PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO CHILD PROTECTION SERVICES

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At Sydney on

Wednesday 6 November 2002

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The Committee met at 12.25 p.m.

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PRESENT

The Hon. Jan Burnswoods (Chair)

The Hon. Dr Arthur Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. James Samios
The Hon. Ian West

Justice ALASTAIR NICHOLSON, Chief Justice, Family Court of Australia,

Justice RICHARD CHISHOLM, Family Court of Australia,

Ms MARGARET HARRISON, Senior Legal Adviser, Family Court of Australia, before the Committee:

CHAIR: Justice Nicholson wants to deal with some matters that are confidential because they involve individual names and cases. We will do that at the end of the public hearing. Our first question is about an overview of the Family Court with particular reference to our inquiries into child protection and the role of DOCS.

Justice NICHOLSON: It is important to remember that the jurisdiction of the Family Court relates essentially to private law; that is, contests between individuals, usually as to the disposition of children—with whom they should live and whom they should see. So there is no real involvement of State or Commonwealth agencies in that process in the normal course of events.

The typical case will be a dispute between two parents, or perhaps a dispute between the parents and grandparents and sometimes other members of the extended family, but it is normally within those parameters. Where the court considers that there are certain factors that require separate representation for children, the court has power to make an order for that separate representation. That is organised through legal aid, who will brief solicitors or counsel to appear for the child. We have recently been developing quite extensive guidelines, which we are about to issue as a practice direction, as to what is required of people doing that sort of work. It is very important work, because it really is one of the few areas where we have a completely independent person telling us about the child.

The normal part of our process relating to children also involves one of our counsellors. It may be someone employed by the court who is a social worker or a psychologist; it may be someone employed on a contractual basis for this purpose. They will provide a report to the court, usually aimed at the relationship between the children and the parents, whoever the contestants may be. It is a specialist report that is intended to tease out, without necessarily asking the question, what the wishes of the children are. There are various other matters that are taken into account. They are very useful and they are very important.

I think it is also important to realise that these people are not employed as investigators as such; they are employed to prepare an evaluation for the court of the relationship between the child and the various people. If they consider there is a child protection issue, they will, of course, alert the court to it. But they come into the picture really at quite a late stage. Their involvement is shortly before trial. One has to remember that probably about 95 per cent of Family Court matters are settled beforehand. So as a child protection mechanism, their role is extremely limited.

The other way in which child protection issues arise is that under the Act the court is obliged to make a notification to State child protection authorities if an allegation of sexual or serious abuse of a child emerges. That often emerges on material that is filed in the court by the parties. However, it may arise during the course of confidential counselling. Although the councillor doing the evaluation comes into it late, the court process is otherwise to have an early intervention by a councillor/mediator, which is the confidential exercise. On those occasions there may arise an issue of sexual abuse. If that happens, the councillor is required under the Act to make a notification to the department.

Curiously enough, there is also a section of the Act that says that anything that is said in such a discussion is entirely confidential and cannot be used in any court. The Commonwealth is currently considering legislation to make an exception to that, at our request, in relation to situations where there is evidence of serious child protection issues, so that the confidentiality would be waived in those circumstances. I think that is very important.

We have had cases—in fact, one on appeal last year—which sparked this off. I have been in favour of some action being taken over this for many years. However, a recent case, without going

into all the details, led to a situation where there had been a disclosure of sexual abuse of a child during a confidential interview. It had to be excluded from the court hearing. Yet, for the case to the heard without knowledge of that allegation was really, we considered, a travesty, because the issue was whether that child had been abused or not. This was an alleged admission that had been made in the course of those discussions.

CHAIR: Are you saying that the court was actually aware, so the process is confidential to the court, so the judge is in the position of knowing something but not being able to deal with it?

Justice NICHOLSON: No. In that case, an attempt was made to introduce the evidence to the judge, and the judge was required, as part of that process, to understand what the allegation was, but he ruled that the evidence be called before him. That was tested on appeal before a full court, and that is how the matter came before us. Normally, but for that situation, it would not have seen the light of day at all.

CHAIR: You say the Commonwealth is considering amending the legislation, on the court's recommendation?

Justice NICHOLSON: Yes, it is.

CHAIR: Is that likely to occur soon?

Justice NICHOLSON: With legislation, you never know. We are certainly at the point of looking at drafts, but how long it takes before the legislation goes through is another matter.

CHAIR: Is any statistical information kept about the number of obligatory notifications made to State child protection bodies?

Justice NICHOLSON: We certainly do have those figures. I do not have them with me today, but if the Committee is interested I could provide them.

CHAIR: It has been put to the Committee that child protection issues are increasingly raised in contested matters. Evidence about the number of notifications indicates increasing percentages—

Justice NICHOLSON: Regarding the number of child protection issues that arise, in 1997 Monash University conducted a review of 700 cases awaiting prehearing conference in the Melbourne registry. At that time more than 40 per cent of those cases, which were child related, involved allegations of some form of child abuse. So it is a fairly high level. The same research found that if you looked at all the child applications, the allegations were only in about 5 per cent of cases. It meant that the 5 per cent of cases stuck on in the system much more than other cases did. I suppose it is not difficult to understand why, once you have child abuse allegations there.

That second study of the 5 per cent related to Canberra and Melbourne. Of the cases going to trial, about 25 per cent involved allegations of child abuse. As you can see, once you get to the trial stage it is a very significant part of the court's work. I will come to the Magellan issue later, but I think that gives some picture of it.

The other thing that is emerging—[refers to later in-camera evidence]—is that anecdotally we get information that solicitors are bringing proceedings in the Family Court because allegations of child abuse have not been acted on by the department, and the only way they can get the matter aired is by making applications in the Family Court in relation to them.

The Hon. JAMES SAMIOS: Your honour, in that regard, what is your view in relation to DOCS' willingness to have child abuse matters determined by the Family Court?

CHAIR: May I interrupt. Mr Samios, we just finished agreeing that you would ask your question when we got to question 4.

The Hon. JAMES SAMIOS: But his honour has just raised the point.

CHAIR: I am sorry. We have agreed that questions should have some sort of logical order. I will ask Justice Nicholson to continue. We have asked the question about child protection issues being raised and how these impact on the processes of the court. Of course, further down we are get onto the issue of the court's relationship with DOCS in New South Wales, and obviously the court can make comments about other States as well. For the moment, can we complete the detail about the way the court itself has been impacted on? We all seem to agree that there is an increase in the raising of these issues.

Justice NICHOLSON: So far as question 2 is concerned, I think I have probably said all I can say, in the sense that there is an obvious impact. There are many cases that involve child protection issues that are going on as contested cases.

CHAIR: One of the things we had in mind in asking this question is the suggestion that these issues are being raised not for good motives but for motives in relation to where the child becomes a pawn in a battle, so that there is perhaps a lack of bona fides in some of the child protection issues that arise.

Justice NICHOLSON: There are some, but I think that is exaggerated. Statements are often made that that applies to many cases. That certainly was not the effect of the Monash University study that was undertaken. Again speaking anecdotally, there are a minority of cases that fall into that category, but I would say it is a pretty small minority. My own experience has been that you get the one end of cases where the child abuse allegations are serious and are clearly made out; you have a middle range where, towards the bottom of the range, people are interpreting certain behaviours as child abuse which may not be abusive, but are doing so genuinely—in other words, they have a genuine concern. They are difficult cases.

Then you have somewhere between the clearly-made-out cases and those sorts of cases; you have cases where it is very difficult to determine whether abuse has occurred or not. The High Court certainly gave those some direction in a case in early 1990, where it held that the Family Court was not required to find that there had been an abuse of the child in order to make certain orders to protect the child. The test is whether there is an unacceptable risk to the child involved in making a particular order for a contact or residence.

In that particular case, the judge was left with serious doubts but was unable to find that there had been abuse. In that case the High Court's view was that you should, in effect, give the benefit to the child in that situation, and not take an unacceptable risk with the child. That is the broad picture as I see those allegations.

CHAIR: Question 3 relates to that decision. I do not know whether you need to give a personal view on this, but do you think the Family Court should be involved in any investigation of child protection allegations, or can it be involved? If it can, should it? Or should there be some other mechanism for doing this?

Justice NICHOLSON: I think you have to remember that basically we are a court, not an investigating body. Traditionally, courts do not conduct investigations of their own. So that looked out from a judicial point of view, I think the answer is clear. I suppose the issue is whether the counselling service should act more as an investigating body than it does. I think the whole structure of the Family Law Act and the State Acts do not support the view. Of course, our primary obligation once an allegation of abuse is made is to give a notification to the State department about it, not to investigate it ourselves, the theory being that the State department will conduct any investigations that are necessary.

CHAIR: And, in turn, will get back to be court with the result?

Justice NICHOLSON: Yes. That is where the problem starts to arise.

The Hon. JAMES SAMIOS: Your honour, what is your view in relation to DOCS' willingness to have child abuse matters determined by the Family Court?

Justice NICHOLSON: I would rather not answer that in a direct form. I am not trying to avoid the question, but my experience over the whole country, not just in relation to DOCS, is that the child protection agencies are not sufficiently well funded, I believe, to be able to deal with the full workload that they get.

Understandably, where there is a residence order and the child, so far as the department is concerned, is happy with that resident parent, the department tends not to investigate the allegations in relation to the contact parent. That is where a gap emerges, because the Family Court does not have the investigative capacity either.

The Hon. JAMES SAMIOS: And it should!

Justice NICHOLSON: There should be an investigating capacity by someone. Ideally the State departments would have the capacity to do that, if they could, because that is their function. If they do not do it, there is a gap and we become very concerned that we make judgments or decisions without information that we should have in relation to particular cases. At the same time we have a fairly limited capacity, using evaluators to look into those issues.

The Hon. AMANDA FAZIO: If you had a dispute about property before the Family Court, and conflicting evidence was given by the two parties, how would that be resolved? Would you ask for any other agency, or would it be up to the parties' legal representatives to try to sort out who owned what and who could claim what?

Justice NICHOLSON: In the final analysis the judge has to sort that out on the evidence placed before him or her, that applies in any other case. The problem is that if the judge does not have the relevant information, he or she is in some difficulty in producing the right result. Normally, in a property case it is a bit easier because the issue usually is evaluation or contribution, or something like that, and the judge relies on the evidence of the parties to make a decision.

The Hon. AMANDA FAZIO: What would a judge do if there were conflicting reports about child abuse allegations in a custody matter? Would the judge adjourn the case if he or she felt that there was not adequate information to make an informed decision on custody?

Justice NICHOLSON: The judge might try; but the problem is that a mechanism must be put in train by which that information can be obtained. That is very dependent upon legal aid funding being available. One thing that is done, and when we discuss Magellan I will refer to this further, is to ask the child's representative to obtain a psychiatric or psychological evaluation on particular matters in those circumstances. Whether that is done depends very much on the willingness of those funding the child representative to do so. In the final analysis, the court will not make a decision willy-nilly if it has a real concern about a child. Obviously, that occurs. I am more concerned about cases in which we do not know something that we ought to know about.

CHAIR: Question six relates to the shortage of legal aid. Given the relationship with the New South Wales department has been raised, can you comment on the way the court relates to child protection agencies in other jurisdictions?

Justice NICHOLSON: We have protocols with every State child protection agency except New South Wales about what should happen. However, there have been meaningful discussions with DOCS in relation to such a protocol. Justice Chisholm might like to comment on that.

Justice CHISHOLM: Currently, people in the Family Court and DOCS are discussing a draft protocol. It has been under consideration for a long time. I suspect it has been bedevilled by problems of resources as well as difficult legal questions; in particular, a protocol would require people to make a decision, at least in principle, about the circumstances in which they might intervene in Family Court proceedings. To be fair to DOCS that question is probably difficult to formulate, and expensive. I suspect that partly the reason that the protocol has never happened is that there are genuine problems about priorities and how DOCS should handle some difficult cases.

CHAIR: How long have protocols with other States existed? How similar are they?

Ms HARRISON: 1994 or 1995 I think.

Justice NICHOLSON: Protocols are not the complete answer either. You can have protocols, but someone has to look at them and they have to be updated and understood at all levels, not just by those at the top. I see some problems with them. I think they are a good starting point, but not the end point.

CHAIR: Justice Chisholm, would the resourcing implications you mentioned apply to the other States that have come to these protocols somewhat earlier?

Justice CHISHOLM: I am sure they do, and I suppose it depends on the protocol to how specific it is. It may be that it would be relatively easy to formulate a protocol that was in general terms and did not commit anyone to anything in particular. People might feel comfortable about having a protocol at the bottom of their second drawer.

Justice NICHOLSON: In relationships with other agencies, and it may be a product of size, I have always noticed that there has been a particularly good relationship between the court and the Northern Territory's child protection agencies. Usually the Northern Territory child protection department is represented at court not by counsel but by an officer when dealing with matters that have child protection issues. They will be of direct assistance to the court. Similarly, I have noticed that in north Queensland; again, in those smaller areas it is a bit easier to achieve.

CHAIR: That is not the practice in Victoria or South Australia?

Justice NICHOLSON: No, but it is a very good practice. How to achieve it is a problem.

CHAIR: Some people have expressed a view to the Committee that the shortage of legal aid in the family law area and the apparent reluctance of DOCS officers to be involved in matters before the Family Court contribute to a situation in which rulings could be made for children to have contact with parents who are abusive. You have mentioned that already. Do you have any comments to make on that assertion?

Justice NICHOLSON: Regarding the shortage of legal aid, I sound like a broken record; I have been complaining about that for a very long time, during the terms of two Federal governments of different political complexion. It definitely has created enormous difficulties in many cases. Probably one of the difficulties arise even when there is a professional representative of the child, or children, in the case, because there may not be representation of the parents. The parents may be inarticulate, or may not know what issues they should bring out. Often, when they do bring them out they may do so in a way that is so incomprehensible that it is difficult to know what they are raising and where it is going.

It becomes even worse when English is not their first language. I see that as a enormous problem. In fact, our reaction has been to try to develop better information systems for unrepresented people through web sites, documentation, translation, and so on. That helps, but, of course, we cannot turn a person into a lawyer by supplying information. Once they get to the crunch point it is very difficult for them. Suggestions have been made that perhaps there may be a move towards a more inquisitorial system in family law matters, simply because we cannot do justice to people if we cannot find out what their case is about. It is an enormous problem, and I am sure it has its implications on children.

In response to the second part of your question, that is a reluctance on the part of DOCS officers to be involved in matters before the Family Court, I cannot speak of that personally. Normally departmental material comes before the courts on subpoena and then the officers attend. In my experience the officers are quite helpful when they attend, but their involvement is brought about by the intervention of someone subpoenaing them, not by any direct involved. Justice Chisholm may care to comment.

Justice CHISHOLM: In my experience, the most common form of interaction is simply that DOCS files turn up in court on subpoena, and they are available to the court. People make submissions and direct our attention to particular notifications and entries. That is very valuable.

CHAIR: The files turn up, but no person goes with them?

Justice CHISHOLM: Correct. Normally, people only want the files. Normally, a subpoena is issued to DOCS asking for files to be reported, and there they are, and people make a great deal of use of them. In my experience, it is very uncommon for a person from DOCS to give evidence. I do not recall that happening in my court. In theory it would be possible, I suppose, to subpoena the individual DOCS officers who wrote the files entries, but I have not heard of that happening.

