



**LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL
TERRITORY**

STANDING COMMITTEE ON HEALTH AND DISABILITY

(Reference: Early intervention and care of vulnerable infants in the ACT)

Members:

**MS K MacDONALD (The Chair)
MS M PORTER (The Deputy Chair)
MRS J BURKE**

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 14 MAY 2008

**Secretary to the committee:
Ms G Concannon (Ph: 6205 0129)**

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents relevant to this inquiry that have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

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The committee met at 9.35 am.

BUSH, MR WILLIAM MURDOCH, Member, Families and Friends for Drug Law Reform

LEY, MR JOHN, Vice President, Families and Friends for Drug Law Reform

WESTAWAY, MS JOAN, Committee member, Families and Friends for Drug Law Reform

THE CHAIR: Good morning everyone, and welcome to this public hearing of the health and disability committee inquiry into the early intervention and care of vulnerable children in the ACT, with a specific focus on the unborn child and infants aged zero to two. Have you had a chance to read the privilege card?

Mr Ley: We have.

THE CHAIR: Do you understand the privilege implications of the statement?

Mr Ley: Indeed, yes.

THE CHAIR: For the record, I move:

That the statement be incorporated into *Hansard*.

That is accepted.

The statement read as follows—

The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the Resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings. Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it.

Parliamentary privilege means special rights and immunities attach to parliament, its members and others, necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.

While the committee prefers to hear all evidence in public, if the committee accedes to such a request, the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing.

Welcome, and thank you for appearing today. Thank you very much for your submission, which the secretary has just given me. We have only just received your submission; there has been a fairly short time frame with this inquiry, so we thank you for having brought the submission. The committee wants to hear from interested

organisations and individuals. We have been emphasising that there has not been a need to put in a written submission; people can just come and speak to us. So would you like to speak to us and address the submission that you have put in?

Mr Ley: Thank you, Madam Chair. First, we are grateful for the opportunity to put in a submission and address you today. I will lead off with a short opening statement and then Joan will make a brief statement. My statement will be a broad overview and Joan will talk about the nitty-gritty—the practicalities of the situation as we see it.

There is no more important issue than the one that the committee is considering—the wellbeing of our children, and it is hard to imagine a tougher and more challenging aspect than the wellbeing of children of drug-affected parents. We would all agree that the best interests of the children should come first. Families and Friends for Drug Law Reform has one central and essential request of the committee: to promote that end.

The committee should acknowledge the large body of evidence which shows that many measures dictated by existing drug policy cause serious harm to children, including to unborn children and infants aged up to two years old. Women and men who are drug-dependent have children, just as do other members of the community. Children cannot, as a matter of course, be removed from drug-dependent parents. There are not enough carers or people to adopt them, and we know that great harm can be caused by forcible removal of children. At the same time, we cannot afford to wait for crises to develop because what we have learnt over the last 10 years about the influence of the environment on brain development from conception until early childhood is that damage will already have been done.

We must support parents, and particularly mothers, the whole way through. Above all, we must stop deterring drug-dependent women from engaging in treatment out of concern that their children might be removed. The committee should take notice of the large body of evidence showing that it is possible for people to live fulfilling and socially responsible lives while remaining addicted if they get the proper support. Families and Friends for Drug Law Reform have seen this happen and can point to model parents who are drug-dependent but receiving support. We can, and must, minimise the stress that drug-dependent parents presently suffer in juggling their substance dependence with parenthood. As a result of drug policy, these people are so often treated as criminals and outcasts. When this happens, their children suffer.

Families and Friends strongly supports interventions to combat problems like child neglect and abuse fashioned in the light of this large and growing body of knowledge of risk and protective factors. Our submission identifies risk factors embedded in existing drug policy. The absence of discussion of this aspect at the policy level is a gaping hole in the consideration of effective policy responses to the serious and growing problem of child neglect and abuse.

Just as parents have obligations towards their children, so do we all have the obligation to do what is within our capacity to avoid harm to them. Thus we share responsibility for harm to children if we support the continuation of measures that are known to harm them. We ask that members of the committee give open-minded consideration to the need to recommend changes to policies and programs that, in

their operation, lead to harm to drug-dependent parents and their children. We will provide detailed recommendations to go with our submission as soon as we can.

Ms Westaway: I am a mother and grandmother. I am financially secure; I have got a professional working background behind me. I am strong, resilient and a copier. I find it hard to cope with a problem of drugs in the family and young children. If I find it hard, and I am tough, how do young mothers with nothing going for them cope? The mind boggles. If a young mum finds herself with a drug problem, what she needs first and foremost is a strong family behind her. She needs a fighting mum like me. She is unlikely to have it. If she acknowledges she has got a problem and tries to seek help then the help she needs must be accessible, flexible, supportive and therapeutic. And I am telling you, in Canberra it is none of those things. It is abominable.

Start with a young mum who has, say, two toddlers and probably a boyfriend. She is probably unmarried and she is struggling. She has to acknowledge the problem. How might she get help? She might be lucky: she might have a mum who pushes her off to the doctor. By sheer luck, it might be the right doctor who is able to prescribe, but that is unlikely. She will go to a GP and she will say: "I've got a problem. I've got an addiction"—if she is as clearheaded as that, and that is unlikely. The doctor will say, "Oh dear, I can't help." The mother will say, "Well, who can help?" and the doctor will say: "Well, as a matter of privacy, I can't tell you. I don't actually know, but I can't tell you what doctors are allowed to prescribe." He might have the guts to say: "Go to Directions. They'll help you." But the doctor is unlikely to be able to help.

By sheer luck, she might strike a doctor who can help, who can prescribe, who is able to talk about the problem, and he might say: "I can help. I need to get you monitored and then I can get you into a pharmacist who has a spot and who can prescribe methadone for you." I am talking about heroin, by the way. But that is unlikely. He is most likely to say, "Ugh, go somewhere else." With the best-willed doctors in Canberra, I have one who said to me: "Well, I don't know anybody in Tuggeranong. I do know you can go to the Interchange practice, but I'm sorry, I don't know anyone in Tuggeranong. If you can't get into the Interchange program, come back and I will have found out for you someone in Tuggeranong." I have since found out that he could not have found a doctor in Tuggeranong who could prescribe.

So this young mum is likely to find her way, through Directions or social services, to the methadone program at Woden, and then she is trapped. Imagine if this young mum lives in Harrison. She has to go to Woden Valley hospital for prescribed methadone, two hours each way on the bus. There is a story they tell about the clinic in Woden. It may be apocryphal but the users repeat the story with such relish that there is probably an element of truth in it. The story is that the clinic closes at 3 o'clock. They look out their window and see, running down the road with a child on one hip, a young mum. It is one minute to three and the staff shut the window.

If you miss your dosing at Woden Valley hospital, at the methadone clinic, you are punished. The punishment is that you are off the program. Methadone, like the heroin that it treats, is addictive. If you miss a dose then you are hanging out. If you are a young mum then you are going to go home and you are going to be cranky and crabby and withdrawing, and you are probably going to give your kids bad treatment. You then have to get to the clinic the next day, if you have only missed one day. If you

have missed three days, you are totally off the program. If you are totally off the program, you are back in that whirlwind of, “What do I do next for a hit?” We are talking about an addictive substance.

Woden Valley hospital is inaccessible. Local GPs are accessible but very few GPs can prescribe. So what we need is an accessible service, a welcoming, open, non-judgemental service, from GPs who are willing and able to help young mums to get themselves stable. They might be incredibly lucky. They might have a forceful mum who sits there and says, “Help me!” And they might get into the rehabilitation program for young people at Watson. But Watson cannot take young kids. Karralika can take young kids. Karin, you were at the meeting where the worthy residents of Fadden objected to the services at Woden. That meeting made my stomach churn; I do not know what it did to yours.

There are very few services available for young mums with a drug problem. It needs to be flexible enough to help these young mums by saying: “You missed today. That is really bad, Kim. You mustn’t miss. What can we do to help you,” instead of saying, “Naughty girl, you’re off the program.” There has to be a supportive attitude, not a punitive one. Somebody needs to say, “Let us help you, let us help you.” Instead, the whole environment we are in is one of punishment, punishment, punishment. And it needs to be supportive and therapeutic. This is a crime. It is a shame that it is a crime but it is a health problem. We need to look at the policy that makes this a health issue, and just about an untreatable health issue. It is heartbreaking.

MRS BURKE: When you said Woden Valley, just for the record you did mean the Canberra Hospital, did you?

Ms Westaway: I did.

MRS BURKE: Yes, that is okay.

Ms Westaway: I meant specifically the methadone clinic.

MRS BURKE: At the Canberra Hospital, yes.

Ms Westaway: Yes.

THE CHAIR: Thank you for that, Joan. Bill, do you want to add anything? I hope you do not mind, but I have met each of you before so I am addressing you by your first names, which I probably should not do.

Mr Bush: In the dark picture which Joan has painted, which is the reality out there, there is at least one bright light. We would like to congratulate the government on the IMPACT service that it is developing for supporting families, particularly mothers who have a dual diagnosis of a mental health problem and an addiction problem. Addiction is a mental health problem, but by dual diagnosis I mean an addiction and another mental health problem. This is being rolled out. It involves the coordination of health, mental health, alcohol and drug programs and care and protection. That is a start and is the very sort of thing that we need across the board.

THE CHAIR: Thank you. I am just going through my mind in terms of questions. I thank each of you for those comments and presentations. Joan, from a practical point of view, what do you think should be done?

Ms Westaway: I think the service should be privatised. A clinic in one location is going to be hard on people in Banks and Harrison. It is just too hard. And it has restricted hours. So flexibility—either clinics in several locations or allowing more GPs to prescribe, and more pharmacists. I do not understand the legislation that says, “You are not a doctor that can prescribe; you are not a chemist that can supply a medication.”, but it is very restrictive getting through that system. I went through this organisation; I rang the clinic. I would love to tell you about my phone call to the clinic. I have a son who has a job that is very hard to get out of. Any job that says “You must be here for certain hours” is going to be too restrictive. But that is well down the line for a young mum with a drug problem. Even acknowledging the problem and saying “I want to deal with it” is probably going to take at least a year into the process of drug using. So first I want more outlets but second I want a catch-them-early process. What would be a catch-them-early process?

THE CHAIR: So you are talking about some sort of thing where maybe the Division of General Practice might be brought into the scheme, as well as the Pharmacy Guild, in terms of treating them as a network rather than operating in isolation, so that they are feeding information to each other?

Ms Westaway: Yes. First there has to be a service available. And then the GPs, assuming the GPs are the first port of call. They may not be; it may be Centrelink that is the first port of call. “Why did you miss your Centrelink appointment?” “What is that mark on your arm?” “You can hardly stagger. Are you by any chance hanging out?” That is not the way a conversation is likely to go, but we need people who are sensitised to listen. “This is the problem. How can we help, pick it up and stop it early?”

I looked at the family next door to me. Young Kim was the unconfident member of the family. I could not see it happening until I was on the telephone service that answered anonymously. People rang up: “Where can I get help?” “I’m talking to the woman next door.” I had to say, “I’m the woman next door.” Young Kim, a very pretty young teenager, still in high school, had got herself a wild boyfriend. She had not had any other boyfriend; he was her first boyfriend and he was a wild one. The family could not cope. I saw this young couple walking up the street. He was walking behind her thumping on her back: “You stupid effing bitch; can’t you see I effing love you?” That is it; you can see it coming.

It is the unconfident kids in school—the non-copers, the dyslexics, the school dropouts—who are sitting ducks for somebody to say, “I know something that makes you feel good. You can have one or two without getting hooked.” Anyway, there is Kim, a write-off with a child. God knows what has happened to her. She was next door to me. I do not know how we pick up these young kids when it starts.

Mr Ley: Can I just say something in relation to what the government is doing concerning improving the system? There was an inquiry conducted by a consultant firm called Siggins Miller—

THE CHAIR: We are aware of it.

Mr Ley: They made a reference to it. They have completed their report, but as far as I know the government has not taken active steps to implement it yet. That report does provide some very good ideas, particularly for getting people out to GPs and pharmacies in their community, which are so much easier for them to access. Joan was talking about the south side. The north side—to go out to Woden—is further still, for people in Gungahlin and so on. And there is the problem of there being far too few GPs authorised to prescribe methadone, buprenorphine and so on. But that report provides a very good basis for greatly improving the system. What we are wanting to emphasise is the importance of having a good drug policy to then improve the situation of vulnerable children, young children.

MRS BURKE: Thank you very much to all of you for appearing before us this morning. We are running drastically short of time; there is never long enough to discuss the topics that are there. I am interested in your comments in regard to page 9 of your submission: “Women are deterred from engaging in treatment out of concern that their children will be removed”. Joan, you did touch on that. Obviously, in any drug user’s life there is a window of opportunity that passes with that drug use and they want to completely make the clean break, particularly for young mothers. That is the issue for young mums that I see. You are telling us, the committee, that that is not possible. It would be more likely to happen in the UK, because of the legislation, as you have said here, and I understand about that. It does not seek to remove children—“They are on drugs; let’s take the children away.” What can we do in the ACT? Is this a thing about changing legislation?

Mr Bush: The first thing is to jump out of the silo. If I may say so, the Vardon report was appalling. It simply referred to processes. It said that we need more resources, better training, more information flows and so on—in relation to process. That was in accordance with its very narrow terms of reference. It was the exactly the same with the Murray report that followed. It ignored the world out there—the very world that Joan is talking about. It ignored the fact that there was education involved, that there are drugs involved. It ignored those policy things. The one thing—the one big thing—that we really want you to do is to break through those silos and look at all the policy settings, including drugs, that impinge upon the lives of people and kids in Canberra.

MS PORTER: I want to go back to the attitudes of staff that Joan referred to—I think in some ways you have already referred to that—and the reception that someone gets at any particular level, be it the GP or be it at the clinic or wherever; it could be from their own family in some instances. You mentioned that the various reviews and inquiries talked about resources, one of them being training. Would you not see the value of better education and training for people—GPs—staffing in various contact points where people may have contact? We do not have control over Centrelink, so that is not an area where we can put resources into training people, but we do have places where we can put resources into proper training for people. It may be mentioned in your submission—I have not had a chance to read that yet—but would you not see value in that overall training of people across the board, in education, health and all the contact places where people are going to, being identified so that people can be assisted in a more helpful way?

Ms Westaway: Could you use the word “normalisation”? It is a word they use in disability services. If you stopped the control—the treatment services are tightly controlled; and that control, as in a prison, creates a punitive attitude. If the services were totally normalised as part of every clinic, every GP service, and accessible easily, it would be much better.

Mr Bush: With the criticism that I have made of the Vardon report and things like that, I do not want it to be thought that any of those measures are wrong. They are right. Including more training and better education—they are all vitally important. But I urge the committee to look at the graphs on pages 21 and 22. You will note that, since the Vardon report came out, of the \$42 million odd provided every year in relation to child protection we still seem to be having a problem that is growing and not reducing. We cannot gain comfort by looking at increasing detail in relation to these matters. Yes, we have to do those things, but we have to do other things. This is not being done and the problem is getting worse. From a point of view of economics, it is unsustainable.

It costs \$800,000 a year sometimes to maintain a particularly difficult child who has been damaged as a result of drug using. We just cannot afford this. At the moment what we are paying for care and protection is something like 17 or 18 per cent of the entire government primary school budget in the ACT. We cannot get enough people to do it. It is more than these little things. This is a mindset that has to be broken through, broken out of. All those things need to be done, but if we want to make that graph go down we have to do something else.

THE CHAIR: Thank you very much for your time today. We sent you copies of the committee’s inquiry into ice, crystal methamphetamine. The report was tabled in the Assembly very quickly on Thursday evening. If you have not received it yet, it should be in the mail to you; you should have got it in the last day or so. We have spare copies here if you are interested. Thank you for your submission to that inquiry as well. We will look through this. You know the usual process: we will be sending you the transcript of today’s hearing and if we have any further questions we will be back in touch with you. Thank you for making yourselves available.

Mr Ley: And we will send our specific recommendation to the committee shortly.

THE CHAIR: That is lovely.

JAMES, MS ROBYN, Senior Project Worker, Women's Centre for Health Matters Inc.

KORPINEN, MS KIRSI (KIKI), Executive Director, Women's Centre for Health Matters Inc.

THE CHAIR: Welcome, and thank you for appearing today before the health and disability committee, which is inquiring into the early intervention and care of vulnerable children in the ACT, with a specific focus on the unborn child and infants aged zero to two. Have you both had a chance to read the privilege card?

Ms Korpinen: Yes.

Ms James: Yes.

THE CHAIR: Do you understand the privilege implications of the statement?

Ms Korpinen: Yes.

Ms James: Yes.

THE CHAIR: For the record, I move:

That the statement be incorporated into *Hansard*.

That is accepted.

The statement read as follows—

The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the Resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings. Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it.

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I would like to thank you for your submission to the committee. Because of the short turnaround time and because we had a fairly busy week last week, the committee has been a little bit pressed. Would you like to address your submission and make an

opening statement?

Ms Korpinen: Thank you. I would like to acknowledge that we are meeting today on Ngunnawal land and pay my respects to the traditional land-holders and their relatives, both present and past.

I thank the committee for inviting us to appear before you today. I will start by saying a little bit about the focus of the Women's Centre for Health Matters submission on vulnerable mothers. We have taken the perspective that, throughout the submission, we are referring to vulnerable mothers in the ACT—those who are marginalised and isolated. We also acknowledge that women can move in and out of vulnerability from time to time. We are not immune from it. Of course, a risk factor which can result in women becoming vulnerable is when women have children.

The submission refers to antenatal and postnatal care and support services currently available for women and their children in the ACT. Through this we have explored the strengths and weaknesses identified through a consultation process with a number of services which are listed on the last page of the submission. We looked at issues around care and protection, community support, housing, mental health support, the prison system, refugees, women who have children with a disability or women who have a disability themselves.

We also note and acknowledge that throughout the submission we do not mention Aboriginal and Torres Strait Islander women. This is not due to any oversight; it was due to the lack of availability of these representative groups throughout the consultation process, and also CALD women—women from culturally and linguistically diverse backgrounds—although the submission does make reference to refugee women.

The centre recently released a report which I think all three committee members would have a copy of—*Marginalised and isolated women in the ACT: risk, prevalence, and service provision*. I note that on page 23 of that report there is a section about Aboriginal and Torres Strait Islander women. It states:

Aboriginal and Torres Strait Islander people experience the poorest health of all Australians and are at high risk of marginalisation and isolation, politically, economically and socially. At the *2006 Census*, 0.6% of the ACT population were women who identified as of Aboriginal and/or Torres Strait Islander backgrounds. Despite the relatively low number of ACT women who identify as of Aboriginal and/or Torres Strait Islander background, this group are significantly over-represented in statistics on drug and alcohol dependency, homelessness, poverty, incarceration, and report notably poorer health than the population at large.

On pages 22 and 23 of the same report, there is a section on women from culturally and linguistically diverse backgrounds. It states:

Women from culturally and linguistically diverse backgrounds including (but not limited to) women who have migrated to Australia, or are refugees, are at risk of marginalisation and isolation socially, culturally, politically, and economically.

The report goes on to state:

Statistical and anecdotal research suggests that general health and wellbeing levels are lower for women from a culturally and linguistically diverse background, than for the population at large. Research into the experiences of maternal depression for culturally and linguistically diverse women in Melbourne, for example, indicates that there is significant prevalence of maternal depression for women who are under 25 years of age, have been resident in Australia for a short period, speak little or no English, have migrated for marriage, have no relatives in the area or no friends to confide in, have physical health problems, and/or baby feeding problems. The research also showed that socio-economic status was not a factor for women's experience of maternal depression, and the biggest identified problem for these women was social isolation. While this study has not been conducted in the ACT, it is a useful indicator of possible health and wellbeing concerns for ACT women from culturally and linguistically diverse backgrounds.

So we can see from those two additional pieces of information that the issues that we have noted and written in the submission would be relevant to these two groups as well—and, if anything, we would imagine they would be heightened.

Although this standing committee is looking at health and disability, we cannot ignore the social determinants of health and the impacts of these on ACT women. It is not just about health services; it is also about an intersection of factors such as housing, economic status, transport, access and equity issues and how we could better work together through integration and a holistic approach.

Currently, the Australian government as well as the local ACT government funding structures often mean that services are not well positioned to support women in a holistic way, but work through a silo sort of model. One point which kept surfacing throughout our consultation process was the high levels of fear that women experience. This often creates a barrier for women to actually access services. I refer also to the lack of information on assessment and processes, particularly around care and protection issues. These were significantly heightened for women with mental health issues, drug and alcohol dependencies or issues, women who had been incarcerated or involved in the correctional system and also for women with disabilities.

With respect to the model that we have outlined on page 9 of the submission, I will read through our process and the feedback from a number of services:

The system of antenatal and postnatal care that is needed for vulnerable women and their children is part of an integrated holistic women-centred health and wellbeing service system (for all women) that encompasses the following characteristics:

- strengths based
- provides continuum of care
- collaboration and partnerships
- locally provided
- accessible to all women when they request support
- affordable to all women

- tailored to individual needs
- provides early intervention
- has an education/information component
- information is made available in a variety of formats and languages
- culturally appropriate
- provides support to groups and/or to individual women
- includes an outreach and follow-up component
- recognises the generational impact of vulnerability
- a work force that is trained in and understands integrated holistic womencentred service provision

In addition to those significant key points in relation to the model, additional characteristics which were necessary for vulnerable women were also identified by the group—the provision of suitable adequate housing, affordable childcare, adequate income support, and an accessible community public transport system.

