ROYAL COMMISSION
INTO DOMESTIC, FAMILY
AND SEXUAL VIOLENCE

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TUESDAY, 25 FEBRUARY 2025

COMMISSIONER NATASHA STOTT DESPOJA, Presiding

Commissioner: Good morning, everyone, and welcome to the fifth day of public hearings at the Royal Commission into Domestic, Family and Sexual Violence. My name is Natasha Stott Despoja, and I'm the Royal Commissioner for this Commission. I begin of course by acknowledging the traditional owners of the land on which we are meeting today, the Kaurna people. I pay my respects to the elders past, present and emerging and to any other elders from other communities who may be present or listening today. I do want to thank Mr Robert Taylor for his initial welcome to country at the beginning of these hearings. As many of you are aware, the Commission has been in place since July last year, and we have endeavoured to engage as many stakeholders as possible. We've had more than 350 submissions, more than 800 surveys returned and at this stage, around 100 consultation sessions. These have helped us to hone in on particular themes requiring additional exploration and investigation. So we're now in the public hearing stage.

Our first session examined the issue of housing, including homelessness for victim-survivors of domestic, family and sexual violence, emergency accommodation and funding arrangements for assistance. Our second set of hearings examined issues such as the lack of access to forensic medical examinations for victim-survivors of sexual assault and how this is exacerbated, particularly in remote, rural and regional areas. And the third hearings examined some of the ways that we can prevent domestic, family and sexual violence from occurring in the first place, namely, education strategies in schools and primary prevention practices. Today, we move to the topic of children and young people. You will hear about the work of the Commission and the work that we've done to hear directly from young people and children, as well as their representatives. I'm particularly pleased with the youth forum that we held last year, at which young South Australians had the opportunity to tell me directly their views about what constitutes safety for them, what they consider a safe, peaceful environment.

And, particularly pleased about the postcards that we've received, thanks to the Commissioner for Young People and Children, Helen Connolly. What I've heard many times over from young people, and on that day at the forum in particular, and meetings with the South Australian Youth Forum and the Ministerial Council on young people, young people feel they don't have a voice and with good reason. Our forum was a chance for them to be heard and for me to gather some important information and insights from this diverse, passionate and impressive group of young Australians in all their difference and diversity. It was abundantly clear to me that young people and children deserve a voice, they deserve a role, they deserve to be believed, be safe and have a say in what's going on around them. In the words of victim-survivor from Victoria, Connor Paul, who is now an advocate on these issues, he says, "We have the right to feel safe and live a life free of fear", which today is why I'm particularly pleased that we're having this topic examined. Before counsel assisting outlines the witnesses that we will hear from today, I wish to address an issue in relation to the child protection system.

The Royal Commission has learned, and I expect that we will hear today, that the South Australian child protection system is closely linked to the domestic, family and sexual violence system. At the time of this hearing, there is a bill before the State Parliament which proposes reforms to the child protection system. The purpose of today's hearings is not to explore the bill or any of the specific reforms to the child protection system that

are set out in that bill. While issues in relation to child protection are likely to be explored today, I wish to make it clear that nothing the witnesses or indeed counsel assisting or myself might say should be taken as a reflection of the Royal Commission's views on that legislation. The Commission will, in time, carefully review and consider any reforms and may make recommendations relating to the child protection system in its final report. After the first set of witnesses today, we will anticipate a short break around 11.15 am. I now invite counsel assisting to give her introduction. Thank you.

MS K. ORR: Thank you, Commissioner. Today and tomorrow we are conducting the Royal Commission's fifth and sixth days of public hearings. Today's evidence will be, as the Commissioner has said, focused on children and young people. Tomorrow's will be on intervention orders. Before we commence today, I will reiterate some comments that have been made at the commencement of our previous public hearings. First, I acknowledge the domestic, family and sexual violence lived experience of anyone involved in the hearings, following on the live-stream, or watching the recording of this hearing at a later time. Today I acknowledge particularly the lived experience of children and young people who are experiencing, or have experienced, or have otherwise been exposed to domestic, family or sexual violence. People may find the content of today's hearing distressing. I remind anyone watching or listening that if you wish to seek support or advice, a list of support services can be found on the Royal Commission website, which is www.royalcommissiondfsv.sa.gov.au.

In relation to terminology, when we refer to domestic and family violence, it includes all forms of violence that can occur within relationships. This includes intimate partner violence, violence perpetrated between family members and in family-like settings, coercive and controlling behaviour and sexual violence. Sexual violence, whether in a domestic or family setting or otherwise, includes any sexual activity without a person's consent. We will continue to use the term victim-survivor to refer to people, including children and young people, who have experienced or who are currently experiencing domestic, family and sexual violence. And we will use the term person who uses violence when referring to an individual who uses domestic, family or sexual violence to cause harm to another. Children and young people can for some systems, services and studies include people up to 24 years old. But for today's purposes we are really focusing on those who are under 18. Children and young people are an important part of the Royal Commission's inquiry, and we have made a deliberate choice to dedicate a day of public hearings to these members of our community.

Evidence regarding the prevalence of adverse childhood experiences is emerging in Australia. The 2023 Australian child maltreatment study found that child maltreatment is an endemic and nationwide problem affecting today's children and young people. The study revealed the high prevalence of childhood experiences of physical abuse, which was 28 per cent, sexual abuse, 26 per cent, emotional abuse, 35 per cent, neglect, 10 per cent, and exposure to domestic violence, 44 per cent. The rates of children and young people experiencing two or more types of maltreatment were high, 40 per cent, as were the frequency and duration of these experiences. The same study affirmed that experiences of childhood maltreatment are associated with severe mental health problems and behavioural harms, both in childhood and adulthood. Evidence is also increasingly revealing the strong links between adverse childhood experiences and the subsequent use of violence in adolescence and adulthood. A 2022 ANROWS study into

adolescent family violence in Australia revealed that 89 per cent of young people who had used violence in the home reported that they had experienced child abuse.

This data paints a clear picture that, firstly, children and young people in Australia are at significant risk of experiencing violence, and secondly, that they must be supported to escape and recover from that violence and to break future cycles of violence. In the National Plan to End Violence Against Women and Children 2022 to 2032, the need to recognise children and young people as victim-survivors in their own right is a theme across the four domains of prevention, early intervention, response and recovery. The National Plan notes the long-term impacts of domestic, family and sexual violence on children and young people and rights. Children can witness violence, but children can also experience violence directly. A child's world view is shaped by the violence they see, hear and experience each day. These experiences affect their perception and understanding of the world which can have long-term and ongoing impacts. It goes on to say, "This underlines the importance of preventing and intervening early when children are experiencing violence, abuse and neglect. Supporting children as victim-survivors in their own right and addressing the impacts of developmental trauma will help break future cycles of violence."

Consistently with the National Plan, the Royal Commission's terms of reference direct it to have regard to recognising the rights of children as victim-survivors of family, domestic and sexual violence and to ensure an approach that includes the experience of children. The Commission has proceeded with children and young people in their own right as an important focus of its inquiry. It has put many mechanisms in place to hear directly from children and young people. The Commission has engaged Professor Kate Fitzgibbon to conduct a research project within South Australian children and young people to inform the work of the Commission. At the time of this hearing, she has interviewed over 30 children with lived experience of domestic, family and sexual violence. As the Commissioner has mentioned this morning, in November the Commission met with 89 Year 7 to Year 12 students from South Australian public, independent and Catholic schools at a student summit on creating safety for all in South Australia. The students were invited to advise the Commissioner on the issues the Commission should focus to make life safer for young people and how the Commission can most effectively deliver change.

The Commission also partnered with the South Australian Commissioner for Children and Young People, to distribute postcards to services working with children and young people so that they could share their views with the Commission. We have received over 131 postcards from people of ages ranging between 8 and 17 years old. Some of the comments written on the postcards provide a clear insight into what children say makes them feel safe, such as "being around people I trust", "when I have good people with me" and "when I am accepted and not judged". The postcards also included some suggestions for the Commission to consider in helping to prevent family and domestic violence in South Australia. Some of the comments were, "stop parents fighting because they are drunk", "have more intense education from young ages", "better supports and a better system that people can trust". Sadly one child responded with, "I don't think they can prevent it", which is exactly why we are having this conversation today. The Commission has also engaged with and received submissions and reports from the Commissioner for Aboriginal Children and Young People, the Commissioner

for Children and Young People, as I've mentioned, and the Guardian for Children and Young People.

Engagement with the Commissioners and the Guardian will continue through the Commission's work. In its work so far, the Commission has heard that despite the risk of various forms of violence to children and young people, and the importance of providing support to children and young people in their own right, there are very few supports available in South Australia for children and young people experiencing, using or at risk of domestic, family and sexual violence. This was raised in evidence in previous public hearings when witnesses explained that St John's Youth Foyer was the only service in South Australia providing housing for unaccompanied young people aged 16 to 24 who are homeless or at risk of homelessness and that Kind is the only service in South Australia providing therapeutic interventions for children and young people using violence. It has also been clearly articulated in submissions received, in responses to our online share with us tool and in listening sessions attended by the Royal Commission. The Commission has also heard that children and young people who experience domestic, family and sexual violence feel like they do not have a voice, that they are not heard, or they are not believed. This was a clear theme in a report received from the South Australian Commissioner for Children and Young People.

Participants described wanting their views and wishes to be sought and recognised, particularly when they may differ from a parent. They expressed that they have no choice or control, and they were not part of the service response. One young person shared that children know more than adults give them credit for. They might be confused by what is happening, but they know it is wrong and will often be able to be clear about how things should be different. The first witness for today is Professor Leah Bromfield. She is the Director and Chair of Child Protection at the Australian Centre for Child Protection at the University of South Australia. The centre is Australia's premier research centre for the prevention of child abuse and neglect. Professor Bromfield is an internationally recognised and award-winning researcher in the field of child abuse and neglect, child sexual abuse, and issues affecting child protection systems. She is also the 2025 South Australian of the Year. Professor Bromfield will give evidence about children and young people who experience domestic, family and sexual violence, including incidences of violence and its impact. She will talk about some systems which impact children affected by violence, abuse and neglect and some issues seen in those systems.

She will also give evidence about children who display harmful sexual behaviours. Then we will hear about therapeutic services for children and young people who experience violence from Ms Sarah Decrea and Ms Chloe Henderson from Relationships Australia, South Australia or RASA. They will discuss the importance of providing these services and describe the therapeutic programs run by RASA. This afternoon we will hear from three witnesses from SA Health, Rachel Kirby, Melissa John and Heather Baron. They will give evidence about the role of SA Health in providing services to children and young people in the context of domestic, family and sexual violence. In particular, they will give evidence about the services offered by Child Protective Services within SA Health and the new model of care that has recently been released. Finally, Associate Professor Rhiannon Pilkington will give evidence. She is an Associate Professor at Better Start Health and Development Research at

Adelaide University. She will tell us about Better Start's Thriving Families model, which is a vision for how South Australia can reach thriving families by 2045 based on research and data collected by the Better Start team. Thank you, Commissioner. I call Professor Leah Bromfield.

LEAH BROMFIELD, AFFIRMED

MS ORR: Welcome, professor.

A/PROF BROMFIELD: Good morning.

MS ORR: We've heard you are a professor and I understand you are the director and chair of Child Protection at the Australian Centre for Child Protection at the University of South Australia. Is that correct?

A/PROF BROMFIELD: That's correct.

MS ORR: Can you tell us a bit about the Australian Centre for Child Protection?

A/PROF BROMFIELD: Absolutely. The Australian Centre for Child Protection is the premier national centre for child protection. We were established at Uni SA in 2004 by a grant from the Commonwealth Government to create a national centre that would generate new knowledge and help to bridge the gap between what we know and what we do in preventing and responding to child abuse and neglect. We are very proudly a mission and values driven centre and strive to develop practical evidence-based solutions to address the problem of abuse and neglect in Australia.

MS ORR: Thank you. Before we move on to the substance of your evidence, I understand you're also currently the chair of the South Australian Child Protection Expert Group.

A/PROF BROMFIELD: That's correct, yes, we've been charged with developing a 20-year vision for re-imagining the way we approach child protection in South Australia.

MS ORR: You're the chair of the Tasmanian Uplifting Care Independent Expert Group.

A/PROF BROMFIELD: I am.

MS ORR: And the co-chair of the National Strategy Advisory Group for the National Strategy for Preventing and Responding to Child Sexual Abuse.

A/PROF BROMFIELD: I am, and I should look for roles with shorter titles.

MS ORR: And you were also the Commissioner for the Commission of Inquiry into the Tasmanian Government Responses to Child Sexual Abuse in institutional settings.

A/PROF BROMFIELD: Yes.

MS ORR: And this year's South Australian of the Year.

A/PROF BROMFIELD: Yes, it's an honour.

MS ORR: Professor, in your research and other work in child protection or child abuse and neglect, I assume you consider children who have experienced domestic, family and sexual violence?

A/PROF BROMFIELD: Absolutely. We consider children's experience of family and domestic violence to be a form of abuse and neglect. So there are five types of child abuse and neglect. They are sexual abuse, physical abuse, neglect, emotional or psychological maltreatment, and experiencing family and domestic violence. The evidence is quite clear on the harms to children of experiencing family and domestic violence.

MS ORR: So I want to ask you a bit about that now. Can you explain some of the ways that children may experience domestic and family violence.

A/PROF BROMFIELD: Yes. I think it's really important to explore this. I think historically we've tended to think of children as passive bystanders or witnesses to domestic and family violence, and that so underestimates their experience. Children's experience of – I'm just going to say DFV to shorten my evidence.

MS ORR: Yes.

A/PROF BROMFIELD: It can be really multifaceted. So it includes, obviously, seeing violence, hearing violence. Children can be, I guess, caught in the crossfire. So, for example, a baby in arms can be hurt during a violent incident. Children are not passive so often, though. They will at times be harmed when they're intervening to try and protect a parent. They can be threatened with harm as a form of control, or their parent can be threatened with harm as a consquence of their behaviour. So that's part of the coercive control or manipulation. They can be told that they're responsible for the violence towards another. So, you know, "I had to hit your mother because you didn't do this." So really enmeshed in the violence. They can actually be forced to enact physical and sexual violence against other family members. And they can suffer violence in terms of – and threats of violence towards their pets. So really every aspect of the experience of family and domestic violence is also experienced by children.

And it doesn't only impact children when it's happening. So I think that's – when we talk about seeing and hearing, it's very much in the moment. Children know and understand so much more about violence than what they see and hear. You know, they will notice the bruises. They will notice the broken – the damage to furniture or property. And they can feel this fear, this pervasive fear about the violence and the impacts of violence whether they're inside or outside the home. So, for example, I've seen kids talk about being afraid to go to school because they need to be at home to protect their mum or their younger siblings. Or being at school or outside of the home

and just being so worried the whole time that they can't concentrate because they're worried about what's happening at home. So violence is not just about seeing and hearing. It is part of the daily lived experience of children who are growing up in households where there is active domestic violence.

MS ORR: What are some of the impacts on children of this?

A/PROF BROMFIELD: Well, I guess not surprisingly, given what I just explained, the impacts are really significant, and they affect all domains of a child's development and well-being. So obviously children who experience family and domestic violence are at great risk of physical harm, and physical abuse and domestic and family violence are the two abuse types that co-occur most frequently. But that state of living in a constant state of fear, that actually has been shown to affect the developing brain. So we actually see from brain scans, neurological impacts to children who are in that constant state of fear. When you're in that constant state of fear you can have what is called hypervigilance. You know when we talk about fight/flight/freeze, when you're ready for violence all the time, your stress response system is constantly switched on. And that's really functional if you've got to be ready to run, hide because domestic violence can happen. But when that's switched on all the time for kids it can be hard then for them to switch it off. So they go into the classroom and they're still ready to fight/flight. So they're interpreting so many things as threats. So we see a lot more externalising violent behaviours, dysregulating in classrooms, for kids who are experiencing domestic and family violence.

When the people that you love the most are also a source of harm, that also creates attachment difficulties. So it's really hard to have that secure, trusted relationship with a person who is supposed to care for you when they're a source of fear. And that can flow through into later difficulties in forming and maintaining positive relationships throughout life. Obviously, there are significant psychological impacts. So depression, anxiety, PTSD, self-harm, suicidal thoughts, suicide attempts, suicide, complex trauma, plus, plus, plus. So really any kind of mental health condition, you are at greater risk if you've experienced chronic abuse and neglect and FDV.

I talked about that link between FDV and what I talked about as externalising behaviour problems. So that is things like violence, aggression, harmful sexual behaviours. That's partly about that being dysregulated and misinterpreting everything as threats, but also that you've been socialised that violence is the way you respond to things. Violence is the way that when you're feeling out of control that you re-create control. And in households where family and domestic violence is tied to negative gender attitudes towards the role of women, then that also can manifest in kids in their attitudes to girls and women.

MS ORR: And you mentioned behaviour of young people at schools. What about school attendance, educational outcomes?

A/PROF BROMFIELD: Yes. So these can flow through then to school attendance. So school attendance it might be because you're afraid to leave the home because you want to protect someone at home. It might be because mum and dad are so struggling

with everything that is going on in their life that they're not getting you to school. Or it might be that you've gotten so behind because of those impacts in the classroom you're disengaging from the school. So that of course affects your educational outcomes. So all of these impacts that I've talked about, they accumulate, so they have these knock-on effects. It's not like they stand alone. So they accumulate across they lifespan and they reach into adulthood. For example, that not attending school – so you're not attending school to protect your younger sibling, you're distracted and dysregulated when you're at school, you're getting behind. You don't catch up. Eventually you disengage from school because you feel so negative when you're there. You start interacting in youth spaces where you start engaging in high-risk adolescent behaviours. And this impacts your later life opportunities so that it's really hard to thrive.

MS ORR: I wanted to ask you, then, about longer term impacts, which you've started to address. What are some of the long term impacts?

A/PROF BROMFIELD: I want to say, because I'm being – family and domestic violence is so bad for our kids, it's so negative. But it's also not a life sentence. So I don't want to suggest that everyone that's impacted by violence is irrevocably damaged and healing is totally possible. I myself have experienced childhood violence. But we do know that experiencing family and domestic violence as a child is associated with a range of long term impacts that can extend into adulthood. So your adults who have experienced family and domestic violence as a child and other forms of abuse and neglect are at a disproportionate risk of poor mental health outcomes, of substance misuse, of unemployment, poverty, socio-economic disadvantage – which is often related to those poor early school outcomes – relationship difficulties.

Adults who have experienced violence as children are disproportionately at risk of re-victimisation, physical and sexual violence as adults. And adults who experience violence as children are at greater risk of using violence as adults. And sadly, the impacts of violence can directly impact victim-survivors' parenting capacity. So all of those impacts – the substance misuse to try and dull the intrusive traumatic memories, the mental health as a result of the domestic and family violence, they can make it really, really hard to parent, to meet the needs of your own child and can lead to intergenerational transmission of violence. And we see this really often when we look back at the childhood experience of parents who are reported to Child Protection.

MS ORR: I want to ask you now about the incidences of domestic and family violence in Australian children and young people. I understand you've got some data with you, some figures.

A/PROF BROMFIELD: Yes. So I don't promise to remember all of these.

MS ORR: No.

A/PROF BROMFIELD: Yes. Sorry. Go ahead?

MS ORR: Yes, go ahead.

A/PROF BROMFIELD: So you spoke about some of this. There's different data sets for how we understand the prevalence of family and domestic violence in terms of children's experience of it. But the Australian Child Maltreatment Study is an Australian landmark, our first national prevalence study of child abuse and neglect. It was actually a recommendation of the Royal Commission into Institutional Responses to Child Sexual Abuse, for which I was the professorial fellow. And in that we recommended a national prevalence study that looked at all abuse types together. Even though the Royal Commission was looking at sexual abuse in institutions, we had heard so much in our evidence about the co-occurrence of different abuse types, we understood we needed a prevalence study that looked at all the abuse types.

So the Australian Child Maltreatment Study is the response to that recommendation. It's a nationally representative study. It included a sample of eight and a half thousand Australians aged 16 to 65 plus, but it looked at that sample of eight and a half thousand people in age groups. So there was three and a half thousand in that sample aged 16 to 24 years, so what I call the young Australians sample. So sometimes I will talk about the whole sample, the eight and a half thousand, everyone from 16 to 65 plus; sometimes – most of the time I will talk about the young Australians, 16 to 24, because that's our best estimate. I'm also going to just be a little bit professorial here.

MS ORR: Please do.

A/PROF BROMFIELD: There's a difference between prevalence and incidence. So because I'm a professor I'll use the terms precisely. So prevalence is did it ever happen in your life, whereas incidence is about did it happen in a specific period. So incidence rates are often a little lower than prevalence rates because prevalence you're looking at any incidents up to, you know, age 18, and incidence you're often looking at things like your Child Protection data in the last year this many children experienced X. So the Australian Child Maltreatment Study is a prevalence study, so anything up to age 18. 61 per cent of young Australians reported experiencing one or more forms of abuse and neglect in our landmark nationally representative studies. 61 per cent. That's telling us that child abuse and neglect is actually experienced by the majority of the population of children. That's really shocking. I don't know why we're not shouting about this from the rooftops. Our kids are our greatest asset for the country and 61 per cent are experiencing one or more forms of abuse or neglect. One in four children actually experienced three to five types of abuse and neglect, and that was often repeated incidents over a prolonged period of time. So what I talk about as chronic abuse and neglect. And within this study, as you mentioned in your opening, experiencing family and domestic violence is itself a form of child abuse and neglect.

And in fact, the study showed it was the most common form of child abuse in Australia. So 43.8 per cent of young Australians had experienced what they termed in the study exposure to domestic violence or EDV. I want to point this out because you talked about your definition of family and domestic violence for the Royal Commission. Exposure to domestic and family violence is actually a subset of that because that stunning statistic, 44 per cent of young Australians having been exposed to family violence, is actually them seeing or hearing intimate partner violence between their parents or a parent and their intimate partner. So it excludes violence between other

family members, and it also excludes the aftermath of violence, you know, being aware but not seeing and hearing. So narrow definition relatively and still 44 per cent. I guess the thing that really staggers me in this is it's actually increased. So when we look at the total sample, the 8500, 39.6 per cent of Australians 16 to 65 plus had been exposed to domestic violence, whereas in our young sample 43.8 per cent. We should be really concerned as a nation when we are going backwards in any statistic that relates to the prevalence of violence.

MS ORR: I want to ask about co-occurrence.

A/PROF BROMFIELD: Yeah, yep. So, as I said, it's actually a really important issue, co-occurrence. Let me find my way back to what I was going to say about this. So it's not just the most common form of abuse and neglect. Witnessing or exposure to domestic violence in the study was also the abuse type that was most likely to co-occur with any other form of abuse and neglect. So physical abuse, emotional abuse, sexual abuse, neglect, they were all the most likely to co-occur with exposure to domestic and family violence. This tells us something about, I guess, the dynamics of violence and that there's mechanisms within the households when family and domestic violence is occurring between adults, children are at greater risk of experiencing abuse and neglect.

MS ORR: Thank you. Sticking with data, but moving slightly to the prevalence of family and domestic violence in children in contact with Child Protection systems, can you help us with that?

A/PROF BROMFIELD: Yes. Again, I will keep telling you statistics that are shocking because one in three children in South Australia are reported to Child Protection by age 10. I just think we should sit with that for a minute. One in three South Australian children are reported to Child Protection by age 10. And within Child Protection, the prevalence of FDV is really, really high in the Child Protection reports. And it might be the primary reason that someone calls Child Protection, you know, "I'm worried about this child because of the violence happening in the home," or the police saying, "I've attended this call out for family violence and there were these five children in the home, and they were involved in this way." It also might be noted as additional context or an additional risk factor. So, "I'm really worried about this child who's attending school and seems to be suffering from chronic neglect. You know, they don't have lunch, their medical needs are not attended, and I think there's violence going on within the home." At the Australian Centre for Child Protection, we've done quite a bit of research here in South Australia where we were able to work with the Department for Child Protection – and I do acknowledge the department for actually doing this kind of research – where we were actually able to look at the narratives that are written in the intake reports for Child Protection.

So rather than just looking at the fixed format data, you know, you extract, here's the tick boxes, we were actually able to look at what was written and that told us a huge amount about family and domestic violence in Child Protection that we didn't otherwise know from the usual ways we studied this. So looking at case file diaries, we found that in a 20 per cent random sample of families who were just reported to Child Protection in a six-month period in a geographic area in South Australia – wasn't the best, wasn't the

worst in terms of socio-economic disadvantage – there was family and domestic violence either past or present for 70 per cent of the families in that case file review. Similarly, we looked at a qualitative case file review for 131 mothers who were reported during pregnancy, so what's called an unborn child concern. That, again, was a 20 per cent random sample of mothers who had subject to an unborn child concern in a six-month period in 2014. So 70 per cent of that sample, again, keep coming back to that 70 per cent, had experienced past or present FDV. I keep mentioning the past or present because the aftermath also matters in terms of impacts for kids, impacts for parenting. But 41 per cent of mums who are reported during pregnancy to Child Protection had active FDV.

The study used the narratives to also understand the nature of the violence that was occurring. I guess you can sometimes hear in the community people dismissing it, you know, maybe it's just a bit of push and shove. It was not. The violence reported towards women during pregnancy was severe. It included incidents of attempted murder, and it was pervasive. The other thing that by doing the research this way, looking at what's written in the narratives, we're also able to find and give estimates on the way in which we were underestimating the extent of family and domestic violence in Child Protection. So in our usual way of looking, we use what are called the fixed format fields, the tick-the-box fields. So there's a tick-the-box field, I think that's an easier way of understanding it, for if domestic and family violence is the primary concern or a secondary concern. We compared where FDV was noted as the box was ticked versus where it was mentioned in the narrative. So it was in the text that it was happening. For 493 reports, the study found that only 8.9 per cent had a box ticked, but 28.2 per cent had current concerns. So, it's a two to three time underestimate of the extent of violence. It's a lot more information in the narrative records. I think that's something we need to be aware of when we look at some of our big population studies that have to rely on the tick-the-box, the fixed format data.

MS ORR: And I understand that, or the Royal Commission has heard, that First Nations children and young people tend to be over-represented in child protection systems?

A/PROF BROMFIELD: Yes, multiple data sources point to Aboriginal women and children being disproportionately affected by violence. I think Aboriginal people would obviously be the best place to speak to those experiences. My concern is when anyone uses that data and misconstrues that over-representation to suggest that Aboriginality or Aboriginal culture is a risk factor. That's not true. There's really strong evidence in multiple domains that demonstrate that culture is really protective. It's also an important element of healing. So it's the best, not the worst. The direct and continuing impacts of colonisation are what make Aboriginal women and children more vulnerable to violence. I was really struck by a research study that I'm involved in for the Royal Commission into institutional responses to child sexual abuse. In that study, we examined archival records from First Settlement, so accounts for people or from people on the First Fleet, and I think it's worth noting that that was at a time when British children were on the First Fleet as child convicts and exposed to significant violence as child convicts.

But the accounts of all the archival records in relation to first settlement were about how Aboriginal children were thriving. So, for millennia, Aboriginal people have grown Aboriginal kids strong and safe in culture to be thriving. The impacts of colonisation have been absolutely devastating for First Nation peoples and those impacts continue to contribute to the experience of violence. The evidence shows that we have to see culture as healing. I had one other bit of data that I'd forgotten to mention about the Child Protection system. If I can, I mentioned the data in the Child Protection System, but the South Australian Family Support System is our other system that's closely interlinked with, so Child Protection is kind of our investigative arm, Family Support is our main response to families who are struggling. And their current data indicates that 60 per cent of families in receipt of family support had active domestic violence, and that 80 per cent had either active or historical family and domestic violence. So keep coming back to the same data. Sorry, I should have had that note earlier.

MS ORR: Oh, not at all, thank you. I'm going to move on from data now and not that we're going to stop you sharing that with us, of course, but I want to ask about some statutory systems that we have in South Australia. And we understand there are many, many systems in South Australia which deal with children and young people who've experienced violence, but for today, and for your evidence, I want to ask you about two in particular and that's because they are two systems or the two key systems that are required to adjudicate in relation to the care and placement of children who experience violence. So they are the Family Law system and the Child Protection system which we've touched on today. So if we can start with the Family Law system, what role does the Family Law system play for kids who experience violence, or who are experiencing violence? How does that interact?

A/PROF BROMFIELD: I definitely won't kill you with data here, because my experience of the Family Law system is through the lens of a Child Protection expert - - -

MS ORR: Yeah.

A/PROF BROMFIELD: - - - so it's all through the lens of how it knocks up against the Child Protection system and child abuse and neglect. So historically the Family Law system has perceived itself as not having any kind of primary responsibility in matters of violence, abuse and neglect. And in particular, it's not seen itself as responsible for investigating or substantiating abuse and neglect, referring these matters to Child Protection. Now, in my work and particularly because I've been able to spend so much time looking at those Child Protection case reviews here and in other states, really seeing the details of what's happening in children's lives over time as they report to Child Protection, I've seen families bouncing between the Child Protection and the Family Law jurisdictions with both systems seeming to treat those matters with what I perceive as a level of bias. So, for example, I observe a tendency for the Family Court to fail to recognise children's experience of family violence as a form of child abuse and instead to see them as witnesses or unaffected bystanders. So they might find that mum experienced family and domestic violence and that have no bearing on contact arrangements.