Justice NICHOLSON: There is a difficulty with that too; often, different officers are involved over time. I have had the officer in charge of a case being present, and that happens in the Territory and in Tasmania, the smaller jurisdictions.

Justice CHISHOLM: I apologise if this is already known to the Committee, but the legal arrangements are such that DOCS have a choice of jurisdiction. The provisions of the two pieces of legislation result in the Children's Court orders prevailing over any Family Court orders. There is nothing to stop DOCS from going to the Children's Court and getting orders or exercising its powers under its legislation. That is fully protected by the Family Law Act. Anything we did, or attempted to do, could not trump whatever DOCS does. That is very clear, and has been a feature of the system for a long time.

That means that if DOCS does not like what it happening it can either intervene in the Family Court or leave the Family Court alone and bring proceedings in the Children's Court. It is possible for DOCS, if it did not like the outcome of a Family Court decision to not appeal, or not be involved at all, but to then go to the Children's Court and ask for an order that in effect reverses the Family Court outcome. That is a matter for DOCS to decide, but as a matter of power it is quite clear that it can do that. I understand that it has happened from time to time.

CHAIR: Hypothetically is it common for DOCS to take that action?

Justice CHISHOLM: I am not talking hypothetically; I understand it has happened. I would not necessarily know, I suppose. If I am the judge who decides a case and I make certain orders, and if people go away and do not come back, DOCS may go to the Children's Court and have it make different orders. That would not necessarily come to my attention. We do not have any systematic information about how often that happens. It has happened on occasion.

Justice NICHOLSON: That is not normally a desirable outcome; to have the same issues litigated in two courts, but it has happened. Fortunately, it has not happened very often. I do not have any figures on that but I know that there have been discussions in Victoria between the department and the court to try to avoid that occurring. It places enormous strain on people and their funds to have to go through allegations of child abuse in two different courts and have the usual cross-examination. If you get inconsistent results it does not say much for the system, either way. Clearly it something that is open for DOCS to do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It has been put to the Committee that your court is mainly involved in sorting out disputes between adults, and that it is not really equipped for children. That is a problem. It would be better if matters that involve children were referred. What do you say about that?

Justice NICHOLSON: I would not accept the criticism of the court that it is simply involved in disputes about adults. I think this court has become much more child focused than it ever was in recent times. By and large, although people are not always happy with what happens to children in any court in terms of their disposition, I think we are able to handle that quite well. I think our system of evaluating—and I am not talking about child abuse here; I am talking about the general run of cases where it is considered to be appropriate for a child to be with one parent or the other—is working as well as anywhere else in the world.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But your court is adult-focused and the Children's Court is child-focused.

Justice NICHOLSON: I do not agree with that. I do not accept that because all of our decisions in child areas have to be made in the best interests of the child, not the adult. In fact, one of the things that the court gets criticised about frequently by pressure groups is that we do not take into account the "rights of parents" sufficiently because we are concentrating on the rights of children. Frankly, I do not mind those sorts of critic isms. I prefer to concentrate on the rights of children and try to get the parents' rights and responsibilities to fit in with that.

CHAIR: Justice Chisholm, you mentioned the way in which the court gets DOCS files, and that people are able to go through them and so on. Various people have expressed criticism to the Committee about the inadequacies of DOCS information systems, files and so on. You seem to suggest that the court subpoenas the file, the file arrives and the information in it enables the court to come to a satisfactory decision. I thought I should ask you about that matter, given the rather unflattering kinds of comments made by many people about the state of DOCS information systems.

Justice CHISHOLM: My comment was essentially that we get the DOCS files, and they are very useful. Of course, we do not know how complete the information in the files is. It is often very useful because the material may be inconsistent with what people say in their evidence. Sometimes, if somebody says, "No, I have never complaint to DOCS about X" and there are 17 different complaints recorded in the DOCS file, that can be very useful evidence in deciding who to believe. Similarly, there is a lot of valuable information, but I cannot say whether it is complete or whether DOCS should have investigated things more thoroughly from that sort of material.

The Hon. IAN WEST: Do you find consistency in the documentation?

Justice CHISHOLM: In the sense of coherence within the DOCS files?

The Hon. IAN WEST: Coherence, and the way they are presented. Is their process consistent?

Justice CHISHOLM: For my part, I find that often the DOCS files are voluminous and have quite a lot of repetition. Quite often, the same document gets copied many times. You turn over the page, and there it is again. But, in the context that the people preparing these documents, I assume, are busy caseworkers who are flat out and doing their best to record things as they go along, my own view is that the records are very helpful. I would not argue that the records are manifestly inadequate, on the basis of those that I have seen. Often, I find that the material distinguishes appropriately between what people say and findings. The DOCS records often say, "So-and-so rang up and said this." Then it is clear whether the officer accepts that is likely to be true, or not true, or there is some comment on it. So I find them useful. Whether they could be improved, and whether there is not there material that should be there, are not things that I could say.

The Hon. JAMES SAMIOS: Justice Nicholson, can the court compel a State agency—for example, DOCS—to conduct an assessment of a child at risk?

Justice NICHOLSON: No.

The Hon. JAMES SAMIOS: It does not have the power?

Justice NICHOLSON: We have no power. When I come to discuss the Magellan matter—which I think is the next question—I will deal with that, because that is a co-operative effort, and it has worked very well.

CHAIR: Shall we get on to Project Magellan? We have asked you about objectives, elements and the evaluation of Project Magellan, and whether it should be used more widely.

Justice NICHOLSON: If I could go back a step. I have already mentioned the 1997 research that led us to look at ways of better dealing with these cases. We then took 100 cases in Melbourne and Dandenong registries. We did not actually comb the files to get that, as someone said in evidence. We decided to take new cases where there were allegations of child abuse and deal with those promptly in this particular way, because the others were already bogged down in the system and we did not think that would be a fair test of how to deal with them.

Basically, the Commonwealth agreed to remove the legal aid cap from the cost of child representation. Normally, there is a cap of I think $15,000 or something of that order in child protection cases given to the child representative. The Commonwealth agreed not to apply that cap. It also agreed that if the parties otherwise qualified for legal aid, it would similarly remove the cap from them. It did not mean that everyone was represented, but it meant that those who were represented were able to proceed on the basis that the rug would not be pulled out from under them halfway through the proceedings, as sometimes happens.

The whole concept was dependent upon co-operation between that contribution by the Commonwealth and its instructions to its Legal Aid Commission in relation to that. It was dependent also upon co-operation between the court and the Victorian State equivalent to DOCS, together with the police, who also are involved. There was a steering committee consisting of a judge and representatives of the State department, legal aid and the court, in terms of registrars and counsellors. The whole concept was that these cases would be called before a judge—and I think something like five weeks was the idea from the time the allegation was made; and that the judge would hold a case conference and give directions, which would involve a request to DOCS to investigate the allegations and produce a report within a particular time. I am using DOCS for convenience, but DOCS were very co-operative and did that. They produced very useful reports.

CHAIR: In other words, everyone agreed to speed up the process and cut down the normal delays?

Justice NICHOLSON: They did, and also to do it, because until then the Victorian department was not necessarily acting on these notifications. In these cases it agreed to do the assessment. The matter would then come back before the same judge. So it was not a very complicated process. It is really a case of co-operative case management of these sorts of cases. If things had not been done, the judge would ask why they had not been done, and certain pressures would be put on the parties to act. There would be a child representative appointed in each case, and that child representative would obtain psychological or psychiatric reports, if they were necessary. That was all done as part of a co-ordinated project.

Effectively, in terms of outcomes, the reduction in the time taken to achieve a resolution came down from 18 months to nine months, on average. The number of cases processing to a judicial determination came down from 30 per cent to 13 per cent. The breakdown of the final orders that were made reduced from about 37 per cent to 5 per cent. And there was a reduction in the number of actual court events from five to three. So that, generally, we regarded it as a pretty significant result. It has been independently evaluated, and that evaluation supported that proposal.

I am very anxious to start it off in various States. I held a very useful meeting in Sydney in, I think, July which involved legal aid representatives, Commonwealth representatives and someone representing all of the State departments. There was pretty general enthusiasm for doing something along these lines. The thing currently holding it up is that the Commonwealth has not yet committed itself to making the same concessions about legal aid as it did in the experimental area, and the State legal aid commissions are therefore not anxious to commit themselves financially without the Commonwealth approval.

CHAIR: From the trial, did it turn out that the removal of the caps meant a massive increase in the legal aid funds?

Justice NICHOLSON: No.

CHAIR: Presumably, if the number coming to court dropped, it may well not have been an expensive project.

Justice NICHOLSON: It was not. There was something of a dispute—not a major dispute—in this sense: that the independent evaluation actually claimed there were very substantial financial savings involved in this process. There certainly were in terms of court time. There is no doubt about that. Victorian legal aid said it was more of a break-even situation. However, it still supported doing it. It said it was not as convinced that there would be substantial savings involved in it.

CHAIR: Did the Victorian equivalent of DOCS have any comment about whether it was more onerous for it in resource terms?

Justice NICHOLSON: I think they did. Perhaps Margaret Harrison might like to comment on that particular issue.

Ms HARRISON: Initially there was some concern because before Magellan they were filling out a very short form that had boxes which they ticked or crossed. We were asking for more information. But I think as they got engaged in the process, realised that cases were settling, and settling earlier, and that there was more co-operation, they really got quite enthusiastic by the end of the project. I gather, anecdotally, that the Victorian reports, where Magellan is not proceeding, are more detailed than they had been before. So they are finding it useful. Of course, they had the information in their files, but they were not necessarily always putting it together for the court. So it was not such a massive investment of time for them as they might have been concerned about at the beginning. We also found that some of the most difficult cases were the ones that had already been through the Children's Court and were relitigated in the Family Court.

CHAIR: This is out of the 100 "new cases"—that is, cases new to the Family Court?

Ms HARRISON: Yes, that had already been through the Children's Court. They were the most expensive, and they were the most vulnerable children.

Justice NICHOLSON: I think it is fair to say that this did not actually shorten the cases that went to court, because they were still just as complicated as many of these cases can be. But there was a reduction in the numbers. Also, the resolution of these matters seemed to stick better. I think one of the crucial aspects was the investigation, because it gave all parties a pretty clear idea of what the findings had been. Add to that early obtaining of psychiatric reports. Of course, our counsellors would still evaluate in these circumstances as well. So they would co-ordinate with the State authorities. It was just a much better co-ordinated system. I think it works much better for child protection than anything we have had.

The Hon. IAN WEST: I thought the evaluation showed a 50 per cent reduction in legal costs.

Justice NICHOLSON: It did. Legal aid was not quite as convinced about that, but they were still happy to say it did not cost them any more.

CHAIR: So, just to complete the question, do you think it should be used more widely?

Justice NICHOLSON: Indeed.

CHAIR: In terms of the barriers at the moment, the Commonwealth presumably is worried about a cost blowout in legal aid. Are there any other barriers?

Justice NICHOLSON: I do not think there are any other barriers. In fact, we were proposing to pick Parramatta as the most suitable site to run the first program in Sydney, given the nature of the population of the area and the number of child abuse cases that arise there. I have a judge all ready to go on that.

CHAIR: And DOCS is co-operative?

Justice NICHOLSON: Yes. When I say "co-operative", I have not taken it as far as that, but a few weeks ago I had a discussion with the Minister, who was very interested in the proposal. I went to see her to explain where we were and to seek support. I am hopeful. I have no reason to think it would not be forthcoming. I think her concerns, which are reasonable, were what sort of a commitment in terms of resources it would involve. But, beyond that, I think it was quite a co-operative discussion.

The Hon. IAN WEST: Magellan was 1998?

Justice NICHOLSON: It ran through 1998.

The Hon. IAN WEST: I understand there was also some project in Western Australia in 2001?

Justice NICHOLSON: That is different but it is based on Magellan. I should explain that the Family Court of Western Australia is quite independent of the Family Court of Australia for historical reasons. Following on from that, it set up a program, which involved not only sexual and child abuse allegations but also serious violence. They have not as yet evaluated that, but I am very interested to see how that goes.

The Hon. IAN WEST: There was a pilot in Brisbane.

Justice NICHOLSON: We conducted one there but we used a different technique where we were using cases already in the system. We found that this was not as effective a method of dealing with those as taking the cases from the start, simply because the matters have already gone beyond the early intervention techniques and people were locked into position, so it was much more difficult to deal with them. It did actually improve the handling of those cases. It was not a complete failure but it was not as effective.

The Hon. JAMES SAMIOS: If the lawyers are bringing Family Court proceedings because they cannot get DOCS to intervene, what does that tell us about what is happening at DOCS and what will be the impact on the Family Court? Is it effectively creating family conflict where there may be none?

Justice NICHOLSON: I do not think it is creating family conflict where there is not any. As I understand it, the reason the lawyers are bringing the cases to the Family Court is that there is an allegation of child abuse, which is not being dealt with by anyone and, therefore, they are using the Family Court as, in effect, the last resort to try to get someone to look at the particular problem. That is how I understand it is put, not that the court or the lawyers are seeking to promote a dispute. It is simply that the lawyers are looking for a way—

The Hon. JAMES SAMIOS: To resolve the situation?

Justice NICHOLSON: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously, part of that resolution is that the two parents, by definition, are brought into conflict?

Justice NICHOLSON: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Whether that would have been without the need to get some action for the child, presumably they would not have been too happy if one were alleging the other is abusing the child?

Justice NICHOLSON: No. You have a conflict anyway usually and the conflict would be if DOCS investigated and took proceedings in the Children's Court; you would have a conflict there. I do not think either way avoids the conflict. I am more concerned with the fact that there is not early enough action in relation to the children involved.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but they would have to go to litigation to get the cutting edge rather than it being settled out of court?

Justice NICHOLSON: Yes, that is true—not necessarily, because many of these cases are settled out of court once they are brought, and we encourage that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So your suggestion is that it does not actually make much difference. It is in your court rather than the Children's Court?

Justice NICHOLSON: Not so much that it does not make any difference because it is in our court. I think it does because we do not have the capacity to call on DOCS to produce a report. We can only do that by co-operation. The Children's Court can require a report, so there is a big difference there. The Children's Court's function is directly with the protection of children. I would much prefer these cases go to the Children's Court. I think it is more appropriate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is suboptimal if they do come to you by the mechanisms suggested?

Justice NICHOLSON: Yes.

The Hon. JAMES SAMIOS: What is the impact on your resources?

Justice NICHOLSON: Obviously, we just have to make people available to hear these cases and do the best we can with it. That does not just include our judges and judicial registrars, of course. It includes counselling, mediation staff and others.

The Hon. JAMES SAMIOS: So your resources are stretched?

Justice NICHOLSON: Yes. They are always stretched but they have to stretch a little bit further.

CHAIR: The Family Law Council recently issued a report suggesting the establishment of a Federal child protection agency. How would that affect the work of the Family Court?

Justice NICHOLSON: I think it is a very sensible suggestion. Whether it comes to fruition, obviously, is in the hands of those who hold the purse strings, but I think it would overcome some of the problems that we have been discussing today. I think one could even look broader than that and say that child protection is a national issue and should be treated as such, including court systems, child protection agencies and the like. But that always has its difficulties. It is a very long-term view of these things. Certainly, there is a move in the United States towards what are described as unified Family Courts, which would carry out all of the functions of the Family Court of Australia, together with the Children's Court, in one organisation/. I think that is probably the way of the future, but I think it is a long way in the future.

