related, graffitis and drug abuse and all that sort of stuff, so I was just recommending that these sort of organisations could help prevent or minimise the risk of a child being put into resi homes and therefore taking less money on taxpayers as well potentially if there was less kids in resi care, this could be a problem.

From my understanding of working with Care With Me, two kids every week in Victoria alone, two Muslim kids every week alone are taken out of homes and put into non-Muslim homes, which I don't have a problem with personally because I've had a good experience there, but in terms of when you grow up, the long-term effects of it, I don't know how to explain it to you unless you've lived it. It's just so hard to move into your culture and connect with your community, so you sort of distance yourself from that, so I really again would want to stress out the importance of trying to establish these sort of groups or organisations and the importance of them. I appreciate your time once again and thank you for listening to my story.

MR CUMMINS: Youssif, thank you very much first for coming forward. Second, thank you very much for the work you have put into that preparation. Personal experience such as you have given to us is most important to the Inquiry, so we are very obliged to you for coming forward and doing that presentation. The Inquiry publishes on its website the submissions that have been verbally presented to the Inquiry. Is that acceptable to you that we do that, or would you like to have your submission not published on the website?

MR ASSAFIRI: No, whatever is the process.

MR CUMMINS: We'd normally do that, we'd normally publish it, but of course if you'd prefer any part of what you've said to in effect remain private, it's a public meeting here of course, but to remain private electronically then we'll fulfil your preference.

MR ASSAFIRI: I'm more than happy to - I tell my story to speak on behalf of all children, I don't do it to glorify - I'm not saying that you guys are implying that at all - I'm just saying that I don't do it to hide myself. I'm proud of who I am. I think it's made me who I am and I'm proud of what I am and I want children to know that if they can achieve half of what I've achieved then they're in a lot better place than what I am.

I mean I've been listening to two other people come here and they've all got

valid cases and they all have a common trend, it's always about mental health, it's always about drug and alcohol, it's always about those things, but I haven't heard a story or someone arguing to a point the importance of culture and the diversity that comes with it and how important it is in terms of structure because we all come from - I mean Australia is a multicultural country. There are so many, so many cultures in Australia and each one of those cultures have their own communities and have their own structures and they all need to be shared upon and educated to all of us so we can work and understand each other, but in terms of what you're asking, do you mean you want me to tell my story to a newsagent?

MR CUMMINS: No, we record it and whatever we record here we do publish on our website, so if you're happy with that, that is the normal, correct procedure.

MR ASSAFIRI: Okay. Yeah, I am happy with that.

MR CUMMINS: Youssif, thank you very much. No questions?

PROF SCOTT: If I could just ask briefly a question and thank you so much because this has been very, very helpful to us. It seems to me there are several strategies. One, as you've said, is to help families to prevent families getting to a situation where one of their sons or daughters would need to live away from the family, and then second is, if that's necessary, to have those children go into an environment which is similar to their cultural background.

Given that it may take some time to develop the number of foster carers who could be of the same cultural background as the children who may not be able to be prevented from coming into care, would you see any place for a residential unit for children and young people of a similar cultural background with culturally competent or similar cultural background staff, that's not something I'd previously thought about, and I'd be very interested, given your background in residential care, your thoughts about that as a model of care.

MR ASSAFIRI: Possibly, but from my understanding of residential homes, when I was in resi homes, we actually had two people 24 hours around the clock, compared to today, and they were called family group homes.

PROF SCOTT: Yes.

MR ASSAFIRI: Which they no longer exist because they were supposedly too much money to run. I don't know how that works, but yeah, so my understanding was that was the reason why they closed them down. I don't know how DHS and the department would fund those sort of things. I, personally, if that's what would help children and had a positive effect on

keeping their cultural identity intact as they get older then, yes, I'd be all for something like that.

One of the things I did for an excursion currently at school was the NJC, which is the Neighbourhood Justice Centre. What it did to me was it enlightened me on how their court system was different to the formal court system. They preserved and respected the Koori people's culture and they dealt with, not just Aboriginals, but also people with the City of Yarra.

What they did was they had a range of services in-house instead of like the formal courts today where they refer you to certain organisations and tell you to go here, but there's nobody monitoring that, and in the Neighbourhood Justice Centre they also do it immediately so it's not prolonged, it's not over a lengthy period. Whatever issues that were the cause of that person offending, they had that basically dealt with a lot more efficiently than the formal courts because the formal courts are a lot bigger and obviously have a longer process in dealing with things.

The reason why I brought this up to your attention was my ultimate goal is to have social change. How I plan on doing that, I couldn't give you a black and white answer, but I want to impact society because I've been through this system and so many kids who are currently in the system today sit there and say to me, "Oh, the system's against me. The system screwed me up. The system did this to me. The system did that to me." What I'm trying to embed into these kids is that, "If you go against the system, the system will not help you. You need to work with the system. It's not perfect. It's not designed to be perfect. It is really hard, but it is more beneficial for you to be able to work within the system instead of going against it."