This model would be available for all women in the ACT, not just vulnerable women. That would be part of the early intervention strategy: it would provide an opportunity for women to build support networks, reduce the risk of isolation and marginalisation, create an opportunity for women to feel more connected, and provide a capacity for mentoring.

Finally, I note that data collection for the ACT currently is very limited. We do need better data collection, particularly around gender disaggregated data, to inform future services and to address and respond to the needs of ACT women on an ongoing basis.

THE CHAIR: Thank you for addressing your submission and, as I said before, for putting in the submission as well. We do appreciate that. We will also refer to the reports that you talked about. On pages 3 and 4 of your submission, you say that, while there are many good services within the ACT catering for women—postnatal and antenatal—who are vulnerable, they are traditionally tailored towards the working week of nine to five, Monday to Friday. Quite clearly, that would be a major problem if you have a screaming child and you are not sure what to do at 3 o'clock in the morning.

You also talk about the lack of collaboration across the sectors. A recurring theme on the committees that I am involved in, and I should imagine that other members have experienced this, is that people tend to work in silos and they are not speaking to each other. How do you think that the government can work towards improving in that area? It is not always just the government services; it is quite often the case that people in the community sector are not speaking to each other as well and are not aware of other services that are operating. What thoughts do you have on that?

Ms Korpinen: It is tricky. Although the community sector is getting better at talking to one another, there are still areas that are more difficult to collaborate with than others. One of the bits that we come across, and certainly through the preparation of this submission, is that if you let somebody know in a different service—care and protection, for instance—particularly for women who have had experience with care and protection in the past, already there is a level of fear and there is this gap or barrier that says, “Well, if I go and seek support from this service and then they need to tell or note my issues to care and protection, I’m not going to do it.” So it is

about—and I do not know how—providing a system whereby women will not be judged or shamed, so that it is not coming from a punitive perspective. It should be more about saying: “We’re here to support you. We’re here to provide what you need from us without shaming you or making the problem worse.”

That is one area that has been strongly identified—this level of fear, and knowing that, “If I talk to X service, they are going to then mandate it to report what is going on to service Y.” That will snowball and it will increase the woman’s fear and perhaps her mental health capacity to continue to do what she is doing, or to make positive life changes.

THE CHAIR: That is certainly interesting. There needs to be a balance. People who work within government departments are required to abide by the legislation that is put in place. The Assembly puts legislation in place in order for there to be things like notification systems, because we have seen issues when notification systems have not been abided by. I have a teaching qualification which I did not ever use, but there was certainly always the question of being aware of a child who was at risk, and what you had to do in terms of balancing that. I suppose that is the ongoing tug of war: how do you balance the necessity to support the needs of the child with also supporting the needs of the parent who might be causing long-term problems for the child? Do you want to comment on that?

Ms Korpinen: Yes. I think that it is certainly necessary to have that framework and that legislation in place. I think for us—and I talk on behalf of the women’s sector as well—it is about the process; it is about the procedures; it is about the lack of information that women have; it is about the lack of support once they are actually told that I am going to have to report this; it is the fear that then arises. So it is about the process of how we get from A to B. Once there has been a notification made—you have caught that woman and her child in the system—it is then about how are we going to support her to successfully come out the other end with as little damage and harm done to her as well as to the child.

Currently what we are hearing is that it is not a very supportive model or process to go through. Women quite often state that they are stereotyped. Care and protection, for instance, just look at the negatives, look at the bits that I am not doing very well but they do not actually note or see the changes in my parenting or behaviour that are positive. So it is coming from the glass is half empty rather than half full.

I do think that one part of that which could assist is to have the support and the information and to have a clear understanding; the woman knows and understands clearly what it is that is expected of her. What are the milestones? What are the hoops that I need to jump through? Once I have done that, are there going to be additional tests for me to undergo, or is this it?

Then also we are hearing from women who have been part of that process, who may or may not have a child that has been removed and are having another child, that the level of fear is heightened. In some instances, too, I think that, for valid reasons, it sometimes seems that once that has happened, once you have got the black mark against your name, you are not a fit parent or you are not able to access support services and make positive life changes, even though you may have done that. So the

stamp stays there, and care and protection appear to be very quick to jump on these women rather than provide a more supportive framework of monitoring, if that is what is required.

THE CHAIR: Robyn, did you want to make a comment?

Ms James: Yes. I wanted to talk a little bit more about collaboration. I think what is really important with collaboration is that there is actually somebody who is funded to be able to get people to collaborate. At the centre we have actually made a strategic decision to do a lot less service provision and to be supporting collaboration. This submission is an example of that. But we are also doing it in the mental health sector.

What we are finding in just a short time, really since October last year, is that women from government, from non-government, women who have mental health issues, are all working together to try to make a difference, together to try to change some of the existing practices in well-funded organisations. We are also trying to do something similar with women with disabilities in getting access to fitness activities, waiting to hear about some funding. But, again, what we are trying to do, and I think quite successfully, is get people—women, in our cases—to work together to have a more integrated, better supportive system for women.

MS PORTER: I had one question in relation to what you are talking about and then another couple of questions. With regard to the joined-up services and collaboration and the fear of information being passed from one to another, those two things can work against one another in some ways. So I would like you to think about how we can manage those two competing things, the fact that information can be shared and then women may be worried that information is shared.

The other thing I want to know is: have you got any impressions of how the child and family centres are working with regard to your model at the back here, whether or not that is a model that could be further extended or built on or changed in any way? Could you comment on those two things?

Ms Korpinen: Shall I do the first one and you do the second one or you can—

Ms James: Go on.

Ms Korpinen: In relation to the sharing of information, if we are working from a real women-centred, holistic way, no information would be shared with another organisation or service without the woman knowing, for starters; and, where possible, we would get a release of information form signed so that we can actually do that. And the consultation or the information sharing could happen with the woman being present. It is about her. So she has got every right to be at the table to discuss what the steps forward may need to look like for her and to have input into that so that she has got the ownership.

But I think also some protocols are needed—and I do not know what extent that would mean with changes to legislation—something where everyone is coming from the same understanding that we are actually trying to make a positive life change rather than make things more difficult and we are only sharing information that it is

necessary to share and there is the strictest of confidentiality within that. Once again, it is about the procedures and the processes of individual organisations. I am a firm believer that you can say anything to anybody; it just depends on how you say it, whether you are coming from a supportive, holistic perspective, really concerned and interested position in the woman's wellbeing or whether you come from a different perspective.

Ms James: I will comment briefly on the child and family centres. I do not know enough about their actual model to comment on the model, but I do know that, if we are only going to have those centres in, say, Gungahlin, Belconnen, Civic, Woden and Tuggeranong, then a lot of vulnerable women will be affected because of our public transport system and because they are reliant on public transport. It is not accessible, mostly because it is not very frequent. As someone who catches three buses from home to work, unless I go at peak hour it takes me about two or three hours. So I think that is a real issue.

We have talked about outreach as one of the principles of a model. Having centres in major areas will work if there is a really good outreach component.

MS PORTER: Could I ask a quick question about the data collection. You mentioned that. Is it because we are not collecting the right data or not enough data, or is it that we are collecting apples and oranges that cannot be compared? What is it about the data collection?

Ms Korpinen: It is about the lack of gender-disaggregated data in the ACT. A lot of the data that is collected is not gender disaggregated. I do not think we are collecting enough data. I think that some services that could be in a position to collect more data could do that.

My understanding is that, for instance, the ABS, the Australian Bureau of Statistics, has reduced the amount of data that is collected in a gender-disaggregated format. I think that was a decision that was made quite a few years ago now. My understanding, too, is that it has not been a priority for a number of years. We are referring back to figures on, for instance, mental health from 10 years ago. Lots of government services also are making reference to a report that was written in 1997. I do not think that is good enough. I do not think that we have got the most recent, up-to-date information on what are the demographics, what is the profile of ACT women and what are the services that are required. What is it that women want and need in order to do their day-to-day life, particularly when there are complex issues and marginalisation, isolation, involved?

We at the centre have started to compile reports on what this group of women particularly look like in the ACT and we will have a follow-up research report out, hopefully by the end of June, to follow on from the first piece. But that is something also that we have made a commitment to and would like to work collaboratively with government and non-government services to see what we can come up with and lobby for ABS data to start focusing on women more so in the ACT.

MRS BURKE: Thank you, ladies, for appearing this morning. I have some concerns in regard to the Population Health Research Centre ACT Health report 2007, the one

that you refer to, maternal and peri-natal in the ACT, 2000-2004. We are seeing almost six per cent of women that you would assess as not getting antenatal care and then probably 12½ per cent not even getting ultrasounds. What more can we do? Are they not turning to health, particularly mothers with a drug addiction problem, for fear of having their children taken away?

That links to part B of my question, which was care and protection. How do we better get good relationships? I think we have come from a base of the Vardon and the Murray reports where it was very process driven and did not centre on the issues that really were affecting them. I can understand that to a large degree at the time because it was an enormous upheaval. It has had an impact, obviously, on what is happening now. Would either one of you or both of you like to comment on that and how we could perhaps look at focusing in on that better?

Ms Korpinen: Those numbers from that report are alarming and the question that we have had, as well as every service that was consulted, was: what happens to these women who do not? And we started looking at why that may be so. Absolutely, Jacqui, you are right that a lot of that is around the fear.

For CALD women and refugee women, it is the language barrier as well as cultural issues. When women are coming from countries which may not have as good a medical system as what we have, here in Canberra particularly, there is this thing that any intervention is going to be bad, so it is lack of information and sometimes lack of interpreters who are specialised in medical issues.

As we know, that is very different to just picking up the phone and ringing TIS, where the issues also include, when women come from very small communities, a confidentiality fear as well. You might know who is coming to interpret for you and you may not want your community to know what is going on for you. So I think that is also something that we need to look at. I think a number of women are not actually accessing those services because of fear or lack of information provided in a culturally appropriate way or in their own language that they can understand.

MRS BURKE: I know we are running out of time but just on the back of that, postnatal—and you were talking about disaggregation of information—would we have any indications of, after that, who has or has not sought prenatal service?

Ms James: I do not know.

Ms Korpinen: I do not think that information is available; I certainly have not stumbled across it, no. It is interesting to note, too, that some research that the centre did a couple of years ago—we run a session on having a baby in Canberra, which is a monthly information session for women who are either pregnant or thinking about having a baby—in preparation for that package identified that Canberra does have one of the highest rates, if not the highest rate, of postnatal depression in Australia.

As we know, there are a number of factors that could contribute to that—women being marginalised and isolated and the nature of Canberra being quite itinerant; families are left behind or overseas. Yes, it is alarming but also there is a lot of room for us to improve what we are currently doing.

THE CHAIR: We might finish there, unless there was anything else that you wanted to quickly add. No? Okay.

MRS BURKE: It always goes too quickly.

THE CHAIR: Yes.

Ms Korpinen: It does, yes.

MRS BURKE: But thank you so much.

Ms James: Thank you.

THE CHAIR: Thank you very much for appearing today. We will be sending a copy of the transcript to you to check for accuracy and we will keep you informed of the progress of the inquiry. We expect to be presenting the inquiry report to the Assembly by the final sitting week in August. We have got a short turnaround time for this particular inquiry. It is short, sharp and shocked.

Meeting adjourned from 10.35 to 11.05 am.

STEWART, MS ANNA, Lesley's Place Coordinator, Toora Women Inc.

LIOSATOS, MS NATALIE, Counsellor, Womens Information Resources and Education on Drugs and Dependency, Toora Women Inc.

THE CHAIR: Good morning everyone and welcome to this public hearing of the health and disability committee inquiry into the early intervention and care of vulnerable children in the ACT with a specific focus on the unborn child and infants aged zero to two. Have you both had a chance to have a look at and read the yellow card?

Ms Stewart: Yes.

THE CHAIR: And do you understand the privilege implications of the statements?

Ms Stewart: Yes.

Ms Liosatos: Yes.

THE CHAIR: Could you ensure that any mobile phones you have are either on silent or switched off. Witnesses need to speak clearly and directly in to the microphone—that is also a note for me—for Hansard to be able to hear and transcribe them accurately. Only one person is to speak at a time. Could you start by stating your name and the capacity in which you appear today.

Ms Stewart: I am Anna Stewart and I am the coordinator of Lesley's Place, which is a service auspiced by Toora Women Inc.

Ms Liosatos: I am Nathalie Liosatos and I am the counsellor at WIREDD, Womens Information Resources and Education on Drugs and Dependency, also auspiced by Toora Women Inc.

THE CHAIR: Thank you for appearing today. I understand from our conversation outside that you will later be providing the committee with some dot points as a submission, which we appreciate. There is no need to do a big extensive submission. We are aware that it is a fairly short turnaround time, but we are keen to get this inquiry done before we go into caretaker mode. Would you like to make some comments? Then we can ask questions and proceed that way.

Ms Stewart: I thought it might be helpful to briefly explain a little bit about what we do in each service and then talk to why we thought it would be useful to inform you about the work that we do and how it meets the criteria addressing the inquiry.

Lesley's Place is a service for women and women with children. We have three components to the service. There is a residential service called Lesley's Place; that is for women just out of detox. It was set up in recognition of there being little support for women with children and single women after they leave detox. It gives women an opportunity to continue looking at ways that they can maintain abstinence or their recovery. Also, it is an option for women rather than going home, to have that extra time out. And, for women with children, there is that support around their parenting

and getting into a routine with their young children—managing meal times, getting to school, that sort of stuff. Women and women with children can stay up to three months at Lesley’s Place.

We have a lot of contact with women who are involved in the care and protection system. Quite often we are working with women in terms of advocating for them with care and protection and also trying to relay what care and protection expectations are for the women. And we work with a lot of the shame; that would be something that we really want to talk about today in terms of the shame that mothers experience around addressing their parenting, their relationship with their children and their using.

We also have Marzenna, which is a halfway house for women and women with children. It is for women who have had a longer period of recovery. Again, it is an abstinence house. It is often just continuing through from Lesley’s Place; however, women from the community can access that service as well.

Then we have outreach support. We go and visit women and take them out for coffee. That can be before they are going to detox; they might be just contemplating changes they might want to make. We often visit women in detox as well. That can be also if they choose to go home—if it is not a possibility or they are not willing or wanting to go to Lesley’s Place residential. That is a little bit about Lesley’s Place.

Ms Liosatos: I am the counsellor at WIREDD, as I said. We have been around for probably 12 years; most of you probably know what WIREDD does. Currently our service delivery is—I should say that we are a gender-specific drug and dependency service. Women can access for drop-in counselling and other kind of advocacy and support in our specific opening hours, which are on Monday, Tuesday, Wednesday—not Thursday and Friday. That is specifically for women who have chaotic lives and find it difficult to engage consistently—to have a safe space and be able to grab us and our information as they need. We have a resource library that they can access that has a lot of gender-specific information on a whole variety of issues, specifically dependency. We do counselling—one-on-one counselling—for women. We get lots of referrals from probation and parole, care and protection, and the diversion programs.

We run relapse prevention groups every Tuesday. Specifically, referrals from Lesley’s Place and Marzenna, through detox, come to that group. We run a family-of-origin group, which is for women to look at the generational trauma that they have had as children—also around their parenting and how it is for their children and to—

MRS BURKE: Sorry, what was that group called?

Ms Liosatos: Previously the dysfunctional family group. We thought we would broaden our language—broaden it for women to feel a bit more open to coming.

THE CHAIR: It is a much nicer name.

MRS BURKE: Yes, I like that.

Ms Liosatos: That looks clearly at the trauma issues and the impact that has had on their dependencies. It is a good space to start talking about how that might also be impacting on their children, should they be parents, in a non-shaming and safe way.

We also run a body-image group. It is a broad body-image group. We do not look specifically at eating disorders: we look really closely at the links between family-of-origin issues; we look at food as a dependency in that context; and we look at feminist issues around body image. Specifically, we look at the fact that, when women are clean and sober, food is often the next thing that they will turn to and can be a real trigger to going back to using. Women who used chemicals to keep their weight down are often triggered by weight gain or that kind of thing. We do both of those groups as well.

We access women in the remand centres, and have done that for a very long time. We occasionally do counselling there. We run groups there—or advocacy, whatever is needed. We will take on board any way to engage the women. We access women in the psychiatric unit on a fortnightly basis. I have recently done a lot of dialectical behaviour therapy training with Sandi Plummer in the ACT. Accessing women at the PSU is really useful; they are often women that fit borderline criteria and self-harming. There are a lot of gaps for women who have eating disorders, self-harm and are chemically dependent, around accessing rehab and detoxes, so we often access them at PSU. What else do we do? But wait, there is more!

THE CHAIR: That sounds like quite a lot.

Ms Liosatos: Yes. There is more. You probably know that we do a fair bit of systemic work and lobbying. We will work at that level as much as we can—breaking down the stigma for women around their dependencies and issues like that. In terms of service delivery, that is what we do.

THE CHAIR: You are based on the north side?

Ms Liosatos: We are in the Griffin Centre in Canberra City.

Ms Stewart: Lesley's Place is in the Belconnen area and Marzenna is on the north side.

Ms Liosatos: I should add that a large number of the women that we work with have children in the care and protection system.

THE CHAIR: Before you arrived, there was commentary from Families and Friends for Drug Law Reform about issues in terms of accessing services if you are a drug-dependent parent and problems with the fact that the methadone clinic is located at the Canberra Hospital and, if you live in Banks or Harrison, let us say, it will take you up to two hours to get there on a bus and they operate only until 3 o'clock in the afternoon. And, if you miss three sessions, you are booted out of the program. Do you want to comment on that? And do you want to make a commentary about WIREDD's ability—not so much Lesley's Place but WIREDD—to reach out their services, given the location?

Ms Stewart: I can comment a bit on the first part. I am not sure if you are aware of the Siggins Miller report on the AOD sector.

THE CHAIR: We are.

Ms Liosatos: I was going to make that comment too.

Ms Stewart: One of the recommendations there was looking at pushing for community dosing. I can speak for women who have come to Lesley's Place and have to dose at Woden. It is an incredible set-up to say, "Try and be manageable with all the things that we are asking of you and that you are needing to address for your recovery"—and if you have got young children as well. We just do not have the resources to be able to drive and take women around to appointments often. That is something that, hopefully, should be addressed out of the Siggins Miller report. That is that first bit.

Ms Liosatos: I was going to make the same comment. Recently I spoke with a woman who was accessing WIREDD—she was accessing Lesley's Place—whose children had to go to school on the other side of town. Her car had broken down. I think she was dosing; I am not sure. The comment from her care and protection worker was that she seemed emotionally dysregulated—which is DBT, dialectical behaviour therapy, language. I am really pleased that people are taking dialectical behaviour therapy on board, but to use it in that context is invalidating and shaming. What woman would not be dysregulated? I can probably talk to that kind of stuff a little bit later on, but clearly the need for community dosing is huge.

THE CHAIR: I think women who do not have drug dependency problems and have young children and are sleep deprived are often emotionally dysregulated as well.

Ms Liosatos: That is right. That is exactly right. Emotionally dysregulated, yes. Hello, me, this morning. Exactly—any of us that may be parents. So, yes, I am absolutely happy to hear about community dosing coming out of the Siggins Miller report. I would hope that that would go further and look at holiday dosing and the ongoing issues around people on pharmacotherapies and the restrictions that they have.

In regard to your second comment about WIREDD being more broadly based in the community, I would love to see that. Clearly it is a funding issue. Maintaining staffing at WIREDD is difficult given the pay rates of the community sector and their expertise. That is obviously a task force issue. I do not know what is happening with the task force about the community sector and the parity of wages. That is a really big thing. Funding is clearly a very big issue, and attracting expertise for pay rates is a really big thing. You are all aware of what happens in the community sector. Hopefully we are spiralling upwards and not spiralling downwards in terms of knowledge, but lots of knowledge gets lost as people move to the public sector. New people come to the community sector; we repeat programs that have been done before. My understanding from talking to people who have been around for a long time is that the information is going upward and change is going upward. I do not know if that answered that, Karin. I have got a bit of a beef there all of my own.

THE CHAIR: That is fine.

MRS BURKE: I could tell that.

Ms Liosatos: I did say I was going to be calm today.

MRS BURKE: It is all good. Do not be disregulated; you are all good. I have been asking this of other groups that have appeared this morning. There has been a huge upheaval in terms of the way they do care and protection now—and around the country. I do not want to dwell on that too much, but what is the feedback from your stakeholders in relation to care and protection and some of the pitfalls and issues that they would have in relation to not accessing services, for example?

Ms Liosatos: That is a very broad question. Can I just go to the last bit about not accessing services? You are asking whether women feel as though there is a barrier in accessing services because of information sharing with care and protection?

MRS BURKE: There is a whole raft of issues, so it is broad.

Ms Liosatos: Clearly that is a very big issue, and one that we have addressed with Denise Lamb and the Murray-Mackie report. As an organisation, we have been working quite closely with care and protection to make those changes. That is clearly what we want to talk about here today—the very same thing: how to engage with women in a non-shaming way so that you have access to their children and can effect change in a positive way and not a way that continues to create generational trauma. Some of the confidentiality issues and the information sharing that came from one of the recommendations were particularly concerning to our organisation.

