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TRANSCRIPT
OF PROCEEDINGS

PROTECTING VICTORIA'S VULNERABLE CHILDREN INQUIRY

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

DANDENONG

9.03 AM, MONDAY, 11 JULY 2011

MR CUMMINS: Good morning, ladies and gentlemen, a very warm welcome on a cold day to Chisholm. We would like to commence by acknowledging the traditional custodians of the land upon which we meet, the Wurundjeri people of the Kulin nation and we pay our respects to the elders, past and present, and we trust their elders also in the future, and we pay our respects also to any other elders who may come during today's proceedings.

This is a Public Sitting, ladies and gentlemen, of the Inquiry into protecting Victoria's vulnerable children. We are holding a series of Public Sittings across Victoria from the CBD on Swanston Street, on the corner of Collins Street, the Melbourne Town Hall, so it's pretty central, across to Bairnsdale, Wodonga, Mildura, Warrnambool and the many regions in between and of course in the metropolitan area, including relevantly today.

As you know, ladies and gentlemen, the nature of this Inquiry established by government in January this year and to report in November this year is systemic; that is to say, to look at the system of child protection in Victoria. It is one which is focused on the future, in that we seek to learn from you as to the system and the way it can be improved for the future. It's not an Inquiry which looks at individual cases or individual organisations. Indeed, our terms of reference proscribe us from doing that. Although of course we can be informed by individual cases, we do not investigate them as such. The Child Safety Commissioner or a Royal Commission or an Ombudsman can investigate individual cases; we do not.

It is essential that we do look at the system as a whole and I'm quite sure we'll be most assisted by your submissions on the question of the system and the question of improving it for the future. Because it's a Public Sitting, ladies and gentlemen, and what you say is transcribed and is published on our web site to the world, bear that in mind, ladies and gentlemen. It's a Public Sitting; whatever is said is published progressively, not just in this building but electronically.

It is not a court of law, ladies and gentlemen, and thus the normal protections in a court of law against defamation do not here apply. I'm sure none of this applies to any of you personally, but bear in mind that it is not a court of law, it's truly a public event. Also, you will understand that under the Children, Youth and Families Act, there is a provision which proscribes - that is, prevents - identification of persons who are the subject of or have been the subject of Children's Court proceedings, including not just the parties, the children or their families, but also witnesses. So again, I'm sure you will bear that in mind.

We are pleased, ladies and gentlemen, to commence with Eden Parris and we will proceed. Please come forward, Eden. Eden, we're happy to proceed with

whatever is the most convenient way for you.

MR PARRIS: I've just got a short statement that I might read.

MR CUMMINS: Yes, that would be good.

MR PARRIS: I work as an advocacy coordinator for a government-funded disability advocacy service and I am also a foster carer. In terms of my employment, over the last decade I have worked on behalf of a number of groups of marginalised Australians, including those affected by homelessness, those with substance abuse issues, those with mental illness, and at present I work on behalf of those with serious disabilities, including cerebral palsy, motor neurone disease, muscular dystrophy and autism.

However, there is no group on behalf of which I have worked that were as profoundly marginalised and disadvantaged as the group of Australians with whom I worked for a period several years ago. The group to whom I refer are those teenagers who are in state care and have been placed together in residential units, commonly known as resi kids, and I worked as a resi worker in a department-funded agency across a number of homes.

I want to first say that anything I say today is in no way directed against the children who call or ever have called a resi unit their home, or to the many dedicated workers who have done their best within that system. To both groups, if there are members of you here today, I honour you and I take my hat off to you. What I am speaking about is the system itself.

Residential units of this sort are found throughout our city and frequently appear as normal houses from the outside but that is where the similarity stops. They are home to usually between three or five children and the one I worked in had an age range of 12 to 18 years. They are staffed 24/7 by agency staff. The children are free to come and go. One of the rooms in the house is usually converted into an office for staff.

I said a minute ago that no group with whom I have worked was as profoundly disadvantaged as resi kids. Why is this so? Because with all the other groups I have mentioned, ie, those affected by homelessness, mental illness or disability, the problem is usually a lack of access to resources, a lack of access to the system supports; for example, a lack of access to housing or appropriate mental health supports or appropriate disability supports. The difference, when it comes to resi care, is that it is the system itself that is causing the damage.

The agency I work for relied on about 50 per cent casual staff. Straightaway that is a problem. There is no continually or relational base formed with the highly-vulnerable children in its care. On my very first shift, I was struck by

the way the workers told me, "We don't refer to them as 'kids'. We refer to them as 'little shits'." I was struck by the way the staff were locking themselves in the room for the majority of their shift, while the kids banged and bashed and wreaked havoc in the house outside. I was struck by the way the kids did not go to school and that that was generally accepted as okay. I was struck by the way the kids roamed the streets during the days and would only occasionally come back to the house sometimes if the police had been called to bring them back or to take them to secure.

Kids would try to break into the office, staff would lock themselves away. A common term used amongst staff was "contamination". The term "contamination" refers to the situation where a child, usually a younger child, maybe more along the range of 12 to 14, would be placed in a resi unit usually because of a breakdown in the home environment and behavioural concerns and yet before too long was being introduced to drugs and to crime by the older kids in the unit. There was nothing therapeutic at all about this environment. It was glorified babysitting to ensure that we as a society are not seen to have street children. It was a holding pattern until the children turned 18, at which point I believe they may indeed have been directed to caravan park accommodation.

At one of the units I worked for, the morale was at an all time low. Half the staff was off on stress leave. There are a number of practices in resi units which could be termed enabling behaviour. For example, we were told that if the kids wanted to be driven somewhere, we needed to take them. So we would frequently drive a couple of the children down to the shops. We knew they were going there to either purchase or steal chrome paint. They would buy the paint or steal it and then inhale it in the park and then we would need to go and pick them up and bring them back to the house, where the chroming would often continue in the bedroom. On one occasion, a child sliced their wrists, sucked the blood and blew it at the workers through the screen door.

I'm giving you these examples not to be sensational, but to point out the extremity of the problem. Workers on about $20 an hour with minimal training were put in charge of these children. As I said, many of them were casual workers who would have never met the kids before that shift. I remember a 15-year-old who was literally frying his brain from excessive cannabis use, and this was tolerated by the staff. He would just have an arrangement where he would walk out onto the nature strip on regular intervals to get stoned and then come back into the house.

Case managers had dozens of children on their books and could not provide the interventions needed. There was a fatalistic mentality that pervaded the department and the agency with which I work which said that there was nothing that could be done and that these kids were already too damaged and

that it was just about keeping them alive. But to put children into such a holding pattern, to put some of our most vulnerable citizens into a holding pattern like this in these crucial formative years with relational discontinuity, casual staff coming and going, to accept the corrosive destruction of contamination, throwing kids together with other children who may be more damaged or have more risky behaviours, to accept that all we can do is keep them alive, to accept that the idea of school attendance is a distant dream, to accept that they will necessarily roam the streets of our city at night is, in my view, systemic child abuse.

It is such a corrosive and damaging system that I said to myself if I ever had the opportunity, I would speak up about it, which is why I've done so today. The truth and the important thing to note is that it does not have to be this way. Three solutions come to mind. The first is early intervention, a strengthened foster care system. My own experience as a foster carer is that children who may be suffering from ADHD, may have behavioural problems, whose home placements have broken down, can be successfully fostered. However, these children are often presented as having no alternative but to enter resi care.

How might the foster care system be strengthened? More intensive and paid foster care training, promotion of foster care as a value in our media. If our government is able to promote with millions of dollars big picture ideas such as the carbon tax, why are we not, as a society, able to promote the value of foster care to our community? Payment to honour the work to work as an incentive. The reality is if something is seen as a lower valued occupation or role in society, it will necessarily have that role. It's not obviously about money for foster carers, but it's about some way of holding up that role in society and if foster carers were given intensive training, perhaps you could have a second class of foster carers who were willing to work with some of these most troubled and disadvantaged children, who were given the adequate training and a higher level of pay as an incentive.

There must be a way of encouraging families, encouraging individuals to step into that. The second suggestion I have is that the therapeutic model of resi care, which has been in place for a number of years at the Hurstbridge farm and, as I understand it, has worked successfully, needs to be worked out across the board. It needs to become the standard, not the exception. There is no reason that if a model has been found both here and overseas that is producing better outcomes, that it not be rolled out completely. The third suggestion is outback interventions, compulsory outward bound courses for children in residential care. I have a colleague who used to run one-on-one bush outward bound type experiences for resi kids and would see immense transformation of those children within the course of a week and yet it would break his heart, he said, to have to return them to the unit. These are the sort of things that the government should be investing in.

My final suggestion is that anybody who is involved in policy creation with respect to children at risk, particularly with respect to this group of children who are likely to find themselves in resi care, needs to go out and work a few shifts in a resi unit. Anyone from the minister down needs to do this. I'm not talking about a special visit where the red carpet is rolled out and the place is tidied up and only the best kids are at home on the day. It was said by Mahatma Gandhi that the measure of a country's greatness should be based on how well it cares for its most vulnerable populations and it is my submission that there is no more vulnerable population to which this applies than resi kids.

MR CUMMINS: Eden, thank you very much. That's most thoughtful and presented with feeling, which we respect. The fact that you have thought about this over a period of time obviously and come forward for the reasons you've stated, this being the opportunity to say what you have held in your mind and heart over a long time is most valuable and it's particularly good that you have your three solutions towards the end, plus the extra suggestion, because that is a systemic positive set of proposals. So thank you very much. Prof Scott?

PROF SCOTT: Yes, I do have some questions. Sadly what you've described is what the Auditor-General described in 1996, only you've done it more powerfully and very eloquently, and two decades on this situation can still be described and seen again. There were two things that really interested me. One was that you thought there was the potential to have professional foster care and certainly in New Zealand there's a multisystemic therapy program with paid professional foster carers dealing with very troubled young people in the way you describe and embedded with other supports.

But the other thing that really interests me in what you were saying is that you were really, to me, criticising a laissez-faire permissive ideology or philosophy where there's freedom of movement, freedom of association and I don't want to put words into your mouth but can you say a little bit more about this issue of, say, a compulsion to participate in outward bound. It seems as if you're saying a very vulnerable group of young people need care and control and yet we operate in now a context in which you've described some of the care and you've also described some of the lack of controls. Can you venture into that difficult area about control, about physical restraint, about compulsion, about where authority may need to be exercised to get the outcomes that you need while understanding, of course, that it is not all that is required.

MR PARRIS: Yes, as I stated, professor, the focus I believe needs to be on the early intervention and the strengthening of foster care placements because I believe that if that was done correctly the population of children who would find themselves in resi care would be much less; it would be a lot less just in terms of numbers. But for those who are in resi care at the moment or who

may find themselves in the future, despite the best of intentions, I do believe that what vulnerable children are crying out for is boundaries and I believe that the system at present provides no boundaries, it's completely laissez-faire and permissive and it doesn't do the children any favours.

If you're asking me how exactly that needs to be configured, I would just need to say I'm not a child psychologist, I don't feel I've got the expertise in terms of particular designer programs. All I know is that in terms of a friend of mine who did the outward bound programs I think initially there was resistance and coaxing, for example, to get the child to go there but within a couple of days they didn't want to go back. So there might be need to be some form of general coercion to get children to enter into therapeutic environments or programs but my understanding is that they have an intrinsic value and once the child experiences them, then it will be a voluntary participation.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales.

MR SCALES: You raised a number of issues around the whole issue of training, both for people in residential care and also for foster parents. Do you want to give us a bit of a sense of what you had in mind when you were thinking about that as for training and development of people in those areas?

MR PARRIS: If you think about the workers, why is it possible that in most areas in our society we need qualifications and yet people quite easily walk into casual relief positions with these most vulnerable of children with no qualifications, simply with police and Working With Children checks. It's an industry in crisis and I think it does go towards the issue of pay. I think if the pay was substantially increased it would therefore attract more people and people of higher professional calibre and then you could also incorporate a diploma or something, a cert IV in a relevant topic. You could design a course particularly for this. It requires so much of the worker. It requires so much.

MR SCALES: Building on your own personal experience, let's just combine that with the discussion that Prof Scott had with you around boundaries of children that are involved in residential care, for example. What would have helped you? How would the system have been constructed in a way which gave you the opportunity as a residential care worker to create some boundaries to be able to provide the, if you like, support, care and maybe even discipline? I don't mean that in an pejorative sense but in the sense of which I think you're trying to describe it, combined with the sort of training that you're suggesting. How would that have been configured in a way that would have helped you?

MR PARRIS: I believe I would have needed to have done some training

before taking the role up.

MR SCALES: Yes.

MR PARRIS: I believe once in the role to be in an organisation that didn't rely on 50 per cent casual staff so that there was a continuity and sense of unity among the team and obviously ongoing, compulsory training along the way.

MR SCALES: That is helpful. Let's talk just about the team for a moment. Am I right in saying you've worked for a number of community based organisations that would have been involved in residential care?

MR PARRIS: No, it was only one.

MR SCALES: I don't want you to be too specific here - - -

MR PARRIS: No, I won't.

MR SCALES: - - - so please understand that. But I'm trying to get to the heart of whether what you observed and experienced had anything to do with the structure of the organisation itself. I mean, would you have described the organisation as being well managed? Was it able to put in place the sort of systems that you would have hoped for or are you really saying it was the system that wouldn't have allowed that organisation to do any of those things in a way which would have made much of a difference?

MR PARRIS: I think the organisation I worked for was not necessarily well managed by my understanding is it was constricted by the broader system and it was operating in a climate where, as I said, there's chronic shortage of suitable workers. My understanding from colleagues who worked for other agencies is that it was a widespread problem. The problems I'm describing today are not limited in any sense to the particular agency with whom I worked.

MR SCALES: Okay. Thanks very much.

MR CUMMINS: Eden, that's been most valuable. Thank you very much.

MR PARRIS: Thank you.

MR CUMMINS: Next, Ms Holly Reid, Menzies. Welcome, Holly. We are very pleased to hear you in whatever is a convenient sequence to you.

MS REID: Thank you very much. I appreciate being here. Please excuse, I'm coming off a sickness. I've written down a few thoughts here. I don't come

with horror stories. I come with a few suggestions and a few concerns that I think, not having had the chance to give you a written submission, I needed voice and come today to provide that. I have given a brief background in front of you of Menzies. I know some of you do know all of this but I think it's important to note that some of our organisations have a long historical context and they have changed over the years because of society's demands. Founded in 1865 in Melbourne, it was the Latrobe Street Ragged School and Mission for Boys. You can imagine the political correctness of that kind of term now.

They moved to Frankston in 1901 to get the boys out of the city and established a major orphanage for boys, the Minton Boys Home, in 1924. In 1943 to 59 it became the Menzies Home for Boys which later included girls and in 1965 Menzies sold the "home on the hill" as it has been affectionately known in Frankston and purchased 10 family group homes for boys and girls and Menzies was one of the first in the state to do so, as I understand. In 2003 residential care reduced to four homes and Menzies purchased Sages Cottage Farm in Baxter to provide a variety of children's services.

So we have gone from an outreach program to orphanage to family group homes and now we're looking at therapeutic care. We have a therapeutic residential care pilot which I will talk about in a moment. But also at Sages Cottage Farm we provide an animal assisted therapy program that helps over 50 local children annually in social behaviour modification caused by domestic violence and trauma. In addressing the Panel, I would like to point out our main concerns with both the Victorian child protection and out-of-home care systems. Obviously we run a residential care program, not foster care or anything like that, so I direct my comments to residential care.

MR CUMMINS: Yes.

MS REID: We also wish you to know which programs are working and what our recommendations and endorsements include. Our concerns are divided into two different groups, one for young people and one for our organisation surviving so that we can provide the services to young people.

There seems to be little flexibility in placements. We have four young people placed in each home with little care as to the mix of their care needs and their subsequent fit with the group. On a Friday at 5 o'clock we could place Billy at a certain home and that has to be done because we're told it has to be done. So it's a kneejerk reaction and often doesn't work. Also, some regions, I understand, allow five young people in a home; the model here in the southern region seems to restrict us to four and I don't understand that. So there's that inflexibility that I would like to explore and point out.

There are no real choices for young people when leaving out-of-home care,

particularly no provision in the region for young mothers before and after their children are born, so it would be great if we could establish some service for leaving care for these young mothers in this region.

Mildly intellectually disabled young people need appropriate placements after care and it's been extremely difficult to find a good fit within the disability sector. We're trying to explore that as well. There is little stability for educational continuity, as many young people discontinue school before finishing due to turning 18 midyear and they have no stable placement after leaving out-of-home care. For example, if a child, a young woman turns 18 in July and we have to say goodbye, it's very, very difficult for her to stay in school, especially if she has to move away.

Case management for young people often remains with DHS but would be better served by case managers within the agency who do the work already. That is a concern for the young people. The workforce, I know has already - you've heard about workforce, and we've just received press releases from Mary Wooldridge's office about what she's doing with workforce, but you're going to hear it again.

MR CUMMINS: That's all right. That's what we're here for.

MS REID: The low pay and the high stress cause high staff turnover and that affects the stability of role models and relationships with young people in out-of-home care. We know - and it's been evidence based research - that relationships are what it's about and this is what young people need when they come into care, some trust in a relationship, and with staff coming and going all the time, that's difficult.

There is an inability of the system to ensure accommodation of siblings within the same home and agency, and I know that's a luxury but it really, really does matter when young children come and brothers and sisters are split. We see the ramifications of that in a lot of our homeless people in the community now.

Our concerns for Menzies - I'd say this because organisations often struggle and they struggle in different ways - there is no security of funding at least that we're aware of beyond June 2012 for this most successful therapeutic resi care pilot that was first funded in 2009 and without that funding, we can't plan, we can't look ahead and know what we're going to be doing with those children or with the program, and we can't continue with the service which has been externally evaluated with a plan. There are few or no plans exist for replacement purpose-built housing. I see them on a list but I've seen them on that list for three or four years. I don't know what's going on with these purpose-built houses which look terrific but it's just frustrating for us to plan as an organisation without knowing when we can get purpose-built housing.

Case management I've already mentioned but Menzies has only five of 12 possible young people at the moment under contracted case management and this affects our funding as well as the wellbeing of the young people. As registration compliance requirements have become more onerous, costs have risen with no funding given. Smaller organisations feel the squeeze. Workforce stress claims for WorkCover cause organisational stress. At the moment we're okay, but I know that some organisations have five, six, seven WorkCover claims and that must be very, very difficult for those organisations to carry on.

Evidence based programs of early intervention and prevention such as our animal-assisted therapy which works for eight to 12-year-olds on a day program, they're given no financial support from DHS and we've approached and been told that there's no money, but without this, we cannot afford to continue this program which supports so many local children.

What is working well? The therapeutic resi care pilot, I just want to tell you, it has been a very successful program and that's why I'm telling you this, because I commend it to be rolled out across the state. It has made such a difference in the lives of these young people.

MR CUMMINS: Yes.

MS REID: Okay. A residential care program for severely disabled young people, autism spectrum disorders, Menzies is the only provider of such a service for children in our region and I believe there's more demand for that. I don't know all the statistics but it's been a real eye-opener and wonderful for our staff to have that ability to work with these children and to help them, so that's working well.

We have a respite care service for disabled young people living in foster care placements and we've been able to maintain that placement which saves the government costs, so respite beds in residential care homes do work or can work. Being one of the smaller agencies, Menzies has developed a supportive culture for staff and young people who get to know each other across the organisation and I'm just pointing this out because some of the smaller organisations have that benefit. We know the children. I go and eat dinner with the children. They know who I am. We can become a family. So the larger organisations, where they provide many, many benefits, perhaps don't have that close culture.

Sages Cottage Farm also gives Menzies scope to develop new programs, often a partnership with other agencies serving special needs of local people. My recommendations from our point of view is to establish some sort of reception

centre within the southern region to make assessments about the best placements for young people when entering in care, and Menzies is prepared to take this on if given the chance. We do have one home that was supposed to be like that but these children are staying longer and longer and it's not a reception centre at all, it's another residential home.

We need more government support for smaller agencies to ensure their viability within local areas to serve the needs of local young people and their communities. I am on the board of the Centre for Excellence, Child and Family Welfare, and head a small group - it's a small group but it's a small organisation - to try to tease out some of the issues of our value to the local community and a lot of that is back-of-house problems. Our connection with the local community is enhanced but we really need assistance. We could take that model of the Department of Education where they do provide some sort of stipend or bonus - I'm not sure exactly what it's called - but some package of money for smaller schools such as Buninyong Primary School, which I would imagine gets some extra funding because it's on its own and has so few students and staff. So smaller agencies, if we were assisted somewhat - not a huge amount of money but somewhat - it would go a long way as to making sure we were viable.

We recommend to continue the therapeutic resi care model and provide funding to implement therapeutic practice across the out-of-care home care system, and our last recommendation is that young people need that option of remaining in out-of-care until they finish their education. I'm passionate about that as a past educator. Midyear 18th birthdays should not prevent young people from remaining in school. By requiring them to move, they often cannot remain near their school. If we can change that mandatory leaving age till when the school year finishes after they turn 18 and provide support to these students, they go away with a piece of paper; as it is now, they often never get it and they have worked so hard to get that close and then they're out and we can't help them.

Menzies Inc endorses many of the recommendations put forward by the Centre for Excellence, including the establishment of the Independent Office of the Children and Young Persons Guardian and that the minister of consumer affairs take on the registration requirements for all community service organisations that's separated in that funder registration role currently with DHS. Thank you.

MR CUMMINS: Holly, that's most helpful, if I may say so. Thank you for that and thank you also for your very valuable work. Prof Scott.

PROF SCOTT: Yes, thank you very much. I think people have often spoken about the disadvantages of small organisations; you've emphasised some of the

advantages. I wonder if you can say a little more about how the local community actually supports you, perhaps in funding, perhaps in boarding arrangements for young people leaving care, employment experience, work based experience. How, if you are, is it possible for a small organisation to draw on the resources in a community that might make a difference for young people compared with a much larger organisation without close community contacts, so social capital. Can you tell me about how that works for Menzies or doesn't work for Menzies?

MS REID: I think it's working. I think it's building on it. A lot of people, as soon as the home on the hill disappeared, the services disappeared because they didn't understand that they went into the community, and that was a long time ago. So we can't put kids in the parade. I can't say, "Here are the Menzies kids," like private schools would do if they had a parade or major civic function. So we do involve the community; in fact I just left early from a business breakfast that we hosted down at Sages Cottage Farm this morning because I thought this started at 10.00. Anyway, we had about 15 people who came to hear more about us and to listen to the Mayor. We had the local member of parliament there and everyone is trying to get their head around youth and what are the problems with youth; not just at Menzies but really in a broader social context in Frankston.

So we invite people in. Our cafe has traineeships. We have a horticulture, nature, conservation and land management traineeship that we provide and one of our resi care kids was part of that and did his traineeship and that helped him become a part of the community and understand what volunteering is all about and gained some really valuable skills. Some of our other residential care children have volunteered in the cafe and I think that's marvellous that they understand the value of volunteering. I always introduce them to people in the cafe if they come in and say, "This is Susie, she's one of our trainees," or, "one of our volunteers," and it helps them connect with the community and have the community connect with us. Those are just tiny examples.

PROF SCOTT: They're nice examples. Can I also ask how you deal with issues - I don't know if you were here before when we were having a discussion - about difficulties in residential care around being able to encourage young people to attend school and some of those issues around limit setting, around substance misuse et cetera. What would Menzies do in a situation where a young person was resisting, say, attending school? How does your organisation see and respond to that situation?

MS REID: We've had a good track record of children remaining in school but recently of course there are some who refuse to go to school. They're not just the 17-year-olds, they might be the 13-year-olds, and this is tragic really. So we have prepared some home schooling programs, but our carers are not

teachers. They don't understand how to really make work interesting and present the curiosity that needs to come when you're engaging in work sheets in maths or a little bit of work on the computer. It helps fill the day but it's not really what I would call education, and they don't have that social interaction which is the most necessary part of education I think to understand being in a classroom, in a leadership group, on the stage, in the band, all those things that education can provide. So we really try to cope with getting them back in.

