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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

WERRIBEE

10.04 AM, FRIDAY, 8 JULY 2011

MR CUMMINS: Ladies and gentlemen, welcome to the Public Sitting of the Inquiry in Wyndham. I am honoured to invite Uncle Ron to welcome us to his country.

MR JONES: Thank you very much. You're saying Uncle Ron but my name is Ron Jones for the people that don't know me here. I'm an elder of the Wurundjeri Council. The Wurundjeri people are traditional - I don't say traditional owners no more, I say traditional custodians of this land which extends from the Werribee River up to the Great Divide, across to Mount Baw Baw, then across to the Yarra Ranges in the east and then back down to the Mordialloc Creek and back around Port Phillip Bay back to the mouth of the Werribee River. Our ancestors have looked after this country for over 40,000 years - which I think is a pretty good deal, you know - until the present 300 years. You have a look at the country now prior to that.

But our people are custodians of this land. In our present day we try to care for land and my biggest problem is trying to protect our sites within the western suburbs here which is very, very rich - some beautiful sites we have on the Maribyrnong, Werribee River, Kororoit Creek, Toolern Vale, around through those areas and we have a park in Melton shire, Bullum Bullum, which is named after my mother, the last princess of the Yarra Yarra tribe.

I'm very pleased for someone to name that park after my mum because my mum worked for the Advancement League and worked for Aboriginal children when she worked for the Advancement League some 40-odd years ago. She was one of the co-founders with Mollie Dyer and all that when they set up the children's organisation, Fitzroy, for children being neglected and all that type of thing. So I'm very proud of her family history.

I suppose I can say I'm very glad and honoured to be here today because it does affect us a lot the way our Aboriginal children are being treated especially today. A lot of people don't realise - when they look at me they think, "Well, he's a white fellow," but they forget that we have what we call the quarter caste breed which we actually come from. I'm a direct descendant of William Barak and his sister - that's where our family started from actually. I see a lot of racism today on different issues, especially with young children. A lot of people, as I was saying before, don't realise that I'm an Aboriginal person so I pick up on a lot of different things, not only with Aboriginal kids, it's right across the board, whether it's African kids or Maltese kids or Lebanese kids. You get to see this a lot.

So on behalf of my ancestors and the elders of the Wurundjeri Council I take this great opportunity to say Wurundjeri Bik - welcome to our country. Thank you.

MR CUMMINS: Uncle Ron, we're very grateful for you being here to welcome us to your country. We pay our profound respects to you, to the traditional custodians of the land upon which we meet, the Wurundjeri people and their elders past and you present and we look forward to elders in the future as well continuing onwards. I'm a great admirer of William Barak, of whom you're a direct descendant. He was, I think, just a young child at the feet of his father, Jerum Jerum, when the so-called treaty with John Batman was made in 1834 and he died, I think, at Coranderrk in 1903, which was also the year for the High Court being established, which took another 90 years before it revealed an understanding of the traditional custodians of the land in Mabo and Queensland No 2.

So there's a long connection there between you as a Wurundjeri and me as a lawyer and that's, I think, a good think that we ultimately do get to a true understanding. So thank you, Uncle Ron, very sincerely for welcoming us.

MR JONES: Thank you very much for inviting me here to do the welcoming today. Like I say, I have a bit of - how can I say it - interest in this type of thing. Of course, I was brought up that Aboriginal people - when something happened to an elder or a family member that that family come in and looked after that other family and took care of the kids and looked after the welfare. I wish this tradition still followed on today which I say it's a pretty sad thing that you don't see no more these days. Within the Aboriginal community that was always the care - the children always come first before anything else. So if someone was sick or someone couldn't feed the kids, they would come in. The other family within that family group would come in and take control and look after those kids, feed those kids and try and to look after them the best they can. Of course, I've had a lot of that from growing up and seeing it with my other relations and like I said I take a very big interest in this type of thing, and I worked with a woman called Mollie Dyer many years ago. We set up the first Aboriginal medical centre in Fitzroy.

So a lot of the things that people don't realise, nearly everything that Aboriginal people have gained today has come from within Victoria. The first medical centre come from within Victoria. The first adoption service, which was set up by Mollie Dyer, come from within Victoria, and the first legal service. So we've got a pretty good track record here but I'd like to see more done for our children and the protection of our young children. Thank you.

MR CUMMINS: Thanks, Ron, we're honoured to have you. Ladies and gentlemen, let me just make a couple of brief preliminary comments. This is a Public Sitting as you know, and thus anything which is said here in submissions to us is part of the public record. We publish it on our web site. It

can be reported in the media. So bear in mind that this is a Public Sitting. It's not a court of law, ladies and gentlemen, so the ordinary rules of defamation apply; that is to say that persons are not to be defamed. As you know in a court of law, evidence is given in a court which is privileged against proceedings for defamation. This is not a court of law and thus the ordinary rules apply to this Public Sitting.

Also under the Children, Youth and Families Act there is a prohibition which does apply here and applies generally of not identifying any person who has been through the Children's Court process, past or present; not just parties or children but also witnesses. So please observe that requirement as well. The Inquiry, as you know, ladies and gentlemen, was established in January this year by government and it's to report in November this year. It's an Inquiry looking at the whole system, not at individual cases. We are looking at the whole system in order to recommend to government improvements in the system for the future. Thus we don't investigate individual cases or individual organisations. We are, of course, informed by the past so that we can better address the future. But we don't actually investigate, like an Ombudsman might, individual cases or individual organisations.

They're the essential ground rules, ladies and gentlemen. We do appreciate your coming here and being prepared to come forward and speak, and we will proceed now to our first speaker. I'm very pleased to invite Ruth Payne, Colac Area Health, to come forward. Good morning, Ruth.

MS PAYNE: Morning, how are you.

MR CUMMINS: Good, thank you. Just take a seat and settle yourself in for a moment.

MS PAYNE: Okay. Thanks.

MR CUMMINS: Thank you very much for being here and for your written material that you've helpfully provided to us which we have read. We're very pleased to hear you in whatever method you'd like to proceed, Ruth.

MS PAYNE: Thank you for the opportunity. Colac Area Health has been delivering family services for about 15 years. We cover Colac, Otways and Corangamite Shires, which is primarily Colac and Camperdown in the main centres - Colac is about 30,000 people - and we are in between Warrnambool and Geelong. We found over the years we were getting lots of visiting services outreaching to us, so we decided that we would like to integrate some services into our model. We have alcohol and other drug services, financial, children's and generalist, and family violence counsellors, transitional housing, regional

housing, some housing network staff, adolescent health nurses and a neighbourhood house.

We have a generic child protection team that's co-located with us and I think we're kind of unique in the state with that. We've got a visiting sexual assault worker, gamblers help, Jigsaw and legal services. So we feel that we're integrated in that we can offer a kind of three-year service to respond to vulnerable families. We have Child FIRST, which have 1.6 intake staff and a .8 coordinator, and we've got the .6 early childhood development project worker in that structure. They manage about 30 to 35 families at any one time. They've got an approach where they actually go and visit the families in the intake phase to get a sense of the issues and problems and the pathway that family might be best to take.

Monthly intake - 10 to 12. We're actually up to about 15 and 20. It's become quite a busy time of year. We've got family services, have a .6 coordinator and four and a half EFT across six staff and they work between 45 and 53 families and also develop a number of groups.

We're going to respond to the family services section of the Inquiry. As I said we have a multi-service response to families. We have consultancies with Jigsaw, which is a mental health service, we have alcohol and other drugs, and we're building up an effective practice model each month that looks at complex cases, and we include Child Protection staff in that. We're looking at online training with Dr Bruce Perry from America and again that would involve Child Protection staff, so we feel we can offer team building and joint training together. We're looking at a therapeutic framework to consider what trauma-informed case management would look like in family services. Trauma-informed case management is quite big in out-of-home care, quite extensive there, but hasn't moved across to family services.

With our early childhood development pilot project which each Child FIRST catchment got we now have that person attending the allocation referral meetings and helping us to think about supported playgroups and three-year-old kinders and other early year services that can help our families, support our families.

Child protection - this is unique. They can refer straight into Family Services, they don't have to go through a Child FIRST intake, and we usually carry about a third of families that are shared with Child Protection. We have the community based child protection worker that sits in with the intake team and she can do section 38 consultations directly with anyone in the family services team. She also does a lot of joint home visits with the intake team and she does share community education sessions to schools - mostly schools, mental health,

housing sector and family violence.

We can move resources across. On [redacted] there was a fatal car accident in [redacted] and they were [redacted] known to Child Protection and Family Services, so at [redacted] the family services worker got a call to go out with the child protection worker [redacted] We have that ability to be quite responsive and flexible. Family Services has been unit costed and we don't believe that's a model at the moment that suits the presentation of our families. We try to develop skills in parenting education and improve protective factors and look at the safety, security and development of the children.

We monitor risk and we can offer more consistent involvement perhaps with Child Protection, given their workload and their forensic risk framework. We believe episodes of care would be a more appropriate model to use. We hope that would offer short-term intensive work with the families, like the Family First model. KPMG tells us that 36 per cent of the child protection families don't engage with us and they seem to revolve between the two systems. We feel a more intensive, short, sharp response might assist the engagement process with families.

We'd also like to see the family coaching pilots extended into catchments because our families are very complex. Demand is increasing, throughput is a problem, managing demand at the front end, we can't close because the risks are so complex. Most of the families that cause the most challenge are the dual diagnosis families that have personality disorders and alcohol and other drug issues. So at the moment we're trying to look at a holding worker that can do some of that diversion work and intervention and mediation at the front end. We find we've got child protection co-located. We don't have a lot of scaffold points that assist joint planning, so we'd like to see that the community based child protection team leader and the Child FIRST coordinator be trained in family conferencing to assist in diversion.

Care planning, which is again part of the out-of-home care system, hasn't really been structured into family services and we think that would give more intentional planning through the life of the case and we believe that joint case closure meetings should be mandated to be part of the closure process cases and that families that have drifted for six months need to be reviewed through the principal practitioners and that Family Services can bring their own cases to Take Two.

A lot of families move across into Child Protection because they can't access PASDA, Families First, Family Coaching and Take Two and we believe if those resources were shifted to the front end of Child FIRST and family

services, it would stop a lot of families moving across to child protection. We believe that both sets are not remunerated adequately, although that changed for child protection as of yesterday, I think, with a pay increase. But the work is very complex and it needs to be valued and respected in the community. The VCOSS workforce survey said that 80 per cent of staff will perceive that they will have some psychological distress at work so there needs to be a structure for intentional health and wellbeing and self-care to be integrated into the sector.

As I said, it's complex, it raises anxieties and Judith Gibbs here in Victoria and Tony Morrison in the UK have done fantastic work in terms of reflective practice. I did 12 months as a team leader in Child Protection last year and I've been a social worker for 32 years and nothing prepared me for the stress levels and particularly the demands of the court work last year. We believe that the community based child protection work action needs to be a team and then we can locate perhaps family services workers with that team in universal services, like schools that have the highest vulnerability.

As I said, I've worked in the field for 32 years. We don't seem to have sophisticated change management tools and we need to develop some common tools that do that. We've got questionnaires like the Strength and Difficulties Questionnaire or the North Carolina Family Assessment Scale or the work that Marianne Berry has done from the University of Adelaide. But a lot of those are subjective and we need to be much more sophisticated about how we get feedback from our families and we've tried to have focus groups and they're not an easy group of people to engage and hear back from and that works need to be a well-funded body of research. Thank you very much for the opportunity.

MR CUMMINS: Ruth, that's a most thoughtful submission and most helpful.

MS PAYNE: Thank you.

MR CUMMINS: Thank you very much. Prof Scott.

PROF SCOTT: Thank you. I'm interested in a lot of what you've said but I wonder if I could just focus on a few things and one is the KPMG data about 36 per cent of child protection families not engaging with the family service model.

MS PAYNE: Yes.

PROF SCOTT: Thinking about your own location, do you have any insight to offer on the characteristics of that group of families and what might be useful in encouraging them to use such services, including levers of authority. One of

the things we have been discussing in various Sittings and on our visits is, is there potential for some mechanism which would be between a completely voluntary use of services and a Children's Court order, as it would now be constituted, and what are your thoughts about the challenge of engaging with that group of families, and not just Family Services engaging with them but if they are, say, families where you've got a personality disorder and an alcohol and other drug issue within the parent or parents, do you see a potential for alcohol and other drug treatment services, adult mental health services, the other parts of the service network being able to work with such families being mindful of the child? So I guess I've got two questions in there.

MS PAYNE: Engagement is sort of like a black art. I don't know actually what helps families. I know a lot of families on the threshold of Child Protection becoming involved will say, "Yes, we'll engage with Family Services and, yes, we'll work on a child and family action plan to reduce risk and then Child Protection closes." When it comes to that engagement, they're not that motivated, I suppose, and they do seem to move across the two systems. I guess there are a number of families in Colac that we would have worked with over five or six years that have just revolved through.

I don't know. It's selling change and I guess it's selling to families their wellbeing and that there are ways to work with their children and protect their children. It's not an easy road. One of the things that I didn't say was that Child Protection is saying a lot of these parents have trauma and they're parenting under a trauma kind of experience that they've had of their own as children. Until we address perhaps - and we often use behavioural based or cognitive behavioural based interventions and that can miss people that have a lot of trauma or that have had and experienced trauma in their lives. You almost need to get back to some of that practical, old family aid sort of work.

To get back to the second question, we've had some good visits where we've taken a drug and alcohol worker because sometimes they have an immediate understanding about the drug use in that family whereas the family services worker wouldn't and that has often been a point of engagement because the family has felt, heard and understood and it's not a blame or punitive kind of environment. So we try if we know but, again, they're seeing clients back to back as drug and alcohol workers. It's hard to get them to come across to a joint visit. Mental health similarly in their own system, it's very difficult to get a joint visit with mental health. But that would be fantastic. We can do consultancies but again it's often at the axis 1 end where there are a lot of psychotic episodes. They have to be quite florid for mental health to get involved in terms of more acute presentations.

I don't know, I'm not sure about the engagement. I don't know what leverage

Family Services can use other than often we say, "We don't want to escalate this through to Child Protection," are the things that we can change now and stop that escalation.

PROF SCOTT: Can I pursue that a bit. When you say that families agree to receive a service and then discontinue service involvement when Child Protection closes the case - - -

MS PAYNE: Yes.

PROF SCOTT: - - - are you suggesting in those cases the case is closed very shortly after the family agrees to receive the service or would this be, say, a case being closed many months after the family agrees? Is part of the problem the premature closure of the case by Child Protection during that assessment phase before they made a decision to take a protection application or not, that the closure is happening prematurely in relation to your capacity to engage, that you need some authority in the background.

MS PAYNE: Yes. I think Child Protection ideally would like to stay in longer and have that authorising environment but within two months they'll close after a case conference.

PROF SCOTT: Within two months. Is that local policy or practice?

MS PAYNE: It's sort of more a practice, just because of their front end. They're under huge demand and they're to get through push as well. They'll often say, "We'd like to stay longer. We'd like to do more joint work," but often at the case conference or protective planning meeting they will close within the next couple of months.

PROF SCOTT: Right. The other issue I'd like to take up from what you said is about the old-fashioned family aid and I think we probably understand that to be someone who may not have been professionally qualified but who actually worked in the family home on very practical issues.

MS PAYNE: Yes.

PROF SCOTT: Are you suggesting, as others have - or others have suggested and you may suggest it or not - but can you tell me if we still have that in your services?

MS PAYNE: No.

PROF SCOTT: There is no capacity or some capacity to work in a very

practical way in the home teaching and coaching and encouraging and getting children to school. What is happening around that practical work?

MS PAYNE: No, I don't think - there is just the time factor and again it goes to that unit-costed service where there are a number of hours that you are funded to work with that family. It sort of predicates against that longer-term involvement so we're really trying to move them to after six months, so that longer-term family aid work where sort of that skilled volunteers and other agencies in Barwon use a group of volunteers to do the homework, to do the breakfast, to help with the tea, a laundry routine, whatever. But that's where Families First can do that work. They can go up to 20 hours. I don't know what tips a family over to manage change and then sustain that change. I'm not sure if that's a time interval or what it is and I guess that's around how do we measure change in families and what sustains that change to that family and it has resilience and protective factors so that it won't come back into our system.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales.

MR SCALES: Just a couple of questions. On that very last point - please excuse my ignorance here - can you explain to me your view of what the difference between a unit-costed service and an episode-of-care approach would be.

MS PAYNE: A unit cost is we get a cost per hour of service. We just get a number of hours between - it's up to 100. I'm not sure how many hours. An episode of care is how drug and alcohol are funded. They can work as long as they can with a family.