Now, to me the NJC had no metal detectors. They had I think one or two guards between the whole - it was a double-storey floor - and they also let the victims of crime talk to the people who offended them and committed those crimes against them and they got told about how they impacted on their lives. To me it was just really good to see that this not only had a good impact on the victim and the client if you like or the perpetrator, but it also had a good, positive - like crime rates were down, homeless people were down in the City of Yarra, so all this stuff helped people, helped taxpayers, helped the government save money.

Short-term, it did cost a bit of money to run up the NJC, but long-term, the effects of it was enormous, you know, it was a better place to live, you had less drugs, less homeless people, less things and it all started by the NJC respecting the Aboriginal community and the culture of it. So to me this shows the importance of culture because without culture it could lead you to anywhere, it could lead you to drug use, it could lead you to violence, it could lead you to

gaol. I've had people say to me, "How is it that you are not in prison? How is it that you have got such a good head on your shoulders and you sit here and tell your story to people like as if it's nothing?" You know what, I was one of the lucky ones.

MR CUMMINS: Good on you, Youssif.

MR ASSAFIRI: Thank you for listening.

PROF SCOTT: Thank you.

MR CUMMINS: Thank you very much for coming forward. We've had a request for photographs being taken for the Centre for Excellence, which request we are happily to grant, on one condition which I'll state in a moment. However, there is two things I want to say.

The first is this: it's the Panel, Prof Scott, Mr Scales and me that is conducting this Inquiry, not some external entity, and it is the Panel which is conducting today's Public Sitting, not some external entity. It is we who will decide how the hearing is to be conducted. That is a matter of our function and no-one else's function. The second thing is this: there are considerations which may not be apparent to external entities, but which are crystal clear to us. One of them is that it is quite a different thing for the hearing to be conducted in public and another thing for photographic or film recordings to be taken of it which are published externally. We have at times given permission for the media to be present and, as I say, we certainly are happy to give permission for the Centre for Excellence to take photographs of its proceedings, but the photographs are to be limited to the participants in the hearing, whom we would be very pleased to hear in a minute, but should not include other persons in the room who may not have agreed to their photographs being taken and published. As a corollary of that, there is no permission given by the Panel for the photographs, if they were taken of the previous speaker, to be published because we have not given our permission prospectively.

Marilyn Webster and Josh Ferguson, you're most welcome to come forward. Thank you, Josh. Thank you very much for your extensive written submission which we have read and studied and we are most assisted by it. Josh or Marilyn, would you proceed according to whatever is most convenient to you.

MS WEBSTER: Thank you. Firstly, I'd just like to make a few comments. Josh will address the substance of the submission and then we'll jointly respond to any questions you might have.

MR CUMMINS: Thank you very much.

MS WEBSTER: But I'd like to preface my comments by making an apology if any offence to the Inquiry has been caused by the taking of photographs. We were under the impression that permission had been granted to be present and we were aware of specific permissions that had been given in relation to Youssif, so I apologise for that.

MR CUMMINS: You're most welcome to have photographs taken of yourself, which I'm sure will be good photographs.

MS WEBSTER: So we'll turn to Josh.

MR FERGEUS: Thank you and thank you for this opportunity to further expand on the ideas we've presented in the Centre's submission, It's Their Outcomes that Matter. Before I begin, we'd like to acknowledge the traditional owners of the land and pay respects to their elders, past and present.

Just a little bit about myself and my experience, in addition to my current role as the acting manager of sector development in the Centre, I have 13 years of experience as part of a foster family, six years as an accredited foster carer and five years experience recruiting, training and assessing foster carers and working across the out-of-home care sector, which includes foster, kinship, residential, permanent care and also some work with adoptive services.

Today, along with Marilyn, who is the Centre's director of research and social policy and who, as you all know, has probably double and more of the experience I have just listed, I'd like to speak on behalf of our boards, our CEO, Dr Lynette Buoy, our members and the many networks on behalf of whom we advocate. I've been asked to present to you some additional views and concerns of the Centre specifically relating to the range of placement options available to children and young people and the capacity of the system to fully and appropriately meet demand.

Our presentation today particularly seeks to inform the third term of reference for this Inquiry, with a focus on the quality, structure, role and functioning of services. The Centre's view is that in order to best understand the true impact of neglecting the need for adequate placement capacity and options, we need look no further than contingency placements. For some years now, an unacceptably high number of extremely expensive contingency placements around Victoria have shown a clear need for developing the capacity of service providers to respond in a flexible manner to the needs of children and young people requiring protective intervention. The placement of young people in motels and caravan parks, as has been reported, supervised by protective workers, is a costly and ineffective indictment on our restrictive and at times ineffectual system.