We've explored many alternative schools. There are a few alternative schools that really work. Some of our mildly intellectually disabled children going to special schools; in fact they're probably the better school attenders than some of the others. But the special schools have been very helpful for us and engaging with disability, we've made some good strides there. It's a constant battle if a child doesn't want to go to school and refuses to do work at home. It is difficult. I don't know if Menzies does it any better than anyone else.

PROF SCOTT: Thank you. I've got a couple more questions, if I may, Mr Chairman. One is about the model of reception care that you would envisage. I think you've made a very good point that if you have a young person coming into a residential unit or family group home environment at 5 o'clock on an afternoon, it's hardly a home. It may be housing but it's not a home for that group of young people who are already there. There's enormous instability in that and I can see why you would argue for a reception facility that would then allow a more individualised matching for a young person going into the more stable form of care. How would you see that working? What size would you see is appropriate? What would be the staff model and the mix, the ages of children and young people? Could you say a bit more about the reception care model?

MS REID: Yes, I couldn't say ages of children because all children coming into care would be able to come in and be assessed. So often we don't have the material given to us, we don't get the whole referral. I'm not complaining; that's just the way it is. So we get the child and we really don't know that there's a great deal of sexualised behaviour happening with this child and then he comes in with other children who are not going to benefit from that kind of behaviour. So it becomes this whole re-engaging about the pecking order, who's going to be on top, who are the dangerous ones, who are the bullies, and it takes them maybe not too long but a week or so to figure that out. Then if you have someone going and then coming in immediately like that without having been assessed prior, it changes the whole dynamics of the home. So a reception home would enable counsellors to come in and assess, child protection workers to come in and assess the children, instead of all this crisis-driven kneejerk reaction, "Quick, get a bed."

PROF SCOTT: Thank you. The last question is really about your work with

children with a disability, both the autism spectrum disorder and the young people with a mild intellectual disability. I wonder if you could clarify for me, are these people who are in state care for other reasons, for protective reasons who happen to have a disability?

MS REID: Yes.

PROF SCOTT: Right, okay. The funding to Menzies for their care comes out of Child Protection rather than out of Disability within DHS?

MS REID: That's correct, yes. So they're in the child protection system.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales.

MR SCALES: Just to follow up on that very last question, there is no Commonwealth funding for that?

MS REID: I don't believe so, because the pilot is state funded.

MR SCALES: Okay. Just check, and if there is, that's fine, but if there's not, that's fine too. Can I just follow up on a couple of questions that Prof Scott has mentioned, not in any particular order, but let's take the issue that you raised I think not only in your written submission but also just a few minutes ago about what I would describe as, if you like, lack of planning for what the demand might be for children in out-of-home care.

To put a bit of context, it seems to me what you're describing is a situation where it's unusual for there to be a broader plan that says, "Over the next 12 months, two years, five years, we may need to have various forms of residential care." It may be residential care like the one you described that will make an assessment of the child, then make some sensible determination about what is the right form of residential care for the child, whether foster care might be the best approach rather than residential and so on and so on and so on. Do you know of anything that's happening in Victoria where any of that such planning is going on?

MS REID: I don't, I'm sorry. You know, when you come to work and you get focused and you're right there in your own organisation, you try as much as you can to learn about others, but I don't.

MR SCALES: But in terms of Menzies, would you ever be involved in a discussion about what might be the likely future demand for the various children who might need to go into residential care for a whole range of

reasons?

MS REID: Yes.

MR SCALES: Have you ever been involved in any discussion of that kind?

MS REID: Yes. This is not my idea, I just endorse it as what I think is a good idea because I've heard it mooted in other forums.

MR SCALES: But have you ever been involved in any such discussion yourself?

MS REID: Around the table, yes.

MR SCALES: I'm trying to think about it, in any organised way either with the department or anything like that?

MS REID: No.

MR SCALES: But amongst your own colleagues, you've talked about the need for such an opportunity.

MS REID: Yes. But sometimes when we meet with the department, these discussions do take place - - -

MR SCALES: Do they.

MS REID: - - - as generalised, "What about this? Would you consider - - -"

MR SCALES: I'm sorry to lead you on this, but is there any formalised process that Menzies would be involved in, for example, would anybody ask you for the data around what is the likely requirement of Menzies in terms of their clientele for residential care over the next two, three, five years?

MS REID: I haven't been asked that.

MR SCALES: Thank you. Can I talk a bit then about the education issue that you've raised and I think also Mr Parris raised it similarly. A number of people have talked to us about the same thing and what they seem to be describing is a very different pedagogy, if I can describe it in those terms, for the way in which we might think about the education of children in care, that it's not like any other form of education for all of the reasons which I think Mr Parris and you also have described. Is that an unreasonable proposition, that we should be thinking about education for children in care very differently than the way in which we think about children who would normally go to a primary or

secondary school?

MS REID: I think we do need to think about it differently but not necessarily treat it - you know, that the outcomes should be the same.

MR SCALES: Yes, that's right. No, I'm not arguing outcomes should be different.

MS REID: Okay.

MR SCALES: I'm not arguing but other people have argued to us that to get to the same outcome as a child who would go to school in the normal way, whatever that normal is these days, we would need to try and construct education for this particular cohort differently than we might construct for others. Is that your experience or do you think we can - fit is not quite the right word either - accommodate children who are in care within the existing education system?

MS REID: Often we label children in care as, "He's in care, he's a disruptive child," and it's the disruption that gets them out and school can't cope with that and I understand that, rightfully so. However, if we know that there are trauma issues within this child and complex behaviour problems that need to be addressed, yes, we do need to treat them differently on a case by case basis, so give them that support. You can't just sit there and fiddle when you've got Tourette's disease and you can't pay attention in class. So we do need to treat them differently if they are identified specific problems. But if they're not, I think we - the more normalisation we have with children in out-of-home care I think the better. I often just say we try to give them a normal life.

MR SCALES: Thank you. The last question related to your suggestion that relates to how a child leaves care. Do you have any particular views about what a system, what a program might look like to assist a child to leave care?

MS REID: I know there is Leaving Care brokerage now, so there are some organisations that provide this. What we're finding though is that it doesn't cater for young mothers in this region and it doesn't cater for mild intellectual disability. When these very complex young people leave the system and they have such specific needs, such as looking after children or a brand new baby with all sorts of complications, or if they just can't cope in the wide world without a slew of services that they've been connected to, the placements can be very difficult and a young 17-year-old or 18-year-old woman is often placed then with a 40-year-old guy in the house and I just don't think it's appropriate. It's very difficult.

We have been able to have some great liaison recently through our pilot with

disability so some of those silos have broken down which is really good but we really need to attack that Leaving Care and get people to understand that these children need specific housing somewhere that can handle those needs.

MR SCALES: So your model of addressing that would be through some form of brokering approach where you can sit down with the individual, determine what their need might be and then accommodate that through some form of brokerage.

MS REID: Yes.

MR SCALES: Is that the model that you were thinking about?

MS REID: Yes, that's correct.

MR SCALES: Thanks very much.

MR CUMMINS: Holly, thank you very much and I do commend you for your work on the cottage farm and also with animal-assisted therapy. Excellent.

MS REID: Thank you very much.

MR CUMMINS: Good wishes.

MS REID: Thank you.

MR CUMMINS: Mr Paul Bird, Mission Australia. Welcome, Paul. Just settle down there for a moment and we would be pleased to hear you.

MR BIRD: Thank you for the opportunity. I am Paul Bird. I'm the state director for Mission Australia. Mission Australia is a large organisation that works in 400 communities around Australia. Our experience comes from us as a service provider in Dandenong or Greater Dandenong and Frankston. We operate the Communities for Children program which is a federally funded program and we also offer a number of alternative education programs from young people as young as eight through to 19 for school leavers. We've also designed and run some family based programs in other states which are probably applicable to this Inquiry. One is Pathways to Prevention which is a Queensland based program which you may know and are happy to provide that. That was in partnership with Griffith University.

So my comments are really in respect to the system. Mission Australia is not a direct provider in the Child FIRST or other child protection system. But we work with families that do have children as part of that system. My first comment is it's difficult to know the extent of the issue because there is a lack

of data. It's very, very difficult to get data, especially around a region or a location. From our view in the south-east region Child FIRST is increasingly crisis focused as the resources are stretched and, as such, their work in the early intervention space is limited, including connection with other agencies.

Many CALD families are not aware or family services and as such they don't access family services and we would see a high number of early school leavers in the region. As I say, some from the age of eight. I have five suggestions in terms of improving the system: the first is there's an urgent need for a parallel investment in early intervention. Early intervention is a place based approach. One that uses existing community infrastructure and one that can focus on education. As an example, Mission Australia runs a program called Dads in Dandenong which has got referrals from schools, maternal and child health agencies et cetera. It works with potential perpetrators of violence, those where a child has undiagnosed developmental delays and ones where the family may be involved in shift work or casualised hours. We also run a program called Aiming High which is around single mothers, single teenage mothers who have left school early and this is provided at one of our childcare centres in Doveton whereby the mother completes VCE whilst their children are in care.

We would also like to advocate for alternative education for these young people in a range of settings. We're encouraged by the Victorian government's implementation of flexible learning options which allows a student resource package to be allocated to a child, to an accredited agency and a level of education delivered in an alternative setting as a transaction back into school. So Mission Australia doesn't necessarily support special schools or alternative schools, but the provision of education and support around the family in different settings to enable that child to come back. We have a number of those programs operating in Victoria.

My understanding is that the DEECD are implementing those flexible learning options which will enable the student resource package funding to be used in those settings and the budget announced three pilot programs in that respect. Mission Australia would also like to see service integration which enables joint and long-term case management for the child and the family members across a range of interventions, recognising that sustained behaviour change requires a longitudinal approach, such that one case worker can develop trust in the child and the family member and case manage a range of interventions over a longer period of time, for example, at least two years.

Mission Australia recognises that sometimes the service system is siloed, such that we all are funded to deliver a range of programs with a range of cohorts over different periods of time. For the benefit of the child and the family, those need to be integrated, so the child and the family gets the right service at the

right time. As such, that would mean that that child and the family has one senior case worker over at least a two-year period to ensure that happens.

Two other points: we'd like to see in the system a more localised response. We feel sometimes the regions are too big to enable that coordinated response. By becoming more local in terms of smaller areas, it enables those linkages with other service agencies to be identified more readily and acted upon.

Lastly, we'd like to see the government encourage more innovation, including between local state governments and service sector agencies; to encourage partnerships, to encourage new approaches, possibly more open tendering and outcome based funding; to enable different models, different approaches. You can call it "coordination", we call it "integrated" because there is a mixture of services that have very clear criteria around what you can do to deliver those services, and there are some programs that offer more flexibility, say, around some brokerage to actually develop new models, of which Communities for Children is one of those. So some of it is coordinating different services at different times because they already exist. Some of it is integration because there is a way you can actually build services together through designing something with that brokerage, and the supported playgroups' model is a good example. You're actually bringing a range of things together. So the maternal and child health nurse can come into that supported playgroup, for instance, so you enable some integration there.

I think the coordination of the integrated services through a case worker or case manager is extremely challenging in our system because we have a myriad of complexity of different agencies who are all funded at different levels in any particular area. We haven't achieved that, I don't think, in any sector. The closest we've come is the Better Youth Services pilots, especially the one in Frankston which have advocated an integration of youth services, starting off with a Youth Navigator. So starting off with a web site where you actually can know what's available in your area by answering a questionnaire. That's the kind of precursor to actually having common referral case management or assessment case management. So I don't think we've achieved that. I think it's extremely complex.

There's enormous issues around privacy. There are case management systems that can offer that. The challenges are we've had, what, two to three years of the Better Youth Services pilots which have now gone into youth partnerships. There may be an opportunity under that funding which has gone through DEECD. But I would suggest we'd need to work on a pilot in a particular area; that would enable that to happen. So I think that's a goal in our sector, but I think that it is extremely challenging to do.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales.

MR SCALES: One of the first points you mentioned was the lack of data. Can you give me a sense of what information you're looking for and how it would help you to do your job well?

MR BIRD: Obviously working with a number of families and the confidentiality and privacy arrangements, it would assist us I suppose at an area level to know from a macro point of view whether the instances of child notifications are going up or going down in any particular area. This area is particularly changing because you've got a metro area, Greater Dandenong, and you've got Casey and Cardinia as growth areas. So for us to focus our resources in this area, it would be helpful to know the trends in those notifications. It would also be helpful to have data in particular as micro as possible, so on a suburb by suburb basis, and then particular causes behind the data that we can relate back to our programs. So, for instance, if we see a big jump in data in a particular area, we can then link it back to various schools. We work a lot with young people who have left school early; we can more intensively with those schools. So for us, it's really a question of can we direct our resources better in a particular locality.

MR SCALES: Does that relate to the point that you made a bit later when you said "a more localised response"? Is that what you were driving at, the data linked to your ability to be able to plan to accommodate the need?

MR BIRD: Yes. I think at the moment, the size of the region and because of the complexity around the various agencies that are involved means the more local and smaller area you can have, the more integration between different agencies and services the better, yes.

MR SCALES: Okay. Did you have in the back of your mind that there would be an organisation or construct that would enable you to do that?

MR BIRD: Yes, a good example is Youth Connections which is a federally funded program that responds to 13 to 19-year-olds that have left school. Mission Australia is the lead agency and we basically coordinate a range of five other agencies, including Southern Health and employment service provider, Link, the task force, so there's a range of agencies that sit around the table. We have a common referral system and we have an allocation of one case manager to that. I'm not saying it's exactly the same as what we need, but that's the closest - - -

MR SCALES: Sure.

MR BIRD: It's a true collaboration. Again, they're not easy and they take time to develop. It takes time to develop the trust between the agencies, but our approach is we have to go down that direction. It's easier when it's focused on a local - if you're talking about a region that has different agencies in different areas, to have say more than five to 10 agencies around the table is getting more difficult.

MR SCALES: Thanks very much.

MR CUMMINS: Thank you very much. That's been most helpful.

MR BIRD: Thank you very much.

MR CUMMINS: Anne-Marie Laslett. Anne-Marie, thanks for being here and thank you for your written submission. You've been here a little while, so thank you very much on this cold morning.

DR LASLETT: Thank you.

MR CUMMINS: You can take it that we have fully studied your written submission, so you don't need to address it fully. What I'd like you to do is perhaps concentrate on the things you'd like to emphasise in an oral presentation, whatever suits you best.

DR LASLETT: Sure.

MR CUMMINS: Because you have data in here which we'd like to take away with us.

DR LASLETT: Sure, thank you. This submission draws on the work of the AER Centre for Alcohol Policy Research which looked at data on the range and magnitude of alcohol's harm to others and some of the work that I'm doing as part of my PhD looking at alcohol's role in child maltreatment.

Our work uses five years of deidentified Victorian Child Protection data and a national telephone survey of alcohol's harm to others. It's really divided into three sections. The first part of our research looks at that five years of data and identifies alcohol in a significant proportion of child maltreatment cases. That's not unusual. That's the case internationally and in Australia, but when we look at the numbers of cases, there were 38,000 cases that were substantiated in the Victorian state Child Protection Services between 2001 and 2005. Those rates were fairly stable over the five-year period, which you can see on the graph.

Alcohol abuse was identified in significant proportions in all different types of

child abuse; 33 per cent of substantiations, 36 per cent of cases that went further through the system in protective interventions, and 42 per cent of the smaller group that were eventually subject to court orders. Alcohol abuse was more common in emotional abuse cases and psychological abuse cases in particular and in neglect. It was more common than in the physical harm cases and the sexual abuse cases.

We did some multivaried analyses and we looked at all of the factors that went into some of these outcomes and the serious child protection outcomes were after adjusting for a whole range of other factors. So other drug abuse, mental health of the carers, socioeconomic factors, as well as whether the carer themselves had been affected by child abuse in their own childhood, alcohol still was a significant contributor to these more serious outcomes after taking into account all of these other factors. When we looked in particular at the social background of those children from families that were substantiated in the system, the group where alcohol was involved was more socially deprived than that group where alcohol was not identified.

We also looked at repeat cases in the data and we found that almost one-quarter of Victorian children in the child protection system were resubstantiated during the five years that were studied and they were substantiated on average 1.3 times in the data, and a total of almost 40 per cent of children who experienced these resubstantiated cases, alcohol was involved in these cases. Again, we looked at all the other factors. After adjusting for all of these other factors, alcohol was still a significant issue.

This probably moves a little bit away from the most vulnerable children, but we did look in the study at the general population. We looked at alcohol's role in alcohol-related harm to children and examined how children have been affected, who was reported to have harmed the children in the general population and what sort of backgrounds they came from. We looked at around 1100 Australian adult respondents who indicated that children that they lived with or they had a parental or a carer role for, of those 1100, a total of 22 per cent of respondents reported that children had been affected in one or more ways because of the specified or unspecified ways because of other people's drinking in the last year, and 3 per cent in the general population reported substantial harm from others drinking to their children.

Again, looking at those demographic characteristics of that general population group, we found that this group - there weren't great demographic differences. There were still effects across the range of social strata. When we looked at those children of those families where some form of alcohol-related harm had been reported, 61 per cent of children in the general population were affected by a parent, guardian or a sibling and 12 per cent were affected by other relatives because of their drinking.

So whilst the majority of alcohol-related harm identified in this study was probably unlikely to be severe that we found in the general population, it's of concern that one in five respondents reported that a child or children they lived with or were responsible for had been adversely affected by others drinking in some way in the past year. I guess that absence of differentiation by social demographic factors highlights that children from a wide range of social backgrounds experience harm because of others drinking, suggesting that alcohol policies with wide application may be indicated, rather than those which focus only on - single out those who are most vulnerable.

I guess bringing these different findings together from the Victorian Child Protection data and the national survey that we conducted, we can see that heavy drinking of others impacts on the relationships and experiences of children within families and is implicated across the spectrum of harm. At one end, alcohol is implicated in single incidents with perhaps relatively minor consequences, while at the other end, children are neglected and abused repeatedly because of the drinking of others.

So using the data we found from the Victorian Child Protection system, 0.3 per cent of Victorian families included one or more children who had been a victim of alcohol-related substantiated child abuse, and when we look at the Australian Alcohol's Harm to Others survey measuring the reach of these issues, 22 per cent of families reported that their children or a child had been affected in some way. So families in the general population who reported that their children had been a victim of alcohol maltreatment were far more socially advantaged than families identified in the Child Protection data, and the rate of alcohol-related adverse effects on children in the general population was some 60 times the rate of alcohol-related abuse identified in the Child Protection system. I guess that data supports a structural explanation where the most severe cases end up in the system, whilst less severe manifestations of child maltreatment are common but not managed by the system.

Alternatively, this evidence may be used to support a hypothesis that child abuse may be occurring at a similar rate in the general population but more economically powerful groups are less likely to be observed and managed within the system, perhaps as should be the case. Both factors are likely to be part of the explanation of the disjunction between the pictures from the two frames of data.

I had a small number of other additional comments on the terms of reference. The data quality that we see from the Victorian Child Protection system, CRIS, would be improved by changes that ensured that the risk factors were mandatorily recorded. This used to be the case between 2001 and 2005. Other changes would see parental alcohol abuse and other risk factors recorded both

for alleged perpetrators and for protective parents or recorded for each carer in the case. Referrals to alcohol and drug treatment systems, indeed all referrals, are not recorded well electronically, and having access to that kind of data would enable better monitoring of the system.

We received deidentified data from the Victorian Child Protection Unit and we were very grateful for that. However, in order to determine how some fields were completed, access to child protection workers for interviews were sought. This access was not forthcoming which made interpretation of the data field sometimes difficult. Whilst we understand the demands on workers' time, there is a recognised need for research to inform practice and future improvements in practice and that depends on accommodation of reasonable research requests.

Finally, we have a small number of recommendations: mandatory recording of risk factors and referrals from child protection workers in the CRIS data system would enhance the capability of the system to monitor both the epidemiology of child maltreatment and evaluate the outputs and effectiveness of child protection services. Children in the child protection system and those affected by others drinking but not identified as such in the general population experience the effects of the problematic drinking of their parents, carers and others. Both vulnerable and less disadvantaged children would benefit from effective alcohol control policies.

Population strategies that encourage pricing and licensing controls on alcohol and have an increased effect upon lower-income and younger people would probably be most effective in limiting these forms of alcohol-related harm. Treatment interventions are also called for when children are severely affected by the heavy drinking of those around them. Brief interventions may be useful in situations where the alcohol problems of carers are not severe or entrenched. Early diagnosis of drinking problems by maternal and child health nurses or family services might operate upstream to prevent entry into child protection services. Otherwise, referral to appropriate services for carers identified by protective services is crucial.

Individual-level alcohol treatment service options such as intensive detoxification and withdrawal and counselling programs would assist drinkers and thereby their children and families. However, when the outcomes for children are compromised and the alcohol misuse and abuse is ongoing, harm minimisation strategies that involve the full power of the child protection system will also continue to be required. So I guess really, I was just wanting to put forward that alcohol misuse is a substantial contributor to a range of effects upon children, particularly to those who are most vulnerable and I think we need to see widespread alcohol policy changes that support that. Thank you.

MR CUMMINS: Anne-Marie, thank you very much for that. Plainly, you are speaking about a most significant area. Also, it's not easy to present a verbal presentation on material which has so much data integrated into it, so thank you very much for that. Prof Scott.

PROF SCOTT: Thank you. Yes, thanks, Anne-Marie. It's just marvellous to see the results of the study we talked about quite some time ago coming to fruition and this is such valuable research as you know. I've got quite a few questions. They may be questions that are more like questions on notice that you and your colleagues at Turning Point could come back to the Inquiry Secretariat with, and it may even be better, when I mention these, we could even email these to you if you are unable to take them right now.

DR LASLETT: Sure, yes.

PROF SCOTT: I'm not expecting necessarily that you can answer these or give us further information on the spot. One would be: what do we know about heavy drinking in adolescence in relation to the risk of a continuation of a heavy drinking pattern in the child-bearing years? The reason I'm asking is that we've got strong data about increased adolescent alcohol abuse in the last two decades and I'm trying to get a sense of what the trajectory of that is, what proportion of heavy-drinking young people are expected to be heavy-drinking adults in their child-bearing years.

The second one is: do we have good data on the effectiveness of the population based measures that you're advocating which many in the alcohol and other drug sector are advocating, particularly the minimum pricing and perhaps a ban on alcohol advertising, those population based measures? What evidence do we have, if any, about their impact, particularly on socially disadvantaged subgroups, usually seen as price-sensitive groups in the population, but in relation to an alcohol dependence, will people go without food? Will their children go without food in order to be able to afford more expensive alcohol because of the level of dependence on alcohol? So it's the impact of those and the possible counterproductive impact in terms of the wellbeing of children in very disadvantaged families where there are serious parental drinking problems that would be very helpful to us.

DR LASLETT: Yes. I may not be the best person to speak to those issues, but I know there is an increased risk of - if the younger people start drinking and the more problematic their drinking is in adolescence, the more likely they are to go on to have long-term problems. So I guess earlier intervention with their alcohol problem would be advisable and supported. I can't tell you the exact proportion, and I guess there would be a number of factors that would come into the type of treatment that might be required for specific young

groups.

The population based measures, some of the data that speaks to whether minimum prices are effective or whether advertising is effective perhaps comes from some of the indigenous communities in the Northern Territory and Queensland where some of these more interventionist strategies have been shown to have quite significant effects on domestic violence and on those people turning up to hospitals. How effective they are in a broader metropolitan community I think is not so well known, although I think there's general evidence to suggest that price is one of the most effective ways of affecting the drinking of groups who have less income.

PROF SCOTT: Any data you may have on that - - -

DR LASLETT: We could forward that to you.