MR SCALES: So the assessment at the front end is what's the nature of the problem and how much is it likely - how long is it likely to take to get some form of remediation or solution to that problem. Is that the way - - -

MS PAYNE: An episode of care for drug and alcohol is that they will have a significant treatment goal, so they have negotiated that goal with the client and when that's achieved that's then seen as an episode of care.

MR SCALES: That's relatively open-ended.

MS PAYNE: Yes, that's open-ended.

MR SCALES: Excuse my ignorance on that. Thanks for that. Can I go back to the point you make about Child FIRST. It's more about clarifying Colac

Area Health's role in this. You're the lead agency?

MS PAYNE: Yes, we're the only agency.

MR SCALES: You have alliance partners who work with you?

MS PAYNE: No, we're the only partners. We've only got the Department of Human Services and us.

MR SCALES: That's it.

MS PAYNE: That's it, yes.

MR SCALES: So all the services are really provided primarily by you.

MS PAYNE: Yes, as an area health service.

MR SCALES: That looks very similar to the way you read about people conceptualising a public health model of child protection in some ways, doesn't it?

MS PAYNE: Yes.

MR SCALES: It's interesting. Do you believe that in the Colac area that you would want to be developing organisations that would join with you in an alliance arrangement, or do you think that the way it operates within Colac Area Health is the right approach there?

MS PAYNE: We sometimes differ but we're trying to work really actively with family violence, so we're trying to target family violence, adult mental health and the housing sector, and get them on board as kind of invited participants to the alliance so they would have a level of involvement and I guess a level of commitment to working with vulnerable families, and particularly being child focused. A lot of those services are adult focused. Yes, we're trying to develop that sense of being child centred, so we're actively trying to get them on. They wouldn't be partners but involved in the alliance, yes.

MR SCALES: Thanks very much.

MR CUMMINS: Ruth, can I ask you a question about your recent 12 months' experience. You said that one of the things you weren't prepared for was the court experience. Can you tell me a little bit more about that, both in relation to the court experience and, second, what you might see as a way of improving

that?

MS PAYNE: We had a legal services officer, which was fantastic because a lot of the appeals that families make are very complex and it's very legalistic and they have very strong advocates in there - solicitors and barristers - which is fine, but I just found that cases just get adjourned and adjourned and they drift. Sometimes the decision-making is not consistent so you're just never sure in terms of recommendations and points of law, and dispute resolutions seem to be very adversarial and you've got to really prepare people almost at the DRC level let alone the contest level. So there's all this kind of adversarial polarisation of the parties, rather than trying to come to some sort of consensual, conciliatory mechanism.

I think the Scottish model where the magistrate determines - proves the PA, proves the rules of evidence and then what happens to the family after that is decided by someone else, because some of the orders, you can have like 25 conditions on the orders. I think that's a risk management sort of strategy, but families just couldn't meet 25 conditions in a custody order. It's setting families up to fail.

MR CUMMINS: That distinction between responsibility legally ascertained and disposition expertly otherwise dealt with is something which has come through in a number of submissions. You've mentioned about the adversarial nature, even of the ADR part of the process. Do you have anything to say about the court process once you get into court beyond the ADR - into court, giving evidence?

MS PAYNE: After 32 years it's really nerve-racking still, and I guess that's the way the legal system works, you know, that you are kind of grilled over your case notes and over your decision-making points. It's always nerve-racking, and people that you'd be at court with are kind of veterans and they still say, "This is terrible." I must say we had one magistrate who was there mostly and he was very good, I think, in terms of trying to understand where Child Protection was coming from. Yes, you don't get a lot of respect in the witness box.

MR CUMMINS: Respect from whom?

MS PAYNE: From the cross-examining lawyer/barristers there.

MR CUMMINS: Thank you so much. Ruth, that has been most thoughtful, as I said.

MS PAYNE: Thank you very much for the opportunity.

MR CUMMINS: I would like to invite forward Yasmin Hassen and Maryum Chaudhry, Care With Me. Thank you both for being here. Thank you also for your written submission, which we are familiar with. We express our thanks for that. You may proceed upon the basis that we are familiar with what is in the written document. Yasmin and Maryum, you may proceed in whatever is the most convenient way for you.

MS CHAUDHRY: Thank you. As you know we're speaking on behalf of Care with Me, so we're really happy to have this opportunity to speak in front of all of you because it's evident that you all care. For me, Care stands for Care with Me, it represents cultural and religious engagement. It's been something that's been very much missing. I've been told in inquiries such as this it only happens once every decade, so we're going to use this opportunity - as the motto of the Office of the Child Safety Commissioner states - "to be seen and heard".

MR CUMMINS: Very good.

MS CHAUDHRY: For the last few weeks you've had an opportunity to meet some of our Care ambassadors. Mohammed Elmasri is the president of Care with Me. He went to the Bendigo session. He outlined the need for cultural and religious engagement and support services. Jasinder (indistinct) the Queensland researcher, she came to the Melbourne session. She provided an overview of her research and the lack of cultural competency within the sector. Dr Sundum Arun, you probably met her yesterday at the Broadmeadows session. She highlighted the importance of early childhood development and learning. Other various key representatives have come to Shepparton, as well as the Melbourne session, carers and Muslim leaders, such as the Shepparton Mosque Society and the Islamic Council of Victoria. There's still more to come.

My name is Maryum Chaudhry. I'm actually the vice-president of Care With Me and here is Yasmin Hassen, who is with me. She's a young, dynamic upcoming leading researcher in the politics of identity and has a deep understanding of the Muslim community. We stand here today not as experts within the field but rather as observers. As an observer, I have seen a very passionate sector with truly committed individuals who are willing at all costs to help these vulnerable children during their time of need. I've seen a system which is crumbling due to lack of processes and quality assurance to meet the very best practices that the sector has created yet not adequately implemented. I have seen people wanting change. That's leading us to be here today.

We have been following the Inquiry through the news and monitoring public

views. Simply stated, in relation to such complex issues, there's a lot of misunderstanding about the processes and system in place within the child protection system and failures of the past have already been highlighted. So the very existence of this Inquiry acknowledges there is a problem. We are here not to simply criticise the system but rather here to improve it. Our aim here today is to provide an overview, so (1) is to highlight the need to make CALD care a priority; (2) to find solutions within the existing frameworks and services; (3) provide examples of struggles and stories within the CALD minorities and to give recommendations as well to improve the standards of current services.

We have consulted far and wide throughout Victoria and each and every agency believes there is a need for CALD-specific services. The need isn't actually in question but rather the query lies in what are we going to do about this? What will it take for Victoria to actually do something and how will we ever find a solution if we're never willing to start? This is exactly what Care With Me is trying to address. We actually believe the answers are already here.

I'm actually going to give a brief overview of the differences between the Aboriginal and the CALD community and what current practices are in place. With Aboriginal children and their families in the north-west region, they're supported by the following: in intake, when receiving the report, the intake worker asks, "Is anyone in this family Aboriginal or Torres Strait Islander?" This is abbreviated as ATSI. This is in response to a specific question on the intake report and it's also entered into a specific part of the client record information system, known as CRIS. If investigation is required, the case is sent to the Aboriginal Focus Unit. The case is then managed within this unit, even after going to court and long-term out-of-home care case planning. If at any point in time of the Child Protection involvement it is discovered that the family is of Aboriginal or Torres Strait Islander background, the case is transferred to the Aboriginal Focus Unit for case management.

Workers in this unit are specifically trained in working with the Aboriginal Torres Strait background during time in child protection. The Aboriginal Focus Unit has many links with the Aboriginal community through the Victorian Aboriginal Child Care Agency, VACCA, and associated programs such as Aboriginal Health Services. When lodging a referral to the placement coordination unit, one of the first questions a PCU worker is instructed to ask is, "Is that child of Aboriginal or Torres Strait Islander background?" which is in response to what is written on the PCU initial contact list. This is also entered into the placement database. If the child is of Aboriginal or Torres Strait background, the PCU are required to contact VACCA for a placement prior to contacting any other agency.

When contacting agencies for placement, quite often the foster care worker will ask, "Is the child of Aboriginal background?" If the ATSI child is placed in a non-Aboriginal placement, a referral is then made to the PCU worker to the Kinship Care and support program. This program assists the child with making contact with their mob, also called "return to country". Basically the program tracks down the child's ancestry and helps them to make contact with the people and the place where they're from. The program will also work with the foster care worker and the foster care family on identifying issues to do with child Aboriginality.

In comparison, when dealing with people of culturally and linguistically diverse children and families in the north-west metropolitan region, the following support is provided. At some point during the Child Protection involvement, a worker may ask, "What is your religion and/or ethnic background?" They might then enter this into the CRIS and communicate it with others who are involved with the family. Even less likely than the above, the worker may receive some minimal training in dealing with families of CALD background, that they may apply with or without the direction of a line manager.

For Muslims, the most common application of this is to remove the shoes when entering the family home, which, in the big scheme of things, is a small but not insignificant thing to do. If a referral is made for an out-of-home care placement, the PCU worker is not instructed to use the CALD background of the child, although they may do so if the child's name is slightly unusual. Unfortunately, Muslim names are not always that unusual though. The PCU worker will not specifically look for or request a CALD placement for the child as these generally do not exist. There will be very little, if any, CALD support put in place for a carer of children with CALD background. If any are put in place, it will be due to workers' own diligence but not because of a specific process that is in place. When you contrast the processes that are in place in support of people of Aboriginal and Torres Strait backgrounds and families and those that are put in place to support CALD families, there's no comparison.

If you ask me what we can do to support CALD families, I'd tell you to look at the Aboriginal model and start from there. It's fantastic. The only drawback is the lack of Aboriginal workers within the child protection system and the fact that it's only for Aboriginal and not CALD people as well. So one of our first recommendations is establishing a CALD support service based on the VACCA model and implementation of the best practices that are already there.

The other aspect that we would actually like to talk about is looking into, I guess, the African community as well as the Muslim community. We were

going to go into a bit of a story about the migrant experience but we're thinking maybe we might go a bit further into an open discussion and actually talk about some of the issues. So feel free to contribute and ask questions, but we thought maybe a starting point could be asking questions such as, "What do you consider to be the biggest challenges facing the African community, in particular for the parents who have migrated to Australia or the youth growing up in Australia?" Just our perspectives on things and what we have experienced.

MR CUMMINS: Yasmin.

MS HASSEN: Okay. The African community in Australia is a recent community. It's probably about two decades old, three at most. Generally most would be categorised as first generation and just a few would be second generation Australian born. Some of the challenges I find, not only as a researcher as well as an African woman, is the lack of communication abilities from first generation migrants, the parents, whether it's language or social dislocation with existing community groups and things like that. Another one is the youth have - what I find is also another form of dislocation. It's not through language but it's access through education or pathways to further education, and maybe the sense of dislocation.

What I mean by "dislocation" is the whole ghetto mentality that's afflicting African youth. When you look at a map of Victoria, Melbourne in particular, you see that there's a large concentration of African communities in certain parts, whether it's the inner west or somewhere out in the Preston and Heidelberg regions. So whether it's facilitating services, it shouldn't be a service that is particularly unique through an African-only community group but one that is somewhat broad range and captures or encaptures youth engagement.

Simply put, I guess, I would say things to do with education, the lack of awareness of services and facilities that do exist - sorry about this, I'm a bit nervous.

MR CUMMINS: No, that's all right.

MS HASSEN: Services that exist to engage them and not engage at a superficial level but something more meaningful that will ultimately in the long term cost the Victorian government less to fix up if something does arise.

PROF SCOTT: Maryum, also what do you think of the current social services programs and do you think it addresses the need of the African community? What do you think is their perspective of the child protection system?

MR CUMMINS: Yasmin?

MS HASSEN: As the voice of Africa, I don't have a particular opinion on the child protection services regarding the African community, except to say that they are somewhat wary of what it entails. So the notion that someone will come and take your child away from you and you are unable to contact your child or to see about their welfare is very alarming and of a big concern to the African community. What was your first question, sorry?

PROF SCOTT: What do you think about the current services and their view of them?

MS HASSEN: One of my main critiques of the current service is that generally they are not initiated by the community and if a program isn't initiated by the community but for the community, and the community may feel as though it either doesn't want it or it wasn't consulted in the initial stages of bringing about the program, they will be less inclined to contribute and to participate with the program. Whatever it may be, whether it is in solving youth delinquency in the African community or in increasing higher retention in the education system and things like that, the community feels probably somewhat disinclined to participate if they feel as though they weren't consulted or if the program wasn't initiated by them. That's just from an observation perspective.

MS CHAUDHRY: I think that's completely true and that's what we're trying to address with the Care with Me program. All our services that we're doing we're engaging directly with the community. So we based it on their leaders, their perspectives. We do it in different languages. So we try to make sure that they're part of the process and not actually wary or scared about the actual child protection system. A large part of it is raising awareness about the child protection system. The other part is actually engaging. That can be engaging within the sector for case workers. It can be training sessions as well. We're trying to get, for example, people within the African community to come and do sessions where they talk about cultural awareness and what are some of the customs and traditions that people should be aware of, whether it be religious or cultural.

We're also doing sessions where people come to certain events and programs where they get to experience that cultural background and environment, and that child can remain connected to that community as well. Just based on my experience in the past, working with the Muslim community at large and even within the sector, words such as "African community" and "Muslim women" and so forth, they have almost turned into buzz words. None of the services

have really been - for example, I feel they don't connect or reach the target audience. They don't address the needs of the CALD community and they're not long term or sustainable.

I think that's the key word, they're not sustainable, they're not effective for the long term. They're not necessarily new issues, they have been existing for very much a long time, but it's more about will this be a priority now, will something actually be done about it. This Inquiry is important in the sense you're changing, you're creating reforms. So this is an opportunity for this to actually be addressed. While you're changing and making best practices, why not put this into consideration and into the processes, into the system. Even when looking through the Aboriginal model and so forth, something as simple as a question, "What is your ethnic background? How do you identify yourself? What's your ethnicity?" Something as simple as that can help the process in the long term as well.

Other states, they have notification of CALD backgrounds. In Victoria we seem to be really behind in relation to all of this. We really do see this as a unique opportunity for this to be brought up into the agenda, and hopefully this will lead into other social services where, once again, it's sort of been ignored, actually having long-term, sustainable programs.

Our second recommendation is to have sustainable programs which meet the needs of the CALD community. We leave you with the Care with Me motto, and that is by caring together we can care for all children and young people in out-of-home care. We must care for the vulnerable children in Victoria and we must make CALD support services a priority.

MR CUMMINS: Thanks very much, Maryum, and Yasmin as well. That's been very well prepared and presented. Prof Scott.

PROF SCOTT: Thank you. Just one question, and that's a step before and hopefully a step that will prevent children coming into contact with the child protection system. Do you have any experience, even just of one family - and obviously well disguised if you were going to refer to that - where a child has been able to remain with the family and the risk factors that would have brought the child into state care, for example, exposure to domestic violence or severe physical discipline, or children being left in the care of older children, the sort of things which in the wider community would be deemed to be serious protective concerns but may not always be within the particular family, but have you seen any approaches, not even inside a formal program necessarily, that you think has prevented a child or children coming into child protection? Does that give us any insight into the types of models of services that would be necessary to achieve the prevention of children coming into child protection?

MS HASSEN: I'll start by saying I'm not a specialist within the field but just, I guess, observations. Preventative measures start within the community itself. For example, for the Muslim community and background there's support services within, whether it be through the imam, whether it be through a community organisation, whether it be through direct families and so forth, so when issues do arise they have someone they can actually talk to. What does occur sometimes within these communities, they actually lack qualified experience or resources to be able to address such magnitude of social issues. But they are, a lot of the time, the best point of contact as well, because you will go internally within your community first. I think a lot more investment needs to be done in skilling within the community, having more variety of people available of different ethnic backgrounds within the system itself. That's my perspective.

MS CHAUDHRY: If I may add, my main critique of the Muslim community in Victoria is, the first thing when anything goes wrong is to go to the imam. Often the imam either doesn't speak the language or doesn't understand the sociocultural realities of life in Victoria because it's an import imam, if I may use the term, and so is not able to fully grasp the magnitude or the significance of preventing children from going into - so internalising problems has been the biggest problem for the Muslim community or the African community for that matter.

I don't have a concrete example, however elaborately disguised, from a personal perspective but to allow them or to let them know that reaching outside your community and outside your comfort zone won't bring problems or won't create problems, but may ultimately in the long term prevent other problems from arising. So to create more outreach programs within the Muslim community and to let them know - you know, coax them and say, "It's not a big deal. You may help that child in the long term and ultimately your own family and other families," and use that as a mouthpiece of forwarding the foster care program or the child protection services here in Victoria and just to ease them into it would be my only critique. Just running to the imam or someone of religious significance or cultural significance isn't always the best thing to do.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales?