It is not an issue that is only happening at care and protection. Lesley's Place, for instance, is support service and landlord all at once. WIREDD and services that are providing counselling are really needing to maintain their autonomy and protect the information of women so that they are able to have somewhere where they can work to effect change in their own lives. If there is any fear that the information I am hearing is going to care and protection, unless it is absolutely clearly a mandated issue, there is no way women will access—and if they do it is a complete waste of time.

MRS BURKE: Obviously, the government has a duty and a role in terms of mandatory reporting and so on, and so do other offices. It goes back the other way: what linkages do you, as NGOs and government organisations, have with care and protection to make sure, for example, that care workers are working in a way that is sympathetic and empathetic?

Ms Stewart: I was just going to say that one of the biggest things that came out for us from the Murray-Mackie report and from talking with Denise Lamb is that respect around information sharing; for instance, care and protection employees being able to understand that as a profession we have certain bits that we do with women that do not need to be communicated with them, and respecting that—that confidentiality, safeguarding, for women.

Ms Liosatos: There are a number of issues, and we are working with care and protection; I really want to make that clear. I think Denise Lamb has been fabulous in

engaging with the community sector and really can clearly see the issues, some of which are new social workers coming on board with limited experience and clearly needing training. We are offering our services to go and talk to them about how they engage with women in a non-judgemental and non-shaming way, because if you do not you will not have access to their children.

MRS BURKE: So that is directly with case workers you are talking about, the training or whatever?

Ms Liosatos: We are looking at that. We were going firstly to talk to the management teams—I think they have some in-house staff training stuff—and then hopefully we will have access to on-the-ground case workers. That is incredibly important. Some of the feedback we are getting from them as workers is that they do not understand the stages of change; they do not understand that it is relapseable. They do not understand dependency and they do not understand trauma and shame on a really deep level, so they are wonderfully idealistic, which is great, and think that the changes they ask women to make will happen and it will kind of all be okay from there on in, and so feel somewhat disillusioned when that does not occur. That is certainly the feedback we are getting from care and protection, that that is an issue: “I asked her to make these changes. I asked her to access you and she didn’t. I don’t know what I’m doing wrong.” So they are internalising a lot of that is what we are hearing.

Ms Stewart: The really effective engagements we have had with various care and protection workers are where they are seen as a support, where they are seen as a point of networking for women, giving them information and resources and that kind of thing, and therefore the woman is much more able to communicate with that worker. We have actually had women who willingly engage with care and protection around their needs so that they are getting that support; that is where we have seen really positive outcomes. So there is room to move with that stuff and I think it is around that engagement.

Ms Liosatos: Absolutely. Some of the other concerns that have come up in the contact we have had with care and protection have included a lack of belief in the expertise of the drug and alcohol sector, needing to see our qualifications. People in this sector are not always qualified. and I know there are moves to have that happen. That has been particularly unhelpful; that is something that is being worked on I am sure. There has been some great training come from the Murray-Mackie report that has happened. I am a bit lost, Jacqui. Can you come back to the question, because I think there is so much more; your question was so broad.

MRS BURKE: It was; it was just about the relationship with case workers and you have answered that. The other thing was fear of accessing the service because of the children being—

Ms Stewart: That is massive.

THE CHAIR: Just before you go on to that, I understand there is a child-focused training program called “what about me?”

Liosatos: So that was Robyn’s?

Ms Stewart: Yes. We have had a worker attend that. It was apparently also a really good networking opportunity to find out what is on offer and what is out there. The other thing we thought would be useful to mention was that I believe Directions have started up a support group for parents who are involved with care and protection. I guess we just wanted to say that that would be highly valuable for women to have access to.

MRS BURKE: If people are trying to make a go of their life, we have got to give them every avenue to do that, not be punitive all the way through.

Ms Liosatos: Absolutely. Again, though, we have concerns about the need for it to be gender specific. The issues that arise for women around their parenting are really triggering towards that it is about their own generational shame and trauma. We would really like to look at that and we are looking at how to do that. We have been talking about that internally for some time, and it is again a resource issue. We have thought about running that in our relapse prevention group. We have a break and we do various things in that time, so that is something we might offer to women and see how that goes.

There was a pilot that Belconnen Community Service did. Women had to be within the care and protection system to access that. I have not heard too much about it. I know the woman who ran that pilot is now working for Directions—I cannot think of her name—so clearly that work is growing and that is fantastic. I am not sure what kind of model they are using at Directions. The fact that it is happening is a really great start, but again I would like it to be gender specific.

I just want to come back to the training that was provided by care and protection. The great thing about “what about me?” was that Sally and Robyn came and grabbed our expertise before doing the training, so there was a massive consultation by them. Sally has worked at rape crisis for years and years and has understanding of women and really specific issues that are relevant to women with dependencies. So the fact that care and protection are employing people like Denise and Sally is really positive, and the fact that they came and sought our expertise was wonderful.

We saw a lot of that in the training. My understanding is that the training is really hard to get into now. We have not been able, even though it is in our contract with ACT Health, to do the training because it has been so well received. And that is great.

MRS BURKE: Oversubscribed?

Ms Liosatos: Yes, absolutely

MS PORTER: Which is an indication that it is a good program.

Ms Stewart: Exactly; there is a real desire and need, yes.

Ms Liosatos: And from that training have come other conversations with Denise Lamb. Clearly, there are gaps at the care and protection level about their knowledge, and there are clearly gaps at the drug and alcohol sector for our

knowledge around childhood development stages—that was something we wanted to bring up—around the fact that, if we are trained in that kind of stuff, we are much more able to click into what care and protection are talking about, and support women to have that information; in a gentle and non-shaming way to say: “This is really what I am saying. How can we support you to make this change?” We need that kind of acceptance and change model of working with someone, rather than a punitive change, change, change model. Is that making sense?

MS PORTER: Yes. While I quite understand the focus to be gender specific, how do you make the connection or how do you help the women make the connection with their male partners, if there are male partners involved, to share the information that they are getting from you? How do you support that? Sometimes I imagine they might go back into a relationship from there that is not supportive.

Ms Liosatos: Absolutely. We very much work with women where they are at and by that we mean that, if a woman is in a domestic violence situation and if there are child protection issues, we would need to talk about that with them. We would encourage her to ensure that she is safe and her child is safe and engage with her current partner in the best way she could. So we would be teaching her skills to do that, encouraging her to offer him information about where he can access support. We will work with women’s partners if that needs to happen. I have done ad hoc couple counselling if it means I am going to better be able to engage with that woman and help her to engage with her partner.

We will work with families, where necessary, if it is crucial. Part of our commonwealth funding is to work with the families or provide information for the families of drug dependent people and dependency impacted homes. So, yes, we will work with that however we can in a therapeutic way. And by saying that I think the gender specific stuff is necessary does not mean that I do not think that men need their own stuff. I would like to see a MIREDD funded, absolutely, in the ACT—a model very much like WIREDD, for men, modelling great change around specific issues, issues that are specific to men’s dependencies and the things that manifest for them. Domestic violence and gambling issues, sex addiction—there is a whole heap of stuff particular to men. That would be great, it would be fantastic, as long as it is not at the expense of funding for women, obviously.

THE CHAIR: We are having Greg Aldridge from the Canberra Men’s Centre coming in—

Ms Liosatos: Good. I am sure Greg will have plenty to say. Don’t let him take away our funding, thanks.

THE CHAIR: I have heard him speak before and I know that he does not intend to take your funding.

Ms Liosatos: No. I know Greg well. I am forgetting we are recorded.

There is a place for Directions to be doing parenting groups—absolutely. I am not open to that. I think that women will not be able to explore the issues that may be specific to them in that space. We are happy to work with Directions and go and do

some gender specific things there. We obviously network with Carol and have talked about collaborating on groups. They have more resources than us and we have the expertise for women. So it is great that movement is happening. The other—

MRS BURKE: Your funding, before you go on: is it commonwealth and territory?

Ms Liosatos: And ACT, yes.

MRS BURKE: What proportion?

Ms Liosatos: Mostly national illicit drug strategy and not enough from the ACT. I should not say that as it is recorded.

MRS BURKE: No. I just want a percentage so that we know where we are coming from.

THE CHAIR: You were about to say something else? You said, “And another thing”

Ms Liosatos: Yes, but I should stop and see if Anna would like to talk, because I can hijack conversations.

THE CHAIR: Just before Anna says something, I would say that you are not the first and you will not be the last to say that they would like more funding from a funding organisation or from the government.

Ms Liosatos: I am sure. The ACT Health funding provides funding for one position, our coordinator’s position, which was the very first funding we received when we went for it 15 years ago. Does anybody remember Sukalpa Goldflam—Kalpa.

MRS BURKE: No.

Ms Liosatos: She was very active. She started the women’s alcohol and other drug network and WIREDD used to facilitate what is now the EDs meeting, in fact—ACTADA before it became CADACT

The other thing, talking about groups—I am not sure if you are aware of this—is that Anglicare Canberra and Goulburn has a young carers service. I know this because I used to work for them. In that is a very specific group of young carers from drug-dependent families that we ran a group for a long time ago and they are looking at running groups for again. There is some funding and some research happening at the moment. Meg Richens has been employed by the institute of child and welfare studies and Anglicare Canberra and Goulburn to look at the needs of children from drug-dependent families and whether they fit into the carers model. That is fantastic work and I know that your first dot point talks about children of drug-affected parents. I know you are talking about infants. I think, though, that looking more into that research and funding for that specific group, which are again the ones that so often become drug-dependent parents in that cycle of generational trauma, would be fantastic to pursue. I tried to get in contact with Meg to see if I could bring some information here but I have not been successful.

THE CHAIR: Anna?

Ms Stewart: The only thing that I was going to add, when we are talking about communication between care and protection and AOD sector workers, is that as an AOD worker we can be really effective in communicating to women the expectations of care and protection, and often we are not adequately informed on those bits. Where I am going with this one is that with the prenatal reporting, I think the expectation of women is voluntary engagement around a report being made prenatally. However, what are the implications for women if they do not engage? How do we measure that? As an AOD worker supporting a woman, it would be really great to have that information so that she can make informed choices about those bits and the consequences of not engaging or not meeting requirements. The restoration plans that are put in place for women only move up; they do not recognise the stages of change; that you can lapse but that does not mean that you are back where you started and you drop out of the ability to move through a restoration plan. As AOD workers, it would be really good to have that kind of information.

Ms Liosatos: Yes, and realistic plans. We probably have not covered nearly half of our dot points—

THE CHAIR: That is all right. We look forward to getting the dot points.

MRS BURKE: Yes, very much.

THE CHAIR: I am appreciative of you making yourselves available for the time. I am going to have to finish it there, though, and thank you for your attendance. You will be getting a copy of the transcript to check for accuracy—and, no, you cannot take back those things that you said before that you wanted to take back!

Ms Liosatos: It is so often the case; it is the story of my life.

THE CHAIR: The committee might also have some follow-on questions, which we will send on to you. I am not sure if you are aware that last week the committee tabled in the Assembly the report of our inquiry into ice.

Ms Liosatos: Yes, we have a copy.

THE CHAIR: Okay. Thank you very much.

ALDRIDGE, MR GREGORY LAWRENCE, Manager, Canberra Men's Centre

THE CHAIR: Have you had a chance to read the privilege card?

Mr Aldridge: I read a copy of it the other day. I have not read it since arriving.

THE CHAIR: That is fine; that is all I need to know. Do you understand the privilege implications of the statement?

Mr Aldridge: I do.

THE CHAIR: Welcome, and thank you for appearing before the health and disability committee in its inquiry into the early intervention and care of vulnerable children in the ACT, with a specific focus on the unborn child and infants aged zero to two.

Mr Aldridge: Thanks for the opportunity to be here.

THE CHAIR: Would you like to start by making a statement and we can then go to questions. Tell us a bit about what your organisation does.

Mr Aldridge: The Canberra Men's Centre is a community service organisation that provides support to men living in the ACT and the local region. We are a relatively rare organisation in that having a community service focus we are not funded primarily to provide support to men who are involved in issues related to safety of children, although we do have clients who come to our counselling service who have issues around anger and violence and have posed a risk either to their children or to their partners.

We provide supported accommodation to single homeless men. A lot of those are single simply because their relationships broke down so long ago that they no longer have any contact with anybody. Occasionally, they do reconnect and we support them in trying to maintain good relationships with their families. A number of clients who come to our counselling service have been recently separated. Despite the fact that we are not funded to provide services specifically to that particular group of men, there are so many of them out there that we inevitably see them anyway.

The other thing that brings them to us is really what underlies the submission that I made and the comments that I would like to make today. A lot of the guys who come to us acknowledge that they have problems with anger and violence. I always like to tell people about the guy who rang me up one day and said, "Look, me and my buddy want to come along to one of your anger management programs." A lot of men who contact us are only there because they have been forced to come by courts or they are afraid of the consequences. But a surprisingly large proportion of them are eager to get help.

When it comes to issues of anger and violence, they are often creating problems for them in other parts of their lives as well. A guy from Customs rang me the other day. He desperately needs to have some anger management support or else he is going to lose his job. So it is interesting from our perspective to look at the sorts of issues that men bring to us around problems with violence and anger that are not necessarily

directly related to what is happening at home, although there are often things happening there as well. It gives you a very different picture of the place that violence has in the lives of a lot of men. Many of those men also come along and talk to us about their own experiences of being victims of violence while growing up and as young men. A lot of guys who come in have lost jobs because they have injuries after being assaulted, as well as witnessing friends who have experienced violence.

As a men's organisation that helps us to make a distinction regarding men who use violence in a very utilitarian way and who just use it to get what they want. They see nothing wrong with putting people at risk in pursuit of their own ends, and I am sure this committee has heard a number of representations about the risks that a lot of men pose to children. We have talked with guys who have hit their wives while they have been carrying babies, but we have also talked to guys who suffer from being pushed to the outside when their partners have postnatal depression and where there are concerns that mums might be putting their own children at risk after they are born. So we really see this issue of vulnerable children in terms of children being at risk from violence and other directly harmful behaviour and also through neglect and inability to care.

With respect to the major issue that I have, I know a lot of the organisations and individuals that would have already appeared before the committee, and I think that the child protection system and the health system have a lot of people who are very dedicated to looking out for young children and mums and making sure that the safety of the children is being dealt with. When I was a family therapist in Adelaide, I had a very unfortunate case involving a relatively young mum with an intellectual disability and whose husband had an intellectual disability. Her first child had died under suspicious circumstances. The second one had a broken arm, which she was believed to have done. She had a third child with her. It was an infant and she was not able to care for that child. She told me some terrible stories about having been sexually abused from the age of two to about 14. She said the only happy times she could ever remember in her life were when she dreamed—when she was asleep. The child that she had with her later died. She was pregnant at the time, and the state made a decision to remove that child from her when it was born.

All the way along, while I worked with this family, which was probably one of the most distressing cases I had in my young career as a family therapist, there was her husband. He was a guy who had an intellectual disability, who loved his wife, was terrified of what was happening to the kids and really wanted to be a good dad for them. I became aware at that time that the system did not really have the capacity to understand how to use him as a resource, partly because he was intellectually disabled but it was almost like saying, "Well, he's got an intellectual disability too, so he's not going to be much help."

On the other hand, there was a lot of intervention going into supporting the mum, who had an intellectual disability, but I think that was because there was an assumption that if they could keep the child safe then she would be better off staying in her care. I remember thinking at the time that people just did not really know how to engage men, how to provide services that could actively support them. Sometimes it is just too hard. If you do not have anywhere to refer a guy to, especially a dad with an intellectual disability, to get support in being a dad, then he ceases to live up to his potential in

that family as being someone who can provide protection and care.

I think the system has improved a bit, but one of the things I notice is that a lot of the organisations that are working predominantly with women and children think about providing support to men in terms of propping them up to help the family. But what you see, when you are looking at a dad from that point of view, is very often quite constrained. It is about, “They need to improve skills in this area, they need to improve skills in that area.”

I had an interesting conversation yesterday with somebody who runs the family skills program at Marymead, for whom I have quite a lot of respect and whom I have invited to be involved in some activities that the Canberra Men’s Centre is doing. I found it fascinating the way the conversation kept coming back to dads when we were talking about men. It was my position that the community needs to have a range of support services for men that build up their capacity to cope with life. When they encounter stresses like having a partner who is suffering postnatal depression or taking drugs and putting the safety of the child at risk, there is no body of expertise about working with men generally that can then be opened up to allow those men to come in.

The amount of expertise that exists around working with men’s issues is very narrow. I think that a lot of men feel that the only time they ever get any support is when they do something wrong. So we have an entire system that is based on a strength-based approach for everybody but men. Having this conversation with this guy, I remembered having exactly the same focus about 10 or 15 years ago when I was a family therapist. I found it really hard, even when I was aware of the issues, to think about a man in a family as anything but some sort of appendage or support for the mum and looking at whether he was doing a good enough job.

We know that there are many families with dads who are the sole parent, and we do not ever doubt that. It is easy to trust men when there are no problems, but as soon as there is a crisis and a child’s safety is at risk then in some ways people become a lot more wary about believing that it is okay to turn around and expect that the dad can do a good job.

I grew up in a single-parent family. My mum died when I was 13, so I experienced how hard it was for my dad to cope. There were no social supports back then and we had to rely on my auntie to come in and do cleaning three times a week. When I first started getting in trouble with the police when I was young, she was the one who kept the secrets from my dad instead of my mum.

I know that the system has really improved, but I still have this terrible sense of loss for guys who start to get into trouble. They may have drug or alcohol problems, intellectual disabilities or mental health problems; they could have grown up in abusive families. But as soon as the stresses of being in a relationship with children start to get too much and they react very badly to that and start becoming aggressive, controlling or violent, there is nowhere even to refer them to in the early stages. There are no services. If you are a health nurse and you go out and visit a family and you notice that dad is being inappropriate or unhelpful, where do you get somebody to come in and provide that early intervention and support to try and build up a sense of

connectedness to somebody else in that man, so that whatever the strains are in the family do not affect him in that way? They are not there.

I have a couple of quite interesting potential partnerships with the Canberra Men's Centre in the ACT. One is with SIDS and Kids. We were approached not too long ago by the executive officer because they were having so much trouble engaging men in the support process. I have made some comments about what I call the "women and children first syndrome". When a child dies, it is such an overwhelming experience for the mums that very often the dads do not feel like they can ask for help. They sit back quietly and wait for somebody to come along and notice them. But, even if they start getting too much help, often they will push the helper away because they feel like the support needs to be going to mum.

It is funny where you get your inspiration for things from. I was watching *The Bill* a few months ago and every now and then one of the cops goes off to become the family liaison officer and deals with children that go missing and things like that. It suddenly struck me that, even though these guys still had their uniforms on, so they still looked like police, calling them a liaison officer takes the investigative and social control element of their role away, even though they are all separately collecting evidence and doing these other things that they do. For me, "liaison officer" suddenly became a really good title to give to somebody who could work with a man and it could just be seen as part of the system. As soon as you say, "We're going to send a social worker around," there is an immediate reaction.

The other thing I know from having worked in the out-of-home care system for so long is that a lot of the guys who we see who are having problems with being a dad or being a partner grew up in out-of-home care. With respect to the ones with multiple placements, when you look at the things that they lost in terms of understanding how to be a man in a relationship and how to sustain a relationship, how to deal with crisis and conflict, they do not have it. But we do not tend to look into the lives of a lot of the men who present as being problems in terms of the safety of their partners and their children, and try and understand something about whether they have ever had the opportunity to see how that works or to form an attachment with carers that lasted long enough so that they could internalise that.

Those of us who managed to survive in reasonably intact families for a long time often find that, when the crunch comes and you are in the middle of a crisis, what you do in terms of doing what comes naturally very often is what people used to do in your own family. I learnt that a very long time ago in my first residential program job. I came into the kitchen one day and a couple of the kids were doing the dishes. I went over and stuck my finger in the water and said: "That's not hot; that's lukewarm. You can't wash dishes like that." I suddenly had this vision of my dad saying exactly the same thing to me years and years ago when I was young. I never liked putting in too much hot water because it would burn; you know what children are like. I became acutely aware in that instance of recognition of how you never really know how much you incorporate into yourself of what your family life was like until you really need it. With a lot of the men who we see in these situations, nobody ever looks at them or assesses them to find out whether they have had those sorts of experiences.

I know that, with a lot of the family support programs that work with men who have

not had good parenting experiences—the parenting after separation programs—a lot of these sorts of resources have been really helpful for the guys who do those programs. They are just not available for guys whose children are at risk through violence or neglect. We really need to look at diversifying access to these sorts of training programs. In the first instance, I think the system has to be willing to go out and look at men and say: “Okay, what do we know about how to tell whether this guy has the capacity to be a support in this situation? What do we know about this guy’s capacity to learn different sorts of skills so that he does not resort to getting angry and getting mad?”

I know that a lot of the guys who have problems with anger and violence—especially the ones with intellectual disabilities and mental health problems—have learnt very early on in life that if they cannot cope with a situation, if they explode, somebody with power and the ability to do something about the situation will eventually appear, whether it is the police, the manager of Centrelink or the social worker supervisor at the mental health office.

I hate to say this but I learnt a very good example of that from my own family. Every now and then, my brother likes to boast to me what happens when he has a problem with a piece of equipment he has bought. If he buys a DVD player from Harvey Norman, he will go back and if the person that he is talking to will not immediately give him a refund he just starts talking really loudly until the manager comes out. He usually gets his refund but they also ask him not to come back to the store, and I would probably do the same.

THE CHAIR: He is going to run out of Harvey Norman stores soon.

Mr Aldridge: No, he will just start sending his wife out to do the same thing.