PROF SCOTT: Yes, I agree, the extrapolation from the Northern Territory and some of the Queensland data is very hard where it's actually the availability of alcohol, which has been controlled in some settings, and the availability of full strength beer et cetera.

DR LASLETT: Yes.

PROF SCOTT: Anything that could help us around that. Then the last questions are really about treatment, early intervention and not so early intervention. Whether you or your colleagues at Turning Point may be able to provide us with information on the role of people like GPs, not just maternal child health nurses, in the early identification of parental problem drinking and what the capacity in general practice might be, as well as other parts of the health system.

DR LASLETT: I don't know that specifically, the future about whether GP based advocacy for brief interventions or more severe interventions. I'm not quite sure about the - I think the GP based brief intervention work is effective but I don't know whether that's particularly effective, or more or less effective with particularly advantaged or disadvantaged groups. I'm not sure how that plays out.

PROF SCOTT: If any of your colleagues have that, that would be very helpful.

DR LASLETT: Yes.

PROF SCOTT: The last question was - and again this may not be something that you feel you can comment on right now, but if we are able to identify

families, including those who have been identified via the statutory Child Protection system, the effectiveness of alcohol and other drug specialist treatment, particularly for parents, and the capacity of alcohol and other drug treatment agencies to be mindful of the parenting role of their adult clients, the barriers to treatment; once we've identified, how effective are we able to actually treat serious alcohol misuse in families? If you or your colleagues had views on that, we would be most appreciative of that.

MR SCALES: Probably best to take that on notice.

PROF SCOTT: Sorry there's so many questions on notice.

DR LASLETT: Sure.

MR SCALES: Just to follow on on a couple of those: in relation to the treatment interventions - and I'm not expecting you to answer this now - if there was any research that your colleagues have done that looks at what might be the most effective interventions, in addition to the ones that Prof Scott has mentioned, that would be really helpful. Secondly, if there was any - and I think Prof Scott may have covered this - data on the extent to which, what you might describe as universal approaches, which is looking at encouraging pricing, licensing controls, planning issues and so on, and the effect of that on the particular cohort that we're inquiring about, which is those families where children might come to the attention of the child protection system, that would also be most helpful.

Then the very last one, which is around the very last point you make in your verbal submission, which is however where the outcomes of children are compromised and so on, whether there is any research that says what is the right approach to the intervention at that point in time; whether the intervention is at the tertiary level, that is, removing the child from the family where that's identified, or alternatively whether there are other forms of intervention which are not quite as drastic as that, given the likely risk that you raise in your submission, and how the system then accommodates that.

DR LASLETT: I don't think I know of any Australian research, but in terms of looking in the UK, I think they've looked at outcomes of removal of children where substance use was involved and I think that it depends on how you measure that outcome. In the UK I think Harwin and Forrester were finding that removal of children in some of those situations was more - I guess it seemed to be more effective perhaps than - I'm not sure at what age. Is that what you're asking about?

MR SCALES: I was really just bouncing off the words which you used, which is "the full power of the child protection system will continue to be

required", and the full power of course of the child protection system is removal of the child, I mean at its most extreme. I suppose I was just trying to understand whether you know of any research that says at a particular point in time that the identification of a risk factor would require that. By the way I'm not suggesting that it's necessarily Australian research, but whether any of your colleagues know of any information or research that says once those risk factors are identified, then that automatically, or becomes a very large mitigating factor in the removal of the child in those circumstances.

DR LASLETT: I mean, I think some of this research can assist the individual decisions that protection workers make in those cases, but I don't know that there would be a clear-cut answer to that, apart from - I mean, some of the risk assessment frameworks can kind of provide probabilities of what might - but I don't know that they're widespread.

MR SCALES: Well, that's the reason why, I suppose, I'm asking the question because I think what you're alluding to, quite sensibly by the way, is this is a very large risk factor - - -

DR LASLETT: Yes.

MR SCALES: - - - and your data says it, but, I mean, the logical consequence of that is you either do something about these substantial risk factors or you don't. You either do what your last line of your verbal submission is, you bring the full power of the child protection system or you don't. I suppose I'm trying to understand is at what point do you decide that these risk factors, even though the child may not have been immediately affected by those, the child protection system then intervenes. I'm really just trying to bounce off your submission really, not on my view about this. Anyway, you should take that away and think about it.

DR LASLETT: Yes. I think that I would rather take the public health approaches that, where possible, push people to healthier ways of living, and where necessary I guess. It becomes a sort of primary prevention and then you move towards the tertiary system where necessary, then that risk has to be accounted for. How people make those risk judgments is very complicated and difficult.

MR SCALES: Thanks very much.

MR CUMMINS: Well, Anne-Marie, thank you very much for that. The Inquiry is most desirous of being evidence based and data informed, so it's very helpful to us to have this data any anything further you send in, we'd be delighted to receive.

DR LASLETT: I'm happy to take the emails. Thank you.

MR CUMMINS: Thanks a lot, Anne-Marie. Next, Valerie Rand. Just take a moment coming forward, Valerie. Just settle yourself down.

MS RAND: I feel a bit like Breaker Morant.

MR CUMMINS: Valerie, thank you very much for coming forward. We'd be pleased to hear you.

MS RAND: Thank you very much for hearing me today, not as a professional unfortunately but semi-professional. I worked in kindergartens for 19 years and when I retired, I worked as a voluntary child care assistant, so I think I do have something to say. Over that long period of years, I saw many cases of child abuse, many. But going back to probably 1968, if we made some fracas about child abuse, we had to be prepared to go to court and go through the proceedings.

Now, this meant of course taking time off from work. It meant that the children were left with emergency staffing and of course the natural inquisitiveness of parents of where were the permanent staff was a bit hard to overcome. I'm really glad nowadays that you can make a complaint and you don't always have to go into court because you can get into a hell of a lot of trouble by complaining.

But who complains for the children? If we can't complain for the children when we are carers of them, who will? I've just heard a submission regarding alcohol and drug abuse which of course will play a big part in children's welfare, but I worked in two of the biggest grammar schools in Melbourne and, believe me, child abuse can come from very influential parents in government and the business world and their children, to me, were very disadvantaged. So you can't put all the blame on drug and alcohol abuse.

Personally, I think today the very high divorce rate leads to a big percentage of alcohol abuse, drug abuse, child abuse. To listen to a little three or four-year-old child telling you a story of what mummy's boyfriend did to them, well, I'll leave that to your imagination. But how do you follow through on something like that? I don't know. How do you follow through? But I did find when I retired that working in child care in the country was quite a different kettle of fish. I don't know even now what kind of subsidies these child care centres got, but children were very, very happy and I believe that had a lot to do with the cohesive family atmosphere in the country. Country people are very family orientated. In my years of voluntary work, I never came across one case of child abuse at all. So I think you have to draw deductions from things like that.

But I must say this, and I'm not incriminating anybody: I worked at two of the biggest grammar schools in Melbourne and these were church-funded kindergartens and generally any complaints we made, staff, were acknowledged but we never saw any practical movement to rectify the situations. That's my submission today. Thank you. Thank you for hearing me.

MR CUMMINS: Valerie, it's most important to us to receive insights from persons who have seen over the years relevant events occurring and, in relation to your very last point, relevant events not occurring. So it gives the Inquiry a quality and character of the submission which is very important. Thank you very much for that.

MS RAND: Thank you.

MR CUMMINS: Are there any questions, Prof Scott?

PROF SCOTT: Just one clarifying question. I'm just wondering in relation to your experience of the lack of response in the two schools in the environments in which you worked to concerns about children, was that lack of response at the school level or the statutory Child Protection authority level?

MS RAND: No, that was at school level.

PROF SCOTT: Yes, thank you.

MS RAND: But the kindergartens were subsidised by the church and we were employed by the church.

PROF SCOTT: Could I also ask when that was, in case it was before mandatory reporting legislation was introduced?

MS RAND: Yes. I don't know the year of the mandatory reporting. Can you tell me?

PROF SCOTT: 1992, in this state.

MS RAND: Yes, in Victoria. I worked from 1968 to 1986.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales?

MR SCALES: No, no questions.

MR CUMMINS: Valerie, thank you very much for that. We're obliged to you.

MS RAND: Thank you.

MR CUMMINS: Our warmest wishes. Ladies and gentlemen, we've been going nearly on two hours, so we might take a 10-minute break and when we recommence, we'd be very pleased to hear Julie Kun and Joy Stevens. So we'll take a 10-minute break, ladies and gentlemen.

ADJOURNED **[10.48 am]**

RESUMED **[11.09 am]**

MR CUMMINS: I am pleased to invite Julie Kun and Joy Stevens to come forward. Welcome, Julie and Joy. First of all, thank you for the original substantial submission and also thank you for the additional papers. We're very pleased to hear you in whatever sequence you like.

MS KUN: Thank you. We did initially have two separate 15-minute time slots and we've now got one, so we're going to do the best that we can to fit it in within that 15-minute time space.

MR CUMMINS: That's all right. You're most welcome.

MS KUN: Yes. My name is Julie Kun and I'm an organiser at the Australian Services Union and I'm speaking on behalf of the Australian Services Union Victorian and Tasmanian Authorities Branch. The ASU is a union that covers workers in the not-for-profit community sector; in other words, agencies that provide support and assistance to those in our community experiencing disadvantage. The great majority of these services rely to a significant extent on funding from government. As you are aware, the ASU lodged a written submission to the Protecting Vulnerable Children Inquiry, but this verbal submission will not traverse the same ground.

MR CUMMINS: Certainly. You can take it that we're well familiar with the original submission.

MS KUN: Yes. In our submission we do not seek to claim expertise in selecting the preferred methodology or methodologies for successfully managing the needs of vulnerable children in Victoria. However, it is our strong belief that whatever the methods and actions agreed to by this Inquiry and by the state government, in order to be well positioned to provide best practice, the community organisations that provide those services must be

sustainable. It is this matter of sustainability that I will address today.

The ASU asserts that in order to provide services to vulnerable children in Victoria, the not-for-profit sector must be able to recruit and retain a skilled, experienced workforce. At present, the sector is facing a significant workforce crisis and it is directly linked to the low-paying conditions experienced by its workers.

Since the ASU wrote its original submission in April 2011, there has been significant movement in relation to the Community Services equal pay case currently before Fair Work Australia. The impact of this case and its significance to the sector was raised in some detail in our original submission. On 16 May 2011 Fair Work Australia issued an interim decision that found that the work of social and community services employees have been undervalued and it was appropriate to make an order to remedy that undervaluation.

Essentially Fair Work Australia agreed with the proposition that the ASU made in our original submission to this Inquiry that workers in the not-for-profit sector, including child and family services workers, are currently underpaid because caring work is a largely feminised industry and that this has resulted in them receiving lower rates of pay than those in the public sector and local government doing comparable work.

These findings also confirmed the proposition put forward by the ASU and peak bodies such as VCOSS that staff turnover in the community sector was unacceptably high because workers were leaving for better paid jobs within other sectors. The impact of the high turnover threatens the sector's ability to remain sustainable. The exodus of skilled and experienced workers leaves organisations constantly needing to expand time and resources to recruit and retrain staff. It also results in worker burnout, as those who remain must cover the workload whilst positions are vacant. This also impacts significantly on the quality of care as vulnerable children and their families must constantly start again with a new worker which causes loss of valuable time, established rapport and often trust. These difficulties only compound what is already very often a complex and precarious situation.

For all these reasons, the ASU contends that for a sustainable sector, workers must receive proper wages and given that the sector is heavily reliant on government funding, I wish to restate the ASU's recommendation to this Inquiry that equal pay for community sector workers be fully funded by the Victorian government. In recent weeks the political landscape has changed quite significantly in terms of the positions of other governments towards equal pay and I would like to update the Inquiry.

The Queensland government has already committed to fully fund equal pay for

community workers. In 2011, the Western Australia government set aside $600 million primarily to increase wages in the sector and link this money in part to the outcome of the equal remuneration case. In June 2011 the South Australian treasurer committed publicly that the South Australian government was meeting the full share of costs arising from the equal pay case.

Also in June 2011 the ACT chief minister advised the ASU that her government will meet its full share of costs arising from the equal pay case. Just last week the Commonwealth made a commitment to provide additional funding to the sector specifically for increases to wages resulting from the equal pay case.

It is obvious that other governments around Australia are seeing the value and importance of having a community sector that is fairly remunerated and that the responsibility for ensuring this falls to government. To date, regrettably, I am unable to report that the Victorian government has committed to fund for any outcome of the equal pay case exceeding $200 million over a four-year period. Whilst the outcome of the case is unknown, we believe that that amount is unlikely to bridge the average 25 per cent wage gap between community sector workers and their colleagues in public and local government sectors. Without commitment to meet its full share of costs of equal pay, the ASU predicts that the workforce crisis will worsen, as workers who have already been told by Fair Work Australia that they are being underpaid and undervalued will leave the sector in increasing numbers. This view is confirmed by a recent survey conducted by the union of workers in the sector which showed that around 65 per cent of them would be less likely to stay in the sector if services or jobs were cut because of funding pressure. This is something that the sector and the community, including vulnerable children, can ill afford.

The ASU takes this opportunity to reiterate recommendations submitted in its original submission. We believe that if Victoria is to be a leader in the provision of services to protect the most vulnerable in our community, we must have the infrastructure to support those services. Adequate funding to pay for those services must include providing appropriate and just remuneration for community services workers. This is a vital part of ensuring that Victoria achieves best practice in relation to protecting vulnerable children. Thank you for your time.

MR CUMMINS: Thank you very much, Julie. Joy.

MS STEVENS: Thank you. Good morning. My name is Joy Stevens and I'm here to speak as a worker in the sector. I'm a union delegate with the ASU Community Sector Division. I've worked in child protection for more than 15 years. I hold a social work degree with first-class honours, a master's

degree in child and adolescent welfare and two other degrees. For the past two years, I've worked as a practitioner for Connections Uniting Care in the Families First program. Connections is a large non-government provider in the eastern suburbs of Melbourne and southern suburbs. Families First is an excellent evidence based program. We use the North Carolina Family Assessment Tool and it is based on the Home Builders model. We provide intensive reunification and preservation services for children and families who are all clients of the Department of Human Services.

This program is an example of social work par excellence. It works in context with families using a range of practice models to support change. Our program has achieved outstanding success. We've provided intensive in-home support to parents, children and young people. This is highly skilled work, assessing concerns while modelling boundaries and parenting skills in an unstructured and often chaotic home environment.

Essentially, this work is about relationships, building a strength based therapeutic relationship with the family. We get alongside the family and help them to harness their motivation for change. The key to our success is the authenticity of the relationship we form. In the past two years, our Families First program has brought hope and positive change for many families and children. I know that I'm good at this work. This is not magic. I am good at the work because I am a university-trained and experienced social worker. But I'm here today to tell you that I resigned my job last week. All but one of my five skilled colleagues have now left this program.

When our team leader started two years ago, she said, "Collectively, we offer more than 70 years' frontline child protection experience," and it has all gone in two years. At a recent staff meeting for frontline workers in the east, the area manager asked new staff members to stand up. I counted one-third of the workers in the room standing up, more than 20 workers. How can an organisation grow in expertise and achievement if it has to renew a third of itself every year? In a field where practitioner experience is the major resource, this ongoing loss of organisational memory and expertise is akin to arterial blood loss.

Why, you ask? The answer is simple: no money. No money for decent wages and poor conditions in the government and non-government sector. No money for decent wages; I am paid $20,000 less than for wages equivalent in the government position. No money for training; I have received no significant high-level training during my two years' employment. No money for career advancement; there are no specialist or senior practitioner positions at my previous workplace, despite being a large provider in the sector with more than a hundred frontline staff. No money for portability of long service leave; despite having worked in the non-government sector for more than 15 years, I

have not been able to accrue long service leave. The Brumby government had put together a plan for a long service leave pool for non-government workers but the Baillieu government has sidelined this basic entitlement.

For me, I have taken a job in the New South Wales government child protection system. I shall be paid $76,000. This is $20,000 more than my current wage. I will work a 35-hour week and on my day of commencement, I will receive four weeks' training. My previous employer has a good record in the non-government child and family welfare sector but without government funding for improved wages and conditions, they can do nothing to rectify these issues.

During the past decade, the public health model of child and family welfare has seen government services in bulk handed over to the community sector as the more appropriate provider of preventative and early intervention programs. This is a good thing. However, it is not an opportunity to provide services on the cheap. My experience has shown me that non-government services have the capacity to make a difference for children and young people by intervening early and before the point of need becomes a statutory risk, but only if funded well.

Designing better evidence based interventions all comes to nothing if we don't have a skilled and robust workforce. I am here today to tell you that to make a real difference for vulnerable children and families, there is no more important issue than securing a fair and equitable industrial future for non-government workers. This can be done by the Child Protection Inquiry sending a strong message to the Baillieu government to fund the current pay equity case before Fair Work Australia. I am asking the Inquiry to see this industrial issue as within its ambit and advise the government to fund our pay case.

Fair Work Australia has recognised that our work is undervalued. Last week, the Commonwealth government committed to funding our pay case. It now falls to the state government to meet its election promise. A commitment to pay community workers commensurate wages to their government counterparts will secure the future for the sector. This commitment will give skilled and experienced workers the value we deserve and ensure the provision of quality services for families and children. Thank you.

MR CUMMINS: Thank you very much, Joy. Thank you both, Julie and Joy, for your complementary perspectives with the common theme. I'm obliged to you both for that. Prof Scott.

PROF SCOTT: Thank you. Thank you for how comprehensive your written submission was, as well as for the articulate verbal submissions. There is just one area that you may wish to take on notice and that is on page 9 of the

written submission which you may or may not have there, but it's about research from WorkSafe analysing stress claims in the community services show that the main causes are work pressure, harassment, being assaulted by person or persons, exposure to traumatic events, exposure to workplace or occupational violence and other mental stress factors. That I think is citing 2007-2008 data.

MS KUN: Yes.

PROF SCOTT: I just wondered if you had available - otherwise we could do this independently - more recent data and any trend in that data over the last five to 10 years, that would be very helpful.

MS KUN: I'll see, although I think we would have put in the most recent, I would say, because the original submission is only a few months old now.

PROF SCOTT: Right, okay.

MS KUN: But I will check and if I can find some newer ones, you will all have it.

PROF SCOTT: Thanks.

MR CUMMINS: Mr Scales.

MR SCALES: Thanks very much. I think your industrial claim is going through a process and you've made your case pretty clearly. But I did want to ask you a question on page 20 of your submission where, under the heading of the Revision of the Competitive Tendering Model For Funding, you argue for a cost based model. You say, "Social and community services should be funded on a cost based model." How did you imagine that organisations would be chosen by government to provide services under that model? What was your approach here?

MS KUN: It would still be based on quality. What we were getting to is that the government needs to fully fund what does it cost to adequately provide these services, and so you're actually providing, saying, "This is what it takes to adequately provide those services and what are the KPIs or the outcomes that you can get for this amount of money?" At the moment with the tendering, some organisations feel that they have to sort of say, "I can do more for less, I can do more for less, I can do more for less," and that's not necessarily - that may give you a productivity increase here and there but it also may mean cutting corners. It may mean not actually saying, "This is what's actually happening out there in the real world." So what we're suggesting is that you have a system in place where services know that they're

going to get adequate remuneration for what they're going to provide because the bulk, about 85 per cent, of money usually goes towards wages but there's also 15 per cent for admin and other costs as well.

MR SCALES: Can I just ask, just to tease this out a bit more, it seems to me there are two sorts of processes that you describe.

MS KUN: Yes.

MR SCALES: One is what is the cost of the service and then the second is the sort of quality of the service. Are you suggesting that the tendering - for want of a better word, by the way, I don't want to get hung up on the word here - but the tendering process is based rather on the quality of the services provided rather than the cost of the services? Is that your argument?

MS KUN: Yes, we don't want a system that is based on whatever the lowest quote is. It really needs to be on quality, but also maybe the methodology as well, that those factors are given primary - - -

MR SCALES: So you would have a panel of people who would judge the community sector organisations on the quality of the performance - - -

MS KUN: Yes.

MR SCALES: - - - and those sorts of matters?

MS KUN: And also there would be submissions where we wouldn't want to be judged on anecdotal information, but giving organisations an opportunity to put their best foot forward and to say how they could value add to the sector.

MR SCALES: Okay, thanks very much.

MR CUMMINS: Julie and Joy, without derogating from your central submission which is that funding is fundamental, can I just take you to something on page 11. I'd just like to have the benefit of some further thoughts of you both or either of you about it. On page 11 you speak about high and difficult workloads and that that is a factor in staff sustainability as well, bearing in mind what I've said as to your fundamental and central submission as to funding. Can you say anything more about that issue, of the high and difficult workloads of any particular context? Is it a matter of numbers of case loads? Is it a matter of the type of casework? Is it a matter of some step in the process of casework? What are the critical factors in that area?

MS STEVENS: In my experience, it's the case load numbers. My colleagues would carry a case load of between 10 and 15 cases, which is very

burdensome. As a family worker, if you're doing that work and support work that goes without the ancillary work of case notes and follow-up referral, record keeping, in order to - I mean, you're a caseworker, but as I was saying, it's about relationships, working on relationships. Once you've got that sort of case load, it's very difficult.

MS KUN: I'd also add that we have quite a few members that come to us and say there's this constant pressure to close cases because there's always more people waiting and they're dealing with very complex - they're not just dealing with the child, they're dealing with the family, and at times, it's a multifaceted family that they're dealing with and they're dealing with many different organisations that are trying to put in supports. There's no quick fix. But there is this pressure of throughput to get more people on, so that also puts them under pressure to have a higher work case load but they often need very intensive support. So it's the pressure of speed and also the pressure of numbers of people requiring the service.

MR CUMMINS: Including the question of throughput that you've just identified.

MS KUN: Yes.

MR CUMMINS: All right. What about training, what's the provision for training like? It's a complex area as both of you, particularly Joy, has said. What's your view as to the training that's provided across the board?

MS KUN: It varies between organisations and you have some organisations that have a culture of providing a lot of training and you get some organisations that have a culture of not providing training. You often find that in services where there has been a very high throughput, that they're saying, "We don't have the money and time to put in the training." But of course that causes a bit of a vicious cycle of people not getting the training, so they're more likely to leave because if you've got the skills to deal with the complexities, you're probably more likely to stay. It's hard to give a very yes/no answer. Yes, there's training there.

MR CUMMINS: It varies across the field. What is your view as to the significance of training? It sounds a very naive question and I suppose in a way it is, but sometimes these things need to be put on the table.

MS KUN: Training is significant, very significant.

MS STEVENS: It is. For me, training is maybe around two areas; the information is constantly updating and changing in the field, so there's specific information that you need to have regular training on the latest research, new

techniques or ways of working with families on specialist issues. Generally that, in my experience, has been reasonably adequate. It seems that working for a large provider, they provide in-house training, so you will possibly get a half-day workshop, quarterly or something like that. The high-level training is like hen's teeth, it's not possible. Workers are told repeatedly within the funded model there is no provision for high-level training. So the opportunity for people to take up some study part-time, do some external training, those kinds of things don't occur.

MR CUMMINS: All right. What about administration, what used to be called "paperwork" in the pre-IT era, is that a significant issue, the extent - and obviously one needs proper administration for a raft of reasons - but has that become a dominating factor beyond its true role?

MS STEVENS: In my opinion, not so, I think. I mean, record keeping is a critical part of what we do.

MR CUMMINS: Of course.

MS STEVENS: There are systems in place. DHS have developed the CRIS system which supports - in my organisation, they don't use it which is a particular specific issue related to that organisation, but there is that tool available. In all of our areas of work, beyond child protection, risk management, it is an issue. It controls much of what we do and needs to - - -

MR CUMMINS: So the bottom line is, number 1, plainly it's necessary, correctly you've said, but number 2, it's within its proper bounds so far as you would see it?

MS STEVENS: I would think so, so long as time is given, as we're saying with case load burdens.