MR SCALES: No, that's terrific, thank you.

MR CUMMINS: Thank you both very much. That has been most helpful.

We wish you both well.

MS CHAUDHRY: Thank you.

MR CUMMINS: Prof Anne Buist. Professor, thank you very much for being here. We've received the written paper and we would be very pleased to hear you.

PROF BUIST: Thank you. Look, thank you very much for this opportunity. I wanted to share some of my experiences over the last 25 years which, whilst primarily in mental health, has had a huge overlap in protective services and also the fact that I've just come back from overseas for a year and part of which was a sabbatical in the States where I had a chance to see some of the best practice programs there and whilst I was there I'm thinking, "Boy, would this plug a hole up in some of our problems here." When I heard about this I was too late for the written submission but thought I'd come and try and get you as enthusiastic about what I think our future direction might be.

Firstly, in my background, we deal in the mother-baby units with many women with very complex needs and very frequently protective services. We have a community of perinatal health professionals who meet regularly and we would all agree - and we've done some research looking at this - that the number of protective services' clients we have in our mother-baby units has dramatically increased in the last 20 years we have been doing it. We now run outreach programs as well and they also have a lot of protective services involvement. At one stage I did a report and chaired a subcommittee of the Child Death Review Committee and that was about 10 years ago where we highlighted the mental health, drug and alcohol, personality disorder, the complex needs and the difficulties the protective services had coordinating all of the information together. I read the most recent report and it's saying exactly the same thing 10 years later, which is a little disappointing though I understand why.

I really shouldn't be here in Werribee though Werribee does have its mother-baby unit. My experience is in the north-east. In Box Hill alone the protective services worker there that I was dealing says they have 200 open cases of babies involved. So obviously most of my interest and experience is with under-twos - which I've gone on to talk about - and this is a really vulnerable group and where I think we really need more attention than is currently being provided.

I also privately do assessments for protective services and end up in Children's Court with those, as do some of my outreach workers. Just noting your question before about experience in court and my experience has been relatively positive. My outreach workers who are nurses have not been and it

may be just different magistrates, but my pick would be it's because I have "professor" in front of my name and I get more respect and my nurses don't and that's very much the experience. That's only my guess but it may have just been different magistrates. So there are a number of problems, as I'm sure you're aware.

One of the things that may not have come up is the poor integration which really starts at a governmental level which I find enormously frustrating and I'm sure you're not going to be able to solve it, but maybe there is some way. For instance, talking to the infant mental health and CAMHS, they've been funded and part of their funding is they're starting to deal with maternal child health nurses. Well, through a mother-baby initiative we have also been funded to do that and we didn't even know what the other person was doing. Similarly, there's a new mother-baby initiative which is more mother-baby unit beds in the country. There are fabulous reasons to consider doing that but protective services haven't been involved in that at all.

One of the areas that has put up their hands for those mother-baby unit beds is Shepparton. We do have a lot of mums from Shepparton and whilst some do have schizophrenia and very serious mental illnesses, a lot of them primarily have borderline personality disorders, drug and alcohol and major social issues. So they come down to our unit and we deal with crisis, which is usually a crisis for those, and then we can't send them back because there is nowhere that they're currently safe with the baby - and we think they can be with the baby - but there is no way to plug that hole to keep the baby safe and help that mum improve her skills. This is where one of the interventions I saw in the States would work beautifully. Personally if I was Mary Wooldridge, rather than put mother-baby beds in Shepparton, I'd be putting day-stay beds where I could work really strongly with this group.

The attachment I included was the only bit of official paperwork I could dig out from when I came back from my sabbatical. I just wanted to highlight the second page of it which was the parents and children together in Grant County, that that sort of day stay - this is the promising visitation program, so probably the last page of your handout, is one I'll talk more about. But if there was something like that in Shepparton rather than mother-unit beds and if the mother-baby initiative people had actually been together with protective services, maybe they would have come up with that rather than sitting in different departments.

So then really what I'm concerned about is the problems with the whole setting of protective services. Obviously they have to put the children's needs first, I understand that. But sometimes the children's needs are not best managed by taking the child away if there had been a better program to keep the mum and

the baby together because when the child is under the age of two an attachment is still happening. There is an enormous amount of research that is very clear that attachment is crucial and that by pulling baby out of those families and sometimes for weeks or months they're in and out, the mum is feeling less skilled and when the child finally does return, the child is "behaving badly" and I put that inverted commas because the child is just totally confused and then the mother feels rejected by that behaviour and the whole cycle continues on and on.

So that considering is there any way to keep this mum and baby together - often there isn't in the short term currently but that's what I would like to see change, that there are different programs. So if we look to the Grant County model - and there's another child seminar in Louisiana as well - has programs with day centres or with foster families and these are very exceptional foster families that are recruited to have only short-term care with these children and to work with the families, with the idea that they are kind of case workers to get this mother and baby back together. So it is quite a different format to our current foster system.

But I was thinking a day centre would actually work better here but I haven't had a lot to do with the foster families so I may be wrong. But the advantage of these integrated programs - and it works under a similar way to Mind the Baby, which is Yale based Arietta Slade program, where the workers are highly skilled and very heavily supported in attachment and promoting the positive parenting. In Mind the Baby there is one worker that deals with the physical needs and helps mum look after, making sure the immunisations are up to date, et cetera, and the importance of that. But then there is another that is looking much more about the emotional care of the child.

I haven't run a day-stay program like that but we have been running a group program and have been running that for a couple of years very successfully. It's similar to a thing called the Circle of Security program, which again is an attachment based program, and we have had the most amazing change around in mother's ability to see through the eyes of her child and put her child first over 16 weeks. This is only one day a week for 16 weeks and we've seen a huge transformation. If we could do that in probably a day-stay, because I don't think one day a week is enough because you're separating the child way too long. You need at least three days and they were recommending five days a week in fact.

This increases the confidence of the mother in her parenting. It also would allow protective services to do a way better assessment. I mean, at the moment they are trying to pull in things from health professionals that don't return their calls or, if they do, you can't get onto the protective services anyway. That

whilst they're there for at least three days a week you'll have what Queen Elizabeth concurrently do but much, much more because Queen Elizabeth will only have them for about two weeks. So this is not just an assessment but a therapy programs. So you need the courts very heavily involved and integrated and they have great programs for the judges. I've got a DVD that the judges have actually made with infant mental health specialists and so they are trained very heavily in this area too.

The positive of this program also is that it does put babies first. If the babies are not deemed to be safe with mum, then the babies go home to the foster mums in the evenings, but it's just all this extra time with mum. Certainly the early data they were showing was that, with the exception of the drug-abusing mums, the very heavily drug-abusing mums who can't clean their act up, quite frequently, in six months, virtually all of the rest of the mums went home with their children at the end of six months and didn't come back into protective services. So that's really the outcome we want for these families and for these children.

The negative of that is - and perhaps if I was doing it here, I would certainly pilot it perhaps without those heavily drug-abusing mums to begin with - the courts have to be kind of on board with it, so that at the end of the six - there's a three-month review in court and then maybe a six-month at the end of it, but then there's a final decision made about that baby's welfare, that it either is returned to mum or it is put in full-time foster care.

In summary, I think this is a fantastic sort of process that I hope will fill in some of these holes that we currently have because I think there are lots of fabulous things we are doing around this state. If we integrate them better and make them more universally available, then our children of the next generation will not need to see me.

MR CUMMINS: Professor, that's terrific. Thank you very much for being here, slightly out of your own north-east area or from the University of Melbourne and the Austin. We're glad you went to Yale for six months, we're glad you came back, we're glad you came here.

PROF SCOTT: Hi, Anne. We've shared an interest in this area for a long, long time. Would you see the current facilities of Queen Elizabeth, Tweddle, perhaps O'Connell, as being the platform on which you would develop the intensive three-day-a-week stay or would you see them as coming out of mother-baby units that are within your type of service?

PROF BUIST: I've looked long and hard at my mother-baby unit and if you've ever been to the Austin, it's propped up on the top of a hill and there is

no space anywhere to put anything. I think at the Queen Elizabeth probably would be those type of facilities but I think what the Queen Elizabeth does is fantastic. It's more of an assessment rather than this sort of intense program. But I think you would need a lot more mental health intervention than they currently have. I used to work at the Queen Elizabeth back when it was in Carlton; it would need a lot more, but I think that would be perfectly feasible to do.

The other thing is would you put them in the country? If they were in the country, where would you put them? Again, if I was reputting the mother-baby unit money, then maybe you would attach it to the psychiatric facilities so that these mums who are inpatients in the psych facility could come out of it. But I think, particularly as I gather that money has been earmarked for mother-baby mental health, it might end up there by mistake, but I think the early parenting centres are much better equipped to really look at this and extend it, so it's probably easier that way and it's probably more acceptable to the women as well.

PROF SCOTT: Yes, I think so. Could you even go one step further and envisage the possibility of building the mental health capacity in, say, one maternal and child health centre in every local government area? I mean, we have day stay now in some local government areas around sleeping and settling and breastfeeding, and I know it's a big leap, but do you think - - -

PROF BUIST: If you think of dollars, we'll get someone very agitated. Look, I don't think it's impossible. We do a lot of work in the Yarra Ranges and Whittlesea; they're two really kind of - what are those corridor areas - growth corridor areas, but they're two areas that have really embraced us and embraced mental health and embraced getting help with this area. I'm sure they would be very positive about that, though I'd have to say Box Hill would be probably the place I'd put first, just because there's such a huge need and a lot of disadvantaged there and perhaps a little more central. You would have to look at the location.

Again, it probably would all come down to cost, what's going to be the cheapest, I suspect. But one of the problems if it's a day stay is getting the women to come. We have a real problem. With my privately insured people, they will come from anywhere to Northpark. To get them to come to Austin for a group is much, much harder. I'm not entirely sure - I think it's complex, why that is the case. So the less distance they have to go - actually that was one of the things, with Charlie Zeanah's program, one of the things they put down to being the most successful thing was the bus that picked the women up and brought them to it. So it's having kind of smart thinking, it's not all that expensive, and that could take them to anywhere, whether it's taking them to

Queen Elizabeth or it's taking them to the local health centre.

PROF SCOTT: Thank you.

MR CUMMINS: Practical, simple things like a bus can make a big difference.

PROF BUIST: Yes, and in this case, certainly Zeanah's program, they thought it did.

MR CUMMINS: Mr Scales.

MR SCALES: Prof Buist, thank you very much. It's very helpful. You obliquely alluded to a link between the particular cohorts you're dealing with and the child protection system. Do you have any hard numbers about how many women and young babies that you're working with might be associated with the child protection system?

PROF BUIST: Look, I can't give you an exact number. We would at any one time have one or two in the ward purely for a parenting assessment. So, yes, they have a mental health history but their mental health is relatively stable. We've just had a couple where both mum and dad had schizophrenia but it was stable enough. Possibly Queen Elizabeth could have done it but there was a possibility of dad being aggressive when he's unwell and it's the sort of one that Queen Elizabeth would probably go "ooh", so we would have either the couple or a mum always in the ward, purely for a parenting assessment, and then of the others, usually one or two would always have - so we have about 90 admissions a year, so that makes it about half, so about 45.

MR SCALES: About 45.

PROF BUIST: That's true - we did a mother-baby unit survey a number of years ago and I think it was just under half of all mother-baby units. The south is a little different because their mother-baby unit runs a little differently. They have a bit of a different attitude. But Werribee and us feel that borderline personality disorder is a mental health issue and that it is our job to do parenting assessments, so you've probably got to keep the southern one slightly separate.

MR SCALES: Would you say that the consequences of not dealing with these various symptoms exhibited by the parents is very dangerous for the child?

PROF BUIST: I think you have to break that up into a couple of things and unfortunately this is what happens: the less obviously dangerous gets missed. Certainly at the high end when someone is acutely psychotic - and I do a lot of

legal cases with infanticide so I see those - obviously they are very dangerous.

MR SCALES: Yes.

PROF BUIST: But we can assess that, and as long as protective services have been involved, and they usually are, the only ones that they miss are the ones where - we had one where no-one really knew she was pregnant. She lived in a caravan park. So there are those exceptions with known mental illness versus the pregnancy denial who have no mental health history. Those symptoms can generally be managed. We gave recommendations to separate from our cohort. It was severity of illness more than diagnosis, but schizophrenia certainly featured more highly in that, though you tended to be able to go home with your baby if you had a mother or a husband that could help. It was only if you were a single mum with schizophrenia and the schizophrenia was unstable that tended to be too many things, that it was just too dangerous.

But the next level of problems, which is the ones we all struggle with, is really the - there might be a little bit of risk, like, risk of physical harm, and that's what's got the mum into protective services in the first place, and neglect. So this is more the personality disorder with the drugs and alcohol that are much, much harder to deal with. These are the ones that bounce in and out because they can put a good front on, they can look terrific but they can't hold it together because they're too disintegrated. The emotional trauma is potentially extreme, but often gets - - -

MR SCALES: But presumably professionals like you and the people that you work with are the ones who are probably the most capable in this state of being able to detect that.

PROF BUIST: Yes, this is the work we're doing. Us and infant psychiatrists, the Campbell Pauls from Royal Children's Hospital - - -

MR SCALES: So is it going too far to suggest that you're operating at the very pointy end of the pyramid, almost at the top of the pyramid?

PROF BUIST: Yes, I mean, I think that would be - yes, certainly.

MR SCALES: Can I ask you then what is the process for assessing demand at that very pointy end?

PROF BUIST: I don't know. I know once it gets to us but I have no idea about how protective services decides to - - -

MR SCALES: Is there any organisation that systematically and regularly tries

to determine the cohort - the nature and the need of that particular cohort. Just the demand story, do you know of any organisation that does that?

PROF BUIST: I think there's lots of organisations doing bits of that and that's kind of again lack of coordination. Since coming back I've been running around talking to everyone. I know Berry Street is doing some fabulous stuff but they have some people, and then some people are doing something else with another group, and it's that lack of oversight really - - -

MR SCALES: But you don't know of any that would come together on a regular basis? I mean, given your professional standing, if you didn't know about it, would anybody know about it?

PROF BUIST: I mean, unless it's happening in protective services but I don't think so, certainly not in my experience. The perinatal psychiatry group get together regularly. We don't do so much statistic but we could. But it's certainly sharing our experiences. We have a professional organisation that meets for conferences and again shares some of those things. We're meeting in Perth in October. That's an Australia-wide thing. But it's not doing quite what I think you're asking about and I don't know of anyone else that does.

MR SCALES: Just going one step below that, is there any organisation in the state that currently assesses whether the appropriate programs, and whether there are other appropriate programs that might be used, to address that particular cohort?

PROF BUIST: My understanding is it's all very localised and none of that broad stuff happening which I would love to see.

MR SCALES: So would it be therefore reasonable to say that there's nobody matching the demand at this stage, nor anybody kind of matched that demand with appropriate programs?

PROF BUIST: Absolutely. I think ministers listen to what they're told and I think mother-baby unit beds came out of that, but it was looking like this rather than looking like that.

MR CUMMINS: "This and that" on the transcript - "looking like this" is "no", "looking like that" is "broad".

PROF BUIST: Sorry.

MR CUMMINS: Thank you.

MR SCALES: Just one last question on this: is there any organisation at the moment in Victoria that's systematically looking at research in this area, other than the work that you would be doing with your own clients and all of the clinical work which would be going on.

PROF BUIST: There are places that are doing their own kind of - I mean, Louise Newman down at Southern has a particular interest in borderline personalities. I think she's doing some work with protective services so she's got that niche. There's Judith Lumley's group, the Centre for Mothers and Babies, but they are more population health focused rather than intervention focused. They're not really looking at what I consider is the important issue. So it's more again patches of where our own interests led us rather than - and, I mean, I heard a couple of programs, one somewhere in Broadmeadows that I haven't found yet that is trying to do something like Mind the Baby Program, an intense in-home - again it's like these little pockets of things with nothing doing that broad overview which is desperately needed.

MR SCALES: One request really: if there was a way that you could bring some of this data together that we have very briefly discussed today and provided to us, I think that would be helpful, particularly the extent to which appropriately disguised and put within numbers and covered with - - -

PROF BUIST: Yes, I'd be happy to do that. As I said, I've only been back in the country a couple of weeks.

MR SCALES: Given your work I'm loath to ask you to do more work but it would be quite helpful to try to at least get an understanding of that.