While contingency placements are reported to be reducing in number, it has been shared with the Centre that an increasing number of transitional placements are emerging. Hard data relating to this is not available to the Centre; however, further clarification around this issue may be required. Whatever we call them, we believe that contingency or transitional placements are like incident reports in that they are great indicators of system pressures, of the degree of complex needs exhibited by our client group and of the lack of our system's capacity to respond flexibly to individual needs with appropriate support or resourcing. Those children and young people that are placed in contingency or transitional care are often those with the highest level of need, they are also reported as the most complex, unable to be placed in home-based settings because of their life experience and their subsequent behavioural issues, sometimes violent, sometimes acting out in an overtly sexual manner or presenting a threat to other children, animals or carers.

At present, the best our system can do to respond to these most vulnerable Victorians is to place them in a holding pattern in the hope that an appropriate placement option will present itself. It is critical that we recognise this group of children and young people and immediately take steps to provide the care they require by investing in developing our carer pool and residential care system to a level of oversupply which includes specialised placement options and that we ensure that carers are trained and supported to a level which ensures that appropriate placements are always available.

Sibling separation in care, as this Panel as previously heard, also requires urgent attention through the lens of placement options and capacity. Damning evidence is detailed in Anglicare Victoria's recent report All Together Now, which you have also been told about before. This includes statements that over 40 per cent of all foster children with siblings in care are separated from their siblings and 84 per cent were separated from at least one sibling in care. These findings are in line with other research in the area, both internationally and within Australia.

Urgent action is required to ensure that sibling groups are kept together wherever possible and appropriate in order to preserve these vital relationships. I have personally been involved in several cases where a child has been born who has a sibling known to be in care and the carer of the older sibling has not even been notified of the birth, let alone asked if they would consider also providing care for the younger sibling. This is simply unacceptable, in my view. Similarly, there are multiple occasions when there are appropriate, ready made placement options available for children which are squandered or which have their stability needlessly compromised. To provide examples of this, I would now like to turn to the issue of permanent care.

The Centre's membership believes strongly in the preservation of family in

children's lives in our care system; however, we also believe strongly in stability of care. As this Panel has previously heard, volunteer foster and kinship carers, who are already providing an excellent standard of care, are regularly forced to make the unfair and unnecessary choice between having the child in their care removed after they have raised them for years, or accepting the almost complete withdrawal of financial and case support by signing up to become the child's permanent carer. In reality, the task they are performing does not change, nor does the relationship with the child, but the resources with which they are provided are worlds apart.

By continuing to allow this to happen, we are not only completely abusing the goodwill and compassion of the members of our community we rely upon, but we are also creating jaded, untrusting people who go forth into the wider community and tell the world about how the system abused their efforts and failed to do right by the children in their care, and they are entirely right to do so.

I would like to now bring to your attention a range of observations related to a critical service currently provided by the Centre, funded through the Department of Human Services and conducted in conjunction with our membership. For years, an area which has been overlooked and under-resourced is the state's capacity to recruit and adequately support foster carers. Foster care, a critical element of the out-of-home care system, has been the backbone of the Victorian response to children and young people requiring protective intervention for decades. The reason we continually hear about the crisis in foster care and the impending doom of the program model is continued under-investment, lack of recognition of the complexity of the work and the refusal to acknowledge that it is inappropriate to ask volunteers to shoulder the work of government with next to no support or appreciation.

As the manager of the foster care recruitment project since 2009, I can quite confidently say that contrary to widespread belief and misinformation, the number of Victorians seeking to provide foster care in recent years has actually been steadily increasing. Since the start of 2011 alone, 1109 households across Victoria have sought information about becoming a foster carer. These figures can be fully substantiated through data collected by the foster care hot line service coordinated and delivered by the Centre.

To the best of our knowledge, the foster care hot line is the only central information and referral service of its kind around Australia. With one free call or web inquiry, any Victorian can have all the information and advice they require about foster care or becoming a carer provided to them in a comprehensive, clear and timely manner. Since the 1990s, this service has proven so successful that several other states and territories are currently in the process of developing their own similar service. However, despite a minimal

level of recurring funding being provided to operate the bare bones of the service, across Victoria there is no consistent funding allocated to the promotion of foster and permanent care as options for volunteering to the general public. The last allocation of funds specifically to this end was provided as a one-off payment to the Centre in 2006 to be utilised on behalf of the sector across the entire state of Victoria with the support of one single pre-existing staff member in a central Melbourne location. This means that the service has no funding to update the Foster A Brighter Future website which accompanies the hot line, no funding to print and distribute materials across the state which promote the hot line - which I've given each of you an information pack which goes out to inquiries - no funding to alter and upgrade the way we record and analyse data relating to inquiries, and limited capacity to respond in a timely manner when the volume of inquiries unexpectedly increases.

The reason that we do not have enough carers to meet demand is not due to a lack of goodwill or altruism within the community. The truth is that the number of foster carers remains insufficient due to attrition of potential carers, both before and after accreditation, caused by the consistent inadequacy of resources provided to supply the level of information, training and support required to allow these highly valuable volunteers to provide care for our most vulnerable children and young people.