I've seen a bias within Child Protection to dismiss allegations in the context of Family Law proceedings as fictitious or malicious. This is part of that kind of bouncing I talk about. Oh, this is about trying to win your Family Court case, so you're making fictitious allegations. When I've looked into Child Protection records, I've actually not seen in that context, great evidence of that occurring. There will always be the exception that proves the rule. I've also seen a bias for the Family Court and for single expert assessments provided to the Family Court to make allegations that mothers are making factitious or malicious claims, and they don't appear to be informed by the dynamics of violence and control. So I'm really worried about those kinds of decisions where there are allegations of domestic and family violence, and you see in the narrative echoes of what used to be the old, which is debunked, parental alienation syndrome, still in that thinking, still influencing decision-making. The problem with that is that the actions of a parent who was deeply fearful that their child was going to be physically or sexually harmed by their ex-partner would look exactly the same as what are the alleged actions in parental alienation syndrome, denying contact.

MS ORR: Could you just explain for us, for anyone who doesn't know, what parental alienation syndrome is?

A/PROF BROMFIELD: Yeah. Parental alienation syndrome is not a diagnosis, but it was popular at a time, and so pushed as a diagnosis, that was popular in particularly the Family Court system for a period of time, and it was quite gendered. So typically it was alleged that mothers were planting ideas in their children's head and alienating them from their dads typically, so hence the parental alienation syndrome. And that would involve getting children to make false allegations, children to act fearful around their dads, the children not wanting contact, denying contact, you know, absconding with their children to avoid. Which, as I say, are also the actions I would expect of a mum who was desperately fearful that her children were going to be harmed by her ex-partner. So as a diagnostic criteria, it's not useful at all.

MS ORR: Thank you. I think I interrupted your train. I'm sorry.

A/PROF BROMFIELD: Oh, no, that's fine, that's a bugbear of mine, so happy to talk about it. I think that with that bouncing between, there's a tendency for both systems – again, my observation of bias – for both systems to see an absence of a finding as a finding of no substance. Now, they're actually really, really different things. So finding that there's no substance is kind of saying, you know, "I've proved this to be untrue." But just having no finding doesn't mean you've proved it to be untrue. And in my view, that bias has resulted in children through both systems being placed with or forced to have contact with a parent who's a perpetrator of physical or sexual violence towards them or their mums or both.

MS ORR: Can you give an example in this context of that kind of absence of a finding?

A/PROF BROMFIELD: Yeah, so the Family Law system, because it doesn't see it's self-responsible for investigations, will often refer to Child Protection to investigate. Now, Child Protection uses this term "substantiation". Now, I can see how a bystander

might go, "Well, they must be substantiating or not substantiating whether that thing happened." But Child Protection systems are actually really overwhelmed, and so a substantiation in Child Protection is not about did it happen or not. Actually most allegations to Child Protection are not denied abuse. Most allegations that are reported on to Family Support Services, everyone's saying it's happened, and so substantiation really has become a threshold for are we substantiating that the State needs to use Child Protection laws to intervene in order to protect the child. So when Child Protection go, "We're not substantiating," it effectively means we're not opening the case. But some of the rationale in those case notes can be because mum's acting protectively, because mum's denied contact. But then in the Family Court system, you can go, "Well, Child Protection did not substantiate, and she's denying contact with dad, so we actually are seeing mum as the problem now." And similarly I've seen in the Child Protection system going, "Well, Family Law didn't make a finding that violence abuse or neglect happened, therefore we don't think there's any reason for us to be involved."

So the balancing between each system is actually a whole lot of closed doors and children that we're worried about who are actually getting nothing and their voices not being heard or when they're saying that something has happened to them being dismissed as untrue and that really concerns me because I see in then these Child Protection histories – because I've been able to look over periods of years at the reports over time – that when those reports are denied, when children's disclosures are denied, that they're said to be fictitious in the context of Family Law, all of their subsequent presentation is consistent with that being true. But they've been told, they've learned not to speak up, that actually when you speak up it can make things worse. It can mean you don't have contact with your protective parent, you're forced to live with dad. I'm using the gender terminology because often physical and sexual violence is perpetrated by men against women and children. But that's devastating, because not only have you not protected the child, you've placed them in greater harm, and you've taught them that it's dangerous to tell the truth about abuse and neglect. Look, I think – sorry. Do you want me to go on?

MS ORR: Yes.

A/PROF BROMFIELD: Like I said historically, the Family Law system didn't see itself as having a role and perhaps there was a time where the Family Law system could have held that position, that it didn't have a substantive role in Child Protection decision-making. But we also have to consider the changing context for both of these systems. So over the last several decades, we've seen the Family Law system implementing reforms which have diverted the majority of separating families to settle financial and childcare arrangements outside of a court adjudicated decision. So the Family Court system has gotten smaller. At the same time, the Child Protection system has just been besieged by unrelenting demand. So it's gotten so much bigger and there's multiple reports that say it's overwhelmed, it's not able to respond to the amount of need. I've been advised by Family Law experts and leaders that a consequence of some of their reforms that have made their system smaller is that now those cases that do come before the courts include a disproportionate number of cases in which there are allegations of violence, abuse and neglect. So it's become a primary part of the Family Law system.

I think that you've got to think about the two systems together. Some of the difficulties when we are trying to make good recommendations about policy and practice to respond to violence, abuse and neglect is when we look at one system at a time. So you kind of go, Family Law system's changed, it's got smaller. Violence, abuse and neglect is a big part of its system. Child Protection's gotten huge, it's overwhelmed. I don't think in that context that the Family Law system can hold its ground, that it's not got a primary responsibility to respond to violence, abuse and neglect. Our data says that those systems now need – it's incumbent upon them to recognise their role to recognise, respond to the data, to systemically address the fact that the Family Law is one of the statutory systems with a primary role in addressing safety concerns for children that are affected by violence, abuse and neglect and to equip itself to act accordingly. And I'm concerned that without this recognition the Family Court will continue to not be equipped to make good decisions, and the consequence of that is ordering children to have contact with perpetrators, to be in unsafe living arrangements due to that failure to understand and address violence, abuse and neglect.

MS ORR: Thank you. I want to move to Child Protection systems and I just want to address the matter that the Commissioner raised this morning because we know about your extensive expertise in the context of Child Protection, and we also know that there are proposed reforms before Parliament at the moment. The Royal Commission is going to consider those in time, but we are not addressing those today, just in case anyone thinks we've forgotten to ask the expert about these issues. What we do want to understand from you today is how the Child Protection system is important in a domestic, family and sexual violence context, how they interact and some of the issues with it. So we heard some data from you just before about the one in three children in South Australia are reported to the department, that's the Department for Child Protection, by age 10.

A/PROF BROMFIELD: Yeah.

MS ORR: Is that trending up or down?

A/PROF BROMFIELD: Well, at the time that the Nyland Royal Commission report was handed down in 2016, one in four children were reported to the Department of Child Protection by age 10. So a decade of reforms, and we've got more children rather than less who are now reported to Child Protection. And that's despite those attempts at reform. And we're not alone either. You know it's not that South Australia is uniquely failing to address the problem of child abuse and neglect. Nationally our long-term data trends show the numbers of children and families reported to Child Protection are growing rather than reducing over time and that demand on Child Protection services as I've said has just been unrelenting.

MS ORR: I'm going to ask you about why, in your opinion, but before I do, can you tell us about what the research says about outcomes for children and families who are known to Child Protection services?

A/PROF BROMFIELD: Yeah. I'm proud to be part of the Child Protection field, and to be in a field where every day you get to go to work to try and make a difference for

kids who are harmed. And I say that because actually the evidence about the Child Protection system is pretty dire, and I say it with respect to the practitioners and people within those systems. But research and inquiries have consistently found that our main system for responding to abuse and neglect, the Child Protection system, is not working for children, their families, or the people who serve within it. And our research is consistently showing that the majority pattern is that the more children and families are known to Child Protection, the poorer their outcomes are. Now, if I was interacting with the health system and the more I engaged with the health system, the sicker I got, we would say that we had a major problem with our health system. That is true of our Child Protection system.

MS ORR: And you talk about children needing a protective parent, I think?

A/PROF BROMFIELD: Yes, actually, I think we should cut through the research and technical language here and talk about love, because actually it's really, really important that kids experience love. It's one of the most protective things we have as humans, to experience love, to be cared for, to have someone to go back to. So where a child loves and is loved by a parent, then we need to do everything we can to support that family unit to remain safely together. Recognising for some parents that will mean extensive support to make that happen. But we also have to look at the evidence about our out of home care system, and it's not that we are removing children from homes where parents are struggling them and placing them in a utopia; we're not. Our out of home care system, some children have amazing carers and do better and thrive in care and protection. For too many, it's multiple placement disruptions, ongoing experiences of violence, abuse, and neglect in the care system, and not having – exiting care without someone who loves you, without experiencing that love. So to me, it's quite clear, rather than investing in removing a child, it's far better to invest in that family unit and seeing the sacredness of love.

MS ORR: So with that being said, I want to go back to the system, and you spoke about attempts at reform, but they haven't worked, to speak plainly. Can you explain in your view why that is?

A/PROF BROMFIELD: Yeah. So firstly, when we've reformed Child Protection, actually, if you look historically, the main thing we've done to reform Child Protection is to implement reforms to keep people out of Child Protection. That's not actually reforming Child Protection. I think we have to name that truth. Broadly speaking, the Child Protection system is not fit for purpose due to the scale of the problem of abuse and neglect and the many ways the world has changed since we established our contemporary models of child protection. To understand this, it's worth briefly looking at our history to understand how we got to where we are now. So we designed our modern Child Protection systems in the 1960s, and that was in response to the discovery of the battered child syndrome, which was low incidence, high severity problem of very severe physical abuse – so kids with multiple bone fractures, subdural hematoma from shaken baby, very severe physical abuse. And so we created legal powers to require people to report and to enable the State to intrude into family life and to investigate and remove children.

I use that language purposefully because at the time we had to create these mandatory reporting laws because people thought it was outrageous to intrude on family life. Our times have changed. We grafted that system of kind of investigation and removal onto the existing system of institutional care in the 1960s. Now, that is a time when we know that that system of institutional care was a tool of colonisation, and we know that our orphanages were sites of horrific abuse and neglect. So that is part of our legacy. And when a Child Protection practitioner knocks on the door, they carry that legacy with them when families say, "What, are you from the welfare?" normally with some other words in between. The thing that has happened though since we designed that system for this small problem of physical abuse is that we learned more. We did research, and we recognised additional forms of abuse and neglect. Thank God we recognised child sexual abuse; we recognised the impact of neglect or rediscovered it, because our earlier kind of colonisation welfare reforms were about neglected children. We recognised the impacts of emotional abuse and in the 2000s we recognised family and domestic violence for the harm it is as a form of abuse and neglect.

And so our Child Protection system now encompasses physical, sexual, and emotional abuse, neglect, and family and domestic violence. And the thresholds for what we consider to be abuse and neglect have also changed over time in response to that research. So we don't require you to have multiple bone fractures to recognise that it's physical abuse. If you are hit with an implement, and you are bruised, that is physical abuse. Again, that's good evidence that's led us to those lower thresholds. What we haven't done, though, is we haven't then revisited the founding assumptions of our Child Protection system, which was founded on it being a low prevalence incident detection system for families who, you know, really the only path was removal. So, we talked about the Australian Child Maltreatment Study. It tells us that 60 per cent of the population have experienced one or more forms of abuse and neglect. In that context we could see one in three South Australian children being reported to Child Protection as still under-reporting. No one ever envisaged a statutory Child Protection system that encompassed the majority of the population. It's not what it's designed for. It's like saying go to the emergency department rather than the GP is the first step in help seeking.

MS ORR: And you mentioned earlier the world has changed around us as well.

A/PROF BROMFIELD: Yeah, so it's not just our understanding of abuse and neglect that's changed. As we've attempted to restructure and reform our response to families in need, the world around us has also shifted and changed, creating new challenges. So we now have, as we all know, a really significant housing and cost of living crisis that's pushing more families into poverty and disadvantage, and that has downstream effects. So it's actually impacting decision-making in relation to child removals and reunification. I think it's a travesty that in Australia we have children who are being removed from parents who love them because they don't have a house, and it's not safe to raise a baby in a car. That should not be a Child Protection response; that should be a helping response. We continue to see the devastating impacts of substance addiction on families. Again, I'm getting old, but we didn't have crystal meth when I started in this field. And it's had a devastating impact on families. The nature of the violence and what violence actually looks like when there's crystal meth involved, it is deeply shocking, the severity of that violence.

That has a really significant impact on kids. And when we fail to disrupt disadvantage and support healing, we also see cycles of vulnerability that accumulate, and they compound over the lifespan, and they reach across generations. So we have to conclude that our Child Protection system is doing what it was designed to do, investigate – take reports, investigate and remove children, but for a population that it wasn't designed to serve. So we've got a punitive response when actually the majority of our families who report to Child Protection need a help response. Many of them are help seeking, most of them are willing to voluntarily engage with services, but we have this punitive response. And so the reason we've failed to stem the tide of demand on child protection is because the incidence of abuse and neglect and family and domestic violence is so very high and the needs of struggling families are so often not met. In South Australia two-thirds of families who are reported to the Family Support system don't get a response because we don't have the capacity in the system to respond to them. So that's after, you know, there's been a report to Child Protection, Child Protection have assessed it, Child Protection have taken some of those cases and said, "We'll respond to those, that needs statutory intervention."

The majority they report to the Family Support system, and then the Family Support system says, "We'll see one-third of you because we can't see the rest of you even though you have desperate needs to be seen." And then our families and our kids are left in that struggle. Problems escalate, they become more entrenched, and ultimately we remove parents, and we blame them for the failure even though we didn't help them when we could.

MS ORR: On that topic of help seeking and providing help to parents, the Commission's heard that in fact the risk of Child Protection involvement may actually provide a barrier to the help seeking.

A/PROF BROMFIELD: Absolutely, and in fact I'm a professor, I run a research centre, I have no formal role in the operation of the Child Protection system and I get calls from parents who – I had a call from a GP recently who talked about a mum she'd been supporting. This mum had had her children removed. GP didn't feel like that was a fair removal, but mum was pregnant again, and she was at the GP saying, "I'd really like to go to the antenatal visits, but I'm afraid to. I'm afraid that as soon as I go to those antenatal visits, I'll get a report to Child Protection and this baby will also be reported and removed from me at the hospital." I'm happy to say that that mum was able to access maternal care and her and her baby are doing really well. But that's terrible when mums who are help seeking are too afraid. We see it in the context of domestic and family violence where, you know, you might have a mum who is wanting to leave a violent partner, but there's no housing, and so she knows that if she kind of puts her head above the parapet in any way, she's going to be trapped because it's unsafe. She's not protecting her children by staying in an unsafe home, and she's not protecting her children by living in a car, and she's got nowhere to go. I think that's a travesty for our system, that it actually discourages help seeking.

MS ORR: Based on your evidence this morning, is it safe to say that you think some reform is needed to the Child Protection system?

A/PROF BROMFIELD: Yeah, I would say that we have to stop reforming the Child Protection system that we have. We've built it on the wrong foundations. So we actually need to go back to our underpinning assumptions. Child abuse and neglect is a big problem. Families in which children are abused and neglect, the majority are willing and able to engage in services and supports, and we should pivot our system to a system that offers help first and only uses the powers of the State, those punitive powers, when there's evidence to show we need coercive intervention. Otherwise, we should be helping our families. The Child Protection system, if you think about it like medication, you know, there's some medications that have got really toxic side effects, and they are necessary at times. But you only use a medication with toxic side effects that can cause harm in and of themselves, when it's really indicated for the treatment of that medical condition. The Child Protection system needs to be seen like that. It's a system that has a really, really important role to protect children whose parents can't or won't protect them from harm. But for the majority of our parents, they shouldn't be exposed to that punitive system because it causes harm along the way, so help first.

MS ORR: So, turning to that then, the Family Support system and the help that's provided to families, it seems from your evidence that we're not doing enough to support children and families experiencing violence.

A/PROF BROMFIELD: Yes, so there's two parts. So investment in supports for families, they're a really, really important part of the solution. So in South Australia, we are the third lowest in the nation for our investment in family support. As I said, two thirds of families who are referred to our Family Support system are unable to access a service because there's just not enough services. So investment in family support has to be a part of the solution, but alone it's not enough. So we also have to look at those foundations of the Child Protection system. We've also got to turn our attention to healing. So we have to talk about trauma. When we've got such a significant proportion of our population who've experienced violence, abuse and neglect, we have to consider more than just physical safety. And we've talked about how the impacts of violence, abuse and neglect, they accumulate across the lifespan, they reach across generations. So if we are to support South Australians to break from the chains of trauma, then we actually have to treat trauma. So, as part of a helping system, we have to look at where is the healing in this. And I think that's a really, really important part of what we do for kids, because they're kids, and they deserve it, but also how we reduce violence, abuse and neglect in this state and prevent that intergenerational transmission.

MS ORR: Is that the case for both mums and dads and children?

A/PROF BROMFIELD: Yeah, for children, mums and dads. So we talk a lot about where are your optimal windows for intervention, and we recognise in this state that children are harmed from violence, abuse and neglect. We know it, we know where they are, we know who they are, we know what kinds of harms they've experienced, and we know that they're really struggling, and we'll provide them with speech therapy, we'll provide them with OTs, but it's really, really hard to get any service for healing from trauma. So there are some limited services typically funded for one form of trauma. So if you've been a victim of child sexual abuse, there's some sexual abuse

counselling supports in South Australia, mostly quite centralised. There's waiting lists for sexual abuse services across the whole country. You might be able to get some support.

Counselling support is limited, again, if you've experienced family and domestic violence. But as we've said, the co-occurrence of all the abuse types is really significant, and so we need to be thinking more about healing from childhood trauma, from violence, abuse and neglect. We don't have a service system for that. If you attend CAMHS, complex trauma is not a diagnostic category that makes you eligible for CAMHS. I'm not even talking about increasing the investment in our children's services system for healing trauma. I'm talking about creating one. I think it's pretty shocking actually that we know so many children have experienced violence, abuse and neglect, and we're not at that key window of opportunity, healing then, supporting that healing then. But we also know that so many of our mums and dads who are involved in the Child Protection system are themselves victims of childhood trauma and so again trauma is often the underpinning driver of the mental health condition, of the substance misuse, of the use of violence, and so we need a trauma lens across all of our services for mums and dads and kids as part of breaking that cycle.

MS ORR: Still talking about help or access to help but if I can just move along a little bit to available services and the idea of universal services, can you explain to us what universal services are?

A/PROF BROMFIELD: Yeah. So universal services are how we describe services and supports that are intended to be accessible to everyone. So healthcare is a universal service, education is a universal service.

MS ORR: And what is their role?

A/PROF BROMFIELD: So I'll talk about what their role is in responding to abuse and neglect, because actually that's a really great question, and I don't think we've always had the answer right. So you see, we've often talked in the child abuse and neglect field about applying a public health approach to the problem of abuse and neglect. I still believe that's correct, but I think we've misapplied it, and we've done it to our disadvantage. So in a public health approach, the World Health Organisation talks about taking a public health approach to violence prevention. It talks about there being kind of four steps around knowing your epidemiology. We designed our system without a prevalence study, that's a big first error. It talks about then matching interventions to those critical change points, evidence-based treatments, scaling them up. The other thing that is often talked about in a public health approach is what we call primary, secondary and tertiary prevention services.

So that's where primary prevention might be something like health promotion messages and a tertiary service might be a hospital. So primary, secondary, tertiary going from lowest, least intensive to most intensive. So we've tried applying a public health approach to child protection and in doing it, we categorised the existing service system according to what we saw as its role in a public health approach. So primary prevention, which is for families with known vulnerabilities for abuse and neglect. We

often talked about universal services and primary prevention being the same thing. Then secondary prevention being for families with known vulnerabilities for abuse and neglect. And tertiary prevention referring to interventions to prevent further abuse and neglect in populations where it's already happened. So we made this assumption that the primary prevention population was our largest population and that the tertiary was the smallest.

Our data actually doesn't suggest that's true because 60 per cent of the population have experienced violence, abuse and neglect. So I'm repeatedly told that things like health care and education are primary prevention and that child protection is our tertiary service for child abuse and neglect. That's actually a problem because it's inadvertently created these service cliffs for children and families, because it means that our universal health care system doesn't have to be equipped to respond to violence, abuse and neglect. It doesn't have to be trauma informed. Its job is in referring and reporting, not in responding. That's actually not okay. Our universal system actually has to be designed around the needs of our population, so our universal systems need to be equipped to respond to violence, abuse and neglect and to be trauma informed. And those service cliffs, they then act as a barrier to child protection really being everyone's business.

And they mean families who are the most vulnerable end up having doors closed to them. Oh, no, there's violence in this family, you're not eligible for our service. But when you look at the Child Protection system, the tertiary response, it's not a therapeutic system. It's not actually the helping system. It's the accept reports, investigate, remove, and it's our out of home care system. So what's left for our most vulnerable families if the primary and secondary doors have been closed to them? Where are they getting help? And when they don't get help problems escalate, they become more entrenched and then our intervention is to remove children.

MS ORR: You've mentioned health care in the context of universal services and access to trauma informed services, and so I take it that health is one of, you know, the big areas that needs to incorporate the needs of children who've suffered abuse or neglect.

A/PROF BROMFIELD: Absolutely, and across the continuum of needs. So our health system needs in universal services, in primary health networks, to be equipped to recognise and respond to violence, abuse and neglect, and to be trauma informed given the extent of the population who've experienced violence, abuse and neglect. Our health system, though, is also where we see our specialist clinicians, you know, our most specialist clinicians for dealing with children's mental health, and that's kind of our main response to children who've experienced trauma, the main therapeutic response is a mental health response.

MS ORR: The Commission has been hearing that those specialist units that you're speaking about and the tertiary response tend to be set up as small specialist units. Can you comment on that in the context of what you've been explaining to us?

A/PROF BROMFIELD: Yes. In South Australia at what – I think they're called the

Child Protection Services, or they may have recently changed their name, they are situated within our local health networks, but not in every one. So we have these very small service of amazing clinicians, but they're centralised in the southern, central and northern health networks. So if you're in the country, you either have to travel or you don't have access to those services. And they're very, very small, and we've talked about a problem that's very, very big. So in my view, because they're the best of the best, health really ought be the stewards of our mental health healing system for violence, abuse and neglect.

And that means maintaining a specialist role into a statewide role in responding to violence, abuse and neglect. Even in those specialist services, it's actually very, very hard for children to get treatment for trauma. Those great clinicians, a lot of them are doing assessments, parenting capacity assessments or assessments for kids who are in care. Again, where's the therapeutic response? We can't assess and not respond. But also, as stewards of the system, what leadership should we be expecting from health in terms of ensuring that we do have a statewide response to violence, abuse and neglect? There is capacity in services like the Family Support system in Western Australia where our centre also does quite a bit of work. We partnered with government and a number of philanthropic organisations to try and build up a statewide capacity to respond to childhood trauma.

So we've provided free tertiary accredited professional certificates to thousands of frontline people in schools, in child protection, in youth justice, in country health nurses, in understanding childhood trauma. We've got mandatory trauma training now for all WAPOL officers. So I think the latest stats on that, 9000 had already completed the training. And then we have a graduate certificate in responding to childhood trauma to try and increase the capability of, you know, our existing staff in community services who are already responding to kids, to have the skills to respond to childhood trauma, because we've repeatedly heard that our workforce doesn't feel like they have that confidence. So I think we really have to look at the role of health in that specialist response, health being trauma informed, but also who's our lead agency for creating a healing system outside of the hospitals? Where's the equivalent of our primary health and our secondary health networks for healing? Where's our workforce strategy? And that would help in the demand then on those specialist services, so they can be reserved for the most complex of cases.

MS ORR: And not trying to meet the needs of the 60 per cent?

A/PROF BROMFIELD: Not trying to meet the needs of the 60 per cent. But being trauma informed in health, in terms of childhood trauma, it is still across the whole lifespan. You know, I do a lot of work with victim-survivors of child sexual abuse. And the health system can be really, really scary when you've experienced sexual abuse or sexual violence because you have a repeat of that pattern of losing control of your body and there are particular medical procedures that are really triggering when you've experienced sexual violence. So birthing can be so triggering, and it can then trigger a whole lot of mental health concerns that impact then on your ability to parent your baby, and the medical interventions themselves can really trigger the abuse. Similarly, gynaecological care, men experiencing prostate treatment. These can be really

triggering experiences when you've experienced sexual violence. So when I talk about a trauma-informed health system, I'm talking about all aspects of health care, because our victim survivors are saying hospitals are terrifying for us.

MS ORR: Thank you. I want to change topics slightly now and ask about harmful sexual behaviours or children and young people who display harmful sexual behaviours. Can you explain to us what harmful sexual behaviours are?

A/PROF BROMFIELD: Yeah. So harmful sexual behaviours are sexual behaviours that are displayed by children and young people that fall outside of what might be considered developmentally, socially or culturally expected. Now, I say that because actually sexual development is a really, really normal part of growing up. Kids exploring their bodies, kids developing sexually, that is healthy and normal. So it's when it's outside of what are those developmental norms. It can occur face-to-face or via technology. And harmful sexual behaviours when they involve another child or young person might include a lack of consent, reciprocity and mutuality, or involve the use of coercion, force or a misuse of power. And to give a concrete example, because that sounded a bit academic, it might look like a range of things, from preschool aged children playing a sex game, where they lay on each other and simulate sex movement and noises. That's not developmentally appropriate for preschool aged kids.

An adolescent standing under an open staircase and taking photos up the skirts of their same age peers. Right through to children who are harming themselves, so children asphyxiating themselves while masturbating, that's a harmful sexual behaviour. Or an older child using threats or coercion to force a younger child to perform a sex act on them. So we talk about a continuum of harmful sexual behaviours from healthy sexual development through to developmentally inappropriate behaviours or concerning behaviours. Those two categories at the lower end can often be responded to with education and boundary setting. And that doesn't actually have to be complicated. It can be things like saying to your three-year-old, "That's a private part of our body, we don't play with that part of our body in the lounge room or in the open at the childcare centre." So I don't want to overcomplicate this. A lot of harmful sexual behaviours or inappropriate sexual behaviours can actually be responded to really quickly with that education boundary setting, and they go away completely.

MS ORR: What about at the more severe or extreme end of the continuum, can that be treated?

A/PROF BROMFIELD: Yes, so there are some children who I worry about quite a lot more, so there's some context for sexual behaviours – and I know it might sound strange, but it's not so much about the severity of the behaviour, it actually is about the context. So I've seen children with developmental, cognitive disability, display quite intrusive sexual behaviours with a complete lack of understanding. They've seen something on a TV program that they really weren't equipped to understand. They've replicated that behaviour and actually, even though it was a quite extreme behaviour, it could have been intrusive, can be responded to still with our education and boundary setting.

So when I most worry about harmful sexual behaviours, it's actually when children are persisting in sexual behaviours after there's been intervention. When the other child is showing emotional distress, and then they're not responding, there's a clear lack of consent. When they're persisting to create opportunities, what in an adult frame we might talk about as grooming. I don't like to apply that language to children, but purposefully creating opportunities to gain access to children, where the behaviours persist in secrecy. I'm really worried about that child, and I'm really worried that if we don't provide specialist intervention that those behaviours will persist and that they can persist into adulthood.

MS ORR: Is it correct, though, that specialist intervention can assist and prevent it proceeding into adulthood?

A/PROF BROMFIELD: Absolutely. So that's the really important thing to know about harmful sexual behaviours: treatment is super effective. So if we provide appropriate treatment, for most children those behaviours will entirely extinguish, and they should never be tarnished with a label that they carry into adulthood of a sex offender if they've experienced that effective treatment.

MS ORR: I do want to ask you about the response to it in South Australia, but before we do, do you have some figures around the incidence of harmful sexual behaviours?

A/PROF BROMFIELD: Yes. I mean I'm really pleased that you're talking about this as a Commission because systemic reviews put the incidence of harmful sexual behaviours at about 30 to 60 per cent of all child sexual abuse and in the Australian child maltreatment study, approximately half of all the child sexual abuse reported by young Australians was actually caused by another child or young person with harmful sexual behaviours. It's the fastest growing form of child sexual abuse in Australia. It occurs in homes, it occurs within families. It's also been identified in the Royal Commission into Institutional Responses to Child Sexual Abuse and the Tasmanian Commission of Inquiry, which I was a commissioner, as the most prevalent form of child sexual abuse in contemporary institutional contexts. For example, in preschools, schools, youth detention, out of home care, so where children are gathering. This is the most prevalent form of child sexual abuse in institutions. And our data is showing that adolescent boys' behaviours towards same-age peers is the biggest category. So in my view, this is a critical issue that needs to be understood and addressed in the context of any strategy to address family and domestic violence and sexual violence.

MS ORR: Are there common pathways to children displaying harmful sexual behaviours? You've mentioned some in passing, I think, already.

A/PROF BROMFIELD: Yeah, so, I mean, one of the common pathways is what we call the child sexual abuse pathway, and particularly for young children, we'll see them emulating their own experience – so copying. They'll re-enact the child sexual abuse that they experienced. Those children need to be seen as victims and their harmful sexual behaviours need to be understood in that context. There is a pornography pathway that I'm really, really worried about. So more and more children are being exposed to more and more pornography in online contexts. And the pornography that

they're being exposed to, the level of violence in that pornography is increasing, so the lack of consent. There are types of pornography that, you know, you can type in stepmother porn or brother-sister porn. This is actually child sexual exploitation material. There's bestiality. There is so much, and the use of violence. So when our kids are seeing porn, and it's a normal part of sexual development for kids to want to see some stimulating content, you know. But again it historically that might have been the Bras N Things catalogue.