CHAIR: It sounds like it would need major constitutional revolution.

Justice NICHOLSON: Almost, yes. I did not want to minimise it, but if one is looking at the ideal, that is where one would go. Justice Chisholm might like to say something. He has recently retired as a member of the Family Law Council.

Justice CHISHOLM: I would only add two things. First of all, the Family Law Council's report suggests that the to-be-created Commonwealth agency would supplement the work of the State departments and not displace them. It would essentially respond to a request from the Family Court and would not duplicate. Quite a lot of thought has been given to how the new agency would fit in with the existing agencies. The other point I would make is that it is a very well-written report, in my view. It is very clear and illuminating. Even if people did not agree with the end result, it is a good read.

CHAIR: We have a copy. My next question relates to suggestions by the Family Law Council in relation to the one-court principle, specifically the practical reforms that are necessary for that principle to be realised and the current relationship between the Family Court and the Children's Court. Is this the revolution, is it?

Justice NICHOLSON: Not really. I simply took the opportunity to say that when one is looking at these sorts of issues, the really broad issue would be to look at one system. So far as the one-court principle is concerned, it is a very sensible suggestion. Really, if proceedings in relation to a child are commenced in one court, that court ought to continue to deal with it. Hopefully, the Family Court, for example, might have some child protection powers if a case is before it and similarly in the State courts, the State courts would exercise Federal jurisdiction if the matter started off there. It

seems to me that there is a lot to be said for that. It means you do not have people being battered between different jurisdictions over different issues. It makes a lot of sense.

Justice CHISHOLM: Absolutely. The report proposes a mechanism to try and identify at an early stage which court it is going to be for this case and then adhere to that. It seems to me that is an idea that is well worth pursuing.

CHAIR: Many at the cases we are talking about appear many times in either the Family Court or the Children's Court. They are not just a one-off. How would such a proposal cope with matters that may come back before either court over a lengthy period of time within one family or about one child?

Justice CHISHOLM: I do not know and one could not necessarily give a cast-iron guarantee that a case that they decided would be in the Family Court would never again come before the Children's Court, but the sort of plan that the report envisages is that all the relevant players would be consulting very early on about which was the appropriate court. If that sort of consultation remained in place, if there were a new development, the same people would be saying, "Okay, can we handle this new development in the same court" and only if there were some insuperable difficulty would they, I assume, agree to the matter popping up in a different court. As the Chief Justice says, if we equip both courts with powers to make orders that we think of as being the other court's powers, then in a sense it may not matter all that much which court the matter starts in, and perhaps it could be pursued in that court. No matter what happens, that court could deal with it.

CHAIR: At the moment is the relationship between the Family Court and the various Children's Courts nil and do they operate absolutely independently without any formal relationship at all?

Justice NICHOLSON: I think it is fair to say yes to that, probably because neither court has any control over who chooses its jurisdiction. In the case of child protection that is normally DOCS so in the case of the Children's Court—that is not to say that we do not talk to each other in a sense. There was a very successful international conference held in Melbourne last week which involved both child protection and Family Court issues and that was a very productive exercise. People attended from all over Australia and internationally but there is not a formal relationship between the courts as such.

Ms HARRISON: There is a bit more where there is a protocol.

Justice NICHOLSON: Yes, there is a bit more where there is a protocol. I think it is a good idea.

CHAIR: To work on increasing the relationship?

Justice NICHOLSON: Yes, I would like to develop it more.

CHAIR: Did you wish to say something, Margaret?

Ms HARRISON: I was just saying that in the State and Territories where there is a protocol, that relationship is a bit closer because there is interrelationship between the officers at different times.

CHAIR: What does that mean in practice?

Ms HARRISON: Transfer of files, suitability of certain matters for certain jurisdictions, provision of information. It is tighter there, but it is not necessarily close.

CHAIR: When we talked to the Children's Court people they made comments about their relationship with DOCS, DOCS files and so on. It would be true to say, therefore, that in New South Wales without such a protocol it is DOCS that is responsible for bringing the two courts together through its files and its knowledge that one child may be involved in both?

Ms HARRISON: Yes.

CHAIR: Do you have any other comments to make about how the child protection system could be improved in New South Wales and what would you like to see come out of this inquiry?

Justice NICHOLSON: So far as child protection is concerned—and it is not confined to New South Wales but it includes New South Wales—we just do not spend enough money as a community on child protection issues. We have to have better trained, more child protection officers. It is a very difficult job to perform. It is one of the really hard jobs in the community and they need more support than any current State or Territory government gives them. If we are serious about looking after our children, it is a pretty important thing to do.

CHAIR: I do not know whether you have had a chance to look at our interim report and our report on another inquiry we are doing, but we have strongly recommended that as a community and as a government we try to shift our focus as much as possible to prevention and early intervention as, in the end, the most effective as well as cost-efficient way of preventing problems happening. Do you have a view on that broad issue?

Justice NICHOLSON: I have no disagreement with that all. That is entirely sensible.

CHAIR: The Family Court would be happy if problems did not get to the Family Court?

Justice NICHOLSON: Indeed, yes. It is a very sensible approach, which should be adopted.

CHAIR: Do you have any other suggestions other than more money?

Justice NICHOLSON: It is a bit more than more money. What I would really like to see is the whole idea of people working in child protection being treated with more dignity and respect, and the job being recognised as a much more significant job in the community. I think the same perhaps can be said of Children's Courts. The direction in South Australia and Victoria of having at least the head of the Children's Court a judge at the District Court level is a good way to go, but it considerably improved the Victorian Children's Court.

CHAIR: Because of the increased status?

Justice NICHOLSON: Yes, and with a judge heading the court, she is able to direct more attention and get more notice taken of court problems.

The Hon. IAN WEST: Does that also relate to practitioners within the system who seem to be considered the lower end of the profession?

Justice NICHOLSON: I think there is probably a bit of that in it too. That is what is quite likely. I think again the importance of children's law has got to be better recognised. If you look at England, for example, when they passed the Children Act—talking about the judicial side of things—their county district court equivalent judges deal with these issues, but to deal with child protection you actually have to have a special warrant to do so. So it was regarded as a prestige job to do it, and I think that has got some merit.

The Hon. JAMES SAMIOS: Your honour, under the current system if lawyers are referring cases to the family court where DOCS cannot or will not act to protect children at risk of harm, can you order a child to be cared for by DOCS, that is, become a ward of the State?

Justice NICHOLSON: No, we cannot.

The Hon. JAMES SAMIOS: Is your court not limited in what it can do as to a placement of the child?

Justice NICHOLSON: Very much so.

The Hon. JAMES SAMIOS: The preparation of pleas and restoration plans; in other words, the concepts under the Children and Young Persons Care and Protection Act?

Justice NICHOLSON: There is no doubt about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So how do you overcome that?

Justice NICHOLSON: You cannot. We are sometimes faced with the situation where we do not want this child to go with either of these parents; we are very concerned about it one way or the other, but we have no powers to do much about it.

CHAIR: Given the lack of powers, that must surely limit the extent to which these lawyers were talking about going to the family court. If the lawyers presumably know that they cannot get the various things we have just ruled out, in one sense what is the point of going to the family court?

Justice NICHOLSON: The more usual situation is that one parent may be the best of two not very satisfactory alternatives, and at least they can achieve that.

CHAIR: The lawyer is also representing one parent rather than the other, so there is a very adversarial choice being made as well?

Justice NICHOLSON: There is indeed, unless of course the lawyer is representing the child.

CHAIR: I just wonder, given the fact that to all these questions your answer has been "We do not have the power", whether there is any incentive for a sensible lawyer to go down the family court path rather than another path, if the interests of the child are the things that are paramount.

Justice NICHOLSON: I was going to suggest that this particular lawyer I was speaking to about this would probably be more than happy to speak to you. I think those questions might be better directed to her because lawyers are dealing with these cases on the ground.

CHAIR: We should try to do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What reforms would you like to fix this?

Justice NICHOLSON: I think, going back to the Family Law Council report, the concept of the family court being able to make protective orders is something that would be one way of doing it. I have had, interestingly enough, some experience of this in a Queensland case under the old cross vesting scheme. The Supreme Court of Queensland referred a case to the family court involving two children so I sat hearing for the protective jurisdiction of the Queensland children's court as well as the family court jurisdiction. It was a much more satisfactory way of dealing with a difficult case involving child protection issues and to actually make protective orders with family court orders to take over after the protective orders had ceased.

CHAIR: If members do not have any more questions broadly, we agreed earlier, at the request of Justice Nicholson, that we have a short private hearing because there is something he wants to raise with us which involves named individuals.

(Evidence continued in camera)

LOUISE KATHRYN NEWMAN, Child and Adolescent Psychiatrist, New South Wales Institute of Psychiatry, and Chair, Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatry, 5 Fleet Street, North Parramatta, affirmed and examined:

CHAIR: You have a summons to appear before us and you are conversant with the terms of reference?

Dr NEWMAN: Yes.

CHAIR: Please tell us about your various roles in relation to child and adolescent psychiatry as they relate to the child protection system.

Dr NEWMAN: There are several interrelated roles and functions that I perform. Obviously my role in the College of Psychiatrists is to chair the Faculty of Child and Adolescent Psychiatry, which represents all the child psychiatrists in Australia and New Zealand. In that capacity I am informed about any issues or concerns that people may have about clinical issues and the functioning of the child protection system. I have been involved in several such discussions recently in New South Wales. I am also the Chair of the New South Wales branch of the College of Psychiatrists. So, in an official capacity I would cover both child and adolescent psychiatric issues.

I am the director of the New South Wales Institute of Psychiatry, which is a teaching and training body. We are responsible for the training of all psychiatrists and child psychiatrists and other mental health professionals in New South Wales. We also have some programs interstate and overseas. In that role I have been involved in the design and implementation of training courses for a range of mental health professionals and professionals working within the child protection system. So, we have been involved in the development of a course in infant mental health and also training in parenting capacity assessment, risk assessment for both child protection workers and others.

CHAIR: Which we will get onto more specifically further in our questioning.

Dr NEWMAN: Yes. Prior to working in my current position I was the Director of Paediatric Mental Health in the South-West Sydney Area Mental Health Service, where the majority of my work would have involved child protection cases, given that that is an area of considerable social disadvantage and many high-risk families. That is my direct clinical experience working in child protection. I am also conducting research into the prevention of child abuse, which is my main area of academic interest.

CHAIR: It struck me while you were talking, do child psychiatrist have any training in child protection issues?

Dr NEWMAN: Yes, they do. What has become apparent in public sector services particularly is that that is a major focus of the work of child psychiatrist.

CHAIR: We talked to the AMA yesterday and it became very clear that that is the case.

Dr NEWMAN: As part of our curriculum we have a clear component on child protection and also focusing on the medico-legal responsibilities of child psychiatrists, but their clinical role in both identification and prevention of child abuse is interventions for identified cases of maltreatment, and as part of the training we have been familiarising our trainees with the functioning of the legal system so they do attachments and visits to Family Court, Children's Court, and so on, and to child protection units.

CHAIR: When you refer to the large percentage of your work when you were working in south-west Sydney as a child psychiatrist involved in child protection, I guess that is probably a growing percentage. Are children referred specifically because of child protection issues or, for instance, in another inquiry we know that children with learning difficulties will often see a paediatrician or a child psychiatrist, if not both. Are we talking about a situation where child protection issues go along with other issues for lots of children or are we talking basically about the massive referrals for child protection issues per se?

Dr NEWMAN: I think it is fair to say that child protection issues are involved in a vast majority of cases that any child psychiatrist or a child and adolescent mental health service would see in a disadvantage area. That having been said, there are several routes of referral or referring questions. Occasionally children would be referred directly for an intervention program if it had been already established that they had experienced maltreatment. That might be working with primary carers. If the child was to remain in that situation it might be working with alternative carers, depending on the scenario.

The very common issues facing child and adolescent mental health services that are the most common reason for referral to those services would be disruptive behaviour of whatever sort—a child who is having difficulty in school or at home. Many of those children would receive elsewhere a diagnosis of attention deficit hyperactivity disorder, because that seems to be probably the most common diagnosis given to that syndrome. In many cases, I would think, after a more comprehensive assessment it becomes apparent that some of the issues for those children might well relate to maltreatment or parenting disturbances of various sorts. It is more a process of uncovering child maltreatment if that had occurred.

Part of the tension within services and working between public sector child and adolescent mental health services and the department has always been this question of whether child and adolescent mental health services are there to offer a service in a direct way for the Department of Community Services. Many referrals might have been made to services requesting an investigation or a report, and the experience has been that some of the services have not seen themselves as offering that, not seeing that as core business.

CHAIR: Because of the ethical issue?

Dr NEWMAN: Largely because resourcing and clinical services see themselves established to provide clinical care. Not being the first to provide appropriate reports in the context of that but not necessarily seeing themselves as a report or investigatory body. That, I think, for most child psychiatrists would be a constant source of tension in how the system operates.

CHAIR: You have probably partly answered our second question. That issue just struck me listening to your description of your career. You have mentioned disadvantaged families in some areas but we are interested in how mental health problems, drug and alcohol abuse and its effects, and so on, impact on families and parenting, and then related to that if it is possible to talk about the typical way families come into contact with the child protection system.

Dr NEWMAN: There is some variation across areas. In the most disadvantaged areas we frequently see families who already have contact with multiple agencies and health providers of various sorts. They can be some of the most problematic families in engagement and doing a comprehensive assessment. They have already traversed numerous systems and are identified by many systems as difficult to engage—families often with multiple problems, compounded by social disadvantage and such, a lack of basic resources, and so on.

Part of the difficulty for those families is that psychiatry and mental health are seen as a last resort: when all else fails call in the mental health service or the psychiatrist. You have often got very established, complex problems for children in those families. It is well known to the child protection service that these are very problematic families and that probably these children have already experienced maltreatment and developmental problems relating to that. One of the tasks then becomes to sort out who co-ordinates in a more efficient way the care of these sorts of children and families and where they should be and who should provide a service. With a complex system like that there is always a risk that some families will fall between different agencies. That is being addressed at a cross-departmental level at the moment by Health, Juvenile Justice and Education having a fairly high-level forum that I am involved with currently to look at these very vulnerable children and families and why they are falling between services and the lack of effective co-ordination happens.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is ADHD overdiagnosed, with the corresponding lack of understanding of social factors, because of parental pressure? I gather that the incidence of this disease, so-called, as diagnosed has gone up astronomically in the last few years.

Dr NEWMAN: Yes, there is certainly concern about the increasing rate of diagnosis and particularly the rate of prescription of psychostimulants and other drugs for children.

CHAIR: As I mentioned, we are doing an inquiry into early intervention for kids with learning difficulties. We are in the process of preparing a final report.