PROF BUIST: Yes.

MR SCALES: If I could stretch our friendship just a bit further, by trying to understand the change over time - - -

PROF BUIST: For?

MR SCALES: For the cohort that you're dealing with - - -

PROF BUIST: Length of stay and - - -

MR SCALES: - - - and whether the numbers of young mums and babies in this particular category we're describing has changed over time and by how much.

PROF BUIST: Yes. That would be a bit harder.

MR SCALES: Whatever you can give us, that would be helpful.

PROF BUIST: Okay.

MR CUMMINS: We're most obliged to you. Welcome back, and thank you for coming to Wyndham.

PROF BUIST: Thank you.

MR CUMMINS: The next is Mr Glenn Broome. We would be pleased if you could come forward. Take a seat, Glenn.

MR BROOME: Thank you.

MR CUMMINS: Thank you for the material in relation to Whitelion. We've read that and have been assisted by that. So you can take it that we're familiar with the material in the written form and we would be very pleased to hear any verbal submission you'd like to make further.

MR BROOME: Okay. I was anticipating being on between 12.00 and 1.00, so my rent-a-crowd hasn't arrived yet. That's okay. I'll probably find this a little bit difficult to speak to. I'm not the author of this. However, just going back a little bit, I was a ward, I grew up in care and went back to school when I was a young man and got "edumacated" and become a social worker and have worked in the field for the last 25 years. Big plans and big ideas as a young man to change the system and conquer the world, but that hasn't happened. Realistically we do what we can do in the environment that we're in.

Whitelion is an organisation that supports young people predominantly in the out-of-home care system, but it started with Glen Manton, the former AFL footballer, and Mark Watt, who originally worked in the juvenile justice centre, and then in more recent years we've been doing mentoring programs as part of the out-of-home care, live-in care system. There's three areas that we'd like to talk about today and that is placement options, case planning and transition support. If I can read this, I won't wander off somewhere else I shouldn't be.

MR CUMMINS: No, you're most welcome to do that.

MR BROOME: Thank you. Through our experience, working with young people in residential care we have developed the opinion that there is a lack of appropriate placement options for young people involved in the child protection system. Going back to the days of the likes of the Burdekin report and the Richmond report, it sort of de-institutionalised everything. We tend to

have pendulum swung from putting everybody and everything out into the community and not sort of swinging in the middle where there's a need for support and probably accommodation for young people outside of an institutional setting.

Now, we're not suggesting that we bring back institutions but there's a middle road there where a number of our young people are finding it very difficult to cope within the community. There is a lack of consistency in care across the system which engenders disengagement and inappropriate behaviour of young people. In addition, vulnerable young people with no prior history of drug use offending or disengagement from education are often placed in alternative care settings with young people who have a negative influence on them. This is particularly pertinent for young people entering the system for the first time who are at a crucial point of their personal development. We see this as a key difficulty within the care system that contributes to the perpetuation of entrenched cycles of disadvantage.

Many of the young people that we work with come into the care system through a family breakdown, are engaged in school, have social networks, in particular come into the resi system and are extremely influenced by their cohort very quickly; start disengaging from school; further damaging the relationships they have with their families; experimental drug use. They're at a vulnerable stage where they're experimenting. Soon we're finding kids that have never had a forensic history starting to develop one and that's of a great concern to us, which was the whole part of the closure of Allambie, Baltara, Tally Ho, which was to stop this cross-contamination. It's just happening more in a concentrated effort.

Whitelion argues that the system be revolutionised to provide a greater degree of flexibility such that young people can be placed in alternative care settings that is appropriate to their needs and level of vulnerability. Whitelion advocates for a range of care options such as residential care, home based care and high-structured care settings, et cetera, that are designed to meet the needs of young people and are appropriately resourced to provide young people with the therapeutic and practical support that they require to overcome past trauma.

We argue that workers and volunteers within the system should be provided with a high level of ongoing training and support and that a carer in human services should become a sought after and respected role in society. In addition, we advocate for the system to aspire to a greater degree of staff retention, to fostering increased consistency such that young people are able to form positive and meaningful relationships with workers. I can't categorically say what the life cycle of a worker is, they're so transient, that they're not very consistent in the lives of young people. So there's all that transference of trust

that is continually on the agenda of a young person that they have to form new relationships with people every couple of months.

We believe this is crucial in supporting the personal and social development of vulnerable children and young people. We argue that the current placement options present a systemic issue resulting in vulnerable young people being exposed to negative influences, damaging their future opportunities. Our experience suggests that young people need to have access to varying levels of intensity of care from skilled professional foster care environments through to high-intensity and structured-care environments for young people who pose a risk to themselves and others around them. In addition, the system needs to provide appropriate care options that fill the spectrum between the two extremes of the pendulum such that young people have access to responses appropriate to the needs and their care requirements.

Overall we argue that the system must provide a safe environment for both young people and workers in which all parties are provided with consistent support and resources. We believe that this will foster the positive development of young people and negates much of the risk posed within the context of the current system.

Case planning - and this has come through a lot of the submissions that I've read online and the like - our experience working with young people through case planning processes has indicated there are a range of issues with the current system. Young people too often don't attend case planning sessions and when they do, are not provided with opportunities for meaningful engagement with the process. This function is to negate the young people from decisions around their future further putting them into a service system that supports a trajectory into entrenched disadvantage. Again, this point is linked to other earlier arguments that the system must aspire to greater consistency in care to enable young people to form trusting and meaningful relationship with workers.

We suggest a shift to case planning that involves an advocacy model with the young person supported at case plan meetings by an independent party in addition to their regular worker. This party must be separate to the service system and carry influence within the context of the broader system. The Office of Child Safety Commissioner may be an appropriate entity to provide these independent advocates. In addition to case plan advocacy we would suggest an increase in the level of information available to young people regarding case planning, as well as increased dialogue with young people around case planning processes and how best to advocate for their own interests.

This may include targeted education for young people around the various care and placement options to enable them to advocate for themselves to be placed in the most appropriate form of care; an intake and assessment of the level of understanding a young person has of the care system and care plans and a structured training module for young people, similar to those that have historically been delivered in a youth justice context to provide young people with information in preparation for their court and parole hearings.

In the past Whitelion has delivered case plan training to young people in MYJC just to empower them and make them aware that they actually have a part to play in their case planning, around collecting evidence to justify doing particular things on their entry or exit from the system and that had huge results or impacts on young people as far as where they went within the system and how much control and ownership they had over that.

Transition supports: following from the above points regarding case planning, Whitelion argues that there is significant room for improvement in transition planning for young people involved in the alternative care system, drawing on data from CREATE report card that indicates that around two-thirds of young people leaving care are not aware of a transition plan being in place for them, which suggests that there are significant additional resources invested in transition planning for young people leaving care.

In addition to formal training outlined above, we suggest that a resource is developed to provide young people with access to appropriate information to support them through the transition from care. A similar resource has been developed for adults who are incarcerated in the correctional system which provides vital information to prisoners with the aim of reducing risk factors that may lead to recidivism or harm. Further we argue that the age at which young people transition out of care would benefit from being increased, such that young people are provided with support until at least the age of 21.

In our experience working with young people it is the age between 18 and 21 that they become particularly workable and are more open to pathways into vocational education, training and employment. If workers were appropriately skilled, supported and resourced, we believe that vulnerable young people would realise significantly improved employment outcomes, feeding into improved long-term economic and social inclusion.

We would highlight that for some reason we treat young people in the care system differently to those in mainstream society. For example, the majority of young people living at home do not move out until they are well into the 20s these days. Why should we expect young people in care to make the transition any earlier, particularly as they do not have the support of family around them

for much of their upbringing.

We suggest that young people in the care system between 18 and 21 have access to vocation and pre-employment training options that enable them to make a positive pathway as opposed to being launched into the world alone with no continued support. Again, increased flexibility in care options would need to accommodate an increased level of independence for young people as they transitioned to adulthood in a similar way to that experienced by young people living at home.

Our conclusion is that overall Whitelion argues that the system needs to have the resources and flexibility to provide appropriate care and protection to the full spectrum of needs of vulnerable children. We argue for a range of flexible alternative care options staffed by highly skilled, trained and supported workers with whom young people can form and engage in relationships and receive the therapeutic care and level of supervision that they require to minimise risk factors of those and others in the community. Through the formation of positive relationships young people experience a greater degree of ownership over their futures engendering positive responsibility over their actions. With additional transition support and graduated transition options, vulnerable young people are more likely to make a transition into employment or further education thereby supporting their continued economic and social inclusion.

We believe that a revolution in the way that Victoria's vulnerable young people are supported in care systems with break the cycle of disadvantage and enable them to reach their full potential.

MR CUMMINS: Glenn, that was very well presented.

MR BROOME: Thank you.

MR CUMMINS: Thank you very much for coming forward and presenting it. It's most helpful. Prof Scott?

PROF SCOTT: No, I don't have any questions but thank you.

MR CUMMINS: Mr Scales?

MR SCALES: I have a couple of questions that I think are covered in both your submission and also what you've read out today, so thanks for doing that. You make reference first of all under Placement Options, page 1 on the one you have read out. You make reference to revolutionising the system actually.

MR CUMMINS: It's about one-third up from the bottom.

MR SCALES: You say at the third dot point under Placement Options:

> *Whitelion argues that the system be revolutionised to provide a greater degree of flexibility.*

Then you talk about the range of options, some of them which are already available. But you don't talk in any detail about what you think that revolution might look like.

MR BROOME: That's right.

MR SCALES: By the way, I don't want to put you on the spot here, so if you're not sure of that, please get back to us.

MR BROOME: Sure.

MR SCALES: But do you have any thoughts about that?

MR BROOME: Yes. Look, I've worked and lived in the system my entire life and I think we're moving forward. We've got a lot of work to do and I think one of the key shifts in the last 10 or so years has been in relation to therapeutic care. Again, speaking from my experiences of being in the system and working in the system, I'm also a parent and the therapeutic model I believe is the way to go. I stopped at having three children because - really I believe I probably should have had two, one for each hand. I think the minute we start taking on more, we have some problems. I think therapeutic is the way to go, especially in the residential care system, but we need to reduce the numbers down to two, so that it resembles - - -

MR SCALES: So more like a family.

MR BROOME: It resembles a family. I had opportunity in the '70s of spending a number of years at Tally Ho Boys and Girls Home. It was a big block of land with a number of houses on it and it was what they called a cottage parent model. I think it had a lot of pluses. The only downfall of the system was the management. I think the model and the concept was good but it needs a reduction in numbers. As a hardworking parent, I was able to manage three children, could have done a lot better with two, and I think that it's a model that the care system could take on board.

Also now as a foster carer, some of the demands that are placed on foster carers can be a little bit unrealistic. We've almost got to the point now of being

unpaid workers and allowing us to go back to a model of being actually carers would be nice. Again, I know a lot of this all comes down to dollars and in an ideal world, you would have therapeutic professional foster carers, but I know that the bucket of money is only so big. But if we're fair dinkum about it, then we probably have to put our money where our mouth is.

MR SCALES: The second question I have is - it's on the same page, it's actually under that same dot point - where you talk about the high level of ongoing training and support for workers and volunteers. Do you want to just give us a sense of what you and Whitelion had in your mind when you were wanting to raise that?

MR BROOME: Yes, I guess it's looking at - it's only been the last probably 12 or 18 months that, in particular, residential care has gone to being untrained, in-house training available but we've pretty much got a mandatory Cert III entry level. What we're asking is probably our most unskilled workers. There's still a perception that resi is an entry level for workers, so we get a lot of young people, pretty ordinary pay, working with some of the most difficult kids in the state. So I think unfortunately the whole system is notorious for this; in order to get financial remuneration for the good work you do, you have to go up a level. So if I'm the best residential care worker, in order to provide for my family, why should I now become a coordinator or a manager and take me away from the very thing that I'm good at? So it's about resourcing those and skilling those staff, that if you're the best resi worker in the state, then we want to keep you there. We don't want to turn you into a CEO or a manager. So it's about remuneration and acknowledgment for the skills at that level.

MR SCALES: Okay, thank you. The last question I have is you make reference to leaving care - and thank you for doing that - and you talk about two elements of leaving care, that is, vocational education and training, and then you talk about that sort of leading on maybe hopefully or in conjunction with some elements of employment. There are two ways that people have come to us during this Inquiry about that one issue; one is not unlike yours. Another way that people have described it is having almost like a leaving care plan, not unlike the way in which you described the plan for a child when they're in care. Did you want to make any comment about that - or feel free to take it away and think about it if you wish - but does Whitelion have a view about what that leaving care program might look like, how extensive it is, how sophisticated it needs to be from your own experience?

MR BROOME: Half of it I'd have to take away.

MR SCALES: Sure.

MR BROOME: But the other part of it too is that there's a lot of serendipity in this sector. I guess there's not the pathway or the availability for everybody. We run an employment program within Whitelion. Because of the nature of the way that it's structured and society's perception of young people, a lot of our workers with the older kids - so those that are hitting 18, 19, 20 - (1) because they're probably a bit more marketable - they're a bit over their silliness and their experimental phases and a whole range of different things that makes the opportunity to make them employable, so it's about creating opportunity for younger ones. There needs to be some community education around that. But one young person we can get into a particular position and another one we can't. So it's almost making it fair and equitable for everybody, not by chance. The most difficult ones are the ones that tend to drop off and it's about finding a hook to keep them engaged and involved.

MR SCALES: Thanks very much.

MR BROOME: Thank you.

MR CUMMINS: Glenn, apart from your presentation which I've commended you for, your personal insights are very valuable indeed.

MR BROOME: Thank you.

MR CUMMINS: Thanks very much. Next, Justine Webse. Good morning, Justine.

MS WEBSE: Good morning.

MR CUMMINS: Take a moment to settle down.

MS WEBSE: Thank you. I wasn't able to print my notes, so I'm just going to have to read it.

MR CUMMINS: That's quite all right. Justine, we've read the written material which we're familiar with and you can take it that we are familiar with it, so you proceed in the way that's most convenient to you.

MS WEBSE: Sure. I guess I wanted to really come and present to the Panel today in a verbal way because I've been a foster carer for about two years and I've had about seven different placements during that time. Some of them have been respite, some short term, some longer term. Obviously I have some big concerns about the way that the children are treated within the system and particularly at that early stage when they first come into care and they're quite young and very, very vulnerable in my view.

So I guess beyond what I've written in my written statement, the most important thing to me out of this Inquiry would really be to see addressing that issue of certainty and stability for children because if we can get that right and we can give them certainty and stability at an earlier point in their lives, then I really believe that you will avoid a lot of the bigger issues that are more difficult to address and more expensive to address and potentially avoid some of those cyclical effects with their own family later on.

MR CUMMINS: You proceed then on that basis, all right.

MS WEBSE: What I have to say is actually relatively short. I suppose my experience really is that what children crave most of all when they're in care is that stability and that certainty. So I think that the system has a bit of an obsession with reunifying families, so we take a really long time to try and work towards that reunification goal, even when that goal can be completely unrealistic. Because we have that as our central aim for so long at the beginning of a case we tend to take a really long time to allow children to have a stable, certain environment to live within. I've seen the effects of this in that you have children who don't have any friendship networks. They don't have a community to belong to. They've moved schools multiple times. They've had multiple carers, multiple foster carers. They've lost touch with siblings. So having that stability early on is just so critical to their development and it's so critical for them to become really good citizens later on in life.

I also think that my personal experience has been that children will become more comfortable with living in a situation where they know where their parents are, they can have access with their parents, but they are living with people who are not their biological family necessarily. They will become more comfortable with that split more quickly than the system will allow them to have that. It's been my experience that we tend to look back in the past at some of those really bad examples of closed adoption and of state care where it has gone terribly wrong, and we worry that putting children in foster care for the long term is going to be very detrimental and we want to focus on getting them back with their parents.

While this is sometimes the right thing to do, sometimes it's clearly not. If we can recognise that earlier in the process then we'll have a better outcome for children. As long as they know where their parents are and they can have that access with them - which is something that they haven't been able to do in the past - yes, I think that will be a better outcome for children.

There were two things that I wanted to say that we should focus on to make sure that that can happen. The first thing is to find really good people to be

foster carers. I'm not sure of all of the reasons why this is the case but it seems to be very difficult to get into foster care programs with community service organisations. The one that I'm with only runs two sessions per year. They have limited spaces. They have limited availability to assess your application. Then they also have constraints about how many cases they can take on at any one time. Even if you are accredited you can wait a time for a case to become available for you. I also think we could do more to support families to be able to hold onto foster placements for the entire duration. There are some things around access requirements and things that make life very difficult as a foster carer that we could change so that foster carers could hold onto one placement until children either move to a permanent placement or they return to their families. This would really help kids not having to move to multiple foster families.