Now our kids are online and so what they're seeing is not the Bras N Things catalogue. What they're seeing is really explicit sexual content and some of it is really outside of what we would consider, you know, normal sexual, healthy sexual relationships for children. But our kids are absorbing this as normal. When 12-year-olds ask, "Is it normal for my boyfriend to try and choke me when we're kissing?" that's a real problem. And so that's a pathway to children displaying harmful sexual behaviours, and it's part of it because they're being socialised. This is actually what a sexual relationship looks like. The other pathway is what we call the FDV, the family domestic violence pathway. So in households of children who display harmful sexual behaviours, they are disproportionately more likely to have experienced family and domestic violence. And in terms of the mechanism for that, you think about how family and domestic violence and harmful sexual behaviours can both manifest in a form of sexual entitlement towards women or girls. If that co-occurs in a sexualised environment where there's hypermasculinity, then I'm really quite concerned about that pathway in terms of growing our kids to display sexual behaviours endemic in gendered violence.

MS ORR: So how do we in South Australia currently respond to harmful sexual behaviours?

A/PROF BROMFIELD: Piecemeal. So, harmful sexual behaviours was actually recognised in the Royal Commission into institutional responses to child sexual abuse. It's actually a national priority in the National Strategy for Preventing and Responding to Child Sexual Abuse. And so we've seen some responses in some agencies. So, for example, our education system has implemented quite a systemic response to harmful sex, equipping teachers to recognise and respond to harmful sexual behaviours. But all of our departments have acted as islands in relation to responding to harmful sexual behaviours. They're also using a whole lot of different definitions. That might seem like it's not important, but it actually is, because they have different thresholds for when they should report to the police, when they should report to Child Protection. They can't agree on that when you don't have one common definition and one continuum with agreed thresholds and roles and responsibilities for who does what. And we know that when there's confusion it's kids and families that fall through the gaps. We also in South Australia have a very limited treatment response.

So we have one FTE for children 12 and under who are displaying harmful sexual behaviours only available in the central Adelaide Health Network, the Children's Health Network, and we have two FTE for responding to harmful sexual behaviours in CAMHS. I've just talked about this as the fastest growing form of child sexual abuse in Australia, and we've got three FTE within our state. We also don't have any kind of

dedicated system for helping. You know, when you've got so much harmful sexual behaviours that sits that inappropriate sexual behaviour or the concerning end, then what would be really helpful is instead of reporting children into Child Protection or police or trying to get them a tertiary, you know, a very specialist health response, actually supporting parents so that you can say, "Look, actually, that's an inappropriate behaviour or actually that's a healthy – that's a normal sexual behaviour." So some education and resources and supports for parents, consultation for your family support practitioner who's dealing with this system as it's uncovered as they're supporting a family, or for domestic and family violence services who are working with mum and then this issue emerges, not uncommon given the DFE pathway. So we need a clinical consult, kind of advisory service, resources and supports, and we desperately need more than three FTE, and we need to stop the postcode lottery. You know, it's not right that if you're a child in country South Australia you don't get access to specialist services and supports.

MS ORR: And so that's the response. Is there anything we can do – given that it's growing, is there anything we can do to prevent harmful sexual behaviours?

A/PROF BROMFIELD: Yes, so obviously, the home and parenting is really important, reducing the incidence of domestic and family violence, supporting parenting. But I'm really, really worried about the role of the virtual world in the socialisation of our children. We were winning in the battle against child sexual abuse. Adult perpetrated child sexual abuse has decreased. We put in a huge amount of strategies around consent and respectful relationships, education. The keeping children safe curricula in South Australian schools was nation leading, and yet we've lost ground. So what's happened at the same time that we've been doing all that? Well, in my view, it's the rise of the virtual world. So our children are exposed to physical and sexual violence as part of the virtual world.

They are now being socialised by influencers who are promoting toxic masculinity. It's really hard as parents to fight the influence of the virtual world. The eSafety Commissioner's Mind the Gap report found that 71 per cent of young people, 14 to 17, have seen sexual images on the internet, 47 per cent received a sexual message from someone online, 25 per cent opened a message or link that showed pictures of naked people, 11 per cent, one in 10 kids, have been asked online to send sexual images of themselves. But the same report also found that one third of children use the internet as a source of emotional support. So we can't just demonise the internet. It's especially important for young people who are feeling marginalised or isolated, such as children with neurodivergence or young people who identify as LGBTQIA+, sometimes the virtual world is their only source of support for people who look like them, you know, if they're in a regional area. So we do need to monitor our children's use of technology. But we can't just focus on children.

At the moment, my concern is that we're just regulating kids. And to me, that's analogous to when we told women not to walk alone at night. We can't just regulate children. We're just accepting that the virtual world is not safe, and it's up to kids to be regulated or to keep themselves safe. So we need to go further to regulate big tech to actually create more safety within the virtual world. There is so much technology that

our big tech companies already have that would enable them to implement age verification, that would enable them to identify child sexual exploitation material, that would enable them to identify violent pornography. This technology already exists and in fact, some of our big tech companies that don't implement that kind of technology on their own platforms have developed it and sell it to others. I think we have to raise our kids as responsible digital citizens, so aware of the risks. We have to talk to our kids about sex, sexuality, sexual safety in the physical and the virtual world as well as consent, respectful relationships and bystander intervention, but we can't leave protecting our children solely up to children protecting themselves.

MS ORR: Thank you, Professor. I have no further questions.

CMR STOTT DESPOJA: Thank you, counsel assisting. Can I keep you a little longer, Professor - - -

A/PROF BROMFIELD: Yeah.

CMR STOTT DESPOJA: - - - because you've given us a lot to think about. I'm curious, when you talk about pivoting in the Child Protection system, your evidence suggests more starting from the drawing board and re-imagining the foundations. So you're talking not reform per se, but significant new novel creation.

A/PROF BROMFIELD: Absolutely. Think about things like pregnancy and birthing. Look at all the evolutions of the ways that we've approached pregnancy and birthing. We kept rewriting the rules on how we did that. We actually have to rewrite the rules on how we approach Child Protection. We do have to re-imagine what a different approach would look like, and it is easier to reform to try and patch up our existing systems. Let's add this extra thing; let's try and divert people out of the Child Protection system by creating this Family Support system. Everyone's still reported to Child Protection, though, so Child Protection is still our front door. We have to think about where our front door is, and I think that's a major change to our assumptions in the Child Protection system. And the hardest part of change is actually being willing to dismantle systems that are no longer serving us.

So I talk about radical redesign because I think that's what we need, and I talk about how we should be starting with a blank page. Start with the problem that we have today. And that's not about throwing out everything, it's actually about being purposeful. Let's drag onto the page all the things that are serving us well and leave behind the things that are not. And it's why I think we have to talk about long-term change, because you can't make that kind of radical change in a year or three years or four years. You have to, in my view, have a long-term vision. So we were charged as a Child Protection expert group with supporting the Minister to establish a 20-year vision for what we wanted the Child Protection system to look like. Because change does take time. By creating that 20-year vision that doesn't mean leaving change to 20 years from now. It means every change that we make now we test against that long-term vision. Is this a step towards?

What are the things that we need to be doing now to get to that long-term change?

What are some of the key populations? For example, women who are reported to Child Protection during pregnancy for their first pregnancy, often they aren't hitting the threshold. They're not bad enough yet to get a whole lot of intervention. But if we threw everything at supporting those women, who often are still children themselves, to overcome their childhood trauma to maintain that baby within family, then in 20 years time we've prevented that baby from being a mum involved in the Child Protection system. So that's some of the generational change that we need to be thinking about. So we have to know where we're headed, and then we create the steps to get there.

CMR STOTT DESPOJA: Obviously this is a Royal Commission that's dealing with South Australia, but should we be looking to standardise some of these Child Protection systems? I mean, are there jurisdictions – I mean you mentioned WA, for example – from which we could be learning, or is it a case that most of those systems are somewhat outdated and require remodelling?

A/PROF BROMFIELD: Across the US, the UK, Canada, Australia, New Zealand, essentially the Anglicised countries outside of Europe, we have all adopted essentially the same model of child protection. So there's innovations within the systems that look good, and we should look to those. But I can't point to anywhere where we've got it right, because we're still operating on the wrong foundations. When the assumptions that we designed our system upon have been proven wrong from our prevalence data, the problem we're solving has now changed, we have to build new foundations.

CMR STOTT DESPOJA: Again, the issue of State versus Commonwealth laws, when you talk about the bouncing between Family Court and Child Protection, is that further complicated by the fact that you're dealing with Commonwealth legislation and state-based laws or is it the case that your premise that the Family Court needs to, I think your word is, equip itself to deal with those issues of investigative roles when it comes to child abuse and neglect. Clearly you are advocating for it to adopt that as a primary role and consideration. So even though again we're state-based, we can look at some of those intersecting laws and agencies.

A/PROF BROMFIELD: Yeah. And I suppose equipping oneself also is around what a system expects of itself in terms of these professionals within it, their knowledge and skills, their understanding of dynamics of violence, abuse and neglect, so that they're not vulnerable to things like parental alienation syndrome type thinking.

CMR STOTT DESPOJA: Yes.

A/PROF BROMFIELD: But your question was about the Commonwealth/State. Look, I don't know is the answer to that. I don't see Western Australia as saying, "We've got family law sorted here," and they do have a different approach to the family law system. And I still see children and families between the state-based Child Protection system and the criminal justice system and bouncing between the health system and the Family Support system and the Child Protection system. I think when you've got chronic unmet need, you see a whole lot of service systems responding by trying to close their doors.

CMR STOTT DESPOJA: You were talking about local health networks and the health care system. I'm just wondering if you had a view – I note there was a system of child safety advisers within the women's and children's health network, since retired. Do you have a view on that – and it's understandable if you don't.

A/PROF BROMFIELD: I don't have a view on that network. However, I have a view generally on the premise.

CMR STOTT DESPOJA: Yes.

A/PROF BROMFIELD: So in Queensland they have quite a well-developed child safety network across Queensland Health, and that's for a range of different people who are involved in responding to children's health. So obviously your paediatricians and paedriatic hospitals, your health professionals who are involved in forensic medical examinations, but also your social work departments. And as part of that network, they do ongoing professional development. They actually have an annual conference where they look at themes in child safety across health. I don't know what the impact is on the ground, because it's not something I've evaluated myself, but I've attended some of those networks and I'm impressed that you have such a large number of people coming together and demonstrating an interest – health professionals – in how they can better respond to abuse and neglect. I think it's been enabled by having that ongoing function.

CMR STOTT DESPOJA: You said that we should be shouting these statistics from the rooftop. Why aren't we?

A/PROF BROMFIELD: I think there's a number of reasons. I think the statistics are so high that some people find them hard to believe. I've heard media reporting before, "What, no, surely I must have heard that wrong," or, "Could that be true?" or, "That must be – you must have defined this problem in such a way that it's not really something we should worry about." And yet at the ACMS study showed that of the 60 per cent of Australians who had experienced one or more forms of abuse or neglect, about half of that problem had current mental health – clinical level mental health concerns. And that was at that point in time, noting that impacts of trauma can manifest and ebb and flow across the lifespan.

CMR STOTT DESPOJA: Finally – and I'm mindful of time, I apologise – I'm curious as to how we seriously embed young peoples' and children's perspectives. Not just in law and in the services that they utilise or need, but how they can be part of shaping and creating some of those services and supports. Do you have any recommendations for the Commission in relation to that?

A/PROF BROMFIELD:: Yeah. So I was really privileged to be involved in the National Royal Commission in the work we did to develop the National Principles for child safe organisations.

CMR STOTT DESPOJA: Yes.

A/PROF BROMFIELD:: And to have – been able to commission and oversee all the

research program that we did looking at children's views of safety in institutions, and from that research we realised that one of the principles for a child safe organisation actually needed to be that children participate in the organisational governance, not just in the decisions that affect them. So children are heard and participate in how that organisation responds to child safety. South Australia has done less than a large number of other states in terms of implementing the national principles for child safe organisations. So in New South Wales, in Victoria, in Tasmania, child safe organisations are regulated.

CMR STOTT DESPOJA: Yes.

A/PROF BROMFIELD:: You have to demonstrate that you're meeting the principles, and there's a whole lot of support that goes alongside of that to support implementing the principles. That's one kind of systemic observation that I'd make. But we also know that of the 10 principles, empowering children to have a voice is actually one of the ones that organisations have said, "We really struggle. How do we do this?" So I was – I worked with Associate Professor Tim Moore, and we did a project for – actually, at the same time for the New South Wales Child Guardian and the Victorian Commissioner for Children and Young People about creating some practice guidance on how you do this.

And the guide – I can't remember the title of it off the top of my head, but, essentially, we talk about if you are serious about children participating, there's four steps that you need to cover. The first is voice, obviously, so – and within this guide we give some – there's some tools, there's some checklists for thinking about, "How have you ensured that your process for children – the way you're thinking about children's participation, that there's actually – that children will have the opportunity to have their say in ways that are developmentally appropriate?" We also talk about space. So where are you doing this. Is it in a room like this, which kids would find terrifying - - -

CMR STOTT DESPOJA: Yes.

A/PROF BROMFIELD:: And, please, you know, the Commission has not taken that approach, or is it in child-friendly spaces where kids feel not scared, but actually comfortable and safe to have a say. And that's – you know, part of that voice and space is also that do kids feel safe to say what they are really thinking. The other thing we talk about is audience. Who's hearing, for what purpose and who's it going to.

CMR STOTT DESPOJA: Yes.

A/PROF BROMFIELD:: So is this just another process of ticking a box? You know, "We brought kids together and then we let them have a say," but it wasn't really meaningful, because it didn't go anywhere. It didn't go outside of that room. You know, well, who was the audience? And that's why the last step we talk about is influence. So how are you actually ensuring that that process of children's participation actually leads to influence of decision-making. That's an adult-generated process. I know that you've talked to and engaged with the South Australian Youth Forum. That's an amazing organisation, in that it is actually kids getting together and saying,

"We've got something to say." So it's truly youth governed and, to me, if we did a better job at these adult-generated processes of getting kids equipped to participate, we would see more child-led groups and child-governed groups.

CMR STOTT DESPOJA: Yes.

A/PROF BROMFIELD:: So part of it is practice. Having, you know, the opportunity to have a say, so you know how to do it. The other thing I'm heartened by is that more and more large strategies are involving youth in the governance, and – now, I sit – I co-chair the National Strategy for Preventing and Responding to Child Sexual Abuse. We as members identified that young people were not sitting around the table, so we – the National Office for Child Safety have created – we've done a whole expression of interest process. Interest was overwhelming. Young people want to talk about safety.

CMR STOTT DESPOJA: Yes.

A/PROF BROMFIELD:: And that's – now, that's the other thing we know from the research evidence. Kids are already worried about child safety issues. They think about it, they're aware of it, it's impacting them. And they have ideas that we don't have about how to address it that are really, really important, because they see things that we don't. But, yeah, so we've now got two members on the national advisory group who are young – under 25, young members. That's changed for all of us the way that we are conducting those meetings and the care that we're taking to not always speak in jargon, to create the space for those young people to have a voice, for it to be connected to a broader youth forum. But I think the more that we get used – in the same way that, you know, it's been a journey around having people with lived experience as part of governance - - -

CMR STOTT DESPOJA: Yes.

A/PROF BROMFIELD:: - - - we've got to travel that same journey in ensuring that young people aren't just advising or informing, they're deciding.

CMR STOTT DESPOJA: Thank you. I appreciate you letting us go a little later, because I think that was valuable evidence. You've given us, as you said, some shocking statistics, but you also reminded us of the sacredness of love, in your words, as a protective feature. So I thank you, Professor, for your evidence and I hand over to assisting counsel.

MS ORR: Thank you, Commissioner. I'd ask the witness to be released.

A/PROF BROMFIELD:: Thank you.

CMR STOTT DESPOJA: You are released. Thank you. We'll take a short break.

RECORDING SUSPENDED

RECORDING RESUMED

CMR STOTT DESPOJA: Welcome back to day five of public hearings into the Royal Commission into Domestic, Family and Sexual Violence. I call on counsel assisting to introduce our next witnesses, thank you.

MS ORR: Thank you, Commissioner. I call Ms Chloe Henderson and Ms Sarah Decrea.

CHLOE HENDERSON, SWORN

SARAH DECREA, SWORN

MS ORR: You are both from Relationships Australia South Australia, known as RASA.

MS HENDERSON: Yes.

MS ORR: Can I ask one of you to explain what is RASA?

MS DECREA: Okay, so Relationships Australia South Australia is RASA, and so we're a federation, but every state and territory has its own RA. So the federation is Relationships Australia, and then every state and territory has their own, and so what RASA really focuses into, it's in the name, is relationships and relationships on all levels. So relationships with families, individual relationships. So a lot of our work is done in increasing participation in relationships and really focusing on how we have healthy, safe relationships in South Australia.

MS ORR: And I want to ask what each of your roles are at RASA, perhaps starting with you, Ms Henderson.

MS HENDERSON: Sure.

MS ORR: Could you tell us what you do?

MS HENDERSON: So I am the manager of Children's Services Partnerships, and part of that role is to manage a program called Safe and Well Kids and another program called Walking Together, focused primarily on domestic violence, Child Protection and many other things that our families face in this time.

MS ORR: And, Ms Decrea.

MS DECREA: Yeah. So my role at Relationship Australia South Australia is I'm the executive manager of children's services, so I look after over a sweep of services that work with children and families usually in the Child Protection, domestic violence space and really Safe for All Kids, Walking Together is one of those programs and another one of those programs is Together for Kids that works with children that are experiencing homelessness and the DV services under those and Ngartuitya Family Group Conferencing where we steer families away from Child Protection by allowing family led decision-making.

MS ORR: So you've both mentioned some programs that RASA offer and we're going to ask you about some of those today. But picking up on two of them that you've mentioned, Safe and Well Kids and Together for Kids, I understand that they are specialised therapeutic services for children and young people who have experienced domestic and family violence; is that correct?

MS HENDERSON: Yes.

MS DECREA: Yes.

MS ORR: I'll ask you a bit more about those in detail later, but is it correct that they operate quite similarly?

MS DECREA: Yes.

MS HENDERSON: Yes.

MS ORR: And you've said that each of you manages one of those programs.

MS HENDERSON: Correct.

MS ORR: So before I ask you about those programs, I want to ask you some more general questions, if I can. I've just mentioned that they are therapeutic services for children. To your knowledge, are there many, or any, available services, therapeutic services, for children and young people experiencing domestic and family violence in South Australia?

MS DECREA: I think both of those services are quite unique and I'm pretty sure they are the only services in South Australia that see children in their own right. So in those two services, children are the primary clients, so the child itself is the client and that's who the case plans and that's who the therapeutic plans are based around is around the children. And so they are two very unique services in the space.

MS HENDERSON: And something I would like to add about just in what you're saying, Sarah, too, I do think our two programs are really unique because we have a resolute focus on the children and the children being our primary client. And I think that's what sort of sets these programs apart. We think there should be more programs like this, because gone are the days where we understand that children don't passively witness or experience violence. You know, they're actively experiencing domestic violence. So our programs really centre on not just child centred, but child inclusive. So, you know, the decisions are led by the children where possible.

MS ORR: Is that what you mean by child inclusive?

MS HENDERSON: That's what we mean by child inclusive and the difference between child centred. So when I say "child inclusive", we're not just seeking their voice. I think as a service sector, we are quite good at seeking children's voice sometimes, but it's what you do with that voice, how you're accountable to that child.

So that's you understanding their core experience, but then having a therapeutic loop back to a safe caregiver to actually be able to hold that story, to be able to begin to heal together. That's the key to the work and it's also using children's voices to inform our decision-making as a service sector, how our program runs. That's what that's what we mean by child inclusive.

MS ORR: And can you explain for us why that approach is important in this context?

MS DECREA: So child inclusive practice – so both of these services have really – so Together for Kids has been around for 16 years, so it's a long-standing child inclusive kind of program – but we used to do a lot of child focused work and over the time with support with Professor Jen McIntosh, what we started to really lean into is what we call child inclusive and we really used the Lundee model for child inclusive practice where we kind of give children voice, space, audience and influence. So what we're saying is the importance for children to be able to tell their story, to have the people they love hear that story, to have the decision-makers – because you know often what we talk about in when we see children in their own right is that children belong to someone or something and that's usually a family right, so they're not out there on their own.

They actually belong to family or belong to a mother so we all know that adults have the final decision-making, but children should have the right to influence decision-making. So really a child-inclusive practise really involves children in discussions, decisions that affect them. We really seek to understand their feelings and views and when Chloe talks about we loop that back to the parents, what that is, is for parents, so, you know, we often talk about reintegrative shame. So in the space of family and domestic violence, reintegrative shame is, we can use shame to create change, and that is something that we don't do well as a sector. Right. And so using shame to create change is shame in those that we love the most is where you'll get change. And whether you're a person that chooses to use violence or whether you're someone that is experiencing violence, when people hear for the first time their child's experience in the life of that family, like this might be the first time they hear that experience, what ends up happening is they will create change, because we live in this kind of adult centric world, right, where lots of adults are making decisions for children.

We've gone past the day of children should be seen and not heard. When we're working in the space of domestic violence and family violence and sexual violence, children do need to be seen and they do need to be heard because they are also witnessing and they're also a victim of what is happening here. Often what we do, and this is not mother blaming a lot, is we focus in on the adults in the problem and the child becomes very quiet and we don't seek for them or seek their understanding of the problem. We know that, you know, we've got very unwell children, so mental health in children is raising, and that is usually because we don't do enough therapeutic support when children are in the problem. So we don't intervene early in the life of the problem. We usually wait till we see the behavioural outcomes of children, and so what these programs, child inclusive practice does, is go in and speak with the children, so they can have their voice heard, they can make meaning of what's going on for them, and they can influence their family to create change. Like I said, when we use reintegrative shame, most people love their children.

And I think we forget that. Even people that choose to use violence love their children. So when their child's voice is presented back to them., they usually create the change that's needed because it's that shame, not the shame that the sector gives them. You know, we give them punitive punishments. You know, you can't see your children if you enter into the Child Protection space. You're now left out of the decision-making if you're the perpetrator of violence and then the woman that's left is making all the decisions. We put a lot of responsibility. Whereas in this space we're using the child's voice to actually get both parents to kind of go, let's look through the lens of a child. And when you look through the lens of a child, that is when you're going to get some change occurring and we haven't done that well as a sector and I think we're a little bit scared of children in that space.

MS HENDERSON: I would like to add something, but you go.

MS ORR: I will come back to you, Ms Henderson. I just wanted to pick up on something you said about we tend to focus on the adults, but children are also suffering. I think that's my word, not your word.

MS DECREA: Yes.

MS ORR: The Royal Commission has heard and we've had evidence about, there seems to be a focus on crisis response and physical safety.

MS DECREA: Yeah.

MS ORR: What's happening to the children when that's the response and there isn't a focus on the child.

MS DECREA: So often what we do in these spaces is we remove children to keep them physically safe. We might take them out of the domestic violence situation and we stick them into hotels or DV shelters and we think because they're out of that physical, everything will be okay. That's usually when behaviours escalate for children because often we don't think about this is the first time that they're not in their fight/flight/freeze, right? So I can now sit in my own screen and that's scary to sit in because what happens with children is they start to also do exactly what mothers do, which is start to create their own safety behaviours. So when you take them out of that, they don't know when dad's – because we're going to talk about dad because this is usually where the violence occurs, right, so we don't know when dad's going to turn up.

Usually we've got this pattern of he turns up at this time so I don't know when dad's going to turn up. I can't see him so we've got more fears and anxiety actually occurring and then we don't concentrate on the emotional safety of children, the psychological safety of children and even the spiritual safety of children. And what we think is we create safety with a mum that should all be okay, when actually this is the time when children's behaviours are escalating and you've got so much pressure on a mother who's now preoccupied by lots of things that the sector puts her through, to look for housing, to do these appointments, if you've got Child Protection on your space, you've got to do all these appointments and we're making her unavailable for the child. And

then what you've got is a child that now not only is doing behaviour issues but has a caregiver that's not attuned because of the pressure that we stick on the mother.

And that actually makes the child escalate even more and we've seen lots of times where we see children become perpetrators by the system. We hear from teachers, "Oh, the child's putting a lot of pressure on the mum to visit dad," and it's like all of a sudden, we're turning children into perpetrators. And it's like, no, this is the time the child really needs that serve and return from her mum, and we call it the serve and return. Where, you know, just to be able to find a time where they can sit in a therapeutic relationship. And we're not talking about healing all their problems. We're talking about finding safety in the relationship, in that dyad, in that attachment dyad, because that is where children will feel safer, children's mental health can be supported and when mum can feel like she is doing good enough parenting. So that's where that is really important for child inclusiveness work.

MS ORR: I'm going to ask you about that relationship first, but Ms Henderson, did you want to add something before and I'm sorry we've gone off?

MS HENDERSON: No, no, I really appreciate it. Always, when Sarah speaks, I've always got more that comes to my mind, but talking about the physical safety aspects that you raised in that question, I think it's also really important to reiterate what Sarah's saying, what we are definitely not doing as service providers is saying that mothers that have experienced domestic violence are incompetent or somehow bad parents. Absolutely not. What we are saying is that mums that are escaping violence remain feeling quite powerless, unable to regulate themselves or their children. We have our detection of overall risk screening data that tells us this. We have some data that suggests that 60 per cent of mothers that were entering our Safe and Well Kids programs said that they just could not understand their children's behaviour. 77 per cent said they were struggling to respond to their kids at all and over 50 per cent were actually being a lot harsher with their children than what they wanted to be.

So this is an impact on the relationship because of the domestic violence that doesn't stop just because you are physically out of the environment. And I think what tools like this – evidence-based tools like risk screening, our DOORS and our use of Outcome Star really helps us to screen for this risk, but it also helps us to move away from, I think, a bit of a fallacy that's in the system of, like, incident-based. You know, the incidents of violence have stopped, so they're okay. Well, no, they're not. We know that kids stop inviting friends over. They learn to tiptoe around the house. They learn how to gauge mum's response. They don't go to school. Their behaviour's become out of control. We've got a lot of data that suggests that our kids are telling us they feel heaps of feelings of emptiness, they've got no cultural connections, their sleep routines are all over the place. So this really helps us, particularly in the coercive control discussion as well, to start to understand – and I think it's David Mandell that speaks of this – that you know all of this reveals a complex web of controlling behaviour that shapes every aspect of children and survivors' lives.

So that's what we mean when we say just removing, getting physically safe is not the way. And just the other thing I wanted to add about both of our services, Sarah talked

about the Lundee model, but both of our services at their core call for the full participation of children and they rely on relationships being the vehicle of change. So we believe the healing happens between caregiver, protective parent, mum and child because children often are always the most harmed by the reason we're walking into their front door because they are the most vulnerable. And just tacking on to something Sarah was talking about shame because I think this is such an important discussion to have. The orthodox way in which as a system for years we've been othering men that use violence and we other young people that offend you know we think, yep, put them in prisons or move them to the side and just work with mum.

Whilst Safe and Well Kids as a program doesn't work directly with men, we still need to give effect to that child's relationship with their father. They still love their father. And if dad is feeling a lot of this shame, which he is, because like Sarah said, dads still love their kids, they've probably got intergenerational issues leading them to their violence. But children will then take on that shame. We know that children take on the shame of their parents. So if we're not working directly with children to help them make sense of their story around their relationship with their dad, because otherwise they blame themselves, we need to be able to sit in that story with that child. Even if we deem it a dysfunctional story, we need to be able to sit in that story to then be able to help children to co-create a new story that's a healthier story. I think that stuff's cycle breaking.

MS DECREA: Yeah. Because we know children are egocentric, right? That's just children. It is, you know, it's not the world and me, it's me and the world. So if we don't help children understand that, they will blame themselves. And just being able to sit with a child and say things like, "Did you know that actually mum dad used to argue before you were born," is sometimes big information for children to go, "Oh, I never knew that." But these are the little things that we can do to support children to understand that this is not their fault. And if we don't speak to children directly and get them to help navigate their story, they will lead into this world thinking that's their fault. And I want to talk about physical safety in the eyes of whose physical safety, right? So when I speak through in an Aboriginal sense, around when I work with some of our families, and this story will always stick with me, when I was working with a mum who was now having her child removed because of domestic violence, her response to me was, "Where were all these people when I was a child?" and what she was saying is that he might give me a black eye every now and then but I'm not being raped every night.

Now this is someone speaking straight into their experience of sexual abuse, right? So we've got traumatised children will turn into traumatised adults who will turn into traumatised parents. So you know, when we're talking to this mother about violence, her threshold of violence is way higher than some of us would think, and that is because of her childhood, because no one got in there to explain to her that was not okay when she was a child. And so if we know that we need to start setting up different responses which is why we're so hell bent on child inclusive practice. We do need to help children navigate this. Otherwise, we know that they turn into adults that will experience domestic violence themselves or will be perpetrating domestic violence or have drug and alcohol issues. So early in the life of the problem, a therapeutic intervention early in the life of the problem is where we should be starting to do our

interventions and I think we leave it way too late in the life of the problem before we decide to jump in.