Dr NEWMAN: Yes. The Faculty of Child and Adolescent Psychiatry has just put together its position statement on this. We are certainly concerned about overdiagnosis. We are not disputing the existence of that cluster of problems in children. Many children present with that group of difficulties and certainly need some intervention. Our concerns are that in a way it is using a medical label in a rather reductionist or simple way and that there are many pathways for getting to that group of difficulties, some of which may well be specific neurological problems, but probably more commonly would be the whole group of social and family factors. So it is not surprising that you see very high rates of diagnosis of this sort of problem with associated disruptive behaviour disorders in very disadvantaged areas where you have many other social factors impacting on parenting and people's parenting capacity but particularly family breakdown, relationship breakdown, child abuse and maltreatment, substance abuse and so on—that clustering of risk factors. All those things can equally cause the difficulties that these children present with. So we have concerns about premature, if you like, diagnosis and use of medical labels because in a way that then prevents further exploration of the situation the child is actually in.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Theoretically, presumably, if it was a medical condition it would be diagnosed with the same frequency across all social groups. How much is it actually raised in these disadvantaged groups, by what sort of factors?

Dr NEWMAN: I cannot give you exact figures but in New South Wales the rate of diagnosis and prescription is highest in the outer metropolitan fringe—Liverpool, Campbelltown, those sorts of areas—and rising there. Part of the difficulty is that in social disadvantaged areas there are increased rates of disruptive behaviour disorders, conduct disorder and oppositional defiant disorder anyway and it might be that some of those children are being given the diagnosis of attention deficit disorder. So that might elevate it. A group of, largely, paediatricians who work in those areas are under increasing pressure, if you like, to provide a solution to very stressed families and schools around very difficult children. They may be quicker to diagnose than some others. But that is not to say that the diagnosis is not made elsewhere.

CHAIR: We have taken evidence that a lot of doctor shopping went on. Certain paediatricians were known to be relied on to give the diagnosis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the medication work in this situation?

Dr NEWMAN: I think that the short answer is probably not. Those sorts of medications for children who have attentional problems can help but there is no medication that works for conduct disorder and for the sequelae of child abuse. It is not going to fix that cluster of problems. The hope amongst family and referring agents is that there is a quick solution to a very complex problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does it mean that children in care are more likely to be drug oriented? Is this kind of a starter drug? Does the idea that there is a drug for a purpose lead on to other drug-taking behaviours?

Dr NEWMAN: There is some concern about the long-term use of particularly the psychostimulants in children who then become adolescents with the disruptive behaviours and other developmental problems in personality functioning. Anecdotally, we have seen several groups of adolescents who remain on long-term stimulants where they are really using them as a recreational drug or a drug of abuse as opposed to a therapeutic use of the drug. There have also been documented cases of families where children are taken to medical practitioners for the prescription of psychostimulants when it is the parents or carers who are interested in taking stimulant medication. In some schools there have been difficulties with black-market selling of dexamphetamine, Ritalin and so on. That is known to exist but I do not know whether we know the extent of the problem.

CHAIR: We really do need to get on to child protection more narrowly defined.

The Hon. JAMES SAMIOS: Bearing in mind the culturally diverse society that we are in, with over 230 ethnic groups, is there any cross-cultural training provided for your members?

Dr NEWMAN: Yes, our faculty is particularly interested in cultural issues. We do provide training in what might be called cultural competency. We have been having a consultancy process around that with the universities. Rather than try to teach trainees about every possible culturally specific issue, we are trying to produce people with an awareness of the importance of culture and family in terms of our assessment. So that is seen as fairly fundamental to practise. But I think it is fair to say that we need better resourcing and more people with particular language skills and other culturally specific skills to work in services.

The Hon. JAMES SAMIOS: In the outer areas that you mentioned the representation of culturally diverse groups would be noted.

Dr NEWMAN: It is very important particularly in southwest Sydney. We have been very involved with the refugee and asylum seekers groups.

The Hon. JAMES SAMIOS: Are services provided for refugees who have experienced trauma?

Dr NEWMAN: Yes, we have been arranging for our students to work with refugees and asylum seekers' families. We have been doing a series of visits to the detention centres. We also have our students linked into STARTTS the service for trauma survivors.

CHAIR: We wanted specifically to talk to you about the training that you are contracted by DOCS to do, to provide training for DOCS caseworkers and others on mental health issues in child protection. We wanted you to go into a little detail of what that involved and how adequate you think the understanding of caseworkers of these issues is and what the department should do.

Dr NEWMAN: I have specific concerns about the overall level of training in mental health issues provided for departmental officers, particularly those who are starting in terms of their orientation when they are new to the field. I think is appropriate to say that many of the experienced officers, over their years of service, have built a very impressive knowledge base and perform exceptionally comprehensive assessments and have an understanding about the issues. The Institute of Psychiatry was involved in providing part of the core orientation training in mental health this year and last year. Our concern raised with the department's educational staff was that in the time allocated it was impossible to cover the complexity of issues that—

CHAIR: How much time is given?

Dr NEWMAN: We have three hours training on mental health and three hours on neglect and the effect of neglect on early brain development.

CHAIR: And this is in an orientation course that is how long?

Dr NEWMAN: I think it was over a week. From what I heard about the spread the bulk of that was covering some substance abuse issues and domestic violence. Our argument was and remains that issues of mental health and parenting capacity are fundamental to the work of child protection officers on a daily basis and that without an understanding of the basics about parenting capacity and the many factors that can impair parenting capacity it does not make much sense then to look at things like domestic violence and substance abuse problems in isolation in that way. So we had issues with the amount of time allocated to core business about mental health and child neglect and also the way that was programmed into their overall training experience.

CHAIR: Are you in effect saying that mental health issues are at the root of most child abuse and neglect?

Dr NEWMAN: Yes. I think part of the difficulty in making such a statement is that the department might interpret that as saying mental illness and they might be wanting us to talk about parents affected by, say, schizophrenia or other psychotic illness. That tends to be the way they would think about it. I am using it in a broader sense. We would be meaning issues about people's emotional maturity, capacity to become parents, capacity to nurture children and understand the needs of children and parent in such a way that develops children's confidence. So we are talking about mental health in a very broad sense and obviously mental illness is an important thing that can affect parenting capacity—not always but it certainly can.

But there are many other issues that are related to people's fundamental difficulties in emotional and psychological functioning, particularly people who misuse substances, people who are so-called emotionally maltreating children. Probably the biggest group would be parents who have personality difficulties who frequently have experienced maltreatment, neglect and abuse themselves.

What we are seeing is the transgenerational transmission of those sorts of problems. I would say that that is mental health, and that is fundamental to the job of risk assessment, assessment of parenting capacity, and that without an understanding of that it makes it impossible to plan an effective intervention, let alone identification and prevention, which is the focus that we would have.

CHAIR: Is the training that you offer directed towards establishing an understanding amongst caseworkers of the sorts of issues you are talking about, or it is it also directed towards helping to train then in how to respond to parents who may have the difficulties you are talking about?

Dr NEWMAN: Within the limits of having a three-hour slot on mental health, when we negotiated this with the department and made it fairly clear that we thought it was impossible and inadequate, we made a decision that we would try to do it, if only to make the point that a lot more could be offered and needed to be offered.

We were told that all the other issues would already have been covered, that people had done another module on basic risk assessment and would be familiar with that. What we found when we went into the training was that they were not adequately familiar with the concept of parenting capacity or doing a risk assessment, so the whole question of how to identify people who are potentially at risk of abusing children was difficult for the participants.

So we launched into talking about the concepts of mental illness, in how that can affect parenting, transgenerational transmission of child maltreatment and so on in a fairly broad way, and issues of how they could incorporate that into a risk assessment, engaging with difficult families, and so on.

We certainly were able to get feedback from the district officers themselves in the group, who all found the material essential for their work. They were very interested in it. They told us that they would have liked more time on those sorts of issues. In discussions with me, they said that they also felt they did not get enough opportunities to discuss in their workplace, in an ongoing way, some of the difficult issues that they confront on a daily basis.

The other important area we tried to teach is how to assess young children, particularly in the 0-3 period, and how to identify signs of maltreatment or risk and developmental problems in the very young. That has certainly been identified as a major issue in the child death review reports, as has the question of personality disorder in parents, which is the other area I tried to cover. Though, I think clearly it became obvious that we were not going to get through that sort of material, and we provided written material and references for people to pursue themselves, but I do not think that is adequate.

CHAIR: Do all the people you are training have tertiary qualifications?

Dr NEWMAN: Of various sorts, yes.

CHAIR: Given the kind of degrees that I assume most of them have, it strikes me as odd that they would not have more of an understanding from their tertiary education than you are suggesting they have.

Dr NEWMAN: They do not appear to. My only knowledge of what goes on in terms of undergraduate curricular in relation to child abuse relates to the universities that I am familiar with. I think it is fair to say that there is a lot of variation across university departments and different disciplines with regard to the adequacy of the focus on those sorts of issues. Some would be very well trained in those sorts of issues, while others may not. With regard to medical schools, I think it is true to say that medical trainees have not had an adequate exposure to these sorts of issues until very recently. So you might find exactly the same difficulty in talking to a group of young interns, even in the last five years.

CHAIR: You would think that a social worker with a welfare degree would have encountered a lot of the issues —

Dr NEWMAN: The more recent curricular, to my knowledge, do. I think what you see in the intake level of people working in the department is people coming from a variety of different settings, some recent graduates and some not so recent graduates who might have been in different areas.

Overall, the basic knowledge of child development and how to use observational skills is particularly lacking. That seems to be very important, because often district officers are in the position of going into the home, looking at the child, and they need to be able to make fairly accurate observations of child behaviour and make a quick assessment of whether the child is developing as they should be at that age. Those sorts of observational skills are generally not taught well in most undergraduate courses. We would teach those at the institute, but they are postgraduates.

The Hon. AMANDA FAZIO: If they had done a psychology degree, would they be better equipped to do that observational work than if they had done an ordinary social work degree?

Dr NEWMAN: Again, it would vary between universities. Again, some psychology graduates who have done child development as a unit during their psychology training would be very well equipped to start focusing on that and would have some exposure. Some social work departments might not have, but again I am not aware of all the details.

The Hon. AMANDA FAZIO: Are some of the people you train graduates of the TAFE training system, where those welfare situations—?

Dr NEWMAN: Yes, some would have done those sorts of courses.

The Hon. JAMES SAMIOS: We have had advocates speak about the need for fairness in dealing with people with disabilities who themselves have children. I think it is fair to say that it is a challenge for them in that regard. What assistance do you offer there?

Dr NEWMAN: In terms of our training programs, we certainly train people in those sorts of issues. I think they have been inadequately addressed overall, even in general psychiatry training. Child psychiatry tends to do more of those, because we teach specifically about the various causes of delay in working with families where disability and learning disorders are an issue.

With regard to general psychiatrists, in terms of training we are currently introducing a whole module on developmental disabilities and its relationship to mental health overall. We have probably only a few child psychiatrists who would specialise in those sorts of issues. The majority of those would be working at the major teaching hospitals, seeing some of the more complex cases and offering ongoing support. Certainly we need to raise awareness of the issues across the system. Some of those families do not access child and adolescent mental health services; they would be seen by other services, so we do not necessarily offer as much as we could.

CHAIR: In your view, what could be done by the department to address the situation? You have clearly stated that more training is needed. Is that using more of your time, is it changing the nature of the pre-service qualification, or what is it?

Dr NEWMAN: All of the above, but being very clear about what the entry requirements might be, what level of basic qualification people ideally would have before going into that sort of work. Overall, I think there is a need to sit down, in a co-ordinated way, with the department and

experts in other fields and actually plan a curriculum. What the department has tended to do is to contract out bits of curriculum. I think part of the difficulty is that there has been no-one with mental health expertise who has been charged with co-ordinating a curriculum in an ongoing way—not just the entry level, but where that fits in terms of ongoing professional development.

I do not necessarily think it is a matter of taking entry level officers and giving them incredible amounts of information in a didactic way; they are certainly not the sort of principles that we would consider important in terms of how you help adults learn on the job. I think they need some orientation and some basic information, but it should be around the principles of child development, risk assessment and parenting capacity initially.

To back that up, there need to be other additional training opportunities, particularly in the early years of someone's career, if we are to help them develop and retain people within a system of child protection. They need to have opportunities for ongoing professional development. I think a key to it is to provide clinical supervision by clinicians, as opposed to managers. I think some of the officers have certainly tried to provide what they would call supervision, but it is not really what mental health people or clinicians would think of as supervision, where people have an opportunity to think through the process of assessment and intervention and develop their skills in that area. It is almost as if people reach a limit in terms of the opportunities they have within the system for professional development.

It seems to me that there is not a culture of clinical supervision or clinical development within the department. There is certainly a managerial culture and a culture of risk management, and maybe that has developed because of the obvious need to self-protect, in a sense, and the overwhelming demand in terms of a forensic approach to child protection. But that is not going to necessarily help people develop their clinical acumen or capacity to observe and make decisions.

CHAIR: We went to one CSC in which the almost total lack of clinical supervision was mentioned, not only in the context that you are referring to but also as a factor in burnout and stress and simply not doing the job properly, in often very difficult circumstances.

Dr NEWMAN: Yes. I think there is a lack of recognition from senior management. From my discussions with the junior staff, who are doing most of their direct face-to-face work, I learnt how emotionally demanding and difficult that work is. The long-term toll of that sort of work on anyone, and no support for people to even debrief or talk about some of the terrible things that they have to deal with on a daily basis, directly contributes to lack of morale, burnout and people moving on.

I had discussions with the department some time ago, when the half-day closure system was being introduced, about perhaps offering a supervision system at least to some of the areas in the western suburbs. We offered to set that up and come to some arrangement about that. However, the offer was not taken up, which I thought was unfortunate, and it was seen as an opportunity to close the office and do some more internal supervision, which I think became more of a managerial approach. So it did not really seem that that system was used in the way it could have been.

There have been long-term plans in terms of supervision and support for staff, giving them adequate time for skills development. But there has been a certain reluctance to consult people with mental health expertise in terms of curriculum planning, so they have tended to call them educators and others, as opposed to clinicians, who do child protection work.

CHAIR: What about the way in which DOCS officers in the CSCs work with specialist agencies or the sections of agencies in their local areas? Is that another way to give them access to the kind of expertise you are talking about?

Dr NEWMAN: Theoretically, it should be. We have had some discussions in the health department about perhaps linking DOCS areas with the child and adolescent mental health areas. That would obviously need to be worked through at a fairly high departmental level, but it could potentially be a system that allows much better cross-communication between departments.

Currently you have child and adolescent mental health departments in one area and DOCS in one area, and the communication is all about "Will you admit, takeover, or do something for these

very difficult families that DOCS are trying to deal with", and there is not much activity in terms of shared discussion, case conferencing, planning and educational activities. So you have opportunities for doing that but the system really does not allow that in terms of current structures.

That communication element is particularly important. Potentially we have linking up between health, education, DOCS and juvenile justice on an area basis or a divisional level, which I think might really improve communication about some of these very difficult children and families who are known to all the agencies. But it is very hard to pull people together to actually plan, in a coherent way, better management for them.

The Hon. AMANDA FAZIO: I have the pleasure of also being on the mental health inquiry. One issue that concerns me is the liaison between the two departments when there is a time of crisis for a parent who has a mental health problem but who also has dependent children. If that sort of crisis situation arises, are you aware of there being appropriate mechanisms to ensure that if the parent is contacted by one of those mental health crisis teams, or they intervene, DOCS is informed so that the appropriate processes are put in place for the care of the child?

Dr NEWMAN: I am aware that that has been a problem with some people in mental health services being very quick and acting appropriately to contact the department. Sometimes they have been too slow or people have not thought about the children of the adult with the mental health problem who is going to be hospitalised. The department has improved our response to that through documentation around child protection, through the Moaitt documentation that I am sure you have been made aware of. Obviously that is time-consuming and some find in problematic, but at least it addresses child protection.