As long as we can find those ways, whether it's part of the legal framework or it's part of the way that we operate within the bureaucratic system in DHS that we can bring forward those long-term decisions, I think that would be good. Just to sum up, one of the things that I had been listening to, some of the other presentations, and over the course of the Inquiry, it's my view that we've got a lot of great people working within the system, and my experience of working with the other workers in the system has been really good, generally speaking. What we need is less bureaucracy and more empowerment of those people. There's some incredible people with great insight, and if they had the ability to act on that insight, and we removed some of the restrictions for them to be able to do that, then we'd have a better outcome for children.

MR CUMMINS: Excellent. Prof Scott?

PROF SCOTT: Thank you for your very valuable written, as well as verbal, presentation. I wonder if you could say a little bit more about what could be done to support foster carers so that a child is able to remain with them until they're successfully reunited or maybe moved to a permanent, stable family placement. What might you have had in mind in that?

MS WEBSE: There are a couple of things. I've had different cases with access. I've had cases where I've had six-day a week access, and I've had cases where we've had no access with parents, where parents consistently don't come to access. So when you have a daily access requirement you can't go too far. You can never go away for even a local holiday on school holidays. You find it difficult to enrol children in sporting activities and get them involved in the community. It also places a lot of restrictions on friendships and other things that they might do in their community.

We've had a case where we've had a situation where it's been access as agreed

by the parties and that can occur when parents are not present at court. So the DHS workers, community organisation and the foster carers work out an access arrangement that works for everybody with the parents. I think that would be really sensible that access is not necessarily something that we have to go to court to determine, and that it's not necessarily determined at the beginning of a case because things change as the case goes on, and it's just unrealistic to expect that foster carers can be in a situation where you might have six-day a week access for two years, for example, and ultimately, if the carers do decide to go on a holiday or they have other commitments, the children then have to move to another placement so they can continue that access schedule.

PROF SCOTT: Can I just ask, is that a situation that occurs?

MS WEBSE: Yes.

PROF SCOTT: Two years of six days per week access.

MS WEBSE: Look, I don't know about two years but access - there's every possible scenario. What I've been told by my case workers is that you cannot change access requirements unless you return to court. People don't have the time or the resources to be able to go to court for things like that. It's very, very common that children will stay in short-term foster care for a very long time, for multiple years. If parents are involved in their lives - and siblings and grandparents - and you have multiple placements at the one time, you can have lots and lots of access that you need to facilitate. It might not necessarily be that you have that situation with one child, you might have it with multiple children.

PROF SCOTT: I appreciate that, thank you.

MS WEBSE: The other thing too is obviously the ability to get consent to enrol children in different programs. Everything you want to do with them to assist their development, swimming lessons, all the things that normal children do, you need to get consent from parents to do that. I think there would be a better way and an easier way to operate so that if you weren't doing anything that was totally out of the ordinary, if you were just going to do a normal swimming lesson program then surely it would be easier to enable the Department of Human Services case workers to be able to consent to those things. Some of the consents take a long time and they're very laborious and I think that does become frustrating. Then carers don't get the opportunity to help those children develop.

PROF SCOTT: Thank you.

MR CUMMINS: Understood. Mr Scales.

MR SCALES: Can I follow up on that last point you made. From your own experience - and I don't want you to in any way describe a child that anybody would be able to identify - can you give us a practical example from your own experience of how access affects your life in the way in which you've just described it.

MS WEBSE: Yes. I've had situations, as I said, where we've had six-day a week access and that particular child was not able to attend kindergarten, even though they were of kindergarten age. The parents of that child consented to kindergarten and were happy for that to occur. It's just that we were unable to get the resources to go back to court to change the court order.

MR SCALES: Let me clarify this. This is a child who should be at kindergarten - - -

MS WEBSE: Yes.

PROF SCOTT: - - - everybody agrees should be at kindergarten - - -

MS WEBSE: Yes.

PROF SCOTT: - - - but the access arrangements by their very nature was stopping the child from getting what everybody in the system said the child should get.

MS WEBSE: Absolutely. That access occurred during the middle of the day, so often you will find, particularly with high access schedules, as people go to school, there are so many issues around access that are just impractical from a foster caring point of view and from a child's point of view. If you go to school all day, and you're six, and then you have to go and see mum or dad or mum and dad and siblings at an access centre after school, you've got a very, very long day and you get very tired and frustrated, all the things that can happen to you if you're quite young and you've got to travel and you've got these kinds of high levels of commitment, let alone doing all the other normal things that you might do as a kid.

With very, very small children as well, it's very difficult because you often have to wake them up from sleeps, you have to disrupt sleeping and eating patterns in order for them to attend access and there's not the flexibility to be able to change those things around.

MR SCALES: I don't want to put words in your mouth here, but did anybody

ever raise with you whether that was in the best interests of the child?

MS WEBSE: No.

MR SCALES: Do you know why not?

MS WEBSE: I mean, I expressed an enormous amount of frustration about that particular situation. I think the answer was not about whether it was the best interests of the child, it was about what available resources we had to be able to change that situation and there were none. So the best interests of the child was not raised in that context.

MR SCALES: Thank you. That's most helpful. Can I ask a couple of other questions in relation to your written submission which I found really helpful. At the bottom of the second page, you make the comment about - these are my words, not yours - the lack of flexibility about the relationship between you, the carer, the DHS worker and the agency. Do you want to tease that out a bit and give us sort of a bit of colour and light about that?

MS WEBSE: Yes.

MR SCALES: The way you've described it, it looks as though everybody is trying to do things but nobody has got the authority to do things and therefore nothing gets done.

MS WEBSE: Yes.

MR SCALES: That's what seems to come through from what you've written. Is that a reasonable interpretation?

MS WEBSE: Yes.

MR CUMMINS: Do you want that page or have you got it on computer or are you okay to go through it?

MS WEBSE: No, that's okay.

MR CUMMINS: All right, thank you.

MS WEBSE: I think the difficulty that I've experienced with multiple people being involved in a case - and that's why I say we need less bureaucracy rather than more - it's wonderful to have a lot of people who care about children and who want the best outcomes for them but often with a couple of people who know the child very well and who are generally insightful people themselves,

they will be able to come up with the best ideas and the best outcomes for the child. I guess what happens with the inflexibility is that you have a caseworker in DHS or you may not have one and then a lot of those decisions fall to a duty worker or somebody who doesn't understand the case and somebody who is very difficult to get a hold of. So they are the people that hold the power to be able to make decisions and they are the people who you are always trying to influence to get the best outcome for the children.

Now, if they're not available - for me personally I have an excellent relationship with my agency worker and she is just fantastic. She always responds, she is always on the phone to me and we're always working out answers to things. But even if we come up with those answers, we still need to go to DHS to get that authority to do those things. So there isn't that flexibility. When there is no caseworker or that person is unavailable, in a commercial setting, those decisions would naturally fall to somebody else in the commercial organisation just because it would have to, whereas in this setting, that person is the only person who is able to make that decision.

MR SCALES: So it sounds to me as though if the system could be organised so there was more scope for the agency worker to be able to authorise what I might describe as routine opportunities to be able to meet the child's needs, that would meet your need presumably.

MS WEBSE: Absolutely. It would negate the need for multiple conversations about the same thing. The agency workers actually have an enormous amount of involvement with children. I live five minutes from where the agency worker works and I'm in there every other day. So they know the children and they have a relationship with those children. That's well in excess of what a DHS worker is going to be able to do, particularly if you're not actually allocated a caseworker.

MR SCALES: There was just one last question I wanted to ask you and that is that on the very last page of your submission - you won't need to look at it because you'll know about it - you listed a whole range of meaningful data about the children in the system. That was a most helpful document, so thank you for doing that. Did you have a view about who should publish that data and how it might be published? As you were writing it, I'm sure that there were a lot of thoughts going through your mind about how that might apply and how it would best suit your needs and the needs of the community.

MS WEBSE: Yes. I guess I'm a fan of us looking at efficiencies and looking at the data to make some decisions because I think there's a lot of really good information that we could learn if we understood a little bit about what happens, what the patterns are. I do have reservations about DHS necessarily

creating that data and then publishing that data because I think it's very easy for us to blame the Department of Human Services for all the failings and it's not necessarily the case and I think then it's very easy for them to feel that they need to defend themselves. So it's difficult when you have that kind of situation and then ask them to publish a whole lot of data that may show up that there are big problems in the system. Personally I think it would probably need to be compiled and published by somebody else.

MR SCALES: So it's independent, you're saying, of DHS?

MS WEBSE: Yes. I mean, there may already be another body that's involved like the Child Safety Commissioner's Office or there could be multiple people or even the agencies themselves could provide reports about some of that data anyway, but obviously they would need to access that data, so I'm not sure how complicated that would be.

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

MR CUMMINS: Justine, both the written and your verbal presentation have been most thoughtful and helpful.

MS WEBSE: Thank you.

MR CUMMINS: Thank you very much. Finally, in the pre-lunch session, Mr Raymond Caruana. Raymond, welcome, and take a seat.

MR CARUANA: I'm not very good at doing stuff like this, especially writing.

MR CUMMINS: That's all right.

MR CARUANA: I hate writing. That was my worst thing at school, English.

MR CUMMINS: That's all right. You don't need to worry.

MR CARUANA: But with my experience, I've gone through a lot and I've seen a lot of things and it's just a joke. This has been happening for years and years. The stolen generation and the government has apologised to it - you know, for the stolen generation - that's still happening now. There's still kids being taken away from their parents or vice versa. Most of that is all due to lies or drug abuse. That's got to change. There's got to be some legislation that changes - anybody that lies should be accountable for it. That's happened just recently in the news, when that girl about two weeks ago disappeared and they still haven't found her. Then there was another girl that stated she was abused too or tried to be abducted and she wasn't. So that's got to change. This is

now, not what's happened in the past. This is our future.

Like, with my experience, I've done an independent person program, you're helping kids that have been in trouble, you know, when they get interviewed and I've done team mentoring with the Red Cross and I've found that very helpful for the young kids because it comes down to communication and trust. Kids have got to find something or somebody that they can trust in. A lot of kids won't tell their parents because then they're going to know, they're going to get into trouble, but if they find somebody independent or big brother or something like that, it's going to help the whole community.

Pilot programs, they come and go, but do you ever see the end of it? It seems like everybody wants the money. What I've been hearing over - I've been to the Melbourne Town Hall and heard some of the speakers there and you see the same sort of thing and something has got to be done about it.

MR CUMMINS: You use your notes for reference as you're going through. It might be more convenient.

MR CARUANA: Yes. Like, the foster care payments, they get very minimal allowances, right, for kids that they're looking after, but then I've known people that look after international students and they get a lot more allowance than looking after foster kids. So how can you see the justification in that sort of system? We're looking after kids, international students, that are old enough to work and earn their own money, when we're not even looking after our own young kids. That's one thing that I recognised.

MR CUMMINS: Yes.

MR CARUANA: The stolen generation, I've already mentioned that, it's like kids are being taken away from their parents. It's not easy on the parents and it's not easy on the kids. It works both ways. Some kids are better off without their parents because of whatever circumstances there are but then there are others, it's just an abuse of the system. I've seen teachers seeing children being abused and it gets swept under the carpet. There's nobody that will take responsibility. They turn a blind eye to it. That shouldn't be happening. Like on Wednesday, the social worker, he reckons there needs to be changes in the Family Court because there's a lot of child abuse being held there, and children go through a lot of stress going through that system. They reckon they're going to change it and all that but I've been to Parliament House in Canberra - I don't know who was in government - but anyway, they said they were going to change it, but it doesn't change.

The biggest problem is there's a few bad apples in the system, and if they can

get rid of the bad apples; it's not going to change because they're so high up, and I can prove it. I know that there's bad apples. It's very similar to the police system. There's the commissioner; they got this new police officer from England. What happened? They kicked him out; the other one has resigned. Why is that? They know that something is going to be uncovered. We're just going to have to wait and see what's going to happen.

I know that it can't be a perfect world and nobody is perfect and nothing is perfect, but we can try our best. This is our future. Another thing that I heard on Wednesday, both parents should be involved in the child's interests and stuff like that, whether they're separated - I've seen families that are together. They still have problems with their children because kids have got their own mind. You can't force children to do what the parents want, it's whatever the child wants. You can try to lead them or get somebody else to get them off the track, but it's up to the parents and the child to try to work things out because once you get more individuals and more people - that's what I've been hearing right along - it gets too much and nobody knows what's right and what's wrong. But then sometimes there's people that are lying and that shouldn't be happening. There should be another space where you can go and see who's telling the truth and who's not, but that's not an easy task either.

I was at this little seminar once and this lady turned up with a seeing eye dog because she was blind - I will never forget this and I was there with a mate of mine - and there was a member of a high public office and this dog - I've never in my whole life seen a seeing eye dog growl at a person. When I saw that, me and my mate said, "There's something wrong with that person," and I reckon the animals are better respected to human life than anything else, so that could be one thing that we could bring in. That's my experience.

Violence, you hear that all the time. Where does it come from? You've got to find out what's causing it. Like, you stick a pin in anybody, they're not going to stay quiet, they're going to jump, so there's a reason for violence. You've got to see where it's coming from, why it's happening. There's a reason for everything, so it's got to go back to the ground, why it's happening. There's a lot of - some is misleading information, some is true, I'm not an expert at that sort of thing, but I know of experience a lot of things in my life and you hear - you know, like violence. You try to get help and somebody just turns a blind eye and there's got to be a place where you can report something and it gets followed up.

Even to come to this Inquiry, there was an ad in the paper and they had the wrong number in the paper, so I had to ring up, ring up, ring up. Then somehow I ended up in the complaints department but they never returned the call till the next morning. Now, if there was a child that really needed help

there and then, it's too late waiting till the next morning. It's way too late. That's got to improve. There is money in there, there is. Instead of wasting money on this carbon tax, you know, advertising - I heard on the radio that they're going to spend - they have already spent so much millions advertising for this carbon tax. Just keep it, put it where you really need the money.

The best interests of the child, that's another thing. It's not always the case. Like, I've known of a case where the child was woken up - well, at child care, 7 am in the morning, went to child care - this is a primary school student, went to school for the day, went on an access visit. This is during the week on a Wednesday. Then from there, the other parent was taking it to music lessons straight after an access visit and she wouldn't get home till 8 pm. That's a 13-hour day for a young primary school - and I find that very unfair. When it got mentioned to the child representative, he didn't want to know about it. Do you call that the best interests of the child, because as far as I know, it's not.

Another case that I know of where a child accused the person of sexual abuse and it wasn't true, and the guy that the accusations were done against, all his family disowned him except for his wife and three kids, and eventually the system just took so long - you know, the police took so long to investigate it - he was sick and tired, he just killed himself, suicide. What for? Just because this one little kid told a lie, and then they found out later that this girl had told lies before. So there's things that have to change and things - when there's accusations like this - it's got to move faster than what they do, because a life is worth more money than anything else. Now, these three children, one is disabled, and they have got no father. The mother isn't coping very well either because she hasn't got a husband, so what price do you put on that?

I believe the federal and state - there should be one umbrella because they say, "This is a state government," or "This is federal," and if there's one body over both of them that's got the power to change things, I think it will make things a lot easier, because just say if there's a broken family, they go interstate and then they say, "We can't do nothing because that's a different jurisdiction." There should be a proper complaints department that takes things a lot serious and get things moving. Even I've heard through the other submissions of volunteers - some don't get paid - some are having financial difficulties themselves, but there needs to be an improvement, some sort of payment or help for them to cope with the whole system because it's not an easy job, looking after foster care parents or the kids.

Even from Wednesday's submissions, when there were questions brought up to the joint submissions, they're all professionals and they're all working in the system and they were lost for words on some questions, but then when there was a single person representing himself or herself, it's a lot harder when

there's one person and I think that there should be more of this. The people that have got involved in this sort of thing, there should be a round table conference and everybody talks to each other because, like, some of the people you never see again and we've got some valuable people that have gone through the system and know what's going on. It comes down to communication and just commonsense. That's what I see. You've got to trust - like, the kids we've got now, that's going to be our future, and what's going to happen to them if they don't trust in us? It comes down to communication. That's about all that I've got.

MR CUMMINS: Mr Caruana, thank you very much for that. We agree that, as you have said, personal experience is most important, not just professional input but personal experience is most important. We agree, as you have said, that causes need to be looked at - like you were talking about the prick of the pin and the reaction - and we must look at causes.

MR CARUANA: Yes.

