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VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE

MELBOURNE

TUESDAY, 11 AUGUST 2015

(17th day of hearing)

BEFORE:

THE HONOURABLE M. NEAVE AO - Commissioner

MS P. FAULKNER AO - Deputy Commissioner

MR T. NICHOLSON - Deputy Commissioner

1 COMMISSIONER NEAVE: As I have said on a number of previous
2 occasions, the functions of the Royal Commission can be
3 performed by one or more Commissioners separately. Today
4 we are sitting two Commissioners, as Patricia Faulkner
5 cannot be present. Mr Nicholson has something to say as
6 well.

7 DEPUTY COMMISSIONER NICHOLSON: Yes. Before we commence I wish
8 to state that I am Executive Director at the Brotherhood
9 of St Laurence. This morning we have Gabriel Aleksandrs
10 giving evidence. He is a social worker and employee with
11 the Brotherhood of St Laurence. In that capacity he has
12 no direct reporting relationship with me. I don't believe
13 that my role of Executive Director at the Brotherhood is
14 in conflict with my role as Commissioner this morning.

15 COMMISSIONER NEAVE: Thank you, Ms Davidson.

16 MS DAVIDSON: Thank you. Commissioners, the definition of
17 "family violence" is broad and there is a diverse range of
18 victims. Intimate partner violence does not just occur
19 between heterosexual couples. While women are more likely
20 to be victims of intimate partner violence, there are also
21 male victims and female perpetrators. Intimate partner
22 violence can occur within gay and lesbian relationships.
23 There are also different experiences of family violence
24 within different cultural groups and additional barriers
25 to receiving help for victims.

26 Family violence is not limited to intimate
27 partner violence. It includes elder abuse as well as
28 violence by a child, including an adult child against a
29 parent. These areas of violence have been the subject of
30 much less research, but can clearly involve both male and
31 female victims and male and female perpetrators. In

1 today's hearing we will explore the different experiences
2 of family violence in these diverse groups, what services
3 are available for victims and perpetrators and the
4 barriers to accessing support and services.

5 We will be having five panel sessions today
6 exploring these issues. Firstly, for LGBTIQ communities;
7 that is, lesbian, gay, bisexual, transgender, intersex and
8 queer communities. We will then have a panel session in
9 relation to people with disabilities. We will then have a
10 session in relation to older people, including those who
11 experience what is termed elder abuse. We will have a
12 panel session after the lunch break in relation to what
13 are often called CALD communities, which means culturally
14 and linguistically diverse communities. Finally, we will
15 hear evidence in relation to men as victims of family
16 violence.

17 The first session, as I say, will be LGBTIQ
18 communities, and for convenience we will use the acronym
19 rather than the full name on each occasion, and
20 Mr Moshinsky will lead the evidence in that case.

21 COMMISSIONER NEAVE: I think you might have omitted to mention
22 the very last witness, am I right, and our very last
23 witness will be Superintendent Charles Allen from the
24 Victoria Police who will be discussing some of the police
25 responses to this.

26 MS DAVIDSON: To all of those issues, yes.

27 COMMISSIONER NEAVE: Thank you.

28 MR MOSHINSKY: The first panel comprises Dr Philomena Horsley,
29 Anna Brown and Gabriel Aleksandrs. If they could please
30 come forward to the witness stand.

31 <ANNA SHELLY BROWN, affirmed and examined:

1 <PHILOMENA ANNE HORSLEY, affirmed and examined:

2 <GABRIEL ALEKSANDRS, affirmed and examined:

3 MR MOSHINSKY: Could I start with you, Ms Brown. Could you
4 please state what your current position is and give us a
5 brief outline of your professional background?

6 MS BROWN: I am currently for this purpose the co-convenor of
7 the Victorian Gay and Lesbian Rights Lobby. That's a
8 voluntary organisation. So, my professional current role
9 is at the Human Rights Law Centre as Director of Advocacy
10 and Strategic Litigation and I previously worked as a
11 commercial litigator and also in government as a lawyer
12 and as an adviser to a minister.

13 MR MOSHINSKY: Thank you. Have you prepared, together with
14 Sean Mulcahy, a witness statement for the Royal
15 Commission?