MS PORTER: I have a quick question with regard to what I asked the previous witness about. I asked a question about that very thing that you are talking about. How did they engage with the male partners of the mothers that they are working with in order to support them in whatever way they need to, like support the mother with the child, but also to engage with the father, be it in a healthy relationship or an unhealthy relationship? Let us not make any presumptions about that.

What I wanted to know is: do you see the need for organisations that are working already with mothers and children to incorporate working with the partners more often and value the partners’ contribution and pick up on those signals you were talking about before, or do you think that we need more separate services in order to respond in the way that the men need the responses, or is it both?

Mr Aldridge: I would say it is both, but I think the expertise and the understanding of how to support men within organisations that work predominantly with women and children needs to come from a community having a solid base of male practitioners, male service providers who work predominantly with men. I have been in the community sector since 1977 and I know that the majority of people who work in community organisations are women; the majority of women who work with male clients, who are able to provide them with adequate support, is quite high.

But it is very difficult, as a man, to stand up in that organisation and say, “I think the sort of help that you are giving this fellow is based on what you as a woman think men ought to want rather than what the guy might actually feel like he needs. I do not think you understand where he is coming from.” I have not said it that often. The reaction usually keeps me refrained from doing it again. The number of women who say, “Yes, you are probably right; I probably do not understand enough about what it is like to be a man in this situation” really is not very high.

I made a reference to football codes and motor cars. I did not grow up as a football fan or into cars at all but, for most of my friends, those sorts of things were really important. They often go on into adulthood. I do not do it, but I do not devalue guys who do it because I can understand it gives them a sense of belonging; they get together with their mates and they do things and it gives them a sense of creativity when they do up their cars and all the rest of that. But a lot of the women that I have worked with do not really understand the value of that and can sometimes be a little bit patronising towards guys for whom those things are important.

There is no dialogue between, say, a men’s sector and a women and children’s sector about how to deal with these issues because there is no men’s sector. There are very few services that have actually been able to develop a practice framework that is based on evidence and experience that can then be taken over to the women’s organisations and say, “These sorts of things are really helpful.”

There are a lot of guys who I think would be quite happy to receive help from a man or a woman. In our supported accommodation program, the guys are so desperately happy that somebody has got an interest in them and is going to help them stay out of jail and be able to live in a place of their own that they do not care who is helping them; the gender does not really matter. But we get clients for whom gender does matter.

In situations where children are at risk, I think it is really important for guys to have the choice or be offered the choice or even to have somebody come in early on who might be able to withdraw, if they have assessed that the guy would be okay to be supported by that service; but if not, they have already connected with them and they can stream them off into a service that is going to be able to be gender appropriate.

I started to talk about our involvement with SIDS and Kids. The executive officer who contacted me said, “Men come to counselling there with their wives; women come on their own; men never come on their own.” Most of the counsellors there are women—in fact, they all are. They only had one man when she started working there, but he did not have any counselling qualifications. He ended up as a counsellor, through a very informal process when the organisation was very young and somehow stayed there.

They cannot get men to go and work in SIDS and Kids. But then I do not know what it is like to recruit male counsellors. We are about to find out now that we have just got \$150,000 from the ACT government for our counselling service.

But a lot of these areas are not ones that are really promoted in the professional training pathways—the educational institutions for men who are starting social work

or men who are psychologists or men who are going into counselling courses. So when they come out, if a job came up like being a counsellor at SIDS and Kids, they would not have been predisposed to see it as being a good opportunity to come and work with the family. But, because they were a man, they can be there to explore the experience of men in that situation.

To answer your question in a very long way: I think it does need to be both. But what we need to do in terms of resourcing the men's services side of things really requires some creative thinking about how that is going to happen.

One of the things I like about living in the ACT is that we have got government departments that are interested in talking about those things. I know, in other jurisdictions, there is the idea that you might be able to start slowly building up a men's sector to work with guys—guys who are disadvantaged, guys who have got these sorts of issues but also mainstream, middle-class guys who want to come in and talk about their family breakdown, along with the rest of it. So you have got a broad-based, whole-of-life men's expertise.

MRS BURKE: It is harder because men do not really like to talk about themselves in that way; it is too touchy feely.

Mr Aldridge: But that is not true.

MRS BURKE: But that is the perception. You talk about a predisposition by staff to take the woman's side. Linked to that, are men saying: "What is the point of my speaking up? Nobody wants to know"? They just walk away. You do not hear a lot about men's services.

Mr Aldridge: No. Sorry, you are quite right, Jacqui. In a lot of the existing services, some men will have that feeling because that is what they expect. The guys who come into our service get engaged very quickly. We have got clients who have been coming to a counselling service for ages. The guys who come to our men's groups very quickly find that it is a transforming experience to be able to talk about what is going on in your life in front of other men and to be helped by them; and then, in return, to be able to help them. A lot of these guys do not want these groups to finish because they know that, when they go back out there, back out onto the building site or the office or whatever, they have to go back to the same sort of culture.

The men that we work with really value having a men's place that they can come to, where they feel like they are going to get a fair deal but where they are also going to be understood. And I think that feeling of unfairness that some of them have comes from going to places where people just assume that they know how to work with them and very often they do not.

THE CHAIR: We are going to have to finish up, but I want to ask—I thought of this question about 20 minutes ago—about the relationship, if you do have any relationship, and your experience with the child and family centres.

Mr Aldridge: We do not at present. I expect that I will start to build that up once I have got my full-time counsellors. Having only had two very part-time counsellors,

I have not been able to use the counselling service staff to do any sort of community development or any sort of significant outreach. I would really like them to be doing that. I think that we are in a good position to be providing an alternative for the guys who are coming through that system. If they are happy to go to Relationships Australia if they have got marriage problems or if they are happy to go to some of the existing services, they do not need to come to us. But we want to build up some partnerships with those organisations so that we have got the capacity to do that.

With the SIDS and Kids option, we are looking at trying to develop a model for our service that we can then use as a way of engaging some of the other organisations. Having a men's liaison officer who might come down when the family first contacts and say, "Hi, we are from the Canberra Men's Centre; we are just here to talk with you so that if anything comes up and you do not want to bug your wife about it or if there are any problems that you are having that you do not feel like you can talk with her about, we are here to talk to you. If there is a service we can help link you up to or if you need somebody to arrange things for you, that will be that person's job," and then pull out. We may look at the same sort of thing, where a counsellor can present in a non-counselling role but then engage that person in a relationship over a period of time and pull them back into our service for some additional support.

The only constraint on what we do is the amount of staff and resources we have. We will certainly be looking into that.

THE CHAIR: Greg, thank you very much for appearing today. I should have said before, "Thank you also for your submission." You will be sent a copy of the transcript to check for accuracy. Because you have done a fairly extensive submission as well and you have given us a lot to think about—we really appreciate it—we may come back to you with further questions at a later time.

This report should be into the Assembly by the final week in August, the last sitting week before the election. We will keep you apprised of where we are at with that.

Mr Aldridge: I imagine you have all got great motivation to get your work finished by then.

THE CHAIR: We do.

Mr Aldridge: Thank you very much for inviting me to appear. It has been a good process for us too. Thank you.

Meeting adjourned from 12.05 to 1.05 pm.

DUGGAN, MR FRANK, Senior Director, Office for Children, Youth and Family Support, Department of Disability, Housing and Community Services

GALLAGHER, MS KATY, Minister for Health, Minister for Children and Young People, Minister for Disability and Community Services, Minister for Women

LAMB, MS DENISE, Practice Support Team, Care and Protection Group, Office for Children, Youth and Family Support, Department of Disability, Housing and Community Services

LAMBERT, MS SANDRA, Chief Executive, Department of Disability, Housing and Community Services

MITCHELL, MS MEGAN, Executive Director, Office for Children, Youth and Family Support, Department of Disability, Housing and Community Services

THE CHAIR: Thank you for your attendance here today and for the submission that you have put in. I was just saying to the minister that it has been a fairly short turnaround time for getting submissions in. We have had a very good response. So far we have got 11 submissions, but I think we have another four yet to come in. Only one of them is up on the website because we have not had a chance to authorise them yet. You are all aware of the privilege card: I do not need to explain that to you; you have all been before hearings before.

Ms Lambert: I do not know that Denise has.

THE CHAIR: Denise, have you had a chance to read the card?

Ms Lamb: Right now.

THE CHAIR: Okay, do you understand that? Thank you. I remind people to put mobile phones onto silent or turn them off. Minister and officials, do you wish to address the submission that you have made and make some opening comments?

Ms Gallagher: Thank you, chair. Because of the time that is available, it is probably best just to move into addressing any questions you may have out of this submission. I would just say quickly, in opening, though, that this has been an area of significant reform for us over the past few years. This is also an area that has been heavily inquired into—not necessarily by the standing committee, although standing committees and estimates committees have always been very interested in care and protection matters, but by external inquiry—most notably with the Vardon review, with Gwenn Murray’s later review and then, following that, with the Murray-Mackie reviews, of which there have been two. We have provided all of that information to the Assembly.

I am very comfortable with how this area of our business is being managed, and that is with a focus—very much so—on the nought to twos who may have some contact not only with care and protection but more broadly across government, particularly in ACT Health. We have made some significant changes there. The government has also invested quite a bit of money into new programs around this; that signifies the importance that we place on how we treat these vulnerable children. They are a particular group for us in the sense that they are not themselves able to articulate if there are problems going on. From our point of view, that makes them more vulnerable than children who are older—although, of course, our eye is very much

focused on those very young children as well. Babies particularly are more vulnerable than toddlers and younger children, for a variety of reasons. That has been seen in the Murray and Mackie reviews.

We have had to respond to that; we have done it in a pretty comprehensive way. We are quite lucky in a sense that in the ACT—because we are small, because we are a small government and a smaller community—we should be able to respond to these families and these babies in a really comprehensive way. There are always areas to improve; there are always gaps and new service responses. But, as much as we can, we are very much heading in the right direction and we have a real focus on these vulnerable children.

I would also say that we do not ever stop looking at this. This has been very much headed by Sandra. If there is anyone in this age group who, for one reason or another, dies—particularly—or has a significant incident occur, then, as a rule, we contract out an external review of that situation just to make sure and see—I think you call it running the ruler over it—if there was anything we missed or anything that we should have done or could have done. We are learning from it all the time.

THE CHAIR: We might deal with it by asking some questions. We heard from four groups this morning and a few things have come up from that. Also, because the submission from the government came in last week, which was budget week, I confess that we have not had a chance to fully apprise ourselves of it. But we are all capable of asking questions; we might come back with questions at a later point if we need to.

There was some comment made this morning, by at least one of the groups that appeared, about the way in which we deal with parents of vulnerable infants who end up in the system and have a child taken away from them and then may address—I am paraphrasing here, so I am going on my memory; forgive me if I stutter a bit in this. I am talking in terms of the fear of a parent who has had a child taken away and then has another child—the fear that they have a black mark against their name even if they have gone and done sessions to become a better parent. Am I remembering that right?

There was also a bit of commentary—positive commentary as well—about the work that the department is doing in terms of interacting with parents and fully explaining the process to the parents and what it means. There is often fear that they will have a mandatory report made against them and that will end up in the child being taken away. Would you care to comment on that? We have seen what happens when reports do not get made, but we have also talked about the explosion of reports of incidents that have occurred in the last few years and, while there is the need to report on things, how we support the parents to become better parents.

Ms Lambert: I might start off, if that is all right, minister, in relation to the issue of someone whose child has been taken away and then has another child, and the fear. Certainly all the studies that we have done have alerted us very strongly to the need to pay particular attention to siblings and the importance of doing that. Having said that, and we do need to be alert to it—I did not say anything in the opening but I have said before when I have talked about these matters in the committee—this is the hardest

area of government business. We have to make judgements, and it is very important to us that we get those judgements right. If someone has had a child taken away, then that is an alert to us. That does not mean that their next child will be taken away, but it does mean that we will be interested in the way in which the parent—whether it is a male or a female—actually goes about the parenting process. Frank Duggan, who is here, can talk about the programs—and Denise as well. But it is important for us to work with parents as well, to make sure that we build their skills. And we do that. The child and family centres have a significant role in that. They do work with parents who have had involvement with the care and protection system.

There is a range of things, but I would not resile from the fact that we are on alert when we have had to take a child away. Remember that we cannot do it without getting court processes. We have to prepare evidence. When we do take that move, it has to be something that is agreed by the courts. When that has happened, we certainly are alert when there is another child born into that family.

Ms Gallagher: I will follow on what Sandra says. The Murray-Mackie reviews did look into the deaths and near-deaths of a number of babies. When you have the opportunity to look over a number of cases and a number of files relating to those cases, it does really show you the significance of needing to look at what else is going on in that home. Another thing is that care and protection need to come from the position that the child is their main focus. The parents are important—they are essential—but it is the child they have to respond to. That is always a challenge for them in terms of parents often seeing themselves as the client, when they are not.

Another thing that care and protection has to do, when these children are placed out of home, for whatever reason, is balance the new home, the foster carers or the kinship carers or whatever other arrangement is in place. The criticism I get quite often is that these children have too much contact with their parents and too much contact with their siblings or whatever. It is just not that simple.

We do try. From my point of view—I think it is supported by the department—the main goal is to restore care where that is at all possible and feasible. We are pretty heavily criticised by a number of people in the sector around the focus on restoration. But we do not like to remove children—and cannot remove children—just because there has been another child in the system. As Sandra said, you have to have evidence. You have to go through the court processes. When that child leaves that home, it does come into our care and protection system.

We are not in the business of wanting to grow our business at all. So we try and see it from where the motivations are but where the balancing act is as well, and the competing interests. At the end of the day, after all of those are out on the table, often in a quite heated state, it is the child, and, in this instance that you raise, those siblings, that we would see as the people that we need to respond to first.

MRS BURKE: Could I ask—

THE CHAIR: I would like to ask some follow-on questions before we go on. Another comment was made today by the Canberra Men's Centre. A few comments were made which I thought were of great interest. One was that everything except

support services for men seems to be focused on strength—a strength focus except when it is related to men—and men were often seen as being an add-on. With SIDS and Kids, it is the mother who has lost the child—just looking at the counselling from a different perspective. He did actually make note of the fact that there has been an allocation within the budget, so—

Ms Gallagher: I am very pleased to hear that.

THE CHAIR: Yes, he did, and he was very happy about that.

Ms Gallagher: That was Greg or Gerald?

THE CHAIR: It was Greg. He did say that he was about to discover how difficult or otherwise it was to get men counsellors—to employ men counsellors—but looking at things from this perspective of men rather than what women thought men needed. He also made the comment, and this was the point that I wanted to raise and ask for comment on, that often you could only get assistance for men—and this goes in a lot of cases in lots of different areas—when it got to crisis point. He said that just supporting men to be better fathers, to be better partners, was not necessarily there to start off with in a great deal of cases.

Ms Lambert: Again, the child and family centres have been running programs for dads, so there is that work going on there. But I would also say that a number of our workers in the care and protection system now are male, and they do work for some of our families from that perspective as well. I personally have involved the Canberra Men's Centre when I have wanted somebody to be in a court situation next to a father who was going through a tough time and things like that. I think the services are not as developed as the women's services, but the Canberra Men's Centre has developed a strong profile over the last few years and we work very closely with it in a range of areas, not just the care and protection area.

As the minister says, the money will go some way towards expanding that service. We try to be alert to the needs of both parents. Often, though, we are dealing with a single mother or mother and their children. That is the profile generally. When we are dealing with a family, with a mother and a father, we are alert to the need to have males who interact with that family as well. Frank and his team are very aware of that. That does not mean that we have enough people to go round all the time, and we cannot always do that, but that is what we work on.

In relation to your previous point, I was thinking of a case I dealt with recently where we had a young mum who had been part of our system. This highlights the difficulty that there is for workers. Both Craig Mackie and Gwenn Murray said to me that what I had to acknowledge was how courageous and determined our workers were and that every day they go into situations which often put them at risk. I am always alert to that. But also sometimes they get very emotionally involved with the people they are working with. You cannot avoid that. They have been working with this young woman for some time; then she has a child. We do have to take that child away because of her behaviours.

To get our workers to switch focus onto the child, because, as the minister says, that

must be our focus—it is a very hard thing for them to do as well. But that is what we have to work with all the time. The situations are extremely complex—that is what I am trying to say—and there is no equation around them. Each one has to be dealt with in particular ways and has particular stories and circumstances around it. The same would occur when we are dealing with male clients.

THE CHAIR: I will come back to the child and family centres, but I want to mention that earlier there were quite a lot of compliments about the training that has been introduced, the what about me? training. That got some extremely positive feedback from a couple of the groups that we heard from.

We were talking about the child and family centres; you have raised the child and family centres. Do you want to talk a little bit about the programs that the child and family centres are operating? And there was a specific question about outreach programs as well. The Women's Centre for Health Matters was talking about the child and family centres being located in Gungahlin and Tuggeranong town centres, and people looking to put more in Belconnen, and that there is an issue for a lot of women who are considered to be in a difficult situation in terms of transportation et cetera and outreach-type services. Do you want to talk about the services that are offered through the child and family centres?

Ms Lambert: I can start by saying that one of the things that the child and family centres do is part of our response when we get reports. When we assess that a family is not going to meet the threshold for care and protection, we seek to involve them, but if we think the family needs assistance we then seek to involve them with the child and family centres. They work closely with—it might be best if you talk about this, Frank, because you deal with these children.

Mr Duggan: We basically deployed care and protection staff to the child and family centres. We think this is probably one of our most innovative approaches. As was said earlier, we have a significant increase in care and protection reports. The ones that are the most serious will come in to the agency and we will respond to those. With respect to the ones that we know do not meet our threshold but need to have some level of support for families, we have now put staff in the child and family centres. This is in cases where they are vulnerable, where they are not coping particularly well but the children are not at risk of having a statutory intervention.

The child protection worker has the information from us centrally. They work with a worker from the child and family centres. We go out and engage the family and we then get the family to engage with the child and family centres and their mainstream programs. We have seen a significant change, even with particular clients accessing the child and family centres, now that they know that a child protection worker is there. They are seeing that as a very supportive environment in which to seek a service and be supported. Also, it allows us to minimise the risk factors to the child. We are about to start doing some evaluative work on that but anecdotally it has been a very successful program to date.

Ms Mitchell: I will add something about the transport issue that you raised. Obviously, the current child and family centres are located in areas that have reasonable transport because they are in a transport hub. That was a deliberate part of

that model and it works particularly well. We know that there are other areas of the ACT where a number of vulnerable families are also concentrated, especially in the Belconnen and west Belconnen area. There are plans to look at that area as well.

Child and family centres are one part of the early intervention model but connected to those are a range of family support services and regional community services that we also fund and work with in partnership, and have active referrals of vulnerable families. To add to what Frank was saying, the system now allows us—and this is reflected in the new Children and Young People Bill—to treat all the information we get in terms of reports on its merits, so that we are able to use information that is actually a concern, rather than something that would lead us to a statutory intervention. We can treat that as a concern and as information and pass that on to our relevant partners or our own areas of service delivery like the child and family centres. We might proceed to a more full-blown appraisal if we have additional, more serious concerns.

That first element that Frank was talking about is called assessment and support. So we can continue to support those families through the child protection workers at the centre or through our other staff. They are doing a lot more of that front-end work. But we may also go to a statutory appraisal if that is seen to be in the best interests of the child and if the child is at serious risk. Even within the statutory system, if those concerns are substantiated, we can also seek to put in place supervision orders as opposed to removal of the child while we work with the family to achieve a restoration. Of course, that is the goal in most cases, but sometimes that is not achievable. I just wanted to give you a flavour of the different ways of intervening, depending on the concerns. When you get so many reports, and an increasing number of reports, to be able to differentiate the information is an absolutely important policy and practice direction.

Ms Lambert: In relation to your question about outreach, we do go out as well. After the minister enabled us to consolidate in one position, the whole philosophy around that was that, rather than expect people to come to us, we would actually go out. The same applies at the child and family centres. Clearly, they are a hub and people come there, but there is outreach as well.

THE CHAIR: Do you still have the over-the-trolley sessions?

Ms Lambert: Yes, absolutely.

THE CHAIR: I thought they were a fantastic idea when I heard about them, and I mentioned that during the morning tea break to one of the groups.

Ms Lambert: The whole Tuggeranong Child and Family Centre was operational before we got the building. It was all out there in the community, and that still continued. The Gungahlin one also works in the Belconnen community and works with Uniting Care Kippax as well.

Ms Mitchell: Perhaps I could talk about some of the programs that are running out of the child and family centre. We obviously have the community health, maternal and child health folk in there. We have community-based child protection workers, as

Frank mentioned. We have universal playgroups, paint and play and targeted playgroups. The coffee playgroup is a very successful initiative. We have an infant referral system from care and protection—nought to five—into the child and family centres. We have a young parents program. We have a particularly important and growing partnership with the Smith Family. I refer in particular to Learning for Life scholarships and support for kids through their whole life.

We also run, out of the child and family centre, the integrated family support program, which is a joint initiative with the commonwealth and other community partners. The YWCA runs the young parents program there, and the parent and infant relationship support group, or PAIRS, is run from the Tuggeranong centre. We are thinking about making that more widely available. It is about anxious parents learning to deal with the behaviour of their children and learning to play with them in a positive way.