MR CUMMINS: We agree that early intervention is most important, as you have said, and ultimately of course, as you also have said, testing the truthfulness of things is also very important. So thank you very much for that. I've got no questions of Mr Caruana as such.

PROF SCOTT: No, I don't either.

MR SCALES: Thank you very much.

MR CARUANA: Okay.

MR CUMMINS: Thank you for coming forward and I'm glad you referred to your notes to assist in your presentation.

MR CARUANA: Thank you very much.

MR CUMMINS: Thanks a lot, Mr Caruana. Ladies and gentlemen, we'll now take a lunch break and resume at 1.15.

ADJOURNED **[12.21 pm]**

RESUMED **[1.20 pm]**

MR CUMMINS: Ladies and gentlemen, it's 20 past 1 now so we'll resume for the afternoon Sitting. We're very pleased to invite Marita Scott and Helen Riddell to come forward - Baptcare. Thank you very much for the written submission and you can assume for the purposes of your verbal submission that we know it and we would be very pleased if you would like to take us to any either additional matters or any focus you want to place on it and we will go in whatever order is suitable to you.

MS SCOTT: Thank you. Phillip, as noted in our formal submission to Protecting Victoria's Vulnerable Children Inquiry, Baptcare has the benefit of providing intensive family support services across Victoria and Tasmania. There are distinct differences between the two child protection systems. This experience enables us to make some high-level observations and comparisons across the two service models and the outcomes for children and their families. A formal evaluation of the Tasmanian government reform of child, youth and family services is yet to occur, and we're partnering with the Department of Health and Human Services in Tasmania in this process.

However, we are able to extrapolate from our experience some themes relating to the access to meeting full intervention for children and families, and the benefit of a partnership between Child Protection and the Integrated Family Support Services. In this partnership, Child Protection and Family Services work together to assess at-risk children and identify the most appropriate service response. For example, does a family who have a child protection notification require a statutory response, being Child Protection, or a capacity building response, being our integrated children and family services.

In Victoria, families who are the focus of a statutory notification and do not reach the risk threshold for child protection and intervention are referred to the Child FIRST system. This process can occur over an extended period of time whilst the child protection worker undertakes an initial investigation and assessment of risk, and then determines whether a statutory response is required or a referral through to Child FIRST. Once Child Protection conclude their assessment and then refer the child on to Child FIRST, they will often close their case. This occurs prior to the referral assessment and acceptance by Child FIRST, so there tends to be the potential for a gap or a child slipping through that system.

This practice creates the potential gaps, particularly when Child FIRST assessment identifies that the case is not suitable for a Family Services intervention and requires a statutory intervention. It's what we call the argy-bargy between Child Protection and Family Services. This difference of

view in negotiations between Child Protection and Child FIRST regarding the appropriate case intervention creates further delays. For children and their families this can mean a delay of some weeks before they receive suitable support services.

Conversely, in Tasmania, recent amendments to the Child, Young Persons and Families Act of 1997, and reform of the Child and Family Services sector, authorises Baptcare to receive notifications through the Gateway Service. When a notification is received, a detailed assessment is undertaken by our intake worker and then there's a consultation between our Gateway intake worker and a co-located community based child protection worker. The community based child protection worker is based at Gateway on a full-time basis. I think in Victoria we have a model where there are community based child protection workers but they're not necessarily available full-time.

The simultaneous preliminary assessment process gathers evidence of risk from a statutory perspective, as well as from a strength based family assessment. The approach is collaborative and it allows the robust discussion between the practitioners and then clear identification of the appropriate pathway for the family. There is agreement between the child protection worker and the family support worker on the planned response to each child and family. I think the benefits of this collaborative approach is the streamlining of families into the appropriate system to best protect the child. Now, that can either be statutory or strength based and family capacity building.

There is also the benefit of efficient use of limited resources to ensure that child protection workers are focused on high-risk families where statutory intervention is required, with the majority of children and families streamed to an integrated family support service. Indications to date - we've done a preliminary scan of our data - approximately 90 per cent of notifications go through an integrated family support service referral. Only 10 per cent of notifications actually require child protection intervention.

A strong and respectful partnership approach of two notifications, assessment, documentation and substantiated, is developed in that collaborative approach. One of the key issues inherent in the Victorian model is the adversarial nature of the child protection system - and I've noted that's been observed by a number of people during the Inquiry - - -

MR CUMMINS: Yes.

MS SCOTT: - - - and decisions regarding the appropriate intervention and service response. Our experience in Tasmania demonstrates that a shared

approach leads to more timely and targeted responses to children identified as at risk or potentially at risk. The introduction of Gateway has ensured that Tasmania has a robust referral and assessment system to reduce the likelihood of families slipping through the service gaps and improve the integration and coordination of services available for at-risk children and families.

Furthermore, on occasions when individual cases have escalated quickly, the ability to undertake joint work by a community based child protection worker and the integrated family support worker has improved the response, capacity and timely intervention. An example of that comes to mind where we had a family who had come in - we initially thought a child protection intervention would be required and they went out. They identified that a family support intervention would be more appropriate, so we engaged with that family. But what happened was when Child Protection withdrew, the family disengaged so then they were once again in that same situation.

What we did in that situation was to bring back the child protection worker, re-engage with the family, be very clear that if they came down the pathway of capacity building and working with Family Services, that was one outcome, or they would go down the statutory pathway. We found that being co-located and that capacity to have face-to-face conversations makes it very real and the response really was excellent. I think the outcomes for that family were particularly very good.

We recognise the tensions that build up between services when determining the most appropriate response for a child at risk. The Gateway model enables Baptcare to take notifications of children at risk and to co-assess complex cases with child protection workers. This model has allowed the development of respectful relationships to be built between skilled child protection workers and skilled family support workers who, in partnership, determine the best response for a child who is identified at risk, and ensured that this is done in a timely way.

One of the key learnings of the reform and our experience in the provision of an integrated Gateway model is the benefit of shared decision-making. This is done through a collaborative partnership approach between Child Protection and Family Support Services, whilst critical decisions are made. The partnership approach ensures that children and families do not slip through the gaps whilst critical decisions are made as the appropriate service response.

We welcome the opportunity to share these learnings of the Gateway and the sector reforms that are happening in Tasmania. One of the things that we would like to do some more work in is developing an evidence base around it, what are the actual outcomes for that reform so I can give you some

preliminary information. But what we really want to have a look at is what's the time of response and how long are those families in care. I think there would be some benefit to actually having some comparative work across the two states because they are so different as far as their systems are concerned.

I think in a nutshell that was essentially what we wanted to bring to your attention, is that there is a different experience in Tasmania. We work in both Victoria and Tasmania and we provide out-of-home care in Victoria. We provide kinship care, foster care and integrated children and family services, plus disability services, so we have experience in both camps.

MR CUMMINS: Marita, that's very helpfully focused. It's of great assistance to us to have written material but then a particular concentration on that, so that's very, very helpful. Prof Scott.

PROF SCOTT: Thank you, yes. I've got two areas I'd like to ask you about; one is about what you've just said and the other is about what you've said on page 9 of the previous written submission on the new model conferencing. Assuming that other Panel members may be interested in responding to what you've just said, it might be that we come back to that one later, so we keep the theme around the one issue.

I've been very interested in the Tasmanian approach, and the reason why they originally modified the Victorian Child FIRST model as they did was to encourage people who would otherwise feel they had no choice but to make a notification because they felt they could be charged under a failing to notify - mandated notifiers - that they allowed them to in a sense fulfil the mandatory reporting obligations whether they notified the department or whether they referred a family to Gateway. So that's the origin of their system being different. I'm very interested that it's evolved so that a non-government organisation employee does the detailed assessment. I'm just interested in whether that detailed assessment is something which is done by phone only, a triaging sort of, or would it be that the Gateway intake worker, a Community Services employee, would actually do a home visit? Is that the case? Is it the latter when you say "detailed assessment"?

MS SCOTT: Yes.

PROF SCOTT: It's a full protective assessment?

MS SCOTT: No. Can I respond?

PROF SCOTT: Yes, please tell us.

MS SCOTT: Okay. What it is that the phone notification is taken, so details are taken at Gateway by an intake worker. Then from there, it depends on what is tabled in that notification. If there is anything in regards to physical abuse, sexual abuse, anything of a high-risk nature, it automatically goes to Child Protection, very clearly.

PROF SCOTT: Right.

MS SCOTT: But if there is a phone call from a concerned community member who says that they saw a child who seemed to be inappropriately disciplined at a supermarket, then that response may be a telephone call from the intake worker to that family, if we gathered the information. So, no, we don't do child protection investigation, it's just assessing the level of risk and does it require child protection or would this family probably benefit from some capacity-building family support?

MS RIDDELL: That intake is done - when risk identifications occur - in contact with the co-located worker. It doesn't have to refer through to the child protection system as such. It still continues to occur live within our building and then once there's an agreement reached between us and Child Protection, they would say, "Yes, there's enough here for us to agree that it needs to go through to investigation," or they would say, "I think it sits better with you. Could we continue to hold it in a family support environment and go and do a home visit together?"

PROF SCOTT: Right. So when you say "detailed assessment", it's the initial telephone based assessment.

MS SCOTT: It's a screening.

PROF SCOTT: Screening, great.

MS RIDDELL: It's not an investigation.

PROF SCOTT: Yes, right. So we're not asking Community Service employees to perform a statutory assessment role.

MS SCOTT: No.

PROF SCOTT: No, that's really helpful because that concerned me. So it's really the closeness of the collaboration that you have with the co-located community based child protection worker that allows that to happen and it's mostly in cases that at first sight would not look - they could prove otherwise but at first sight would not appear to be high-risk cases.

MS SCOTT: And what we've found is that's why that - the argy-bargy doesn't just happen at that first point of contact because what happens is that the initial review is that Child Protection don't need to be involved, "This is an IFS, off you go," and so we might go out to that situation, but once you get into the home and you identify there's a number of risks happening there, you attempt to engage with the family and there's a resistance from the family, then that can be an opportunity where that partnership, where you - we've had situations where the child protection worker goes out with the IFS worker and they go together and do a home assessment. It's not the carrot and the stick. In a way, the child protection worker can be that additional encouragement sometimes for a family to engage with some capacity building or some changes in their behaviours that are of concern.

PROF SCOTT: Which leads me to my second question about this issue and that is your concern at what may look like - my words - premature closure of the case by Child Protection which a number of organisations have mentioned to us. I'm just asking - I made a note to myself - if you request it, in your experience in Victoria, is the statutory child protection service, DHS, willing to not close it and keep it open so that you've got an authoritative lever in the background while you engage and work with the family perhaps over a number of months?

MS RIDDELL: The sense that we're getting from our staff is that it's closed before they even have a first contact, so it's closed very early on. So the ability to have that dialogue with Child Protection around, "Is this an appropriate place for this referral?" the decision is made and it's already been transferred across.

MS SCOTT: I think the other thing too is we recognise the demand pressures. The demand pressures are intense on Child Protection.

PROF SCOTT: Yes.

MS SCOTT: I think that probably sometimes they get taken up in this volume of work and notifications - to me, there's an efficiency in the Tasmanian space that takes away from that volume and actually allows them to become targeted on the truly at-risk situations. In regards to case closures, one of the things we have found is that in the main, Child Protection will have done their investigation, found that there's no substantiation and will close the case at the same time as making the referral. But as I said before, with some of the examples, the integrated family support services can have some challenges in engaging that family into the intervention space and I think there is a benefit to that partnership approach between Child Protection and the IFS working

together to work with some of these families. I don't see it as a lack of willingness of Child Protection, it's a demand, and how do you manage the demand and the workload?

PROF SCOTT: Yes, I recognise the reason for what I would describe - my words - as gatekeeping and closure, but it would seem to have the effect of making it difficult with one subgroup of families for your services to successfully engage with them and to lower the risk factors so that you reduce the likelihood that they will be child protection cases. I'm not sure if they're very resource-hungry cases from a DHS perspective because presumably you are the ones actively working, and it would just I think be - would it not, I won't lead you - but I'm not sure how resource hungry it would be from the DHS perspective to just leave the case open until they had had sufficient feedback from you that you now really had a good engagement.

MS SCOTT: Yes.

PROF SCOTT: So you're saying that it would be helpful - - -

MS SCOTT: Very.

PROF SCOTT: - - - for the department to hold open some of those cases.

MS SCOTT: Hold the case open until there's formal feedback from us that the family is engaged, yes, that would be very helpful.

PROF SCOTT: Good, thank you. That's my question on that issue, Mr Chairman.

MR CUMMINS: Any other matters?

PROF SCOTT: The other matter was about the new model conferencing but it might be that you and Mr Scales might have questions about that issue.

MR SCALES: It might be related, but I have some questions; on your submission, page 2, where at the very top of that, you talk about the scenario, that is, the growing complexity of the cases that are appearing and you argue that it's opening up a gap in the service system and you say:

> *Families with an identified single risk factor or a reduced parental function are unable to access the very much needed family support services.*

Do you want to just go on a bit more and talk about that? Your commentary is

quite helpful in your submission but you're highlighting that really Child FIRST is now operating almost at the tertiary end, I think aren't you?

MS RIDDELL: It's almost like there's becoming three levels; there's the statutory end, there's a tertiary end and then there's the heightened intervention end. We've been working with a lot of families in rural regions that have contacted the Child FIRST system and the intervention system and requested help themselves and have been told, "Well, you seem to be doing okay. You've been able to make contact with us, therefore you're showing a fair bit of initiative and capability. I think you'll be okay," or they have been given one or two counselling supports and then they're left on their own.

Most of these families - well, all of them really - are isolated into the community. They've moved into that regional area and have no family supports. They might get a little bit of help but it's not enough to embed them into the community. A lot of the families have been experiencing extremely high levels of violence within the families of child abuse and of neglect. They have not reached the threshold for whatever reason. They've not received a notification. But we've been doing some intense work where we've had a volunteer go in for two hours every week to provide some support and attachment and connection with the community and to role model parenting and to help them link into their environment - to their doctors, their GPs, their community health services. It's a different level of intervention. We're getting fantastic results from it.

MR SCALES: What you're referring to there, is that the Home-Start Program?

MS RIDDELL: It is the Home-Start Program.

MR SCALES: Help me to see whether I've got this right. You have people that are going to Child FIRST, and Child FIRST are saying, "We really can't help you." Then Child FIRST are referring them back to you, even though the Child FIRST system doesn't fund you.

MS RIDDELL: Exactly right.

MS SCOTT: Yes. Baptcare fully funds the Home-Start Program in Bendigo and it's very much capacity building and a social inclusion. It's actually transformational. We've done some recent research in regards to the Home-Start and their case studies where it's literally transformational for these families because of that sense of working with someone, affirmation of positive parenting and skill development over a two-year period. I think the frustration is that some of these families do try to interface and access services but they

don't reach the tipping point of access, and then they're sort of back out into the community again with fairly limited support.

MR SCALES: Yes. But you seem to also be arguing that - I'm not trying to put words in your mouth here - the services have now gone right up to the point, the pyramid, to the tertiary end. So the resources are now not available for at least a secondary level of support.

MS RIDDELL: They're available for families with very young children. The enhanced Child and Maternal Health Service can provide this level of support and intervention but only for six visits. It's a limited service. A lot of our referrals come from the Child and Maternal Health for that program because again there isn't anything else once their service runs out. There's nothing else. There's nothing in the middle between the tertiary or more acute end of family services, and once you've exhausted your early intervention services.

MR SCALES: Can I also - it's along a similar line - take you to page 9 of your submission which again was very helpful. It relates to the Tasmanian context and Child FIRST. You simply make the very sensible point really that Tasmania is actually relatively small compared to the rest of the country, so you've got to be careful about comparisons you make.

MS RIDDELL: It's the size of the north-west region.

MR SCALES: Yes, that's right. That's a helpful intervention. But then you go on and say that the Victorian Child FIRST model has a disaggregated and complex lead agencies' arrangement. What's at the back of your mind there? What were you thinking about when you wrote that?

MS RIDDELL: When I wrote that I was thinking about - there's a number of Child FIRST providers that each Child FIRST provider has a different assessment or documentation process. They do their assessments differently, then they work down to their alliance partners and refer it through. In Tasmania we have a single assessment tool that's used across the state. There's two lead providers that undertake the process in the same way, and the referrals down to the alliance partners are conducted in the same manner. The same documentation is used all the way through.