I am involved in increasing that because I think it is fairly fundamental. It will alert any mental health worker to ask the right questions about the child and to act upon it. It will be clearly spelt out, which I think should help. Part of the problem is the department's capacity to respond to those sorts of calls. Unfortunately many situations arise and again we come up against the triaging system in the department, which is frustrating for many mental health workers and does not necessarily lead to a speedy response. I certainly think that mental health services need to become more aware issues involving children of adult customers.

CHAIR: You were anxious to tell us about your knowledge of parents with a personality disorder. That would relate to similar issues and the Committee's focus on what happens to their children.

Dr NEWMAN: Yes, I am using that term to refer largely to parents who have experienced abuse and maltreatment themselves. We know they are overrepresented in coming to the attention of the department and in drug and alcohol services as well as the mental health system. They are known to be people who often find it very difficult to parent appropriately and are at high risk in that maybe they repeat with their own children the sorts of thins that happened to them. The mental health system is not particularly effective or adequate in its response to that group. Sometimes they are not seen as needing hospital treatment even though often they are depressed, suicidal or presenting in crisis. The hospital system would not see them necessarily as a priority over and above management of their immediate suicide risk.

Yet, there is a considerable amount of research into the difficulties parents face and recognising that having a parent with a personality disorder is more harmful to the child's outcome and development than having a parent with managed so-called serious mental illness such as schizophrenia bipolar disorder. This has been known since Rutters work in about 1950, it is not new. It is surprising that we do not have a co-ordinated approach to people with personality problems, let alone to their children. Yet they frequently present to services asking for help. They are certainly very well known to the department. It is often quite difficult for us to engage with and work with them.

The risk of not addressing the issues for those parents is that we end up allowing, if you like, the next generation to develop similar problems. One of the major challenges for any child protection or mental health system is how to intervene and prevent repetition of child abuse. The Child Death Review Team identified parental personality disorder as a major issue and said that the system needed to be better educated and informed about problems facing those parents. In Victoria there was an

inquiry conducted by Health into the needs of people with a personality disorder and how the health system could better respond to that. Some of us have been lobbying for that with New South Wales Health; to date we have not had that sort of response.

Appropriately, we have put money and research into the needs of parents with major so-called mental illness, but the group of parents with diagnosable personality disorder is probably a bigger group in the community. That is a much more common disorder, with potentially much greater effects on children and much more clearly related to the rates of child abuse and maltreatment.

CHAIR: DOCS people need to understand that. Are you saying that treating or helping people with a personality disorder, as you defined, is a job for the health system?

Dr NEWMAN: It is a problem that crosses boundaries. It is not only for the health system, which needs to provide interventions for those who will benefit from them. The problems facing those people are broader than their immediate health needs. Often they have multiple social problems, and ongoing adversity because they find it difficult to function in a stable relationship, employment, family life, and so on. They tend to have ongoing difficulties. Obviously their children are caught up in that and the families are usually known to multiple services. A better approach would be a departmental co-ordinated approach, but initially we need to have consultations across departments about what people are doing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As a member of the Select Committee on the Increase in Prisoner Population and the mental health committees I have come across personality disorders. There has been some argument over whether a personality disorder was a diagnosable psychiatric illness or not. Has that been resolved?

Dr NEWMAN: It depends on which classification system one uses. In the prison system, the legal definition of a personality disorder is not mental illness. It is not a condition involving, on the whole, delusions, hallucinations and other symptoms of major mental illness that the legal system would define as mental illness. In psychiatric diagnostic systems, it is on a separate axis; in other words it is not a major mental illness, it is seen as separate, but as a long-term disorder as opposed to an intermittent illness.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is also difficult to treat and you use behavioural treatment.

Dr NEWMAN: Yes, they can be used.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sometimes that might be getting certain behaviours in parenting. You may say that whatever resentments people must hold from the past they need to behave in a certain way towards their children. Is that the sort of approach you advocate within the practicalities of supporting parents with a personality disorder? Should that be the aim in practice?

Dr NEWMAN: Yes. Some parents have major difficulties in managing anger and frustration, so their own feelings are very difficult. Often they have been abused and neglected themselves, so they are not good at the basics of child development or parenting. Often they do not know how to play with children or how to encourage appropriate development in children. The sorts of approaches that can be helpful for people are to help the adults with their own feelings and how to deal with anger and frustration and giving them basic education about children as well as more direct cognitive behavioural techniques to help them respond in a more empathic and tuned way with their child.

Those are the techniques that mental health professionals can be trained to do. There is a good body of evidence looking at what will be effective for those adults like that. It is important that those interventions start early rather than later, because children can be very much adversely affected from birth by having a parent with those sorts of problems. We advocate early identification of that group of parents and early treatment programs in the 0-3 years. The earlier the better, essentially.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If one were to treat care leavers, who might be at risk from having personality disorders, is that likely to show benefits? You would then be treating the at-risk group. What is the prevalence of personality disorders in care leavers? To what extent are you overtreating if you put the effort into care leavers as a target group, for example?

Dr NEWMAN: I do not have any figures. Because of their experiences, those young people who have attachment disruption, maltreatment experiences and general lack of intervention will be at very high risk. They would be a good group to identify and work with in a preventive way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This morning the Committee heard that people in care tend to have children very early and are not very stable. That often happens before they leave care.

Dr NEWMAN: That is correct, so they would be an ideal group. Many other groups in the community could be identified as potentially at risk of reproducing parenting problems with their own children—if we ask the right questions.

CHAIR: You seem to be endorsing the Committee's interim report on prevention and early intervention from the point of view of children in the child protection system. In the end, that is the way to go?

Dr NEWMAN: Yes. At the moment the system is not geared towards that. There are minimal attempts at that and people are genuinely interested in that approach. But we have an investigatory and forensic system as opposed to a preventive approach, in child protection.

CHAIR: Are you familiar with the work of the Families First Program and other programs in south-west Sydney?

Dr NEWMAN: Yes.

CHAIR: Do you think that they are the kinds of programs, with their mix of home visiting, et cetera, that would treat people with a personality disorder? That is a harsh and invasive word for a complex matter. It is hard to move in and treat someone whose situation is very diffuse, is it not?

Dr NEWMAN: Through Families First and the Department of Health's home visiting and other universal projects there is certainly evidence that they support early parenting and can reduce overall the amount of child maltreatment of various sorts. I cite Olds' work and other evaluations of those approaches. That being said, my reservation is that they are one level of a system that we need to build up to make it a much hierarchical approach. We can identify people who are already at extreme risk in parenting. They need targetted interventions. My concern is that maybe in the spirit of having universal preventive programs, we may not focus adequately on those who are already at risk.

As clinicians we would see very young children, in the first few months of life, who are already showing developmental problems. I refer to the children of parents who are quite severely affected by their experiences, or parents with personality disorder and other mental disorders. We are very underresourced to enable us to offer interventions for that group.

CHAIR: What interventions are offered to that group?

Dr NEWMAN: Very few. It depends on geography; on what area health service the person lives in. Some areas are better resourced than other. South West Sydney Area Health Service is particularly underresourced to offer child mental health services. I worked there for five years and was the sole child psychiatrist for a population of about 850,000. Clearly that was unsustainable and unmanageable with my team of three. We were meant to offer tertiary level services for multiple disadvantaged families. Fortunately some of the non-government agencies in the area do important work and manage very difficult families very well. There is a basic lack of infrastructure and underresourcing. If a family was fortunate enough to be in a better resourced area, that family might be engaged in more ongoing support and intervention, which is much more likely to be helpful.

Under the very underresourced areas what is offered is a brief assessment, short-term intervention and if risk continues cross-referral to DOCS, who is then placed in the position of not being resourced to do what it thinks of as monitoring. In effect, not much treatment intervention is offered in many areas.

The Hon. AMANDA FAZIO: You mentioned that soon early childhood nurses will be doing universal visiting. Are they provided with the training that you provide to DOCS workers to enable them to identify parents with personality disorders or other mental health issues? If not, do you think that would be of benefit to them in recognising families who might need a greater level of support?

Dr NEWMAN: As I understand it, there will be two levels of health home visiting. There will be the universal home visiting by the early childhood nurses who have received a basic level of training and are very competent in terms of their understanding of parenting, early child care and so on. There will be a psychosocial assessment, a screening process, to identify those who are at greater risk, who may have a history of previous depression, other stresses and so on. Those people will be offered what is called sustained home visiting.

Several of us feel that sustained home visiting is a very different proposition in terms of the demands on staff. If that is to be effective, there needs to be further training, particularly in the sorts of issues we are talking about—the more complex issues, the mental health issues—for those people. However, to my knowledge, I think the department is in the throes of organising that at the moment. It has not finalised its planning regarding the level of training. I personally think they need training very similar to the entry level district officers that is currently given, just for the purposes of being able to maintain contact with quite difficult families and, most importantly, to know when to refer elsewhere; not to use those staff as a panacea for complex problems but to give them enough skills to enable them to maintain some contact, and to know when issues are beyond their brief and they should refer to mental health.

CHAIR: You have talked quite a bit about parents who have been in the child protection system before. We also wanted to ask you specifically about outcomes for children and young people who have had poor experiences in out-of-home care, particularly with multiple placements. What can the department do now with the current generation, as distinct from the just past generation that we have been talking about as parents?

Dr NEWMAN: I think that is a very important issue, and it is an ideal place to be doing preventive work in terms of reducing the number of multiple placements and attachment disruptions that many of these children experienced in the past. It is clearly established that those sorts of multiple disruptive upbringings are related to a whole range of personality and developmental problems for those young people, and then other outcomes such as depression, poor social functioning, unplanned early parenthood themselves, repetition of abusive relationships, and so on. Taking that as a given, it is an ideal opportunity to have the system function to prevent that. What that takes is another issue. I think that is a question not only for the department but also for the Family Court and the Children's Court and people at that level in terms of how we make decisions about children's care arrangements.

The sort of work I do with the courts is that I have been involved in the judicial education programs, with the Children's Court magistrates and the Children's Court clinic and those sorts of areas. We are trying to educate the system about the principles of attachment theory and the requirements that children have in terms of consistent ongoing care and the importance of having at least one primary carer who is a sustainable person, then what strategies will be effective if that is going to be difficult for the child, as in having regular alternate respite care and so on, so that children have an opportunity to develop stable attachment relationships.

When we discuss this with various groups of the department the response usually is: We do not have enough appropriate alternate carers for children. It is inevitable that this will happen. But I think on closer examination of several of the cases that we have been concerned about and involved in, the failure is systemic rather than necessarily at the individual care taker level. I think the principles are clear. Fundamentally, there does not seem to be an understanding of the principles of attachment, so that sometimes the decisions made are not in the best interests of the child, particularly decisions in early childhood, when it is most crucial that children have a stable attachment figure.

CHAIR: What sort of decisions are you talking about—short-term emergency, foster care, when a child is first removed and then moved on to another, and then another?

Dr NEWMAN: Yes, particularly about babies and young children in the first couple of years of life. Often, decisions are made in terms of removal, then putting children back with suboptimal parents, waiting for that to break down and then removing them again. That process tends to go on without adequate planning. I think the planning process needs to be underpinned by an understanding of what children actually need. If decisions are going to be made about introducing alternate attachment figures, that needs to be done at the right time developmentally so that the child can form a relationship with someone, rather than leaving it too late or removing a child from the primary attachment figure where a lot of damage has already occurred in that relationship.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying this is about permanency planning early?

Dr NEWMAN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, essentially, you are supporting the legislation for permanency planning, provided it is well-informed?

Dr NEWMAN: It has to be well-informed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The worry at the time it came was that, yes, it was permanent but was it well-informed, or was it merely perpetuating a situation that had been poorly researched?

Dr NEWMAN: Exactly. I think in practice it probably had not been informed enough by the available evidence about attachment and children's development.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the time for attachment is very short, is it not, in the sense that if there has not been a significant attachment in the first couple of years it is very difficult to get an attachment, is it not?

Dr NEWMAN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If a pathological binding to someone is destructive, it is very hard to unstitch it, is that right?

Dr NEWMAN: Yes. And if a child has not had the opportunity to develop an attachment with anyone within the first two or three years of life, that child might well—and usually does—remain permanently impaired in terms of its ability to form attachments. Generally, we see children who are in a pathological attachment insecurely attached to a primary carer. The way the system has operated, in terms of inconsistency of approach and lack of support for alternate attachment relationships, all we seem to have managed to do is increase the child's insecurity, which eventually leads to the relationship breaking down.

The net result is children who really have an impaired capacity to relate to other people. We then put them into foster families, alternate care, and they test those relationships to the extreme, and those relationships break down, and on and on it goes. Those are the typical stories that the Committee will be familiar with—children who have had multiple placement breakdowns and the eventually become the children we call unplaceable. There is also a need to recognise that those children are out there. Unfortunately, because of the combination of what they have experienced and systemic failure, there are a group of children who are essentially unable to be placed in close intimate relationships within a family or social unit. There are some children who will function much better in a less intense setting, such as a group environment or group home.

CHAIR: Or with professional carers.

Dr NEWMAN: With professionals and semiprofessionals. Obviously, it is in difficult to arrange that at the current time. But that would be preferable to some of the arrangements now being made for those children, such as the motel room scenario.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if you push people who are presumably programmed not to bond into an expectation where the other person thinks they can, is it common for them to keep testing that relationship until it breaks down? In other words, do they keep stressing the carer until the relationship breaks down and explodes?

Dr NEWMAN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Thus proving their thesis that "nobody cares about me".

Dr NEWMAN: That is right. Often they are sabotaging their own placements because some of these children basically cannot believe that anyone would actually remain available for them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So in a sense they have a personality disorder by that time.

Dr NEWMAN: They certainly are very damaged in terms of their capacity to relate, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And probably, in realistic terms, not fixable.

Dr NEWMAN: Not in the way we currently are doing it. We do not have enough alternate programs that might be more effective for those sorts of children.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you talking about programs that in a sense highly respect their autonomy, in the sense that it does not move into their space; that the supportive relationship leaves the emotional issue somewhat untested and merely supports them in practical terms so that they have to do the best they can in making their own way?

Dr NEWMAN: Yes. It is a very consistent and clear relationship that allows those young children and adolescents gradually to build up a sense of trust, because essentially that is what they have not got. They do not have a fundamental belief that anyone will be there for them, so often they become very provocative and very angry to prove the point that no-one will be there for them. The only interventions that have been demonstrated to be helpful for those sorts of children are those very structured, low-key, unobtrusive, supportive relationships that gradually, over time, for some children, can build up a sense of trust in other human beings.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can these be institutional? When I was a kid I was near Burnside, which had large pseudo-families, with a dozen or so kids per house parent. In a sense, they were not in a family, and from that structure they could get a sense of what a family would be like. Obviously, the degree of personal intensity could never have been there.

Dr NEWMAN: Some of those programs have been shown to be quite effective for children who otherwise have been seen as being intractable, because they have that support and they have a sense of social connectedness and belonging to the group, and they can learn how to get on with other people and function in a group. If we put some of those children in a very intense, emotionally close family relationship they find it intolerable. They need a bit more distance and some more containing structures.