MR CUMMINS: Yes.

MS STEVENS: In the particular program that I worked for which is why I focused on it as my area of expertise, the Families First program, it seems to have been sort of isolated and protected in some way. I carried a case load of two families and working intensively with those two families, so it's a beautiful little program that enables you to work very closely with a family and achieve great outcomes. We worked up to 15 hours a week with a family over a period of time and that intensive model, it has been researched and it has achieved good outcomes. So that sort of throughput and burdensome case load issue is not so in my particular work, but the remuneration for the expertise that's required to deliver that program is just not there.

MR CUMMINS: Thank you both very much. Thank you very much for your original substantial submission and also for you bringing us up to date in the submission which you have done. We're obliged to both of you.

MS KUN: Thank you.

MS STEVENS: Thank you.

MR CUMMINS: Thanks a lot, Julie and Joy, equally. Next, Mr Mark Zentgraf, Life Without Barriers. Good morning, Mark.

MR ZENTGRAF: Good morning.

MR CUMMINS: Mark, thank you for your original substantial submission and for material you have further provided. We're very happy to take it in whatever is the sequence that's most convenient to you.

MR ZENTGRAF: Okay, thank you very much. I hope you don't mind if I just read off the following sheet?

MR CUMMINS: Certainly.

MR ZENTGRAF: Basically my name is Mark Zentgraf, I'm the state director for Victoria for Life Without Barriers. I have responsibility for our operations in not only Victoria but Tasmania, Northern Territory, New Zealand and our refugee services across Australia. I am here today to represent the views of Life Without Barriers. We appreciate the opportunity to provide evidence to the Inquiry into vulnerable children and young people and supports the Victorian government commitment to improving services to vulnerable children and families.

Life Without Barriers is one of the largest not-for-profit providers of community service in Australia, including supports for the following: family support and out-of-home care which is a large component of our business; mental health; reducing homelessness; unaccompanied refugee children; disability services and youth justice. We support almost 4500 vulnerable people each year through our 87 offices across every state and territory and also New Zealand. In Victoria we have three offices in Cranbourne, Eltham and Mildura and we also invest in research, innovation and development which informs our practice across the country.

We have, as you've already mentioned, provided a submission to the Inquiry. My evidence today complements this. I'd particularly like to speak to three matters: the importance of early intervention and prevention services; the need for new approaches to deliver better outcomes for children in care and the

need for a wider range of service providers of care in Victoria.

Going to my first point, the early intervention and prevention. Firstly I'd like to note that Victoria has a long and strong record investing in early intervention and prevention services. This has enabled Victoria to position out-of-home care services as the service of last resort. It has also meant that resources have been able to support families to remain together and to assist families through periods of crisis. Many families call out for help and do not receive it and often struggle without assistance until they reach a crisis and by the time families become known to the child protection system, their problems are usually extremely complex and quite difficult to resolve.

Faced with the incoming tide of reporting, many child protection systems have understandably tended to prioritise at the end of this spectrum and it is vitally important that there is ongoing commitment to comprehensive early intervention and prevention services, as we all know. We believe therefore, whenever possible, supports must be available for families to safely retain the care of their children which is obviously the best outcome.

For out-of-home care, which is our second point that we wanted to bring up, when children come into care, every effort should be made to work with the family to enable the child to return home as soon as possible. The likelihood of successful restoration of children with their families where this is safe needs to be a clear objective in every case plan and supported through the range of interventions. According to the Create report 2009, children in out-of-home care have the worst outcomes of any group of children in Australia. 64 per cent have no leaving care plan. 35 per cent are homeless in the first year of leaving care. 46 per cent of boys are involved in the juvenile justice system, 29 per cent are unemployed, 28 per cent are already parents themselves. This is why out-of-home care we believe must be the last resort.

In cases where it's not safe to restore a child home, our casework effort should focus on placing children in stable family based care. Victoria has done well in minimising the number of children entering the out-of-home care sector when comparing to the rest of Australia. However, like other jurisdictions in Australia, Victoria has struggled to achieve good outcomes, including placement stability for children and young people in care. This is a key indicator as it relates directly to school placement. If children are moving from home to home, they are probably moving from school to school as well and therefore decreasing the possibility of good outcomes. Placement stability also impacts directly on the capacity for children to develop and maintain relationships with family and friends. Almost half of the children in long-term care in Victoria had more than two placement changes last year and it would be good if we could improve this situation.

To ensure greater stability, we believe that matching carers with the needs of children need to be comprehensively assessed for likely compatibility; placement with siblings should occur where possible to maintain stability in the child's life and maintain family relationships, and ongoing agency support to monitor the child's progress and ensure their best interests are being met, including health, education, nurturing and care.

Where a placement breaks down, all efforts must be made to assist children to maintain their school placement and their relationships with friends and family. The out-of-home care must raise the expectations of ourselves and of our capacity to assist children and young people to reach their potential. We need a greater focus on outcomes. LW believes that funding should be linked to outcomes as well as to outputs. We must find new ways to offer opportunities and second and third chances for children and young people to find their place in the community and build a brighter future for themselves.

Thirdly, we believe that more providers in the out-of-home care sector would be of benefit. Part of meeting the complex challenges on a range of issues being faced by the sector is to ensure that it remains vibrant, continues to learn and grow. To do this and to enable greater choice of models and service delivery it is imperative that new providers are able to access the out of home care system by ensuring that there's a straightforward registration process in place which is transparent and accountable. A greater openness to new providers can only enhance the capacity and capability of the sector.

MR CUMMINS: Thank you. That's been very clearly set out, Mark. Thank you very much.

PROF SCOTT: Just a clarifying question initially: in the three offices in Cranbourne, Eltham and Mildura, are you currently providing out-of-home care services?

MR ZENTGRAF: No, we're not currently providing out-of-home care services in Victoria at this stage.

PROF SCOTT: Your organisation clearly wants to do so.

MR ZENTGRAF: Yes, very much so.

PROF SCOTT: I mean, I don't have a problem with your suggestion that the registration process be transparent and accountable of course, but can you comment on the advantages or disadvantages for children in this very vulnerable situation of there being a large number of community service organisations involved in the delivery of out-of-home care services rather than a smaller number, because, you know, the issues of duplication and

fragmentation of the service system, which some have said is a feature of the Victorian system - the level of fragmentation, the number of community service organisations involved. What would be the advantages of increasing the number of organisations involved?

MR ZENTGRAF: Well, we think that to maintain a sort of a vibrant industry by having maybe a more diverse group within the sector - let me take it a step back. The sector is not necessarily a straightforward component, so there are different complexities that are managed within the sector itself in out-of-home care. So there is a variety of opportunities for organisations to play a part in different parts within the sector; so they range from generalist up through to more complex needs. We believe that in regards to some of the specialised services there is not necessarily all of the expertise there that's required and that, in actual fact, the sector could quite readily take on new providers who may have expertise in those particular areas.

In particular one could talk about maybe children with disabilities who are also in the out-of-home care sector, and the matching of those and the complexities that sit around that, and developing another level of expertise through there. So, yes, there may be a lot of providers and there may be a creation of some sort of fragmentation, but also I believe that there's the ability for new providers to come in as well who can offer maybe something slightly different, but also to provide different models of service delivery to maybe enhance and improve the sector.

PROF SCOTT: In those three current sites, could you say what services are provided? Not out-of-home care, I understand that that - - -

MR ZENTGRAF: At the moment there is disability services that is being provided and also there are services to refugees and asylum seekers.

PROF SCOTT: Thank you.

MR SCALES: Can I just follow up on that issue about your desire to become a provider, but I get the impression that there is some barrier to you becoming a provider.

MR ZENTGRAF: I'm not so sure that I would class it as a barrier. I think that our view would be that there is some inconsistency in the registration process, or lack of clarity in the registration process. So I think that from our viewpoint, even from a departmental perspective I think there may well be a difference in view of the registration process between the central office and the regional offices. So therefore I think at times it feels like you might be on a registration roundabout.

MR SCALES: How long have you been trying to register to become a provider?

MR ZENTGRAF: As an organisation, since 2009.

MR SCALES: So two years. That's a long time to be going through that process.

MR ZENTGRAF: Some things take time.

MR SCALES: Have you made representations to the central body? I presume it's within DHS.

MR ZENTGRAF: Yes, we have and we've also now met with the minister as well.

MR SCALES: Your organisation is quite interesting from a number of points of view, partly because you do operate in a number of states and territories.

MR ZENTGRAF: Correct.

MR SCALES: Do you want to just give us a thumbnail sketch about what might be some of the strengths and weaknesses of the Victorian system compared to other systems in which you operate.

MR ZENTGRAF: We think that the Victorian system is actually reasonably well placed as it currently is, although, having said that, if you look at statistics from Victoria and the other states, there is decidedly a lot less children in out of home care, which I could argue is a very good thing, which it is, however I think there's been an ever increasing decline in the amount of carers that are available in Victoria compared to other states. Victoria, I believe, has probably gone down from about 5000 carers probably about five years ago and I think we might be at around 1500 carers in the latest audit that was just completed I think by the industry body here in Victoria. I think that there are probably a number of factors in relation to that. Also there's less children per 1000 in Victoria that are placed; I think there's only about 4.4 children in Victoria versus, I think it's up to about seven is the Australian average. So I think there are some advantages there. However, some of that placement may well, once again, relate to the lack of ability of attracting carers into the system and retaining carers into the system.

MR SCALES: One of your three points was about innovation really, about adding some innovation to the system, I think, as well. What would your organisation bring to the system in Victoria that, say, the majority of others may not bring?

MR ZENTGRAF: Well, we believe that as an organisation we have a very good record in recruiting and retaining carers. We believe that, given the opportunity to operate here in Victoria, we would actually be quite successful in increasing the amount of carers that are available to the out of home care sector, but not only that, to retaining and maintaining them and also to increase placement stability. We believe that the wrap around model that we have, which looks at not only the child but the entire component of the placement including the carer, is one which is fairly unique and has been successful interstate. We currently have over 2000 carers in Life Without Barriers and we believe that our placement stability is very high.

MR SCALES: So if you were operating here would you operate in that foster carer end of the sector?

MR ZENTGRAF: Yes.

MR SCALES: That's how you - yes, okay.

MR ZENTGRAF: And at the high need end.

MR SCALES: So would it be residential care?

MR ZENTGRAF: We do, as an organisation, have residential care and we have some therapeutic models in place, however we have built up our organisation predominantly through foster care.

MR SCALES: Okay. Thanks very much.

MR CUMMINS: Well, Mark, that's most helpful. It's particularly helpful to have the benefit of the breadth, both in terms of numbers and in terms of geography that you bring to the table, so thank you very much for that. We're most obliged to you.

MR ZENTGRAF: Thank you.

MR CUMMINS: Well, Jo, you've got more speakers to come with you, so we'll wait until they arrive so we don't call you on prematurely. I think what we might do is take a slightly earlier lunch. Your co-speakers will be here by 20 to 1, half past 12?

MS CAVANAGH: Yes. They were expecting 1 o'clock but we've called them and they're on their way.

MR CUMMINS: That's very kind.

PROF SCOTT: Thank you.

MR CUMMINS: Well, why don't we take a break and resume at a quarter to 1, which gives them a bit of time to catch their breath. So we'll take the lunch break slightly early and recommence slightly early, so we'll resume at 12.45. Thank you very much.

ADJOURNED [11.55 AM]

RESUMED [12.45 pm]

MR CUMMINS: Ladies and gentlemen, it's at 12.45 which was the revised recommencement time and so we're very pleased to invite Jo forward. All of you come forward. You're obviously well organised. Take a moment and all settle in and then we'll proceed. For the purposes of the transcript, when each one of you speaks, if you'd be kind enough to state your name. We know who you are but the voices won't identify themselves on the transcript. So if you commence in whatever is the best sequence for you and adjust the microphones, Jo and every one of you, as you are speaking, if you'd be so kind, so welcome.

MS CAVANAGH: Thank you. Thank you for the opportunity to come and meet with you today.

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

MS CAVANAGH: Thank you. Consistent with our submission about the whole of community approach to protecting vulnerable children, we have representatives of our work and wider community here with us today to share with them their experiences and their involvement with vulnerable children. We would hope today that through them sharing with you what they actually do on a day-to-day basis, we can bring to life for you a question that I think Mr Scales asked the other day at Swanston Street about what is early intervention, how does it apply in practice to vulnerable children, without the need to have a statutory compulsion.

We particularly want to address that through bringing to life what people do on a day-to-day basis which we then describe in our submission as a whole of community approach, but one where volunteers have a very important role to play working in partnership with our professional staff, not as a substitute for our professional staff. We would encourage the Panel and the Inquiry to consider into the future what is the role of volunteers in terms of strengthening families, connecting people into their community, as part of the solutions around vulnerable children being strengthened and able to thrive. So I'd like to

hand over to Marilyn Ellis who is a family worker with the agency, and we also have here Barbara, who is a volunteer, Suzanne Sibillin, who is our Child FIRST program manager; Margaret, who is a volunteer, ane then finally, Alicia, who is our research manager will share a couple of the measurable results.

MR CUMMINS: Thank you very much. Marilyn.

MS ELLIS: Hi, I work in a community house and several community programs, working with the people who live in public housing. I work in a breakfast program with three volunteers. One of them was a former policeman who used to come in uniform every week and that was a wonderful link for the children to be able to see - he used to actually do the cooking of the eggs and the children got to know him in a different role because there was quite a police presence on the housing estate, and seeing him there every Wednesday they got to know him and the trust was built. Parents started to come to him with some of their problems and for advice.

I also work in a community house very close to a public housing estate where we have a lot of families with pre-school children come along. They're quite isolated and they come along to the house. They get to know some of the other parents that come along. They get to know the volunteers that work there and once we've built up the trust, they start to talk to us about local services and often refer into our own services. We've had people coming along since the house was established eight years ago. We've had children go right through to school and then they come along with their second or third child. We also have mums that come along by themselves when their children are at school because it's become their support group. We have several CALD community families as well. We have some refugee families and migrant families that live in the area as well and they've come along. We've established quite a lot of different cultural diversity at the house, so we have lots of people. It just seems to be their support system and they also have set up social get-togethers on the weekend.

MR CUMMINS: Right. Barbara.

MS WHEATLEY: I've been involved with the breakfast club for the last 12 months and it's been absolutely wonderful. Before that, I was busy working and two of my friends were involved with Southern Family Life, but I loved the work they were doing where they were actually connected to families, working in a hands-on way. It's been a privilege watching the children come in for breakfast, getting to know them. It's lovely to hear what they're doing during the day. We talk about what they're going to do and then they'll respond the next week what they've been doing.

We're also having the mums come along now which has been great too. They chat and we get to know a little bit more about them, their role and their families and really their relationship with their children which has been beneficial. I find it a great privilege and like to do more in the future.

MR CUMMINS: Thank you, Barbara. Suzanne.

MS SIBILLIN: I would just like to talk a little bit about the community bus program which is Family Life's specialist program. I think from a specialist program it works with families and mothers and fathers with children up to two years of age. I think from a Child FIRST perspective what's fantastic about the program is we can actually refer families and mothers in before they have actually given birth, so in the late stages of pregnancy. So start working with the mum before she has actually given birth and start doing some parenting skills work even at that point. So from a Child FIRST perspective it's fantastic.

The model itself adopts different layers of support, if you like. It starts with specialist support from one of our family support workers and then we have volunteers as well who start working with the family and would do, I guess, more day-to-day support, so bringing them appointments and helping them organise their life around having the new baby. Then as part of the program as well and a key to what Family Life does is actually connecting those mothers with very young, vulnerable children back into their communities. One of the ways of doing that is through our Keith Street Community House and Margaret is one of our fantastic volunteers there, so over to you.

MR CUMMINS: Thank you. Margaret.

MS TREBILCOTT: My name is Margaret and I have been working at [redacted] Community House for three or four years, I think. I first started reading stories to little children because I was a primary school teacher and I think it's really important to read stories to children.

MR CUMMINS: Indeed.

MS TREBILCOTT: That was really high on my list. But through reading stories you have to have interactions and you have to choose the books. Currently I'm working with the some children who really aren't quite ready for listening to stories because in their families they're not very used to it. So you have to just read a quick little story and then do something else. So we've been painting, we've been drawing, we've been running around and doing things that children like to do. Seeing children happy makes the parents very happy and so through that I have gained the trust of many of the women there who like to tell me stories of their lives and what's right and what's wrong and through that as a conduit, I suppose, I'm then able to pass on that information to the family

worker.

So over the last four years I have seen wonderful things. Little children - I'm thinking of one in particular. Can I just talk about someone in particular - without a name of course.

MR CUMMINS: Certainly.

MS TREBILCOTT.: A little girl who came along - it was the day we were going to the zoo. Someone had organised a bus and it took the mothers and their children to the zoo for the day and this little girl was very much at risk. She was non-verbal, she was quite big and when things went wrong for her - and I'm not sure what they were - she threw a tantrum and meanwhile her mother had a little one in the pram. As we walked around I tried to help this mother with the tantruming small child and the baby in the pram. I reported all of that to the worker and today - which is about nine months later - this little girl now speaks, she looks you in the face, she's excited. She'll sit with me and listen to a story and interact and from this little girl who really didn't know who she was or where she was, she's now what I consider a functioning child.

Lots of things happened in the background for that little girls and I'm not sure what they are but I'm here to report what I saw at the beginning and now what I see later. So my work with Family Life is very rewarding for me. So as a retired person it's very pleasant to see progress because my profession was as a teacher and I knew what they were like when they came to school if they had a lot of good parenting skills or not. So that's where I come from.

MR CUMMINS: Thank you, Margaret. Alicia.

MS McCOY: Thank you. So just to look at this through a bit of a research and evaluation lens, I've just got two short examples for you. I'll just refer to my notes here. The first, the Community Bubs program that we've just talked about. In 2010, 34 families were supported through the Community Bubs program. Half of the referrals into Community Bubs came from Child FIRST and others from hospital social workers, maternal and child health nurses and housing services. The issues that were worked on with the family included parenting concerns, bonding and attachment, coping, housing, relationship issues, social isolation, financial concerns and mental health issues.

[redacted] The outcome in 2010 for Community Bubs was that in every family the baby was assessed to be able to

be living safely at home by the time the Community Bubs' worker closed with the family.

Another example, and I won't go into too much detail here - it's one of the appendices in our submission - was a request we had from a school in a disadvantaged neighbourhood for support in addressing some complex issues that the school was facing both internally and within the local community. The neighbourhood that the school was in had a high proportion of public housing, high rates of domestic violence and unemployment and the school reported to us that one in three children had a current involvement with Child Protection. The school also had below average rates of literacy and numeracy and there was a high level of absenteeism from school and a high turnover of staff.

Initially some targeted programs were administered in the school but it was a clear that more holistic approach was needed and following sensitive consultation with the school a regular family after-school activity was planned that as a way of engaging parents and children and a number of other local agencies were involved as well as local police, Centrelink, the Child Support Agency. The trust began to be established in the school community and the events proved to be very popular. Parents that would not enter the school grounds previously began to attend the activities. Parents made connections with community health workers and adult education activities and other programs are being established as these activities continue. These include things such as a school homework group facilitated by parent volunteers, a leadership course for some of the other children, family counselling and a local GP has offered to participate. Currently we have approximately 190 students and up to 100 parents attend each family activity afternoon.

MR CUMMINS: Thank you very much. Well, as you're aware, we're familiar with your substantial written submission for which we again express our thanks. Jo, that has been most innovative, I commend you for that, to have a presentation of that richness across a spectrum which you have done. Are there any summary or final points you would like to make to us?

MS CAVANAGH: I would just like to highlight to the Panel that the learnings from these programs we've been able to document into principles of practice and program models which are able to be taken to other communities. So we come from a belief around looking for the leverage in the abundance of resources in communities, rather than seeing the deficits in communities and have documented that work so these things could be scaled and taken to other communities. I think, particularly when we think about the school that Elise was talking about, for instance, and the same was absolutely true of the other housing estates where we started creating capable communities.

Many of those parents have an abundance of something that most of us don't

have which is time, but they actually don't know what to do with it or they don't have the opportunities to use it effectively. One of the things that has really happened by taking an activities approach is helping people to use their time constructively and in ways that engage them around their children so that they can see themselves as a success as parents rather than as a failure and that becomes the point from which we can then engage them into services and pay more attention to the changes they need to have to have ongoing safety in those families.

But I think that early intervention means we need to do that engagement piece and be in the places where the families are and give them an opportunity to build trust in us as a service system and for many of them they don't trust a service system for very good reasons. So we need time to do things. Everybody knows how to go to a barbecue, everybody knows how to sit round at an activity and do things where they get to know us and get to know the volunteers, so that we can build their trust and opportunities for them to do well as parents. Thank you.

MR CUMMINS: It's a commendably positive approach, Jo. Prof Scott.

PROF SCOTT: Thank you. There's some very creative ideas. Jo, I think it's very refreshing when you talk about inviting people to be contributors rather than asking them to be consumers of services. That's a very different way of thinking than we see generally in services. Replicating or transplanting and adapting a program based on principles that have worked here to over there is one challenge and a big challenge, and it's great that you're working on that front, but I guess the bigger challenge is how do you create the organisational conditions? How do you create a family life, short of cloning it? How do you create organisations which have that capacity to be that close to community such that they can invite people to be contributors rather than asking them to be consumers of a service and you've got then that soft entry into services? I'm interested in the organisational dimension of this, and thinking about the service system in Victoria, what organisations would have the potential to work in similar ways?

MS CAVANAGH: Thank you, Dorothy, that's a very complex question. Could I say that I think one of the unique things for Family Life is how it was started and it was started by volunteers in their own community who were concerned about pressures on families and wanting to prevent family breakdown and that ethos has continued through. So we are a place based agency. I think that bigger organisations also run place based programs and have a place based focus for some of their activity, but I think that it's meant that the organisation has a particular history of looking to the community for support whilst we're also looking to government for funding. Because there is a basis around the community ownership of the agency and an expectation that

the community is participating in the agency, that has spread more widely.

So, for instance, we have one opportunity shop that has 80 volunteers who work in it, and I can tell you, they feel quite free to tell me what I should be doing. They feel they own the agency and that sense of ownership and the community they provide through their opportunity shop to the local public housing estate is actually a feature of our service that's not seen.

So I think what we're doing comes from the origins of the agency but I think there are many other organisations that are equally doing interesting things in communities but it may not permeate the organisation to the extent that it does in ours. So I don't see this as being something that only Family Life can do. I think the place based focus is a really important piece and I think some funding for volunteers and volunteer coordination would be extremely helpful. That currently is not something that is systematically funded. Family Life funds it ourselves through our own income earning and donations. Community Bubs is funded by a philanthropic donor. He totally funds that program and has now for five, six years. He is the one who has also bought us a community house facility. So a lot of the resources that we get don't come from government but they can add value to the government resources, and it requires time to be able to work those relationships, build those relationships, and enable people to participate and then the philosophy flows through to the service delivery.

One of the things that we run is a local leaderships program, building residents as community leaders or parents as community leaders in their schools; again, it's in partnership with people rather than providing services to.

PROF SCOTT: Thank you. Could I pick up on that issue of leadership because in your written submission, you also talk about leadership more broadly in this sector. Where might specialised programs for strengthening the leadership in the community service sector be best developed? Yes, how would you go about trying to enhance the quality of leadership at your level across the whole community services sector, given that we have a bit of an ageing cohort of - - -

MS CAVANAGH: We do. Most people like to retire at some stage. I think if you look in industry or in the commercial world, when people are investing in something like innovation or leadership, there's kind of an investment spread where one expects three or four things to be successful. They're the ones that we'll continue to invest in but - you know, Bill Gates would talk about this, that you want to try a whole lot of things because out of that, you're going to find the two or three things you need to work on. But we're always so strapped for resources that we invest in one or two things and then we're surprised when they don't work, you know, because it's not enough to get the energy and the creativity going or get people inspired to be part of taking that extra step.