MRS BURKE: I do not mean to be inflammatory but I would love to hear what you have to say because I do not wholly agree with a statement that was made this morning. One group who appeared said that the Vardon and Murray reports were appalling—their words, not mine. The other words used were that they just ignored the world outside and were process driven. In part, they had to be, because of the systemic failures there. Minister, I wanted to hear your comments on that. The breaking down of the silo mentality was also referred to this morning. Do you feel we have moved on from that and that there is a lot more cross-pollination?

I am looking at some of the good things that I can see happening with IMPACT—the integrated multi-agencies for parents and children together—the Blue Star Clinic and the parenting enhancement program. Going back to the assertion that it was appalling and that it just ignored the outside world, do you think we have moved on?

Ms Gallagher: The review was appalling?

MRS BURKE: Yes, that it was process driven. Do you feel that it has moved away from that?

THE CHAIR: What they were saying was that it was all—

Ms Gallagher: The system was appalling.

MRS BURKE: Yes. He said that it just ignored—

THE CHAIR: The review was very focus—

MRS BURKE: It was just process driven and—

THE CHAIR: Process driven, thank you.

MRS BURKE: they talked about breaking through the silos and looking at policy settings that look at children in the case of people with a drug problem. I wanted to clear that up because that has been asserted and we need to get a comment about that.

Ms Gallagher: I think that, to some extent, it was process driven, and it had to be

process driven because the processes were what had let the children down.

MRS BURKE: That is right, yes.

Ms Gallagher: That was from where I sat, anyway, once we went in and had a forensic look, which is what Vardon did. I think the criticisms have been out there for everyone to see for some years. We have come a long way from there. I think you would have to acknowledge that, having sat in—

MRS BURKE: I do. I said I did not agree with—

Ms Gallagher: this room and been a part of that reform work. I would not agree that it ignored the outside world because I think it was the outside world that put the reform agenda on the roadmap and we moved forward from there. I can accept half of it and I do not accept the other half.

In relation to the silos, I will not stand here and say that it works perfectly all the time but I will say that, particularly in the areas that I am responsible for in relation to health and care and protection or DHCS, we have certainly made significant holes in those silos. Denise should probably take the credit for most of that, in working across both of the agencies and being a key liaison officer between them. Health have opened up their perspective on areas that they should be involved in. I think we have seen that with the funding that was provided in the health budget for a care and protection program to run within Health. Our submission refers to some of those. I have looked at the first report on the IMPACT program since it started and it is already doing an amazing job.

I think it always begs the question: what were these families doing beforehand? They were in contact with us in some way, presumably, but now we have a better way of dealing with them. I think we are better with the AFP as well, in our contacts with them. In housing, I think it has been of enormous benefit to have care and protection fit within the broader Disability, Housing and Community Services portfolio. Sandra ultimately is responsible for all of it as a territory parent. Also, with housing, in looking at the issue of accommodation and even homelessness, it has enabled greater cross-government collaboration. I would not say that we are where we need to be. Governments can always break down more silos.

MRS BURKE: Do you feel you are well on the way to—

Ms Gallagher: Yes, I think we are.

Ms Lambert: I chair and have chaired since I took over this responsibility—and I think we have referred to it in the submission—an interagency committee that has everyone around the table, including Treasury and Chief Minister's. And the whole point of that is to delineate our roles and responsibilities in relation to children who are in the care of the territory specifically. That group has been meeting over a number of years. We do have a document that is a shared-responsibility document. We also have just decided to include members of the community sector at two of those meetings—we have four meetings a year—so that we can broaden out a bit and bring them into our business as well.

There have been some great outcomes just from that. Particularly, for instance, the minister mentioned health. Dental care, for instance, is now much more accessible to children who are in care. With the children in our schools, we have individual learning plans for all the children who are in my care and who are in schools. The office meets regularly with the education department at a very, very operational level, as they do with health.

It is never perfect. I would agree with the minister. It is one of those things that you have just got to keep working at. But certainly the cross-agency collaboration has improved quite significantly but it is something that we continue to work at and find new ways such as this program and some of the other work that we do.

MRS BURKE: Following on from that, my question relates to page 9 of your submission where you state that on the universal first home visit you are hoping to pick up issues that obviously stand out and that require more enhancement through the parenting enhancement program. Is one visit enough?

Ms Gallagher: Sorry, Denise, I should let you speak. But the way that program works is: if you need more after that first visit, you get more.

MRS BURKE: So they ask for it.

Ms Gallagher: Yes.

MRS BURKE: If you can explain how it actually works, that might be good.

Ms Gallagher: Anyone who has a baby goes through it—I have just gone through it myself a few months ago. But you are discharged home. You are contacted by maternal and child health to arrange the first home appointment. That could be as soon as the day after you leave hospital. It could be the same day if you have the baby and go home. And then, at that visit, they talk with you about what you need. In the first week, they can come every day of the week. It is really because women—

MRS BURKE: It is not just a one-off, once visit?

Ms Gallagher: No. But everyone gets a one-off visit, everyone who comes home. Then you can say, “I do not really need it. I have had three kids. I know what is going on. I am not going to get any sleep. It is going to be a nightmare for a while but I do not need you.”

THE CHAIR: There is no personal experience in that statement at all.

Ms Gallagher: That is right. A new mum may want that visit to continue. Then, following that, you can keep that up and then be discharged into the child and maternal health clinics who then pick up and see you.

MRS BURKE: Sorry, just to be the devil’s advocate: what if somebody spots there is a problem, yet the parents say, “No, there are no problems here”? How is that handled as well?

Ms Lamb: I would like to add to that.

MRS BURKE: Please.

Ms Lamb: It is identified by the parents but also there is an assessment that occurs by the maternal and child health nurses or the midwives, depending on which program they are in.

Ms Gallagher: God, I would like to see my notes: “Stressed.”

Ms Lamb: They will make their own assessment. They have quite a defined process that they go through to identify what the needs and possible risk factors are for those families. And they will talk with them about them and make an assessment as to whether that family either needs more regular visits—that is part of the PEP program possibly—or referral to other services.

Ms Gallagher: But also, Denise, they would probably have it flagged if in hospital there were concerns as well.

MRS BURKE: That is what I am saying, yes.

Ms Mitchell: If there were care and protection concerns, the hospital would alert us. In fact, with the new bill, there is the possibility of prenatal reports as well. It has enhanced capacity for prenatal.

Ms Gallagher: I do not know whether you have got this. This is about the IMPACT program, information for parents.

THE CHAIR: I do not think we do.

Ms Gallagher: I am happy to give you that, table that—whatever you want to do with it. It follows on from Mrs Burke’s question. This program is just up and running now. How long?

Ms Lamb: Probably about three months.

Ms Lambert: Three months.

Ms Gallagher: Three months. In the report for April, it says that 11 families have been referred since the program commenced. Ten have a family member on the opioid replacement program. One has a family member involved in mental health. Eight of those families have fully entered the program. Two families are in the process of coming in. One family has elected not to take up the referral at this time. If you look at where the referrals are coming from, they are coming from the antenatal clinic; they are coming from general practice; they are coming from care and protection; from Calvary; and from maternal and child health as well. That shows that all of those areas are working.

THE CHAIR: How would a GP become aware of this program in operation?

Ms Gallagher: GPs are pretty well linked into the health services. We have GP liaison officers that work at the hospital. As part of really going through that women's and child health program or through the antenatal program, they are easily identified. If there are concerns, those areas talk to each other already. If the GP is picking up things that they think need a follow-up, they would possibly contact the antenatal clinic who would say that it sounds like a good referral for this program.

In the development of this program, I think there was a lot of work put down about how to most effectively make this program work because it does rely so heavily on a range of groups, a range of professionals, helping families that do not often want help.

Ms Lambert: I guess the other thing that we worked really hard on as well over the last few years, particularly in our cross-government work, was making sure, from our perspective and from my statutory obligations, that the focus is on the child. And that is what we have worked really hard on across a range of services, that the professionals focus on the child. Even if the parent is doing well on a drug program, how is the child presenting? That has been some of the work that Denise has been leading for us as well and that has been a strong focus. How is the child? Is the child vulnerable as well?

MRS BURKE: That starts at the Blue Star Clinic; is that what you are saying?

Ms Lambert: It can. The Blue Star Clinic is a health initiative. It is where they manage the infant withdrawal from morphine. There are a range of agencies that work with the Blue Star Clinic. As part of ensuring reduction in silos, there has been a process set up with nursery discharge to ensure that there is ongoing case conferencing around what are the needs of the family and the risks to that child when they are discharged home. And that will involve care and protection, maternal and child health, any of the community agencies involved and the hospital staff.

MS PORTER: I have some things that I want to talk about. One was going back to the men issue. One group of people, the Canberra Men's Centre that appeared this morning, said that sometimes men feel supernumerary to the whole process of whatever is going on, whether it is the birth of a baby, whether it is postnatal depression, whether it is some other thing going on; maybe they are not even living together or whatever. The only way that they can get attention, which often happens with little boys at home—the little girl is being really compliant or friendly or talkative or whatever—is if the little boy creates a fuss to attract attention. It is my experience, from having—

Ms Gallagher: I have got one of those, yes.

MS PORTER: two sons and a daughter, one of them was very good at that.

The centre was saying that often the man will create a situation. Then he has a crisis. All the support services come around—not necessarily the support services, even services—and say, “You have been a naughty person.” But at least he gets attention and he gets help. That was a comment that I thought I would share with you.

The other one was about the business with the silos. I think there was comment about how it was really good that agencies are now working together more. But there was a lot of discussion this morning about how people may feel fearful to use a particular service that is not a child protection service because of the fact that people are collaborating more and, therefore, the information would be passed on to somebody else. Then they might find themselves part of the system accidentally and that, as mothers, sometimes they are crying out for help: “Someone help me manage this situation that I do not know how to manage.”

But they are frightened to do that because they know the focus on the child is the most important part of this. They are frightened that, instead of their needs being met, the focus will go immediately to the child, the child will be removed and they will be told they have been a bad parent, and they believe they still have not had their needs met in that. There was that general fear of that.

Then, on the general practice one, there was a lot of report this morning about general practice people actually not knowing where to refer people and not having enough information. And this may be just—

Ms Gallagher: Was that from the division?

MS PORTER: No, this was from an agency that has referred people to general practice and the general practitioner, the doctor, then is saying, “I do not know where you could go for that kind of help.” I am sure that might be just an occasional GP here or there in the system, but we have only got to have that to create a mythology that none of them know perhaps. This particular person’s experience was quite wide in relation to the number of GPs that she had sought help from. They were just some comments. I was wondering whether you would react to some of that.

Ms Gallagher: In relation to the men’s issue, one is a bit difficult to respond to, other than I have certainly come across some very strong male advocates in relation to their children and in relation to their grandchildren. I think, as much as we can, we work with whomever we need to work with. It is not really about gender, but I would have to say that 95 per cent of the parents we are talking about are women, when you are looking at whom you are having to interact with, which is no surprise to anybody.

In relation to silos breaking down and people fearful of services, the only way I could respond to that is: that is not really being seen in any consistent way in data to us, in terms of the numbers of reports being made and the fact that we have got a system of mandated reporting, which we are not intending to move away from. It is not really being reflected in the number of children in the care of the territory, which did increase quite dramatically for a couple of years. But really, over the past 12 months, it has plateaued at around anywhere from 480 to 500 children at any one time.

I can understand the perception out there that there may be people who are fearful but I do not actually think care and protection—although perhaps for some families—are seen as the evil welfare who are going to stomp into your house and remove your children, without your knowing anything about what is going on. That is not the way we really operate.

MS PORTER: I would not imagine it was. I am just talking about perceptions.

Ms Gallagher: No.

Ms Lambert: You cannot get into care and protection by accident.

Ms Gallagher: There is no accident.

MS PORTER: I am sure you cannot.

Mr Duggan: The observation is that, when you come into care and protection, you have to go through the court system. If you want any active mechanism to examine the rights and wrongs of any intervention, the court system is there to do that. I think parents are highly engaged in that process. With respect to men, we have been very conscious over the last 12 to 18 months of engaging male partners quite consistently. In fact, especially with our protocols with DVCS, we have had to work very carefully, because if we engage the perpetrator of the offence, they are worried about their client, which is mum. So we start to look at the client situation.

We have worked very well with DVCS around our obligation, which is to engage the perpetrator and say, “This behaviour is wrong,” but not to put mum at risk of further violence being directed towards her. In the same way, with every intervention we have and with appraisal of any child that goes before the court, we very actively engage males. We also very actively engage the male because that is a major component, if it is a two-partner family, of how that child’s risk factors could be alleviated. When you examine our case plans, our care plans et cetera, there is a significant input from the operational staff to engage both partners, because without having both partners there is often no solution to the issues. In saying that, however, the majority of clients are—

Ms Mitchell: A small number of restorations have happened with the dad, that I have seen over the last little while. Care and protection and others have worked very closely with the dad to get them in a situation where they can care for the children, often on their own, or with the support of grandparents. There has been quite an increase in grandparent caring as well, in terms of being suitable carers for the children. That often involves a very active grandfather as well as a grandmother. So we do work with males in that sense as well.

Ms Gallagher: In relation to the GPs—and it may be something that the committee wants to explore further or have a view on, in terms of the recommendations—we do try as much as we can to get information out into areas where professionals have contact with and see children. Of course, that includes GPs. It may be a relatively easy thing for us to write to GPs and let them know what number to call. My feeling is that most connected GPs know, but there may be some that do not. If we can provide a number and it is useful, we can do that pretty easily.

THE CHAIR: A few comments were made earlier today about the Siggins Miller review. There has been quite a bit of commentary this morning about—

Ms Gallagher: Into the alcohol and drug program?

THE CHAIR: Yes. There has been quite a bit of commentary about the problem, if you live in Banks or in Harrison and you are on the methadone program, of getting yourself to the Canberra Hospital by 3 o'clock if you have got a young child, and the issues related to that. There was quite a bit of commentary from a number of the organisations that appeared this morning about hoping that the recommendation would be taken up about community dosing being made available.

Ms Gallagher: Wearing my other hat—and I am not being minded at the moment by officials from Health—I think we need to move carefully there, and most importantly for people with children. One of the Murray-Mackie recommendations touched on this issue. Particularly for people who may be unpredictable in one way or another, it is quite important that they are witnessed taking their methadone, which happens at the clinic, just because of some of the risks to children if it is not taken, if it is stored or if it is stored to be sold, and they are taking other drugs.

I am more comfortable with saying that we would like to see more dosing of individual people in community pharmacies and in the community. The concern I have is really around people with children, being mindful of the fact that it can create problems for them with respect to transport. The issue with the dosing that we are going to have to grapple with is to work out who can be dosed in the community and who cannot—what will be our client group that we need to come to our facility.

Yesterday, I went out to Directions at Woden. They are pretty keen to start a dosing program there, with a group of clients. I am pretty happy to look at that. They are not ready for that yet because they do not have the set-up there, but I am very open-minded. I do not think the TCH site can sustain the amount of dosing that it is currently doing at the moment, so I think we do have to look outside. The community pharmacies play a very important role here. I met with the Pharmacy Guild last week regarding some issues that they see in the future with expanding that role.

In response to Siggins Miller, we will have a look at all of that. But I have to say that it is the ones with young children that I am most concerned about. I think we have seen that interstate. I do not want to make any judgement about parents in that regard, because there are some tremendous parents. In fact, most parents are good parents. Some of them are tired, stressed and harassed and have other issues, so I do not want it to be seen that I am making judgements about that. Again, wearing a care and protection rather than a Health hat, I would be wanting to look after the ones that have little children with them.

THE CHAIR: I think that is a fair comment, and we needed to hear that.

Ms Gallagher: In fact, if you look at the referrals to the IMPACT program, many of them come in from the opioid replacement program.

THE CHAIR: On the IMPACT program, it says in the brochure that you need to be a client of Mental Health ACT and/or receiving opioid replacement therapy. What happens, for example, if you are a substance abuser and you like ice, which does not have a replacement program at all for it?

Ms Gallagher: I had something to do with this in establishing IMPACT. I cannot recall what the appropriation for it was, but it was not a huge amount of money. From memory, it was \$2.4 million over four years. In getting this program up and running, I did not want it to be inundated. We had to control the entry, in order to make sure we did a good job; otherwise there would be referrals from everywhere for every difficult family or someone they had a concern over. With this one, because it is the first time we have done a program like this, we will watch how it goes for the first 12 months. If we need to expand it then that is a question that the government of the day will have to look at in terms of further funding. But there are a range of other services and responses within Health and within care and protection that do not all need to be met via IMPACT. I am absolutely positive that IMPACT will be a raging success, that the statistics will prove it and that in next year's budget, I imagine, we would be seeking to extend it, and possibly to extend the client group.

I spoke to people when we started the development of this program. I did not want to see it set up to fail. I felt that, for those staff who have this huge job—it is an enormous job to get a program up and running that has not been run before—they needed an opportunity to make it a successful program first.

MS PORTER: On page 10 you mention Aboriginal and Torres Strait Islander children and young people being over-represented in child protection, out-of-home care and the youth justice systems. It is not just in the ACT, of course; it is across Australia. Do you want to make any comments about the work in that area?

Ms Gallagher: We started this work pretty early on, in response to Vardon. I think our Aboriginal and Torres Strait Islander families would comprise up to 20 per cent of children, when they comprise between one and two per cent of the population here. So they are over-represented. Sandra established Aboriginal and Torres Strait Islander services within care and protection with Neil Harwood, whom you would have spoken to before, and started a range of internal responses which we are happy to go through.

With respect to the integrated family support program, there has been some additional money in this budget around that. There has been the setting up of the unit itself, which has been fantastic in order to allow that capacity within care and protection. But it looks at it more broadly than care and protection as well—looking outside the agency.

Ms Mitchell: I will say something about the Indigenous integrated family support program, which is separate from the integrated family support program. It is run out of the child and family centres. It was a small pilot program and it involved a range of government agencies to support families identified to be at risk in various ways. Some are involved with the care and protection system; some are not. It was supporting around six families in the last year, but that represents 28 children in those families. The new money that has come through in the budget will expand that to up to 25 families. That is a significant early intervention response for those families. Because it is coordinated through the Indigenous unit, there is that capacity to engage with those families, and particularly those who have a level of distrust of the welfare system, for all sorts of good reasons. That is very positive and we will be evaluating it over the next year or so.

Ms Lambert: Yesterday, I attended a session at the child and family centre called “engaging our mob”. It is a series of programs around making sure that we do, respectfully and culturally appropriately, interact with Aboriginal and Torres Strait Islander families. With respect to the program that Megan mentioned, we will get a formal evaluation of that as well. We are just looking at who we will get to do that. Anecdotally, we already know that the children who have been in the program that has been running, until we got the expanded dollars, have attended school a lot more, for a start, and that is a key feature for Aboriginal and Torres Strait Islander children. So their participation rates in schooling have improved quite dramatically. We have enabled those families not to be over-serviced in the sense of having lots of people from lots of agencies coming to see them; rather, we have been able to coordinate the response so that there is a key contact for those families. So getting the additional dollars in the budget has been fantastic because we can expand it now that the model is working.

Ms Mitchell: The Aboriginal service within the department also run a foster care service for Indigenous kids. They engage with potential and existing Indigenous foster carers, some of whom might have kinship links but most of whom do not. If we cannot find a kinship placement outside the family, either temporarily or for the long term, we look at getting an Indigenous carer through that service.

MRS BURKE: On that issue of kinship care, I know that it was an issue raised some time ago when I was doing the shadow stuff. I think I raised it with the minister. I think there was an issue with Aboriginal and Indigenous elders not being brought into the loop. Do you remember that? I am just wondering whether all those—

Ms Lambert: I think that was very early on in the piece.

MRS BURKE: It was.

Ms Lambert: It was before Neil Harwood was in the position. Neil is in an identified Aboriginal and Torres Strait Islander executive position. He has worked very hard with the community. It has not been an issue that has been raised with me again recently. There is always the tension there, of course, with those families. I would say again that we have to operate always on the principle of the safety of the child, but we work really hard to do that in a culturally appropriate way.

Ms Mitchell: Also, in developing care plans for Aboriginal children in care, we have a requirement to develop cultural care plans when we have an identified Indigenous child. To develop those cultural care plans we need to consult with the community. So there is an in-built mechanism to make sure that we engage with the wider community. Sometimes that wider community could be in the Northern Territory, especially with this population here. They have come from many areas.

MRS BURKE: It just was not happening, but it sounds like it is now.

MS PORTER: Could you take a couple of things on notice and get some information back to us later. What percentage of children would come from refugee families or families who have experienced trauma in their own country of origin? Do you have

some specific training for those staff dealing with those particularly difficult issues?

Ms Lambert: Again, it helps having multicultural affairs in the portfolio as well.

MS PORTER: Yes, I am sure it does.

Ms Lambert: That connection has been fantastic since they have joined the section.

Mr Duggan: With respect to some of our African refugees and families, such as Sudanese families, over the Christmas period we have had great support from the multicultural affairs area, plus the Sudanese community. So we do have very good links there.

Ms Gallagher: We are happy to reappear if the committee wants to follow up things. From my point of view, the inquiry will be useful in identifying if there are further areas or gaps that we need to respond to. Coming from where I sit, I am glad I am able to sit here and talk for an hour about all the things we are doing rather than respond to questions about what we are not doing. But it is a heavily inquired into area, so I think there is an opportunity for the committee regarding those areas that you think we need to respond to further.

THE CHAIR: Thank you very much.

JARVIS, MS SUELLA, Manager, Family Relationship Programs, Marymead Child and Family Centre

THE CHAIR: Good afternoon and welcome, Ms Jarvis. The privilege statement card should have been sent to you earlier on.