16 MS BROWN: Yes, I have.

17 MR MOSHINSKY: Are the contents of the witness statement true
18 and correct?

19 MS BROWN: Yes, they are.

20 MR MOSHINSKY: Attached to your statement is the submission
21 made by the Victorian Gay and Lesbian Rights Lobby to the
22 Royal Commission?

23 MS BROWN: Yes, that's right .

24 MR MOSHINSKY: Thank you. Dr Horsley, can I turn to you.
25 Could you please outline for the Commission what your
26 current positions are, and I note you have a number of
27 academic posts, and also give an overview of your
28 professional background?

29 DR HORSLEY: Certainly. I am a Research Fellow and a Senior
30 Trainer at Gay and Lesbian Health Victoria and at the
31 Australian Research Centre in Sex, Health and Society

1 which is part of La Trobe University. I also hold a
2 position as an Honorary Senior Research Fellow and
3 Sessional Lecturer at the University of Melbourne, and in
4 that position I lecture on gender and violence, sexual
5 violence and gender and health.

6 MR MOSHINSKY: Thank you. You referred to Gay and Lesbian
7 Health Victoria. Could you just give us a brief summary
8 of what that organisation is?

9 DR HORSLEY: Gay and Lesbian Health Victoria was funded by the
10 State Department of Health around 13 years ago now. It
11 was funded in order to do a range of things to improve the
12 health and wellbeing of LGBTI Victorians. So we conduct
13 research, both state and national research. We run
14 training through a range of health and community sectors
15 and run a number of programs such as the Safe Schools
16 program of Victoria. So we are across a range of areas,
17 including training, research, resource development and
18 advocacy in terms of policy to government.

19 MR MOSHINSKY: Apart from the things you have already
20 mentioned, in terms of your work over the years have you
21 also dealt with issues relating to people with
22 disabilities?

23 DR HORSLEY: Yes, since the 1980s I've held a position - I'm
24 working specifically around the sexual rights and the
25 sexual assault experiences of people with intellectual
26 disabilities in Victoria when I was based at Family
27 Planning Victoria. Since then I have maintained a
28 long-term interest in that particular area. I'm currently
29 a member of the duty of care committee of Scope Victoria,
30 also the Human Rights Ethics Committee and I provide input
31 to a number of projects, including one at Women With

1 Disabilities Victoria on the issues around gender and
2 disability.

3 MR MOSHINSKY: Have you prepared a statement for the Royal
4 Commission?

5 DR HORSLEY: I have.

6 MR MOSHINSKY: Attached to that statement is a submission that
7 you provided to the Royal Commission on behalf of Gay and
8 Lesbian Health Victoria?

9 DR HORSLEY: That's right, yes.

10 MR MOSHINSKY: Are the contents of your witness statement true
11 and correct?

12 DR HORSLEY: Yes, they are.

13 MR MOSHINSKY: Thank you. Could I then turn to you,
14 Mr Aleksandrs. Could you please outline what your current
15 positions are and give us an overview of your professional
16 background?

17 MR ALEKSANDRS: Yes, certainly. Currently I work as a social
18 worker at the Brotherhood of St Laurence in aged care,
19 retirement and community programs. I work specifically
20 with people who are homeless or at risk of homelessness,
21 many of whom have experienced family violence or are
22 experiencing current family violence. Some of them also
23 experience violence from carers and various other family
24 members or families of choice.

25 I also work as a consultant in the area of
26 community services and have a keen interest in the area of
27 family violence and particularly the health and wellbeing
28 of LGBTIQ communities, and I have been a long-term
29 committee member of Transgender Victoria and I recently
30 completed my final term with them, which is a transgender
31 advocacy organisation.