MS HENDERSON: Absolutely.

MS ORR: Can I pick up on that and the timing of providing therapeutic intervention? Can you talk to us a bit more about that and the kind of views around providing that therapeutic intervention to children when they're in crisis or not?

MS DECREA: Yeah. Before I hand over, so think what happens is we think therapeutic interventions are a really intense intervention. All right. A therapeutic intervention is as simple as creating space for a mum to delight in her child. Do you know, we forget the simple things of actually in all of this chaos, where is there time for a mum and child just to delight in each other, to actually sit together and do the turn or reserve of I'm hearing you, I'm spending time with you, because we we know that you only have to be a good enough parent majority 40 per cent of the time and then it's how you do your rupture and repair after but we don't even create. So that is a therapeutic intervention but we don't even create that. We think we have to something really intense, and it's not about intense work. It is about getting that dyad to actually be together to actually support each other.

That relationship, as Chloe said, going back into that relationship is a therapeutic intervention. That's enough for the child to go, "Someone is hearing me. I have an attuned caregiver to my needs. They can see that I'm struggling." People don't often think about these things around when someone is fleeing domestic violence they're now in this shelter, they've got all these things to do, my child starts wetting the bed. A therapeutic intervention is helping mum cope with that child wetting the bed, because we know that 60 per cent of our mothers are saying, "I am parenting harsher than what I need to because the stress of that." So being able to sit with mum and work with mum around wetting the bed and working with her and her child about what's going on for that child when wetting the bed. Instead of going, oh, that's just – they'll get over that.

We just brush it aside. And so therapeutic interventions are focused in on just fixing that relationship, helping that relationship sustain because helping that relationship sustain will help that mother not have to enter back into a domestic violence relationship, which is usually what happens. Right, we force mum to go, "I can't cope. I can't do this on my own. The children aren't coping. I'm just going to enter back into that relationship." And we know you know it's a parenting choice to make mums feel like they're not good enough parents and so if we do that again to this as a system to mums we actually put them into that space.

MS ORR: I'm going to come back to that relationships topic again in a minute, but, Ms Henderson, if you had something to add about the timing of the intervention.

MS HENDERSON: Sure, because it is something I'm very passionate about. I truly believe that the crisis time of, and particularly for Safe and Well kids, of having escaped the violent relationship, being in a motel or being in a shelter, is the most opportune time to start to do therapeutic work. And the reason I say that is very similar to Sarah,

we know domestic violence is a parenting strategy that has interfered with the relationship. Mum and kids need to learn to just be together again. That in itself is therapeutic. But also what I wanted to say about that too is waiting for this so-called stabilisation to occur, you could be waiting years. What does stabilisation really mean? Is getting a house stable enough? I don't know. I really do think we need to move away from that because children's needs are actually at their highest upon escape and so is mum, as Sarah just said, this is when people consider returning.

But it is about dosage, you know, I'm not saying we get in there and we sit down for two hours and we have a full therapy session. It's really creative ways that we do some somatic work, some play-based therapy. We run a garden program, attachment focused, but they're fun things to do and you can do them in motels, you can do them in parks, and they work they really work. But it is about dosage, so it's not therapy in that traditional sense. But, yeah, I strongly argue that if mum can organise herself in a child safety in the midst of a crisis, I truly believe she's going to be more likely to be able to do that in future if another crisis were to arise. And Richard Rose actually speaks into this in his work with therapeutic life story work and he says, "I get the same question, is this the best time? It's crisis time." He said, "Well, it's a crisis but trauma is always bubbling under the surface anyway. You may as well do it while it's bubbling up now, then wait for some stabilisation to just have it bubble up again." And that's something I truly believe in.

And look, I'll look I'll just quickly just cite some, I love data, some stats. We have a 14-week program and we get Outcome Star data where children rate how they're going in various life domains of their life, school, self-esteem, being safe, all sorts of things pre and post our service delivery and for a 14-week program – which I would love for it to be longer but funding restrictions. So 65 per cent of children told us that they have significantly improved relationships with their caregivers. 80 per cent of them now know how to deal with big and difficult feelings. 60 per cent have increased self-esteem and knowing their feelings matter. 80 per cent feel an increase in feeling safe and knowing there are people to care for them. So you know, for 14 weeks these are really, really good outcomes and I think that supports the idea that the crisis time is the right time.

MS ORR: Can we come back now to the healing the relationship that we've touched on already? So you said at the beginning that RASA in general works on healing the relationship.

MS DECREA: Yeah.

MS HENDERSON: Absolutely.

MS ORR: But can you explain a bit more about the importance of that in the context of the parent-child relationship?

MS DECREA: So children need attuned carers, we know that, right? And so to have an attuned carer in this crisis time is what we're talking about. Again, I'm going to speak from an Aboriginal lens here around Child Protection. Usually when mums enter

into a shelter, you have more eyes on mothers and children. So when you're in a home with domestic violence, there's closed doors. When you enter into a shelter or into a motel and services are now there, they're starting to have more eyes on them. This is how Aboriginal children are removed, right, because we have children with large behaviours, we have mums that have got some very unusual safety mechanisms, and it is David Mandell that talks around mums and children do – so especially mums, they put a lot of safety strategies in their parenting to keep children and themselves safe, that when you're out of that situation it does not look like safe parenting. It actually looks like dysfunctional parenting, right? And so I'm now having to relearn that relationship with my child. So a prime example is we've had a a mum that we were working with that had to go and do a – because we also know that from our DOORS, 60 per cent of our mothers are also – and DOORS stands for Detection of Overall Risk Screening, so it's a risk assessment.

MS HENDERSON: So screening not assessing.

MS DECREA: Yeah, and so what happens there is when we talk about child inclusive we also have a DOORS for children as well because that's how you include children. But our mums are also saying that 60 per cent of them have increased their drug and alcohol intake, because you're going to self-soothe now, right? So, of course, Child Protection are starting to sniff around here. And so what we see in this mum is, okay, she needs to go in for a day detox. She's entered back into the relationship, but she needs to do a detox because Child Protection are now focusing on her. And this is what happens when we enter into a Child Protection space, right? Mums have to keep children safe and we don't put a lot of responsibility on fathers in this space. For her to go and do that detox, she wrote on butcher's paper, all over the wall, steps for her children on when you get up in the morning, make dad breakfast. When you do this, keep the noise down so dad can have sleep. So she's done all these things and the Child Protection worker went, "Look, she can't even focus in on her children, she's so preoccupied with him."

Actually what that was, was a safety strategy is "I'm not here for this day, I need you to be able to keep him satisfied because I can't protect you when I'm not here." And so she done all of this stuff that actually didn't look like safety through a Child Protection lens but through her lens it was definitely safety, and it had to be pointed out to Child Protection to see that because you know they're thinking about removal because she can't keep her child in mind. She hasn't got her care giving sensitivity. And what we're saying is actually that is care giving sensitivity. That is someone who's so in tuned with her children that she needs to know how to keep them safe. And so this is when in this space, we can put so much pressure on mum and this is where Child Protection comes in and we start to do exactly what perpetrators do to mothers. We start to blame them, we start to do parent control of them. If you don't look after your children's safety, if you enter back into that relationship you're going to lose your children.

So she's being pulled from all directions, and so this is why that relationship with the child is so important because they are both now in positions where they've got behaviours that are escalating each other and so this is the prime opportunity to go in

and mend that relationship. If you mend that relationship you're less likely going to have that mother return to the violent situation, because she's going to more confident in her parenting. She's going to feel like her children are feeling happy and feeling safe and I can do this. And like Chloe was saying, we often wait for some stabilisation and that's often what the system says, there needs stabilisation in there. By then it's usually too late, right? We'll probably get her into a house and she enters into another domestic violent relationship or for Together For Kids we see them back homeless because they can't keep that house because we haven't actually addressed core issues and so children are unsafe again. And so that first attachment relationship we have is with our mother.

It is a sacred relationship and I think we forget how sacred that relationship is and how important attachment is when it comes to domestic violence. We lose sight of that relationship and we start going, "We need to heal mum or we need to get mum out of domestic violence," and we just go, "Look, it's an adult centric world," so we start looking at adult problems. Adult problems cause big worries for children. And if we don't start thinking about children, we'll just keep going down the path of unhealthy children, and really as a state you can only consider how well you do with how healthy your children are. And I don't think we have a lot of healthy children in South Australia because we're not doing enough in a therapeutic space to support children through these very hard times.

MS ORR: I want to pick up on a couple of things you said there. I think Ms Henderson, if you could help us with this. You've mentioned safety strategies to avoid, sorry, in the context of violence, and I think you mentioned earlier about the effect of violence on the parent-child relationship. Could you talk a bit more about how violence affects the relationship between, let's say, the mother and the child?

MS HENDERSON: Absolutely. So, yeah, as I mentioned, domestic violence is also a parenting strategy that sometimes the intent is to separate mothers and children as a strategy for dominance and control. So what that can look like for the children that we work with is that mothers really struggle to understand their children's needs. And, look, what we try and do in that space is it's not just about helping children make sense of their story and what's happening to them and it not being their fault, but we want to help children make sense of their relationships with their parents and to make sense of their relationship with mum and, you know, to understand their story but also to make reparation in that relationship that has been impacted by violence. So what we do in that space is we partner with mums. So they're our partners and they're a partner – and I think the key is they're a partner in the solution, not the problem, which the system does a lot of the time.

And we help mums understand how domestic violence has been that strategy rooted in dominance and control and how it has led to separation or fractures in the relationship. And like Sarah's already mentioned, but I think if I look at some of the thematic feedback we get from mums and children that we work with, most consistently we are getting feedback from mums that say, "It was seeing things through my child's eyes for the first time. I had no idea they had their own safety plan; I had no idea they knew this was going on. Hearing my child's core experience for the first time was my most profound moment of change." Because a lot of times mums are like, "How could you,

you're having your human rights obliterated? You're trying to just keep everybody alive." But domestic violence weaves such a complex web. And just to also tack on to what you were talking about how it's a mutually beneficial process even though we are child inclusive and centred and we have a resolute focus on the children, we truly believe that it goes hand in hand. Helping children is helping mothers. We're helping that relationship. Both need to be nurtured.

Mums need to feel more confident to understand their child's core experience and we facilitate that therapeutic loop back to mum to hold that story. But the most profound moments are when mums can see things through their child's eyes and to actually see for themselves how the violence is actually got in the way of that. And just one more thing I wanted to add on that too. I think I rely a lot on some of the work of David Mandell and he says, you know, "The child's attachment to their mother plays the most crucial role in recovery." And that's something that both of our programs focus very, very heavily on.

MS DECREA: It's that attachment relationship that's going to long last into how you have relationships, right, throughout your whole life. And I think people forget that, that that early attachment relationship is what is going to help you or define how you have your own relationships as an adult, so that's why we need to work on that relatonship. The other thing that gets in the way is when mothers are in this space, and this is why we're not blaming mums here, and I think I just want to make that, and that's why we find it very hard to talk into is because what happens in a lot of these spaces it has been a feminist space for a very long time right, so we're all in for the mother, and we forget that actually we should be all in for the child and the mother. Again, it's that thing of we're just here to concentrate on the mother. My own experience of growing up in a domestic violence shelter in Centacare, my whole experience was a lot of people were talking to my mum and a lot of people were coming to me as professionals kind of going, you know, "You need to stop behaving like that because you're really stressing your mum out."

That started to get in the way of my mum and my own relationship because I started to become resentful. You know, because as a child, I'm like, "Well, what about me?" And no one was listening to me. And so this is why I am a real push forward to listen to children, because I've got my own experience. And it's not that I'm a lived experience worker. I just know that at that time, what I needed was someone to actually say to me, "What's going on for you?" And no one was doing that. Everyone was saying, "Oh, this is what's going on for your mum." And I was sitting there as my own individual saying, "Yeah, but I'm also"– you know, I felt like everyone was taking my mum from me and that's when I needed her the most. And I think as a system we do that right, because she's now I've got to look for housing, or I've got to do these things. Children will do things like, I don't want to go to school because I don't go to school because if I go to school I don't know what happens at home when I'm at school. So for me to protect mum I'm going to stay home. And then what happens is when you get into a space like this, it's like your mum's trying to make you go to school.

You know, before you didn't care that I wasn't going to school, but now all of a sudden you want to push me to go to school. So this is why this relationship – otherwise you're

going to end up with a resentful relationship between mother and child. And so that's why we can't wait for stabilisation. That's why we need to go in and help, even we do a lot of neuroscience work. We use a tool called TECA in our work and that is for mothers to kind of go, "Do you know how your children's window of tolerance looks like?" And for the first time some of the mothers are like, "I've never thought about that for my child." And so again, it just helps them have a different relationship and really think about their child's behaviour as they're not naughty children. Because often we go, "Oh, these children are just being" – and we hear it all the time from mums as well, "My children are being really naughty." So to be able to explain that neuroscience of, no, your child is flipping their lid right now, and always do that because I'm just so used to doing the flipping the lid. And so mums can then go, "Oh, okay," and then they respond differently.

And so it's how they respond differently that helps the relationship. And so this is where this work is really important. So that's why the feedback loop is we work with the children to help them understand their emotions, because the majority of them you know, when we talk about the Outcome Stars, what we notice is the majority of them are very concerned about their peers. You know, and they want to be able to function better at school. They want to be able to control their own emotions. So for children, they're wanting to control their own emotions. So when we work with children around how to control their emotions, we also give the safe parent, which is usually the mother, the skills to be able to help that child control their own emotions. And that's where that work comes in in helping that relationship.

MS HENDERSON: And something I just wanted to add on to that as well, in answer to your question, and Sarah's spoken beautifully about attachment, but what we're also attempting to do, and we're doing it quite well, is that we're understanding that early relationship with a caregiver, it shapes how we are going to make emotional bonds with others in the future, among many other things, including brain development. But interruptions to that, which is what domestic violence does, severely impacts this. This is where we see kids with anxiety, avoidance, trust issues, regulation issues. So that really is how domestic violence, in the sense of what we see with the kids that we are working with, has an impact, not just on the relationship, it's on all of their relationships. It's every facet of their life education. So what we're trying to do is create a home environment where there is a focus, a resolute focus on the children's psychological and emotional well-being that creates a safe environment for all.

You know, if you've got a home – and it doesn't have to be a home home, it can be a motel, but if you're in a space where your resolute focus as a mum is to create emotional safety for your child, you're going to create emotional safety for yourself And this is again the stuff that I think is quite cycle breaking. And Sarah also spoke about the work we rely on a lot of support and expertise and guidance from Professor Jen McIntosh, and she's really, really helped us be skilled on caregiver sensitivity. And we're not saying that we are experts in this field; we don't diagnose attachment disorders or anything like that. But what caregiver sensitivity allows us to do, it's not a measure of attachment but it does help us understand a mum's bond to her child and how domestic violence can interrupt that and make her a preoccupied caregiver. The best joy we get in this work is the moments where you see mums confident, seeking warm proximity with their kids, sharing all these moments of joy. Instead of this

walking or tiptoeing on eggshells. We see very helpless caregivers turn into very confident and attuned mums and, yeah, that's the work, isn't it.

MS DECREA: And so like I said, it's not a kind of complex work, it is just around rebuilding that relationship. Like anything, when you've had such rupture – and domestic violence is a rupture in everyone's life and so to bring children back into the picture to go actually they've experienced a really bad rupture with even the safe parent. And often we we just think I know that that once you get that physical safety sorted they'll just attune back to mum and everything will be fine. No, that needs support and that needs help and guidance, and that's what really these two programs do. We see children in their own right. We use their voice, their experience, their story and then their audience is back to the people that they love. Their audience is going back to the mother, going back to fathers, going back to the school so people can really understand what they're experiencing here. So they don't go to school – and we see all the time. Children will go to school, schools don't understand their behaviour because we don't have therapeutic schools. And so you know we often go and visit children at the school and feedback to the school what is happening with that child as well. So this is around how you use child's voice to actually create change in decision-makers. Because like I said, children don't make decisions, it's adults in the world that start to make decisions. So if you can use that child's experience to actually influence all the decision-makers in that child's life, you're going to have better decisions for children because children are more actively involved in the decision-making, instead of adults kind of going, "Oh, we think this is what's in the best interest of this child", when they haven't even talked to that child.

MS ORR: Can I ask another question about healing in the relationship? I understand there is a First Nations lens to this approach.

MS DECREA: Yeah.

MS ORR: Can you explain a bit about that to us?

MS DECREA: So we always believe that healing is in the storytelling. So we are born of the spiritual realm, we come into the physical realm. But it's stories that make up our world. So I have no right to judge your story because I have not lived it. And so what we need to do is sit together and understand each other's story. And so that is the same for children. So we sit with children and understand their story. We sit with mothers and understand their story, but somewhere those two stories need to connect. And so just in story like when you sit in a space of safety and able to tell your story, what you're able to do is get some justice, right, and we're all looking for justice. You're looking for justice in a space. People don't know they're looking for justice, but in storytelling someone is hearing me and I get a justice and in justice there is healing. And I think we forget that, that when people are able to tell their story and have it received in a way that actually people understand it, it's the deep listening, the dadirri. And the dadirri and the deep listening is, I feel it.

So I'm not judging it, I'm feeling it. I can see the pain in that. I can see the love in that story. I can feel the grief in that story and being able to name that actually allows

people to go, "They know what I'm talking about." And then that allows for that justice. And often we think justice is something different than healing. When justice and healing are so connected, right. If I'm not heard, I'm forever seeking justice. I'm getting louder and louder and louder until someone hears me, right. And often what we see is mums that get louder and louder and louder and then seen as the problem because no one is giving them the justice they need and that's the same with children. You see children's behaviour get louder and louder and louder because no one is listening to their story correctly in the deep listening. So you do have to sit in deep listening. So it's very different to a Western version of active listening. What we say is we listen deeply, we sit, we hear for the emotion that's in there, and actually we don't sit and listen to actually start to make an assessment, to start to make a judgement, to start to make a case, because you'll lose us when you do that, right?

We know as Aboriginal people, when you go in the room and you can already see that they're already starting to make assessments about me. When actually all I want you to do is sit and listen to my story. And that requires slowing down. We live in such a fast paced world, and when you enter into a domestic violence space, you've got 12 weeks to do these programs, you've got 14 weeks to do this, and you've got to go for seven house inspections in the week. When do you get to slow down to sit and understand your story so you can recreate it? And so that's the deep listening, is finding a space in this therapeutic lens where we can just sit with the mother and the child and let them tell their story and make meaning of it, because they've been so caught up in survival. And it is this kind of deep knowledge of First Nations knowledge with this Western knowledge of neuroscience. They so feed into each other. Neuroscience tells us that when people are in that fight/flight/freeze mode, they are not in a space where they can make decisions.

They are in a flipped lid and yet this is when we want people to make their biggest decisions. Change address. How are you going to keep your child safe? They are totally disconnected. Uncle Lewis O'Brien talks about the brain is in two parts, right? There are two parts of the brain and that the Kaurna people knew that for a long time. And we talk about the upstairs, downstairs brain. You cannot make decisions when your upstairs brain is not connected to your downstairs brain. We knew that as First Nations people, but, you know, this kind of trying to push mothers and children into decision-making when they are totally in fear, you're not going to get good outcomes, so you need to slow the process. That's why you need a therapeutic intervention. That's why you need to take that time and allow people to resettle. And that again talks into that just because physical violence is gone does not mean people are feeling safe enough yet, and it doesn't mean mothers are feeling safe enough yet. But where they will find safety is in that beautiful relationship with their child, because that's where safety occurs, in that loving relationship, and I think we forget that.

MS HENDERSON: Sarah, can I add something based on what I've actually learnt from you being at RASA? Hearing Sarah talk about dadirri, which is deep listening, I heard a quote once, I can't remember where it was, but it's something to do with the greatest mark of intelligence is to be able to accept a version of a truth, of someone's truth, without condoning it. And that's what we're doing in this work, we need to sit with people's stories, whether we deem them dysfunctional. And this is exactly what Sarah's talking about, instead of jumping in with solutions, it's we have to sit in that

story before we can work in a family led way to co-create a new story, and that's something I've really taken from what you just said.

MS ORR: And it's probably obvious from your evidence so far, but does this therapeutic work with children have a future-looking prevention or intervention impact?

MS DECREA: Totally. I'll speak – so we can speak into some stats. I'll speak into some stats For Together for Kids. So we like we said we use the Outcome Stars for children to be able to speak because we do a lot of self-reporting in Relationship Australia. DOORS is a risk screening tool that is a self-report by mothers or anyone that use our services. And it's same with Outcome Stars, this is a self-report by children because what you want them to do is tell their own story, not as a system, we decide what your story is and we've done that for way too long in this space. So actually what is your story? So for a lot of the children that have used Outcome Stars for Together for Kids, you know, Together for Kids is unique. It's been around for 16 years surviving on yearly funding, can I say. So every year we get yearly funding. So we never know whether the program is going to last but 16 years it's been going. 49 per cent of our children report making processing feeling safe, so with these interventions, 49 per cent of them saying they're feeling a lot more safer. 75 per cent report that they have better control of their feelings and behaviour.

57 per cent report that they have more confidence and self-esteem, and 49 per cent of them are saying that they feel that they're engaging with their education and learning a lot better. We see in Together for Kids just over 400 children a year and that is through individual casework as well as therapeutic groups. Those therapeutic groups, again, are groups that rely a lot, focusing on attachment. So this is as early intervention as you can get. And this is early intervention in a space where children are included in the outcomes. So this is definitely a space where I think as a sector, we should be moving. I don't think we've done well for children. I think what children bring up in us is our own vulnerability, right, and it means we have to step into there. And it doesn't mean that people don't want to work with children. I think it brings up a lot of vulnerability. What if I harm this child more? What if I ask the wrong question and they start crying? Especially in the Nartwich Family Group conference space, where we had a lot of people saying, "Oh, that was just harmful for children to be in that room," because in that Family Group conference space they're talking about Child Protection issues around domestic violence where children will talk about their experience to their parents.

They're included in that conference. We are really scared when children cry, because it brings up our own vulnerability. Actually, this is a child telling their story. It's sad. Of course they're going to cry, you know, but we've got this fear about speaking to children. So I think we need to start working about how we become more child inclusive. How do we set the boundaries for children to work in, right. Because like I said, children aren't decision-makers, so we need to make sure that we don't set children up to think that when they tell their story they're going to be able to change decisions that are going on for them. It takes quite a skill set to do that. But they will give us better solutions. It goes back to the common restorative practice of you put the problem at the centre, you widen the circle around the problem and those most affected

by the problem should be at the decision-making table. Well, that's children. But often we leave them totally out of the decision-making table.

We don't even bring their voice. We decide that we will speak for them. And we've got a beautiful voice recording of a young child that kind of says to us, "When I decided to speak for myself I'd done that because people will speak for me and think they know what I want to say but they don't." And that's really simple, right? If we ask children, they'll tell you, but we often don't even ask them. We just assume and that's because it comes out of all good intention that we don't want to cause further harm, but by not asking we're actually causing further harm. And we see that because like I said, we have children that are growing into adults who are perpetrating the same lot – we see three generations, four generations of violence within families. So when I speak with families and kind of go, "So where did violence stem for you? Like, did you experience violence as a child? Is it just now or did you experience violence as child?" "I know I experienced violence as a child, so did my mother." Because we're not doing anything to kind of go, so what do you want for your child? And most of the time, they don't want the violence to continue. But, you know, we do a thing called, like, a trauma gram, which is working with parents around being able to see where trauma sits.

And it's a visual. And they will often go, "I did not realise that was our story. That's four generations of the same story being passed." So they want to change it. And we see that. That's why when these mums come in and we use the DOORS, they want help, they're seeking support. These are self-report tools. Right, so they're actually writing down that actually I am struggling with my parenting. I am struggling with drug and alcohol use. I'm not feeling safe. So they're self-reporting this and so if they're self-reporting this we should be acting on that but we don't. We kind of, as a system go, "Oh, look, that's not what you need right now." Chloe was talking about the dosage. We'll go, you need this. It's the wrong dosage at the wrong time. Let's find the right dosage at the right time, which means bring mum and child into that decision-making. And if we're going to be really brave, sometimes we might need to bring dad into that too, and put some - - -

MS HENDERSON: Absolutely.

MS DECREA: - - - of that responsibility back where the behaviour belongs. Because too often what we see, especially in the FGC, is we get into that space and mum's now responsible for dad's behaviour. Well, that's not fair. Actually he should be responsible for his own behaviour. If he chooses to use violence then he should be responsible for that. We shouldn't be putting that burden on the mother.

MS ORR: FGC – Family Group Conferencing.

MS DECREA: Yeah.

MS ORR: Okay, thank you. I'd like to ask just a little bit about the programs that you offer at RASA. Maybe if we can start with Safe and Well Kids; you manage that program, Ms Henderson.

MS HENDERSON: Yeah, sure.

MS ORR: So I understand that operates in a partnership?

MS HENDERSON: Yes.

MS ORR: Can you explain that for us?

MS HENDERSON: Absolutely. So yes, we were created in 2021. So we are a partnership with Women's Safety Services SA, Legal Services Commission and Relationships Australia. And I guess, I want to just be really clear what our program hypothesises, because we've put a lot of work into our program logic model, is that the safety, stability and recovery of women and children impacted by domestic violence is secured through holistic access to coordinated service responses. So that's really the key for me. So it's a coordinated service response because we know that siloed systems cause harm and we actually know that siloed systems can continue to unintentionally perpetuate more violence. And we actually also know coercive control becomes even more dangerous when it's combined with systemic oppression and siloed systems. So in my view, partnership programs like this are vital because women and children come to the service, they are referred to through WSSSA. They have to be referred in by WSSSA. Love in the future for that to look different and to open that up to others, but it's essentially women and children who are involved in Women's Safety Services. So the Women's Safety Service provide child case management. Legal Services Commission provide free legal advice to women, which is very, very useful for them because we know how the legal system can also be weaponised against women who are escaping domestic violence. And Relationships Australia provide the therapeutic intensive work with mothers and children.

MS ORR: RASA did the therapeutic work.

MS HENDERSON: Yes.

MS ORR: How long does that program run for? I'm sorry if you've said that.

MS HENDERSON: So it's a 14-week service model. We would love for that to be more. The feedback we get, we get a lot and we value our client feedback. The feedback that we get a lot from others is we would just love to have a bit more time and we would love to be able to give it. But our KPIs are to see 165 children a financial year. We do really well with that. We're tracking along over the last four quarters on 200. But, yeah, it's just not enough time. But in saying that, the outcomes are still there, which I think is evident of the fact that with even more time, what more could we achieve?

MS ORR: Can I just ask you a little bit more about the referrals? So it's referrals from WSSSA or Women's Safety Services in South Australia.

MS HENDERSON: Yeah, sorry for the acronym.

MS ORR: And so does that mean that the woman has to be a client of WSSSA?

MS HENDERSON: Correct. Yep, so the woman needs to be attached to what they call an adult case manager, so that's a case manager that you get allocated when you're in Women's Safety Services. Yeah.

MS ORR: Does it mean they are in crisis accommodation necessarily?

MS HENDERSON: Yeah.

MS ORR: So this program is only accessible to people who are in that crisis accommodation?

MS HENDERSON: Yes, because that's when you get allocated the adult case manager. Yeah.

MS ORR: And what if that changes and, say, the woman then resumes the relationship, the violent relationship, what happens in that case?

MS HENDERSON: Sadly given the criteria, that can often mean that the decision is made that we stop service delivery. I would love to see that change, but I do understand Women's Safety Services limitations on that at the moment. And to be really fair, there have been times where we've tried to get a bit creative and continue to do some work particularly when we've got kids saying, "I just want to keep doing this therapeutic work," there's some leeway but really as a rule of thumb unfortunately, when you leave the Women's Safety Services as a client you're no longer eligible for Safe and Well Kids.

MS ORR: And what is the age range of the kids for the Safe and Well Kids that we'll see?

MS HENDERSON: 0 to 17.

MS ORR: And you talked about the number of young people in the program, so I think, did you say around 200 last year?

MS HENDERSON: 200 over the last four quarters, yes.

MS ORR: And where is the funding from for Safe and Well Kids?

MS HENDERSON: Office for Women. Yeah.

MS ORR: And is it ongoing?

MS HENDERSON: No. It's year-to-year funding. We are currently gathering a bit of interest because we've been really strategic and trying to put this program out there because of some of the outcomes we're getting. So we are being evaluated soon. We've been evaluated by SWELS already and there's some good data that I can share

there if you're interested but, yeah, unfortunately, it's year-to-year funding which just creates recruitment issues and also obviously when you get closer to the end of that year you've got to start slowing down the referrals which is a real shame.

MS ORR: What about the workforce? At RASA, what's the workforce made up of?

MS HENDERSON: Yeah, sure, so we have myself as the manager, there's a team leader, and we have five therapeutic workers.

MS ORR: Can I turn to Together For Kids which is your program, Ms Decrea?

MS DECREA: Yeah.

MS ORR: So, perhaps if you could explain the eligibility and referral pathway?

MS DECREA: Yes. So, I've worked at both those programs as an executive manager, but Together for Kids is one of our unique ones because it's been around for so long, like I said, 14 years. And where that comes from, it was a directly funded service by South Australian Housing Authority, so House Trust. So children come through the homeless gateway service and that also includes the domestic violence shelters. What we know is when mothers leave, like, when they're physically safe or they leave the violence, it often means that they become clients of the homelessness services, right, and so they're no longer a domestic violence, so they come under the homeless and they get managed under homelessness. So, you know, so Togetheer For Kids, it gets direct referrals from the homeless gateway. And so just recently that has been taken over in 2024 so the funding was transitioned over to Department of Human services and so that's where we get our funding from now.