So I think there's an important piece around - the business schools, for instance, who want to run leadership and management for our sector - whereas they really ought to have resourced leadership and management for our sector - pooling our leaders to help build the programs of leadership for the future, rather than give us preset courses that they then think our field ought to do. I mean, we're much better at getting people to do a whole lot of things for hardly anything. You know, we can do that better than the commercial world. So there's an opportunity I think to focus some effort, and we don't give any time out for our social workers to learn to be leaders.

Dorothy, I don't know whether leadership is actually taught in social work courses yet but I believe it ought to be and we need to be at the table for big government policy decisions to be able to express what is the people impact of this decision to actually put some bones on understanding what the human impact will be of the decision that need to be made. So social workers ought to be at the table for that. I'd like to see some opportunity with social work schools and business schools and looking at our own peak bodies and leadership to design how we think leaders can be supported, taken offline, given time to study and learn but in a way that's sensitive to our workforce and the issues that we work with.

PROF SCOTT: Could I pick up another issue, Mr Chair, and that's around community development, and those of us who remember the 1970s will remember that that was a very vigorous and energetic era in terms of community development which had its roots back in the late 19th century, early 20th century. Where do you see that expertise now in the sector? What you're doing is quite different from what most organisations are doing.

MS CAVANAGH: Yes, and of course I came through social work in the 70s too and have continued to believe very strongly in that outreach community engagement. People have the solutions to their own situations if we enable them. Workers like Marilyn who have life experience as well as studying but have a particular way of building relationships with people need to be valued as strongly as those that have clinical assessment and diagnostic skills. Very few people can do the kind of work that Marilyn does so expertly. She has a team, together with the volunteers. So for some time family work or family support is kind of the poor cousin to counselling or more clinical assessment services when in fact they're of equal value. We need both of them, because there's people like Marilyn who will help the families come into the clinical services, go to the mental health facility. So we talk about investing in a whole range of expertise in the family services, family support platform in order to enable people to use other services.

When we started doing this work, I was using very much what was coming out

of some of the American prevention work by Deborah Daro in particular. Again, the skills around relationship building that are needed to build trust in these neighbourhoods are as specialist and expertise as some of the clinical assessment tools in the work we need to do.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales.

MR SCALES: Can I ask you some questions about Child FIRST and your relationship with it. In your submission, you talk about:

> *The Child FIRST structure is increasingly moving towards more of a service hub model.*

Give me a bit more feeling about what you were trying to describe there.

MS CAVANAGH: I'll say a little bit and then ask Suzanne perhaps to add to that. I think we've achieved in Victoria something really unusual in terms of there is actually some commonalities in terms of a system structure that's developing. Child FIRST is a pathway and a referral process into other services, but sometimes making those decisions about where does this family need to be or what's the best way to work with them requires additional expertise, which can be added in to the one place as a service hub. So we now have the community based child protection worker, we have people with cultural and linguistic diversity expertise. We would like to have an indigenous worker permanently there. An opportunity with the early childhood project is now there, and looking for mental health and drug and alcohol expertise to also sit with the Child FIRST team. Suzanne, do you want to add to that.

MR SCALES: Suzanne?

MS CAVANAGH: Suzanne runs Child FIRST.

MS SIBILLIN: Just following on from what Jo has said, I think there's also a lot of potential, if we're thinking about a hub model, to actually expand what we refer to as assessment within Child FIRST by making it perhaps more multidisciplinary. I think there's a lot of scope to actually build on that, to how we actually are assessing families, and the tools we're actually using to assess families across different agencies and getting some consistency. I think there's a lot of potential as well in terms of developing a more integrated service delivery model by engaging better and more effectively with other sectors - the obvious one is the family violence sector as well - and really building up a model which is about actually how can we, not just as a family services sector

but a wider community services sector, actually deliver the best outcomes for families once they make their way to Child FIRST.

MS CAVANAGH: So I think that does actually mean people spending time with each other too, that the professionals need to be able to get together and talk about the cases as well as send referrals by email to each other. That interdisciplinary conversation, we need to build in time for that to happen to then make sure people get to the services they need as quickly as possible, to the right one.

MR SCALES: Can we just have a conversation around this just for a moment, and we're going to go a bit all over the place again, but there are two themes coming through about Child FIRST - all of them very positive, so I don't want anything I'm about to say to be seen as anything else except in that context. Almost everybody embraces the principle that's behind Child FIRST, and even those that are looking for some change in Child FIRST and doing it within that context, that it's a bit like you suggested here, we're on a very early path here trying to understand it.

I'm paraphrasing really, but one approach is to effectively say, "Child FIRST is going okay. All we really need to do is give it more resources and then everything will be fine." There's another critique, a positive critique, about Child FIRST, which is Child FIRST yet hasn't been fully developed, articulated and even understood, and one extreme view of that is that Child FIRST probably ought to move more towards the tertiary end of service provision.

Again I'm paraphrasing the argument here, but Child FIRST ought to be a process whereby the assessment which you're talking about takes place. There's a very careful, well articulated, thoughtful assessment of the need of the particular family, or child in some circumstances, to determine what are the needs of that child, and then Child FIRST passes that on, almost completely, to an agency or a series of agencies to get on with the job. A Child FIRST role might then be to monitor that that's performing well. There might be, from time to time, a re-meeting up of the case workers that are associated with that to make sure the resources are appropriately available. The clarity of the role of Child FIRST is one of allocating the task with the alliance partners involved in doing the task. I'm just wondering where you sit in that spectrum of views about the development of Child FIRST?

MS SIBILLIN: I think there's almost a kind of a pre-question, if you like, in terms of the assessment phase as well, and it's around access, I think, into Child FIRST, which I think is maybe something that gets neglected, and I think if you start defining it as a tertiary service it removes it actually from early intervention, which is what Child FIRST originally was about. I think what has happened is that we are working with more complex, more high risk cases

and kind of almost becoming a co-delivery service alongside child protection.

So I guess for me there's something around how we're actually accessing communities as well and maybe strengthening that part of what we do. Going back to what Jo was saying earlier in terms of the community development model as well, I think there's scope for Child FIRST to develop and kind of move in that way as well, absolutely, but I think the assessment as well could be done in a more of a care team approach at that early stage as well. I think there's lots of scope to actually build on that and I think if we're bringing in specialist expertise from different sectors, which we're starting to do - but if we built on that I think that the whole care team holistic approach can start much earlier so you're actually thinking about that task allocation as part of kind of the assessment process, but those professionals are actually involved as well more holistically in the whole assessment process.

MR CUMMINS: Thanks, Suzanne.

MS CAVANAGH: I think it's also we can think about this in terms of having expertise that's attached to a hub but can move to different parts of the hub so that if Child FIRST assesses the case needs to go to this agency in an alliance, some of that assessment expertise can go to the alliance agency to assist them with that work. It doesn't all have to be done by Child FIRST. I think it's very difficult if we keep drawing boundaries around parts of the service system, rather than building the overlaps and the interface without duplicating. It's also true that there are vulnerable families and children who don't need Child FIRST. I mean, that's our whole point about creating capable communities and community engagement.

Some of the families that we've done the best work with include parents who have already got children in care and this is a subsequent baby. The opportunity to be a systems interrupter with that family is really quite critical. They've got a long story of things going wrong in their family. If we say, "Well, this is the beginning of the services. You're going to have to work your way through it this way," we're never going to hang on to those families. When we do it softly, in an outreach way, they're well known to the system but we now know there's another baby on the way. If we can engage them through a community house, build trust, help them to learn to use services positively, we can patch in what's needed as we're going along, but we need to trust the expertise of the workers to do that, rather than try and prescribe it in the system design.

The big investment needs to be the supervision and support and training of those staff because they're judgment calls, at the end of the day, about what's needed for this family based on the information we have right now in their context. So that pregnant mum, for some families can come into the system

really quickly based on vulnerabilities, for others it's softly softly, so that then the impact we get is not just for this unborn child, but as they become better parents for that child, they actually go and have better contact with children who are already in care and there's a ripple effect back into the service system. So I guess what I'm trying to say is that I think we can have ideas about things that are needed, we have to put the resources and be clear about the outcomes that we want, and then allow the people with the expertise to use those resources as it works best for this family, but held accountable for what they have done with it, rather than try and a design it top down.

MR SCALES: Thank you for that. As I understand the positive critique of Child FIRST is it has actually raised the question whether what you've described is possible, in that if we move to - and this is the critique - if we are moving - by the way I think, Suzanne, it's actually arguable whether it was actually established to be anything else other than a tertiary service. Some people have argued that it was meant to be a tertiary service, but let's put that aside just for the moment. Let's assume that the critique is right, that it is moving towards being a tertiary service - just for the moment. What that clearly does is create a huge gap at both primary and secondary and particularly at the secondary end, and I think what some people are saying to us is unless we recognise the dilemma which is Child FIRST is better able to organise itself at the tertiary end, then we won't recognise the need for a secondary service that does exactly, Jo, what you've suggested. I suppose that's what I'd be interested in - not now - whether you wanted to think about that and whether you felt that that critique is a sensible critique.

MR CUMMINS: Jo, you might like to perhaps take that on board, have a chat to Suzanne - all of you - and send us in a note; that might be the best way to do that.

MS CAVANAGH: Okay. Because I think we would argue very strongly for it to stay with an earlier intervention focus.

MR CUMMINS: There's an important issue there, so it would probably be worth just giving it a little bit of consideration and giving us your matured view of it.

MS CAVANAGH: We'll do our best.

MR CUMMINS: To Jo and to all of you, thank you very much. That was most helpful and, as I say, most creative and innovative too, so good on you.

MS CAVANAGH: Thank you.

MR CUMMINS: Thanks a lot. Next, Marg D'Arcy and Jackie Kelly. Come

forward and take a seat. Marg and Jackie, we've had the benefit of your written submission so you can take it that we're familiar with it, for which, thanks. You also have a documentary submission today. We're happy to take it in whatever is most convenient to both of you.

MS KELLY: Thank you. I'm just going to offer a little bit of a context for my talk to our paper.

MR CUMMINS: Thank you, Jackie.

MS KELLY: I'm general manager of primary health services at EACH Social and Community Health and in the primary health part of our organisation, we have a range of programs which support refugees, Aboriginal people, people with high and complex needs and people with chronic disease. We have a 90-place long day care centre which supports groups and individual children with high and complex lives, families and special needs. We have an early intervention and family support program and we work closely with these children in a wide range of other programs that involve the support of children and families. So that's the context; now it's over to Marg.

MR CUMMINS: Thank you. Marg.

MS D'ARCY: Thank you. I'll just add to that that we're also, by virtue of having, I have to say, .4 of a family support worker, we get to sit at the table and be part of the Outer East Family Services Alliance. I just wanted to comment on that discussion that just happened because we actually just had a discussion in our alliance on Friday about the role of Child FIRST and one of the concerns that maybe in doing the detailed assessment, sometimes what happens is it might actually delay the work that can be done with families by family service agencies or other agencies and also necessitates - because what happens when you refer to another agency, they're going to do an assessment themselves anyway, so it's sort of like there's a duplication of work.

I think Jo's suggestion of having Child FIRST - once they've said, "Yes, this family meets the criteria and meets the threshold and will be allocated to family services," to actually involve the family service agency that's going to pick that child up in the next lot of assessment, so that you avoid the time delay and you also avoid the duplication of assessments and you avoid families having to retell their stories constantly.

MR CUMMINS: Yes, we follow that.

MS D'ARCY: That's just a comment on that discussion, yes, not claiming to be the expert. As we noted in our written submission, we host one of the 24 early childhood development projects that have been funded by DHS. They

were originally funded as 18-month projects and they have extended them for another six months so it's now a two-year project. So a large part of what we will present actually comes from the work of our early childhood development project.

The aims of that project were really to increase the number of vulnerable children and families that are supported by Child FIRST family services to access and effectively engage with early childhood services. That obviously recognises the long-term benefits for children of participation in early childhood education and care and the impact that that has of improving long-term outcomes.

So the early childhood development project does focus on the children who are currently receiving support, so they already have to be in the system, if you like. They've got to be either Child Protection or Family Services clients. Part of that obviously is identifying how important it is for family services and early childhood services to work together around the interests of the children.

One of the issues that the project has thrown up, which I've already talked about in the written submission but I'll just briefly mention them again, is that there's a need to increase the knowledge of family services practitioners about stages of development in early childhood. There's a need to increase the understanding of those practitioners about the benefits of children engaging with early childhood services and how they actually do that. The other part of that is to increase the capacity of early childhood services to work with families to enhance the wellbeing of vulnerable children.

We believe that those projects are a really important step and they have been, certainly in our catchment area, incredibly useful at actually bringing the sectors together and getting them to talk to each other. We'd argue, for continued funding obviously, for those projects or funding that actually enables that the work of those projects continue, particularly the joint professional development and the secondary consultation that's available both for early childhood services - we've seen some really good stuff that's come out of that secondary consultation that's actually both facilitated children who are already in early childhood services, getting support from family services, but also the other way round, of actually opening up the pathway, by working with the practitioners, for those children to engage with early childhood services.

Also, partly allied to that, we've also been one of the three sites that was selected to pilot the assistance to early learning project; that's funded by DEECD, and that will actually do some of the work that we've been arguing needs to be done, so we'll have a key facilitation worker that will work with children who are basically eligible for the Early Start program. So children who are clients of Child Protection, Child FIRST family services or enhanced

maternal and child health practitioners. That worker will actually identify early childhood services that the children can participate in but also pave the way, if you like, do the paperwork that needs to be done, so assist with that referral process. We'll also have a family support position that will be able to provide additional support to the family to actually increase the children's access.

So that's one part, and that's going to be a really important project. However, I think one of the main issues that I'd like to talk about today is the role that early childhood services can play, if you like, before Child Protection and Child FIRST family services get involved. I guess the argument that I would make is there's huge potential there, if those early childhood services are resourced and supported properly to actually prevent the need for Child Protection and Child FIRST family services to be involved.

Some of the ways that I think that can be improved are around providing professional development obviously to early childhood services to enhance their capacity. However - there's always a "however", isn't there - one of the problems with that obviously is the cost of that. If I focus mainly on our long day care centre - as Jackie said, it's a 90-place long day care centre - we get no funding for that apart from parents' fees and obviously a special child care benefit which covers the parents' fees if the families are eligible. So if we take staff out of the centre to participate in professional development, we have to cover their costs. So cost is a huge issue for us in terms of providing good professional development for staff, and particularly around that issue.

The other one is provision of secondary consultation for staff. We can actually provide that a bit because we have our family support worker and because we have a whole range of professionals that are available within our service; we have child psychologists, we have the Early Childhood Intervention program. So we can provide some secondary consultation anyway to the child care staff and that certainly supports them in being able to work better with families, but to have that available on a more general basis I think is really important.

The other thing I think that is really important for early childhood services is for them to have the ability, which they don't at the moment, to consult with Child Protection, so they can't consult with Child Protection unless they're making a report. So for a day care worker, for instance, to be able to actually ring up and talk about a family, actually provide the family's name so that Child Protection can check whether there's a history or not and actually have a consultation would be incredibly useful and again might actually prevent that family entering into the child protection system because at the moment the only way that can be done is if the child care worker actually makes a report.

The other one is about easier access to subsidies, so that services can carry families who can't pay full fees but also may not be eligible for a special child

care benefit. I don't know if you know about the rules for special child care benefits. If a child meets the criteria, we can apply through Centrelink and we get 13 weeks' fees paid for that child. But every 13 weeks, we have to reapply and every time we have to reapply, we have to have support letters and a whole lot of paperwork to support that application. Sometimes what happens, there's a delay in getting the support letter. We don't want to put the family out of the centre, because we see it's really important. We've got a family in our centre at the moment that's carrying a debt of [redacted] and that's really related to the problems in trying to get access to the special child care benefit because of all the paperwork and all the documentation that we have to provide. EACH at the moment carries that burden but obviously in the long run that's not sustainable, so some better way of providing subsidies where children are vulnerable I think is really important.

The other one is identifying priority places for vulnerable children and families in early childhood services. Again, that raises an issue of resources because if you carry priority places, it means that you actually have to carry vacancies, and every time you carry a vacancy, in our case that's $76 a day that we lose out of our income. So being able to actually identify priority places is quite difficult without some level of subsidy.

Finally I just want to say something about the support for the provision of three-year-old kindergarten in long day care places. There's been a huge recognition which is absolutely fantastic of the importance of three-year-old kindergarten, particularly for children who are vulnerable. Long day care centres are often the best way for families who are a bit chaotic and not quite being able to manage routine to access kindergarten, because there can be a bit of flexibility about when the child is dropped off or picked up. They don't have to be there on the dot at a certain time when the sessions starts, and leave on the dot when the session finishes. So I'd argue that for a lot of families who are in distress or have a bit of chaos in their lives, long day care is a really good setting for providing access to three-year-old kindergarten.

However, for the long day care provider, it's an incredibly expensive option. The salary for a qualified kindergarten teacher is about 25 per cent more than a qualified day care worker. The other thing is because they're kindergarten teachers, they get teachers' leave, which means we have to backfill their positions for about 12 weeks a year. So just to cover the leave costs us about $12,000 a year extra as well as then the extra in the salaries. The subsidy available for eligible children is only around $2900 a year and because of the restrictions around the eligibility requirements, even quite a big centre is unlikely to have three or four, maybe up to six children who fit that criteria in any one year. So there's a huge shortfall between what it costs the service to actually be able to provide that support for vulnerable children.

MR CUMMINS: Yes.

MS D'ARCY: That's basically what I wanted to say.

MR CUMMINS: Thank you very much, Marg.

MS D'ARCY: Thank you.

MR CUMMINS: Jackie, is there anything further you want to add to that or have you both covered it?

MS KELLY: No, I agree completely with what Marg has put forward and just to really reinforce the fact that our priorities are the needy families in our community and we certainly do support a range of them and the cost of that has really been huge on the organisation.

MR CUMMINS: Thank you. Prof Scott.

PROF SCOTT: Thank you. I'm wondering if the community based child protection worker involved in Child FIRST is an appropriate role for the consultation that you mentioned before. I mean, once upon a time it was possible for someone to have a consultation with the Child Protection service before making a notification, and that's very helpful because you don't necessarily want a situation that you refer - that you tell the family that you're referring, you lose your relationship with the family and then statutory Child Protection doesn't think it reaches a threshold before you do an investigation.

MS D'ARCY: Yes.

PROF SCOTT: So I understand the importance of the consultation. Would there be a problem in - - -

MS D'ARCY: No, I think that would be excellent. I think the community based child protection worker is obviously the most sensible point at which that consultation can take place, but at the moment that's only available - if child care makes a report or involves our family services worker, then she can have the consultation with the community based child protection worker. So there's a way within our service that we can actually get around it, but most long day care centres don't have that access. So for them to have the community based child protection worker as a point of focus for secondary consultations without having to go that step of making a report I think would be excellent. It would fit very well with their role, particularly as they sit anyway often with Child FIRST, it actually opens up that pathway as well. It can have the potential to open up that pathway.

PROF SCOTT: So this isn't a problem for EACH but it is for the standard early childhood education and care setting.

MS D'ARCY: Yes, exactly.

PROF SCOTT: Thank you. My next question was about the staff development and I know in your written submission you make a comment about the need for tertiary education institutions in early childhood education and care field to have more of a focus on vulnerable children and their families. Changing university courses is never easy and that's a long-term way of trying to get the workforce development. I'm wondering if - you might be aware of the work of the organisation SDN Children's Services in Sydney which actually uses very experienced family-centred practitioners to teach the early childhood workforce on the floor of the centre, skills, engaging and working with families with multiple complex needs. Have you any experience doing that? Informally, one would have thought that EACH is very well situated - - -

MS D'ARCY: Informally, yes, and again, a lot of what I've said, there's a level where because we're based in EACH, because we're part of an integrated child and family centre, we do have access to those supports. Yes, sometimes we'll get our early childhood intervention professionals in to work with the child care staff. As I said, informally they have access to Sonia, who is our family support worker, and who will provide that sort of one-to-one mentoring and support for staff where she is working with families that might be accessing the centre. So it is an issue for us because there is still an issue of resources. There's also an issue of we see when we get - while all of our staff are qualified, they're either cert III qualified or diploma qualified and, of course, a couple of bachelor qualified for the kindergarten rooms.

But we see the lack of knowledge and the lack of information that they have about working with vulnerable children and families or even really basic things like how to make a report to Child Protection or understanding the difference between Child FIRST and Child Protection. They don't even have very often that rudimentary knowledge. So it's not so much the issue again for each, I think it is more the issue for child care centres across the board.

PROF SCOTT: Right.

MS D'ARCY: That's where I think the problem lies.

PROF SCOTT: My last question, if may, that each is distinctive in having under its big umbrella adult specialist services.

MS D'ARCY: Yes.

PROF SCOTT: I think problem gambling and services for - - -

MS D'ARCY: Family violence.

PROF SCOTT: - - - adults with mental illness and family violence.

MS D'ARCY: Yes.

PROF SCOTT: What are your thoughts about how we build the capacity of adult specialist services to be sensitive to the needs and responsive to the needs of their adult clients as parents and the children of the adult clients.

MS D'ARCY: It's interesting because that's a conversation that we've had a number of times within our team and the number of times - the simple thing of asking a question about, "Have you got children? How old are your children? What's happening with the children?" those sorts of questions I think are not often something that's built in. Services will work with the relationship perhaps and with the problems - I think again listening to the people from Family Life was quite useful because they'll identify the problems but not necessarily the strengths and how they can build on the strengths of families. So I think there is a huge amount of work that actually needs to be done with those adult services to get them to have more of a family approach.

Part of our team is counselling case work team that works primarily with adults and over the last two years we've moved the focus of that team to see everybody they work with within the context of their families. It has been quite challenging and there has been some resistance to it sometimes but I think that that is - you know, if you are going to work effectively with people who are at the, I don't know, pointy end, if you like, who are accessing alcohol and drug services or gambling services, then looking at their family context, apart from anything else, is going to help you understand what's happening with them. So there is a fairly reasonable, basic assumption about why you would do that apart from the issue of actually identifying children in those families who might be vulnerable.

PROF SCOTT: That's very encouraging. Thank you.

MR SCALES: I'm going to refer you to two words in your submission. I'm sorry to do this to you but I want to make sure that I don't misunderstand what you're saying in your submission. On the very last part of your submission you use the words - - -

MR CUMMINS: This is your primary submission.

MS D'ARCY: The written on?

MR SCALES: The written one. In it you use the words "protective intervention". What did you mean by that?

MS D'ARCY: I guess what I mean by that is, I think, particularly where you're working in early childhood services and you're working within a family context you're in a position to reasonably easily - if you've got a child coming to your centre every day and you're working with that child and mum or dad drops them off every day, you get to know them reasonably well. You're in a fairly trusted relationship with them and you can pick up fairly early, if you're attuned to it, signs that these children have the potential to become vulnerable. If you pick it up early enough you can work protectively with that family. So you can work with that family to actually build up the factors that create protection, you know, that help them develop resilience, that help them understand the importance of their attachment with their child, that help them connect to the community if they're isolated. So that's what I meant. Does that make sense?

MR SCALES: Yes, it does. Because we're talking about the system - and I'm going to sound overly analytical here - and please remember behind all of this is a child or a number of children so understand all that.

MS D'ARCY: Yes, absolutely.

MR SCALES: But to make something like that work has to be organised.

MS D'ARCY: Yes.

MR SCALES: Tell me what was behind your thinking about how you would organise that, how you would fund it, that approach and, in a sense as a corollary to that, whether in your own mind you were thinking about something that - I presume it's not at the universal or primary end, it's either at the secondary or tertiary end of the intervention, is it?

MS D'ARCY: I guess what I've just talked about here and about access to secondary consultation and access to supports that can be put around that universal service. So it's not about necessarily - my sense is and I see it in the practice that we have is that if a child care worker has got a bit of a concern and they can go off and talk to the child psychologist with the permission of the parent obviously or they can involve, say, the family violence counsellor with the parent, the support that is provided for the child and the family still sits primarily within that universal service of the long day care. But it's the support that's provided to those staff that actually enables them to work effectively.