CHAIR: Where does kinship care and the particular problems of Aboriginal families fit in with what you are saying? Is it an area where the kinds of problems you are talking about are not really being addressed? Is kinship care a bit of a stop-gap, or is there a hope that it will provide the kind of attachment that you are talking about?

Dr NEWMAN: I think it is much more complex in the sense that our position will be that we will have to respect the indigenous community's desire to work in that way. We certainly do not want

to replicate any of the previous situations where those children were displaced from their culture and community. We take that as a principle. In practice, it is often very difficult and we run into problems of cultural differences and perceptions of what constitutes adequate parenting, and we have problems in that some of the staff across our systems in health and child protection are not necessarily sensitive to those differences. In practical terms, there are real difficulties in finding appropriate families for many of the children.

CHAIR: Given their huge overrepresentation in the system.

Dr NEWMAN: They are hugely overrepresented. Certainly, from my experience in the Children's Court, that is the case. In the Children's Court we are seeing quite an overrepresentation of indigenous families and a lot of concern about decisions being made to leave some of those children in what we would think of as suboptimal or potentially harmful situations because of the cultural issues. I do not have any solutions to that, other than to recognise it as particularly difficult. I do not think the health system is sensitive enough or trained enough in working in that sort of way. We probably need more in the way of specific indigenous mental health services, together with people in those systems who have a child and adolescent focus which we do not have currently.

CHAIR: You have mentioned the Children's Court clinic a couple of times. Do you have any specific suggestions about how the relationship or interface between the court and DOCS could be improved?

Dr NEWMAN: I think it is obviously relatively early in terms of the development of the system and the way it operates. The issues that have become apparent to date are the cultural change that will need to take place, particularly within the department in terms of how it relates to external expertise. The department is probably much more familiar with the system and would contract an expert to do an assessment report for the department, which they could use much more directly in terms of their planning and processes. It has been somewhat of a shift to have independent reports before the court, as opposed for the department. There have been some problems with that, in that occasionally it has been my experience that departmental officers have contacted me when my report might have been released to the department after it has been tabled, concerned that they do not necessarily agree with the recommendations that I or other clinicians might be making. They say that the report is not helpful because it does not help them in their care planning. I think it is a process of saying: It is not necessary for that purpose. I think there is a lack of clarity on the part of the department about what the purposes of those reports are. I think there is a process that needs to go on in terms of educating the court in how to ask more efficiently questions of the clinical experts that will make the reports ultimately more useful.

This gets back to the point I was making earlier about the importance of cross-departmental training and educational activities. These have been quite lacking and it is only relatively recently that child psychiatrists are talking to senior people in court and the judges. That has been the beginning of something that will be potentially quite helpful. We have had some very productive training and discussion evenings between us and the court system, which will help them frame questions of us. Some of it is about learning a shared language and understanding each other's frameworks a little more clearly. I think we are just at the beginning, but in many areas we have still got the silo mentality that has not been helpful. In principle, psychiatrists are very pleased with the concept of a Children's Court clinic. We see it as an opportunity to build up that expertise.

CHAIR: How long has that been operating?

Dr NEWMAN: About 12 months. It will give us an opportunity to look at issues we need to look at about the quality of reports and whether the reports address questions in a way that is useful to the court. It could usefully serve as a training ground for people in the department if we did some joint training activities.

CHAIR: We spoke to Chief Justice Nicholson and others from the Family Court this morning. Could you comment on whether the Family Court is further ahead in its understanding of the principles of child psychiatry?

Dr NEWMAN: My personal belief is, yes, I think the Chief Justice has done a very impressive job in raising awareness across his system of these sorts of issues. In fact, he instigated the judicial education program for Family Court judges. There was some initial resistance to that because it was a new process. I was involved in that. We had the opportunity to meet with judges over some days and talk to them about domestic violence, mental health issues and the effects of trauma on young children, and work with them in a way that I think was new for them and for us, but which was very useful. That will now be an ongoing process.

CHAIR: The same sorts of things should be happening in the Children's Court?

Dr NEWMAN: Yes. It could usefully happen with the Children's Court. I have done some sessions with them but not as many. The Family Court has introduced an ongoing rotating judicial education program so that all the judges attend every two or three years for a week block on various topics. It was a very impressive program that was run last time, covering a whole range of issues, including domestic violence, cultural issues, issues for Muslim families and things that are quite important.

(The witness withdrew)

MARY JANINA JELEN, Director of Charmain Clift Cottages and representative of the Mental Health Co-ordinating Council, affirmed and examined:

CHAIR: Have you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act 1901?

Ms JELEN: Yes.

CHAIR: Are you conversant with the terms of reference of this inquiry?

Ms JELEN: Yes.

CHAIR: Do you wish your submission to be included as part of your evidence?

Ms JELEN: Yes.

CHAIR: Would you like to elaborate on your submission or make an opening statement, otherwise perhaps you can give the Committee an overview of the role of the council and Charmian Clift Cottages?

Ms JELEN: The council is actually the peak body for non-government organisations. It gives an independent voice on mental health issues and provides a liaison role between the government, non-government and private sectors. It acts as an information clearing house and provides cost-effective or low-cost training to non-government agencies, access to information and awareness raising in the community. That is an overview of what the council does.

Charmian Clift Cottages is a service for women who have a mental health issue and who have dependent children. It is jointly funded by the Department of Health, the Department of Community Services and the Department of Community Housing. It is a State-based service so we receive referrals throughout New South Wales, and we have actually received referrals from Victoria and Queensland. To my knowledge it is a fairly unique service in Australia. It provides supported accommodation for women and their dependent children. Our focus is in providing a service that responds simultaneously to the needs of women but also to the needs of children.

We operate in a team approach, so I have a team of health workers and a team of child development workers. We also have a community worker who provides an outreach service once the family goes through the program. We try to network and work with the local community base. Because we are State based, it is difficult to provide an outreach service to Lismore or the country areas.

Part of our programming is to provide an environment that is safe and nurturing for women and their children. Our programs deal with self-esteem building, self-confidence, looking at the dynamics of domestic violence, independent living skills, and development of parenting skills. The team provides a positive role model. There is a lot of one-to-one work with the women. In a nutshell, that is what we do.

CHAIR: How many women and children do you have as a maximum?

Ms JELEN: The maximum we can accommodate is nine women with children. The service has received funding from Community Housing. It is communal living and that is one of the difficult aspects. We have two large cottages and whilst the women have private bedrooms, they share the facilities of the dining room, kitchen, laundry and bathroom areas. That can be problematic with communal living, especially with women who are stressed and have anxiety. Community Housing has approved for the communal cottages to be torn down and individual villas to be built. This will mean that we will actually downsize and we will have six villas. They have approved us for four and I am still fighting. They are putting the plan through council for six and they do not feel that there will be a problem to actually make up the money to ensure we have six villas.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it a big disadvantage to have them share kitchen facilities?

Ms JELEN: Communal living can cause problems. If a woman is becoming quite unwell sometimes she will take things that belong to other people. There is a problem about sharing food. We recently had a consumer who, because of her illness, was cooking masses of food and this became quite distressing and it was problematic to try and control that. She would cook three chickens and throw out two, which was quite distressing for the other residents.

When some women become unwell they become aggressive and violent. Some residents have actually threatened and become violent to other residents. Sometimes it can be positive in that from the process some of our consumers will actually develop very good mediation skills and in retrospect will say, "That was a learning experience for me." When we are working with women it is also about developing their independent living skills and being able to look after their children, the housekeeping and have a daily routine.

If you have a woman with an obsessive, compulsive cleaning disorder, she will clean the whole unit and no-one else will get to do it. Therefore, they cannot actually develop those skills because she got up at 4 o'clock in the morning and cleaned the whole place. When you have individual units it is actually less of an artificial environment. If they are have their units, they will be able to take care of the unit and you will be able to work much more individually with them because they will be responsible for their own space.

CHAIR: I visited the cottages many years ago. How long have you had this communal experience?

Ms JELEN: It was established in 1995.

CHAIR: So you have had a lot of experience with it. Would you tell us something about the range of needs or difficulties of the women you deal with, keeping in mind child protection issues, whether they have had previous contact with the child protection system and whether their range of mental health issues automatically means that the children need some intervention in the child protection sense?

Ms JELEN: More or less, yes. We receive referrals from mental health teams, the department, community-based organisations and self-referrals. The consumer does not necessarily come via DOCS, but invariably what can happen is that we will actually report to the department.

CHAIR: When a woman and children arrive?

Ms JELEN: Yes. In working with our consumers, we have a very fine balance between the child's rights and the mother's rights and competing needs between those. The bottom line is that the child's wellbeing is paramount and that will always be our focus. Women coming into our service have multiple complex problems. It is just not a mental health issue, illness or disorder. There can be an element of homelessness, social isolation, victims of domestic violence, and victims of child abuse. Some of them have already come from the care system. We are in a new millennium but we are still faced with the stigma of mental illness and the wider community is still fairly ignorant. Although there has been a lot of work done in the awareness and understanding of mental health, it is still problematic. Part of it is working with these women on illness management and acceptance, but getting other people to accept it is difficult.

A lot of women come to us who have already had children removed. They are very fearful of DOCS intervention as they do not have good experiences with that intervention. A lot of women have had children removed, a number of years have passed and nobody has followed up with them, no casework services, and suddenly they have got a new baby and they say "Why is everybody so interested in me now? Nobody cared about me before". So we are dealing with issues such as that.

There is also a dilemma for us when women become unwell and we need to contact DOCS and the child is removed; we do not have the services. The child is taken and placed safely somewhere but what can we do with the mother who is left behind? Many of the refuges that are set up for single

women are overcrowded. We are faced with the dilemma of what to do with this woman. Community-based services are not enough. We are constantly faced with resource problems.

Hon. AMANDA FAZIO: Do you think in those cases you talked about where the child is taken away and the mother is left on her own and there are housing issues for the mother, the separation actually ends up compounding the mother's mental health problems?

Ms JELEN: Most definitely. Yes, because it becomes stressful in that "Where is my child? What is going to happen to me?" and we cannot give answers. We just had a consumer where the child was removed and we were trying for two weeks to find a refuge placement. In the end she was scheduled. Needless to say, mental health really did not want to do that but in the end they decided to because it became an issue. She is in the acute award at the moment and what will happen to her after that is still questionable because of the over demand for places already.

CHAIR: Do the children get removed because of specific incidents of abuse or neglect or because somebody makes the decision that the mental health of the woman is sufficiently poor or precarious that the child is, in a general sort of sense, unsafe with her?

Ms JELEN: It is specific. When we make a child protection report we are working off specific factual information. We attempt to either eliminate the risk to the child or minimise the risk, but in this instance—

CHAIR: Having not been able to.

Ms JELEN: Yes, then we contact the department and that is where it can start becoming very problematic because the response from the department is so inconsistent that in some offices they will say "No, the child is safe because the child is with you" and then you try to argue "No, we have identified very real child protection concerns and there is a very serious child protection issue here". Our service does not provide primary care; we do not provide 24 hours supervision for children; we assist; it is supported accommodation for women. We do not take over the role as the primary carer. In this instance I actually put it to the department that because the consumer could not stay with Charmian the only alternative was for the child to be removed. I put the option to the department "Give us 24-hour support to maintain the placement and see how we go". We had been working with this mum for six weeks and we were very clear on the issues. In fact it was not a mental health issue, it was a cognitive impairment which is something very very different. It was almost dismissive: "No , we are not going to do that". I then said "Well, give me a 24-hour support worker to maintain the placement" and at a cost of $7,500 a week the department was not interested in pursuing that so the child was removed and the mother scheduled.

CHAIR: When you say you have this problem with inconsistency between different DOCS offices is that because when you make a report it ends up being handled by a CSC from where the mother and child last lived? On the face of it I would have thought you would deal with the same DOCS office all the time.

Ms JELEN: That is one of the interesting things with Charmian. With mental health if the referral comes through the mental health team they will actually transfer the case to Blacktown mental health, so we only deal with Blacktown mental health. With DOCS they retain the case, so we will liaise with the CSC who has actually referred the case. We will liaise with Lis more, Bateman's Bay, or it could be east Sydney. That makes more sense because otherwise Blacktown, which is already quite an overworked office, would be just overwhelmed. It is consistency of intervention for the family as well because in a lot of cases if the child is removed they only deal with one caseworker and in some instances they have established rapport with that caseworker. That is where the inconsistency comes in because if you recognise that the department's caseworkers are overloaded, high stresses, poor resources to implement care plans or case plans, the question I ask myself is: they all face that so why is it that I get a very professional service from someone and I do not from another? I think it is about their professional attitude, their level of experience, their interagency approach. When I look at why has the case had a really good outcome, why have we been able to work with the department, the thing I can identify is that the caseworker and the casework manager I worked with had an interagency approach; they were involved in the planning; they were involved in regular reviews with us; they were listening to what we were saying, they were listening to the mother and what was happening;

they reviewed the case regularly; the risk assessment just did not stop when they became involved, it was continually reviewed for the life of the case. That is what gives a good outcome, yet I could tell you horror stories about other dealings I have had with the department, such as where you get what you could only term as the dump job; they bring the mum and children over and then you never see the department again.

I have one client at the moment who has had eight children removed; this is her ninth child. We have not seen a caseworker for six weeks. Yet when I asked the caseworker can we have background information, the exchange of information that is so critical to the interagency approach, they said "I can't tell you anything". I said "The department has removed eight children from this mum. You are telling me you don't know why? Where is the information?" The answer was "I can't find it". The last child had been removed 18 months prior to the birth of the new baby and the child was actually made a ward of the Minister until 18 years old. I said to this caseworker "For such a serious decision to be made, the magistrate must have had a whole variety of reports and recommendations, so where are they? It is critical for us to be working with this mum on a day-to-day basis". They could not give us anything.

The Hon. AMANDA FAZIO: Are there technically confidentiality requirements that would prohibit them giving you access to the files?

Ms JELEN: No. Interagency guidelines talk about the need for relevant information exchange. When mums come to Charmian Clift they sign consent forms, so they consent to the release of information. When you are trying to work an interagency approach and you are trying to use the interagency guidelines and you are telling the department what the interagency guidelines state, with one manager caseworker I will get back a letter saying "It is our discretion to give you information".

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When it is not, it is totally against the guidelines.

Ms JELEN: Well, exactly. I am thinking how do I work, how does my team work with this mum on a day-to-day basis if the Department is not giving us information as to what happened in court; what are the undertakings?

CHAIR: You said before that you put this huge discrepancy down to individual case workers and their managers. Would you put it down to big variations between CSCs?

Ms JELEN: Yes, most definitely.

CHAIR: It is not just this individual is a good worker and this one is not, it is the culture of the particular CSC is different from another one?

Ms JELEN: Yes, that is what I am finding.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the local managers presumably have a lot of discretion because the manager could write to you and say "Stick it up your jumper. You can't have eight removals, we can't tell you anything". That would be a local decision, you think, because it is inconsistent with other local decisions?

Ms JELEN: Yes it is inconsistent when I cannot get anything from this CSC yet I will get everything from another CSC.

CHAIR: So do you then go higher, so to speak, Mary? Do you say "Have I got the time and energy to go further up the DOCS hierarchy and say that this is not good enough?"

Ms JELEN: Yes, but in my experience even if you put in a formal complaint about something that has happened, you do not get a response back.

The Hon. JAMES SAMIOS: Have you never had a response back?