MS ORR: You said before year-to-year funding.

MS DECREA: Year-to-year funding.

MS ORR: Yeah.

MS DECREA: So we have six and the KPIs are to see 400 children. We always usually see about over 400 children a year and we've been doing that for 14 years. We're statewide service and so we also have a regional office based in the Riverland in Berri. And so we go around to every area in South Australia as in metro, so we can go from south to north to west. What we are really focusing on is championing the voices of unborn children up to 12 years old who are accompanying a parent into homelessness or DV shelters. So really what we want to do is it's an intensive again therapeutic 14-week session. Often we have not as restricted – as long as we have a good rationale about why we want to extend that out to longer than 14 weeks, we can extend it out at sometimes longer than 14 weeks. We do therapeutic groups. We do school holiday groups as well, because, you know, school holidays usually are the times that a lot of stress comes on back to mums around, okay, now the kids aren't going to school, I'm stuck in this hotel and I somehow have to keep them occupied for the whole week in this hotel. So the school holiday groups are quite successful.

What that also does is allow children to come together with other children who are experiencing the same. So they're not feeling that this is just their problem, they can see that this is happening for a lot of children in South Australia. So like I said, 14-week sessions. There are six therapeutic children's workers. We have a team leader and a manager for that program. So those six therapeutic children workers are fully trained in attachment theories. We do infant – what we call this baby massage for bonding. So going back some of those basics. So because we're talking with children at young, it's getting mums to be able to just do still hands-on babying, because everything's so fast. Finding a little bit of time to go back into those kinds of places where you really put child in mind. So a whole program is set up on helping mums keep children in their mind to really work on their care-giving sensitivity. Because we've got that zero age and a lot of people say, "How do you collect children's voice when you're talking about that?" And you collect that through mum right, and so you know we have worked very close to Jen McIntosh to kind of get these kind of therapeutic questions around rupture, repair.

Can parents speak into responsibility. So you know if you could apologise to your baby for something that's happening right now, what would that be? You know so we bring the parents voice out through that letters from the baby to mum especially in the pregnancy stage, around being able to speak into what they're going to be born into, what they might need. So we do lots of creative ways of collecting that unborn voice and feeding that back to mum around developmental age for young children, what they need at the developmental age and really focusing on what does – because we know that zero to five is really important for brain development. So that's why we do a lot of the brain development work of mums in this space, so they can understand. Because, you know, children that experience domestic violence are forever changed but not forever damaged. That came out from Salvation Army when they were doing a lot of the Safe and Together. So that's what we're focusing on, that, yeah, children are experiencing things and they will be changed, but that doesn't mean that they're damaged children. So that's what Together for Kids really works on. Currently, we've got a book club, and people go, "Oh, what's the book club?" The book club is getting a group of stories, using play therapy to get children's stories of domestic violence, and that will be put together into a book that then they can share around, but it gets written into a storybook.

We've written quite a few storybooks over Together for Kids life to help the sector understand. So we do a lot of sector training. And part of that sector training is we do Working Better With Nangga Kids. So that was designed in Together for Kids for people to understand how to work with Aboriginal children and understand intergenerational trauma and how you be trauma responsive. Because we've seen a lot of trauma informed, but not a lot of trauma responsive. We have conversations on the kitchen table and that is a training that was developed for practitioners to be able to go, you know, you catch those cup of tea moments when you're sitting with a mum who then explains something, you can have this conversation around what you're explaining to me as your child really was outside of their window of tolerance. So you capture those therapeutic conversations where you can put them in. We have the Gardens Therapeutic Group, which is a trainer-trainer program, and we also do a children's strategic round table like a community as a practice. So we do a lot of feeding back into the sector as part of the KPIs as well, of training the sector up.

MS ORR: Can I just clarify, you said before the referrals are from the homelessness alliances.

MS DECREA: Yeah.

MS ORR: Does that mean that they are linked to people in emergency accommodation?

MS DECREA: Yeah.

MS ORR: And then what happens in Together for Kids if people then move out of that emergency accommodation? Is it the same as Ms Henderson?

MS DECREA: No, so we can be a little bit more – and we can hold on to them, so again, it's that right dosage. We usually get them probably when the homelessness or the DV shelters are ready to close and they go, oh, we need to close to something. We would like to actually get them a lot earlier so we can work together, because like Chloe was saying, it's that collaborative approach. People don't live their life with singular problems, but our services are made to kind of hone in on singular problems. So we would like to do more collaborative work in that space and probably get those referrals earlier in that space. I'd also like to have community referrals. It's something that we don't have a lot, especially from an Aboriginal perspective, is usually I'll hear from the community around, oh, this mum really needs support right now, and so then we will often have to ring the homelessness or ring a DV shelter, and say, "Look, we've heard that so-and-so's in there, could T4K be a good referral process for you?" So we're actually kind of pushing it because community will come and actually say, "Can you support my" – and so community referrals are really important what we would like to put that in there.

MS HENDERSON: I couldn't agree more because when I'm just looking at some of our data, 24 per cent of our referrals are Aboriginal families and I think that needs to be a lot higher. The other thing I just wanted to add in talking about outcomes for Safe and Well Kids too is we have – our DOORS data tells us that over 50 per cent of mothers entering the program are aware of Child Protection being notified or involved. So whilst I can't speak data-wise or longitudinal to that, we know that over the last year, none of the children that we have been working with within Safe and Well Kids have been removed during our intervention. I think we also see an increase in our feedback surveys from mums in help seeking behaviour, which is really important. They feel equipped to – they know who to call if they need help, they've had legal, they know RASA now, they know women's safety services, so these are all really good outcomes too that come from having a coordinated service delivering model.

I've already spoken to some of the great outcomes that kids are telling us about the improvements to their life, but I think the key one for me is 80 per cent are saying they are feeling safe and 80 per cent are saying feelings and behaviours are being able to be managed. I think where I would love to see us move as a sector and as programs is to be able to look at some more intermediate or population level outcomes. Because, you know, whilst we have a program logic it would be really good to see at a system level

what impact we're having, how focused on children are we, is the cycle of domestic violence actually being interrupted long-term. I think we need to move into that space.

MS ORR: I have one final question. The Royal Commission has talked a lot about recognising – actually more broadly than the Royal Commission, but we hear a lot about recognising children and young people in their own right. And I think, Ms Decrea, you touched on this earlier, but if we could finish with me asking you, what does that really mean?

MS DECREA: Yeah. I think we need to get children's voice in their own right but we also need to understand that children do not belong without someone. So while we say children in their own right, we need to not set up children for fear of saying they hold all the decision-making power, because they don't. So children in their own right is they're experiencing domestic violence, they may have experienced it first hand or witnessed it and so they will have their own story and trauma around that. And so that's how we see them in their own right, but we need to know that they actually belong in a wider system and that system usually is a parent or a community. And so we need to see children as their own right and loop that back to the safe parents, because if we just work with a child and we haven't done any work with the mother, we're going to set children up. If we just work with a mother and don't do any work with the children, we're going to set mum up.

So, you know, they're so connected, like I said, so instead of just going, we're focusing on women's safety, we're focusing on children and women, or women and children. I think we need to get better at the language of children don't belong on their own. We all know that. Children aren't walking around here on their own. They belong to someone. And the more we take notice of that, even in the space of Child Protection, because DV leads into Child Protection. Let's be honest, especially for Aboriginal families. It leads into a Child Protection space and when we zone out that safe relationship, we're going to create more trauma for children. So it is around who is going to be that safe relationship for that child. So children in their own right is being able to know that they're experiencing their own story of this harm, but it's the adults in that child's life that need to keep them safe. It can't be the system because the system's not there forever. It has to be the adult. Which is why it's so crucial for a therapeutic relational response.

MS ORR: Did you have something to add, Ms Henderson?

MS HENDERSON: I do because this question means so much to me. Sorry, I'm conscious of time, but absolutely what Sarah is saying. I'd also just add that we need to understand what a child's ecosystem actually is without layering that with what we think it should be. We work with kids that are on the streets and their ecosystem, their family are their friends. Now, we might say that they're not the best influences but that's their ecosystem, that's who they believe is important, so we need to value that. I've talked about it already but it's not just about seeking voice, it's about then turning that into some action, accountability and decision-making. And if you can't do that or you're worried, you contract with that child about that. But I think particularly in a Child Protection space which has so much crossover in the two programs that we're

here talking to you about today, you know, there's a lot of talk about privileging the voice of children, but it's just so talked about but it's not operationalised. And I think we also have to look at the reason why that is and I think there's fear. Workers are scared to talk to children.

I remember when I first did it, you know. And it is scary, because they will tell you how it is and they'll tell you to get stuffed. So there's fear. I think there's a lack of skills, tools and confidence and I think there's also a fear about what if a child tells me something and I don't know what to do about it, and like Sarah said, what if I re-traumatise them? Now, Richard Rose would say to that, "Yes, the fear, the risk of re-traumatising children in this high risk space is real, which is why, though, the antidote to that is your understanding of that child needs to be equal to the risk." So you need to know that child quite well, because then when there is risk, you know their safe person, you'll be able to safety plan with them. So that's really, really important. And I also just think infants in this space get overlooked consistently. And we would say, the greatest protection for a baby or any child is to be held in the mind and heart of a sensitively attuned other. So I think that's really important when we think about how we look at children in their own right. And we need to understand who their important people are. And I think something else I just wanted to finish on, too is - - -

MS ORR: I've still got questions.

MS HENDERSON: Oh, right. One more thing. This is just such an important quote to me, because a lot of people say, "Well, my intervention" – you know we're not sitting here saying every time we intervene in a family we just get all these amazing outcomes, sometimes it doesn't work for whatever reason, but Richard Rose does say, "We rarely have anyone's total attention." So the children we come across in our work may have never had an adult's total benign attention. So just to get this in and of itself is healing. So if we are practitioners, professionals, at least doing that, we are doing something.

MS DECREA: And when we talk about that because I always know that those things get used against mothers when it comes to Child Protection, right? It is sometimes the mother can't be that person at that time because they're experiencing a traumatic event themselves. So it is who can be and sometimes as a practitioner is being able to sit there and be the person that's speaking to the child and helping them understand that. So we're kind of the holding space for mum while she is able to then enter into that space. Because again, I don't believe that children should be being removed from mothers because of domestic violence. Again it is another parent control over mothers. You know that actually because you couldn't keep your child safe in that relationship we're now going to remove that child.

That is so traumatic and we've seen that happen with Aboriginal mothers throughout a long time. And so that really needs to be looked at in this space around how do we hold mothers in a space so they can recover from that trauma when they can't keep their child in mind. Because currently right now they can't, because there is so much going on for them. And we slowly have to in tune that caregiving sensitivity. So when we talk about children in their own right, children have the right, and I think we forget this,

it's children that have a right to family. It's not that we have a right to children. And we need to go back to children have that right to be connection, to be loved by their family. And so we need to think wider. And often what we do as a system is kind of go, when we think of family, when it comes to safety in this space, is we leave out the perpetrator's family. They're often worried about that child too. You'll have sisters, mothers, aunties who don't condone that behaviour and are worried about that child but then are also left out of decision-making for that child.

This is the other reason that, you know, I believe Family Group Conferencing works, because we bring that child's ecosystem in to help them understand and hear that child's voice, and what can they do to keep that child safe. Because we can't keep relying on systems, right, and that's what we kind of do as systems, it's service dependency. When we're going, actually, everyone should be keeping children safe. It's everyone's responsibility to keep children safe, and that means if your brother is a perpetrator of violence, what are you doing to help your niece or nephew be able to be safe and we often keep family out of it and let systems do that. The moment the system steps away we're back in the same pretty much. So we've got to help natural supports come in and help them because they're also dealing with a big problem here. This is a wicked problem that we're dealing with and as services, we find it hard to deal with. So imagine families who are going, "I don't know what I'm supposed to be doing in this space," and then they're totally left out.

MS ORR: Thank you both. I have no further questions.

CMR STOTT DESPOJA: Thank you, Ms Orr. I've got a few. First of all, can I just start with a clarification around the age range for Together for Kids?

MS DECREA: Yeah, zero to 12.

CMR STOTT DESPOJA: Zero to 12. Now, with Safe and Well Kids, am I wrong in thinking you said 0 to 17?

MS HENDERSON: Correct, yes we did. I believe for a time it was zero to 14, but we advocated for it to be zero to 17.

CMR STOTT DESPOJA: Thank you. I wanted to correct that because as of the end of last year I think we had zero to 14 in our notes. I was going to ask you about the impact of yearly funding, but assisting counsel has done that brilliantly and you have explained to us some of the consequences, so instead I'm going to ask you what is your funding for those two particular programs and where is it from?

MS DECREA: Okay, so for Together for Kids, as of last year, it is now coming out of Department of Human Services, and that's per, and we have 15186, so we've got about just a million and a half dollars.

CMR STOTT DESPOJA: Yeah.

MS DECREA: Yeah.

MS HENDERSON: And for Safe and Well Kids, it's around $900,000.

CMR STOTT DESPOJA: And that is from?

MS HENDERSON: Office For Women.

CMR STOTT DESPOJA: Office for Women. So these are state-based services.

MS DECREA: Yeah.

CMR STOTT DESPOJA: And as you've identified, unique services.

MS DECREA: Very unique. I always say we train the sector up because yearly funding means that come towards the end we train up some beautiful therapeutic children's workers who then will go and say, "I need something a little bit more secure in my job," so they'll go and work elsewhere. And that's okay too, because you know what we've done is be able to get some beautiful therapeutic children's workers out into the sector who we see doing marvellous jobs in other spaces like New Pins and other programs. And then they go and we hear them talk about children and I get like a proud mum to kind of go, I listen to them like really focusing in on children because I can't emphasise how much we sit in a space where children are so forgotten, yet we're all there because of children. They are totally forgotten.

MS HENDERSON: And similar in Safe and Well Kids, we see the influence and we're open to being influenced within our partnership as well. We work with lawyers who are lawyers and, you know, hearing them speak about child development and it's just amazing and we learn from them but, yes, we do see the impact of our influence in the sector and we'd love to grow that.

CMR STOTT DESPOJA: Okay. So when we talk about growing it obviously if you had additional funding and you were scaling up, you've mentioned additional weeks.

MS DECREA: Yeah.

CMR STOTT DESPOJA: But I'm also curious when you're talking about two locations for one particular program whether you're talking about other regions, other areas and sort of stand alone.

MS HENDERSON: So, I think I understand the question. So yes, so our referrals come from Women's Safety Services, and they're across metropolitan Adelaide. So the scope, you know, can be south, west, north, but I'd love to get into some regional work because we know how limited services are there. And in a perfect world, it would be really good for a program that's not just limited to clients of Women's Safety Services, but people that are experiencing domestic violence that might not be a client of Women's Safety Service. And like Sarah said, community referrals would also be amazing.

MS DECREA: Together for Kids is Riverland, so we have an office in Berri and we

have a Berri worker, so a therapeutics worker in the Riverland District, as well as metro statewide.

CMR STOTT DESPOJA: Can I just pick up on your comments earlier around Aboriginal children? As you would know the Commissioner for Aboriginal Children and Young People has done a report in which she talks about Aboriginal children in South Australia coming into contact with Child Protection at a "staggeringly disparate proportion when compared to non-Aboriginal children". She also goes on to talk about the high rates of removal of Aboriginal children and young people which is compounded by the declining rates of Aboriginal children being placed with family or kin. I know that time is against us but would you care to make some comments on that – and I think that hones back to some of your comments about how we view mothers in this environment.

MS DECREA: Yeah, and safety, right. So it again cones back to that physical safety. And when we look at mothers acting in ways where we don't think they've got children's physical safety in mind, when actually we can see that they do, it's how they've had to protect themselves. So, for example, and more like I was saying when you enter into these systems more eyes are looking, we've got more mandated reporters so a mandated reporter might just put a report to say actually the children have been left unattended at the park at, you know ,7 o'clock at night. If you speak to the mother what she's saying is I told them to go to the park because I didn't want them to see what was going on at home. And so then what we have is a notification stating that mum's got poor parenting capacity but when you speak to mum, she's actually trying to put safety mechanisms in. But the two systems don't talk right, so Child Protection just get notification, notification, notification and then they go in and do a safety plan or they'll go in and do a removal because it's not safe before they even had a conversation with mum.

And when Chloe talked about siloed services, the amounts of times where DV services are working with mum, but it hasn't been shared to the department, because everyone's working siloed. And we see that a lot in the hospitals. So another program we run is called Western Sea Farm which works in the first thousand days working within the hospital and because we're the case managers in that program, we were privileged enough to sit as an NGO provider on what was called the strengthening links. And what we would hear about the mums that we were working with going, "Oh, yeah, but you haven't heard about the intervention that we're doing, you haven't heard about the intervention that's happening with drug and alcohol. All you've kind of heard is what you're seeing at the hospital." So again mum's become under the scope and that is why Aboriginal children are being removed and it's generational, right.

And then what happens is we've got this way – and this is why family group conferencing is so important. Because if we can find someone in that If mum's not available and dad's not available, there should be someone in that kinship network. But what we kind of do in the DCP space and the Child Protection space is go, "Dad's a perpetrator of violence, don't speak to his family; look at mum's family", they've all got some history on files so we don't look at them as safety and we just remove children. When actually if you brought people in together, they will come up with a

plan. We've seen that in child inclusive mediation, we've seen it in family group conferencing. When you bring people together to keep children safe, they will come together for children. But we don't do that in the systems that we do. We just kind of go, mum can't keep the child safe, dad can't keep the child safe, we remove. And then we just end up with generational removal.

CMR STOTT DESPOJA: Ms Henderson, do you have any final words before we wrap up this session?

MS HENDERSON: Just what Sarah's talking about. I spent a long time of my career working at the Department for Child Protection and I agree wholeheartedly with what Sarah's saying and a lot of the times the rationale given for the removal of children from mothers, Aboriginal mothers, is that they lack protective capacity or that they lack insight into their child's needs, which is (1) why these programs are so important but (2), what Sarah's saying you need to actually look at mum's intentionality in what she's actually trying to do. It might be what a department might deem a maladaptive strategy but she is trying to do something protective.

MS DECREA: It is around the safety strategies that mum uses, right. And we don't see them as safety because we're not creating relationships, and I'll go back to our name of Relationships Australia. If you sat and spoke to that mum, that's why we like DOORS, when we have Child Protection saying, "Oh, she's got no insight into her parenting", we can use the DOORS and go, "Actually, what she has said is she knows she's parenting harsher. She knows that the children are feeling unsafe, she knows that, so actually she is showing insight, you just haven't spent the time to build a relationship or actually ask the right questions." So again, I think risk reining is really important in this space even for Child Protection. Instead of assuming, let's ask.

CMR STOTT DESPOJA: Thank you and thank you for your powerful evidence today. Assisting counsel.

MS ORR: Commissioner, I'll ask the witnesses to be released.

CMR STOTT DESPOJA: You are free to go.

MS ORR: Commissioner, we will have a lunch break now and we can resume a little bit later at 2.15 pm.

CMR STOTT DESPOJA: Okay then, 2.15 we will resume. Thank you.

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CMR STOTT DESPOJA: Welcome back to the fifth day of hearings for the Royal Commission into Domestic, Family and Sexual Violence. Over to assisting counsel.

MS ORR: Thank you, Commissioner. I call Rachel Kirby, Heather Baron and Melissa

John, who are giving evidence as a panel.

RACHEL ELIZABETH KIRBY, AFFIRMED

HEATHER ANNE BARON, AFFIRMED

MELISSA JOHN, AFFIRMED

MS ORR: Thank you. So you each work for SA Health?

MS KIRBY: Yes.

MS BARON: Yes.

MS JOHN: Yes.

MS ORR: Everyone's nodding. Yes. Today, during your evidence we will be talking primarily about Child Protection Services and CAMHS at SA Health. So that's Child and Adolescent Mental Health Services. And is it correct that SA Health have nominated each of you to give evidence about those topics today?

MS KIRBY: Correct.

MS JOHN: Yes.

MS ORR: Let's start with some introductions, if we can. So, Ms Kirby, if I could start with you. Could you tell us your role at SA Health, please?

MS KIRBY: Yes. Sure. I'm currently the interim director of the Child and Family Health Service, but I'm here in the capacity as someone who's previously had an executive lead role and strategic role over these services.

MS ORR: And you mean the services that I've just referred to?

MS KIRBY: Yes.

MS ORR: Thank you. Ms Baron.

MS BARON: Yes. Hello. My current role is senior policy project manager in the Child Protection Policy Unit in the Department for Health and Wellbeing SA Health, and I've had a lead role in the development of the Child Protection Services Model of Care for the State.

MS ORR: Thank you, and Ms John.

MS JOHN: Yes. I'm the director of the Child Protection Services at the Women's and Children's Hospital.

MS ORR: We will probably talk today, I imagine, about Local Health Networks, or LHNs, within health. Could someone explain for me in a very general way what the LHNs are in South Australia?

MS BARON: I can do that. There are 10 LHNs across the state. There are the four based in metro Adelaide, geographically based. There are – there's Northern, Central Adelaide and Southern Adelaide Local Health Network, and the other is the Women's and Children's Health Network, which is the only specialty based network, as opposed to geographically based. Women's and Children's has a statewide remit. And there are six regional Local Health Networks. In the southeast there's the Limestone Coast, there's the Barossa Hills/Fleurieu Local Health Network, the Riverland Mallee Coorong, York and Northern Local Health Network, Flinders and Upper North and the Eyre and Far North Local Health Network, and I think that's six. Ten in total.

MS ORR: I wasn't keeping track, I must say. Is it – this is probably a very basic explanation, but are health services in South Australia divided into those networks?

MS BARON: Yes, and they are – and there's also a regional support service that sits in the Barossa Hills/Fleurieu network that provides support and coordination over the regional LHNs, and services are, yeah, provided across the state, and I should just add that, obviously, while Women's and Children's has that focus, there are child-based services across all the LHNs.

MS ORR: So, as I said before, we will focus today on two areas of SA Health and, in particular, on the health response of SA Health in relation to children who have experienced abuse and neglect or, for the Commission's purposes, domestic, family or sexual violence. So, as I said, we will – for a lot of today we're going to focus on Child Protective Services and on CAMHS, as it's called, but is it correct that Health across the board provides various services for kids experiencing, or in fact using, domestic, family and sexual violence in different LHNs in different areas?

MS BARON: Yes.

MS ORR: Yes. Thank you. And, sorry, I'll just make it clear for anyone viewing or listening that the focus on these two areas today doesn't mean that that is the only way that SA Health is interacting with these children. I want to start with Child Protection Services, if I can, and, Ms Baron, that might be with you, I think, to begin. Can you explain what Child – what Child – excuse me – Protection Services is or are?

MS BARON: Yep. Well, there are three, sort of, dedicated Child Protection Services. One in the Northern Adelaide Local Health Network, one at the Women's and Children's Health Network, and one in the Southern Adelaide Local Health Network. They've recently changed their name to Child Safety and Wellbeing Health Service, but we'll call them Child Protection Services for the sake of this, because that would be way too confusing. But they're tertiary-based services that provide specialist trauma-informed assessments and therapeutic interventions for children and young people who have been harmed or where there are suspicions of harm.

MS ORR: Tertiary based?

MS BARON: Tertiary meaning, if we think about health along the spectrum from primary care, like, going to your GP or seeing a CaFHS nurse in the community, it's primary care, through to secondary care, through to tertiary care. So the tertiary care is, sort of, the pointy end, if you like, and on a pyramid, the tertiary is the top of the pyramid.

MS ORR: Yes. When violence, abuse, neglect is already happening or happened?

MS BARON: Yes.

MS ORR: Those three Child Protection Services, do they operate separately?

MS BARON: Yes, largely. While they have broadly, you know, very similar functions and purposes to exist, they operate in three LHNs that are run independently by their own governing boards.

MS ORR: I want to ask about the services in a general sense that the child, I might call them CPS - - -

MS BARON: Yeah. Yeah. Yeah.

MS ORR: - - - because I know that's the acronym that everyone uses.

MS BARON: Yes.

MS ORR: So Child Protection Services we'll refer to as CPS. So just in a general sense, the services that they provide. I'm not sure who could give me that information, but you mentioned tertiary specialist trauma-informed services. So what are the services that fit within what CPS does?

MS BARON: Well, I'll provide a broad outline. So there's consultancy and liaison, so that's, you know, providing advice and input and direction as to what needs to happen with a child when they present.

MS ORR: With who? Sorry to interrupt you.

MS BARON: I guess, anybody who is seeking that advice.

MS ORR: Okay.

MS BARON: It could be a referrer, it could be an outside agency or it could be someone from within Health seeking advice from the service about, "This child is presenting to us. We need advice about what we're seeing and what should happen next." Assessment services, and they might be medical or they might be psychosocial. So by psychology and social work clinicians, who are, you know, specially trained in this area. And then providing therapeutic interventions for children and young people.

So therapy of a range of types that are determined by the clinician as to what that child or young person is needing most, or it might be working with that family. That, in a nutshell, I think – Melissa, do you want to add to that?

MS JOHN: Yes. So referrals are made from DCP and SAPOL and the age group is naught to 18. In terms of the forensic medical assessment, the age group is naught to 16. So children who have, whether allegations or concerns about sexual abuse up to the age of 16 are seen by CPS, and I'll explain the medical side of things, too. And children where there are physical abuse allegations during the age of naught and 18 are referred to the Child Protection Services for forensic medicals. Could I just also say that the Child Protection Services of Women's and Children's Health Network, the medical staff there have actually formed their own separate forensic medical service called the Paediatric Forensic Medical Service, and they actually provide the medical component of those services that I just mentioned, but always in conjunction with a psychosocial clinician from CPS. So that's a new development.

So that's the forensic medical side of things. Forensic psychosocial. Children up to the age of seven where there are allegations of abuse or neglect are provided with a forensic interview. There's a psychosocial assessment. And children over the age of seven, where there are communication difficulties are also seen. So there are situations involving children, I guess, who have made allegations or there's been notifications of physical, sexual abuse or neglect and the purpose of both the medical and psychosocial is to collect information, to gather information that can be used as evidence - - -

MS ORR: I see.

MS JOHN: - - - for legal purposes, court matter, policing or child protection. We also see children up to the age of 12 from the Aboriginal remote communities. It's the highest, sort of, age bracket due to their developmental status. So that's the assessment component, and the other one – the other one is parenting capacity assessments. So that service is referred by DCP and in situations where children have been harmed, and that harm is usually confirmed, and that could be abuse, neglect, domestic and family violence are very much entwined in all of what I've just said, and we assess the of the parents to safely nurture and parent their children, and we do that as a piece of work for DCP and provide opinions and recommendations about the future of those children.

And domestic and family violence is a – you know, a very common, you know, part of the presentation. Almost, like, you know, in every case. So therapeutically, the CPSs do vary. At WCHN CPS, we provide therapy for children under 12 in out-of-home care who have experienced abuse and neglect, domestic and family violence. We have a infant carer therapy service for children under one, infants under one, again, who have been harmed in the context of physical, sexual or – excuse me, physical abuse or neglect or family domestic violence, and we have a harmful sexualised behaviour service. And the other components to the CPSs are the out-of-home care clinics. So each CPS has an out-of-home care clinic that provides a comprehensive health and developmental assessment to children in out-of-home care with a KPI of the referral really needs to happen within three months of management into care to make sure that their health and development needs are assessed and properly met.

MS ORR: You mentioned the – sorry, I lost, I think - - -

MS JOHN: Yes.

MS ORR: - - - the beginning of it. The infant care program for children under one.

MS JOHN: Yes.

MS ORR: That's at Women's and Children's - - -

MS JOHN: Women's and Children's, yeah.

MS ORR: - - - CPS?

MS JOHN: CPS, yeah.

MS ORR: And can you just explain in a bit more detail what that is?

MS JOHN: So that's infants who, again, have been harmed, either in the context of an injury, you know, physical abuse or neglect, domestic or family violence, and they may have been removed from parental care, or they may live with the parents, but the focus is on to provide therapy for infants at an early age and carers – I guess, early intervention. So that therapy is provided, you know, over, you know, well, whatever period of time is required, but it's – and it also works with the systems involved. So the therapy lens at the CPS is also – it's very – like, it's systemic, working with the other agencies and families and schools and other relevant, sort of, systems and people involved.

MS ORR: What type of therapeutic services or therapy is provided to a child that young?

MS JOHN: Well, it's mainly working with a carer. There's child/parent psychotherapy, which is a modality of therapy that's, sort of, been developed at CPS WCHN. It's often a psychoeducation on – and in child and parent psychotherapy, that type of approach.

MS ORR: Is that a separate thing from the High Risk Infant Program, which I understand is also part of the CPS?

MS JOHN: Yes.

MS ORR: So what's the High Risk Infant Program?

MS BARON: Each of the three CPSs are involved with the High Risk Infant Programs or pathways, if you like, but not necessarily in the same way, and some of that again is just how services are differentiated. Certainly, at SALHN and, I think, at NALHN, I'd have to just double-check, but they provide therapy – aim to provide therapy earlier with the woman when it is identified that, you know, that situation, there is risk of

removal, and to try to support that woman early enough in the pregnancy to potentially be able to keep that child. If the involvement is too late, then there may not be time to actually make an effect. So we don't have a standard approach across all of the services as yet, but that's certainly one of the intentions is to, sort of, look at how do we best look at this whole continuum, the pathway for unborn infants that are at risk right through to, you know, a tertiary service where the child has been harmed. So there's a whole continuum of support that health can provide.