MR SCALES: Thank you. That's good.

MR CUMMINS: Thank you both very much, Jackie and Marg. We're most obliged to you.

MS D'ARCY: Thank you very much.

MS KELLY: Thank you.

MR CUMMINS: Next Associate Professor Margarita Frederico and Lynne McPherson. Good afternoon. Very nice to see you, Margarita, and welcome to you both. Thank you for your patience and courtesy during the day. We've had the benefit of your substantial original submission of 29 April, substantial both in terms of content and in terms of scope, and also your specific documentation for today. So, Margarita and Lynne, we're happy to take it in whatever is the most convenient way for you but take it that we're familiar with the documentation.

ASSOC PROFESSOR FREDERICO: Thank you. What we'd like to do then is to just add a little bit to the context of our written submission and our focus, I guess, in our submission is in relation to professional development for the workforce. We are still focused on the workforce, looking at, I guess, professionalisation of the workforce and also research. So they are the three areas that we would like to address.

MR CUMMINS: Yes.

ASSOC PROFESSOR FREDERICO: We're basing our submission on our experience with the graduate certificate and graduate diploma in child and family practice, experience in teaching of social work and researching in the area of child protection and also Lynne McPherson's experience as manager of workforce development in child protection for a number of years, so we're based on that. We also want to acknowledge, and think it's important to acknowledge, the current staff in Child Protection and in the sector and praise their commitment and compassion to making a difference for children at risk and all children in the complex environment that they work. I guess we feel that that is important to do at this stage when we're talking about workforce development but we also recognise the long hours and the strong commitment that is put in by the workers currently and we do want to recognise that.

We do contend, however, that the sector has not paid adequate attention to ensure adequate knowledge and skill of the workforce. The policy initiatives undertaken by the department over the past 10 years we also commend but we stress that unless attention is given to the development of knowledge and skill in the workforce these policy initiatives, or any policy initiatives, cannot be

fully effective. We feel, and I know you'd agree, that the protection and best interests of children in our community is a task which must be undertaken with sound contemporary knowledge and skills and must be informed by research. Critical analysis and reflection are key capabilities required and these must be in the context of evidence informed practice.

As you'd be aware, when a child who is known to child protection in Victoria dies there is a review. Group analysis of these reviews - and I've done some myself - show that the major focus of the reviews is upon the compliance of the workforce to action prescribed the Act and the procedures listed in manuals, and of course this is incredibly important. But what we're not looking at is whether the worker had the necessary knowledge and skill required to do the work that was required. I think that this is something that we need to look at. As a sector we're very good at looking at what went wrong in a case and describing that. We tend to focus on the worker, in terms of whether they met, that they complied with what needed to be done, and certainly there are lessons to be learnt from what went wrong, but we'd also, I guess, like to put forward that there are also lessons to be learnt in exploring what went right, why things went right, and where evidence and knowledge was being used appropriately, how that impacted effectively and well for the child.

You may be aware that Eileen Munro in her recent report in the United Kingdom highlights the importance of listening to the workers and in encouraging workers to use their professional knowledge and practice wisdom. Just to quote, she states that:

> *The increased prescription for social workers, whilst intended to improve the quality of practice, has created an imbalance. Complying with prescription and keeping records to demonstrate compliance has become too dominant. The centrality of forming relationships with children and family to understand and help and them has become obscured.*

Munro makes the case for radically improving knowledge and skills of social work from initial pre-service education through to continuing professional development. She also highlights the importance of social workers' use of research evidence to help reach the most appropriate decisions.

So we're saying that there are three pathways to building knowledge and skills in the sector: one is professional development; one is professionalisation of the workforce; and the third is increased research. In regard to professional development, I guess we'd like to put forward the success of the graduate diploma and graduate certificate in child and family practice and these, as stated, are led by a consortium of cademe, community service organisation and Aboriginal organisation. As noted in our written submission, the courses are

funded by DHS and in the first instance for 90 students, one-third from the sector and two-thirds from child protection. The courses have recently been re-funded for another group of 90 students.

The focus of the certificate builds upon the beginning practitioner program and presents foundation knowledge in relation to research theory and skills, and the diploma uses, as a framework for the curriculum, the capabilities identified by Atkinson. The courses were proposed by the Department of Human Services as a component of a wider retention strategy for experienced practitioners and managers, and that's the outcomes that are being looked for. There are four key themes that have been identified in the interim evaluation and I'll just mention them and then Lynne will give some examples in relation to this. One theme was enhance confidence and greater confidence to operate as a front line case practitioner in child protection or family services; the second was increase reflective practice and effective decision making; thirdly, enhance competence and competence as a leader, including as a leader of an organisational culture; and fourth, strong capacity for cross-sector networks and inter-agency collaboration.

MS McPHERSON: So some very brief stories firstly.

MR CUMMINS: Thank you, Lynne.

MS McPHERSON: From a senior family services manager who was a participant in the inaugural graduate diploma. He told us a story about, as a result of undertaking the program, examining policy across his agency and going back to his board of management with a strong recommendation and fully developed proposal for a supervision policy to meet the needs of his team leaders and supervisors and, as a consequence, aim to strengthen practice across his organisation. That recommendation was accepted. He then trained his staff to implement that.

A second example, also from the diploma, was from a manager, a middle manager in a rural, regional child protection office who implemented a comprehensive retention strategy that looked at staff wellbeing, staff care, but also knowledge development, largely from the material that she had gained as a result of undertaking the program, and she implemented that with specific measurements put in place to look at indicators of change over a six, 12 and 18-month period.

One example from the graduate certificate comes to mind and that is perhaps more of a quote where it was echoed by a number of the student's colleagues where a family services student said,

At the beginning of this course there was really a sense of us and

them, that is, family services and child protection. On graduation it's now just us and that sense is mirrored in the way I practice in my workplace.

So there really was a much greater sense of power of collaborative practice and the meaning of collaborative practice in the workplace. I'll hand back to Margarita.

MR CUMMINS: Margarita.

ASSOCIATE PROF FREDERICO: What I'd like to turn to now is professionalisation of the workforce and I guess what I'm doing is suggesting the importance of social work qualified staff in key decision-making positions, and I'm not saying that everyone in the sector should be social workers, but I am, I guess, arguing and we're putting forward the view that social work is a basic discipline which provides preparation for working in this area as other disciplines do not, just as you have in medicine, law or other disciplines, the importance of having that foundation knowledge in your workforce. The department has maintained the commitment to employing social work qualified staff and child protection and is seen internationally as progressive in this regard, and we would argue that it's important that this commitment continues to be supported.

Social work, education and training provides courses that prepare students for both generic and specialist fields of practice, including child protection, and the degree programs provide important content that facilitate critical reasoning and high level professional judgment making that is considered essential to practise effectively in child protection. All accredited social work programs now have to meet requirements of specific content on child wellbeing and protection curriculum for the program. In addition the students undertake field work and a minimum of 140 days.

One of the things that we'd also like to put forward is that the department continue to support this and in fact increase their support of field work, and I'd suggest that they look at the initiative of the Health Workforce Australia, which is supporting the development of new allied health placements through funding, through contracts with universities and providers. I would also say if the department of the sector does not do something like this, they could well lose potential recruits to the sector because we know there's going to be a shortage and when students do field placements in certain areas, that tends to spark their interest to go back and work in those areas.

Also at a recent collaborative meeting with the Department of Human Services and the Victorian heads of social work schools it was reported that recruitment of social work qualified staff results in higher rates of retention at entry level.

As we know, high turnover is costly. I guess we recognise that social workers can be difficult to recruit, there can be a shortage but I would also like to put to the Panel that there should be a consideration of pathways into social work qualifications within the organisation and there is a close relationship, I think, between all schools of social work and the department which could facilitate that.

In our sector there is not a culture or tradition of undertaking additional qualifications as there are in other sectors, in other disciplines and this is a concern and, again, we would be wanting to suggest that that also is given attention when looking at building the workforce capacity, recognising that this take resources but we, as a community, do not at the moment spend a great deal of money on children who are the most vulnerable in our community. I think in some of the data in 2009-10 for every child nought to 17 years in Victoria $362 was spent on child protection and out-of-home care. So I guess we'd argue that there could be more for that. Just to illustrate the need of professional - - -

MS McPHERSON: The value of social work education at entry level, Margarita. By way of a story again, a young woman known to me in my time in the Department of Human Services, as opposed to La Trobe, was a relatively recent graduate and looking to her supervisor very much in her early months of practice as a child protection practitioner for guidance but also for development, for assistance in translating theory into practice. She found that a challenge in that her supervisor didn't share her qualification. Her supervisor had a lesser qualification and wasn't able to enhance her translation of theory into practice in the way that she had hoped for and indeed experienced on placement. So she had had her final placement in a Child Protection office.

She was reaching a crisis in fact because the emphasis in her supervision really was on the development of knowledge but knowledge in relation to procedure, knowledge in relation to very important information as a child protection practitioner, court process and manual guidance rather than theoretical knowledge - also critically important - and research knowledge. She had reached a crisis where she was considering either looking outside child protection for alternative employment or looking for other sources of supervision.

As luck would have it, she found herself being offered a new supervisor for a range of reasons - staff changes - who had a social work qualification and she described in a great deal of detail the difference for her in being able to build on her knowledge of attachment and particularly in relation to a case situation, her knowledge of attachment, developmental trauma, her cultural knowledge and translate that with some confidence and growing confidence into the decision-making process and the practice process, in particular the confidence

to pursue quality relationships across the sector, quality relationships in complex situations rather than a tendency toward seeking complex solutions to complex problems.

MR CUMMINS: Thank you, Lynne. Magarita, finally research.

ASSOC PROFESSOR FREDERICO: Yes, thank you. Our sector has not been strong in developing knowledge through applied research. We have been slow in identifying causes and prevention of abuse and neglect. We're very good at describing situations but slower in researching and analysing and obtaining evidence for what works. Thus there are continued practices which are not working and/or not informed by evidence. I give an example of the funding of the Take Two program as an example of bringing research into the applied research which research has been funded as part of that program so it runs continually alongside intervention. So what we would like to put forward is that the department supports staff to undertake research degrees across the sector and these degrees are focusing on practice and knowledge development in the sector.

I would say that Lynne herself is currently undertaking research examining models of supervision that are seen to enhance a child protection practitioner's capacity to practice effectively. It's that sort of work that we need so we really would put forward that the consideration be given to both allowing research to occur and also some funding of the research. So just to draw our presentation to a close, the three recommendations we'd like to put forward are the department continue to examine opportunity to strengthen the workforce across the sector with a greater focus on social work qualified entry level staff who are then supported throughout their career to undertake further learning and that there be a continuing investment in approaches to develop an interest in a career in child protection and one way this can be done through supporting field work placements and strategies to enhance the market supply of social workers which could be developed and there are recent innovations in the United Kingdom.

Also the department provide more opportunities for research and evaluation of practice through research scholarships to the department and sector staff and that opportunities for research and analysis of practice are recognised as important to be funded.

MR CUMMINS: Margarita and Lynne, thank you very much for that. We've had a number of submissions about supporting the workforce and thus ultimately children. A number have clustered around the concept of remuneration, which we understand. A number of clustered around the concepts of workload and work conditions, which we understand. But you have focused on something antecedent and very significant and that is

professional training, professional development, professionalisation of the workforce, research and that is an antecedent and most important area. So we're very grateful to you for doing that.

I am also pleased to hear you, Margarita, say that there is cause to look at what went right, not only as a matter of fairness and balance, which is important in itself, but also in its own right where there is a body of knowledge and also so that we can build epistemologically on that. So it has been most constructive, if I may say so. Prof Scott.

PROF SCOTT: Thank you for the wonderful written submission and fascinating information on the courses you have pioneered. There are two areas I would like to talk about and they're both around workforce and one is around whether you think that there is yet a coherent understanding about what content - and that includes values, knowledge and skills - relevant to child and family practice and child protection in particular should be in qualifying social work courses, bearing in mind that they have been woefully inadequate in areas such as child development and child health and even how to have a conversation with a child. You and I have been working hard to change that, Margarita, but you could even do two placements where you never spoke to a child.

So I think we have to start with saying that social work has really failed to produce its qualifying graduates to be equipped to work in this area as well as it might. So what belongs in, say, the bachelor of social work or the qualifying masters degree; what belongs in induction; what's the responsibility of the department to prepare its workforce; and then what belongs in the post-qualifying courses, the two that you've pioneered. First of all, is there any overlap between those three areas which could be addressed to make room for some more, but perhaps even more importantly, do you think there are significant gaps?

We've been hearing in the Inquiry from people from culturally and linguistically diverse backgrounds saying that culture seems to be only seen as an indigenous matter in child welfare policy and practice, and there's a huge gap in working in culturally competent ways where there are concerns in relation to children. There are still gaps around child development and child health, certainly gaps in an understanding of alcohol and other drugs, which is so central. So I'm just wondering, do you think we've got the mechanism for being coherent and comprehensive in which content belongs in which of those three segments, and are they now inclusive of the knowledge base that's necessary to do this practice? It might be on notice - you might want to come back to us with responses to some of these things, Margarita.

ASSOCIATE PROF FREDERICO: I would like to come back because I think

there's a lot in the question, and thank you. I think the work that you did sort of earlier, I agree that social work moved away from adequately preparing social workers to work in there and to work with children. I think that there has been a change around, and certainly the new accreditation guidelines which require certain content has led to that. I think in terms of the areas you identified - the sort of undergraduate, the entry level and a further research or further education - that the boundaries are blurred.

I think that we're still sort of exploring where things best fit, because certainly there needs to be recognition that workers going in at entry level need to be certainly up to speed, so they certainly need a lot in relation to that. Certainly in terms of approaches to theory, to critical reflection, to knowing how to tackle a situation, is something which I think they need to explore. The theories on development, particularly the new work on the neuroscience, all of that, I think should be part of basic - certainly the understanding of the sector. So maybe it's looking at that. I'd like to turn to Lynne, who did have the responsibility for the early development.

MS McPHERSON: Thanks, Margarita. To answer part of your question first, Dorothy, by saying that there needs to be, at the moment I'd argue, some blurring, in that you, in inducting staff post employment, don't have a level playing field. So you must be looking to address some foundational knowledge, which is not ideal in a post-employment induction program. You would want, ideally, to be attending to those things that pre-service education shouldn't be doing, which might be procedure, an applied knowledge of the legislation as opposed to a more theoretical knowledge of the legislation, for example. So that blurring must occur whilst we have a disparate qualification base.

If we could move to a space where we had primarily social work graduates coming into the workforce, you could have a much more seamless foundational knowledge articulating into a really sharp, "Now we're at the pointy end of induction, what about just focusing on applying your theoretical knowledge to these complex case situations that are just related to your work," as opposed to the generic training that social work offers across a range of disciplines. As for the postgraduate, I guess in a way the initial - we've found in implementing the diploma and the certificate a similar but different dilemma in that we do notice the difference in our students. We notice that some students have different capacities and that, in part, that relates to their pre-service education.

PROF SCOTT: Could I be the devil's advocate on that issue. I'm not necessarily advancing my own views but saying that there is a broad range of people who, in their professional backgrounds, have had a very high level of training and experience in working with children - maternal child health nurses, primary school teachers, the early childhood education and care workforce -

and then there are people who have worked in specialist adult services - alcohol and other drugs, mental health, domestic violence - which are very, very relevant to the statutory child protection population. Why would such people need to have a bridging course into social work which is a very generic course?

Would you see an argument that such people could be able to be articulated into a specialist child and family practice course which compensated for the bits that they don't bring with them from their specific professional backgrounds? So for those from a specialist adult worker background, they would need to have a lot of assistance around children, child development, working with families in holistic ways, and those who have got a more child focused professional background would need to obviously be skilled in working with involuntary clients, all of that.

So I'm really challenging you about why it's an articulation into a social work course and not directly into a specialist qualification. One of my reasons for that is that we will not have the workforce required to meet the current demand, let alone future demand, if we are to be dependent only on social work. I also think others would advance an argument that it might provide a richer, more diverse set of knowledge and skills in a more multidisciplinary team approach within statutory child protection if we were to go down that direction.

ASSOCIATE PROF FREDERICO: I guess I think whatever we call it that we do need to be clear on what is foundation knowledge and that I think that is related to the sector understanding society. I think that if we look at other disciplines, that probably we can all be trained to do part of medicine or something like that, but we don't know in a crisis to go back to the physiology, all of this. So I think whatever we call it I do think we need something that provides strong foundation, foundation knowledge that then can be built on.

I think one of the challenges for our sector is that we haven't focused on that, and we've seen people with particular skills in engaging with families or engaging children, which is also important, and we've said, "Well, if you can do that, then that's fine," and we've skipped over some of the foundation knowledge that needs to be built in. Maybe that could come about by a different type of course, I don't know, but I think we tend to just look at what can be applied immediately and not look at what's a foundation that then people can rely on when they're faced with very complex crisis situations.

MR CUMMINS: Well, specialisation is good but it's not enough, and life isn't always specialised, nor are people.

PROF SCOTT: Thank you.

MR CUMMINS: Margarita and Lynne, thank you very much for that, it's been most thoughtful and helpful. Prof Vinson and Ms Sally Parnell. Professor and Ms Parnell, welcome. Thank you for your very helpful and substantial written submission which we have studied. You can take it that we are familiar with it so we would like you to perhaps take us to what emphases or focus that you would like to deal with verbally because we have studied the written word.

MS PARNELL: Thanks for the opportunity to appear before the Inquiry. I guess we didn't want to go into a whole lot of detail about the minutia of the system, rather talk more about some of our areas of expertise and findings in terms of broader impacts of social disadvantage.

MR CUMMINS: Thank you.

MS PARNELL: Jesuit Social Services has been working with disadvantaged people on the margins for over 30 years. Our interest is in how we reduce that over time. So we're kind of interested in applied programs that help reduce that, as well as understanding the interlinked nature of disadvantaged and how this impacts down the line which obviously Tony will speak to. So a lot of what we're dealing with is young people in the youth justice system and in adult corrections. So we have a long history of people that are probably the by-product of a trajectory through the Child Protection system.

More recently have been working with newly arrived communities where we're noticing failed settlement which is resulting in an interface with the system. Just in the previous group presenting Dorothy mentioned the whole issue around cultural competency and awareness is an area that we're interested in as well. I might pass over to Tony to talk a bit more about our broader research.

PROF VINSON: Thank you. I just begin by saying that I've had an involvement with Jesuit Social Services now for something like 12 years and during that time we've undertaken, as you will have seen, a number of studies just mapping really the geographic distribution of various things that are usually of great concern to governments and to people in the community service game. What we have unearthed - I think this is what I would like to emphasise - is continuing evidence of the non distribution of things that would ordinarily be labelled social or individual problems. No matter which way we have looked at things, always that same compelling piece of evidence comes forward.

In 2004 we looked at it from two points of view. One was just the sheer distribution of acknowledged child maltreatment in Victoria, not at all taking account of the eligibles but just looking at the thing in terms of how it's

distributed. A figure which constantly recurs came out that 2.7 per cent of 600-plus postcodes in Victoria would give you 25 per cent of the acknowledged so-called confirmed cases of child maltreatment. Approximately 8 per cent would give you 50 per cent. Since that time we've looked at admissions to prisons and very similar results occurred, 2.1 per cent in 2004 would provide you with 25 per cent of the total prison population in Victoria.

That has also been reasonably confirmed by something else that we have done. We have looked at young people in trouble with the law and admitted under supervision awaiting court determination of their futures and almost an identical figure emerged, 2.1 per cent. I'm not suggesting something magical about that figure but it just keeps coming up all the time. Now, if you look at it in terms of rates where you take account of not only the number of instances of confirmed maltreatment but the population base from which that could be generated within postcode areas, then you get a somewhat different result but still a remarkable concentration of acknowledged instances of child maltreatment within a very smallish number of postcodes, in fact 13 per cent would give you one in seven or one in eight of those instances in Victoria.

So what else can we say about this? We can put it in the context of repeated studies of that kind which repeatedly produce similar lists of highly - well, we have use current parlance - at-risk locations. Now, we wish something finer could be used below the level of postcode but it happens to be the one geographic unit for which this sort of information is available. When we look at child maltreatment a bit more closely it has one very distinctive feature from a statistical point of view and that is, unlike the other 23, 24, 25 indicators that we have used which range across health, employment, mental health and so on - I'm sure you've seen the list - usually these things rise and fall, wax and wane together. These indicators are interconnected and with very few exceptions from the beginning you tend to get a correlation between this variable and that variable.

Child maltreatment is different insofar as there is a sort of threshold. You don't get that inter-correlation in the low to moderate - in terms of disadvantaged - areas. It's when you get to the upper reaches of geographically concentrated disadvantage that you start to get a highly disproportionate number of instances of confirmed maltreatment. Raising the question, I suppose - and no doubt a body a bit like yours would be contemplating this - is this a reflection of the vulnerability associated with multiple forms of advantage or is it, at least in part, contributed to by the closer surveillance that would exist in those locations by virtue of the number of agencies that might be involved and so on. Beyond the evidence from the Jesuit studies I have had the opportunity in the past of trying to answer that question as best one can by saying, "All right, let us start from the proposition that there will be more attention given to certain

locations, certain families within society."

But if we take the 10 per cent most disadvantaged locations - this is Sydney based evidence rather than Victorian - and ask, "What was the relative rate of maltreatment within each step of that bottom 10 per cent?" and you get evidence of increasingly higher rates as you go down in the direction of the most disadvantaged locations. So I have personally taken that to mean, yes, probably there is a surveillance influence on these results but I have to take seriously the fact that even within that portion of society which would be under the gaze or the authorities you still get an increase as you go down through the bottom social stratum.

The other evidence that I should also just bring in is that I once asked the state authority in New South Wales - I take it it's acceptable for me to cite New South Wales evidence here - to nominate the location within metropolitan Sydney which had the highest rate of child maltreatment. That suburb divided, fairly conveniently, into two distinct halves, one with a low rate, the other with a fairly high rate. So we had before the question, what accounts for this? Instead of working in the traditional geographic units, we looked at the clusters of families and households that where confirmed instances were said to exist and whereas we found little difference between different parts of the suburb, when we contrasted that population, we found very high rates of many other disadvantageous things within the clusters. It wasn't a random distribution.

The thing that all these studies have shown - and I guess I had probably better wind up - to in fact correlate with high rates of child maltreatment have been very, very basic things. They have been low incomes, both individual incomes, household incomes, low levels of education, higher rates of apparent ill health and disability and the occurrence of crime. So that is a table in a sense of what I can adduce by way of evidence and a problem for everyone and no doubt for the Panel is what sense do you make of it and what are the implications.

MR CUMMINS: Thank you, professor. It's very thoughtful and thought inducing as well. Prof Scott.

PROF SCOTT: Yes, thank you for the very powerful analysis and I have read your work for a long time with great interest and observed the work of JSS. I'd like to go to the issue of responding to that issue and the concentrated social disadvantage and there are so many potential policy responses to that.

PROF VINSON: Yes.

PROF SCOTT: I'm particularly interested in the Windale example that was used in the appendix and your comment in the body of the report about the factor of social cohesion as a variable so that you might have similar

concentrations of social disadvantage but a community in which there was stronger social cohesion, that that functioned as a protective factor in relation to child abuse and neglect which is also the finding of studies in Chicago and elsewhere. Thinking about the Windale case study, but not wanting to reduce the complexity of your analysis to social capital and social cohesion - obviously it's much more than that - what do you see as the potential for those sorts of interventions? How is Windale faring today? Has it been sustained? What's required to intervene at that level around social connectedness, social capital, social cohesion using primary schools as the platform or whatever? How long does one need to do that to see the gain and sustain the gain given the power of the other factors operating in this concentration of social disadvantage.