When a member of the public inquires about becoming a foster carer they expect to be inducted into a professional service. However, service providers are expected to siphon off funds and staff time from their core business of case management in order to maintain the bare minimum level of marketing, training, assessment and volunteer management expertise which is required to efficiently recruit, process and accredit these new carers. Program estimations have shown that it takes approximately 358 staff hours to complete the mandatory assessment, training and accreditation processes required to induct a new foster carer. This figure does not include the time taken by recruitment or the mandatory pre-service training, not to mention any additional training which may be required.

Over 2000 households formally inquire about becoming foster care families every year over the last several years, but without the necessary infrastructure to support their transition to becoming carers the overwhelming majority fall by the wayside. Because the training and assessment of carers is often an additional duty of casework staff, potential carers may wait up to eight or nine months or more to be assessed and regularly have to wait months to enrol in their pre-service training. Meanwhile, hundreds of children and young people across the state sit on waiting lists for respite care or are residing in residential care, even though they've been assessed as requiring a home-based care placement and being appropriate for such.

Before I make my next point, I would like to highlight the expertise of the Centre in this area. In addition to the creation, development and management of the foster care hot line, for many years the Centre has coordinated the publicity and recruitment network, the agencies who recruit foster carers from the wider community, coordinated and implemented the Best Practice Engagement Project between 2007 and 2009 which involved carers, practitioners and managers from almost every out-of-home care provider across Victoria; published a manual of ideas and innovations for providers in the areas of recruiting, training, assessing and supporting carers; we have managed the statewide kinship care services network, which often involves details around training and support of kinship carers; and we have actively participated in many highly relevant advisory committees, steering and reference groups, including the advisory group for the carer information and support service, which is run by the Foster Care Association of Victoria, and the Post Placement Support Service.

With the benefit of all this experience and a long history of leadership and bringing stakeholders together in the area, it is clear to the Centre that there is an urgent need for the coordination, consolidation and proper resourcing of the recruitment, training, assessment and support of foster, kinship and permanent carers. In 2007 the Centre's monograph, entitled Strengthening the Recruitment and Retention of Foster Carers in Victoria, called for the establishment of regional promotion and recruitment groups and the employment of regional promotion and recruitment coordinators. Further changes have occurred since this time, including the introduction of new training and assessment packages for carers to the point that the Centre now believes it is necessary to go one step further and create regional recruitment training and assessment units which will oversee the carer intake process across the areas of foster, kinship and permanent care.

We believe that such a move would result in quicker response times to potential carers; large increases in the number of accredited foster carers available for placement; better data and tracking of carers; vastly improved consistency of response to members of the community; a consolidation of resources and expertise; increased transparency of process; reduced risk of people slipping through the cracks; better screening of potential carers; better trained and informed carers; better coordination and integration between foster, kinship and permanent care; smoother transitions for children and young people between foster, kinship and permanent care; greatly improved carer satisfaction; and reduced numbers of costly contingency placements.

Drawing on our considerable experience in this area, the Centre strongly believes that this change would be a relatively simple, straightforward, cost-effective way to greatly improve access for children and young people to appropriate home-based placement options and some of this work is happening

within agencies in an informal way now. Further detail on the Centre's suggestions in this area can be provided if it's considered appropriate by the Panel.

Finally, also related to the ability to recruit and retain carers and thus related to the system's ability to provide a diverse range of placement options, is the issue of carer reimbursement. The basic levels of reimbursement must be raised immediately to meet the true costs of care and clear, transparent information must be provided to carers regarding finances. Victorian carers receive the second lowest reimbursements in the country. It is unrealistic and unfair to expect that Victorians, with the requisite skills, commitment, passion and expertise will also be able to subsidise the provision of services to children and young people whose care is the responsibility of government. Most importantly of all, placement options must not be target-driven, but driven by need. The abysmally high threshold for access to much needed services is inconsistent, unfair and bad economic practice and regularly results in children suffering preventable trauma, abuse, mental anguish and even death. Many children who urgently require therapeutic intervention, unsupervised on supervision orders, inadequate and supported voluntary home-based care placements will sit on waiting lists for Child First or respite care. When it comes to young people approaching the age of 18, we simply count the days until they will no longer be our responsibility. This, too, is an abrogation of our moral responsibility, is short-sighted and it must stop.

We thank you for the opportunity to present and for your openness and fair treatment of all of those who have presented to you so far. Marilyn and I have had the pleasure of being here for most of these Sittings, as you know, and we'll both be happy to answer any questions you may have, either verbally or in writing, about our submission today.

MR CUMMINS: Thank you very much, Josh, and thank you for the assistance you've provided to us. Marilyn.

MS WEBSTER: I have nothing further to add at this stage. I'm happy to respond to any questions.

MR CUMMINS: All right, excellent. Prof Scott?

PROF SCOTT: Thank you for the submission, which we have read, and there is a lot in there to absorb obviously. Just one request, and that relates to page 8, point number 17, around rates of reimbursement. They are under Services For Vulnerable Children, Young People and Their Families, the 17th recommendation:

Rates of reimbursement for foster, kinship and carers must be

immediately raised in line with the recommendations of Dr Marilyn McHugh.