1 MR MOSHINSKY: Thank you. You have prepared a statement for
2 the Royal Commission?
3 MR ALEKSANDRS: Yes, I have.
4 MR MOSHINSKY: Are the contents of your statement true and
5 correct?
6 MR ALEKSANDRS: Yes, they are.
7 MR MOSHINSKY: Attached to your statement is the submission put
8 forward to the Royal Commission jointly by No To Violence
9 and Safe Steps.
10 MR ALEKSANDRS: Yes.
11 MR MOSHINSKY: You were one of the co-authors of that
12 submission?
13 MR ALEKSANDRS: That's correct, yes.
14 MR MOSHINSKY: Can you tell us a little bit about what brought
15 about that submission coming into existence?
16 MR ALEKSANDRS: Sure. I suppose I have a perspective of a
17 person who has worked in the family violence sector as
18 well as being a member of the LGBTIQ community. When
19 I first worked in the family violence sector I noticed
20 there was a strong desire by services to treat everybody
21 equally and that there was a real sort of pride,
22 I suppose, in sort of addressing a diverse range of
23 communities in the service provisions.
24 What I experienced as part of the LGBTIQ
25 community on a personal level was very sort of different
26 to that. So I saw a lot of people who were in my
27 community who had experienced family violence or
28 relationship violence and they were hesitant to actually
29 use the services and the sort of services that I had
30 worked at and worked with. That sort of held a curiosity
31 for me over the years after I had ceased working in the

1 family violence sector and I guess I was interested to
2 know how things had flowed over the years. It seemed to
3 me that things hadn't really changed. I'd originally
4 worked in the sector in 2003 and, yes, prior to
5 approaching No To Violence with some of these issues
6 I couldn't really see that a lot had changed that was
7 being reflected back to me in the community. So I spoke
8 to Safe Steps and No To Violence about those issues and we
9 started to go from there on ideas about how to work and
10 address those issues.

11 MR MOSHINSKY: The submission has two parts to it. Could you
12 just outline what the difference is between the two parts?

13 MR ALEKSANDRS: Sure. So the first part of the paper is more
14 or less an overview of some of the recent research,
15 available research. There is not a whole lot of research,
16 really, and I will let Philomena sort of discuss a lot of
17 that. I just wanted to have a bit of an overview of some
18 of the issues that have been raised so far. So, that's
19 the part 1. Then part 2 is a consultation that we
20 undertook, Tanya Phillips and I, just going through some
21 of these issues with both LGBTIQ organisations, community
22 run organisation, and also some mainstream family violence
23 services as well.

24 MR MOSHINSKY: Thank you. I should just note, in terms of use
25 of language, in my questions to the panel I will be
26 referring to LGBTIQ people or LGBTI people, and I don't
27 want it to be assumed that the experiences of different
28 groups within that acronym are necessarily the same. So,
29 even though as a matter of convenience I may express a
30 question in that way, please feel free in the way you are
31 answering the questions to point out differences that may

1 exist between different groups.

2 The first topic I would like to ask the panel
3 about is what do we know about the prevalence of family
4 violence in relation to LGBTI people. Dr Horsley, could
5 I start with you and direct you to your submission at
6 pages 3 to 4 and ask you to explain to the Commission what
7 we know at the moment about prevalence of family violence
8 among LGBTI people?

9 DR HORSLEY: It is important to note there is very little data
10 available in Australia in terms of this issue, both in
11 terms of domestic violence specifically and family
12 violence more broadly as it affects the LGBTI populations.

13 We do know from our own national research that
14 one in three LGBTI Australians have reported being in a
15 relationship that was abusive and in our
16 Victorian-specific study that figure was essentially the
17 same. This pretty much accords with the limited
18 international research that exists and that in essence
19 seems to be saying at least this abuse or violence within
20 intimate partner relationships specifically exists at at
21 least the same level, if not a slightly higher level, than
22 the heterosexual family violence sector has indicated. So
23 we are looking at a situation where it is very similar, if
24 not worse in terms of its prevalence.

25 MR MOSHINSKY: On page 3, about two-thirds of the way down, you
26 refer to a Victorian study from 2008.

27 DR HORSLEY: Yes.

28 MR MOSHINSKY: Is that the most recent data that we really have
29 about the position in Victoria?

30 DR HORSLEY: The most recent would be our Private Lives 2
31 study, so that was published in 2014. Because these are

1 broad studies, the issue around in general LGBTI
2 population's experience of violence and then being able to
3 drill down in terms of specifically intimate partner
4 violence or family violence, it's fairly general and raw,
5 but certainly those two projects and a number of others
6 have accorded with that.

7 I might add that in terms of transgender people,
8 even though they are included in our research, the numbers
9 are not sufficient to be able to give necessarily specific
10 data on that. But certainly international data, in
11 particular a Scottish study that was done just a couple of
12 years ago, certainly indicates that it is very high levels
13 for the transgender community. Our national and state
14 research certainly indicates that, in terms of overall
15 experiences of violence, both transgender men and
16 transgender women experience higher levels of violence
17 overall in their lives than people who identify as
18 lesbian, gay or bisexual.