Ms Jarvis: It was, yes.

THE CHAIR: You have had a chance to read that, and do you understand the privilege implications of that statement?

Ms Jarvis: Yes.

THE CHAIR: Fantastic. I would like to say thank you for appearing today and also for taking the time to put in a submission to the inquiry. Just as a quick reminder before we get going, if you do have a mobile phone, could you turn it to silent or off, whichever you choose. Could you please state your name and the capacity in which you appear today.

Ms Jarvis: My name is Suella Jarvis and I am Manager of Family Relationship Programs at Marymead Child and Family Centre.

THE CHAIR: We have had a fairly quick turnaround time from the announcement of this inquiry and asking for submissions to come in, and we have been very impressed by the number of submissions that have come in to date. I think we are almost up to 15 in the number that are going to be coming in to us; we have got 12 so far. They are yet to be authorised for publication and the committee has not had a great deal of time to go through them all.

Would you like to start by addressing the submission and talking a little bit about the different programs that Marymead operates? We are aware that Marymead operates a number of programs and they have been talked about by earlier witnesses today as well.

Ms Jarvis: I will start by saying I did not actually prepare the submission that you have in front of you. A colleague of mine, Wendy Rollins, did. She is, unfortunately, unwell so cannot speak herself, so I have prepared some summary remarks of what Wendy said. I have also prepared a couple of other additional remarks around Indigenous families and grandparents caring for young children because I thought that might be of interest.

THE CHAIR: That is great. That is very much of interest.

Ms Jarvis: To start off, just to give you a bit of an idea of the variety of programs that we offer at Marymead that would be working with unborn children and infants aged nought to two: we provide foster care for children who have been removed from their parents' care and have no-one else to care for them. We support parents in disadvantaged families to provide adequate care for their children through in-home visiting programs, including specialist services to Indigenous families, families with a parent with a mental illness and families, of course, who are clients of the office and

care and protection.

We support parents who have had their children removed by care and protection when they have supervised contact with their children; so we facilitate supervised contact. We support parents who require supervised visits or facilitated changeovers post separation. We provide therapeutic counselling and group work with parents of infants. We provide psycho-educational parenting groups for both mothers and fathers and we also have a support program for grandparents who have the care of their young grandchildren. That gives a bit of a snapshot.

I have summarised what are some of the social reasons why we would see infants and children at risk or vulnerable with their families. I know you have already covered a lot of them, but, to summarise, we see parents that have significant drug and alcohol addiction; mental illness; problems with family violence and combinations of all the above; young parents, for instance teenage parents who are not ready yet to really care for their infant; single parents, for instance a mum on her own, caring for three young children, who is not coping with that; poor family relationships; poor role modelling of parenting; poor social connections. In relation to this, because we have been seeing vulnerable children and families in Canberra for 40 years, we are seeing an increase of next generation clients. So, where we have worked with children previously, we are now working with them as adults with their children. There are other social issues such as poverty, poor housing and poor educational experiences and, because we work with separated parents, we also see children being affected by parental separation and ongoing conflict following that separation.

I have also tried to summarise some of the system's problems that we see affecting the care of young children—for instance, mothers who have been known to be unable to adequately care for other children but have still had another child and been allowed to fail to care for that new infant as well; general problems within the child protection and out-of-home care systems, which really struggle to provide stable alternative care where infants can develop good strong attachment to a primary carer. I am not laying any blame there; partly that is a factor of seeing an increased number of children needing out-of-home care and a decreasing number of carers, resulting in fewer options.

Other problems are the lack of permanent care options such as open adoption; court orders around infants that do not put the needs of the infant for stability, routine and ongoing attachment to a primary carer over the desires of the parents to keep trying to have their children returned to their care. I understand that the changes to the Children and Young People Act address those sorts of issues and we look forward to seeing movement there. Where infants or newborns have been removed from the parents' care, there is often a failure to provide the support, education and skills training that the parent needs in order to be able to adequately care for the child in the future. That is sometimes a gap that leads to children being more vulnerable.

Another issue we see is the limited ability of our own family support program to respond to requests for family support from the community. We are funded by the office and we have to take the majority of referrals into that program from care and protection, which means that, when a mum rings up, for instance, saying that she needs help with her kids, we have very limited capacity to respond to that. One of the

ironies of that is that care and protection are trying to keep people out of their system but sometimes we have to then say to that mum, “We really suggest that you ring care and protection, tell them about the problems that you are having and ask them to make a referral to our program,” so that they can fit in under our funding criteria.

THE CHAIR: Do they end up getting the referrals?

Ms Jarvis: It has happened a couple of times, yes.

THE CHAIR: Okay, so they are open to that as an idea in terms of people coming in—not being forced to come in but coming in voluntarily?

Ms Jarvis: I think more and more so. I think they are trying to encourage that moving of people into the community services. There is still a long waiting list that we have for community referrals compared to care and protection referrals.

I would like to briefly talk about some of the specific issues that we have identified around the Indigenous community. We have heard of young Indigenous mums who want to get into detox. They cannot take their children with them into detox but they are reluctant to seek care for their children through care and protection for fear of the children being removed altogether, which is not necessarily a well-founded fear but it is there in their minds.

Isolation from extended family or community where parents grew up is a particular problem for Indigenous parents and can cause their young children to be in a more at-risk situation. For Indigenous families where caring for children is seen as a community responsibility, it can lead to severe social isolation. Added to this there can be an element of victimisation of the parent and children who have come to Canberra, by the local Indigenous community that they have come into.

We have found that there are a number of young Indigenous parents who do not want to access Indigenous-specific programs or services due to the close-knit community and lack of confidentiality. We have talked to Indigenous parents who need support and advocacy as they try to navigate various mainstream systems, particularly where there is statutory involvement. We have had feedback that they sometimes find it hard to understand what is required of them and feel ashamed to say this; they need support around that.

Just generally, there are still a lot of Indigenous adults who feel a great deal of anger towards white people because of past hurts and we have found that children, even very young children, can be caught up in this and really inherit that same attitude, which again is a barrier to them accessing mainstream services.

Just briefly on grandparents caring for their grandchildren, we have found that some of their needs are for information about financial support that is available to them. They also sometimes need support and advocacy in negotiating with the statutory system and information about their rights with respect to their grandchildren, and sometimes a real need for respite, especially where you have got a grandparent in their late 50s or 60s suddenly caring for a baby, or perhaps a toddler and a baby; they can get very tired and need a break from that.

That is probably enough from me. I am very happy to answer questions. If I cannot answer any questions, I am happy to go back and talk to people who can provide more information.

THE CHAIR: Thank you very much for making those comments.

MS PORTER: I am particularly interested in the comments that you made about people being fearful. How can we assist parents to be less fearful so they can access services more constructively?

Ms Jarvis: This is particularly Indigenous families that you are thinking of?

MS PORTER: Indigenous families, but also you talked about it in the context, I think, of drug-affected parents as well. We need to provide an environment that is conducive to them coming forward and receiving support, and you do make the comment here that it is important to view the whole family as a vulnerable family rather than just the child being the vulnerable person; if the family is vulnerable, the child is vulnerable, so you need to work with the whole family. Could you talk a little bit about that?

Ms Jarvis: I will talk about mainstream families that we work with. One of the things that we find—I cannot overstate the value of it—is the importance of having a worker who can visit people in their home and develop a trusting relationship with that person in their own environment in a very respectful way. That is basically how our family support program works and our families together program, which is a much more intensive —

MRS BURKE: Outreach based.

Ms Jarvis: Yes, outreach-based, going to where the parents are and being there to support them around housing or Centrelink payments. If you can demonstrate that you are walking alongside somebody and there to support them, often that will help engage them and reduce that sort of fear. Specifically with Indigenous families, and having heard the office talk about their Indigenous unit, we see that as the way to go too, to employ Indigenous staff in mainstream organisations so that there is somebody within that organisation that the family might feel more comfortable to approach and accept services from. Other than that, I do not have any other answers. It is a dilemma.

MS PORTER: I also wanted quickly to talk about whether or not you believe your organisation is able to reach out more effectively with mothers than with fathers—or male members of the family, because it may not necessarily be fathers? Do you see any difficulty in reaching out to the male members of the family and supporting them, or them coming forward to ask for help?

Ms Jarvis: Yes and no. One of the limitations sometimes in our family support program is simply that the fathers are at work during the day when we are wanting to visit with the families, but, where fathers are around and wanting to be involved, yes, we will engage with them. On the other hand, we run parenting groups for fathers, and we have more people coming to those groups now than ever before; we have waiting lists for those groups. We find a growing number of men engaging with our services,

and we are certainly working a lot with fathers around separated families.

THE CHAIR: Over what time frame are you talking about in terms of the increase?

Ms Jarvis: Over the last three years even.

THE CHAIR: Is there anything that you can ascribe that to?

Ms Jarvis: I wish I could.

THE CHAIR: It is all right if you do not know why.

Ms Jarvis: We have wondered whether the opening of the Family Relationship Centre has raised some awareness around parenting and family issues. We get referrals through them either directly or indirectly into our parenting programs more so than we would have previously. We have done a lot of networking with other organisations within the Canberra community; we have good contacts with the Canberra Men's Centre and Menslink. We have worked at building relationships with those sorts of groups and maybe that is paying off a bit. Maybe it is becoming a bit more socially acceptable that dads are an important aspect of their family and they need to be involved. We run different types of parenting groups. Some are specifically for separated dads, but one of our most popular is just called being a dad; it is just general parenting skills for dads, and it has certainly grown in popularity.

MS PORTER: How do fathers find out about the groups? One of the comments made was through a general practitioner; that often men will use a general practitioner to divulge something because they will go with a sore throat or something, and if the doctor is alert enough he or she can pick up that the person has come really because they want to talk to somebody. How do people get referred to, or find out information about getting to, your groups? Would GPs, for instance, know that those exist?

Ms Jarvis: We have a very large email network of organisations; whether GPs are on that I could not say but I could find out. We are certainly publicised through schools, both public schools and Catholic schools and a lot of other support services, the community regional services. The courts would be aware of our parenting programs; we certainly get court-directed or court-referred clients. It is probably mostly through other organisations, to be honest. A lot of dads would ring us themselves, but they have got our number from somebody else that they have been talking to, such as the FRC, the Family Relationship Centre.

MRS BURKE: On page 3 of the submission, I am particularly interested in the section headed "The current context for vulnerable families with infants 0-2 years of age in the ACT". The second paragraph states:

For a community to be truly providing for all families, but for vulnerable families in particular, there has to be holistic, system wide policy and practice. There needs to be seamless service provision around fundamental needs of families and infants. Families in stress with young infants should not have to

Then it lists a range of things that you have talked about: advocating, going from one

department to another, repeating issues, et cetera. Are you saying there that this is where you would like to see improved changes? Is that a recommendation to the committee that you would like to see an improved service—I am just trying to clarify—or does this say that Marymead is achieving this? Do you know or is that something you would like to take on notice?

Ms Jarvis: It is probably something Wendy could speak to more than I could, and I could get back to you with more information.

MRS BURKE: Do you see what I am getting at?

Ms Jarvis: Yes.

MRS BURKE: I am just not sure whether you are saying you are achieving it?

Ms Jarvis: I think the experience of our family support program is that our worker would often be doing a lot of that work around a family, talking with all the different services that they are involved with and trying to make some of those connections easier for families.

MRS BURKE: The inference, if you see what I am saying, is that it is not easy at the moment, so that maybe there is some sort of opportunity for government to be able to look at that and say, “Oh, but we did not realise that was not happening.”

Ms Jarvis: I think that is true, and I remember when housing came into the same area as community services. We thought that should really help a number of the families, because a lot of them have housing difficulties.

MRS BURKE: If Wendy could enlighten that more for us, that might help us, to see whether we need to do something or whether it is just a statement of what you are doing.

MS PORTER: We did have quite a number of comments around that very point.

MRS BURKE: Yes, so we just need to clear up who is doing what, who is doing it well, and who is saying we need to do it better.

MS PORTER: Another point that was made alongside that was that the more joined up organisations become, and the more they collaborate, sometimes a person will not come and report difficulty in their lives, or with their parenting or whatever, for fear that possibly someone will pass that information onto another organisation that they work closely with. Have you experienced parents reporting that to you?

Ms Jarvis: They probably have. Most of the families that we work with doing in-home family support already have statutory involvement and there is an element of, “Are we just part of the welfare?” but that is a bit different from what you are asking about.

MS PORTER: Yes, it is different. It is about communication between departments or agencies. It does not necessarily have to be government departments; it could be

between not-for-profit organisations.

MRS BURKE: Yes. I think people need assurances and, as we get better at this and as we get better at doing the seamless stuff, there has also got to be an overrider or a disclaimer at the beginning, saying “We are not passing your information around.” I know that sounds—

MS PORTER: Without your permission.

MRS BURKE: Yes. Because of the Privacy Act and so on, there may be certain barriers and issues that we need to investigate too; the need to be able to pass on information.

Ms Jarvis: Even within Marymead we find that across different programs: we will have a number of families accessing different programs and how much of that information do you share across programs? How much do you keep it very much within—

MRS BURKE: From Marymead’s perspective, what would you say that we could do to improve that? Do we need to look at the Privacy Act again in relation to vulnerable children?

Ms Jarvis: What we do as an organisation is seek the parents’ approval. We seek their permission to share information, and we find a lot of the time that that is a relief to parents. It is easier for them if they know that the information is being shared. But if they do not give their permission we do not share that information.

THE CHAIR: Thank you for appearing today. You will be sent a copy of the transcript, which we would ask you to check for accuracy, and we will be keeping you apprised of where we are at with the inquiry. As this is an election year, the last sitting week is at the end of the August, so the report will be tabled by the end of August—no questions about it; it has to be. You will receive a copy of that report and, if we do have any further questions, we will get back in contact with you.

Ms Jarvis: And I will get back to you with a couple of things.

THE CHAIR: Yes, that would be fantastic.

MRS BURKE: And thank you for stepping in at such late notice; well done.

COCKING, MS KYLIE, Children and Young People Focus Worker, Domestic Violence Crisis Service

SIMPSON, MS DENNISE, Manager, Domestic Violence Crisis Service

THE CHAIR: Welcome. I understand a copy of the privileges card has been sent to you. Have you both read that privileges card and do you understand the privileges implications of that?

Ms Simpson: Yes.

THE CHAIR: Thank you for taking the time to appear and for the submission which we have received from you in the last couple of days. We do appreciate that. We know it has been a very short turnaround time from the announcement of the inquiry to the cut-off date but, it being an election year we have a shortened time frame. Would you like to start by making an opening statement addressing your submission or just talking generally about the issues?

Ms Simpson: We thank you for giving us the opportunity to speak here today. We are hoping that you have read our submission because it covers the main points that we actually want to talk about. I guess we are hoping that there will be things that you want to ask us.

I am thinking that, given that you have said that it is groundhog day, you have probably been hearing a fair bit about collaborative practice and collaborative practice in relation to better outcomes for vulnerable children, babies and their families. That is certainly a key stand of DVCS in relation to collaboration.

You would know that we are one of the key agencies under the ACT FVIP, but we also collaborate at a number of other levels. And we do that because we believe that it gives us better outcomes. We sit, though, with some concern about what that collaboration can look like. I think that is one of the main things that are outlined in our submission.

THE CHAIR: I do have to apologise to you. We have only just received the submission in the last couple of days, so we are not as fully across it as we would like to be. But did you want to talk a bit about your concerns about the way that collaboration looks and how it currently operates?

Ms Simpson: One of the things is that collaboration has become a buzzword across governments, certainly across the ACT on all levels, government and community, but also nationally and certainly internationally. We know that there has been research done in relation to collaborative practices that have been operating, particularly in other jurisdictions outside the ACT, on child protection and how well they are being regarded in relation to the outcomes. We know that this is a path that is well and truly being followed by the ACT in a whole range of areas. Not only child protection but lots and lots of areas are looking at collaboration.

I suppose we think that there is not necessarily a shared understanding of what it means to work in collaboration. We often find, at DVCS, ourselves at odds with another agency that we would be collaborating with. That is usually more so on the

service delivery area, as opposed to the management area. We think that that shared understanding is one of the absolute cornerstones of working collaboratively. If you are not coming from the same base of what it means to work collaboratively, I think that you are missing out on what could be.

You might be sharing particular information or you might be doing a range of things together. But in terms of a truly collaborative relationship that also demonstrates respect between agencies and mutual understandings of respect to the clients and everything that that encompasses in terms of being respectful with clients, with the people that we are actually there for, then we think you are missing out on some outcomes that could be genuinely supportive and useful to that family.

THE CHAIR: Do you want to add to that?

Ms Cocking: Yes. I think it is important too. We spend quite a bit of time in the submission highlighting the complexity typically attached to vulnerable children and their families across a whole range of different issues. In particular, we have highlighted the domestic violence component of that.

I suppose what we are really trying to drum up is some interest in collaboration as a means of better addressing that complexity and as a means of generating common understandings across a whole range of issues between services and sectors. What we are finding is, say, with good collaborative practices, that good collaboration when it works well actually helps to provide and promote shared common understandings in relation to the client, in relation to the issues and in relation to the roles and responsibilities of each service.

MS PORTER: You talk about one of the features where you think collaboration can be promoted and, I guess, developed more. It may have been in that part or it may have been in another part of your submission. I think it is to do with the care and support and early intervention programs.

You talk about trust and transparency. One of the issues that have been explored quite a lot with a lot of people today is collaboration and that, whilst it is to be applauded, there is some fear of the trust and transparency with regard to women and/or men who may use those services. They bump into one service, either intentionally or by accident, and then find themselves caught up in a system where their information is being passed on to another, maybe with their permission. It should be with their permission, and I would imagine it would be with their permission. But it is getting caught up in the system and how they feel fearful if they actually enter at a point that that might happen, if that makes sense to you.

I wonder whether you could comment about that. Then I will have another couple of follow-ons from that.

Ms Simpson: I think we will both comment on that. One of the things I would say is that I was listening to the end of the last Marymead speaker. She was talking about getting permission of the client to pass on the information. DVCS, being such a specific service, that is, that is actually dealing with people's physical welfare—and, mind you, so does Marymead—very much operate from our duty of care to any

person. So, if that is your overarching policy, safety for any party, then having that as a guide often guides you in what might be the thing to do with that information.

Firstly, we do not name DVCS as a confidential service. We talk to the clients upfront as soon as we possibly can in relation to possible duty-of-care issues, on issues of safety and risk, particularly in relation to children. That actually leads to some interesting discussions. It is not a blanket statement about that. You need to know that, if they are at risk, it is a discussion with the client, which is normally a woman—a discussion with the woman—on concerns of safety, a discussion that she generally enters into on her concerns for her children or her fears, what it might mean if she becomes involved with CPS, her past fears with CPS, all of those things. But it does broaden it out.

The other thing is that you would be aware that, under the DV agencies act, DVCS has been gazetted—not in the DV agencies act but we were gazetted—the authorised agency that is able to be given information from the AFP. So we have that on information sharing. Also as part of the FVIP, there is some information sharing that goes on there. Again, it is all about safety, a needs-to-know basis in relation to safety.

We have also have been appointed a suitable entity under the Children and Young People Act. That is very useful to us as well because we have an incredible commitment and a strong focus that has become stronger over the last years in relation to children and young people.

All of those things lead me to think of the issues of confidentiality around family. Firstly, it is how the information is passed, why the information is passed, how much information is passed and, in that, why the information is passed. If we are talking about the safety of children, I think that is a very particular issue. This is probably getting a little bit away from what you asked, Mary.

I am thinking that we have certainly sat in numbers at forums where we have heard from different service providers information very inappropriately passed in relation to assumptions that have been made about the family, information that does not need to be on the table to understand the role that we might all have in relation to the family and disrespectful ways of talking about the family. So part of our training of any worker would be about the idea that you do not pass on information for passing information's sake. It is not a gossip fest in relation to a family and what that family is up to. It is around that family's safety.

Ms Cocking: I think, too, the only thing I could really add to that is that, in my experience of collaborative practices and the issue of confidentiality, the issue of indiscriminate information sharing is not what I typically encounter. In fact, what I typically encounter are barriers to appropriate communication sharing.

THE CHAIR: Do you think some of those things are being addressed within the new act, the proposed bill?

MS PORTER: The Children and Young People Bill.

THE CHAIR: Yes, the Children and Young People Bill.

Ms Cocking: From the top of my head, I cannot recall. What I could say, though, is typically what is reflected in policies and legislation is not always what is reflected on the ground in practice.

MRS BURKE: That is right; one thing on paper and another thing doing it.

Ms Simpson: I think that is the thing about saying, too, that it is typically from the service providers that you might find there is no shared understanding of what it means to work in collaboration. And that is not a general rule either. It can be one or the other. You can be talking to management on one level and you feel as though you are really on the same page, and yet in the day-to-day service provision you do not feel like you are on the same page at all.

THE CHAIR: I think that is a common theme, a theme that comes up all the time. That is my impression anyway. I suppose you have got to keep in mind the senior management level; they are the ones who are drafting the stuff; they are across all the issues. How much information is flowing down? You have to keep in mind turnover of staff—new, inexperienced people coming in. There is, I think in this area, a reasonably high turnover of staff as well.

Ms Simpson: All that is very, very true and it does impact.