Ms JELEN: Well, in my limited experience with Charmian Clift, no. At this point I have not got a response back.

CHAIR: How long have you been there?

Ms JELEN: I have been there four months now. It is so unnecessary. It just makes it so much harder and it should not be. If we are talking about working in partnership, working together and planning with the consumer we say well, the consumer has no problem with it, they have signed off a consent form; your own interagency guidelines direct this approach. I think the other thing is that the department in many cases does not work from evidence-based practice. Research is telling us this is a good way to work, it has good outcomes, yet I am still coming across manager caseworkers and caseworkers who do not implement it, do not work from evidence-based practice. I think it is part of that culture; it is either because they are so overwhelmed or there is a lack of resources that we get this inconsistency. It is not only the application of protocols and processes and policies, it is also resources. One office will fully support the consumer going through our programs; another office will not help at all, to the point where they say "Well, if it means they cannot come to Charmian Clift, so be it". Sometimes it means that we absorb the cost. For a community-based organisation that is so difficult.

In one instance I lobbied very hard for the young mum to come to us. I said "We will absorb the cost. If you can't pay for it we will somehow do it", because it meant that this young mum would not have the opportunity to develop the skills. She was schizo-affected disorder and she needs intensive 24 hour support but the staff are committed and we are seeing progress—small progress, but progress.

CHAIR: How long does someone normally stay with you?

Ms JELEN: It is fairly flexible. Usually they stay about three months but that can be extended. Again, getting back to the type of consumers we get, along with the issues that are raised you have also got to look at dual diagnosis, and by dual diagnosis I mean a developmental disability and a mental health status, and then you have the associated problem—and it is a growing problem: mental health and drug abuse. That is a huge problem that is out there. We are taking these women and we are finding it extremely difficult because we do not have access to tap into expertise; I just do not have the money to do it. We are trying to develop our own expertise but, again, it is difficult because I only have so much money for training.

When I am coming across case workers—again it comes down to this evidence-based practice—usually with the drug addicted mums who have a mental disorder or illness, research is telling us deal with the drug issue first; you do not deal with the mental health issue, it does not work like that, and good outcomes do not happen. Yet there is a lack of understanding; all they see is it is mental health: "You are funded for mental health, you have to take her". Then you get into this argument . Sometimes the consumer will bounce from service to service. Drug rehabs will say "No, there is a mental health issue , we won't take her". Mental health will say "No, it is a drug issue". In the end somehow they end up on our doorstep and we end up taking them . It becomes problematic because we do not have access to the resources we need at the time. When we put it to the department that we need these resources we hit a brick wall.

There seems to be at the moment in the Department—whether it is some sort of secret message that has gone out—no spending, don't spend. Caseworkers are telling me this. My manager is telling me "I do not have access to money.I have already paid out so much for this client, I won't get any more under the family initiative ". It is almost like they are on a quota.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Money per case you mean?

Ms JELEN: Yes, and the difficulty with mental health is mental health does take resources; it does take investment of time; it is something that you cannot do with a quick fix.

The Hon. JAMES SAMIOS: What establishment strength have you got there?

Ms JELEN: At the moment?

The Hon. JAMES SAMIOS: Yes.

Ms JELEN: I have all up 14 staff but we work 24 hours, seven days a week.

The Hon. JAMES SAMIOS: Professional?

Ms JELEN: At the moment I am trying to get the money together—we are negotiating with the Institute of Psychiatry to do specific training for Charmian Clift.

Charmain Clift paid for five staff members to attend university. So I have four, one at the University of Western Sydney, one at the Institute of Psychiatristy, one at Wollongong University, and our administrative officer is doing advanced training at TAFE. We absorbed that cost because we value training, it is critical to professional development. And I have a Bachelor of Social Work myself.

CHAIR: We know you believe there should be more training for caseworkers about mental illness and so on and ongoing support and supervision. You were here for all of Dr Newman's evidence and she talked at some length about the same things. Would you agree with what she had to say?

Ms JELEN: Most definitely. I think one of the difficulties with training is, they have one day of mental health training, so they have one day for mental health.

CHAIR: This is in the inaugural week's training?

Ms JELEN: Yes. And that is just appalling really when you look at it. Mental health clients make up quite a substantial percentage of the case work.

CHAIR: I still find it odd that the tertiary-trained people who come to work in DOCS do not have more from their basic university.

Ms JELEN: I think that is because it is an elective. Child protection and mental health are not core units. When I was doing my Bachelor of Social Work I could choose between doing women's studies or child protection, so it was an elective, you choose. One would think that child protection would be a core unit in any sort of social work or psychology, but it is not.

CHAIR: And I think we have to look at the tertiary training as well as the in-house DOCS training.

Ms JELEN: Yes, that is right. The other problem with the in-house DOCS training is there is no access to ongoing training. I worked for the department. When I came in as a case worker I received the initial training of three months prior even to going into the field.

CHAIR: How long ago was this?

Ms JELEN: I worked with the department for 13 years, from 1988 to early this year.

CHAIR: You had three months training when you started?

Ms JELEN: Yes, before going into the field. Now caseworkers, inexperienced graduates, are going straight out into the field and then you negotiate when they will go in to do their modules. So you have inexperienced, untrained caseworkers going out and doing home visits and undertaking assessments, and they have not even received basic training. When I was a case worker I went straight into three months of training and then went to the field. I also had access to ongoing advanced training. That is no longer available to caseworkers. So, once you actually do your training, to get any other sort of training you have to pay for it yourself or lobby to try to get something internally. When I was a manager case work I worked in very well with community and we got community health nurses in. When we had the under-one policy a lot of these inexperienced young caseworkers said how can I do an assessment, the baby is three months old? I said with a baby you look at body language. You

look at the interaction between mother and child. I said go back and remember your unit on child development and apply what you learned. So, I got community health nurses in and we did a series of training—what are you looking for 0 to six, six-months to 12 months, 12 months to 18 months? I was doing things like that. In some ways you are forced to be more creative and innovative in getting the resources for your caseworkers.

CHAIR: Were you able to negotiate that with the Department of Health?

Ms JELEN: It was what one calls social capital. It was my own network. It was influencing other managers at my level and doing an exchange, saying if you give me this, we will provide you with child protection training, and stuff like this. It was more on a personal level.

The Hon. JAMES SAMIOS: And at a minimum of cost.

Ms JELEN: At no cost when you really look at it.

CHAIR: We could be told that the interagency relationship at the local level is a crucial element in child protection.

Ms JELEN: Yes.

CHAIR: Some people have suggested that the helpline and other changes have made it much less likely to occur. What you are talking about is a good example of a local interagency network.

Ms JELEN: Yes. But what I believe is happening is manager case work is able to get it less and less because the computer system is so cumbersome and user unfriendly that it takes up a lot of your time. So, instead of being out in the field caseworkers are actually sitting in front of the computer. They have a risk assessment tool that is too cumbersome, too complex, it is not user-friendly. In some instances with inexperienced caseworkers it can take them anything up to two weeks to do a risk assessment. When you look at somebody sitting in front of a computer trying to sift through information, what else is happening? Where is the ongoing case work? It is not happening, because they are sitting in front of the computer.

CHAIR: You do not mean two weeks visiting a child?

Ms JELEN: No, two weeks in actually putting it on the system and trying to work it out.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mean 80 hours or 70 hours?

Ms JELEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In one case?

Ms JELEN: With some inexperienced workers it is taking them that long.

CHAIR: That is the second half of that question. Support and supervision is the other side of training, I suppose.

Ms JELEN: One of the difficulties is if you look at it historically, the department does not come from a clinical base. It has almost devolved from a lot of people who were in clerical positions coming into the old child welfare system, and then with the advent of child protection that developed. You have some managers who have no academic qualifications but they do not appreciate somebody who came through with a Bachelor of Social Work. In their case reviews, you cannot even say it is clinical supervision. I requested outside clinical supervision because as a professional I am social worker trained and therefore I would like my clinical supervisor to be social worker trained—not available. As a professional how do you get supervision from a person who has no academic training, who has no understanding of theory or working within a theoretical context?

It becomes problematic for you as a professional, if someone is not academically trained they do not talk to the case worker and say remember when you did child development, apply those

principles that you learned at university. They are exactly what you should be doing. Every case worker who has a degree, no matter if it is psychology, social work, behavioural science or welfare, would have done a unit in child development. One of the major assignments would have been to find a child, observe the child and then do a developmental assessment. So, any case worker with a degree should be able to do a developmental assessment. It is an interesting culture. It has stopped being a learning organisation, the department. It is my personal view. You have managers that do not talk about applying your knowledge. Caseworkers go off, become enthusiastic, come back and then they have a manager who is not interested in what they have learned. All they get is you have his case, go out and do it. They are not interested in talking about a dialogue, and that is one of the things I enjoyed about being a manager case work, the briefing, the discussion, implementing the risk assessment tool. One of the other difficulties is they have a risk assessment tool that is basically imposed on people.

CHAIR: On the workers or the families?

Ms JELEN: No, on the families.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You think the risk assessment tool has a fundamental flaw in it?

Ms JELEN: No, I think it is a good thing. It is an effective tool. Any tool that is effective and makes your job easier is good. I think the current risk assessment tool is problematic. It is too complex and the focus is on information gathering not on critical analysis. They come to the determination you have a mental health illness but they have not broken it down. How does it impact on your capacity to parent?

CHAIR: Are you familiar with tools that do this much better than the one that DOCS uses? Are there good models?

Ms JELEN: I think it can be streamlined. I understand they took the model from Victoria and just applied it here.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is it called?

Ms JELEN: The risk assessment that they do?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, what is it called? Does it have a name?

Ms JELEN: Yes, risk assessment.

CHAIR: We have been given some samples of them.

Ms JELEN: They did not pilot it. I was talking with colleagues who work in child protection in Victoria. They said the tool is very complicated and then they streamlined it. That is what we asked, why it has not been streamlined? Why has it not been piloted to see how effective it would be? Prior to that tool being implemented last year they worked off the Dalgleish model, which was very similar to what we have but is so complex now and they are so focused on information gathering that a lot of case workers are not developing the skills of critically evaluating the information.

CHAIR: Is this focus on information gathering a self-protective or defensive sort of thing because DOCS has been under so much criticism or attack?

Ms JELEN: That could be part of it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They have gone on wildly collecting data for the sake of having it and they never use this data?

Ms JELEN: Yes. Almost to the point where caseworkers get the date of birth of family support workers and other people. Almost to that extreme. How is that relevant? They have lost the

focus. The risk assessment tool is for doing an assessment on the risk. If a person receives one day of training in mental health or no training at all and they are out there, how can you apply a risk assessment model if you have minimal knowledge, minimal experience? All they see is mental health, Charmain Clift, I will refer. Ask them why they are referring. One of the things I have been asking—it is the department's protocol that when a report is allocated, they go out and do the risk assessments, I am asking for the risk assessments to accompany the referral. I have not received one to date.

CHAIR: You mean it is in the protocol that it should accompany it?

Ms JELEN: Yes. Well, I am asking for it but, if they have got to the point where they have identified service providers they should have concluded something at that point.

The Hon. IAN WEST: Sorry, is that a yes or a no?

CHAIR: It is not in the protocol?

Ms JELEN: No, it is not in the department's but we are asking for it. That would enhance our ability to respond to the consumer's needs.

The Hon. IAN WEST: You are saying it should be in there?

Ms JELEN: It should be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have to do it anyway, do you?

Ms JELEN: You have to. A risk assessment has to be put on the system so you have to do it anyhow. If you use your commonsense, they have gone out, they have intervened with this family and now identified service users, so one would think they have finished their risk assessment. They have concluded certain things and identified, but it does not appear to be happening that way. I have asked caseworkers for a copy of the risk assessment and they say they have not done it or they have not started it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are saying it is very complicated. That must be the thought process, surely?

Ms JELEN: That must be but when you look at what is good intervention, good intervention is identifying what are the risks here and why am I seeking a referral to this service? What is my outcome? You have to be outcome focused.

The Hon. AMANDA FAZIO: Do they discuss it with the family?

Ms JELEN: They should.

The Hon. AMANDA FAZIO: So they do a risk assessment and work out a program but they do not sit down with the family and work out an agreed approach?

Ms JELEN: They should.

The Hon. AMANDA FAZIO: I know that with some people they probably cannot.

Ms JELEN: Yes, but one has to question whether that happens, and that is where I say that I think in some cases the intervention is imposed. You can do it. When I was a child protection specialist I worked with five families where I did the risk assessment with them in partnership. I got them to do their own risk assessment. Yes, it was a process that took longer but the outcomes were so good for the consumers. In two cases the children were removed and placed in alternative care but the families said they could understand why. Having gone through that process they understood why decisions were made, but if you have somebody who comes out and asks you a few questions and then go back and from this—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Police come and take the child away.

Ms JELEN: Yes, doing this risk assessment and the client does not even know. There is something very wrong with that whole intervention.

CHAIR: Earlier today we heard from some care leavers who told us the other side of it, where the child does not have a clue what is happening or why.

Ms JELEN: That is one of the things that underpins the new Act, participation.

CHAIR: We should move back to our questions. Our excursion into your history working in DOCS has been useful. We have covered a lot of the issues in the questions. In relation to five, do you have any particular comments to make about the Children's Court and out-of-home care?

Ms JELEN: This is where it really does affect women with a mental health status. At this point in time if a child is placed in the care of the Minister what usually happens is that a child file is established. There should be a parent file established. That is what is not happening. Once the child is removed and a final order is made there is no follow-up, no caseworker services.

CHAIR: Do you mean there should be a parent file to look after the mother that you talked about?

Ms JELEN: Yes. Caseworker services should be provided to the parent. Caseworker services are provided to the child. In some instances not even the child is receiving caseworker services. The child's case is unallocated. In most cases the parent's file is unallocated. So you end up with consumers coming through our service that say, "I have had three children removed in five years. They promised me a lot. They said a lot of things were going to happen." The case becomes unallocated and nothing happens until the woman has another child.

CHAIR: So it drops to the bottom of the priority list because there is a view that the problem is solved because the child has been removed.

Ms JELEN: But the problem is not solved for that mother and the child. Because of mental health they almost end up in a wilderness where really no-one is intervening and access to the child is not facilitated. So the bond between the natural family and the child breaks. In some instances where the child is placed with extended family there are relationship difficulties. A grandmother takes the children. It is really great to keep children within the family but you know there is a relationship breakdown between the mother and the daughter. The case is closed. How do you expect a grandmother to facilitate access if there is no relationship? So mum loses contact with her children.

The Hon. AMANDA FAZIO: It is also a waste of resources in that if the woman had a child taken away and then three years later she has another baby they start again with a risk assessment?

Ms JELEN: Yes, the whole thing starts again.

CHAIR: Because it is a child file, not a parent file.

Ms JELEN: Yes, eight children removed and they could give us no information. I just find that amazing. One would think that the caseworker would show some interest that there had been eight previous children removed. And we have not seen this caseworker. The department makes short-term orders. That suggests that we are going to work towards restoration, that there is a light at the end of the tunnel, that the short-term order is going to facilitate. They will actually close the file. They will file it. And then—

CHAIR: Then the child gets restored to the—

Ms JELEN: No, that child does not get restored because what invariably happens, because there were no caseworker services, is that the mother has been sitting around waiting and doing nothing and then the two years or the five years is up, the department reactivates the file and finds that the short-term order is coming up and they take it back to court and they seek long term.