And there is a reference to her report. That's a 2002 report.

MR FERGEUS: There has been updates each year, yes, according to the CPI.

PROF SCOTT: Yes, I understand Dr McHugh has done more recent work. I'm wondering if the Centre might want to develop some very specific recommendations there that relate to the Victorian system which would be very current, it would be very helpful to us.

MR FERGEUS: Certainly. We support most of Dr McHugh's work in that area, but we'd be more than happy to provide you with a specific recommendation.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales?

MR SCALES: No, I've got no questions.

MR CUMMINS: Josh, thank you very much. Marilyn, thank you very much as well.

MS WEBSTER: Thank you for the opportunity.

MR CUMMINS: Next, Mr Kim Rea. Thank you very much, Mr Rea. We'd be pleased to hear your submission.

MR REA: Okay. Mine's fairly short and simple I think really. When we're talking about protecting Victoria's vulnerable children, they don't cease being children at 18, they continue being children for quite some time after that. My specialty has been looking after boys and 25 is the age at which most boys suddenly become men, and I'd support that notion. Before 25, they have a habit of reverting to younger ages, seven sometimes, even when they're 24, and the notion that any young person could leave home at the age of 18 and live independently I think is not supported by what happens in the community. I think since about 1985 the Australian Institute of Families Study table, which I've reproduced in that submission, indicates that over half, well over half of people in the 24 and under age group still live with their parents and I think that the state has a responsibility to reach out and protect and provide that parental support for young people, even after they reach 18 years of age.

As a corollary to that, I've also given you a reference to CREATE's report card

that they released last month which talks about leaving care plans. I can say that in 11 years of looking after young people I have never seen a leaving care plan. I've heard them mentioned from time to time. I once had a young lad traumatised by somebody who called him up just about a couple of weeks before he turned 18 to talk about what he needed to do to leave my care and he was immediately rushing to me just saying, "What have I done?" So leaving care plans, formal planning for young people leaving care, one of the other people this afternoon has referred to that as something that should kick in very formally from about the age of 16 and the leaving care plan timeline shouldn't be necessarily based on 18 but, you know, what's going to happen to that young person over the next two years so that by the time they reach 25 years of age they are well-equipped to live independently, so I would encourage that, as well as encouraging the Inquiry to be making recommendations to government to formalise that 18 to 25 age bracket as falling within the ambit of state care.

At the moment I guess formally the state will support carers until they finish school when they reach the age of 19 in that year, they'd keep the payments going until the end of that school year. There isn't formalised support for the carers beyond that age. There are modest amounts of money that can be paid out to young people when they actually become independent and leave care, but they are trifling sums of money and I think it would be a great help to carers as their young people get to 18 to know there is a care system that's there that they can rely on. That would be helpful to carers and encourage them to continue looking after their young people, as many do when they turn 18 years of age. That's really all I have to say in the way of a formal submission. I've repeated that in the submission.

MR CUMMINS: Mr Rea, it's an important group and a group that isn't always focused on, so thank you for doing just that, for focusing on that group and also for your written submission which spells it out further. Prof Scott?

PROF SCOTT: Yes, thank you. I haven't had an opportunity to read it, it's just to hand, but I just wondered on the basis of what you've said whether you have any thoughts about the best type of organisation for continuing to provide support to a young person and to a carer family after 18.

MR REA: I think the existing community centre's organisation should be funded to continue that arrangement because typically what would happen with someone like myself, I might have a young person who gets to 18 for whom I continue to care, but I'm continuing to work with my community service agency for other young people that come into my care, so it would make it a lot easier for a carer to continue to work with the team that they're familiar. The needs I have at that agency for the later age groups is relatively small, my time needs are very small. It's really a question of, "Hey, listen, this young person needs X dollars to embark upon this program. Will you help me fund him

through that?" that kind of assistance. So to start with another agency who has no background on that young person or me is reinventing the wheel, I think. I think it would be best to continue with the existing community service agencies for a post-18 support system.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales?

MR SCALES: I'm just looking at your background, it's a fairly rich background for this work, isn't it?

MR REA: It's different.

MR SCALES: I mean you've had some considerable experience since 2000.

MR REA: Yep.

MR SCALES: Can I try and draw on some of that experience, particularly in two areas. One area is the extent to which the education system has met the needs of these young men who have been in your care over that period. Do you want to give us a bit - I know that's not exactly what you've described here - but I suspect that you might have something helpful.

MR REA: It is getting better.

MR SCALES: Getting better?

MR REA: It definitely is getting better, in my observation. At the beginning, there was a tendency to say that foster kids are a problem that somebody else should look after and schools ought not to be subjected to these people. I think that was probably the attitude beforehand. In more recent times, the relevant year coordinator has accepted that children in care need additional help and resource and I felt very supported in the high school system for children in my care in more recent times.

MR SCALES: Now, was that because of your intervention or was it because the school itself had systems in place to do that?

MR REA: The school itself had systems in place.