THE CHAIR: It is an ongoing situation—let us not call it a problem—and an ongoing reality that there will be new people come into the service who will not have the experience the senior managers have. In some cases, they will actually bring in a fantastic new perspective; I think we should keep that in mind as well. But in other cases they do not necessarily have that depth of understanding of what has gone on beforehand. It takes time to bring them up to speed. That is the way things are, and we need to deal with that continuously. That was a statement or a comment rather than a question, I suppose.

MRS BURKE: Thank you for your report. It is a very well thought-out and articulated report. There is a lot of information. Going to page 4 and the women with children aged zero to two, which is of course our focus, I could not find any disaggregated information in your report that came firstly from a national level and then from an ACT level. What proportion of people presenting to you would fall into that category of zero to two, and what percentage of your clients would fall into the category and/or pregnant? It is hard to say.

Ms Simpson: It is hard to say. I do not have the figure here. Certainly it is a figure that we would be able to get. It would be something that we could pull off our database because we keep the ages of all the children. Mind you, it is probably not on the database whether the child is not actually yet born.

MRS BURKE: No, it does not matter, though, if it is pre-birth or up to two.

Ms Simpson: It would be once they are born.

MRS BURKE: I think the committee might find that helpful.

Ms Simpson: It would be quite high, I would imagine.

MRS BURKE: Has it been on the increase, have you found?

Ms Simpson: I would not be able to say whether it has been on the increase.

MRS BURKE: And have the ages got younger?

Ms Simpson: I think everything is on the increase but—

MRS BURKE: Because of awareness, is it not? I was thinking of that cross-disaggregation of ages. Are the women presenting getting younger? And is that number increasing? Or is it across all age groups?

Ms Cocking: We are certainly actively—

MRS BURKE: You can take that on notice, if you are able to provide us with that information.

Ms Cocking: We cannot give you figures on that but I can say, in my own work, that we are engaged quite extensively with numbers of young parents with young children facing a whole range of issues to do with domestic violence, drug and alcohol use, housing and a whole range of other issues that cut across those sorts of things.

Ms Simpson: But we do keep ages.

Ms Cocking: Yes, we do keep ages.

MRS BURKE: Yes, because obviously you also talk about the early intervention stuff, which we have heard a lot about today. Obviously, if you can get them, get them early, get them often and get them young. That is the best time to give those people under stress and pressure help. On page 6 of your report, you talk about engaging women. You go on to say that there is reluctance on the part of women to engage with support services. Obviously, it does present, as you say here, a significant challenge. We have talked about threats and fear today—they feel perhaps threatened by authority. We have also heard that outreach seems to be more popular. Would you like to comment on that part of your submission?

Ms Simpson: One of the things I would say is that, if you are a young person, particularly a young woman, who does not have your own transport, you have got—

MRS BURKE: We have heard that.

Ms Simpson: at least a young child or other young children, and you are possibly living in a domestic violence situation, either with that person actually residing with you or visiting on a regular basis, the overwhelming complexity of your life can make it much more difficult to attend appointments on the other side of town to do things that take quite a lot of effort—to get your child ready, to maybe catch a bus, to pack everything that a child needs to have packed to go away for three or four hours. It is

having to make all those arrangements that are so much easier when you are throwing them into a car or whatever, but when you are living with those other complex issues in your life it is doubly difficult. To have someone come to your home where you do not have to do any of that, where they can simply come in, you can give them a cup of coffee and you can sit and have a talk somewhere where you are more comfortable—I cannot imagine that, even without those complexities, most of us would not prefer that.

MRS BURKE: Sure.

Ms Simpson: Rather than go and wait in a waiting room somewhere and maybe be held up for half an hour or an hour—all the things that happen. That would be one of the things, I think.

We see some of the orders that are put upon women who might have children in care, for example, or where there is the threat of having children in care—the range of services that they can be ordered to attend. It is supposed to be like a negotiation, but it does not necessarily come across as negotiation when you are a young woman. It might be parenting; it might be drug testing on an ad hoc basis; it might be attending a counsellor—a different sort of counsellor—one to one. It might also be attending counselling or mediation with your partner. You might have legal appointments. You might have your regular CPS appointments. All of these things—your life could be full of it just trying to fulfil these obligations.

MRS BURKE: So people feel threatened by that—just to pick you up on that? They do not see it as an assistance or support; they feel that it is a whole load of orders and it is a “got to do”. How can that be changed? How do we change that?

Ms Simpson: It is so overwhelming.

Ms Cocking: There has to be the recognition that women are attending to their safety in domestic violence situations all the time—and that of their children—plus trying to manage the rest of the relationship issues that that throws up for them. It is quite exhausting. We really need to be communicating with women as much as we possibly can—and consulting with them, informing them and inviting their participation as much as possible in any of those kinds of processes so that they can better access services and feel supported in doing that. For some women in these circumstances, picking up the phone is literally too much to expect.

MRS BURKE: That is the key word, isn't it—invite you to participate to help you through this process. I guess it is wording and—

Ms Cocking: Consult, negotiate—all of those sorts of things—rather than dictating.

MRS BURKE: I want to go back to the outreach thing finally. How much pressure is that placing and what impacts is that having upon your organisation—if you needed to try and focus on that more? I presume you would like to do that more if you could or—

Ms Simpson: There has been a report just done which has not been released yet but is basically about Indigenous women in the criminal justice system. The AIC did that

consultancy. They went through the client files of DVCS for a particular year. Basically, the report says that DVCS went far beyond what they would have expected in terms of their mandate around some of the services that they were providing to women. They said that they could not compare that to non-Indigenous women, because that was not the scope of the consultancy; it was just in relation to working with Indigenous clients.

I would say that the reason that we often end up doing a whole range of things is that Indigenous clients invariably present with a complex web of needs. We often find very little flexibility in other services in relation to what they can offer. If they say that they offer this, and you ask for something which does not seem to be very far different then it is not what they do.

MRS BURKE: I do not think it is unique to Indigenous people, from what we have been hearing today.

Ms Simpson: Absolutely. I was only saying Indigenous because the report was about Indigenous people.

MRS BURKE: Acknowledged. But I think they do have specific needs.

Ms Simpson: I was just using that as an example—we have talked about it in DVCS for years. We would like to have the scope to do more outreach work—almost like the outreach that follows the crisis. That is just not a possibility. At any given time, we have two crisis workers on shift; that is it. We do our best to meet some of these needs, but basically what we are there for is the crisis intervention. That always has to come first; it has to be prioritised. We cannot respond to all these bits. We would like there to be more scope to be able to do these bits and we would also like other agencies to be able to be more flexible in some of the things that they are able to do.

MRS BURKE: Thank you.

MS PORTER: You have a dual focus in looking at the mother and the child—but usually the mother, as you said. But then there is the safety involved. When you are concerned about the safety of either individual, the focus obviously needs to go to that particular thing. When the focus is on the child's safety in that situation, we have had reports from other agencies today that sometimes the mother feels that she is not getting enough support at that particular time. I wondered if you want to comment about that. Another comment we have heard is that sometimes the male members of the family, particularly the father, when he is not feeling that he is having any attention paid to his needs because he does not know how to express them or whatever, may act out in a way to draw attention to himself to create a crisis. Then attention has to be paid to him in some way, in a punitive way sometimes. I wonder if you want to comment about those two things.

Ms Cocking: I think the helping system in relation to women and vulnerable children is not always helpful; that can serve as a disincentive to engagement with services. There is probably a whole range of explanations as to why women do not experience the helping sector as particularly helpful. What was the next part of the question?

Ms Simpson: About some people saying today that the focus switches from the woman to the child.

Ms Cocking: We always prioritise safety. We recognise, of course, that children are typically the most vulnerable parties in any family relationship, so we will act in accord with that and prioritise children's safety where we need to. However, in doing that, it is incredibly important that we try and invite dialogue with the non-violent parent around our concerns—talk to them about what supports they might find useful and encourage them to consider supports. I am talking not just about the helping system or the helping sector but also about their own family and relationship networks—friendships and things like that.

We always prioritise children in any situation where we feel that their safety is compromised. We try wherever we can to have conversations with the parent about that. Sometimes that is not possible, and we recognise that. We understand that sometimes flagging our intentions, say, to make a report may actually promote further harm to the child. But for the most part—I would say in about 90-odd per cent of cases—we are having that dialogue, with the mother typically, about those concerns and inviting her to engage with us around what that might throw up for her and then how we can better support her in that.

Ms Simpson: In relation to your question, Mary, I think that there is a bit of a misunderstanding around DVCS that probably comes from how we were in the past before we had this stronger focus on children. That misunderstanding comes back to us sometimes. Sometimes it comes back to us from CPS workers. They will state, "Well, your focus is the woman and our focus is the child." We always say: "No. We are looking at safety first; we are looking at the woman and the child." We describe it as supporting the non-abusive parent to support the child to be safe. When we come from that, we can have made a report to CPS, we can be very engaged with CPS in relation to particular children, but at the same time we are certainly not withdrawing our support from that woman. She is still our client; it does not shift. I think that we do that very well—maintain that focus. If she pulls back from us, that is another thing. That does not happen that often. It happens more when a woman wants to go back to her partner, for example.

Let me go to the thing that you were talking about in relation to men. Interestingly, Kylie and I might have been having a conversation around that the other day. It is one of the things there for women who are pregnant. Suddenly the man can feel threatened by the pregnancy—not feel that he has got the top spot, not know what the future is going to bring, no longer find his partner desirable or there for him. The focus is maybe somewhere a bit else. In a way, I suppose that is a bit of the same example. If you are in a relationship where there is violence and controlling behaviours then, if you shift that focus away, sometimes there are repercussions in relation to wanting to shift the focus back.

MS PORTER: Back again, yes.

Ms Cocking: Many of the women we work with want to maintain their relationships and are working really hard to do that—to get around the problems and try and seek supports for their partners. One of the difficulties I have noticed particularly in the

sector is the lack of recognition of men and fathers and the lack of support that is extended to them typically in these sorts of situations. In a way, they are almost like the silent partner when the helping sector becomes involved.

MS PORTER: That is useful information.

THE CHAIR: That certainly marries up with what was said today.

MRS BURKE: Yes, very much.

THE CHAIR: Thank you very much for taking the time to appear before us today and taking the time to put together a submission. We are aware that DVCS is a very busy service so we appreciate the fact that you have put those submissions together. The transcript will be sent to you; please check it for accuracy. We will keep you informed as to how the inquiry is going and you will get a final copy. We may end up coming back to you with some questions when we review the transcript; it may throw up more questions.

Ms Simpson: Would you like us to forward to Grace those stats in relation to the age of women and children?

THE CHAIR: That would be fantastic.

MRS BURKE: That would be really interesting. I do not know if you have got them for the last two or three years so that we can have a look at the trend.

Ms Simpson: Okay.

ABBOTT, MRS KERRIANNE, Psychologist, Child and Family Team, Alcohol and Other Drugs Foundation ACT

FITZROY, MRS KERRY, Child and Family Team Manager, Alcohol and Other Drugs Foundation ACT

THE CHAIR: Good afternoon and welcome. Thank you very much for coming along. The secretary would have circulated to you a copy of the privilege card, which is sitting in front of you. Do you understand the privilege implications of that statement?

Mrs Abbott: Yes.

Mrs Fitzroy: Yes.

THE CHAIR: Thank you very much for your submission to our inquiry into vulnerable infants. Do you have any comment to make on the capacity in which you appear?

Mrs Fitzroy: I am the Child and Family Team Manager with ADFACT, the Alcohol and Other Drugs Foundation of the ACT. I work at the Karralika therapeutic community as the child and family team manager.

Mrs Abbott: I am one of the psychologists at Karralika and I work in the child and family team.

THE CHAIR: As I said, welcome to the hearing. I understand this is Kerry's first appearance before us. Please don't be nervous. We are interested in hearing your professional experiences and your views on the issues that are raised in the terms of reference. Would you like to start by addressing the submission that you have made? The committee is aware that it has been a fairly short turnaround time from the date when the inquiry was announced to the date when submissions closed. Because it is an election year we have a shortened time frame, so we are aiming to get the report to the Assembly by the last sitting week in August, before the election. That is part of the reason why it is such a short turnaround time.

Mrs Fitzroy: We have already introduced ourselves. I will talk a little bit about the foundation. ADFACT established the Karralika family program in 1989 to provide a treatment program for parents who have alcohol or other drug issues. The program caters for single parents with children and couples with or without children. The children are aged from nought to 12 years of age and they accompany their parents. Each child then becomes a client within the family program. Specialised supports are in place to best meet the needs of each individual child. So the role of the child and family team is to work with the family. The child is also our client and specialised supports are put in place for the child.

The stronger families project is targeted at supporting children and families before, during and after treatment. It is the first real innovative and collaborative practice and has formed strong links with government, NGO and community-based agencies. The stronger families project builds on achievements of the Karralika family program to help children who have been exposed to parental drug use in their early lives.

Many of these children have suffered a range of social and health problems as a result of poor parenting and disorganised attachment during their early years. In the submission that we presented, some of the key issues facing children between the ages of nought and two with parents who are affected by drug and alcohol are: poor attachment styles, being at risk of neglect and abuse, poorer health outcomes and poor developmental outcomes. Both Kerriane and I have seen, and continue to see, these key issues on a regular basis when families first come to us.

We have babies born into the program, of course. Women come into the program already pregnant when they arrive, so we have that opportunity to have them with us, they have the baby with us and then they are with us for a little bit longer before they move on. We have seen babies that have been born with withdrawal symptoms. There was a father in the program and his partner had his child; she was still using when the baby was born. So we watched that process of the baby being quite ill. We still have that child a few years on; we still get to see him and some of the issues facing him as he has been growing up with withdrawal from when he was a baby.

With respect to attachment, when infants are in the program there is the issue of their mothers, what is happening for them and how emotionally detached they are, so that they are not available emotionally for their infants. Of course, we have a window of opportunity to work with parents because when they come to us they are in an abstinence based program, so we get to work with parents on those issues. Definitely, prior to coming into our program, all those issues have presented between parent or mother and child, especially with an ant, with reference to attachment and bonding. Infants need that overall feeling of being secure and safe and in a consistent environment. Of course, the infant in a drug using environment is in a very disorganised, chaotic environment. They are vigilant about their surroundings. They are not relaxed; they are highly anxious. Sometimes infants can be quite unsettled and are really difficult to settle when they have been in that environment prior to coming to us.

MS PORTER: I noticed in your submission that you talked about some themes that have been quite strong throughout the hearing today. One is working in collaboration with other organisations. Would you like to talk about how that has been working out. What are the good bits about it, what is working and what may not be working? How would you suggest that it could be improved, if it needs improvement?

Mrs Fitzroy: We have worked with Health for a few years with the MACH nurses coming into our program. They come to us, which has been fantastic. When children come into the program, we organise for the MACH nurse to visit, they do a developmental health screen and usually immunisations are organised. So we have a system for the health side of it.

With respect to the needs of the children and childcare, Karralika had their own childcare centre until this year. We were then funded in a different way through Health. Now we are in an integrated partnership model with Communities at Work. Our children attend childcare at two of the services—the long day care services and the after-school and school-age services. Communities at Work receives the funding to provide the places and the staff, and we receive the funding to provide the specialised supports and services back into the childcare centres. The child and family

team do training of staff, and the psychologists do case management with them around our children, making developmental plans for them and just working in general with the staff.

It is really new. It only started in February. I can only comment on where we are up to now. Of course, it was a decision that was imposed upon us. That was how it was, that was the way it was going to be, and we had to embrace it. It has been a difficult, long process to get to where we are and it will be an ongoing process. There are good things and bad things about it. There are good things for the children who are at a stage in their emotional wellbeing to cope in a larger service, but I think we realise there are also other things about it. When children first come into the program, just like when adults first come into our program, they are in an induction phase. They are separated from the larger part of the community and they are in a smaller program for the first six weeks.

We see that is what children need too, in the initial time when they first come into our program. They need a smaller environment with higher ratios and with consistent staff in a less chaotic environment. So one of the areas on which I communicate and work really closely with Communities at Work is ensuring that that happens. There is an integrated model and we do have a room that is separate so that, if children are not coping when they first arrive at Karralika, they have an opportunity, and there are opportunities within the larger centre for the children to be removed and placed in a smaller environment, so that they can start to feel safe and secure and have some consistent people in their lives and be in an environment that is not so overwhelming with so many children. So that is a challenge.

If we are looking at the good and bad points, when we had Karralika childcare we had three full-time staff and that never changed, with respect to the number of children. So we were licensed for 20 and if we had three or four children, we would still be funded to have the three staff there. They were times that provided rich experiences for the children and there was lots of time to do some great work. The staff stayed for a while. The childcare staff did stay and work in the setting for longer than in the normal childcare setting, where there is a high turnover.

I suppose I do have a concern with the higher turnover of staff in a larger service. That comes back to our children needing the consistency of the carers in their life and not so many people all the time. Prior to coming to us, most of them have had lots of people coming and going all the time.

Mrs Abbott: We also work quite closely with the child and family centres that are dotted around Canberra. Obviously, the Tuggeranong one is closest to us, so we have the most to do with them. We utilise them primarily for the parenting education programs that they run. That is one of the biggest gaps with our parents of the zero to two age group—their lack of awareness of basic things like hygiene, food and basic care of a small child.

Working with those agencies is quite important in the early days because if they have numerous children, they all end up, generally, in care, and there is always a response like, “I don’t know,” and “I don’t understand why.” We have the advantage of being able to see, 24/7, how they are raising and looking after their children. There are

massive gaps in their ability to know what to actually do—how to care for a child properly, what to feed a child, what is appropriate and what is not appropriate. For example, a recent client was really shocked and stunned that we pulled her up around putting lemonade in her baby's bottle: "Why is that not okay? I did it with all of my other children."

Working with the child and family centre at Tuggeranong has been really good. However, the problem is that the Triple P programs or the PET programs are pitched at a high level of education, so we are having to do a lot of that stuff in house where we can really lower the level for people to be able to understand it on their terms. We also work with Marymead quite closely in the delivery of those kinds of services and also regarding groups specifically for the parents themselves—men's emotional management groups, women's support groups, stress management for mums who have small children and just do not have the insight to know how to manage those feelings that overwhelm you when you have a child that is anxious, depressed and not responding to anything that they are doing.

There is a little bit of a gap around services that can pitch their programs at the right level for our clients. A lot of it is a little bit more middle-class and for people who are not as problematic as our families are. With that basic level that is assumed for all parents, we cannot assume that for ours.

THE CHAIR: Yes, that is a good point.

MS PORTER: Another recurring theme was that sometimes the men felt a bit on the periphery with respect to getting their needs met, because they often cannot express what it is that they need. So they are more likely to demonstrate that frustration through being angry or through other ways of acting out, which then gets them some attention, but it is usually not healthy attention. Have you experienced that? Can you give us any feedback on men's services generally in the community, as to whether they are appropriate or that we need more of?

Mrs Abbott: We have a lot of problems with the men managing their emotions. However, we also have a lot of success in being able to do that by the completion, the end, of their program at Karralika and once they move into transition. A lot of that is through one-on-one counselling, being able to identify with them early on that they are quite anxious, which then translates to violence, about the uncertainty with young children, particularly behaviours that they perceive as bad behaviours, when in actual fact it is a manifestation of anxiety or depression in the child; they are reacting to the instability of their home environment.

In our environment, it is still a little bit unstable, because there are lots of people coming and going and the children find that hard to cope with as well. There are other people that do keep an eye on them while mum and dad go and do other bits and pieces. But the men do respond quite well in the treatment therapy groups that we run, and we have specific themes that we run on a rotating basis; for example, parenting groups that we have which address specific things such as stress management and how to manage that anger that builds up inside when you do not know what is going on. But we also find that, through education about what to expect, that actually helps alleviate some of that anxiety.

Marymead come to the party quite a lot with us on the men's groups. We have just recently completed a series. Managing strong emotions, it is called. Again, the problem that we have there is it is pitched at a normal person whom you would expect to have a basic level of education and it is just a little bit too high for the guys. To be able to sit in a group and put it out there on the table and go, "How do you cope when your kid is screaming its head off and you feel really angry," that gets things going, as opposed to, "How do you cope when your stress levels are really quite elevated?"

MS PORTER: My stress level was elevated when you said that.

Mrs Abbott: Yes, absolutely. But we also run your basic CBT programs on your actions, thoughts and behaviours and what leads to what, and getting them to identify what their triggers are. That is definitely outlined in their relapse prevention plans when they leave, if they have got small children. What are you going to do when you cannot control your child or you perceive that something is going on that you are not happy with? Who are you going to call? What are you going to do instead of what you have done in the past? How are you going to ensure this child's safety?

But I think the biggest thing that we can give them is an understanding that their child's behaviour is not bad, that it is actually normal, and that children respond to what happens in their environment. And respond to them. The power is with them in being able to modify their behaviour and how they interact with the child as well.

MRS BURKE: Thank you for coming this afternoon. I was actually looking at the end rather than the beginning of your submission—your conclusion. I have two questions. What would be the average age of young women presenting to Karralika for assistance on the program with a child, either prenatal or up to two years of age? If you have not got the figures now, you can take it on notice and that is fine. I would really appreciate the trends. That is the point of my question. Can you give us some figures of age groups of people presenting, say, over the last three years, and the reason?

Mrs Fitzroy: As I say, we can find that out for you because we have assessment records.

MRS BURKE: That would be helpful.