Whilst we're certainly supporting the Child FIRST initiative there are some issues around it. They have developed organically in a way and a lot of the alliances are very different and function very different to each other. We work across two of the different alliances. Even within those two alliances there's a lot of different governance, structures, arrangements and agreements around how they operate. I think this disaggregated approach does lead to a level of

not confusion but just, I guess, a challenge to the system of how cases - - -

MR SCALES: So would I be right in saying, from what you've said here, you're going a bit beyond your recommendations. Your recommendations are really sort of just clean it up at the margin really, whereas what I'm hearing you talk about here is a bit more fundamental. I fully accept that you're not being critical of Child FIRST. I understand that. People are very supportive of the general proposition of Child FIRST so that shouldn't be the question. But let me test how far you're going to go with this. Are you arguing that there ought to be, for example - as you do have a little bit in Tasmania - a statewide approach to the governance, systems, processes? Are you going that far?

MS SCOTT: The benefit of that is standardisation and consistency. I think the downside of that is potentially not being responsive to local area needs.

MR SCALES: Sure.

MS SCOTT: I think it's a balance. The consistency around tools, frameworks and principles are very important. That's an area where - - -

MR SCALES: But you might be able to get the local commitment, understanding and knowledge by having local organisations within the alliance who are local, whilst still getting the benefits of the statewide systems, economies of scale and scope, those sorts of things. Thank you, that's helpful.

MR CUMMINS: Could I take you to page 9 of your submissions.

MS SCOTT: Sorry, we didn't bring it but we are familiar with the submission.

MR CUMMINS: The new model. Just a couple of small things - it's only a typo but I just want to make sure I've got it right because it's important - that is "except the child".

PROF SCOTT: I've marked it with "e-x".

MR CUMMINS: Yes, that's easy. I just wanted to make sure that's right.

MS RIDDELL: So the child doesn't have a representative in the case conference.

MR CUMMINS: All right. Let me just take two points - and the first is this: you propose that the mediators ought to be better trained in non-adversarial understanding. Is that right?

MS SCOTT: Yes.

MS RIDDELL: Yes.

MR CUMMINS: Well, that's certainly a theme that has come through, so we follow that. You also propose that the adversarial nature of the interaction be removed by only permitting the child to be represented by a lawyer. Well, putting that aside, do you envisage that if the lawyers didn't represent the parents there would be less of an adversarial contest, or do you think it would simply be an adversarial contest between the two parents rather than between the two lawyers on behalf of the parents? In other words, do the lawyers add some further layer of adversariality than the parents themselves would?

MS RIDDELL: Yes.

MR CUMMINS: Do you think the whole problem would disappear or half the problem would disappear? I'm not asking you for a proportion but if you could give me a feeling of how you think it would go if the parents were there, in effect, antagonistically, but not the lawyers. Would the temperature be lowered, do you think, or would it just simply happen in a different way?

MS RIDDELL: In some cases I think, yes, it would be lowered. I think there would be some very adversarial parents but I think it would be worth a try to negotiate with the families, or mediate with the families first, before the lawyers are brought in. From our experience the tension lifts dramatically when the lawyers are involved and that's including from our worker's perspective. They feel that it becomes adversarial against them, that they're being challenged and treated as part of the issue rather than being a picture or part of the solution. So there is a sense from our staff, and this is certainly just bringing it up from our staff that work in the court environment, saying that they believe that if there was an opportunity to have mediation before the lawyers became involved, then they would get better outcomes for children.

MR CUMMINS: Thank you. That is very clear. The other point on that page going one up, Cumulative Harm, it is a theme that is coming through quite clearly that a lot of persons consider that cumulative harm hasn't really been either understood or, if understood, embraced.

MS RIDDELL: I agree, yes.

MR CUMMINS: Anything further?

PROF SCOTT: I too was interested in the new model of conference and your perception of it. When you say the focus on the child's needs gets lost in the

discussions, are you suggesting - and again these are my words - but are you suggesting that the department doesn't advocate sufficiently vigorously for what they perceive as the child's needs?

MS RIDDELL: What we're saying is that often it becomes about the parents having right of access and whether that right of access is in the best interests of the child gets lost. So the parents' needs of being parent and playing a role in the child's life - which is also part of the child's needs and I understand it would be a very confusing level to work out which one overrides. But from our staff's perspective they believe that there are often cases where the child's need to have some time away from a particular parent and to settle in a new environment or a different environment is overridden by the requirement for a parent to continue to have access.

PROF SCOTT: Would the child's carer have any voice in this?

MS SCOTT: The foster carer?

PROF SCOTT: Yes.

MS SCOTT: They're often involved in discussions.

PROF SCOTT: So would you be, as the agency, expressing what the carer's view might be? Particularly around access or contact the carer is very vital in this; as we've heard today some very onerous expectations are placed on foster carers around facilitating contact. So would you see yourselves as representing the carer's perspective on contact or - - -

MS SCOTT: We would be encouraging the carer's voice be heard.

MS RIDDELL: Our first voice would be the voice of a child. That would be our primary voice that we would want to express and the second would be around the foster carer and the foster carer's relationship with the child. In terms of the foster care having ability to control the access visits, we would not be advocating or have a voice around that.

PROF SCOTT: The willingness of a foster carer to accept the access that is being discussed would not be considered?

MS RIDDELL: That's never been considered or discussed.

MS SCOTT: It would have to be negotiated. It would have to be very - that would have to be on a very individual basis. I think that the role of the foster carer in facilitating access and how comfortable they are in that process and

where that relationship is too with her - - -

PROF SCOTT: Sorry, no, I didn't mean that we were asking this foster carer to be an active facilitator of the contact, I'm just saying is it that what happens in a new model conference that you would have the department, the parents and perhaps an agency such as yourselves all discussing and trying to come to a consensus about the level of contact that will prevail in an agreement to prevent it progressing and becoming a contested case or whatever? I'm just wondering how the foster carer gets to be consulted in that given that the five-day a week access is going to be agreed upon by the parties in that room. How does the willingness of the foster carer to conform to such an agreement get into the loop?

MS RIDDELL: Often that's not considered.

PROF SCOTT: So it would then be a fait accompli and if the foster carer said, "I can't cope with that because of my other three foster children," would you need to change the placement?

MS RIDDELL: We would look to our staff facilitating the access. Child protection might take a role in facilitating the access if it's under a statutory order. It then becomes part of the system to facilitate the access and certainly transport and retaining connections with family is a huge issue for our foster carers. A lot of our carers have four or five children that they might look after at different times and to get access visits in schools and retain contact is extremely difficult and their ability to do so is often not considered.

PROF SCOTT: Do you think it should be considered?

MS RIDDELL: Absolutely it should be considered.

PROF SCOTT: Do you think you lose foster carers - potential ones as well as existing ones - because of this burden?

MS RIDDELL: We have a foster care recruitment issue. Whether this is one - there are many factors that go into that recruitment, I couldn't isolate a single one.

MS SCOTT: It's not just the foster carers, it's the children themselves because the trauma of being removed from their families and then no contact with their community. So the impact of transport for foster carers is a big - and I don't know whether we have probably focused on that enough in our submission but I think it is something that needs to be considered in this process.

PROF SCOTT: So it seems that from your perspective both the child's interests and the potential interests or the practicalities of what a foster carer could manage in relation to this are not being considered in a new model conference.

MS SCOTT: I agree.

PROF SCOTT: Thank you.

MR CUMMINS: Marita and Helen, that has been most thoughtful. Thank you for the written submission and for your oral presentation as well. We wish you well with your important work and thank you very much.

MS SCOTT: Thank you.

MS RIDDELL: Thank you.

MR CUMMINS: Next Mr S. Good afternoon, Mr S.

MR S: Good afternoon.

MR CUMMINS: Take a seat. If you wish to refer to any notes, you're very welcome to do so otherwise we would be very pleased to hear you in the order that you find convenient.

MR S: That's fine, sir. I can only speak for my own personal experience, which is personally distressing and frightening, and I do hope if I stray you will allow me a little indulgence. My experience - I believe I have discerned a pattern of behaviour from the staff that I have dealt with at Child Protection Services and I believe that that pattern of behaviour is indicative of certain systemic failings and I would like to identify those failings and then I'm at your disposal if you would ask me - - -

MR CUMMINS: Certainly. We would be most assisted, Mr S, by the systemic matters rather than names, which we don't want, as I'm sure you understand.

MR S: Of course.

MR CUMMINS: But we do want the system because we want to learn from the past to make the future better.

MR S: Yes. I believe I have discerned a number of failings. The first thing that I believe I see is a lack of transparency, a lack of accountability and a

cultural attitude that resents the concept of oversight. That's the first thing that I believe I have discovered. I believe there is a need for a review system. I appreciate that the counterargument is that that potentially would open floodgates but they do make mistakes and I believe it's important that the mistakes are identified and corrected. I'm talking about they make mistakes in specific situations and they do need to be found. I believe, for whatever reason, whether it's funding or their remit that they have too narrow a focus on what they determine to be - this is the Child Protection Services - an imminent risk of harm and not a focus on long-term harm and not a focus on long-term risks that may not happen in the immediate future, but risks that do exist and are quite serious. I am concerned, from my experience, as to the extent to which their decision-making process is evidence based. I'm not entirely sure that they actually have an awareness to judge as to what constitutes evidence.

Coming out of that - and the Panel will be perhaps a little bit weary of this - but my experience has been sufficiently distressing that I believe, for whatever reason, not necessarily there being a political agenda, but I believe there is a cultural agenda bias against fathers. I have, in my dealings with them, been told quite expressly by Child Protection that I was making it up and they refused point-blank to investigate my concerns.

The last thing that I believe that I see - and it may be a trivial matter - but it is a lack of courtesy, a lack of respect. The department have contacted my doctor. My doctor was extremely upset because departmental workers told him and his staff that the doctor and his staff were being obstructive when the doctor refuted their concerns to them. There appears to be a lack of care, by which I mean a lack of responsibility and a lack of focus on the precautionary principle, but there is also a lack of understanding that it may be personally distressing for a parent to report their own children into the system. That's extremely hard to not be accorded a modicum of compassion in that very difficult situation.

MR CUMMINS: I follow that. Any further points or - - -

MR S: Those are the matters that I - - -

MR CUMMINS: Let me take you through them one by one, Mr S.

MR S: Sure.

MR CUMMINS: Thank you very much, because I'm going to ask you about solutions to the issues you've raised very articulately.

MR S: Certainly.

MR CUMMINS: The lack of transparency and accountability and oversight. I think you've already touched on that. Would you view an improvement in that issue with a review system?

MR S: I believe that a review system would assist. At the risk of straying into specifics, on one particular occasion I informed one of the workers that I was sufficiently dissatisfied quite recently, that it was my intent to bring the matter to the attention of the minister. I believe the Minister has both a right and a duty to know what is going on within their department and that brought a self-righteous outrage that I should dare to suggest that someone should be able to look into the matter. I was told I was threatening them. That was the exact phrase: that I was threatening.

MR CUMMINS: Obviously then you say an arm's length review of some sort.

MR S: Yes. A review system, because mistakes do happen and they need to be identified and they need to be identified in a timely and accessible fashion.

MR CUMMINS: I follow that. I think your second point answers itself in terms of a resolution, having too much focus upon imminent harm, rather than long-term harm and long-term risks. The resolution there is to look to the longer term, not just be blinded by the short term, is really the point there.

MR S: Yes. I don't know whether it's a matter of funding or whether it's how they construe their remit, but they very definitely focus on, "Is something going to happen to the children tomorrow?" There does not seem to be any consideration whether or not there is long-term injuries being sustained, accumulative, that can't be measured from one day to the next, but can be seen over a period of time.

MR CUMMINS: Both the longer term and the cumulation are matters which are important, as well as of course the immediate - - -

MR S: Yes, of course.

MR CUMMINS: I follow that. The third point, I think, again really has embedded in it its own resolution. Decisions need to be evidence based.

MR S: Yes, indeed. Again, at the risk of straying into specifics, in my particular circumstance, I raised my concerns and directed them towards other agencies that had had involvement in my family and requested them to contact those agencies. They declined to do so and then informed me that there was no evidence to substantiate my allegations. Even being able to distinguish between no evidence and no corroborating evidence seemed to be lost on them,

but to be told there was no corroborating evidence when they have refused point-blank to follow up on my invitation for them to contact parties who do have relevant knowledge of the matter leaves me feeling very, very anxious.

MR CUMMINS: The fourth matter doesn't have built into it its own resolution, but I think I can see what you're directing it to. You've said that at some times there's been a cultural bias against fathers.

MR S: Yes.

MR CUMMINS: Do you think that's a generally wide thing or is it an implicit thing which occasionally emerges or perhaps just something which should not occur at all and does sometimes occur?

MR S: I don't think necessarily that it is explicit that there is a belief that fathers are unreliable and untrustworthy in these matters, but I do believe that it extends fairly broadly through child protection services. Indeed in my experience with this matter, it extends beyond child protection services. I appreciate this is not the Inquiry's purpose, but I did not enjoy being told by a mediator in family law that my concerns for my children were irrelevant and being given a lecture about what has passed between myself and my wife and my concerns for the children being completely ignored in that process.

I have distinguished a similar thing with Child Protection, that they have made a formal finding without identifying the reasons why and they, in that formal finding, acknowledge that they were contradicted by my doctor and they have made a formal finding that my wife has acted to protect the children, despite my having made a notification six months before she did against her. I am at a loss to understand. They will not explain how that has been reached, how that decision has been - that leads me very much feeling that my concerns as the children's father - I might add that, perhaps unusually as a father, I am the children's, or was the children's, primary caregiver. There does not seem to me to be a fair understanding of my concerns personally and I can only infer from that a general failure to regard not just what I say but what a father would say. I cannot comprehend how they can dismiss what I have to say so abruptly without there being some underlying reason for that. I infer therefore that there is a bias. I cannot say categorically that it exists but that is certainly what I believe that I see because I cannot comprehend how they have reached the decisions that they have reached and they refuse to explain.

MR CUMMINS: The final matter was the lack of respect of persons in a personally difficult and often distressing situation, the lack of understanding, lack of compassion and we entirely follow what you say about the significance of that to every individual, including yourself. I think we understand that

without further elaboration.

MR S: As I said, my doctor was even upset at - - -

MR CUMMINS: Yes, we understood the situation as you explained it.

MR S: Yes, indeed.

MR CUMMINS: Mr S, we're most obliged to you for coming forward. We've had, as you would of course yourself understand, a very substantial body of bureaucratic, academic, professional and other data placed before us; it's very important for us to have personal experience, whether it's from a fellow professional or otherwise, but it's a personal experience, and it's most important to inform us in this Inquiry that we have that direct input. So we're very grateful that you've come forward. It's been a most insightful and articulate submission, if we may say so, and we are assisted by it. There's nothing further you'd like to ask, professor?

PROF SCOTT: No, thank you.

MR CUMMINS: Mr Scales?

MR SCALES: No, I'm fine. Thank you very much.

MR CUMMINS: Mr S, we're most obliged to you.

MR S: I'm grateful.

MR CUMMINS: Thanks very much.

MR S: Thank you.

MR CUMMINS: Our good wishes.

MR S: Thank you.

MR CUMMINS: Ladies and gentlemen, we will now take a short break before we continue with the next speaker.

ADJOURNED **[2.14 pm]**

RESUMED **[2.49 pm]**

MR CUMMINS: We are now in a position to recommence. If

Mr Andrew Kauler is present, we'd be very pleased for you to come forward. Thank you for coming forward. Take a seat and just settle yourself in. As you doubtless appreciate, Andrew, we are not investigating individual cases as a matter of investigation or individual organisations but we're looking at the system as a whole in order to seek to improve it for the future. So if you would be guided by that basic set of ground rules, we'll be very pleased to hear what you'll say.

MR KAULER: Thank you. Can you hear me all right?

MR CUMMINS: Yes.

MR KAULER: Okay. I'm a social worker, foster carer, permanent carer and I provide long-term care [redacted] I've got experience in child protection, out-of-home care and adolescent family work. I'm on the FCAV board. I'm also undertaking a PhD candidature at La Trobe in the therapeutic space for the foster carer for and with a foster child. I suppose my presentation today partly takes in the scope of my work experience and caregiving role.

The thing I would put to encapsulate my presentation would be just to put some thinking around childhood developmental trauma and the impact of that on children in care. I think in terms of who are the most vulnerable children in Victoria that this Inquiry is looking at, I think you could look at vulnerability as exponentially increasing with the number of placement changes that a child could have once they enter care. The impact of abuse or neglect on the developing brain and the removal from the family of origin is in itself for a young child shameful enough and proof of their innate badness, and that is compounded by each placement change.