MR SCALES: Was that similarly so at the primary and the secondary level?

MR REA: I've only looked after - - -

MR SCALES: You only look after secondary.

MR REA: - - - only at high school is only my experience.

MR SCALES: Okay, thank you. In relation to what a leaving care plan might look like, what would an ideal one look like for you?

MR REA: The ideal one would be a formal acknowledgment that that young person would continue to live with me, I think that would be an important part of the care. So the young person wouldn't see the transition as out on the street, I think that's a really important part of the process, and specific assurances about support that would be available. For example, that the system would continue to pay tertiary fees for that young person or otherwise support them. If they were eligible for X payments, for example, that system could just work by itself, but reassuring the young person that they would have a Myki card, for example, or core payments to ensure that they were clothed and had textbooks, that they wouldn't be out on a limb from that respect, and perhaps some warranty I suppose at the end that if the relationship with me was to break down, that the system would find an alternative carer to look after them or support them in independent living if that became necessary, so I think they'd be the key things. The leaving care plan framework does have what I call a mechanical side of things of check lists of things that young people should know what to do, how to apply for a birth certificate, how to negotiate the opening of a bank account, those kind of things, but those sort of things would sort of fall into place I think in existing care plan arrangements.

MR SCALES: Given your role with the Foster Care Association of Victoria, would you say that your experiences are representative of the experiences of other foster carers in this regard?

MR REA: Other foster carers of adolescents.

MR SCALES: Of adolescents, of course.

MR REA: Yes, definitely. There is a very distinct reaction, I think difference between looking after young people and adolescents. You know, the issues that concern people like myself looking after adolescents are drugs, sex and alcohol, whereas young people it's interfamily relationships and much more basic things. I must say, I don't get a lot of exposure to other carers of adolescents, but when we have had mutual self-help groups, it's been sharing those stories that's been the most helpful.

MR SCALES: Thanks very much.

MR CUMMINS: Mr Rea, thank you very much for coming forward and our

warmest wishes to you for your continuing good work.

MR REA: Okay, thank you.

MR CUMMINS: Dr David James. Good afternoon, doctor, welcome.

DR JAMES: Thank you very much for the opportunity to be here. I'm just going to make a fairly brief submission. Perhaps I could just introduce myself. Dorothy knows me from way back. I'm a paediatrician. I'm in general paediatric practice still, though less so, I'm in private practice now, whereas formerly I've been working in the Children's Hospital and (indistinct) I was involved in setting up the Child Protection Unit at the Children's Hospital in the early 90s so my experience goes back a fair way, longer than I'd probably like.

My current position is that I am still involved in clinical care of children at all levels and a lot of children who are in care, so what I want to address particularly is the question of just a small group of these kids who are at the top of the pyramid, the kids who are considered for permanent care and out-of-home placements. This is a small group, but how we handle them is obviously critical, and I don't think we're doing very well at all. They are incredibly vulnerable and I think the legal system and the protective system is really letting them down. I thought I'd use a couple of cases to illustrate what I'm thinking about. I think how we handle these sort of kids, who are the most vulnerable, probably is a sort of bellwether for the whole system, because if we can't get that right, I think it's unlikely that we can do the lesser things and I think it's all driven by the law and the legislation, as far as I can see.

One of the issues is the timeliness of interventions. In the case that sort of precipitated me being here today, I'm thinking about two children [redacted] who are still in a legal limbo after being in care since birth with one family. Despite the best intentions of I think all concerned, they are in a situation which is not stable. They are frequently going to court, they have had three Children's Court clinic assessments, numerous other assessments, they both show signs of distress and they're getting frequent and inappropriate access.

The court process has been dragged on and I just cannot understand why this is possible, given the legislation, the professional guidance and so forth, that if you're going to make a decision of permanent care, it needs to be done promptly, acted upon at least within a few years. So six years down the track it's still not happening and the cumulative harm here is potentially horrendous and this is a case in which it's clear to all there has been decisions made - there is no debate about this - this was a case where everyone agreed from the outset that these children were not safe at home, so if we can't deal with a black and

white case, how can we deal with the more numerous ones and in my experience the numerous ones are much more common ones, like the cases where, as we know, the common scenarios are mental health issues, combined with drugs and alcohol and past experiences which have left people unable or unwilling to parent and repeatedly in and out of care, multiple notifications from birth onwards. I mean I still have lots of kids who are bouncing in and out of care. The courts aren't looking at this cumulative harm to all and the department isn't mounting good cases to deal with this.

Effectively what's happening, in my view, is that their rights are just not being considered vis-a-vis their parents' rights, so it is the mantra of reunification, just rules and overrides commonsense half the time. Contrast that to - I might go back a few years - contrast that to another case which I'm very familiar with because I've seen the adult end point, a family I saw years ago, again with a mental health issue, and this was taken to court and an adoption order was made, you know, dispensation, parental rights in court, I think the Supreme Court.