19 MR MOSHINSKY: Further down on page 3 you refer to homicide
20 statistics. What do we know about homicide rates in this
21 area?

22 DR HORSLEY: The Australian Institute of Criminology just last
23 year published I think the first analysis of the gender of
24 both victim and offender in terms of domestic homicides.
25 They indicate that in 2 per cent of cases these have
26 involved same sex couples, but they also indicate that
27 this would be underreporting, that in many cases the
28 gender of both offender and victim are not necessarily
29 identified. So they are suspecting that it would quite
30 possibly be higher than that.

31 MR MOSHINSKY: Ms Brown, in your submission, and I am referring

1 to the page numbers across the top of the page, at pages 6
2 to 7 you refer to some data available about statistics.
3 Do you wish to add anything to what Dr Horsley has said in
4 terms of what we know about the prevalence of family
5 violence among LGBTI communities?

6 MS BROWN: No, I think Philomena has really covered it quite
7 well and I guess the main point to make is the lack of
8 data, that we know it's the same if not worse for the
9 various communities, but those different communities have
10 very different needs and experiences and we need to better
11 understand what those are.

12 MR MOSHINSKY: One of the points that you make, and this is
13 further up on page 6, I think is that family violence in
14 LGBTI communities often manifests itself in different
15 ways. I was wondering if you might be able to speak to
16 that briefly?

17 MS BROWN: Sure. Page 6. I think I might have a different
18 page.

19 MR MOSHINSKY: In the third line where you say "Other examples
20 could include" and then there is a list of examples.

21 MS BROWN: No, I have a different page. I think I have a
22 different version, sorry, Mark. Okay. This is covered
23 also in the other submissions as well, but there's
24 obviously unique circumstances in LGBTI couples, for want
25 of a better expression, and particularly the emotional or
26 psychological abuse that is used includes threatening to
27 out a partner to family or friends. That's outing as a
28 lesbian, gay or bisexual person, outing as a trans person
29 or as an intersex person.

30 They can tell a partner that they will lose
31 custody of children as a result of being outed, using

1 homophobia, transphobia as a tool of control, so they will
2 tell their partner, "You'll be unable to access a police
3 or justice service or other support service because the
4 system is homophobic or transphobic." We can see that
5 partners tell the other partner that they deserve the
6 violence or abuse because they are LGBTI. They will tell
7 their partner they're not a real lesbian, gay or bisexual
8 person. They might threaten to disclose HIV status and
9 they might hide or withhold or stop a partner from taking
10 medication or treatment such as hormones or HIV and, in
11 the case of transgender people, as the GLHV submission
12 covers, it can also include deliberate misgendering or
13 withdrawing affirmation of that person's gender identity
14 as a man, a woman or indeed a non-binary gender.

15 MR MOSHINSKY: Can I invite the other members of the panel to
16 comment about different ways in which family violence may
17 manifest itself among LGBTI people?

18 DR HORSLEY: I think one of the key things is it is often more
19 difficult to recognise domestic violence and family
20 violence from the perspective of being the victim or
21 indeed the offender, that because the language has been
22 extensively relating only to heterosexual couples or in
23 fact families that are all heterosexual, there is an
24 invisibility and exclusion over this whole issue so people
25 don't necessarily have the vocabulary or the sense of
26 recognition around the dynamics that occur.

27 So particularly for victims it's more difficult,
28 as Anna said, to really name or recognise what's happening
29 to them. That in a sense makes it more difficult to
30 leave, both as Anna said because of increasing isolation
31 or we know that particularly older LGBTI people are much

1 more isolated than other people of their age, they are
2 less likely to have networks, and so having that
3 opportunity even to seek support around friendship
4 networks.

5 Because it's also such an invisible issue within
6 the community there's a high level of shame associated
7 with it. So in the anecdotes and the stories that we hear
8 it's very common for friends not to be aware at all of
9 same sex violence that is occurring, which can be a little
10 bit different to the heterosexual community where often
11 women's friends are aware of abuse that may be occurring,
12 and certainly in the case of men in same sex relationships
13 it would be almost impossible for friends to identify
14 because it's seen so much as a woman-specific issue.