Mrs Fitzroy: We can send that information in, but it varies. I am thinking about the last three years. Just off the top of my head, I think the mid-20s is the average age group, but of course we get younger women. We also get a lot of women who come in with one child but they have got another five out there in care and protection. We have got a family that have got two young children under the age of two coming in, and the woman is pregnant. But they have got three others outside. That is a woman in her mid-30s.

MRS BURKE: Whatever you think.

Mrs Fitzroy: We can find that out.

MRS BURKE: Yes, to try to get an idea. You then talk about families needing to engage in programs that are holistic and integrated. A lot of them, though, you say, that are presenting are single parents. When you talk about families, are you talking about mother and child or children and/or ex-partner or broader family networks? How does that integrate in holistic program work?

Mrs Fitzroy: Obviously, to be in the Karralika program you need to have a substance abuse problem. We get lots of phone calls and they ask about the other parent, that they do not have the problem. We do work holistically with extended family members, say, a mum, a dad or a partner that is not in the program. They will come in and have counselling with the psychologist.

We also have a family day on every month, and we run a family group. Extended family come in. They have an education session at the beginning of their visit and they then go and visit with their family. But if we are talking about, say, a mum with young children and there was a partner, a lot of the time there is no partner or there is a fragmented relationship between the partners.

Mrs Abbott: Or dad is actively using and we cannot have him on the premises or if there is any question mark over his drug and alcohol use, because it threatens the whole community.

Mrs Fitzroy: But if the opportunity is there for the other parent to come in and participate in counselling—relationship counselling, family counselling—then that is definitely part of our program and we offer that service because we recognise that it is the whole family unit. If there is, say, one parent in treatment and having parenting, learning and recovering problems, if the other parent is out there waiting then they need to come along on that journey too so that, when finally they leave, the other person is able to support the recovering person and the whole parenting capacity.

MRS BURKE: It is probably a loaded question, but where are the gaps? If you could specifically confine it to prenatal, then nought to two, where are the gaps in programs? You have mentioned that it was probably a double-edged sword having the childcare removed from you. Is that something you would like to see restored? Is that needed? What other things are there that the government of the day could focus on to assist in some of these issues?

Mrs Abbott: We would love to get childcare back.

Mrs Fitzroy: Yes. I do not even know whether it is childcare. We would like to manage that side of the program more. We do not manage. Our children are in a service that is totally managed by a different organisation.

MRS BURKE: It is disjointed. Is that what you said at the beginning?

Mrs Fitzroy: I do not know that it is disjointed. Everything is working okay. Of course, we believe that we know our children, we know their needs, and we are the best people to provide the care for them.

Mrs Abbott: Particularly with the insight into the parents' issues. There are a lot of

attachment issues and emotional unavailability issues. The behaviours manifest again in other things that are lost on childcare workers that do not understand where they have come from.

THE CHAIR: This has only recently changed. I do not know the likelihood of your taking back the childcare program. A situation which might deal with things is for ADFACT and Karralika to actually have somebody working within the childcare centre itself.

Mrs Fitzroy: Definitely. The thing that stood out as very much a disadvantage in this integration is that the childcare staff that were with us and that were made redundant and then went over to communities at work left. They did not remain because, (1), they did not want that to happen, they had to move, they needed a job, they moved on; and, (2), it just was not the same because they lost control of running their own service centre, so to speak.

That is one of the things I have thought about in this new model. I am not saying that it cannot work. I am not saying that we are the best at everything but I would definitely think that a positive aspect would be to have somebody specifically working there just for our children. We have employed a child family support worker. I even thought we could be funded to have more of those positions that I could put back into the centre and send them to the childcare centres and say, “You are going to be there for this many days and this many hours and that is your job to do that and then come back to us and do some work with us.”

Yes, I think that one of the things that concern me is the specific needs of our children within a larger setting that can get a bit lost. I am not saying that anybody would do that intentionally but, in a large childcare centre, when you have got 55 children, it can be quite chaotic. If the children are in a room with 10 other babies or 20 other toddlers, it is a very different type of care that we are not used to, as an organisation, having our children in. We have had 18 years of our children being specifically in a very small environment, with a higher ratio of staff. It is something really different that we need to work with.

MRS BURKE: I am not sure I quite understand why that was done, but that is an argument for another day or a discussion for another day.

THE CHAIR: Did you want to comment on that?

MRS BURKE: Did you know the rationale? Was it a cost thing?

Mrs Fitzroy: Yes, I think it would be funding, more cost effective. One of the things, too, was, if you recall, a few years ago, Karralika did receive a lump of funding to expand at Fadden. It was going to be redeveloped; there was going to be a new childcare centre. And then that all changed. There was the Karralika Action Group. It all did not go ahead.

One of the proposals there, that everyone agreed to, was to have the childcare centre off the therapeutic community site—not to operate the childcare centre on the same site as the therapeutic community. And we all agreed to that. I have been there for

a long time and I do believe that sometimes it is not the best model to have children at home, going across the yard to the childcare, across the yard back to home. There have been some good things about them leaving and going to their own centre.

But we always thought that we would be given the centre to manage, that it would be under the ADFACT management structure as one of our programs and that we would provide a service to the wider community to assist other families in similar situations. One thing that stood out for me in that was that Arcadia ran a pilot program, I think not last year but the year before. It was their detox, where they had women and children, and it was a short-term pilot. We partnered with them. Their children came over and used our centre when we had the centre at Karralika.

We knew nearly all the children that came to us. They had already been with us and had left. I thought, “Are there children or other families that are linked in to other agencies”—because we are such a small place, Canberra—“that we could be of service to and could support as well?” Other community agencies, other ADO services, could use our service to provide childcare. That is what we always envisaged and hoped that it would be that way, but it was then more generally known that we were not going to get our own building, that we were looking at what was available in the community already for us to use.

MRS BURKE: Really, for it to properly work with the model that we have got now is by that cross-pollination of Karralika—everything that the chair said—and to have, perhaps, Karralika workers installed in the childcare centre. Maybe more negotiations could happen on that front. We have run out of time again.

THE CHAIR: Yes, we have.

Mrs Fitzroy: And I have run out of time.

THE CHAIR: We have run out of time. Thank you very much for attending today. A copy of the transcript will be sent to you, which we would ask you to check for accuracy. We will keep you informed of the progress of the inquiry, through Grace. We may, once the transcript has come out, have follow-up questions—you never know—or we might think of something in the middle of the night; it does happen. Thank you very much for your appearance today. We do appreciate it.

Mrs Fitzroy: Thank you for having us. Usually once we start talking, we are right.

THE CHAIR: Yes, it is just like a conversation.

AZIZE, MISS MAIY, Policy Officer, Youth Coalition of the ACT
FOWLIE, MS CARRIE, Deputy Director, Youth Coalition of the ACT

THE CHAIR: Thank you for attending today. You would have been sent a copy of the privilege statement. Have you both read that and understand the privilege implications?

Miss Azize: Yes.

Ms Fowlie: Yes.

THE CHAIR: We do not have a submission from you at the moment; that is fine. We are happy for people to come and speak to us without putting in a written submission. We just want to hear from people. You can start by talking to us about the issues for this particular inquiry, which is an inquiry into vulnerable infants aged pre-birth and zero to two.

Ms Fowlie: Thank you for letting us come and speak with you today. We are sorry that we did not get a submission in to you. Due to our limited resources, we were not able to do that.

THE CHAIR: That is fine.

Ms Fowlie: But we do very much appreciate the opportunity. There are a few things that we want to talk to you about, because this is quite a large, complex type of issue. Probably one of the first things we wanted to talk about was the extent of the issue. The data on this matter is a little bit tricky, depending on what you read, particularly in the ACT.

However, there are reports stating that approximately 10 per cent of children could be in families affected by parental alcohol and other drug issues. So that is pretty significant. Alcohol would be the primary substance of concern. From there, we would go down to cannabis and then amphetamines and opioids. I guess that is also important to remember in terms of our conversations here—that alcohol is the drug that causes the greatest harm in our community.

Ten per cent is a huge amount, but in reality there are likely to be many more children at risk, as the numbers that we are able to access do not necessarily incorporate children and families where a parent might be on opioid maintenance or other types of treatment, and particularly parents that might be accessing needle and syringe programs and that type of thing. Again, those with alcohol issues would not be captured in those numbers.

Following on from that, we also have a few question marks in terms of not knowing which substances necessarily cause greater harm within families. So it is not possible to determine whether, say, parental amphetamine use poses a greater risk to children than parents using heroin. There are lots of question marks for us in terms of some of that.

Another thing that we wanted to raise was the extent of comorbidity issues in terms of

people accessing drug treatment. The results of the 2004 household drugs survey showed that two in five people who used illicit drugs in the past month reported high and very high levels of psychological distress. I know you are familiar with these issues in terms of dual diagnosis—that they are very common. It is important for us to talk about them as the norm, unfortunately, as opposed to the exception.

Interest in the development and wellbeing of children with substance-dependent parents has been growing, which is very exciting. Five years ago, we were hardly talking about these issues and now, for example, we are having this inquiry today. So that is very exciting. It is important to note that the literature that has emerged is still quite limited and is particularly limited in regard to the direct experiences of children, the young people themselves, in these families.

For us, a really crucial area is to talk about what the experiences of children and young people are. Although the scope of what you are looking at is nought to two, we know that drug and alcohol issues are long-term issues, that there will most likely be siblings in the family and, through the cycles of drug and alcohol issues that occur, it is important that we have a broader understanding of how these issues might affect other people within the family. Therefore, asking children and young people what their views are will help us to understand the needs of the family and the needs of the children in these families.

This is a complicated issue and one that can also get hyped up in hysteria. A report came out of Victoria called the *Nobody's client* report. That came out in 2004, and it was a bit of a ground-breaking report in Australia that looked at the experiences of children of parents accessing drug and alcohol treatment at Odyssey House in Victoria. That really sparked a whole movement in terms of looking at children and young people's experiences. One of the crucial things that was found was that not all children of parental drug users had major problems, and that approximately 55 per cent of the children had only minor emotional and behavioural problems. This was similar to most other Australian children.

Most research on children with substance-dependent parents assumes that parental drug use affects children's development negatively in three ways: by depriving them of adequate physical care; impeding their socio-emotional and cognitive development; and influencing them to become drug users. There is the associated expectation that specific services and particularly clinical services may be required for those children.

While this is the case for possibly many of these children, it is likely that the needs of children will vary depending on their circumstances. It is very important to note that a lot of children and young people show huge resilience within these contexts, and that developmental outcomes for children with substance-dependent parents are likely to depend on the dynamic and ongoing interaction and accumulation of multiple risk and protective factors.

For us, this is a really important issue: no one risk factor such as parental problematic substance abuse will necessarily lead to poor child outcomes. That is when we start getting into all the broader issues such as the social determinants of health, and how the risk factors tend to accumulate over time. I know you are quite familiar with a lot of these risk factors. It is important to note that in populations where there is parental

substance abuse, they have similar outcomes to families that might be in impoverished situations. So they are lacking some kind of core resources such as housing, education, employment and those types of social connections. Problematic drug use rarely occurs in isolation from one or more problems such as poverty, mental illness, violence and those types of things.

We do acknowledge that drug use alone is not a sufficient trigger for child protection mechanisms within Australia, but it does cause significant harm and neglect. We do have care and protection systems here in Canberra, and we do know that families involved in the care and protection system have high rates of domestic violence and high rates of drug and alcohol issues, sometimes in up to 50 per cent of cases.

That is of significant concern for us, because it then leads us to issues about the out-of-home care system, and what we are doing for those families. I note that a CREATE Foundation report card for young people in Canberra was lodged last week. We can send you a copy of that report, if you would like.

THE CHAIR: That would be fantastic, thank you.

Ms Fowlie: I can send you the other reports to which I am referring as well. That is a really important report that comes out every year. It was quite harsh in terms of its report on the ACT. It essentially said that the ACT is one of the worst performers in terms of providing support for young people as they are leaving care, compared to other Australian jurisdictions.

That is really significant, and does link in to this inquiry in terms of the types of support that we are providing for young people and children, and as they become young parents themselves, because once young people are in the care and protection system and go into the out-of-home care system, they are more likely to develop their own substance abuse issues. They are more likely to become young parents, they are more likely to be incarcerated and not finish school—all of those risk factors start to accumulate.

They are a really important group. By looking at things like providing support for young people after they have left care, that links in very well with this inquiry in terms of looking at the nought to twos and providing adequate support for that target group.

MS PORTER: Can I ask about the data. You said it was tricky; what did you mean by that?

Ms Fowlie: There is the national drug household survey that happens every four years. That is one of our primary sources in terms of data about drug and alcohol use in the broader population. That tends to be a mainstream type of picture of what is happening in the broader population. We then have other sources of data. There is an excellent web page on the Institute of Health and Welfare site on alcohol and other drug information. On that site you can access all of the different types of drug information that is available. We jump from that straight into treatment data. So there is a really big gap between what people are reporting in the general survey and then people accessing treatment. So we have got lots of question marks in between.

THE CHAIR: There are those people who use drugs occasionally and there are those people who use drugs and do not see it as being a problem; they just see it as being a way of medicating themselves.

Ms Fowlie: Absolutely.

THE CHAIR: And they have no desire to go and seek treatment.

Ms Fowlie: Absolutely. And this is particularly the case for young people. They tend not to seek treatment compared to all the counterparts. So this is particularly significant for young parents, young mothers having specific issues, if they have got drug and alcohol issues. Young people generally tend to be experimenting with drug and alcohol issues at this time in their lives. It is a kind of normal developmental type of thing. So when they become young parents, we need to be very careful and make sure that we have specific interventions there.

It is good to note that most youth centres run young parents groups to try and target those young people here in Canberra. There is a list of those young parents groups available through something called *The Big Red Book*, which is a directory of youth services here in Canberra. There is a young parents section in there which can provide information about some resources that are available.

MS PORTER: One of the themes that we have been hearing today is collaboration between agencies, both at the not-for-profit level and at the government level. Would you like to comment about that—whether it is good, bad or indifferent—ad the good bits about it and the bits that you would like to see improved?

Ms Fowlie: I think collaborations are crucial in order for there to be any effective interventions on this. We know that the effective interventions are family focused interventions that ignore all the people in the family unit, however that family unit is defined. There will be different parts of the service system that will need to come into play to support the different members of the family, as they will have specific needs. It is the responsibility, I guess, of the entire service system to step up and provide holistic family focused support, while acknowledging that different areas will have different aspects of expertise.

But there are some very simple ways in which we can, I guess, improve systems. Some of them can be in assessment forms, adding questions such as “are you a parent?” These are really simple tools by which this can be done.

I guess I would just like to note that Mental Health ACT went through a process with their children of parents with mental illness project, which is very important in terms of the overlapping in this. We did a project with them two years ago now to do something called the coloured kit, which is a care plan for children with parents with a mental illness or a dual diagnosis. That was a really significant partnership in terms of government, Mental Health ACT and non-government in the mental health and the youth sectors. There was complementing expertise in what we were able to provide and what we were then able to produce.

Mental Health ACT has subsequently gone and made this part of the induction process for all their staff. All their staff get trained in it. It is looking at care and consumer participation; it is looking at young people being part of finding solutions within the family, because young people are part of the family, and we need to acknowledge the significant care that they may provide within these families.

I guess it is also import to note in terms of young carers that historically young people in families where there was substance abuse were not considered within the definition of young carers. The ACT has been a bit of a leader in this area in terms of including that group in the definition of young carers. Some work, some research, that we did in 2004 in terms of young carers was one of the first times that that research had been done about looking at the impacts of parental substance abuse on young people and the possible care implications.

The very exciting news from that is that the Australian Catholic University at the moment is actually taking some of that data and doing further research in terms of looking at the implications and the care implications for young people. So that is very exciting and something that could inform you as well.

MRS BURKE: Also on the back of that—and you answered my first little bit of a question—I have got collaboration and partnerships, outreach and programs in focus. In terms of outreach, you might want to describe whether your coalition treats outreach as being critical or not, in terms of what you do for that cohort of people that we are looking at, and what programs and what focus within those programs would there be for single parents, single mothers with or without families attached, with drug or substance abuse problems, with children up to two years of age.

Ms Fowlie: We see outreach as a crucial part of service provision in terms of working with young people generally and working, say, with young parents specifically. There are lots of general types of challenges—catching the bus, getting the trolley on the bus, travelling across town and doing all those types of things, which is hard enough at the best of times. I guess they are particularly some of the challenges in terms of public transport and that type of thing, considering how large Canberra is, and I guess meeting young people within their environment.

One of the core principles of youth workers is working within their ecology and going to them and trying to create youth-friendly spaces. That is something that we would encourage with a lot of services that would be working with young people. There are some very good youth services that do outreach.

There is limited specific support for young parents. If you look in the big red book, you will actually find that there is now a young parent-specific service. It is actually mainstream youth services. They tend to be youth centres which are universal youth services with targeted support as part of it. They are running young parent programs. So it is fitting in with that generalist type of work.

MRS BURKE: Would there be a demand for that, though, if such a thing could be set up—a dedicated service—or are they all right doing what they are doing at the moment, just dovetailing into other programs?

Ms Fowlie: It could be about better coordination of services and existing services becoming more accessible and more user friendly, because a lot of issues that young parents have had are with the health services that currently exist. We had some new data come out actually the other day that the age at which women are having babies is going up and up. So there is this gap that is happening for young parents that is actually not as uncommon as we think.

I cannot remember off the top of my head, but I think it is something like 15 per cent of births are still to women under 25. I guess that grows, depending on the target group that you start to look at; for example, young people in care who have been in the home care system. It is things like looking at child and family centres and looking at how they are accessible to young parents, how they might be able to partner with youth services to enable young parents to access them and how we might be able to work with drug and alcohol services to support them to be more youth friendly and that type of stuff.

I think there is a great opportunity for partnerships within this and complementing skill sets. I guess that the greatest way to improve child outcomes is to support parents to seek treatment. Therefore, the treatment needs to be diverse and flexible and it needs to take into consideration the needs of children.

MS PORTER: One of the other themes that came through today is that sometimes young men or males—men in general but in this case we are talking about young men—may not necessarily reach out because they do not know how to express themselves, talk about what it is that is happening to them; therefore, in order to get attention, they may lash out and then get attention. It might be negative attention, but at least someone is taking notice of me now I am doing this thing, whatever it is.

Would you like to comment about the services that are available to young men who may be parents and whether or not they feel sidelined in that experience and whether or not they are able to reach out and you are able to support them?

Ms Fowlie: I guess generally there is a distinct lack of services for men in Canberra, and that is all men. The good thing about these services is that generally they work with people aged 12 to 25, and most of them are for young men and for women. So we have got that catch there until 25. But the minute they turn 26, there is a huge void for men.

That is very hard in terms of youth services. That is not paralleled in terms of services for women. There tend to be health services and women's services that you can transition into. That is not necessarily the case for men. That being said, also within the youth sector there is a lack of services for young men as well, particularly young fathers.

A lot of services are geared towards mums and particularly, I guess, the older mums. I think a young man of, say, 20 might feel a little bit uncomfortable going into a service that might be full of 35-year-old, middle-class women. So I think those are important things to note.

I guess that being said, what we do know about numbers in terms of drug treatment is

that more men access drug treatment than women. So there is an opportunity for men accessing drug treatment to actually look at parenting issues. Alcohol and other drug services can really harness those opportunities in terms of looking at that.

MS PORTER: Some of the witnesses have said today that one of the reasons that some of these young women or any other women may not seek treatment for their dependency is that they might be frightened that their child might be taken away or they might be referred to an organisation that might want to see the child as their focus and not them.

Ms Fowlie: Definitely, this is a hugely complicated area. Actually we conducted a consultation with young mums affected by alcohol and other drug issues a couple of years ago. It was probably four years ago or something now. I can send you the information that came from that. There were some key things that came out of that.

One was understanding the service system itself, because the system is hugely complicated. For someone that works in it all the time and spends a lot of time trying to map it out and build directories and maps and those types of things, I find it very confusing. Although we may know the difference between a statutory and a non-statutory service, to them they are all service providers. A lot of them said, “Things can be very complicated in terms of whom can I trust, what is their role, what is happening, why can I get one service from one person and another service from someone else.” These types of things are very hard.

I think also it is about how we engage with young people more broadly in terms of explaining the systems and explaining processes to them. So what we would consider best practice in terms of, say, making a child protection report, which sometimes needs to happen, with the young parents we should say, “Listen, I have some concerns in regards to this matter,” sit down with them, explain to them how it works, then make the report with them so that they understand the process and sit with them in a long-term, wrap-around type of way so that you carry them through the reporting process. Then there are not surprises, and they know what is coming. It those types of good practice principles that can really change the way that young parents, I guess, affected by substance abuse actually engage with getting support.

THE CHAIR: That seems like a good place to say thank you very much for appearing today.

Ms Fowlie: Thank you very much for having us.

THE CHAIR: No, it is our great pleasure. Once again, apologies if we appear to be in a slightly zombie-like state.

Ms Fowlie: Congratulations on making it through the day.

THE CHAIR: As you probably would have heard because you were here for the last lot of witnesses, we will send you the transcript for you to check for accuracy. We will keep you informed of the progress of the inquiry. We may yet have further questions which we will direct to you, if we can. We look forward to receiving those reports that you have talked about this afternoon. That would be fantastic. Thank you

again for your time.

Ms Fowlie: Thank you very much.

MRS BURKE: Maiy, if there is something you want to add post this, please feel free.

Miss Asize: This has been as much an educational experience for me as it has been for you.

MRS BURKE: That is good. Thank you.

The committee adjourned at 4.33 pm.