I've now had the pleasure of seeing this child's prodigy and this was a very straightforward matter, contact was maintained with the birth parents, but the parents had total control, as opposed to these current protective care orders, these foster parents are not able to make a decision about whether they can have [redacted] hair cut or provide medication. I prescribe medication that can't be given because one of the parents objects to anything that the system does for them. It's quite unacceptable. My attempts to improve the situation haven't been very fruitful, I might add, because - but anyway.

I think it comes back to the legal system driving all this and the onus of proof, which perhaps should be reversed, and I guess primarily the adversarial system. I mean this adversarial system doesn't make good judgments necessarily and I think a more collaborative welfare-based, instead of having a clash of cultures played out in court, it would work more as a team and a collaboration. There are different models, as we are all aware, of how that can be done and I don't understand the law well enough to do that, but I think we probably need legislative change to drive this.

The other comment I'd like to make is just about communication, interdepartmental, interdisciplinary communication. It's still an ongoing problem and I think it impacts on the assessment of children. Certainly from my experience we are aware, coming from a medical culture, but having pretty broad experience in other things, including family therapy, we reasonably understand how systems work. But the cultural differences, it's quite profound and quite difficult and things like the privacy laws are used as a cover for not providing information. I think if you look at how this works, and to sort of make a metaphor that there are systems that can be set up to ensure teamwork

happens. It happens in the medical system, it happens through mitigation in America, but it happens through a whole lot of other things here and you can even get surgeons cooperating with people if you provide the proper structures, so that can be set up so that people do work together in an effective manner.

Over the last 30 years there has been a revolution in the medical system so the teamwork happens better, it's seen to happen, it's measurable. It hasn't happened in welfare and child protection, we're like we were a hundred years ago, as far as I can tell - we seem to be living in silos - which leads me on to my other beef about professionalism and lack thereof in the child protection system.

As a senior doctor, we're dealing with very junior, very untrained, inadequately supported junior social workers who are working on the front-line in the most difficult, difficult position and it just reminds me of how it used to be, the medicine years ago. I mean when I started in 1971, a junior doctor could end up in the emergency department or in intensive care with the support of a much more senior doctor, one year older. There was no-one else to be seen. That's like it is now a lot in child protection. If you go to an emergency department now, and I hope none of us do, you will find senior people, full-time staff. You don't see a junior doctor in sight. They're not allowed. They are supervised. It just doesn't happen. It's a totally different scenario.

I think we have a lot of issues in how we provide care, but I think the idea of expecting junior people to do a very senior person's job is just never going to work and as a consequence the system falls back on an administrative check list that basically denies professionalism and judgment making so that the workers can't make a decision without consulting with someone else, so I think it's a definite cultural issue.

The other issue is about accountability and it comes up just perhaps with this case that I'm involved with at the moment with the children in perpetual planning for permanent care. I've just tried through the local region to see what can be done to improve things, to get an outcome. That hasn't been very successful. I've gone to head office, I've gone to the Office of the Child Safety Commissioner, all of which are very helpful, but nothing has happened. Nothing changes. Emails go out. People talk. It comes back to the court. I don't know, it just seems that there is very little willingness to try and challenge a decision, for instance, to make an appeal. Here is a situation which I thought would have lended itself to an appeal, "Isn't this a legal matter?" and they say, "No, this we can't appeal." In fact, [redacted] years later, the child hasn't been placed permanently. That's not an appeal matter. Now, if that's not, I don't know what is, and I think it is a legislative lack of, if that's the true position. I don't know if it is, but the legal advice from the DHS is, "We can't do anything."

How do we know if this protective system is working or not? We don't because there is very little data and I think one of the issues is around the lack of data and that's one sort of example. There is a bit of a lack of transparency and if you don't have good data, you can't make good judgments. For instance, if we have, as we all know, the waiting times for emergencies, waiting in emergencies or to have your hip replaced is available on the web now. If you want to know how you're school's performing, it's on the web, you can check your school. If you want to know how DHS is performing. You don't. No-one knows. They might know. I doubt it.

I think there is a bit of a system redesign required. There was one other issue in terms of the foster. Children in care rely on support from their foster families. The foster families get very little support and I'd just like to add to what the previous speaker was saying, but one of the other issues is the lack of Legal Aid. In this situation this very vulnerable family who have few resources, have had no legal advice whatsoever. The parents have had [redacted] years of Legal Aid. I don't think that's fair at all. Their children are not really represented by the department. They need their own representation. The foster parents need legal support. They haven't been able to get it. I that it's a really important thing in this situation where the foster parents are often in conflict, potentially with the department over decisions, but they need legal advice, legal support and I'd be recommending that.

Finally, I just really think it comes back to I think our legal system needs looking at. The adversarial nature is not working very well at all and that is I think the critical point. Everything else will flow from that really I think. It is a complex system, but the apex of the system is really the law. Finally, I think the law has to recognise far more the children's rights. The children's rights, though it is written in as the children's welfare is paramount, in practice that doesn't seem to be what's happening in a lot of cases. That will do me. Thank you.