15 I think the other issues that come out from both
16 our comments is the cumulative impact of violence,
17 prejudice and discrimination throughout the lives of
18 people who identify as LGBTI means that sometimes that
19 absolute accumulation of violence and its impact on
20 psychological health, for instance we know that LGBTI
21 people have higher rates of depression and anxiety and
22 mental illness overall, combined with the social isolation
23 means that the experience of violence just becomes part of
24 a spectrum of experience of violence and abuse or negative
25 reactions within the whole life of a person. So it
26 becomes - it's almost less distinguishable for many people
27 and certainly leads to other issues around services which
28 we will come to.

29 MR MOSHINSKY: Mr Aleksandrs, do you wish to comment on
30 different ways family violence may manifest itself among
31 LGBTI people?

1 MR ALEKSANDRS: Yes, certainly. I think the issue with trying
2 to identify those things is trying to access more
3 disaggregated data where we are going to individual
4 communities and speaking with them. I think also the
5 issues that both Philomena and Anna have touched on in
6 terms of the research and the difficulties of gaining
7 figures.

8 One thing that you could add there, apart from
9 the overlap between hate crimes and family violence, is
10 you are collecting data on very marginalised communities
11 and you really need to, I suppose, consult with the
12 communities as well first before you even go about
13 collecting the data to see what the most appropriate ways
14 are and most respectful ways are of collecting the
15 information to start off with.

16 One example that was raised with me was through
17 an intersex organisation most recently who were raising
18 the issue of medical interventions on people's bodies and
19 normalising of intersex bodies, so to speak, by the
20 medical profession, which wasn't a consensual arrangement
21 with intersex people. Some intersex people have
22 experienced medical intervention like that as a form of
23 family violence, that there has been sort of a coercion of
24 family and doctors to normalise them.

25 Certainly if you are talking about family
26 violence and people accessing a family violence service
27 where they are already quite traumatised, then it's very
28 important to consider those sorts of things in the way
29 that you would be working with somebody.

30 MR MOSHINSKY: Can I take up a point that I think each of you
31 makes in your submissions, which is a particular situation

1 which is violence perpetrated by other family members.

2 I wonder if, perhaps starting with you, Dr Horsley, you
3 might be able to speak to that issue?

4 DR HORSLEY: I think it's a really important issue and it's
5 often hidden behind the focus on intimate partner
6 violence. Certainly in our broad national and state
7 research, as well as our specific research that's involved
8 young people aged 14 to 21 in Australia over a period of
9 18 years, it's fairly clear that young people face a
10 significant degree of homophobia within the family. That
11 can include from parents and certainly around one in five
12 young people indicated that that had occurred, and that
13 includes significant physical assaults like broken jaws,
14 being locked in rooms by parents and being told to kill
15 themselves "or else we'll kill you instead". So, it's not
16 surprising then that within that family violence context
17 young people we know who identify as not heterosexual are
18 overrepresented among the homeless population of young
19 people aged 12 to 20 in Victoria.

20 At the other end of the spectrum, of course, we
21 have older people who, as we know and we will hear, elder
22 abuse is a significant issue in the community generally,
23 but older people who identify as LGBT or I have had five
24 or six decades of a lifelong experience of exclusion,
25 violence, non-recognition of relationships and so on, and
26 very often are disconnected or alienated from biological
27 family members. Therefore, when it comes to a situation
28 where they are older, they are more frail and they are
29 more dependent, those opportunities for family members to
30 exploit financially, to abuse physically and generally
31 make life very difficult come to the fore because there is

1 often a residual anger among family members, whether they
2 are adult children or whether they are siblings.

3 As we have all said, those issues play out quite
4 differently whether it's young people or old people, and
5 certainly people with other diversities as well.

6 MR MOSHINSKY: Ms Brown, would you like to comment on that
7 point of other family members perpetuating violence?

8 MS BROWN: I guess I really just want to affirm everything that
9 Philomena has said about the difficulties faced by young
10 people in the home, whether that's as a young lesbian,
11 gay, bisexual person or a gender questioning person and
12 the links between those issues and the rates of
13 homelessness amongst LGBTI youth, with the limited data
14 available they still establish. So it has flow-on
15 consequences for other parts of the system as well. So
16 I think we really do need to desperately understand and
17 better address those issues for LGBTI youth specifically.