PROF VINSON: If I could address the last part of your comment first that would be helpful, I think. At a much earlier stage - in fact back in the mid-1970s - with other colleagues we became interested through an agency called the Bureau of Crime Statistics in New South Wales in trying to look at the distribution of crime in a city and Newcastle was the chosen place. At that time it was quite apparent that there was one location with that city that had very high rates of the various indices, not as comprehensive as has been possible more recently, and I can say that that was Windale. I didn't say at the time but interestingly everyone named it.

In addition to that we also looked, via the bureau, at similar patterns across New South Wales. One of the salutary lessons I think I have personally and professionally learned from all this over such a long period of time, over more than 30 years in fact, is that locations that were prominent three decades ago are still prominent today. As far as Windale was concerned, it was off the government radar. Several of us had a job persuading the authorities that this was a contender for some special community strengthening endeavour. That was duly provided and I had the chance to look and see what happened as a result, not only in that location but other areas which had been focused upon for community-strengthening endeavours.

What I can say - and it's reported in this publication Dropping Off The Edge - is that in a smallish sample, I think it was three or four areas that we went to and looked at, you had a short-term improvement in the situation. For example, Windale was in the first 10, if I can put it as generally as that, it was very close to the top of areas in New South Wales with registered confirmed child maltreatment. After an effort that last but a few years, it had gone down the list to about 25 per cent of the way down the list and there had been, as you can see from the sorts of things attempted, quite an emphasis on children in that location. The same pattern has appeared in other places that I have had the chance to retrospectively look at the consequences of the special effort and the pattern was repeated. Improvement for a period and then a reversal pretty

close to where things started, in other words back to tors.

Therefore, my answer to your question about duration unequivocally is this: if it's taken 30 years for many of those locations around the state to - or if they have been in that condition of having elevated levels of disadvantage, it certainly isn't going to be remedied in a couple of years. The general pattern in many parts of Australia I think, but certainly in New South Wales, has been three years of effort. There will be a return, there will be an improvement but it will not be sustained once you terminate the special effort at that point.

The Windale project was characterised, once it got under way, by good cooperation from government agencies in the Newcastle region, good cooperation from the housing authority - it was predominantly a Housing Department suburb - and a degree of engagement and involvement of local people, local organisations, local individuals. There could have been even greater involvement of the local people if it ad accorded with orthodox notions of community and community development. The enthusiasm of key institutions like the education authority was of paramount importance in opening the doors of the primary school from which the various programs that I think you've seen listed operated. The reaching out to the children before they came to school, the extension of health services, Aboriginal services of various kinds.

One of the absolutely key programs - and you wouldn't get it just from the listing - was the invitation to local citizens, but that involved quite a large number of single parents actually, to come to the school for recreational activities and that was the starting point and gradually the question was raised, "Would you like to devote some of the time we're together to thinking about bringing up children, family matters?" Within a relatively short time the people offering the program couldn't cater to the level of express need for it. But I also think among the various things that were listed here there was a triggering effect.

For example, the regional head of the education authority confirmed for me that something like 40 to 50 fathers had become involved in the school, some assisting with reading exercises, some were things that were within the scope of their abilities to handle, like ground improvements, but a very substantial number of fathers began to become attached to the local school. Sadly a lot of these things, I suspect, have not fallen by the wayside but a key driving element was the community place manager - for want of a better term - but I would, with my background, say community developer who worked in the location and again it was the case three years were up and phrases like "we must roll out the program, roll out to other locations" came to the fore.

But it was extremely interesting how people started to pick up on the

enthusiasm and the positive thinking. So for the first time in this place which had been highlighted by research 30 years prior, you had the identification of talented children and the recognition of their talents. This had a major impact. Whether or not you get as much out of talented and programs, as some would claim, I don't know, I'm not sure. But one thing I can say with certainty is that the recognition, "We have talented kids here was very, very important." So before long you have displays of art from the schools in the regional hospital and so on and so it goes. Does that begin to answer your question?

PROF SCOTT: Yes, that's very, very helpful. That's given it a very rich flavour. Thank you.

MR CUMMINS: Mr Scales.

MR SCALES: No, nothing.

MR CUMMINS: Professor, thank you very much. We're delighted you're here and equally Sally.

MS PARNELL: Could I just make one final point before we finish and it's a quick one. It's just about, I guess, a related matter and that is our concern about the direction being pursued by the state government in terms of minimum sentencing for young people which end up through our services and consequently in child protection and we have been running group conferencing with is a therapeutic jurisprudence approach to young people and believe that has a great impact and we're quite worried about removing the discretion of magistrates to make decisions about violent crime.

We believe there are lots of other ways where people can be treated and there be some consequence of those very serious activities without putting people in an expensive prison situation. We would argue that there have been a number of pieces of research that would say group conferencing is really good and a much more cost-effective way to be responding to these young people. So we just wanted to have that registered.

MR CUMMINS: We're aware, Sally, of your good work in the area of group conferencing in particular. Good wishes to you both.

PROF VINSON: Thank you.

MS PARNELL: Thank you.

MR CUMMINS: Ladies and gentlemen, we'll now move into having the benefit of persons speaking not on behalf of or in relation to organisations but individually. As I am sure you appreciate, ladies and gentlemen, we do not

investigate individual cases or individual organisations. We're looking at the system as a whole. If you wish to refer to an individual case, what we would be most assisted by is you telling us what that shows about the system, what principle you want to extract from that individual case because we don't investigate individual cases as such but we can, of course, and do learn from what has occurred in the past. If you extract what is the principle that you want to state or what is the improvement in the system that you want to state I'm quite that would be of great assistance to us. Ms Q. You are welcome all to come up, if you like. Ms Q, you're a carer?

MS Q: Yes, I am a foster carer.

MR CUMMINS: Tell us what you'd like to say.

MS Q: I'm a little bit nervous obviously in this sort of setting.

MR CUMMINS: You're very welcome.

MS Q: Just listening to the other ones before me I feel like - it's definitely quite a different topic of mine. My husband [redacted] and I have been carers for about 17 years and I work also at [redacted], two days a week in the recruitment team. So not a social worker but just as a carer to help recruit and retain the carers that we have. Mohamed, who was originally from a Muslim agency, has asked me to speak about a placement that we had a couple of years ago. A young Muslim girl, who I'd like to call Anna for the sake of today, who was with us during the time of Ramadan. So what that meant to the placement and for her as a Muslim young girl. So that was my topic for today.

As I say we'll call her Anna. She was with us for a couple of weeks while her father was unwell and then did return closer to the Ramadan time and was only meant to be with us for a short time. Often with foster care placements, as I'm sure you know, it gets extended and extended. So her father, not being well, was not able to participate with Ramadan so that meant a lot to Anna that she wasn't experiencing that with him. We're not a Muslim family so it was something really hard for us to get our head around and what that meant. [redacted] had spoken to somebody at his work to find out what does Ramadan mean, how can we bring this into our family, into our home, how can we respect her wishes and whatever.

Because she was doing it on her own it was something that, I suppose, Anna was a little bit probably negative about really doing. As much as it meant a lot to her, she was happy to push out the start of it. She said, "I could start it next week, it doesn't matter." It had already started and it goes by the moon or whatever. It had already started so she said, "I can start next week and maybe I

go home and I do it with dad," so it had extended out. But in hindsight I really regret that we didn't look further into it at the time, about how we could make that part of our day-to-day life and respect her wishes, even though she was happy to not do it but, you know, just to want to experience that with her.

It got extended, as I say, and included the family holiday up to the snow which was with two other families so a bit nervous about what that would mean to the household about the disruption of her eating through the night or getting up before the sun came up and the noise of the kitchen being active. It didn't happen and excuses were made. I suppose our point is the need for more foster carers across the board but particularly within the Muslim communities and other communities. As you were saying before, professor, about the need for - the talk about the Aboriginals and the need in that sector but it's also across the whole board with Muslim and Chinese and lots of different areas; the need to have supports in place as well as more families that are prepared to care for children in their own home that would include a wider range of minority groups.

MR CUMMINS: Indeed. Mr Q, would you like to add anything to that?

MR Q: No, I don't think so. I think just getting back to what [redacted] was saying is our thoughts are that Anna didn't want to inconvenience us by bringing her situation and make it affect our lives. We probably would have been prepared to but we were very naive in actually what the whole process means and actually what it represents and all that sort of stuff. So from our perspective we're being guided by what she says. So if she says to us, "It's okay, I can start it later," we take for granted that that's true. Now, whether she actually believed that or she was just saying it to not disrupt us any further with the fact that she is already there, we really don't know, but we think it was probably a bit of the latter rather than the former.

MR CUMMINS: I understand. It's very helpful to us to get personal insights, so that's most beneficial. I don't have any questions.

PROF SCOTT: No, just to say that you've really captured for us something of the practical subtleties and complexities in cross-cultural fostering and it was a really interesting insight. Thank you.

MR CUMMINS: Mr Scales.

MR SCALES: Mr Q and Ms Q, how did you get the information that you need?

MS Q: As I say, it was as basic as [redacted] speaking to somebody from his work that was from a Muslim background. As it was during the end of our

placement I was in contact with Mohamed and I thought he might have been here today, he could put some - I know he has submitted something for this Inquiry as well. He has been a great support for me since. Like, if we did have Anna back or if we had other Muslim children, I'm sure he would be very much a part of that. We get invited to the festival things that are happening even today.

Also Googling, get onto the computer and learn a little bit about it there. That can be a little bit conflicting when you don't know anything about it, your perception of what you're reading as well, I think. So that was a little bit confusing. But getting first-hand knowledge from the guy at [redacted]'s work and - - -

MR SCALES: Would it have helped you if the agency that you were working with had have provided you with good, reliable, well-articulated information?

MS Q: Yes. It definitely was not considered. As much as I love the agency that we're with and I work there a couple of days a week, it was something so new - we haven't had many, if any, Muslim children within the program. So we definitely have learnt a lot from it as well I'm sure as an agency and as a support person that I am to other carers, I hope that we're doing better with that as time goes on. Yes, really interesting.

MR Q: I think it needs to be a bit of a mix too. It needs to be a communication process because not only is it about getting the information, it's about taking the background of the individual case. In Anna's case she had just arrived from Afghanistan weeks before so the way a Muslim in Afghanistan treats different parts of their culture can be quite different to the way an Australian Muslim community celebrate certain things as well. So it's not just one way and as we've all experienced in life, just because two people are of the same particular religious situation it doesn't mean that everything about that religion is exactly the same to both of them. So it's about taking the individual case, not just a broad generalisation.

MR SCALES: Thank you.

PROF SCOTT: Thank you.

MR CUMMINS: That's very good to have that insight. Thank you both very much.

MS Q: Thank you.

MR CUMMINS: Next is Ms M. Welcome, Ms M.

MS M: Thank you.

MR CUMMINS: Please take a seat and just settle yourself in. Thank you for the provision of the document. If you'd like to read it, that's convenient. Whatever you would like to do we'll follow.

MS M: My name is [redacted] and I've been a foster carer for 19 years. I'm also on the board of FCAV as well. I've cared for a great number of children over this time, including emergency, respite, short-term and long-term care. The children that my husband and I have cared for are of all ages. I would like to thank you for the opportunity to highlight strengths in the current system and suggest some areas for further improvement to ensure best outcomes for children and young people in care. A lot of these issues don't just affect me, there are other carers as well that I have spoken to.

First of all reimbursements. While I know that the DHS carer reimbursement is only meant to be a contribution towards the cost of day-to-day care of the child, as a carer who has received a variety of rates of reimbursement for the variety of children we have cared for - this is with intensive, complex, therapeutic and a general rate - I don't believe that the general rate of reimbursement adequately covers the expenses associated with caring for a child. Costs associated with a child include all the household day-to-day costs plus transport, clothing, incidental school costs as well as social costs like friends' parties, pocket money and pets. There are also expenses incurred in relation to extracurricular activities. These are all before consideration goes into the complex needs resulting from trauma the children may have experienced.

One of my concerns is that the process of deciding which rate of carer reimbursement applies to which placement is unclear and lacks transparency and is rarely made in consultation with the carer. It also appears to be rarely reviewed or difficult to get reviewed once the placement has commenced and the child's behaviours are exposed to the carer. While I have usually been able to get agreement and reimbursement for extra expenses, family holidays which we have been interstate and overseas have always been at our family's expense.

It can be frustrating not to know who is responsible for covering these expenses. Items such as child care, specific clothing, school uniform, sporting, extracurricular and recreational activities, transport to access, appointments and school. Also clarification of who will for therapeutic services such as tutoring, occupational therapy and counselling needs clarification. There's also inconsistency with only some carers being able to access Commonwealth government entitlements which are means tested on a carer's own income. Such means testing should be abolished with all children in foster care being eligible for the same additional assistance.

I'd also like to talk about the implement of therapeutic framework of care. As a therapeutically trained and accredited carer, I see many benefits in programs such as the Circle program. I hope that agencies will increase foster carers therapeutic skills through training, information and skills development sessions with expert facilitators. Carers of children with specific and special needs require training and information in various therapeutic topics via a number of different forums such as online, DVDs and podcasts. The training is vital to ensuring the highest quality of care. Some of the things that are important in assisting carers undertake this training are for CSOs to ensure child care is provided and that training and information sessions are convened at times making it possible for carers to attend.

In my caring for children in our home we think that it is important to create a healing environment. This requires us to be therapeutically trained. It also requires us to have access to resources that will assist in this healing. These activities include sporting and recreational activities as well as the counselling and thorough health services. Access to such activities should be timely with clear understanding of where the funding is coming from. It would be useful for DHS to provide clear information regarding where the additional funding to do this therapeutic work or activities comes from.

Also respect for the role of the carer. Carers know the children and young people in their care. I live with and talk to my children and constantly. I'm charged with meeting their every day-to-day need and assisting them to heal from traumas they have suffered. Yet I am often not asked what is in their best interests when it comes to planning. A system needs to be implemented that active recognises and involves carers as valued and contributing members of a team.

Lastly I'd like to talk about the ongoing support for permanent care conversions. Currently permanent care conversions, which is kids going from foster care to permanent care with their foster carers, do not receive any support from the foster care agency beyond a voluntary three-month period post-legislation. This prevents many children from being able to progress to permanent care. This is because they or their carers may need support to facilitate access, have contact with the birth family, access specialist supports, access funding or simple general case management support. It is this lack of ongoing support that has prevented us from taking on a permanent care conversion for a child that has been in our care for six years. This means that this child and other children remain a part of the foster care and child protection system, are subject to the court system and do not have the experience of a normal childhood within a normal family setting. Because of this I feel that agencies should be funded to provide post-permanent care support to children on permanent care orders.

The type of support needed would vary for each child and carer but ideally there would be a system which would allow children and carers to get on with their lives away from the system and then contact the agency for help, advice and support during difficult times such as adolescence or if contact with parents has suddenly become difficult or additional financial pressures.

I strongly feel that foster carers who become permanent carers deserve ongoing support at times when they need it and that ultimately this would lead to best outcomes for children and their carers. Thank you for the time.

MR CUMMINS: That is very clearly expressed, Ms M. Thank you very much. Prof Scott.

PROF SCOTT: Yes, thank you. That's very, very valuable and very clear. I'd like to ask a little about the permanent care, if I may, although all that you've said is very valuable. When you say that a child may be with a foster family for many years, can you say at all, without going into any specific child, what this is like for the child? If the matter is periodically going back to court for an extension of the order, what is this like from the child's perspective in your experience?

MS M: It's frightening. If a court order only goes for a year, it means every year going back and seeing their legal representation. I can speak about this particular child: when it used to go back initially every year, it was the fear of being placed home, even though that was assured that it's not going to happen, but you really never know until the court order is processed. But it's the questions, it's the ongoing questions about what you want for access and it's asked over and over and over again. To the child, it feels like, "I'm not being listened to. I've already stated what I want," and then each year there's another round of more questions.

PROF SCOTT: Unsettling.

MS M: It's very unsettling and it doesn't give them a feeling of belonging when it's just from one court case to the next, whereas a permanent care order would be much more settling for the child.

PROF SCOTT: Can I ask a bit more about that. We've heard from some kinship carers that they would advocate something like a five-year guardianship order as a way of trying to reduce that insecurity, not the same as permanent care but something along the pathway to - - -

MS M: Yes, I certainly think that would be great. At the moment, it seems to be that it's a custody order or permanent care and there's nothing in between.

Sometimes it's very difficult for a child to accept that if they want to go on interstate holidays or camps overnight that they're still having to ask permission from a parent who they may no longer even see. I guess it feels like an insult to them that you're asking this person who is not part of their life, has nothing to do with the day to day, and yet they're going to have the final decision as to what school they go to or whether they can travel. So a guardianship order would definitely be preferable and a five-year term would be more settling as well.

PROF SCOTT: Thank you. The last question I have is who would be best situated to provide the ongoing support to a family once a permanent care order or something like that was made? Would it be the original foster care agency?

MS M: Yes, where you've already built up a relationship, I think that would be the best way to go.

MR CUMMINS: Mr Scales.

MR SCALES: Can I ask you how the relationship between yourself, your agency, the child that you're caring for and DHS works for you? How does that all work? Is it coherent? Is it thoughtful? Is it organised for you and the child?

MS M: It varies from case to case and different children will have different workers and I guess it depends on the quality of the worker you're dealing with. One of the difficulties I find, especially with a child that has been with us for so long is the changeover of workers. Just the CSOs, she's had five different workers in six years; DHS workers, I wouldn't even begin to count how many workers. At the moment, case management - I forget the term for it, she's cased out to the organisations, so she doesn't have anything to do with DHS at all. But just the turnover in staff, it's very difficult to build up a relationship.

MR SCALES: So even within the community sector organisation, there's still been five or so caseworkers?

MS M: Yes. As it comes back to court every year, you have got a new caseworker, so the new caseworker has to give her a lot more questions and it feels like she's being interrogated and not being listened to. Yes, there are a lot of problems there.

MR SCALES: It doesn't sound very satisfactory. Thanks very much. That's all. Thank you.

MR CUMMINS: Ms M, thank you very much, both for your very thoughtful submission and also for you putting into that the benefit of your experience

over time. We're most obliged to you.

MS M: Thank you for your time.

PROF SCOTT: Thank you.

MR CUMMINS: It's a pleasure. Ms F, take a seat, thank you. Ms F, thank you for your written statement as well. We'll follow whatever course is convenient. If you'd like to read it, you're welcome to do so.

MS F: Thank you. Thanks for the opportunity to make this submission and I'm very pleased to be following on from the last speaker. I've got something to add to that. I'd like to acknowledge the traditional owners of the land and pay my respects to their elders, past and present. My name is [redacted]. I've been a foster carer for 10 years and I've provided long-term, short-term, emergency respite and permanent care. I've got one permanent care child now. I've been involved in two different therapeutic programs and have cared for children with a disability. I've also assisted with training and assessment of other foster carers and sector staff.

I'd like to confine my comments today to four areas, the first being permanent care, which is why I've followed on there. Permanent care services are currently linked to local adoption services and I believe they need to be viewed separately. Adoption usually involves infants and its intent is to provide a relinquished child with a family but also to provide a family with a child, so there's that added thing which I think has to be acknowledged. Permanent care, however, needs to be viewed as more closely aligned with long-term foster care. These children have usually had several years at least in the foster care system, as we've just heard, and already often identify strongly with their birth parents, siblings and maybe other members of their extended family.

I believe that in most cases, their best interests are served by providing security and stability in a long-term placement with their current carer if that carer is willing and able, whilst maintaining contact as appropriate with their birth family. There seems to be a belief amongst adoption and permanent care workers that foster carers sometimes have an agenda of coming in through the back door, collecting children, seeing foster care as an easy way in to getting a permanent care child, but in fact carers are often approached by DHS workers to convert a long-term foster care placement to permanent care because it gets the child off the books and so on. So carers can actually feel pressured to take on these children as they have formed a close bond with them and do not wish to see them traumatised by yet a further move. Yet if they agree to convert to a permanent care order, they do so knowing that most of their supports will be withdrawn.

So in contrast to what I've said about adoption, permanent care is not about providing a family with a child, as in the adoption process. These carers have already by default almost developed a relationship with this child and feel a responsibility to provide further long-term care for that child. These children are traumatised by their experiences in the care system, perhaps with multiple placements, perhaps with multiple failed attempts at family reunification, perhaps even with previous failed permanent care placements. Permanent care children and their carers require the same support and services as they did when they were in foster care.

I have an example of a boy that I cared for for [redacted] years. [redacted] But he's been in my care for [redacted] years because I have had the support of the foster care agency and of DHS, Protective Services, so I've had all the supports I've needed to be able to maintain that placement, whereas that wasn't able to be maintained in two separate permanent care settings.

I have one final point to make in recommending the separation of adoption and permanent care and that is that is there is a high demand among potential permanent care families that come in applying for adoption and permanent care. There's a high demand infants as they seem to be regarded as relatively undamaged compared to children who have been in the system for many years. In my experience in the case of infants the adoption ideal of providing a family with a child can seem to take precedence over keeping siblings together and I've had experience of that as well. So I think there is this idea of family forming within in adoption services as providing a family with a child and that somehow that's in conflict with the best interests of the child in keeping siblings together.

My next topic that I'd just like to address is leaving care. As everyone knows the current generation of children are leaving home much later than in the past, you know, mid-20s, late 20s. So imagining a vulnerable, traumatised child who is very ill equipped to be leaving home and setting out on their own, they leave the security of their foster care placement the day they turn 18. Furthermore, there's a higher incidence of intellectual disability and mental illness among young people in care compared to their peers and that compounds the problems of transitioning into adulthood. Young people leaving care are more likely to be homeless, unemployed, involved with the criminal justice system, all of those types of things.

So again there is an expectation on carers that they won't just throw the person out the door when they're 18 and indeed most carers don't want that either and a lot of them willingly continue to support the child. But that is the alternative, they continue to provide housing and support for the young person for another seven years perhaps into their mid-20s in the hope that you're going to have a healthy, well-adjusted child and this is to be done with absolutely no support from DHS. In the case of young people with an intellectual disability or mental illness, a lifetime of care may be required.

It's imperative that leaving care planning involving the carer and the young person starts earlier than it does at present and that care be extended in some form until the young person is 25. What I see as a possibility - everything needs money, of course - but if there are supported housing units based on, like, a Lead Tenant type model where there is someone there to provide mentoring and support for the young people, that should be made available to every young person leaving care and that young person, in discussion with their carer, could have three options then: maybe they can stay on with the carer, maybe they go to one of these housing options where it's supported housing until they feel ready to go out on their own.

Some people are ready to go out on their own when they're 18 but in all of these cases there should be a case manager until that young person is 25 years of age. So that's my second point.

MR CUMMINS: Yes.

MS F: My third point is about the entry threshold to protective care. We've heard about how a child coming in in one particular type of placement it's very hard to then escalate that placement to get more resources and funding if it's need. [redacted]

So there is a long time where she's slipped through the net and hasn't come to the attention of anybody. She was told that she could go into a voluntary foster care placement or DHS would need to be notified. So she agreed to come into a voluntary placement and I undertook that placement with the information at that time that she was quite an independent young lady and basically accommodation in a safe place was what she needed.

But I was to find out that it was much more involved than that. There were many, many admissions, once a week, once a fortnight back to an acute psychiatric facility with ambulances and police required. She self-harms. I need to make decisions about giving her medication, when she needs stitches for the self-harming, when her suicidal thoughts require admission to hospital, all those sorts of things. As well as that this young person has embarked on the

journey of reporting the abuse to police and so she is involved in police interviews and needing a lot of support. Yet she is in a general foster care placement and the supports aren't there, so that's something that I'm expected to take on.

So there needs to be a process by which voluntary placements can be escalated to protective placements where appropriate so that carers can be adequately supported and resourced to provide the level of care required. Another point, which is a different scenario. So that's when a child comes into care. But when foster children leave care carers often continue to provide support to the children's family and yet in a completely voluntary basis; informal respite care, including having children overnight; clothing and other goods; transport and financial assistance. Many of these families are on supervision orders and yet the voluntary work of the carer is unsupported and unacknowledged and unfunded. But it does demonstrate that carers are willing to provide that ongoing support.