The work of the department of course is extremely challenging, fraught and complex; it's also quite rewarding work if you can last the distance. I think staff there need case loads capped at 12 children, not families, so that they can actually do the work and be responsive to the children and to the foster care agency that they work with when we're dealing with foster children. I think families need workers who are more experienced that new graduates. The department needs greater resourcing to attract and retain sufficient numbers of experienced staff and for clients, for brokerage, I think, with particular emphasis on adequate funding and support for children on guardianship for long-term orders, otherwise the state can't be a good parent. I think DHS aren't necessarily good at supporting therapy for children where it has to be private or for funding dental work.

Interestingly, I suppose, in this sort of system where the department now has standards and credentialling for registration of foster care providers and

out-of-home care providers, the department itself is not subject to any kind of standards that I'm aware of in terms of external auditing and such. In terms of envisaging changes for the system as a whole which this Inquiry is looking at, I think it would be great if we saw in Victoria, both in government, in the department, in the media and out-of-home care providers a move towards much more professional and a learning culture, kind of less blaming and an enlightened approach, akin to what you see with the child death inquiries on their own, but with the system as a whole, it would be good if we were looking at what we can do to make things work better.

I would say, having worked at OzChild in the south - that program is out-of-home care for foster care - that is gold standard. As a foster carer with a similarly sized agency now, Anglicare in the east, I do believe that OzChild, by virtue of replicating the department's structure and having people that have worked within the department, have the professionalism and the expertise to be able to read the department and advocate back for children and for carers and to manage carers to be more accountable in what they do and to support them in the difficulty of that work.

I think one of the interesting things having worked in child protection and then stepping out into foster care as a worker is I don't think you understand the complexity and the degree of work and worth that foster carers and foster care agencies provide with kids. Children are not simply safe once they've been removed from unsafe environments. The danger, the inner working model of the world that they have received and how they've come to view themselves and adults and the level of dangerousness that they present and how they seek to invite rejection again from carers and distrust adults, it's quite profound. I would say, just in terms of my own journey, that from the time that I worked in foster care and being a carer as well, that's become more staggering to me, the degree to which healing can occur at home for these children.

As I said at the start, I think the vulnerability, the risk, goes up exponentially with the number of changes. [redacted], and that's a long journey to take. I think that therapeutic foster care as a model should be replicated across the care system as a whole but I don't think that therapeutic care in itself actually meets what these children require, hence my interest in the PhD. It's interesting to me that one of the original family therapists that I was seeing with the kids, who is also a Children's Court clinician, had said that she thought that of all the work that she was doing with us when she had to finish, I would be the main keeper in terms of providing the healing for the children, just through the longevity and hearing them out and weathering the storm, showing them that they are worthwhile and can be loved, and love.

Talking of love and relationships, we learn to find joy and sustenance in relationships through the relationships that we've had. Many of these children don't enjoy such quality. Teaching them that is very difficult when they seek to replicate the experience that they have had. I would like to see perhaps some indicators in the system in out-of-home care around the number of placement changes a child has. I think we should be all striving for stability. I think it's got a direct impact on outcomes for these children. I think the Children's Court and perhaps some other professionals as well don't understand the degree of harm and danger that is faced to the developing brain in a child, even in utero.

Take an adolescent that has been through multiple placements or has been abused or neglected severely and you look at how wild they can become, acting out, no impulse control, a lot of it is driven by this innate sense of shame and sense that they are not lovable or have no self-worth. I look at a lot of kids I've worked with and you look at an infant that is lashing out, tantrumming and is uncontrolled and uncontainable and needs a parent to contain them, I think that's what our care system needs to provide. I think that's what juvenile justice needs to provide. I think that's what residential care particularly struggles to provide because at the end of the day, these kids are going to be healed through a relationship. They need primacy of a relationship and caregiving or particular attachments; where that can't be with a carer, whether it's with a worker, they need constancy.

I'd like to say that there are some programs that work really well, like Anglicare's adolescent specialist support service - I used to work for them. I think that that's a model worth replicating across the whole, in that that program has workers that can follow kids in whichever placement they're in for contracted case management and because they're not part of the department, you get longevity in workers. You can track the kids and be there, in their face, as much as they need you to be there and you become a constancy for them, where families or residential carers may not be able to.

Just thinking in terms of relationship and attachment I would like to see simple solutions like what OzChild do in the south with DHS Southern's agreement that where kids are already in foster care and have been there, in the case of an infant, one year; in the case of anyone else, two years, and that child is up for permanent care, OzChild have an agreement with the region that they can assess that child for permanency with the carer that they're already with, provided that carer wants to put their hand up, and that doesn't have to go up against the statewide register for kids up for permanent care - the carers that are available for such children - in recognition of the attachment relationship that child has with that carer.

What I was saying about Anglicare specialist support service, whatever you can do in the system to build a relationship with a child with an appropriate adult and retain that, we should. Equally, just in terms of that kind of infant lashing out image, I think one of the things that we really - I don't know if you're taking in the scope, sorry. I didn't read that far about juvenile justice or residential care but I'm quite fascinated by some models of residential care in the United States where in some jurisdictions, for decades now they have had a system of gradated care in the houses where if you are not going to school or you are stealing or you are using drugs or whatever, you're in what's akin to our secure unit.

If you are starting to build to engage more in socially acceptable ways and engage with society then you can go into a medium unit where you can have weekend leave, and then if you're working well within that you'd go into what are our units where you have the freedom that most children enjoy. I think in this country we shy away too much from containing children soon enough when they're acting out. These children are deeply hurt and they cannot contain themselves. They need us to do that for them. They need boundaries and limits and the love that they had not received prior.

In terms of that learning culture stuff within the state and the care system, I don't know whether it's feasible but some strategy for educating the media on better representation. I think about HIV/AIDS Australian government response when it was first rolled out the media were engaged in thinking about how to progress debates and media presence in relation to that issue in a kind of progressive stance. In terms of the Children's Court I think perhaps there should be some sort of credentialling of magistrates so that they understand better what the nuances are and the risk is to children in terms of childhood development.

I look at van der Kolk childhood development disorder talking about nought to three as the most crucial period of life in terms of brain development, and whilst there's still some plasticity in brain development and healing that can occur later, at any stage in the child's development you're looking at a developing brain, and the damage - we're not talking about one-off impacts of trauma, we're talking about multitudinous impacts, repeatedly exposed to abuse, neglect or placement changes in the system, create further harm and preclude proper brain development.

I don't think the magistrates necessarily fully comprehend that. I think there's still too much focus on parental reunification. Whilst things like Child FIRST is to be lauded, and anything we can do in terms of early intervention for children, there's always the need for a tertiary response. Perhaps also the adversarial system is not suited to the Children's Court, and an inquisitorial

system would be better than having lawyers or magistrates punish the department for being slack in their response, or other people or parties not being properly represented or prepared.

It's interesting that there are some changes that could occur really easily and could be quite cost neutral if we were brave enough to think past our little silos, like in Ireland probably five years ago. There was an experiment where children that were entering care that were, say, siblings of kids that were already placed long term in care, or with families that were so problematic and the risks so rife that it was known that the long-term outcome passed all the legal challenges, would be that, in all probability, the kids would remain in care. They developed a system where they recruited carers and trained and supported them specifically to take kids for the long term, knowing that it may be for the short term, depending on the vagaries of the court, and how the families responded to the supports that were put in place or not, but they ended up having a 100 per cent success rate in terms of getting kids with the one carer, with the one placement. By the time the court stuff had all finished then they were adopted.

I think those sort of moves are ideal but in our state we can't come at that because permanent care teams operate separately to foster care teams. We think that those things are in competition. But what that case study found in Ireland is that they actually pooled a different group of caregivers that would not have thought about care-giving prior.

In terms of permanent care too, I don't think that should exist as a care option in Victoria without better support for permanent carers. I think there should be a service set up where you could go to for supports as of right. The child is born with all the parts of their brain in place. The synapses, the connections all happen in terms of the environment later, but their brain is fully developed at birth. Damage that can occur in utero can still - even where a child, say, comes into care with only damage in utero, that child can still, once hitting adolescence, act out in ways that the permanent carers aren't prepared for or can't conceive of. It's unfair that the state leaves that child to the permanent care family to resource on their own if they're unable to do so.

I'd say in terms of being a carer and being in the system as a carer that the biggest challenge for me - [redacted] - is not the kids, it's the department. The department is so slow in responding on some things it's just insane and in some ways you just have to forget about them, which is odd to say, but things like when [redacted] first came into my care there was a nine-week delay on caregiver payments and I was put more conveniently as a kinship carer than a foster carer because I was registered with another agency and another region, living in a different inner region to the third region that the

kids had bounced out of, so it was all too hard for the department to manage.

I've had things doing respite and foster care where I've had [redacted] I'd hate to be poor and work and try and be a carer in the system, and I'd hate to be waiting for an outcome from the department in terms of what you do. Sometimes what you have to do in negotiating with the department or dealing with things for the kids is, if you like, take the department on sometimes.

Like, I've appealed to the Minister and the Commissioner and other people - to the SEAV more recently along the way with the kids that I care for, and still responses to things are very slow. I don't know what the solution is but I think DHS run as welfare by bureaucrats, they're not responsive as much as they're busy being accountable and so they're very cautious. I'd say from my time working there - and it's not necessarily a misnomer to say it, I guess - that you get taught that your main role is to protect children from harm, to keep them safe. But then you realise very quickly that in terms of how the funding for a kid goes and what colour form you have to fill out and take to whichever person on whatever floor, that it's about managing the budget. Then when your first Ministerial hits the fan, then you realise that actually that is the first priority, just keeping the Minister out of the media.

I'd say that again, you know, just in terms of a learning culture - it would be very hard for the department, I think, to run in a way where they could actually consider the best interests of the child in practice, when they work in a system that is so public. It's the same as being a carer. It's public parenting. Everything you do has got other people watching over you. But I think that however the work is configured, maybe there needs to be a separation of powers or a separation of roles within the department. I don't know if that's clear.

MR CUMMINS: Yes, we followed that. That's most comprehensive, Andrew. I think that covers your dot points, doesn't it?

MR KAULER: Yes.

MR CUMMINS: That's most comprehensive. You've actually covered a lot of ground which is most helpful. Prof Scott?

PROF SCOTT: Yes, thank you so much. Two things. Do you think it would work more effectively for the carer and for the child, the bureaucratic process

you've just described, if there was a devolution of what is currently the departmental worker's role to the foster care agency so that there was more discretionary capacity at a level lower and closer to the child and the carer.

MR KAULER: Are you talking about something that is different to contracted case management?

PROF SCOTT: Yes. The sort of things that you would be going to the department for approval for. To what extent could that be devolved to the agency level and have you experienced a contracted case management model and, if so, how does it compare for you as a carer?

MR KAULER: I've experienced both. I'd have to say I don't think that that is the answer. Having worked at OzChild, I think that they are particularly adept at - they enjoy a very good working relationship and respect with the southern region and there is a healthy understanding between that agency and the department about advocating for children in care and making representation to the department. A lot of out of home care agencies lack the critical mass, the managerial and professional experience which usually comes from the critical mass of your staff having worked at Child Protection. A lot of out of home care agencies, I think, give up too easily in advocating back with the department. If the department says no, rather than go back with a stronger argument or couch the risk or the impact in terminology that the department will understand and will think, "We have to respond to this," they think, "The department said no. They're our funders. That's it. It can go no further."

I think that my dealings with the department in terms of the kids are - I suppose having worked in the system and seeing it from both ends, I know what could be in place and if the agency can't provide that or gain that from the department, I'd seek it in other ways. Anecdotally I think it's a bit sad that one of the other - I've enjoyed a lot of very, very well-experienced clinicians and teachers in their role. One of them that we were seeing privately had said to me that some of their best carers are also some of the loudest or the best at being their own advocates, but it shouldn't be like that.

PROF SCOTT: So for you personally, if your agency worker doesn't advocate strongly enough for a child in your care, you take that roll on, by the sound of it.

MR KAULER: Yes.

PROF SCOTT: But I'm wondering for most foster carers whether that's as easy to do and in trying to design a system, whether contracted case management may, for most people, be preferable.

MR KAULER: I would think - here I am as an FCAV rep - but I actually think perhaps the scope is better left to FCAV for that kind of work where an agency - the first port of call should be the agency and where the agency can't manage, then I think it should come back to the FCAV to advocate for that carer either through the agency or back through the department.

PROF SCOTT: So a carer advocate located in the Foster Care Association of Victoria.

MR KAULER: Would be more effective.

PROF SCOTT: More effective than delegating powers to the agency worker.

MR KAULER: I think that if you looked at the working relationship that OzChild have in home based care and the southern region have with the department, then I think that's a particularly healthy and robust one, but I don't think that that level of knowledge, expertise, practice is there in any other agency. I think it would be good if you could replicate that relationship in other regions with other programs, but where you can't, the recourse should be to somewhere like the FCAV as a separate body.

PROF SCOTT: Which really was my second question, so you've probably almost answered it. But in some jurisdictions there's a carer advocate within the equivalent of the department at quite a high level, so that you can - for example in South Australia, the foster care advocate sits inside the department - there is also a foster care association - almost like an internal Ombudsman, if you might say that. That's the person to whom carers go when they can't get satisfaction at a regional level.

MR KAULER: Okay.

PROF SCOTT: But you're saying that the advocacy of the association in our current system works.

MR KAULER: Works. I'm not going to talk about individual cases, but at the moment I've got the FCAV advocating on my behalf for one of the kids that I have. From my understanding of what the staff have said, they have better scope than - if a complaint goes to the Minister, the Minister just pegs it at a certain level within the department. The FCAV can start at ground level up within the agency or the department and just go up to whichever level, which can sometimes be higher than what the minister would go. If you have someone internal within the department - I'm not sure that having experts within the department works. I think it's a bit dangerous because if the

department is taking a particular stance and want the - if you look at the - what are they called? The practitioners that - - -

PROF SCOTT: The principal practitioner.

MR KAULER: Yes. If one of them is consulted within a region and what they have to say dovetails with what the department want to do, then that's like a pat on the back for them. It's a bit like the Children's Court looking to the so-called expertise of the court clinicians. They're not necessarily the most well-versed in that situation or the best placed to make that decision, but by virtue of having that role, then all of a sudden they are.

PROF SCOTT: Thank you.

MR CUMMINS: Mr Scales?

MR SCALES: Just one question. You mentioned briefly what an agency might look like that was a very good provider of support for foster carers and permanent carers. What would be your ideal for an organisation? What would its size look like, what would the capability and so on, all of those characteristics?

MR KAULER: OzChild Home-Based Care is very large. It's the single-largest foster care provider in any one region. The only similar program of its size is the size of an average foster care program, about 30 kids less in one region, which is Anglicare in the eastern region in foster care. But of the two my sense is that OzChild - and I'm a carer with Anglicare in the eastern region - as an agency because they have - the size works and the structure works because you have three casework teams for kids in care supporting the kids and the carers. You have dedicated recruitment and training team and you have a dedicated intake team and because of the skill base that's at the program, OzChild - I don't think any other program in out-of-home care in the state would be able to do this the way that OzChild does.

But intake workers at OzChild can look at a referral from PCU in the south and look at it and think, "Well, it says it's temporary, it says it's going to be this number of months of weeks but it's not going" - when you look at the risk issues and what's being referred, it's going to last longer so they'll match it to last longer and if there's inadequate information about the routines for a baby or whatever it is, they'll knock it back to PCU to go back to Child Protection and get more information to match that kid's routines to the best ability possible from what the family had in place. It's all those things.

If there's a complaint comes in - as a carer like at OzChild we would always

say to carers they can complain to their worker, their team leader, the assistant manager, the program manager, anyone in head office and just bump it up until you get an answer. It's not, like, that the answer will be of your liking, that's not what we're about in this sector, but it is about addressing an issue and there is a very healthy understanding of managing issues up and managing issues with carers. I think that whole thing works about looking at permanency, transitioning long-term placements into permanent care placements where that is case-planned in the south works with OzChild because OzChild worked very hard at making sure that carers are reviewed and every placement is reviewed at the end of it and that they're supported through it and that the ongoing training is in place.

So any quality care stuff you're not - there is no risk that you're going to make a match with a carer that is not suited for a long-term placement because there is a great deal of accountability and mutual accountability between the carers and the workforce as well as back into the department.

MR SCALES: That is helpful. Thank you very much.

PROF SCOTT: Thank you.

MR CUMMINS: Andrew, thank you very much for coming forward. We're most obliged to you.

MR KAULER: Thank you.

MR CUMMINS: Ladies and gentlemen, we have a private submission which we will receive separately from in here and then we will come back and have the final presentation in the Public Sitting shortly. So we will currently go to a private area and we will take it from there.

(NO FURTHER SUBMISSIONS HEARD)

INQUIRY CONCLUDED AT 3.23 PM ACCORDINGLY