MS ORR: Yes.

MS BARON: Did you want to talk further about the program for WCHN?

MS JOHN: Well, that strengthening links has been put on hold, so I guess that requires further development, but one thing that we have instituted at WCHN is something called the Cocoon Program, which, I don't know if you've ever heard, but it's quite an innovative pilot program for infants under 12 months, again, that are – who are born with complex medical needs, and they're vulnerable due to, sort of, inter-utero issues, which includes domestic, family violence, drug and alcohol use – parental drug and alcohol use, and further risk after they're born. So these children are seen in this multidisciplinary clinic intensively. It's, sort of, a wraparound service and that's staffed by a paediatrician, a physiotherapist, an incremental health therapist and a coordinator, and children are seen usually up to the age of one year, but we're, sort of, reviewing it now, and, I guess, that's – that program is – you know, is focusing on early intervention in the trauma space. And all of these services are trauma – they're not just trauma-informed. They're trauma-responsive, trauma-underpinned, sort of, thing.

MS ORR: How many children would be seen? Sorry I'm giving this question without notice, but, approximately, how many children in a year by that Cocoon Program?

MS JOHN: I think we've got about 60. I mean, this is just – approximately 60 children at the moment. I oversee that program, but it could be a little bit less, but I think it's been sitting between 50 and 60.

MS ORR: And that's the only one of its type in South Australia; isn't that correct?

MS JOHN: In South Australia at the moment, yes.

MS ORR: Yes. Yes.

MS JOHN: That is correct.

MS ORR: I want to ask you now, if I can about – I think you've both said the services offered in the different CPSs, they vary, and I want to try and get an understanding of some of those variations and what you might get, if you like, when you're in a different CPS. So perhaps if we can start with the Women's and Children's, because that is the – well, we've already spoken about it a bit, but that is the specialist Women's and Children's Health Network. If – I might need to narrow this question, but - - -

MS JOHN: Yes.

MS ORR: - - - I'll start this way. If a child presents at the Women's and Children's Hospital with suspected abuse, neglect, injury, what happens next?

MS JOHN: Well, if they present to the – in Emergency Department, there will be a doctor to – the Paediatric Forensic Medical Service now, it used to be a CPS doctor – discussion or consultation, and, usually, with the psychosocial clinician who's on duty that day. Usually, the medical – the doctor or the medical staff are seeking consultation around whatever the presentation is, whether it be injury or serious neglect or whatever. So they will – the specialist doctors will provide that information and then those doctors will make a determination about notification.

So a notification to the child abuse report line if indicated will be made, and then that will kick off a whole child abuse and neglect investigation. So if that's screened in as a, you know, a 24-hour response, which it probably should be for an infant. I'm sure you'll know what a – there's a 24-hour or a 10-day response. Well, then, they – that – that triggers a response, multi-agency response, which will be a strategy discussion, and the CPS doctors, Paediatric Forensic Medical Services – that's a confusing thing – will be involved as – you know, in addition to the Emergency Department doctor, possibly, but, usually, with SAPOL and – always SAPOL and DCP, depending on the circumstances, and a plan will be made.

Infants under 12 months of age with suspicious or unexplained injuries or inflicted will automatically be admitted. They're usually admitted, because of their, you know, age and vulnerability. So that admission will lead to a forensic medical inpatient assessment, and that's undertaken by the forensic paediatricians and a social worker or psychologist. And that, really, largely involves DCP and SAPOL. The purpose of that admission and the purpose of most – all forensic medicals is to gather information to understand the nature of the injury, how it came about or the neglect. It could be very serious neglect. And then make – provide an opinion to SAPOL or DCP about, you know, the likely cause, and then a determination as to, you know, an outcome with the investigation, whether it goes down the criminal path or the child protection path or both.

And, usually, during the admission, safety planning is undertaken. I guess, at all stages the safety of the child is, kind of, paramount, and there's a lot of advocacy, you know, in relation to that. If there's an infant who there are concerns about the relationship between the infant and the carer, our infant carer specialist will come and do some observations between the infant and the child and feed that into the information for the assessment. And I think it's also important to say that the medical services in each CPS are different. So WCHN CPS has 5.1 FTE, 4.1 of those are paediatric consultants and one – the other one is a registrar. So they actually provide a service to NALHN, they see all NALHN children who are under 12 months and all children who have been sexually abused. All of them. They will do a forensic medical - - -

MS ORR: I might, if it's okay - - -

MS JOHN: Yeah. Sorry, am I – I'm probably talking too fast.

MS ORR: No, no, no, so I can keep up, to be honest. We might talk about NALHN in a moment.

MS JOHN: Yeah.

MS ORR: I want to ask some more questions, though, about what you said. So you mentioned the forensic medical assessment, and perhaps I'll just say for the benefit of the panel, we had a previous public hearing in relation to forensic medical examinations for adults. So we have had evidence about how they work, what they are and from Yarrow Place about their role. So that's part of the forensic assessment, and then you also mentioned the psychosocial forensic assessment. So that also takes place – if it's determined that that's warranted, that will take place at - - -

MS JOHN: It's automatic. So every child who presents with injury or allegations of abuse or trauma is seen always by a doctor and a psychosocial clinician because of the nature of the trauma, and the psychosocial clinician will also see children who the doctor won't see. For example, if a 13-year-old is, you know, alleging sexual assault, but doesn't want to provide a statement or something, they still need a - you know, a psychological response. So our urgent psychosocial response is extremely important, particularly for this cohort, or for the children, and the role of that – the role of the psychosocial person is to informally assess the impact of the trauma, you know, in that moment and the level of supports, what the needs are for safety and make referrals, you know, either back to our service for therapy or to another service more appropriate. And if, for example, the adolescent has some suicidal ideation or something like that, then we'll refer to the psychiatrist on duty or CAMHS for a mental health assessment - - -

MS ORR: Okay.

MS JOHN: - - - so it's, kind of - - -

MS ORR: Yes.

MS JOHN: It's quite complicated - - -

MS ORR: Yes. That's okay. You said – you gave the 5.1 FTE of paediatricians. Can you just say again, I'm sorry, who - - -

MS JOHN: Yeah.

MS ORR: - - - they are? What that group is?

MS JOHN: So they're from WCHN.

MS ORR: Yep.

MS JOHN: And they are now – this is the Paediatric Forensic Medical Service.

MS ORR: Yes.

MS JOHN: They used to be CPS, so - - -

MS ORR: Can you – why have they been separated?

MS JOHN: Sort of a complicating – sort of, complicated - - -

MS KIRBY: They were - - -

MS JOHN: - - - build-up.

MS KIRBY: The Women's and Children's Health Network was previously Child Protection Services and then in May of last year separated to just have a distinct Paediatric Forensic Medical Service in recognition of the – you know, the particular type of work that's done there and so that we're, sort of, able to receive referrals directly into our service. So that hasn't changed the way that we operate in any way. It's just separated internally the two functions.

MS ORR: Okay. And they are – what are they doing in practice? They're doing the forensic medical assessments?

MS KIRBY: Yes.

MS ORR: And that's – is that it, basically?

MS KIRBY: So the paediatricians undertake forensic medical assessments.

MS ORR: Yes.

MS KIRBY: And then provide all of the evidence needed in court proceedings and - - -

MS ORR: Yeah.

MS JOHN: And they will actually also provide a lot of consultation, and an area of growth has been fabricated and induced illness. So they actually develop – you know, they provide consultation advice to other doctors and staff within the Women's and Children's Health Network and beyond in relation to induced and fabricated illness. And psychosocial staff are involved in that, too, but also in psychological maltreatment. So it's, kind of, like that area of work is actually expanding, and that's probably a little bit unique to Women's and Children's - - -

MS ORR: Yeah.

MS JOHN: - - - Health Network, too. Yeah.

MS ORR: I should just clarify, of the, sort of, general areas of response that are provided across the CPSs, would it be safe to say that the Women's and Children's CPS is doing all of it? All of those areas, such as - - -

MS BARON: Yes.

MS KIRBY: Yes. Yeah.

MS ORR: - - - consultancy and liaison of - - -

MS KIRBY: Yeah.

MS ORR: That we listed.

MS KIRBY: Yeah.

MS BARON: Yeah.

MS ORR: Can we move to SALHN, southern Adelaide. So if a child came into a SALHN hospital with suspected abuse or neglect, what happens for them? Is the process the same?

MS BARON: I think by and large the process is very similar. Some positions have different names and there may not be dedicated inpatient versus outpatient teams, et cetera. So some of the structure around the positions is different, but, essentially, the child's safety and wellbeing is paramount and would be the first priority, but they would receive the forensic assessment also. Probably the difference to describe would be maybe the definitions. And there's probably no clear way of describing this, but a forensic paediatrician, as opposed to a paediatrician with child protection expertise, and that's probably the easiest way of, sort of, distinguishing the paediatricians at the Women's and Children's from paediatricians who've done additional training in child protection. So – and that – there are some – there is no national, sort of, standard or requirement to work in this field, but there are courses, there's training as part of the Royal College of Paediatricians, who do paediatrics and community child health work. There are modules that they're required to do and practical placements and those kinds of things. So they definitely have that experience, but probably not the level of forensic expertise.

MS ORR: Okay.

MS BARON: Other than – I'm making broad generalisations - - -

MS ORR: Yes, of course.

MS BARON: - - - probably across the services - - -

MS ORR: Yes.

MS BARON: - - - because there probably are individuals with - - -

MS ORR: Yeah.

MS BARON: - - - that level of experience in the SALHN service, as well.

MS ORR: Sorry. And we're just taking SALHN as the point – the topic at the moment. If those – sorry. Those doctors that you're talking about, they would perform the forensic procedure on the children in the - - -

MS BARON: Yes.

MS ORR: - - - SALHN CPS?

MS BARON: Yes.

MS ORR: Would there be any occasion that it would be determined that the special expertise of the Women's and Children's forensic paediatricians would be needed for - - -

MS BARON: There may be times. If the child requires a medical specialty that isn't available at Flinders Medical Centre, as a general hospital, rather than a tertiary hospital for children, they would be transferred to the Women's and Children's.

MS ORR: But that's about a medical response - - -

MS BARON: Yes.

MS ORR: - - - and facilities, I suppose - - -

MS BARON: Yes. Exactly.

MS ORR: Okay.

MS BARON: There may be some occasions where a SALHN paediatrician would call on Women's and Children's for advice and potentially transfer a child there.

MS ORR: Beyond the forensic medical, we spoke about those other services, generally speaking, are they all available at SALHN? Are there any exceptions?

MS BARON: They don't have the Cocoon Program, as we said, but, yes, they provide forensic interviews and psychosocial support and therapeutic interventions for children. The services have, you know, different workforce composition and volume of staff, and so at SALHN their ability to provide therapy across the age range is limited by their workforce.

MS ORR: Okay.

MS BARON: So they see children – that will be another detail I'll just have to check, but I think it's up to about age six, but at this point in time don't provide therapy for children all the way up to 18, because of capacity.

MS ORR: And so what happens to those children between six and 18?

MS BARON: They would look to find other services who could pick them up.

MS ORR: And then NALHN, so the Northern Health Network, you said before the children under one would be referred to the Women's and Children's Health Network. Can you remind us, please, what you were talking about there?

MS JOHN: Children under the age of 1, where there's an injury that's suspicious, unexplained or inflicted are referred to the Women's and Children's Health Network, and they often are admitted as inpatients, like I said, so, yes, that's – that – I think that agreement was made a couple of years ago. And, likewise, all children up to the age of 16 who, whether allegations of sexual abuse, sexual assault, will be seen by Women's and Children's Health Network.

MS ORR: And why is that? Why do NALHN not see those groups of children?

MS JOHN: It was an arrangement agreed upon by the doctors involved, and it was mainly in relation to capacity and their – how would you say, Heather? Their, sort of, sense of – their, kind of, expertise, because the – yeah. Well, yeah, because, I guess, the volume at the Women's and Children's Health Network is far greater, isn't it?

MS BARON: I think it - - -

MS JOHN: By virtue of it being - - -

MS BARON: It probably relates to a low-volume - - -

MS JOHN: Volume. Yes.

MS BARON: - - - high-specialty field, and the need to develop expertise, have sufficient training, learning and development, support and supervision, and the frequency to see those conditions to maintain expertise. So there – as part of the model of care, there are – you know, is recommendation to have a learning and development framework for the medical staff across CPS to, really, build that capacity across the teams, so that there are – you know, there are skills in every network that, as I said, is balanced with the high volume, low specialty – sorry, low volume, high specialty area where you need to see enough to maintain that expertise. So there's - - -

MS JOHN: Yes.

MS BARON: There's the balance that needs to be found there.

MS JOHN: That's a good way of putting it, actually.

MS ORR: And then for NALHN, other than those exceptions that you've mentioned, is NALHN offering services across the board under CPS? I mean the services we've spoken about already this morning.

MS BARON: Yes. They provide – yes. They do other assessments and provide support and therapy for children, and they have a high-risk infant pathway, they have an out-of-home care clinic and, yeah, they provide all the functions of a Child Protection Service otherwise.

MS ORR: But they don't have the forensic paediatricians that we spoke about that are at Women's and Children's?

MS BARON: Yes.

MS JOHN: Correct.

MS ORR: For the services provided across the three different CPSs, is it correct that they operate separately?

MS BARON: Yes.

MS KIRBY: Separate governance. Yes.

MS BARON: Yes.

MS ORR: Yes. And so the way the services are provided, and you've just said governed, may differ between those CPSs; is that correct?

MS BARON: They each have a director in their service, and the director is a psychosocial clinician, and where they're situated in the hierarchy of their LHN probably differs slightly, but, yeah, they are separately governed by their LHN.

MS KIRBY: Moving forward, though, the model of care that has been - - -

MS BARON: Yes.

MS KIRBY: - - - delivered by CPPU, part of the operationalising of that, really, will involve the three LHNs working in partnership to operationalise the recommendations of the model of care so that, you know, there's a shared understanding of the way that the pathways are going to work across the LHNs and the opportunities to optimise working relationships, processes and, you know, ultimately, outcomes for children and families. So that work is what we will be progressing next.

MS ORR: I want to ask about the model of care, but before I do, can I just ask for people – children and young people, who are outside the three LHNs that we've talked about, so the three CPS LHNs, in particular regional or remote, what happens for them in terms of a CPS service response?

MS BARON: So if a child presents to their service where there are concerns about their presentation, they can contact any of the CPSs. They will be aligned, sort of, roughly by the catchment, so, you know, Mount Gambier or Naracoorte, for example, would ring the Flinders or the SALHN-based service and seek advice, really. And there are opportunities to strengthen how the CPS support those regional networks to manage, you know, the safety of children, but there will be times, if a child requires a forensic assessment, at this point in time that child or young person has to travel to Adelaide for that.

MS ORR: And when you talk about forensic assessment, medical assessment and the psychosocial assessment?

MS BARON: Yes.

MS ORR: And what about therapeutic services? Same?

MS BARON: Yes. There are some LHNs that do provide support to children via therapy, but it's not across the board and it is certainly an area that – where as part of this implementation, that capability could be built. That would be a really great first step.

MS JOHN: Can I just add something? Where possible at the Women's and Children's we will travel to the country to provide forensic psychosocial assessments. We're doing one next week, actually, so we can travel to somewhere like Whyalla or Port Lincoln.

MS ORR: How often does that happen?

MS JOHN: I don't – probably a couple of times every few months, you know, maybe a few times every – it's hard to say. Maybe a few times every six months, maybe three or four, approximately, but it's probably about 40/60 – they will probably travel to Adelaide 60 per cent of the time, and I'll go there 40. It's, I guess, depending on capacity and where they reside and whatnot.

MS ORR: And what about children and young people who live in the APY Lands? Is there any special – any arrangements for people living there?

MS KIRBY: So the Women's and Children's, that – the APY Lands falls under the Women's and Children's LHN catchment, and so Women's and Children's has the – what we call the integrated model of care, which defines the way that we deliver services on the APY Lands from a CAMHS and a CPS perspective, and the model of care we've had in place since 2023. So we're now going to be reviewing that to understand more the needs of the community, what the impact of our service delivery has been. We've been working on rebuilding relationships in community and really, sort of, like, a conscious entry approach into the communities. We've now got teams that fly up every fortnight, which have got trained mental health workers and social, emotional and wellbeing workers and child and family support consultants. And so those teams are, sort of, starting to rebuild relationships and understand what service provision is needed to best suit the community under the ethos of what the model of

care is, which is community-led services, and building capacity within the community to lead these services.

MS ORR: So that brings me to the model of care.

MS BARON: Sorry.

MS ORR: Yes.

MS BARON: Can I just quickly say, too, that SALHN does travel to Mount Gambier and provides services down there. I don't know the frequency, but they do provide services.

MS ORR: And what kind of services?

MS BARON: They do provide parenting capacity assessments down there and possibly other services, as well. I can find that out, if you would like to know.

MS ORR: Thank you. So the model of care. Could you, Ms Baron, just give us an overview. We've heard a bit about it this morning, but what is this CPS model of care?

MS BARON: Well, the model of care broadly defines the way that services are delivered for an individual, for their condition or injury, you know, from start to finish, and the aim is to deliver the right care in the right place at the right time. And so the model of care was developed as a statewide model, noting that there are three separate services, but having a single model, but also ensuring that the needs of children in regional South Australia are considered and how we build that capability in the regional LHNs. So outlines of core functions of consultancy and liaison, including strategy discussions, the forensic assessments that we've talked about, parenting capacity assessments, therapy, plus enablers, like workforce data, the governance is discussed, as well. So that's broadly what the model of care is about.

MS ORR: It was released in December last year?

MS BARON: Yes.

MS ORR: I understand. If you – you could maybe be here for a long time answering this question, but could you give us some background into how that came about?

MS BARON: Yes. So it – there's quite a long history to developing the model of care, but if I go to the recent, sort of, past, it was in about 2020 and ZED Management Consulting was asked to develop a single model of care for the CPS, and that was sort of in alignment with the clinical services capability framework that had been developed, and that's an SA Health document that describes clinical services in a whole range of areas, and child protection is one of those, and it describes functions at different levels. So level 6 being the highest level of service that's provided down to level 5, level 4, level 3, et cetera, and it describes those functions. So that was done for the Child Protection Services. So it was meant to be in line with that and with reference to

governance and reporting and implementation, et cetera.

So ZED at the time determined that it wasn't possible to develop a single model, due to the differing governance across the services, the service differences, the priorities in each of them, et cetera, and so they made recommendations, which included the establishment of the Chief Child Protection Office and the policy unit that I work within, and we were then tasked with doing that piece of work. So the development involved, you know, establishment of working groups and having consultation phases throughout that time, a workshop with staff, a range of things where feedback was gathered from internal and external stakeholders to develop the model that was released.

MS ORR: And is it correct, I think you've said this, that it's intended to align the service functions of the three CPSs?

MS BARON: Yes. Yes. It's not to say that all services need to be identical and then – but it is saying that the core functions, I suppose, are the same, so that if you are a child presenting to any of those services, you have access to the same kinds of services. That may at times mean you are supported by a service at the Women's and Children's, as opposed to one at NALHN, for example, but it's clear the pathways into those services, et cetera, are made apparent.

MS ORR: I want to just pick a few, sort of, aspects of the model of care and CPS. So we've spoken a little bit about consistency of services and how the model of care is attempting to align them. So under the model of care will there now be consistency across the three CPSs about which services are provided to different children and young people across the state?

MS BARON: That is the intention. Yeah. So we're only just at the stage of the model being released, and now we're having that discussion about, "Okay. What next? How do we take this forward?" I think there is goodwill across the three CPSs to work together on that. But, realistically, in order for the services to achieve – for example, it was agreed by the consultation processes that therapy should be available from zero to 18. That's not going to be possible without additional workforce to be able to deliver that, if each of the LHNs are going to provide that kind of service. So there are things that – you know, that are, I guess, ideal or aspirational in the model, but will still require working through in a practical sense to achieve that. Does that answer your question?

MS ORR: It does, and perhaps I can – a reference to the model of care is at page 18, just for the transcript. "The CPS will work towards providing consistent services, practices and achieving consistent standards of care." So if I understand what you're saying, we've got the intention in the model, but the next step is how do we do that?

MS BARON: Yes.

MS ORR: As I mentioned, we had a public hearing about forensic medical procedures for adults and we heard from Yarrow Place and we heard about the centralised model. So they have Yarrow Place, which is the centralised place for providing a response to adults who have experienced sexual violence. There isn't a single central unit for CPS.

Can you explain – sorry, and I should say there isn't one currently and there isn't proposed to have one under the model of care; is that correct?

MS BARON: Yes. Correct.

MS ORR: Can you explain why? Why? Why are there three separate ones, instead of having the centralised model like there is for adults?

MS BARON: Yeah. I think wherever possible, you know, services – we aim to deliver services as close to home for people. That's not possible for everything in health. You know, there are specialties where people do have to travel to Adelaide across, you know, adult services, paediatric services, everything. Ideally, you know, where possible, people don't need to travel, but there will always be services that the low volume, high specialty things where they need to be centralised. So there are probably pros and cons about that argument and, at this point in time, it wasn't seen that there was enough rationale to centralise those services and to mean that there would be more travelling for children and young people to those services, other than where it's essential. Say, for example, at the moment where children from the north will travel to Women's and Children's for a sexual assault forensic examination – medical examination.

MS ORR: The ZED report, which you've referred to, identified some barriers to developing a statewide model of care, and one of those was – this is at page 68 of the report – "Significant philosophical differences between CPS staff on the provision of medical services and who is qualified to deliver them". Is that still a difficulty faced?

MS BARON: I think it's fair to say that those difficulties, yeah, are still in circulation. I think there are just – yes, some fundamental underpinnings that are different across the services, yeah.

MS ORR: Which is then a barrier, if you are trying to have one system, I suppose?

MS BARON: Yes. From a medical point of view, I think that's probably fair to say. I don't think those barriers exist across the services in every other area. I think the medical focus has been more of a challenge than the psychosocial support that children receive.

MS ORR: Still on consistency, but moving to governance, so, again, we've heard that the CPSs are governed separately, but the model of care is attempting to align them to some extent, and you've mentioned the creation of the Chief Child Protection officer. So how will that drive implementation of this united model or – sorry, united approach 1 model?

MS BARON: I think, ideally, there would be some agreement across the three LHNs as to how that is going to happen. So, you know, I think – it's only based on discussions at this point in time, but whether there's a memorandum to – of agreement to support that implementation across the State is one issue, and I also think that – sorry. Now I've lost my train of thought.

MS KIRBY: I can talk to that.

MS BARON: Yes, up to you.

MS KIRBY: Yes. Just to follow on from what Heather's saying, we are now, because we're now at the stages of meeting across the three LHNs to work out the way that we are going to operationalise this, and particularly in relation to the Paediatric Forensic Medical Service component. So we are now starting the conversations to have MOAA, or some other type of agreement, that is going to allow us to have a shared understanding of how the three LHNs will work together to try to get consistency, shared approach and, really, work on those, sort of, you know, collegiate pathways so that we're able to have as – even though it will be under separate governance, still a shared understanding of the way the services will operate, informed and underpinned by an agreement.

MS ORR: So that brings me to my next question, which is an implementation, and what are the next steps to bring the model of care into effect, I suppose?

MS KIRBY: Yeah. So from the perspective of the operational level, we have got a meeting coming up shortly with the three LHNs that I would be leading as an initial conversation, where we would start informing what our next steps need to look like, So understanding, kind of, I guess, the positions of the three LHNs in taking the model of care from CPPU and also in knowing what we're needing to agree from a Paediatric Forensic Medical Service response component. So that's what's happening at an operational level, and we would be working closely with CPPU to feed in the strategy and taking the actions and implementation plan that they've developed, and, I guess, systematically working through those to understand which parts will sit with each of the LHNs respectively, and which parts we would consider would come under a shared, sort of, central viewpoint, I suppose, so – yeah.

MS ORR: I want to ask about the regions, as we've touched on. Is anyone able to say under this new model of care, or perhaps even the work following the new model of care, in, say, five years' time what it might look like for a child and – child or young person, excuse me, in a region? Port Lincoln? Anywhere, really.

MS BARON: Yeah. I think the regional LHNs have been, you know, quite progressive in this area and they – each of the six LHNs now has a key coordinator or a lead clinician in this area of abuse and neglect. So they're called Prevention Response to Violence, Abuse and Neglect. They've picked up the acronym from New South Wales. So there is an individual in each of the LHNs that has that portfolio. So I think that's a great step forward for a connection into the CPS, because it can be difficult liaising with regions of any size and geography, but to have a key contact is really helpful. So I do see that there will be able to be, you know, strengthening in connections between regional LHNs and the CPS.

I think there's opportunities in the bigger LHNs or where there's more of a critical mass of workforce, notwithstanding the real challenges that regional networks have, you know, attracting and retaining their workforce, but building their capability from a

therapy point of view. I think that's really something that we could strengthen, because there are child health teams and social work staff in some of those regions who would have that capability, and we could – they could be upskilled to deliver those kind of services. That would be a great first step.

MS ORR: There is a reference in the model of care to providing services in consumer-friendly locations. Can you explain what that means?

MS BARON: Yes. That's, really, so that if an outreach – a CPS was going to a country area, they could use a location that is child-friendly. So undertaking an assessment in a children's centre or somewhere where it's child and family friendly, rather than, say, in a hospital environment or a police station or somewhere like that. So using those environments, building connections, maybe with Aboriginal community controlled organisations, where we might be able to use their facilities, as well. So we've got SA Health facilities across the State. So linking in with those that are really appropriate for children and young people.

MS ORR: I've just got one more question about the model of care. It refers to the critical need for cultural safety, in particular in relation to Aboriginal and Torres Strait Islander children. And the document also explains that KWY Aboriginal Corporation was engaged to work with the CPSs to enhance culturally safe approaches to care for Aboriginal children and families. Can you just tell us a little bit about that work?

MS BARON: So given the over-representation of Aboriginal children and young people in the Child Protection System, you know, it was, obviously, really – it is, obviously, critical that we pay attention to that, to address that disparity, but also look at our service approaches that might be contributing to those poorer outcomes for Aboriginal children and families. So the Department of Health and Wellbeing engaged KWY Aboriginal Corporation to do a piece of work as part of the model of care, really, to look at the Child Protection Services and see where there were opportunities to provide more culturally responsive approaches to care. Looking at, you know, broadly around the training and development of staff, the support and supervision of staff, opportunities for having an Aboriginal workforce, linking with partner – Aboriginal partner agencies to build that collaboration, seeking cultural advice and support. So they've put a report together and made recommendations for the CPSs to consider as part of their implementation. So as part of the implementation of the model of care, that report needs to sit alongside to consider what they have proposed.

MS ORR: That brings me to my next question, which is, excuse me, is there a plan for how that need for cultural safety will be implemented across the three different CPSs?

MS BARON: Well, I think the – I think there's some – there is some examples of really good practice already. So it would be looking at how can we share that good practice across the CPS, and that – you know, that's got to apply in everything that we do. Where we've got examples of great practice, let's share it, not do things differently, but also, yeah, really building on what they have recommended and working through what – you know, what are achievable things that we can start picking off and doing and trying to build. You know, building an Aboriginal workforce is not an easy thing to do,

but is a really valuable and important part of this, but it might be better having a shared Aboriginal workforce across the three services, rather than one is one of the recommendations from KWY, because they provide support to one another and, you know, it would provide a better response, say, than each CPS trying to develop that workforce themselves. So there are some shared things that could be tackled together.

MS ORR: I want to go back a little bit, because I forgot to ask a question before. Ms John, when you were giving evidence about the interviewing or the forensic assessments, psychosocial assessments of children, you mentioned the seven-year-old age. Can you – is that within Women's and Children's, or is that the other CPSs, as well?

MS JOHN: Consistent across all CPSs, yes.

MS ORR: And what's the reason for that seven-year-old cut-off?

MS JOHN: That's a good question. That decision was made many years ago, actually. I don't – I think it was a clinical kind of decision on the basis of children's development and developmental status, and that number has been queried of late, whether or not it should be actually increased to, you know, possibly 10. But I think that was made at the inception of the CPSs in the late 1980s, early 1990s, and I – from memory, I think, the CPS in South Australia is the only health service that actually interviews children in this forensic capacity - - -

MS ORR: And what – sorry. What happens for children over seven?

MS JOHN: They're interviewed by the police, but all – so children and vulnerable witnesses under the Vulnerable Witness Bill 2015, I think, or something, the Evidence Act, the people at SAPOL and the CPS clinicians have to be prescribed interviewers. So that, sort of, came in, I think, in 2017, and they have to do an accredited training, the CPS clinicians. That's been approved by the Minister as an instrument, I think, in 2017. So it's legislated that way, but like I said, we interview children over seven where there are, you know, concerns in relation to communication, because of ASD, ADHD, trauma and intellectual disabilities. And I think the presentations around trauma are very compelling and, sort of, a one-off police interview doesn't necessarily cater for the needs of these children who are really vulnerable. Yeah. So that's where the number 7 came from.