So if there was more funding and support for voluntary respite placements for children on supervision orders and for children at risk of entering the Child Protection system, regular communication between DHS and the respite foster carers of these children could assist enormously with monitoring the at-risk children because the carers usually have a wealth of information about the day-to-day lives of these children and their families that they would then be able to communicate to DHS. So in effect carers are providing the supervision on those supervision orders a lot of the time in a much more hands-on way than DHS is able to do with their limited resources.

Fourthly - and this is only a small one - access. I'm sure you've heard a lot about access but I believe there are a couple of points that haven't been raised yet. One is removal from school for access. Many children are regularly removed from school to attend access and I don't think it's in the best interests of the child because of the reason I have set out here: the child is embarrassed when they're repeated asked where have they been, where are they going; the child continually misses out on things, notices, newsletters, details of homework to be completed, the introduction of a new topic in a subject, choosing partners for projects or who they're going to share a room with at camp. They're not there when it happens so they miss out. They fall behind in their work due to numerous gaps of introducing new topics, so gaps in their learning. Friendships are made much more difficult because children are very fickle in their friendships and so if the child isn't there at lunchtime a couple of times of week, then they miss out on what's going on with their circle of friends. So that is one point I want to make with access.

The other is carer availability. I will just give you a couple of scenarios that illustrate the problem. Say, a child is collected from the carer's home or from

school and taken to an access, the access is cancelled or the child's parent does not attend. There seems to be an expectation that the carer will be waiting at home to receive the child. Whereas if we're told there is going to be an access for an hour and you're expecting the child back at 5.30, you might go and do the shopping until 5.30, you're not sitting waiting at home. Often I have been the subject of a very cross DHS worker calling me, "Where are you? I can't sit here all day waiting," and that type of thing when an access has been cancelled.

The second scenario, going the other way, is a child is collected and taken to access, for various reasons, for example, the parent is late arriving for access, a decision is made to extend the access but the carer isn't informed and might be waiting at home with dinner on the table or may have an appointment or may need to take another child to an activity or music less. Again, it's expected to just be fine with the carer, that you're just home 24/7 waiting for these children to be picked up and dropped off. My answer is that there needs to be a mindfulness that carers are trying to run a household in a smooth and predictable manner as much as possible to provide a therapeutic environment for these children.

If you've got other children in the placement, they've got their things going on as well and you don't need that added disruption nor knowing when a child is getting picked up or leaving or have sudden unexpected arrivals and departures. The carer may have concurrent placements and be needed to accommodate multiple access arrangements at the same time. So it's not easy for us. Thank you.

MR CUMMINS: Wendy, that is very good. You've put a lot of thought into this so thank you very much for that and you have set it out in a very good sequence.

MS F: Thank you.

MR CUMMINS: Prof Scott.

PROF SCOTT: You've highlighted some things that actually haven't been emphasised before which is very helpful. I wonder if I could ask a general question about the roles and responsibilities of the agency and DHS vis-a-vis you and a child or young person in your care and then ask you specifically a question about access or contact conditions. In thinking about DHS and the agency worker and yourself and then the child, the young person. This at times must be a complex set of communications and I'm wondering if you have any thoughts about how that might be improved. For example, in some situations, case management is contracted to the agency. If you've had experience with that, is that a better model in your experience? It's the delineation of whose responsibility is it to talk with you about certain things and the permission for

this and reimbursement for that. Can you tell us how that works?

MS F: Yes, I have actually had experience with that and the child I have under the long-term guardianship order, his management is case-contracted out to the CSO. That's been the best communication I've had and the easiest way of dealing with the complexities of looking after that child. Obviously things need to be referred to the department where we're needing consent for medical procedures and those sorts of things, but I do that through the agency. So I have found that to be a very good model because it's a person that I'm familiar with anyway. I think mostly the staff at agencies are a lot more accessible than DHS staff, so I have found that model to work very well, yes.

Most of the time I haven't had a problem working with the DHS workers and I see their role more on the legal side of things like going to court, court orders, giving consent and deciding on access conditions and contact with the family.

PROF SCOTT: Thank you. Could I then go to that area of access or contact. This has come up before and you've got another dimension on it here. It would seem from what you've said and what others have said that often, the contact of a child with members of their birth family is decided without consultation in terms of how that may impact on the foster family. I'm wondering what your thoughts are in response to this, just as a possible hypothetical situation: that if the Children's Court were to determine a certain range of frequency or intensity of contact, low, medium, high, if there's a clear reunification goal, for example, but not specified in terms of number of days or specific hours, do you think, if there were guidelines about the level of contact and the nature of contact that you, the birth parent, the child or young person, depending on their age, with the agency, might be able to work out an access arrangement that worked for you and the birth family and the child?

MS F: Yes, I think that's an excellent idea. It's not that we're not wanting to be flexible but we're trying to provide a therapeutic environment for the child, so you want your household to be running as smoothly as possible and dinnertimes to be regular and that type of thing. At the moment, carers don't get asked when access suits. We're just told when access is going to be or when it's not going to be, but it would make a big difference in the lives of carers and children, trying to keep that smooth flow of the day at home to have some say in when access best suited your particular family.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales.

MR SCALES: In relation to your second point about leaving care, what would a practical leaving care plan look like for you? What would be the

characteristics of it?

MS F: Okay. I think there would need to be lots of discussions with the carer and the young child with a caseworker who either knew the child well or could get to know the child well through that process just to find out what the child's goals are, what they hope for their life - often they don't have many goals, they're just going year to year or day to day - to understand the child and their friendship network and their family network and how those networks would be able to support them post-care, so to establish what personal resources the child will have after they're 18 and therefore be filling in the gaps with other things as required.

For example, the young person that I used for an example in the voluntary placement, she has very little support out there at all, and having come into care at such a late age, she is going to have to be linked in to a lot of community services and community support post-18 because her journey is sort of just starting as far as that goes and her healing process goes. So it's determining with the child what supports are already there as far as friends and family, that sort of thing, and what supports need to be in place to help that child transition to a healthy and hopefully happy adulthood.

MR SCALES: I'm going to force you to be a bit more practical with me, and I'll tell you the reason why: if we're to try and think about this in operational terms, we will have to define what might be the sorts of programs that might be included in any such system of exiting care. So let me just test some things with you. Would it include things like continuing education?

MS F: Yes.

MR SCALES: Would it include finding accommodation?

MS F: Okay. So now I follow what you're getting at. Yes, things like dealing with Centrelink, making sure they're receiving what Centrelink payments they're entitled to; helping them to write resumes, apply for jobs, part-time jobs, apply for a place in tertiary education; access funding; there's scholarships and there are places where you can get funding to help with tertiary education if you're a vulnerable child; a caseworker who knows what resources are out there, the child doesn't necessarily know, so helping the child link with those resources. Then the child, if they're requiring therapy, they might need to be linked into a private psychologist and have funding through - you know, go to a GP and get Medicare funding for those visits or victims of crime funding, so someone who broadly knows the system and the way things work and can help the child tap into all of those supports that they may need, yes.

MR SCALES: Okay. From your practical experience over a wonderful number of years, they're the sort of things that you believe the children that have been in your care would value?

MS F: Yes, and that they need.

MR SCALES: Okay, thanks very much.

MR CUMMINS: Ms F, that's been most thoughtful and most helpful. Thank you very much.

MS F: Thank you very much.

PROF SCOTT: Thank you.

MR CUMMINS: Ladies and gentlemen, we've been going for nearly two hours since the lunch break, so we'll take a short break and we'll recommence in 15 minutes.

ADJOURNED **[3.28 pm]**

RESUMED **[3.57 pm]**

MR CUMMINS: Ladies and gentlemen, we will now resume. Mr C. Thanks, Mr C, take a seat. Thank you for your written notation and the documents you've appended to it which we have been through. As I'm sure you'll appreciate, we don't investigate individual cases but what we do look at is the overall system and of course your experience informs the overall system, so we're very pleased for you to tell us what you think would be a way forward with the system, how to improve the system from your own knowledge and personal experience.

MR C: Okay. My name is [redacted] and I'm a Forgotten Australian survivor. I've already sent you a written submission. It is no wonder there is another inquiry into vulnerable children when we seem to have so many forces working against us; when you have the police department not doing checks where children are placed, when you have the Corrections Department allowing child rapists and murderers to view child porn whilst incarcerated; when you have VCAT allowing to overturn Working With Children checks when they have been refused by the Department of Justice. A judge has publicly stated that he's already conducted two inquiries into children after numerous scathing ombudsman reports.

I was in and out of care for the first two years of my life, then adopted. I was moved from Western Australia to Melbourne when I was six years old. I was

then placed before the Children's Court when I was 10 years old in Melbourne and I was made a ward of the state because I was uncontrollable. I've never met my birth mother. I got a photo of her when I was 51. I've got a photo here and an article which I didn't even know which I'd like to pass up.

MR CUMMINS: Yes, we'll get that, thanks.

MR C: This article and this photo came into my possession when I turned 51. There are very few records of wards or photos. I didn't even know I'd been in a children's home; up until two years old, I was in and out, in and out of care. I would like the Panel to read the psych report that was done on me when I was 10 years old. There are specific reasons for this.

MR CUMMINS: Thank you.

MR C: That was a psych report done when I was 10 years of age.

MR CUMMINS: Yes, thank you.

MR C: My mother, when she passed away, kept that photo of me all her life until the day she died. I got that photo and that article, being a photo of my mum, off my half-sisters who got in touch with me when I was 51, from Western Australia, from Perth. So I was put in the home system when I was 10. I was repeatedly sexually abused in care by someone who worked at the home when I was 11 years old. When government departments or out-of-care service providers get things wrong, the impact can be devastating and the cost to the public purse immense. After a lifetime of hitting out at society and rebelling, be it stealing drugs, alcohol abuse, I finally started to settle down in my mid-40s just after being totally out of control.

I have had a lifetime of dealing with DHS in one way or another. At 18 years of age and coming off years and years of wardship, a social worker made the unwise decision to allow myself and my girlfriend, aged 16, who was also a ward, to live together. It didn't take long for her to become pregnant and we ended up having two children, two girls, one whilst she was still a ward. After our split-up after a couple of years, the children were taken off her and put into care. She had a serious drug problem that made her incapable of looking after the children. Her partner and father to another one of her children was murdered, with accusations that he had molested all three girls. The mother was charged with murder, along with two males, and they were acquitted because of lack of evidence. There was one witness for the crown, a 16-year-old girl, and tragically she was murdered.

Eventually I found out where the girls were. They were aged nine and 10. They actually ran away from the institution, not on my calling, but someone

else did it, and came and lived with me for several years. As I said, when things go wrong, they really go wrong. When the wrong decisions are made, there can be absolutely shocking consequences. The mother is 54 years of age currently. She's been in and out of prison all her adult life. She is still on drugs and she's met her birth mother recently and found out her mother is an elder, stolen generation, and also she was stolen generation.

I've just had a four-year battle with DHS Housing over a transfer for a house for my disabled daughter. It was only with the threat of taking them to VCAT and exposing them as a laughing stock did they take me seriously and give me the transfer that I was entitled to. I waited four years for a priority transfer. They had me on segment 3 and all the time, because I had a disabled daughter, I should have been placed on segment 2. She's a 16-year-old that weighs 120 kilos. They were given written evidence from the school, from a doctor, everything else, sworn affidavits from me, with a history of falling over and it still took them that long, an appeal, and even though they were going to knock the appeal back to put me on the segment that I was entitled to, it's in their own guidelines. This is for people living in unsuitable housing who have high support needs and need major disability modifications to their home. I said, "If you won't give me the priority transfer I'm entitled to, you're going to have to put a lift in the walk-ups in South Melbourne." It's just been finalised and I've moved to a home close to my children where my daughter doesn't have to walk down those steps.

In another case with DHS, the department, I applied in a separate department for something and sent them photocopies of 20 pieces of paper dealing with medical evidence, only to be told when I rang them three weeks later that they had never received them, even though they had been clearly marked with a return address. I have found DHS staff to be patronising, incompetent and condescending. They do not listen and they will do whatever they want, regardless of what is requested. How the hell they can be left in charge of children at all is beyond me. DHS is too big. Senior staff dominate the minister, leaving the ministry in crisis mode, defending the department. DHS needs to be split up into various departments. It needs a stand-alone minister to work with vulnerable children. In other words, it is too big a job for one minister. Someone has to be the parent, someone has to put in the hard work and say, "I am responsible for these children who are in care," and that entails taking the blame when things go wrong.

Children should never be separated from their siblings unless absolutely necessary. A child should not be removed from a parent unless it is absolutely necessary. There are many bad parents in this world but if they are struggling, then give them a bit of a hand. A bit of a hand should be shown to them. If a child is removed, it must be only in extreme circumstances and then all the family, other family members, should be consulted as to where the child should

go, maybe an auntie, uncle, grandparent, anyone - except in care with strangers - should be considered if possible and whoever puts up their hand, make sure that they are compensated or give them financial help.

Any person that is struggling with children and housing should be given priority segment 1 in housing if that's the reason they're having troubles. It costs money to look after children but we need to work smarter than we have. I ask the Panel have they looked at the last two Inquiries to see if there were any good recommendations that haven't been implemented. You have a huge task to undertake and I wish you well and I hope your recommendations are taken seriously and implemented. Thank you.

PROF SCOTT: Thank you.

MR CUMMINS: Thanks very much, Mr C. As to the first part of your submission, the personal story, we understand entirely what you have said - in fact you said it twice during your submission - that if the wrong decisions are made, there are huge consequences. So we follow that point fully. As to the second half of your submission, we are assisted by your analysis of the size of the department, the size of the issues involved and also your reference to Fogarty J's two reports and the importance of implementation of reports, rather than just the writing of reports. So we understand that.

MR C: Sorry, this is what I fear with this Panel; is it possible to have a follow-up in 12 months' time or something?

MR CUMMINS: I think what we'll do is this: we'll put this report to government at the end of the year and we're hopeful that things will move forward from there, so that's worth bearing in mind, Mr C. I have no questions of Mr C.

PROF SCOTT: No, I really thank you for coming.

MR CUMMINS: Mr Scales?

MR SCALES: Terrific, thank you.

MR CUMMINS: Thanks very much, Mr C.

MR C: Thank you.

MR CUMMINS: Good. We'll return your documents to you. Thanks a lot. We'll leave the Panel for the moment. Thank you.

ADJOURNED **[4.10 pm]**

RESUMED **[4.15 pm]**

MR CUMMINS: Ladies and gentlemen, we will recommence. We are pleased to invite Aza Katar to come forward. Please take a seat, Aza. Thank you for being here and thank you for your written documentation. If you'd like to read it or whatever way is convenient for you, we'd be pleased to hear you.

MS KATAR: Okay. If you don't mind, I'll just read from it.

MR CUMMINS: Certainly.

MS KATAR: There might be some little additions that I'll make but I'll try and be as succinct as I possibly can.

MR CUMMINS: Thank you.

MS KATAR: We're talking about the importance of culturally appropriate placements. The Australian government acknowledges that cultural sensitivity is important to the delivery of services. However, this tends to be predominantly limited to the Aboriginal and Torres Strait Islander communities in an official manner. In almost all applications belonging to a government organisation, there is a question about Aboriginal or Torres Strait Islander ethnicity; however, there is rarely a question asked about other ethnicities. The only illusion to CALD backgrounds is generally around proficiency in English.

CALD communities encounter many of the same experiences as those of the Aboriginal and Torres Strait Islander communities in terms of wanting to retain and practise certain aspects of their specific cultural identity and some generalist services not being fully understanding or sensitive to their cultural needs. Therefore, it is not clear why there is not a consistent position taken by the government in delivering culturally sensitive services to all communities.

In the case of child protection there is no clear protocol regarding the placement of CALD children in the same sense that there is regarding Aboriginal or Torres Strait Islander communities as outlined below and there is a principle which has been endorsed in legislation by all Australian states and territories which talks about the order of placement being as such. Firstly, if an Aboriginal or Torres Strait Islander child is removed from their family, the order of placement is, firstly, the child's extended family; secondly, the child's indigenous community, and thirdly, other indigenous people. Only if appropriate placement cannot be found within these three groups, then the child is to be placed with a non-indigenous carer. These same principles do not apply to children from a CALD background or they don't apply officially.

MR CUMMINS: Yes.

MS KATAR: The principle provides an important acknowledgment that previous policies cause suffering to Aboriginal and Torres Strait Islander people and reflects the right of indigenous people to raise their children and retain them within their communities. Removing children from their families is sometimes a "necessary evil" in order to ensure the safety of the child. However, it is also well acknowledged that the placement of children in out-of-home care can have a negative psychological impact on these children.

There has much research outlining that children who are placed in foster care generally have poorer outcomes than children who are not placed in foster care, and I'm certainly not suggesting that we keep children in an unsafe situation but I'm talking about once a child is removed from their family, they are more vulnerable, and if we place on top of that a child from a CALD background who has come in from one particular culture, language, religion, whatever that difference may be, and placed with a family that is not from that same community, those psychological impacts are compounded.

It is acknowledged that when a child is removed from parental care, the aim is reunification when the situation becomes safe for that child. Research indicates that one of the correlations or indicators which quicken reunification is frequent parental contact. If the parents from a CALD background feel intimidated or alienated by a system which removed their children and placed them with a family from a different cultural background, they may feel less comfortable in maintaining regular contact with their child, thereby potentially increasing the time the child is in out-of-home care. In some situations, parents may believe that their children cannot be successfully reintegrated into their family of origin due to them becoming too Australian. I think we do have - certainly from an anecdotal perspective - some indications that some families are fearful of their children becoming too Australian and that could just be by having limited contact with their social groups or within the school system, let alone removing them totally out of that family.

The child will also inevitably experience difficulties in reunifying with their family of origin as they will have become accustomed to certain cultural practices which may not be condoned or practised by their family. I have met personally a few people from a CALD background who were removed from their families for a period of up to two years and they described severe identity issues. It's kind of a bit of no man's land. You don't belong to your community and you certainly don't belong with the white community. What I've seen longer term is that these young people struggle with their identity for quite some time and this becomes a particular problem when they become parents themselves. So I think we have to be aware that short-term solutions do not lead to long-term problems.

Some of the solutions that I think we could perhaps initiate, the first one which I think is kind of fundamental is proper record keeping. As far as I'm aware, there is no systematic record keeping that clearly identifies one's ethnicity, religion, language in the same way it is for, as I said previously, Aboriginal and Torres Strait Island communities. Sometimes when we're trying to find young people from our own community, the way we do it is in a very crude manner, by looking at surnames which is not a very reliable indicator of whether they are Muslim or not.

Prevention is a very important factor. CALD communities need to be educated on what is acceptable child-rearing practices in Australia and particularly the newer CALD communities, and service delivery is very important. They could be delivered at AMES programs where most migrants tend to attend, community health centres, ethnic organisations. They could also be run in generalist organisations with input from community leaders.

Recruiting foster care providers from CALD communities is essential, as this makes the transition to out-of-home care easier on the child, encourages greater contact between the parent and child, therefore speeding up reunification and makes the transition of the child back home easier. Furthermore, the foster care provider can act as a mentor or role model to the parent and an ongoing support. This can only happen in any real sense if that person is from the same cultural background.

It would also be good to have child care workers from different CALD communities as well, as they will be able to have a greater understanding of the culture that they're working with; ongoing support and training to child protection workers in issues of cultural awareness, having a cultural awareness pack or a particular assessment tool. We're not saying that you bend the rules for particular communities but you have to be able to understand what are the cultural practices in a community and whether this breaches Australian laws.

If it is not possible to place the child within their particular ethnic community, it is crucial to keep that child engaged with their cultural community by attending activities such as language schools, religious schools, cultural activity, going on outings with community members where appropriate. I'm thinking of something like a Big Brother Big Sister program where you would have a mentor, perhaps a prominent youth in that community who would take on this youth or young child, whoever, and keep that link with the community; also, individually tailor-made case planning and review where you would consult the child, if appropriate, and the parent about important cultural issues. That's all I have to say today.

MR CUMMINS: Thank you very much. It's helpful. Ms Katar, it's very

helpful having the written submission that you've spoken to. You've identified an important area and it's particularly helpful to have the solutions that you propose on that final section. That's very constructive, so thank you very much for that.

MS KATAR: You're most welcome.

PROF SCOTT: No, I don't have any comments. They're very clear and they build on what we've already heard, so thank you.

MR CUMMINS: Mr Scales.

MR SCALES: Ms Katar, do you know how difficult it is to get people from CALD communities to be involved as carers, particularly the Muslim community?

MS KATAR: Sure. My experience within the Muslim community is when Muslims have found out - firstly, there's a bit of denial, it's very head in the sand, "Our children don't get removed," so once we get over that barrier and say, "Well, our children are being abused within their families and being removed," once people are becoming aware of that fact, we've had a lot of people raising their hands and saying, "Why aren't the government coming to us? Why haven't we been notified that our children are being taken into care and some sort of campaign to help us become foster care providers?" So once we get past the denial, then we get to the real stuff and say "yes". We've got quite a few people that have put up their hands.

MR SCALES: Does that go to the first point that you make here under your Solutions, which is about an education/information program about child protection laws?

MS KATAR: Yes.

MR SCALES: What would that look like from a culturally and linguistically diverse community, particularly from the Muslim community? What would we need to build into that to make sure that it was acceptable, likely to be received by the Muslim community?

MS KATAR: I think that the whole issue of child protection needs to be mentioned, that there is a government agency called Child Protection and their job is to do A, B and C, and these are the minimum standards that are required by the Australian government. No-one is suggesting that you bend the rules for any ethnic community.

MR SCALES: Yes.

MS KATAR: But before you - I don't want to use the word "punishment" - hold people accountable for their actions, they need to know that what they've done is unlawful. So it starts with the training, "These are what are the minimum standards," and talk about the challenges of parenting. You often have people that are coming from quite traumatised backgrounds; that's no excuse for bad parenting but it helps us understand where they're coming from. So we have to target the services in a way that says, "Okay, we're starting again. Parenting in Australia is different to parenting in Sudan," Iraq, wherever we're talking, Afghanistan. "What can we do to help you, resources?" talking about what the children will actually be exposed to because families don't know what their children get up to, what they actually have to see. I mean, some of them make it up and think that it's so bad that you have to even keep them from attending school and others just have no idea, and really that's coming from the more established people in their community that can say, "Hey, we've been through this and these are some of the strategies that we've come up with to help us."

MR SCALES: That's most helpful. Particularly within the Muslim community, I know there are very sophisticated organisations within the Muslim community that would be able to distribute that information.

MS KATAR: Yes.

MR SCALES: I suppose that's the right distribution method, is it?

MS KATAR: Yes. We have a peak body - and I certainly don't want to limit this discussion to Muslims - but there is a peak body called the Islamic Council of Victoria, and many different ethnic groups are attached to that. So you have the Bangladesh community, Albanian, Turkish, Egyptian, the Lebanese, a whole lot of communities that are a part of that and they would be the peak body to go to for any of that information.

MR SCALES: Thanks very much. That's helpful.

MR CUMMINS: Aza, thank you so much for that. We appreciate you coming forward.

MS KATAR: You're most welcome.

MR CUMMINS: Thank you. Ladies and gentlemen, there was one final presenter listed for 4 o'clock but apparently he has been held up and unable to be contacted. So I'd like to thank the Secretariat once again for doing all the hard work in organising everything so that it ran so smoothly. I thank our security personnel for their work as well, I'm most appreciative; the

transcription service as always, and I'd like to in particular commend the transcription service. It's a most accurate and professional service that we have the benefit of receiving. I wish you well. I now close the Public Sitting.

INQUIRY CONCLUDED AT 4.30 PM ACCORDINGLY