The Hon. JAMES SAMIOS: Is it the caseworker that imposes that sanction or is it somebody more senior?

Ms JELEN: It would be the manager caseworker that would file it. That is a huge disservice to women with a mental health issue. It is almost as though the attitude is that she should have pursued this or this. This is a person that is extremely vulnerable, that is disadvantaged. Her understanding, especially if you have a dual diagnosis, would be that the child has been taken for two years but the child will be returned after two years. So they sit around and literally wait. When the two years is up they want the child back. Then she is told that she has not done anything. Do you not feel that that is such a miscarriage of justice to the parent to file a short-term order? Again, I find that amazing, not to provide caseworker services to the parent.

CHAIR: We heard from the group of young care leavers—it happened in each case—that almost every child removed from their family will seek contact later. While that contact may often be a fairly unsuccessful process, the point was that there is almost always going to be this attempt to re-establish contact or move back home or whatever. That in itself would suggest that unless there is ongoing contact and work with the parent even from the child's point of view there are problems building up for the future.

Ms JELEN: And that is critical. In cases where there have been caseworker services and that relationship has been maintained there is a far better outcome for the child and for the parent. There is a recognition that if you are not able to provide primary care you can develop and maintain a relationship with your child at a different level. But how can that be maintained if there are no caseworker services for the particularly disadvantaged and vulnerable parents? It is systems abuse. They become abused by another system. Then you end up with not only a disservice to the parent but also to the child, because the child will invariably go looking where they come from. But they do not go through that if the contract has been maintained. I am not talking about four times a year for identity purposes. I do not understand why the department cannot facilitate access to a natural parent where it is appropriate on a weekly basis.

CHAIR: One of the issues would be that it would be resource intensive.

Ms JELEN: Exactly. Why is it that if the department does not have resources it becomes the consumer's problem? That is what I say to the department: "Resourcing is your issue. Do not make it the consumer's issue." With mental health and the department's crisis intervention mode it wants a quick fix. With some—I am looking for diplomatic words—incompetent manager caseworkers it is a dump job. "Make somebody else responsible. I do not want to be responsible." These caseworkers have limited knowledge and awareness. When you are talking about families that have mental health illness or disorders we are not talking about two years. I said, "Develop the care plans for the next 15 years, because that is what you are basically looking at if you have a true commitment to keeping children with these parents." They cannot think in those terms. They say, "Oh, good God, no, we can't do that." Yes you can, if you are committed to doing this where you have a case co-ordinator. In many instances caseworkers think that because mental health is involved they will follow through. Mental health does not do ongoing casework; their casework is episodic. They get involved in the acute stage. Once it is stable they withdraw, because usually the client continues with their psychiatrist or GP.

CHAIR: And in any case the mental health people do not take responsibility for the children.

Ms JELEN: Yes. I am trying to get caseworkers and caseworker managers to throw out the attitude that this is mental health. You have to look long-term because the schizophrenia or bipolar disorder is not going to go away. This will be part of the life of the mother and child for the rest of their lives.

The Hon. JAMES SAMIOS: How important is the access where the parent has been abusing the child?

Ms JELEN: Any access for parents is important as long as the access is facilitated where the child is safe. In 13 years of working with the department I recommended to the court only once that access cease—where the mother was psychotic and she was a danger. But once she went on the medication and stabilised access was kick started very quickly. In very few cases would you say no,

because you can have supervised access. It can be facilitated in a way that is safe and beneficial for the child.

CHAIR: A couple of the care leavers we talked to mentioned having secure files and in one case a change of name for safety reasons. I guess there is always a minority.

Ms JELEN: Yes, there always is, but it is such an individual thing. To have this belief that the mother is schizophrenic, she is delusional—

CHAIR: In this case it was the father they were talking about.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That would be because he was aggressive.

Ms JELEN: Yes. It is usually in cases of child sexual assault, which is something very different again. This belief that because a woman is delusional somehow she will harm her child—most of the time you manage that. You work around it. If you have a sensitive, well-informed intervention it can be done and it can be done effectively. We have seen the outcome time and again working with the department, with mental health and other service providers. The biggest problem is that there are limited options. There is an inflexibility by the department. I know that Carmel Niland wanted to make the department a leader. I thought that was a wonderful idea. But basically the department is a hostile environment. It is not conducive to creative thought and innovation. I have been there, done that and I gave up. I walked away from the department. After 13 years with a very strong commitment I said, "I cannot work for an organisation that has stopped learning, that is becoming almost abusive. I think we are starting to see the effects of the Priority One policy. Priority One and early intervention—it actually undermines the process because a lot of the cases in Priority One are early indicators. What is happening to these children? They are being filed, unallocated.

CHAIR: The next question deals with prevention and early intervention. You are saying yes it is important but no it is not happening.

Ms JELEN: Prevention and early intervention are extremely important. I think we need radical changes with the department. It is not about shifting deckchairs any more. My personal opinion is that there is a conflict within the department because we are looking at child welfare issues and child protection—two very different areas. Yet they try to combine it. I have a belief that child welfare is the long-term welfare of the child. That is where I think more money should be put into community-based services, where family support workers and other community-based workers can be trained in detection and child protection, and that is where the department should define its core business. You cannot do both. I think that has always been the problem for caseworkers. In some cases you are talking about not good enough parenting. Parents are dealing with difficulties. It is really about child welfare where you have the serious cases where it is specifically child abuse. I think those two need to be separated.

CHAIR: Into separate departments or into the recently-announced three streams within the department—prevention, protection and out-of-home care?

Ms JELEN: If you went with the three streams there would have to be some accountable practice where one would not overtake the other.

CHAIR: Quarantining of resources?

Ms JELEN: Yes. That is what happened. Child protection overtook out-of-home care. The demand was so great that you had to decide whether to provide casework services to a child that is safe and in alternative care or to a child where there are serious child protection concerns. This one will always overtake the first one. What invariably happened was that children in out-of-home care stopped receiving the appropriate services. Parents received nothing while this system overtook it. It is about finding your core business so that one does not overtake another. It is the same with prevention and early intervention. It is identifying and being accountable for the dollar being spent there. That is what it will be spent on. Having separate budgets would ensure that there is an effective use of the dollar in that area.

CHAIR: And yet you said yourself a moment ago that people need to be trained in detecting. In a sense, you are building in that conflict where the people whose role is prevention or early intervention—

Ms JELEN: I do not agree with that. If people are trained in identification and there is serious abuse, they are not going to deal with it, it will be referred to the appropriate CSC or whatever. I think the dilemma for the department is wearing too many hats, trying to do too much, and in the end child protection just overtook it. Having definite roles and responsibilities about who does what and who gets to pay for what, and maybe from that if so much is targeted for community-based from each sector, then you are going to have a much more integrated community-based service response because there will be more choices for consumers than what you can do with families.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that these other functions should be contracted out to Families First or other non-government groups. You are saying that one department cannot really do it unless someone at the top quarantines the money?

Ms JELEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you not be better to put that money into non-government organisations, to do the early intervention support work?

Ms JELEN: I think so, because the way the system is now, the accountability factor for NGOs is quite high, whereas the accountability factor for the Department of Health and the Department of Community Services—

The Hon. AMANDA FAZIO: Do you also think there would be more acceptance within the families who need support if that service provision were from the NGO sector rather than from DOCS?

Ms JELEN: This is true. In a lot of issues where you have mental health, it is a child welfare issue, it is not child protection per se the stock there is a big difference to that. When you have a consumer who has already gone through a process and they are fearful and distrustful—and I think that is one of the big stumbling blocks for the department—it makes more sense to have child welfare types of services from a community base because it is within the local community. It is also easier access.

CHAIR: If you look at NGOs that are involved in out of home care, for example, I wonder whether some of them are not so large that you can no longer describe then as community based.

Ms JELEN: The delightful thing about those large NGOs in alternative care of or foster care is that they have actually being able to maintain quite a good ratio of cases to caseworkers. Barnardos is in a position to say "We provide quality services" because their caseworkers have a ceiling of five to six cases. Compare that to a DOCS case worker, who can have anything from 30 to 40 cases.

CHAIR: DOCS workers have told us how unfair that is. They have said that if doctors did not have to take all comers, and therefore continually increase their caseload, if they could save like the NGOs can, they would be able to provide quality services.

Ms JELEN: And that is so true, because overall there is a level of expertise and experience in the department that the department itself does not even tap into.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean they are squandering their people?

Ms JELEN: Yes. It is amazing that they will actually pay for consultants to come from Queensland or Victoria, yet you say to central office, "You have the expertise in your own field. Why don't you tap into your own expertise and knowledge?" There are people out in the field who have really wonderful expertise and knowledge, yet they are looking elsewhere.

The Hon. AMANDA FAZIO: What are they using these consultants for—to evaluate performance?

Ms JELEN: Yes, or to develop new policies and procedures. I think central office does its own thing.

The Hon. AMANDA FAZIO: You said earlier that to you think one of the problems is that caseworkers are not able to critically evaluate the information. Surely, if they were involved in some of these other evaluation work, their own legal skills would improve and they would be better performers all round?

Ms JELEN: One would think so, yes. But central office seems to operate on its own, and you have the helpline, which is another little unit out on its own, so there does not seem to be a lot of dialogue going on within the department itself. Then you have this expectation that you are going to work with NGOs or other service providers, when they cannot even to eat internally themselves.

CHAIR: You work with the department until four months ago?

Ms JELEN: Yes.

CHAIR: So you left just as our inquiry was beginning, shortly before the appointment of the new director-general, and some of the decisions, such as the three streams?

Ms JELEN: Yes, that is right.

CHAIR: What would you like to see come out of this inquiry?

Ms JELEN: I would like to see caseworkers having be opportunity to access to better training and clinical support. It would be good to see more resources available, more money put into community-based services, and more prevention and early intervention.

CHAIR: Do you mean almost deliberately limiting of the size and scope of DOCS by shifting resources to the non-government sector?

Ms JELEN: Yes. I think in some instances we need a statutory organisation that responds to child protection. But I think we need to really identify what is child protection, as opposed to child welfare. I think that is a critical question. When we talk about child welfare, that is where prevention and early intervention is critical. I think that with child protection it is a knee-jerk reaction; it is crisis intervention, a quick fix, in and out.

CHAIR: Would you also therefore strongly support our quarantining of out of home care away from those other two streams?

Ms JELEN: Yes.

CHAIR: With all that means for support for foster carers and so on?

Ms JELEN: Yes, and casework services to parents. That would be a wonderful start: Where parents who have lost the care of the children actually have an ongoing relationship with the department or whoever is working with the child, so that ongoing access is facilitated. In some instances, in the working with natural parents, the case worker is actually in a position to identify that the parent is becoming unstable and is able to divert the parent back into the mental health system during that stage. But if nobody is involved, these parents become homeless and more socially isolated. It is almost as if they are forgotten, and they should not be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In our earlier report we suggested that we should have a department of child development. Would you suggest that that simply be quarantined money and given to the NGO sector—in other words, it would merely be administered? The criticism that has been made about our suggestion is that it is just another bureaucracy, and certainly for all concerned it seems that you have taken it off the front line by definition. If you are not

going to do that, consistent with your framework of early intervention being done by NGOs, would you simply say the money should be quarantined and given it to NGOs to do that task?

Ms JELEN: May be that is a better option. But then you have the problem: Do you develop a bureaucracy within the NGO? It is really problematic.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you will have to have that anyway, would you not?

Ms JELEN: Exactly. But at the moment the funding for NGOs is that you are accountable, you have to actually provide a standard, you have to show how—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that is a good tradition that you can build on, rather than having to develop a new one within DOCS? You are already expanding your activities of Family's First anyway?

Ms JELEN: I would agree with you. The other thing that is important is that it is not about creating another bureaucracy, but the culture in DOCS is quite negative and apathetic. Maybe something like that needs to the away from DOCS, so that it does not take on that culture. I think that is one of the other things you really need to look at.

CHAIR: Although, for example, I think the Public Service Association would say that the problems in dogs have being made worse by this enforced shift away from the positive and productive areas of prevention and early intervention, and the more That DOCS has been forced to a crisis into, the more the cultural sorts of problems that we have spoken about have infected the organisation; that the workers in docks and the department as a whole perhaps need the range of activities, that they have the positives as well as the crisis and perhaps much more difficult end of things.

Ms JELEN: I would not necessarily agree with that, because there are people who are attracted to child protection and mainly want to work in child protection. With your own professional development, you actually move from organisation to organisation. So I would disagree with that argument. People will move where they are attracted. If you have another organisation but that specifically looks at child development, people who are drawn to that area will go there. There are certain people who really enjoyed working in out of home care, and that is where they will stay. So I do not necessarily agree with that.

CHAIR: As you can tell, we have had so many different views put to us, and some of them are dying magically opposed. But certainly the union has expressed concern about some of those carve-up options and the effects they might have on workers.

Ms JELEN: I suppose the question is: Is the service for the consumer or is it for the worker?

CHAIR: They would say that unless you have well-motivated and moderately contented workers, the service will also suffer.

Ms JELEN: I do not think that will change because they will get more money to have a section called child development. In all of my networking and from talking to people who continue to work in dogs, I have yet to hear anything positive at the moment. There is a real apathy; there is nothing positive. Over all, I think workers are looking for a change. I think a lot of workers have come to the conclusion that this system is becoming abusive. Priority one colludes with abuse. How can it not? If you have information before you that somebody has made an allegation where the well being of the safety of a child is compromised, and a departmental officer in closes it, how can you tell me that that is not colluding with abuse?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think there has been any change to the departmental culture since that has not filtered down to the bottom, or is that too recent to assess?

Ms JELEN: It has filtered down. It is almost like a bush telegraph in the department. I am sure that people out in the field know things before Dr Neil Shepherd. It is still very much the same,

except the clear message they are getting is: Do not spend money; curb your spending. That is the biggest thing the case workers have picked up; we cannot spend. There is no other positive message. It is just that they will not let us spend money.

In many instances, in our referrals, where you have a mum and dad, my suggestion is to put in a submission for home-based intensive family support? Family support services will do it. It costs too much money. Your services are already funded; you are the cheaper option. That is not a positive intervention for this family; that is not what they need. So it is a game of trying to fit the consumer into the service provisions.

CHAIR: Some witnesses have told us that that approach has been going on for years. For example, the people from the women's refuges have said, as you and other witnesses have said: This child is safe, this child is at least in the service; we will get onto the next crisis. People have certainly made the point that that sort of thing has been the practice for many years. Are you suggesting that has become more so?

Ms JELEN: There has to be a flexibility of identifying the needs of the family and responding to those needs; not identifying the services and then getting the families to fit into the services. That is really not a good intervention approach.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You say it is topped down. It has always been top-down driven? It is always: This is available, what service do you want? It is not: What do you need? We will get it.

Ms JELEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Historically that is the essence of the problem?

Ms JELEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Paternalism, in a way, or convenience?

Ms JELEN: Convenience, yes.

CHAIR: You have given the Committee useful evidence about health and mental health aspects at Charmian Clift Cottages and also from your long experience at DOCS. That is twice the value. If you think of anything we did not cover could you correspond with the Committee?

Ms JELEN: Yes. It has been an interesting and pleasurable experience.

(The witness withdrew)

(The Committee adjourned at 4.32 p.m.)