MS ORR: Okay. Thank you. I want to change topics now and ask about CAMHS, or the Child and Adolescent Mental Health Service. Could someone explain for us what services CAMHS provides in South Australia?

MS KIRBY: Yeah. Sure. I'll give a high level overview and then Melissa can speak from a clinical standpoint. So CAMHS sits under the Women's and Children's governance, so unlike what we've previously discussed with the CPSs, it's a statewide service with a central governance model, and it provides tertiary level mental health care to children and young people and also perinatal women. We have inpatient unit at the Women's and Children's Hospital and Helen Mayo House, which is inpatient

postnatal unit, and then community-based services across the State.

MS ORR: Who – you listed off some groups of people that those services are provided to.

MS KIRBY: Yes.

MS ORR: Is there eligibility criteria?

MS JOHN: Naught to 16. Do you want me to jump in?

MS KIRBY: Yes.

MS JOHN: Children naught to 16 in the community settings and up to 18 in the inpatient setting and some others, I think, but children displaying significant and complex, serious and complex mental health issues. So the service has recently undergone a strategic review, and it's cemented, I guess, the criteria, being it's a tertiary level service, and it's for the – that end of the, you know, the spectrum of children.

MS ORR: So, sorry, I missed what you said. Is it a criteria of – that they must be displaying complex mental health issues - - -

MS JOHN: (indistinct)

MS ORR: - - - or is that another category of - - -

MS JOHN: Severe – so children and young people experiencing severe and complex mental health issues. These may include acute suicidal thoughts and actions, psychosis, persistent emotional difficulties, such as depression and anxiety, and also a service for children and young people experiencing severe reactions to traumatic events. And the CAMHS is staffed by multidisciplinary teams, and the staff mix are, you know, obviously, psychiatrists, psychologists, social workers, occupational therapists, some speech pathologists, social workers and the rest of that. And so it's very much a multidisciplinary kind of framework that's utilised at CAMHS.

MS ORR: For those children and young people with those complex needs?

MS JOHN: Yeah.

MS ORR: Where do referrals come from?

MS JOHN: There's a central triage and referrals are, from memory, I – they have to be made by a GP or a health practitioner; although, I – they do take referrals from the general public, as well - - -

MS KIRBY: Yeah.

MS JOHN: - - - but I think primarily - - -

MS ORR: Okay.

MS JOHN: - - - the cohort is from a health provider or a – because they're a tertiary service, so, possibly, a secondary referral – secondary level referral.

MS ORR: And what types of services are provided? You mentioned inpatient care. Is this a therapeutic service, really?

MS JOHN: Yes. It's based at the Women's and Children's Health Network, and it's a – maybe a 15- or 10-bed unit and children are admitted there for a range of reasons, and there's a – again, a range of, you know, psychiatrists, psychologists, social workers who are involved. There's community teams, and they're, sort of, similar to CAPS, I guess, you'd compare them to. So they're based in different locations providing service in the various areas. There's statewide services and the statewide services include a forensic service, a guardianship team service and, in the Helen Mayo House, a perinatal inpatient facility, I think, is placed at Glenside.

MS ORR: But when you talk about forensic and guardianship, it's around mental health; is that correct? Rather than a medical response?

MS JOHN: Yes. Yeah. And so there's the Aboriginal Emotional and – Social and Emotional Wellbeing workforce, too, that's, sort of, involved in this part of that multidisciplinary team, but, yeah. That's the criteria.

MS ORR: You've mentioned it's a statewide model and across locations in the state. How does the CAMHS reach regional and remote areas?

MS JOHN: They have community-based sites. They've got them in, you know, regional areas, you know, Port Lincoln and Whyalla, Port Augusta. They're, sort of, dotted throughout. They provide a service to the APY Lands as part of the integrated model of care, and they've got services at Mount Gambier. Dotted all around an extensive range of, you know, locations.

MS ORR: Thank you. And one last topic, if I can, which is harmful sexual behaviours, which we heard a bit about from Professor Bromfield in evidence this morning. Are any services available through SA Health for children and young people demonstrating harmful sexual behaviours?

MS JOHN: So at CPS at WCHN we have had a service now, I think, possibly for about 15 years that provides therapy for children under 12 who are displaying harmful or problematic sexualised behaviour. The FTE is one. The history to that actually was years ago, a few years prior to that, the government provided two positions, one to CAMHS and one to CPS for, like, a joint service, and they were originally based out of northern CAMHS, but I reviewed that and we actually separated them out. So CAMHS had one position, we had the other, and it's been that way ever since. The criteria, like I said, is children displaying, you know, harmful sexualised behaviour, and referrals can

be made by, you know, the usual, DCP, Department for Education, child care centres and carers and parents themselves.

MS ORR: So that's for children under 12. One FTE.

MS JOHN: Yeah.

MS ORR: Is there a service at the Women's and Children's for children over 12?

MS JOHN: Yes. So CAMHS has a service called the Adolescent Sexual Abuse Prevention Program, and that's for adolescents between the age of 10 and 18, and these adolescents have been in the, sort of, juvenile justice or police system. Those matters, as part of the criteria, need to be resolved and they're usually – I think the referrals usually come from, again, DCP, SAPOL, family conferencing, those types of, sort of, organisations. So, yeah, from 10 onwards, and they use a similar, sort of, model to what CPS uses, which is the AIM model and the Good Life model. Their FTE is 2. They have a multidisciplinary team that surrounds that, because they're based in the Statewide Forensic Team at CAMHS. So they have access to other specialties, if you like, psychiatrists, psychologists and the Aboriginal Social and Emotional Wellbeing workers.

MS ORR: And is that the extent of it in terms of harmful sexual behaviours - - -

MS JOHN: Yes.

MS ORR: - - - services?

MS JOHN: Yes.

MS ORR: How – I don't know if you can answer this, and I'm sorry for the question without notice. How many children approximately would those services see in a year?

MS JOHN: Well, I actually – CAMHS did present, but I can't – they presented recently at the Harmful Sexualised Behaviour Forum. I'll have to take that on notice and find out the numbers. At CPS I've got the numbers, and they're, sort of, sitting around 20 to 30, but the issue is that we could have more children, but because we've got such limited FTE, we can't go promoting the program. So we're, sort of, in the middle of a rock and a hard place, which is very frustrating, because there's – well, in fact, we had a meeting this morning with Education and talking about the needs that they've recognised there, the demand on the SWISS team around harmful sexualised behaviour is quite significant. So, yeah, it's – our numbers aren't high, but we can't go any higher, because we've only got one FTE to provide the service.

MS ORR: And how are the young people – how is it determined who gets that service?

MS JOHN: Well, we don't – another reason why we don't sell the service a lot is waiting lists for me are problematic. I don't, really – I find it, you know, difficult to have a waiting list for children who need the service. So I think it's that managing. So

we – referrals, how they're made. Is that what the question was?-

MS ORR: How is the decision made who gets the service?

MS JOHN: Who. Well, basically, there's no waiting list. So they just – if they meet the criteria, like, whether the behaviour – the harmful behaviour meets the criteria, the threshold and the age group, and there's also a catchment area, too. So our catchment area is narrowed down to the equivalent of the central CAMHS catchment area. That's - - -

MS ORR: And what are we talking?

MS JOHN: I think the eastern regions, maybe a bit of the west. So it's a discrete catchment area that we have; although, to be honest, we do take children from other parts, and we also provide consultation, because that's a really key component of the work around sexualised behaviour. You know, school teachers, social workers and DCP, SAPOL, you know, consulting to them around, you know, these issues and, you know, trying to build the systems and giving them advice, which is a key component of the service, too.

MS ORR: That narrowed catchment that you spoke about, is that the same for the CAMHS program, or is that just the - - -

MS JOHN: No, these are statewide, I think. Yes. From memory, it's a – I'm pretty sure it's statewide.

MS KIRBY: It provides outreach services in the metropolitan area and telehealth services to rural and remote.

MS JOHN: Okay.

MS ORR: Thank you.

MS JOHN: Thanks.

MS ORR: But that's not available for the CPS two to 12, or is it?

MS KIRBY: Yes. No. Well, so the CPSs are under different LHN catchments, whereas CAMHS is a statewide service, so not beholden to boundaries in that way. So the referral criteria is different.

MS ORR: Thank you. I have no further questions, Commissioner.

CMR STOTT DESPOJA: Thank you. Thank you, assisting counsel. I've got a few. I'm going to start just where you finished.

MS KIRBY: Sure.

CMR STOTT DESPOJA: Not beholden to boundaries - - -

MS KIRBY: Yes.

CMR STOTT DESPOJA: - - - because it's a statewide service. I go back to the discussion around the rationale for not having CPS under one entity or a statewide service. I'm still curious as to the rationale for that, and I know that assisting counsel has quoted from the ZED report and philosophical differences, and you've also talked about governance and different needs, but I'm still trying to work through how the cons outweigh the pros for a single identity, albeit with different regional and the WCHN CPS. Can anyone help me?

MS BARON: I think – look, I think there are pros and cons, and it's probably something that can be debated, you know, for a long time about the various structures that exist and, certainly, the intention was to look at a single service model as part of the model of care development. The oversight committee at the time said, "Let's look at the model of care first, then we'll revisit governance." The decision was made that there was going to be no change to governance. We would just leave the three services under their LHNs and, yeah, we could debate that. I think, ultimately, from my point of view is we can restructure services, but that's probably not going to solve the problem. Governance is absolutely important.

CMR STOTT DESPOJA: Yeah.

MS BARON: But restructures for the sake of restructure, if it isn't, sort of, fairly compelling that it's going to achieve its outcomes, is a really big undertaking, often involving unions and consultation with staff, and, you know, it's a very long and expensive process, as well, that shouldn't be undertaken lightly when good communication, collaboration, willingness to work together, trust and those kind of things that are important as underpinning culture across a service - - -

CMR STOTT DESPOJA: Yes.

MS BARON: - - - are what drives the improvements. And I think that's, sort of, what's fundamental, more than the structure itself. That's, you know, my view.

CMR STOTT DESPOJA: Yes. Yes.

MS BARON: And I know that talking to different people, you'll hear different views, but, certainly through the model of care development there were a lot of polarised views about many things, and that was one of them, where we just did not have any consensus of agreement and, in the end, the higher powers made the decision to leave things as they were.

CMR STOTT DESPOJA: Thank you for that. Can I ask about your unit, the - - -

MS BARON: Child Protection Unit?

CMR STOTT DESPOJA: Yeah, Child Protection and Policy Unit.

MS BARON: Yep.

CMR STOTT DESPOJA: How – what's the structure, and how are you staffed, and can you tell us your funding?

MS BARON: So we sit within the Department for Health and Wellbeing under the Strategy and Governance Division under – Sinead O'Brien is our deputy CE over our division. We're a fairly small team. We have the Chief Child Protection Officer position and – I should know the FTE straight off. We have two staff whose work is very much focused around data and systems, and they're funded by Digital Health SA, within SA Health, and then the other three of us – three, four of us are funded from the Department of Health and Wellbeing itself. We're all part of SA Health. Yeah.

CMR STOTT DESPOJA: And as I used to say, I used to say in my old profession, you can take that on notice if you want to and get back to us.

MS BARON: Yeah.

CMR STOTT DESPOJA: In the WCHN submission to the Royal Commission, there's reference to former child safety advisers and a reference to those being retired, and they had quite a specific role.

MS JOHN: (indistinct)

CMR STOTT DESPOJA: Yes. Could you tell us has that, sort of, role been replaced or is it - - -

MS JOHN: That role was at the Women's and Children's Hospital – actually it was across the network and, yeah, it was retired, I'd say, possibly, seven or eight years ago, and it was developed – we had a child protection program manager who was – who worked within the network, and it was identified, basically, you know, there were a few functions that were desirable, one of which was to promote and inform around, you know, trauma – responsive trauma-informed care. That was one of the objectives of that role.

CMR STOTT DESPOJA: Yes.

MS JOHN: And just given it's a huge network, there's a large volume of children and young people and, obviously, from vulnerable situations, it was determined that having advisors would be helpful to actually work with staff to, I guess, upskill them around trauma-informed care, provide advice in relation to whether somebody might, you know, sort of, be teasing out the notion of making a notification to DCP.

CMR STOTT DESPOJA: Yeah.

MS JOHN: Offering training and development, and it was around child protection

originally, and then it grew to domestic and family violence, as well. So these advisers were placed – strategically selected and placed within the network, but it took a lot of – like, you know, a lot of organising and, you know, strategic work to keep that going and it just, kind of, fell. We also lost our child protection program manager, basically. That was a large contributor to that stopping, so - - -

MS BARON: And it's there – those roles, that was, sort of, like, a portfolio that individuals held in addition to their - - -

MS JOHN: Normal. Yeah. Sorry. Yeah.

MS BARON: - - - day job. They weren't - - -

MS JOHN: Their day job, yeah.

MS BARON: They weren't, sort of, dedicated positions that were funded as that. It was people who did extra - - -

MS JOHN: (indistinct)

MS BARON: Yeah.

CMR STOTT DESPOJA: Yep.

MS BARON: An interest in extra learning and development to be a contact person for people - - -

MS JOHN: Yeah.

MS BARON: - - - in their area to provide advice and support.

CMR STOTT DESPOJA: Okay. I don't underestimate that workload, then, and the burden on those staff, but do you feel that there's a gap now that those, sort of, nominal roles don't exist any more?

MS JOHN: I think they were really effective. I think trauma-informed care across, you know, the major hospitals is so important, you know, and I think people struggle with how to deliver it, you know.

CMR STOTT DESPOJA: Yeah.

MS JOHN: And, you know, there's frequent staff turnover and – so, I guess, it's – for me it's a – really, yeah, I think it is a gap and I think that we, sort of, collectively quite possibly could do something, you know, better than what we're doing now. There are mandatory training courses, you know, within SA Health around, you know, reporting child abuse concerns, child safe environments, trauma-informed, but I think we could probably enhance that somewhat possibly.

CMR STOTT DESPOJA: That prompts me to – I'm just curious, Ms Baron, something you said around those paediatricians, not with forensic specialisation, but with child protection expertise I think was the word. You were saying that there's modules, but there's no national guidelines, and I'm just wondering what the situation is in South Australia. Is there any kind of regulatory, sort of, expectation around those roles?

MS BARON: No, unless something has changed since the model of care work was done - - -

CMR STOTT DESPOJA: Yeah.

MS BARON: - - - I don't believe there's any national or state-based standard that has to be complied with, which was why there was a recommendation, sort of, for a competency-based framework that the medical staff could work towards, obviously, made up of experiential learning primarily, but also coursework. So the paediatricians who do – it's community child health, I think is the specialty, there are requirements within that to do modules to do with child protection and it includes logbooks and other coursework, et cetera - - -

CMR STOTT DESPOJA: Yep.

MS BARON: - - - and placements, but there – and there are – you know, you can do a Masters in Forensic Medicine - - -

MS JOHN: You can do a Masters, yes.

CMR STOTT DESPOJA: Yes.

MS BARON: - - - and, you know, there's a whole lot of training, but there's no single, sort of, standard requirement. There's not a medical – yeah.

MS JOHN: Subspecialty.

MS BARON: Not a subspecialty.

CMR STOTT DESPOJA: Right.

MS JOHN: It's not a subspecialty.

CMR STOTT DESPOJA: That's interesting. Ms John, I want to go back to something that you said, as well, when we were talking about, sort of, access, particularly for those young people or children in rural regional areas, remote regional areas, and talking about how sometimes, you know, you use this example going to Whyalla, and I think the proportions you used were, sort of, 60/40 in - - -

MS JOHN: Approximately, yeah.

CMR STOTT DESPOJA: Yeah. It's okay. That's – we can fix that, if that's not right, but what I'm interested in is what's the consequences of, say, that 60 per cent, if it may be, that have to travel for those services?

MS JOHN: Yeah.

CMR STOTT DESPOJA: I mean, is there an impact or a delay or anything particularly negative around that access? And even the opposite way, you know, the 40 per cent that you actually get to. I'm assuming that that's not an easy thing to provide instantaneously? Does that - - -

MS JOHN: Exactly, yeah.

CMR STOTT DESPOJA: Does it matter?

MS JOHN: Yeah, I mean – I think yes. Yeah. A very important point there. It does usually involve a delay between the referral and when – because, I guess, when our clinicians travel to the rural areas, accommodation has to be booked, and – well, and vice versa when people come to the city. But, I guess, the other thing to mention is that when we undertake forensic psychosocial assessments we need recording equipment and we need a room that's child-friendly and is set up as a purpose-built room, but with a police officer observing.

CMR STOTT DESPOJA: Yep.

MS JOHN: That's part of the requirement. So it's not as if you can just pop in and, sort of, borrow a CAMHS therapy room and see children. You actually – it does take a little, you know, some, you know, bits and pieces to arrange, but there can be a delay. If it's urgent, we'll try and, obviously, get there as quickly as we can, but it's resource intense, too.

CMR STOTT DESPOJA: Yeah.

MS JOHN: So, yeah, there is a delay involved with that.

CMR STOTT DESPOJA: Thank you for that. Can I just clarify, I understand that, you know, the WCHN CPS provides that 24-hour, seven-day care. Can I just confirm, and forgive me if I missed this, but the SALHN and NALHN, is that comparable in terms of hours?

MS JOHN: Yes.

MS BARON: Yes.

CMR STOTT DESPOJA: That's great. Thank you very much for that. Ms John, I'm going to ask a question that may seem a little simplistic, but noting that – going back to the very original point around presenting with injuries at emergency, and I'm just curious, it can't be an exact science, can it? I mean, you were talking about unexplained

injuries, but, clearly, there'll be sometimes when people have an explanation, and I understand you've explained the psychosocial and other supports that come in to make those determinations, and then an admission and then, obviously, contacting authorities, but how confident are we that sometimes people don't slip through that, sort of, gap?

MS JOHN: Well, we have a very strong relationship with ED, and there's, you know, regular, sort of, audit meetings, I think they call them. I think our ED doctors are pretty well attuned to – there's an injury proforma, too, but that's beyond my, sort of, scope of expertise, but – so I think there's quite a close relationship between our doctors and ED doctors, and often they've done a rotation. So there's methodology involved.

CMR STOTT DESPOJA: Yes.

MS JOHN: So – and our doctors will step through with the ED doctors, "So what was the explanation? What sort of history did you obtain? Did that history match the injury?" You know, "If not, why not? What are your doubts?" And then, obviously, if they form a suspicion that the explanation doesn't adequately explain the injury or the neglect or whatever the presentation is, they'll tease that out with our doctors, and then in that context a notification will be made. And the other thing that we – the doctors do and we do is that we, I guess, help – we facilitate that notification by, sort of, encouraging them to, you know, provide a certain amount of information to DCP so they can triage it and assess it properly. So it's quite a thorough – you know, I wouldn't want to – I mean, nothing's foolproof, obviously.

CMR STOTT DESPOJA: No.

MS JOHN: But I think our system is pretty tight, and I think the methodology is very good and is very clear.

CMR STOTT DESPOJA: Sorry, maybe that was more of a Dorothy Dixer question after all.

MS JOHN: Yeah.

CMR STOTT DESPOJA: It gave you the opportunity to, yes, extol the thoroughness, but it is – it's interesting and thank you for that.

MS JOHN: And sometimes injuries are clarified. Sometimes our doctors will get involved and then they'll, sort of, ask – they'll suggest some testing or whatever, and, "Okay," and then come – you know, they do blood tests and intermatch, you know, and they, sort of, look – see what's, sort of – what's happening with clotting or not clotting, and so it's, kind of, you know, it's a real – it's a medical science, obviously, but sometimes the injury is explained after, you know, more of a history, more of a thorough history is obtained with the suggestions made by our doctors, you know.

CMR STOTT DESPOJA: Again, I don't underestimate the complexity involved in that and, indeed, the science, literally, and you have already emphasised that, sort of, trauma-informed approach and, I assume, a culturally safe approach, as well. I imagine

a lot goes into that methodology.

MS JOHN: Yeah.

CMR STOTT DESPOJA: Final question, because I know that we have really worked you very hard today. It goes back to that broader issue of risk and assessment and risk assessment, and I note that, again, in the WCHN submission to the Royal Commission that the reference to the idea of lowering the MAPS, Multi-Agency Protection Service, risk assessment threshold in order to better serve the interests of young people and children. I'm not sure if you have a comment on that.

MS JOHN: Well, I just – I read in the submission that that was a recommendation from the government to you. So, I guess, in my – when I was reading, I thought that was – I think it – so I thought that was a good idea. That's why I put that in, but I think it – we've got opportunities at every step of the way to identify children who have been exposed or experienced domestic and family violence and sexual violence and, I think – I don't know whether we utilise those opportunities. I don't know whether they've been – you know, there are specific pathways and education and clarity around that for health professionals and other professionals. So I like the idea of the multi-agency pathway, if you like, broadening out to include children. And that was always the intent, supposedly, I thought - - -

CMR STOTT DESPOJA: Yeah.

MS JOHN: - - - but it didn't happen. So it was just a way – a suggestion that I endorsed as a way of identifying children's needs at that point. And I know, you know, that SAPOL are reviewing their screening of domestic violence when they go into homes to make – to, sort of, have a look at the child lens in that context. So I think I just believe there's opportunities along - - -

CMR STOTT DESPOJA: Yep.

MS JOHN: - - - that pathway and that being one of them.

CMR STOTT DESPOJA: Yep.

MS JOHN: What it would look like, I don't know, to be honest. I haven't put a lot – you know, and that's - - -

CMR STOTT DESPOJA: Yeah.

MS JOHN: Yeah. But – yeah. And I know in Victoria they did a similar thing with the Orange Door and the – you know, so I think, you know, there's opportunities to explore.

CMR STOTT DESPOJA: Thank you. Yes. And I'm conscious that there is another – you know, one other option is that front door gate - - -

MS JOHN: The front – yeah.

CMR STOTT DESPOJA: Yeah, with multi-agency assessment, particularly in relation to (indistinct) children.

MS JOHN: Because I do think children can get lost in that world of domestic - - -

CMR STOTT DESPOJA: Yeah.

MS JOHN: - - - and family violence, and the focus is, rightly so, on the woman, you know, the victim at the time, but I think the impact on the children isn't always, I guess, prioritised as much as it possibly could be, and, you know, for a range of reasons, probably, but people do the best they can.

CMR STOTT DESPOJA: Well, thank you for bringing us back to the theme of today. That's a good note on which to end. Counsel assisting.

MS ORR: I have no further questions. I'd ask the witnesses be released.

CMR STOTT DESPOJA: You are free to go and thank you for your contributions today.

MS BARON: Thank you.

MS ORR: And then, Commissioner, I'd just ask for a very short break to reset the equipment.

CMR STOTT DESPOJA: Should we aim for a five-minute break, I suggest?

MS ORR: Yes.

CMR STOTT DESPOJA: Okay. Thank you.

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CMR STOTT DESPOJA: Welcome back to day 5 of public hearings for the Royal Commission into Domestic, Family and Sexual Violence. We are about to talk to our last witness. Counsel Assisting.

MS ORR: Thank you, Commissioner. I call Associate Professor Rhiannon Pilkington.

RHIANNON MEGAN PILKINGTON, AFFIRMED

MS ORR: You are an associate professor?

A/PROF PILKINGTON: I am.

MS ORR: Based at Adelaide University?

A/PROF PILKINGTON: I am.

MS ORR: Is that correct? And I understand you work at BetterStart Health and Development Research.

A/PROF PILKINGTON: Correct.

MS ORR: Can you explain to us what BetterStart is?

A/PROF PILKINGTON: Absolutely. So BetterStart is a research group that's situated within the School of Public Health in the University of Adelaide. So we're a group of multidisciplinary researchers. So we're epidemiologists, psychologists, social workers, developmental criminologists. But we've all come together to focus on research that uses data to support achieving better outcomes for children, young people and families. And we have a particular focus on children and families experiencing different types of disadvantage.

I think to help situate some of the things we might end up talking about today, it's important to note that at the core of our work is more than a decade of investment into building the Better Evidence Better Outcomes Linked Data platform, so we call that BEBOLD for short. So this is a de-identified whole population linked data platform that includes data on 1.2 million South Australian children and their parents. So the data spans primarily government systems from health, education, social and justice sectors.

Now, we operate that data platform under substantial ethical and data custodian governance. But it enables us to produce evidence that reflects also what the service sectors in South Australia are seeing. And so there are three areas we focus on using that data platform. We focus on what we call descriptive epidemiology, so we think about prevalence and incidence. We think about what we can understand about target or eligible populations. We undertake risk prediction, so this is essentially a term for screening.

So you can think about screening in lots of different areas. But you know ultimately what we do across our child and family service system is in some ways we actually screen, and we try and work out who's at greatest need. Now, of course the first rule of screening is don't screen unless you have something effective to offer. Right. So it's definitely not a straightforward area to work in, and absolutely you know not something that we say you should just do without being very careful to think through all of the things that involves.

And another big area of our work is focusing on what works. So actually, how do we know what works to support children, young people and families experiencing different types of disadvantage? And so to do that we use the data platform by bringing other

service data in so that we can follow populations forward and understand what their outcomes are using quasi-experimental methods.

I'd also just like to note that we're really committed in the use of data and in fact in anything we talk about today to Indigenous data sovereignty. And so it's really core to our work to take seriously the need for Aboriginal people to own and have control over data on Aboriginal children, young people, families and communities.

MS ORR: You've mentioned disadvantage a couple of times. Does that have a technical definition in your space?

A/PROF PILKINGTON: I don't think technical is probably the term I'd use.

MS ORR: A definition in your space.

A/PROF PILKINGTON: Yeah, absolutely. I can explain what I mean by that, and I guess really I'm reflecting on the fact that there are lots of things that happen in people's lives that can confer some sort of disadvantage. So you could think about that as health disadvantage. So there might be something that happens to a child or that a parent's dealing with, whether that's a chronic health condition, whether that might be being born really early. That can actually, you know, create additional needs for that child and for that family.

That family might be experiencing social disadvantage, so maybe there aren't the social supports that some other families enjoy. And you know we all throw out it takes a village to raise a child, but, you know, so when families don't have that support that can be a disadvantage in terms of thinking about optimal circumstances for parenting, for child development, and you can go on. So obviously one we talk about a lot is poverty.

MS ORR: Yeah.

A/PROF PILKINGTON: You know, so not being silent on some of the fundamental drivers like poverty, like housing that drive many of the outcomes we'd actually like to improve upon in this state. So I think there are many areas you can think about disadvantage. Justice, child maltreatment are another two that have obviously come up today as well and are highly relevant when we're thinking about domestic, family and sexual violence.

MS ORR: If I can turn now to Thriving Families and ask you about that. So I understand that BetterStart has worked on a project called Thriving Families. Can you explain what that is?

A/PROF PILKINGTON: Absolutely. So I'm privileged really to be sitting here today as the university co-lead of Thriving Families. And so Thriving Families 2025 to 2045 is what we describe as a system change innovation. So it recognises there's no one programmatic solution to achieving better outcomes for children, young people and families. And when I talk about outcomes, obviously there's lots of outcomes we care about.

So while often our focus is on safety, which is obviously really important, we care about their health, we care about their well-being, we care about their education, we care about their development, and we care about equitable access to all of the things that might support good outcomes in those areas. So all of those are outcomes we care about.

When I just talked about system change innovation, I want to be really clear that we're talking about government, non-government and community services that support children, young people and families. And so the foundation of Thriving Families is actually a vision for generational change. So that sits on top of a foundation of the ultimate goal of Thriving Families which is how do we shift from a crisis driven system to one where we're providing early, effective and non-stigmatising support before the family actually finds itself in crisis. Are you happy for me to go into a little bit more detail around where it's come from?

MS ORR: Yes, please.

A/PROF PILKINGTON: Thank you. So I really – I'm actually sitting here because of the investment of over 80 non-government and community organisations across the state in Thriving Families. So that also includes children's commissioners. It includes Aboriginal community controlled organisations. It includes families with lived experience. So they've all contributed to the vision for Thriving Families. So over the course of the last couple of years I've had over a thousand conversations with people who care about the future of South Australia. And who care deeply about the opportunity to do better and the opportunity to think about doing differently to achieve those better outcomes.

So really Thriving Families represents a powerful and unified call primarily from the non-government service sector and that's eventuated in actually 53 community organisations signing a pledge to Thriving Families. So that came about from those very organisations saying we actually want a visible way to illustrate our commitment to doing differently in South Australia. So they are a resounding expression of the sector's readiness and desire to do things differently and really to invest in tangible lasting change.

So we've been told this collective pledge is unprecedented in South Australia. And I think it's really important to acknowledge that this really signals a unified sector-wide movement towards better outcomes for South Australians. So this is an opportunity for us as a state to be leading the nation in thinking about innovative ways to achieve those better outcomes.

MS ORR: You spoke before about the BEBOLD data platform. How did that help to generate Thriving Families?

A/PROF PILKINGTON: Absolutely. So in terms of where I've come from as the co-lead of Thriving Families, I've spent the last decade working with government, with non-government organisations, not just in South Australia but all over the country. And the basis of a lot of our work here certainly has been the use of the BEBOLD platform.

So we've been privileged to undertake lots of research projects and be working with lots of agencies and lots of workers who are on the front line trying to achieve better outcomes. And so because of that we've also been able to use this platform to really provide insights into the whole population experience of a range of things we'd actually like to shift. And so, you know, these are things that, you know, many of things that you would already know, some of which we've actually heard today, you know.