MR CUMMINS: Dr James, thank you very much for coming forward, for your skills, your insights and your experience. Prof Scott.

PROF SCOTT: Thank you, David. These have been long-standing concerns, as you and I know.

DR JAMES: They are.

PROF SCOTT: I'd like to ask two questions, one is about what you've said, one part of it around permanent care, and the other is something that you may or may not wish to comment on, but is the role of a comprehensive paediatric assessment of all children as they enter care and how that system may or may not best operate, but if I can start firstly with what you've said.

The current legislation, if it were followed, some would say, and I would agree, would allow for timely permanent care orders and for a recognition of cumulative harm. Given that that is not occurring, and the case you cite is just one case in point, what are your thoughts about actually reducing discretionary judgment in such cases and moving to a legislative process which occurs in some other jurisdictions when a child has spent that proportion of their life with their foster family. I mean the children you're talking about, are we talking about 90 per cent of their life or a certain period of time, that in fact there is a default position, which is something like a permanent care order, where a compelling case would have to be made to in fact not go down that route.

DR JAMES: Yes, I'd be very supportive of that because I mean the legislation is like 700 pages or something and it's pretty hard going, especially for an older paediatrician, but that's why I think reversal of the onus of proof almost needs to apply and your concept of a default after a period of time, one hesitates - and I don't like to be too prescriptive - but having some guidelines and default positions that would prevent some of these things happening, I think. I'm not sure, I think there is more to it than that. These cases will always end up I think in an adversarial position because it's such a critical decision, so perhaps the adversarial nature having an inquisitorial system may work better for non-out-of-home orders, but I'm not sure when you're going for a permanent care order, whether you are going to get away from having the QCs in court really, but I think we can certainly do better. If it was mandated, I think that would be good.

PROF SCOTT: Thank you. The second point is about the comprehensive paediatric assessment of all children coming into care. Some would say that could be a general practice specialised assessment, others would say it needs to be done by a paediatrician. What are your thoughts on the best way of getting a comprehensive health assessment of a child, including their mental health, and a way of ensuring that needs identified are actually followed up?

DR JAMES: There is two parts to that. I can remember doing some research in this area about 20 years ago, looking at kids entering care and using an assessment with a maternal and child health nurse and I think the department published that years ago. They've actually got much better systems now, but they're still not following it all the time. For instance, a critical thing when children enter care is just to measure really basic things, like measuring their height and weight.

For instance, I had a child recently who grew [redacted] when [redacted] removed from an abusive situation. Now, if you don't have those measurements, critical information is lost. I mean that was

clearly a case in which the (indistinct) of the child's needs were not being met and it took a while. So I think a comprehensive medical assessment needs to be done as soon as they are admitted to care. It is not necessarily the job of a paediatrician, but if you're going to have it done by anyone else, we need good guidelines of what that comprehensive assessment is and there's lots of programs that do that, what a comprehensive plan means. That's not hard. That could be done by a nurse, practitioners, or GPs, but it's probably best done by people who do a lot of it, so maternal and child health nurses for the younger children would be perfectly adequate, especially if they were trained, but the big thing, as you mentioned, Dorothy, is following up on that and what it means.

Unfortunately, just getting information is very difficult because of all sorts of complex reasons. For instance, if you are doing a comprehensive assessment you need to know, if the child is small, why is he small? If he's delayed, if he's developmentally delayed, why is that so? If both parents are developmentally delayed, both parents are short and there is a familial short stature, familial intellectual disability for instance, that might be relevant, but if you don't know that, you're not able to provide advice. Often the system, particularly the junior child protection workers don't have a clue about what is required and the seniors don't either, to be frank.

I've had quite vigorous discussions about this, trying to get information. For instance, use of alcohol during pregnancy. In certain parts of Australia, especially the north, but all around, the effect of alcohol on children is massive. If you go to the Kimberley, where I was recently, there is huge numbers of children damaged by alcohol, as there are in the Northern Territory. Here, we have the same thing to some extent. That sort of stuff, that sort of information is vital, but we're not getting it and we're not getting the information because it's refused. We can't ask, "That's private information." "Does the mother have a mental health problem? Does the father have any convictions for paedophilia?" "No, that's private information. Can't be given." That's the sort of attitude of the department. So that sort of lack of openness and very abusive privacy laws is widespread, in my opinion. I don't know how to implement the program, but I think it's a very important thing to have a comprehensive plan and to stick to it.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales?

MR SCALES: No, thank you.

MR CUMMINS: Mr James, thank you very much for coming forward.

DR JAMES: My pleasure, thank you.

MR CUMMINS: Ladies and gentlemen, that concludes today's Public Sitting. It's been a full one from 10 am, so thank you so much for your presence and your participation, and particularly to the Secretariat who enabled it all to happen and to the staff of Broadmeadows who have been supporting us as well, so we wish you well and we now conclude today's Public Sitting.

AT 4.22 PM THE INQUIRY CONCLUDED ACCORDINGLY