So I heard Professor Leah Bromfield talk about one in three children being notified to Child Protection by age 10. So that's come out of the BEBOLD platform. But there are many other points in what we think about as the case for change that have come from the BEBOLD platform. And you know, I can go through those now. But I also just want to acknowledge that while, you know, in some ways it's easy to reel off statistics, I really want to acknowledge these are real children and real families. And many of these represent really serious experiences for these families that have – can have lifelong effects.

So I guess we used BEBOLD as part of the case for change for Thriving Families. So we started off with things that we talk about a lot, but that sometimes wash over us. So you hear a lot about poverty, and you know the latest statistics coming out on that nationally. But then focused on South Australia is we have one in four children living in poverty. We see many signals where the volume of need is too high. So we're at the point now we're actually one in 10 infants in South Australia are reported to Child Protection before they turn one. One in 10. We have to start to ask ourselves what sort of system we're now in where that's one of the main signals of children not thriving.

We know our Intensive Family Support services can't see most of the families being referred to them. They can only see two-thirds of families that are coming through that Intensive Family Support front door, simply because there's no capacity in the system for that. There's many signals that we don't respond early enough. So we know there's more than 40,000 children each year notified to Child Protection. 70 per cent of those are already known to the system.

So this speaks to that idea of children and families cycling through the system and also speaks to the idea of the broader system not being able to actually change the circumstances that are leading to that report in the first place. We know there are too many children being left behind. We have one in four children starting school developmentally vulnerable. So one in four. This was actually the motivation for the Gillard Early Childhood Education and Care Royal Commission.

We've seen now substantial investment, activity and reform being led in that space to better support child development in the early years. So we know that's possible. We know – we know that investment, that long-term investment is possible. And I also want to reflect on some of the work that's come out of using the BEBOLD platform which was supported Commissioner April Lawrie's inquiry into Aboriginal and Torres Strait Islander children in care. When we actually use the data to look at the front door of the child protection system what we saw is one in two Aboriginal and Torres Strait Islander children were being notified in one year to the Department for Child Protection.

And then if we move from that front door of reports to child protection, and we look at children being removed what we could see in those patterns is that for children born back in 1990 to 2000, so we're talking 30 years ago now, actually the proportion of those children born each year being removed into out-of-home care was going down. So we were removing less and less children as time went on. If we fast forwarded a decade and we started looking at children born from 2001 up to 2010, the proportion of children being moved into out-of-home care was relatively stable. There wasn't really a consistent shift upward or downward.

But then if we then focused on children born in more recent years, so from 2011 onwards, we were starting to see the proportion of children being removed into out-of-home care increasing. So every new year, new children being born. We followed them over time and we saw more and more of those children being removed. So then we have to ask ourselves, unless we truly believe children born two years later, three years later, are different at a population level to those children born one year earlier, two years earlier, three years earlier, then what's changed? The only conclusion I can draw from analysis such as that is that the system response is changing and has changed.

That's been a fundamental shift that Thriving Families is really focused on. And one of the key principles of Thriving Families is the need to rebalance that focus on well-being and safety or risk. So connected to all of that of course is what we hear loud and clear which is we're operating a crisis driven and unsustainable system. We know our expenditure on care has tripled in the past decade. We continue to see disproportionately worse outcomes for Aboriginal families and children. We must acknowledge this is related to a history of dispossession of land, disconnection from culture, stolen generations and the ongoing systemic racism and systems that entrench intergenerational disadvantage.

There are challenges unique to rural and rural communities. We also really need to be cognisant of that when we're thinking about how we move forward. And of course we really need to take the time to talk and listen to all of these different groups, including our multicultural communities that make up the Australian community. And we need to be able to also think about newly arrived families and those from refugee backgrounds.

So I guess with all of those things that we know and if we don't, I suppose, kind of let those statistics just go by the wayside, you know, over a thousand conversations it was loud and clear the current system's not working for children. It's not working for young people. It's not working for families. So we need to do things differently and Thriving Families is an opportunity to do chart a different way forward.

MS ORR: I'm going to ask you a bit more about Thriving Families. But before I do, I want to ask what might seem like an obvious question to you. How does domestic and family violence fit in to what you've been talking about this morning and into Thriving Families?

A/PROF PILKINGTON: Absolutely. I mean, it's – it is, and it isn't an obvious question. You know, domestic and family and sexual violence is another acute indicator of families not thriving. So Thriving Families is not a child protection

strategy. It's not a domestic, family, sexual violence strategy. It's a broad strategy saying, how can we do better? And so for things like young people going into youth justice, for parents being incarcerated, for children coming into out-of-home care, they are all indicators of the need and the opportunity to do better in South Australia.

MS ORR: You've spoken about interaction of systems, and we will talk a bit more about that in a moment. And we've also heard through this Royal Commission about – sorry. I'll start again. I'm going to come back to that. I'm sorry.

A/PROF PILKINGTON: That's okay. No, you're fine.

MS ORR: I want to ask about comorbidity - - -

A/PROF PILKINGTON: Yeah.

MS ORR: - - - in relation to domestic and family violence and we did hear a bit from Professor Bromfield about this this morning. But do you see – first of all, can you explain what comorbidity is from your perspective?

A/PROF PILKINGTON: Yeah, absolutely. So in health we often use comorbidity to refer to the co-occurrence of different chronic conditions. You know, so that might be asthma and obesity. But when we're thinking about the space that we're really focused on today, we could think about that in terms of the overlap with homelessness, with domestic family sexual violence, with child protection, statutory involvement, with justice system involvement. So you could think about all of those things as relating to what you're talking about as comorbidity.

So I guess when we then think about where does domestic, family and sexual violence fit into Thriving Families, one of the things I think about is the journey we've been on in South Australia in terms of understanding child protection risk and how common that is. And if we just rewind 10 years, I think since that point we've moved from a state where, you know, child protection risk, child maltreatment was really considered other. You know, it was over there. It's not my business. It's somebody else's business, to a state where actually you know we've come some way to understanding this is common, you know. And it's not common on its own.

So whether it's child protection risk or child maltreatment or domestic and family violence, we know those things co-occur in large numbers with poverty, with housing insecurity, with serious mental health concerns, with drug and alcohol use. And what we've actually done to this point with child protection is, I think, something that also needs to happen with domestic, family and sexual violence. We need to actually come to a point where we acknowledge this isn't other and this isn't somebody else's business. And this is far more common than we actually have thought historically that it is.

I'd like to also reflect on the fact that, you know, because we're focused on children and families, some of our earliest indicators of what's happening with them are actually through reports to the child protection system. But those reports are made by

community members.

MS ORR: Yeah.

A/PROF PILKINGTON: You know, so we'll often sit up here and we'll talk about mandated reporters. But what we mean by that is we mean our nurses, we mean our early childhood workers, we mean our teachers, we mean our police. You know, so these are community members who are identifying something going on with children and families. So we've gotten to this point where many of us now accept – we've still got a way to go – but many of us now accept this child protection risk is common. We've also been doing analysis using BEBOLD to submit to this Royal Commission looking at a similar sort of question for domestic, family and sexual violence. Are you happy for me to go into that now?

MS ORR: Sure.

A/PROF PILKINGTON: So just so people understand what I'm about to refer to, we've used the de-identified linked data platform and particular sources within that. So we've used data from inpatient hospitalisations, from the Specialist Homelessness Service collection. So that's both Homelessness Services and the Domestic Family Violence Alliance services, and then data on screened-in reports to Child Protection. So they're the Child Protection reports that are triaged, if you like, into Child Protection, where they accept it's a Child Protection matter.

So we've used those three sources of information to look within different calendar years and say, well, if we look at all zero to 17 year olds in South Australia, what proportion of children and young people have some indicator of domestic, family or sexual violence? And the answer we arrived at is that about one in 30 South Australian children and young people aged zero to 17 have experienced domestic, family or sexual violence at least once in each year. And so that was looking in the years 2020, 2021 and 2022 and it doesn't really vary over those years.

We also strongly believe this is likely to be an underestimate. Remembering the BEBOLD data platform doesn't actually have SAPOL data. So we don't have a view of many of those first touch points that might come from police. We don't have courts data and at the time of undertaking the analysis we weren't able to include what we might also be able to know from adults corrections data. Now one in 30 is – it's big, you know.

MS ORR: Yeah.

A/PROF PILKINGTON: It's common and like I said we're fairly confident that's an underestimate. Now, this rises to one in 18 for children living in outback South Australia. And about one-third of those children experiencing domestic, family or sexual violence every year were located in Adelaide's north. And so the absolute numbers of the children we see in Adelaide's north with an indicator of DFSV is more than all of the other areas of Adelaide combined. So then when we go back to that idea of comorbidity, we were also able to look at how this – how these experience of DFSV

for children in South Australia looks according to an area level measure of socio-economic disadvantage.

So what you actually see is it does – it occurs across all strata of society. It occurs in advantaged areas, and it occurs in disadvantaged areas. But it's concentrated in disadvantaged areas. So 30 per cent of those children are living in the most disadvantaged areas in South Australia. We also know – so if we go back to thinking about those children reported to Child Protection by age one, so one in five of those children have an indicator of domestic, family violence in the data. And again, we're fairly confident that's an underestimate because it's relying on the service system recording that in a particular way that means we can see that in the data.

If we then think about children who are substantiated from our treatment by the Department for Child Protection, 44 percent had a notification related to DFV. And then if we look at children who've been removed into out-of-home care, one in four, more than one in four, had an indicator of DFV. Again, we know this is likely to be an underestimate. But if we think about that Child Protection population, and then we compare what we know about DFV to the population that have had no contact with Child Protection, that then drops to 0.6 per cent.

So Child Protection and the overlap with DFSV is substantial, and we know there's a significant overlap too with the involvement of state funded homelessness services. And that that increases, that involvement of homelessness services increases too as children move through the child protection system. And of course part of this relates to the fact that the child protection system has become the front door to getting support for children and families and young people. That's reflected I think in all of these signals we're seeing of the need to think differently about how we achieve better outcomes.

MS ORR: So turning to Thriving Families, I just want to ask about some important themes from the Thriving Families vision, I guess. And these as – correct me if I'm wrong, but these are things that you say are needed for families to thrive, to achieve that goal.

A/PROF PILKINGTON: Absolutely.

MS ORR: One is creating an ecosystem rather than discrete organisations. Can you explain that?

A/PROF PILKINGTON: I can. Do you mind if I go a little bit into the genesis of Thriving Families?

MS ORR: No, of course not.

A/PROF PILKINGTON: Just to provide a little bit of background as I delve - - -

MS ORR: Yeah.

A/PROF PILKINGTON: - - - into some of the detail. Because I think it's worth noting

that Thriving Families actually started in late 2022 off the back of the Vice-Chancellor of the University of Adelaide, Peter Hoj, recognising an opportunity for the university to contribute to what could work differently for better outcomes. And so we actually started off with a call to community organisations, children's commissioners, non-government organisations to answer a question which was how do we do better for children, young people and families SA. So a deceptively simple question.

But we positioned that to 2045 deliberately so that we could try and move away from the current politics from the – you know, the very real pain points in the current system. And say if we had the opportunity to start again what could this look like, and then how would we get there? And so what started with 28 organisations coming to a journey lab type process grew really quickly to over 80 organisations. And so the inception of Thriving Families is about the investment of all of the wisdom from all of those organisations and people who work with children and young people and families. The investment of children's commissioners and their officers and the investment of families with lived experience of the statutory systems.

I just want to point out it's deliberately generational. So when I say 2025 to 2045 what that's acknowledging is we haven't gotten to this point where we have these lines like one in three children are reported to Child Protection where we say one in 30 children have experienced DFSV in one year overnight. That hasn't happened overnight. So it's going to take a while, and we know, though, that different is possible. So if we just think about what South Australia looks like in terms of children being removed into out-of-home care.

We have 12 per 1,000 children in care at the moment. We only have to look across to New Zealand to know that could shift. They have four per 1,000 children in care. So that's a third of what we see here. And if you rewind in South Australia to 20 years ago, that's what we looked like here. So it's taken us 20 years to get here on that metric. You could pick up other metrics of course, but on that one it's taken us 20 years. So we're deliberately generational.

So then when we think about those themes in Thriving Families which are all focused on how do we achieve better outcomes, how do we shift from a crisis-driven system to one that's proactive and focused on prevention and early support, the vision is encapsulated in what we call eight levers for change. And I'm not going to go into those. They are in our submission. But within those levers for change are over 130 direct points of reform. So it's big, it's detailed, and it's ambitious. But we expect over time pursuing those areas of reform will lead to the development of a coordinated ecosystem.

Now, we know that that has to happen while also addressing core drivers of poor outcomes. So we're talking about poverty. We're talking about systemic racism. We're talking about serious mental health issues, substance misuse, child maltreatment, and of course domestic, family and sexual violence as some of those core drivers of poor outcomes which have to be addressed. And so then we want to move towards an ecosystem. Part of that idea is actually taking the words we talk about a lot, which is coordination and integration, and going what would that mean?

And, you know, what would that mean from a child's perspective, from a young person's perspective, from a family's perspective, to work for them? So how could we shift to an ecosystem where our starting point is what do you need, not this is what we've got. And so if that is your starting point then for domestic and family violence that then becomes a question we need to be able to answer for thinking about DFSV as well. And so, you know, what's really clear is that there's no one system, no one agency, no one sector that this implicates.

We have to think about child protection, health, education, early years, justice, homelessness, housing, the list goes on, and we have to think about what a holistic approach might look like. So I think that's also about repositioning some of the spaces we get stuck in. So you know we sometimes get stuck in conversations like what's early, you know what's prevention.

MS ORR: Yeah.

A/PROF PILKINGTON: And so Thriving Families is really clear. There is no one space for early. There is no one space for prevention. So if we were to develop an ecosystem which could start from a position of what do you need, we'd really be talking about saying it doesn't matter if it's during pregnancy, if it's in the early years, if it's children and young people in youth justice settings, if it's children out-of-home care, if it's children in residential care.

Every single one of those points is an opportunity to promote better outcomes, to break cycles of disadvantage. And to not reach the point where our investment says it, even if no one else will say the words, but our investment would suggest we don't think there's any point. We absolutely must move beyond that to a point where we say across the life course for a family, for a child, for a young person, it's never too late.

MS ORR: Another theme that has been taken from Thriving Families is the importance of healing the family and not just children.

A/PROF PILKINGTON: So I think, you know, one of the things that struck me in all of the engagement we've done, not just for Thriving Families but over the years, was a conversation we had with a young person in a regional town. This young person had been in care, and they turned to some of the government representatives, and they said, "What did you do for my mother?" And so – sorry – so when we talk about healing the family, it's also about saying let's not take the silos our system falls into and force families into those silos.

So some examples of that are child removal. You know, effectively we hear stories all the time about how, you know, families have said to us, they didn't know anything was wrong or unsafe about their parenting. But, you know, we have a system response which is really poorly resourced. I mean we keep talking about our Intensive Family Support services. But we have to keep mentioning that because at the moment that is you know our best response to thinking about earlier to thinking about prevention for families with really high needs and in complex circumstances.

So if we can't think about shifting that culture of crisis systems being the front door, and we can't think about opportunities to move that earlier, then how do we move ourselves out of seeking – seeing families trapped in cycles of trauma and adversity. And if we can't do that, then I think we're not going to shift and we're going to be back here in another few years. So if we take those notions of silos, and we say we're not – we're no longer going to silo what the child's experiencing from what the family's experiencing. So whilst you know there are absolutely circumstances where it's the right decision to remove children because of safety concerns.

What we then need to do is acknowledge the conditions and the circumstances the family's dealing with. So whether that's poverty, whether that's basic needs not being met like housing, whether that's mental health or whether that's drug and alcohol. We have to ask what's our capacity to then support the family? Ideally that's well before the crisis hits. But if it's not, and we have had to remove a child, then what are we doing for the family at that point. So those are the sorts of questions Thriving Family is asking and saying we must think about the whole family to help children.

MS ORR: Do you have some – if we go back to data – do you have some data that would support that theory, I guess, that we should be responding to the family rather than separating the way we deal with parents and children?

A/PROF PILKINGTON: You know, I'm not sure there's any one indicator that sort of – or sort of piece of data that supports that, other than when we think about the core drivers of the sorts of things we're talking about today. And I've mentioned them a few times when we think about poverty, when we think about, you know, mental health, and we think about drug and alcohol. When children are born into those circumstances that their parents are also dealing with, you know, I think we have to ask ourselves why our response would be to separate children and families in that case. And why we have a response where we are actually not able to address the fundamental drivers of poor outcomes.

There is plenty of research in the space showing that when children get removed into out-of-home care their outcomes are, for many of them – not for all of them; it's not deterministic – but their outcomes are not what they could be in terms of education, in terms of employment, in terms of life chances. So if you just take that as one example, that actually shows us that when we are able to support families to stay together safely, and we are able to support parents and aunties and uncles and communities to support children to grow and thrive when they're connected to family and culture, we see dramatically different outcomes.

I think it's also really important, though, to acknowledge that that's what we hear from children and young people themselves. So while it's not always possible, it is also really important to elevate the voices of those children and young people saying those stories. And to actually understand those as just as important as the evidence we might see from other more traditional research.

I think also in the same vein to think about listening to Aboriginal leaders, to Aboriginal communities, and what they're telling us loud and clear about the need for Aboriginal

people, for the Aboriginal community controlled sector to lead Aboriginal business and support of Aboriginal families. So if we kind of move away from just that, you know, sort of traditional view of evidence, then I think actually there's a lot that says we are much better off supporting families than we are siloing our responses to children and families.

MS ORR: Does healing the family help with generational change?

A/PROF PILKINGTON: It's such an easy question, isn't it? You know there are so many signals I think that we're only just starting to grasp around intergenerational patterns of disadvantage. And what we are seeing in some of the data is also how our service system entrenches those intergenerational patterns. Because families will end up in a crisis, our system response will be to remove that child, that child will grow up and what you hear from those young people who grow up after being in care, is then they feel like they're being watched because them being in care is then seen as a risk when they too become a parent.

MS ORR: Yeah.

A/PROF PILKINGTON: And so by the very nature of how we then assess risk, we are almost precipitating a pathway where you know we're on track to then be looking to remove the children of that second generation. So, yes, absolutely healing the family comes in to thinking about intergenerational cycles. I think in that, you know, we need to listen to the experts, but we need to listen to the families, and we need to do that in a way that's more than listening. I think one of the things we hear a lot is you know there can be consultation and there can be engagement and there can be listening. But where's the action?

So we've got an example now, you know, when we're looking at child development. And we're seeing long-term sustained investment in key things that are going to improve the life chances of children in this state. How do we move in this space to thinking about the same thing? We look at in this state and in actually every state – this is not unique to South Australia – we have 20 year infrastructure plans, and we invest in those over the long term. And Thriving Families is an opportunity to say, well, here's a 20 year plan for moving towards better outcomes for children, young people and families. But that takes investment because you can't switch off the crisis system while you want to move earlier, and that is one of our challenges.

MS ORR: Can I ask you a bit more about that point? So how do we invest in the change? How do we start?

A/PROF PILKINGTON: So I think that really relates to what Thriving Families is seeking to do. So perhaps a more succinct way of saying what I've been saying is that you know, we must embed capacity for early support for a cohesive, integrated and well-resourced child and family wellbeing system. But if we can't turn off the crisis system what does that mean? So that means investment for new ideas for innovation and Thriving Families is going to be a driver and an incubator for doing things differently.

Now, sometimes that means recognising the innovation that's already out there. You know the things that are happening in everyday practice where actually you know we've got amazing examples on the ground of services doing their best to achieve better outcomes. So where that's working, how do we learn from that? How do we scale that? And then so if we take that model of what Thriving Families is seeking to do, we're also starting to ask questions like how do we think differently about those reports to Child Protection that come from our nurses, from our teachers, from our police?

And from what we have done in terms of looking at what those reports tell us, is we actually understand even a single report to Child Protection shows that there is twice the risk of developmental vulnerability at school entry. So just one report. So there is signal in those reports. Now, at the same time what we actually know is half of those reports will get no response, no further consideration in a year. So if we take those two things, and we say we know this is actually a robust indicator of developmental risk at very young ages. We also know the system has very limited capacity to respond to most of these reports.

Could we think differently about how we use them? Could we actually think about a system where we say, why can't those reports go directly to community based organisations, to Aboriginal community controlled organisations, where we can start with a question which is what do you need? Not what we have. And then if you keep taking that idea further, then I think you end up in a space where you go, how do we actually have a joined up front door, if you like, to being able to need support. So that we're not left, you know, with many across the service system who have told us in Thriving Families, we notify them to Child Protection because we think that's the only way we're going to be able to get them support.

MS ORR: Yeah.

A/PROF PILKINGTON: So how do we join up that front door, so we have visibility over need, we have a better ability to respond to what they need rather than what we've got? And how do we directly connect many of these families to organisations that are really close to their communities and equipped to support, you know, some of these basic needs which are human rights really for many of these things. So that's really for us about the first five years of Thriving Families. We have a focus in that first five years across several areas in terms of thinking about doing differently.

So we think to start to shift from that crisis to prevention, there are early places we can focus on that we'd like to see a change in. And this again has come from the investment of all of the people who have invested in Thriving Families. And so I want to acknowledge that I'm carrying, you know, their expertise and their wisdom and their experience in what I'm communicating now. So one of the first spaces everyone would like to see change is Aboriginal leadership and inclusion. So that is about Aboriginal people leading Aboriginal business. But it's also about thinking about a system and a governance model where power is shared and really clearly around thinking about how funding gets redirected to Aboriginal community controlled organisations.

MS ORR: And just - - -

A/PROF PILKINGTON: We want - - -

MS ORR: Sorry, go on.

A/PROF PILKINGTON: That's okay. I was going to say we just – we want to see a shift towards agreeing on what outcomes we want to achieve. So, you know, the different sectors roll off the tongue, but the reality is they all have different focuses. They all have different roles. They all have different scopes of practice. So how do we agree across all of those around what we're wanting to achieve? And so that's really thinking about what are our shared outcomes for children and young people and families.

MS ORR: I just wanted to go back just a little bit. You've mentioned it a few times, so I wanted to mention it. It is an important theme, as I understand it, of Thriving Families that we should be shifting from crisis to prevention.

A/PROF PILKINGTON: Absolutely.

MS ORR: Would you like to – I know you've explained that a little bit, but can you just explain that sort of theme for us?

A/PROF PILKINGTON: So I guess the way we've talked about it thus far with Thriving Families is if we can't stem the flow of children, families, young people, the population coming into experiencing crisis and requiring crisis responses, then it's going to be very hard to turn around a system which 20 years later you know we're seeing three times more children being removed into out-of-home care. So the fundamental question is how do you stem the flow of families experiencing crises, whether that's related to domestic family and sexual violence, to mental health, to drug and alcohol and so on.

And so for Thriving Families it's really been about acknowledging the need for – and the ability I should say, not just the need but the ability and the opportunity for the system to shift in meaningful ways that we believe will make a difference to people on the ground. And so that's when thinking about Aboriginal leadership and inclusion comes in. That's where thinking about actually coming to a common understanding of what we're trying to achieve comes in. That's where, you know, a whole lot of other system level initiatives come in.

They are about creating capacity to spend more time, resources, effort on effective responses earlier. And so it's not that I can sit here and say this is the effective response we need. But it is then about thinking about in all of those things, Thriving Families wants to support or lead or co-lead in the immediate and long term, how do we know what we're achieving. And so I think that takes us to the idea of a learning system. So you know that's really thinking about actually identifying the things we care about that need to shift, and so you could list those things off. You could come up with indicators. You could think about targets. But you know, that's not the only option.

So if we can't get to a space where we actually understand who are we reaching,

because I'm not sure at this point we could even say, well, this is the total population experiencing DFSV. This is the proportion of the population we're reaching with supportive services. This is the proportion of the population we're reaching with crisis services. I don't think we're in a position to say that at this moment. So we can't understand who we're reaching. We then don't understand, even if we do see when we reach them, we then need to understand, well, what do we do when we get to them. How long are we with those families, those children, those young people? And what are the outcomes when we have done those things?

So if we think about a learning system underpinning everything we want to do going forward, we want to understand reach, we want to understand dose, we want to understand what we do and we want to understand our outcomes. If we do that off the back of some changes to how we think about things like evaluation, and off the back of changes of how we actually think about embedding cycles of, you know, rapid feedback so we can shift, then we could actually start to respond to what we are and aren't achieving. Again, really easy to say, not easy to do.

But what we've managed to build with the BEBOLD platform is an example of what you might be able to do with that. So obviously that has to be under really strong governance. We need to think really carefully to make sure we're protecting everybody's privacy and we're doing this in the right way. But I think we've shown it can be done. And so you can start to bring data in from systems and services that we know are supporting children and families. You can start to build a picture. Actually, this is how many we're reaching. This is what we're doing when we get there. And then we can follow those populations and say these are their outcomes.

And then we're going to get some instances where we're saying we're not achieving what we thought we were. And so changing the culture of evaluations about saying is that then about turning that funding off or is that about saying why. Is it that we're working you know with the wrong model with the wrong families? Is it that we're not working with them long enough?

So it's then taking the ability to learn from what we know from that build of that learning system and change what we do, and then actually start to understand quickly. Has that changed outcomes we're seeing? Because I think that is a fundamental challenge not just in DFSV but in so many areas where we're seeing little progress, because we have no visibility over things like that. So I think that learning system is fundamental to thinking about how we can move forward.

MS ORR: Thank you, Associate Professor. Commissioner, I have no further questions.

CMR STOTT DESPOJA: Thank you, Assisting Counsel. Just two questions, if I may. You've given us some extraordinary data in relation to the trend in which we're heading when it comes to removal of children. I just wanted to get your response to Commissioner Lawrie's report which has the statistic that if we continue at the current trend, it's anticipated that the number of Aboriginal children living in out-of-home care will increase by a further 50 per cent over the next decade compared with 13.5 per cent

for non-Indigenous children. Is that your understanding?

A/PROF PILKINGTON: It is, and you know, not just in the way we did that for that report, but in reading that report. When you go through that, you really get to a point where you say our statutory system in child protection, and I think this can be said about justice as well, is getting to the point where we are touching nearly every family, every community for our Aboriginal and Torres Strait Islander communities. And we are on track for that to continue and for that to get worse. And part of that relates to the way we entrench those intergenerational cycles because of the way we judge risk. And so, absolutely, I can't tell you off the top of my head those numbers. But having looked at the report before, you know, there is no greater indicator of a need to change.

CMR STOTT DESPOJA: That's an understandably sombre note. My last question is why don't you have SAPOL and court data, and would it assist you?

A/PROF PILKINGTON: So the why part of that question. So we had got to the point with SAPOL quite some years ago where we had approval and supports from the police commissioner, from the minister, et cetera. However, it was at a time where SAPOL were moving to a new system, which created lots of barriers to that actually happening. The occurrence of this Royal Commission has put us in a position where there's motivation on all sides to actually move that forward. So we have had now multiple productive meetings with various assistant commissioners in SAPOL, and we're working towards a proposal to try and make that happen.

In terms of how that would assist us, our primary motivation for that is to actually get to that point where we can actually say how big is that DFSV population. Because then it's from that point where we can start going well how many of that population can we reach. Then you actually have the evidence to be able to say this is what we would need to appropriately resource responses, to appropriately resource prevention. So that's the need for that. Courts is a little more complicated in terms of how that sits adjacent to government.

CMR STOTT DESPOJA: Yes.

A/PROF PILKINGTON: And so it hasn't always been clear what legislative or governance framework that data sits under. Having said that, we've had really productive discussions with the youth court in particular. And there are a number of judges who are really supportive of the research program in the justice space led by Associate Professor Catia Malvaso, that are very keen to see that happen. And again, that's part of giving us a picture of actually what's happening in the service sector as families progress through different parts of the system that are relevant to thinking about DFSV. Some of it, importantly, is also about creating an ability to understand what works.

CMR STOTT DESPOJA: Yes.

A/PROF PILKINGTON: You know, so diversion through SAPOL, you know. There's opportunities to actually understand, actually, you know, that's had significant benefit in

terms of the flow on of young people into youth justice. But we actually have no idea whether that's the case. So I think it's a key part of the picture for many things, but it is absolutely a key part of the learning system.

CMR STOTT DESPOJA: Thank you for that. Thank you for your research and your submission. We feel for you when you talk about 1,000 consultations or so, speaking as a Royal Commission that has done around 100 consultations in eight months, so we understand. But it's significant research, and we thank you for your time today. Assisting Counsel.

MS ORR: I ask the witness to be released. Thank you.

CMR STOTT DESPOJA: You're free to go, Associate Professor, thank you.

A/PROF PILKINGTON: Thank you.

CMR STOTT DESPOJA: Well, that ends the public hearing for day 5 for the Domestic, Family and Sexual Violence Royal Commission. I acknowledge that we have heard some shocking statistics and stories today. I encourage people if you want support or this may be unsettling or confronting to go to the Royal Commission website for ideas for support and assistance. That's www.royalcommissiondfsv.sa.gov.au. Thank you everyone for your time today.

I think the statistics and the stories we've heard underpin the reason that we are holding this Royal Commission. I end this day where we began and that was examining the need for a child-centric and child and young people inclusive approach to some of these issues. I'll end with the words of the Associate Professor, different is possible. We'll see you tomorrow. Thank you.

MATTER ADJOURNED AT 4.46 pm UNTIL WEDNESDAY, 25 FEBRUARY 2025