18 MR ALEKSANDRS: Could I also add too that the non-biological
19 family as well, that due to so many people being estranged
20 from their biological family they will often seek support
21 from friends or kinships and non-biological families, so
22 to speak, and the violence can also happen in those
23 situations or in the relationship. So, if they
24 experience, if the LGBTIQ person is experiencing violence
25 in their intimate relationship or relationships, then they
26 may have limited resources to turn to within their own
27 biological family to seek support. So that, sort of
28 coupled with the whole lack of access to so many family
29 violence services, really does make people incredibly
30 vulnerable in that sense.

31 MR MOSHINSKY: Dr Horsley, did you want to add anything?

1 DR HORSLEY: I just wanted to add the particular issues around
2 diversity within diversity. We know from broad research
3 done by La Trobe University, the Australian study of human
4 relationships, that communities that are more recently
5 arrived from other countries, communities in rural
6 settings, are much more conservative and negative in their
7 attitude to homosexuality. So therefore we hear, and
8 again very under-researched, that there are specific
9 issues around physical safety as well as emotional abuse
10 for LGBTI people who come from CALD communities and
11 certainly from those in rural settings where the negative
12 attitudes can be hostile to the point of actually being
13 life-threatening in some very conservative religious or
14 cultural settings.

15 MS BROWN: Then that obviously compounds the difficulties in
16 actually accessing services. They have this extra
17 vulnerability and then also an additional barrier to
18 accessing services as well, so it is particularly acute.

19 MR MOSHINSKY: Can I now ask you to address the sort of model
20 or definition of "family violence" and the way that is
21 often approached. Dr Horsley, in your submission at pages
22 6 to 7, down the bottom of page 6 you refer to, after the
23 heading, "The predominant often exclusive explanatory
24 models of family violence". Could you expand on that for
25 the Commission, this issue of how we define or what model
26 we use for family violence?

27 DR HORSLEY: I think the predominant approach to family
28 violence and domestic violence particularly in Australia,
29 from a Commonwealth policy level right through to state
30 institutions, is very much of a gender based one using the
31 Duluth model, which is essentially looking at issues

1 around the inequality between men and women. We know
2 internationally that is a very, very important and key and
3 the main factor in terms of what promotes or what allows
4 violence against women.

5 The problem with that model is that it is pretty
6 much focused only on a notion of gender being
7 relationships between men and women or standard gender
8 relationships within family settings, and it doesn't allow
9 for the greater complexity of what is at play in terms of
10 family violence generally and domestic violence
11 specifically.

12 So we know that issues around homophobia and
13 transphobia are also really strong factors. We know
14 issues around socio and economic status, that issues
15 around mental health, drug and alcohol use are all part of
16 the interplay. But I think for the purposes of these kind
17 of community discussions and policy the focus very much
18 tends to be on gender inequality and the effect of that is
19 that it renders invisible same sex relationships. It
20 suggests that of course there can't be violence in a same
21 sex relationship because two women or two men are equal
22 and that leaves people with nowhere to go, as I mentioned
23 earlier, in terms of understanding family violence or
24 domestic violence. It leaves people who are trans or
25 intersex nowhere to go in terms of fitting into that model
26 that's both a service delivery model, but it is also a
27 policy framework at both a state and a Commonwealth level.

28 So, I guess what we are suggesting is that both
29 from the broader framework of policy, but also drilling
30 right down to community understandings of what constitutes
31 family violence and domestic violence, we really need to

1 actually look in more detail at the intersections of
2 things that are at play there. For instance, disability.
3 We know that people who are LGBTI have the same proportion
4 of people living with disability. We know that people
5 with disability generally, particularly women, are much
6 more at risk of domestic violence and family violence
7 broadly. So, when you add in an issue around sexuality or
8 gender identity, you are actually potentially really
9 magnifying the risk for those communities, and
10 particularly then also we have issues around disadvantage,
11 low education, all those kinds of things that we know have
12 an impact.

13 So I guess what we are saying is it's a useful
14 model to start with, but when we are approaching policy,
15 when we are approaching service delivery and when we are
16 approaching community education programs we need to open
17 up those definitions and allow the diversity and the
18 diversity within diversity to be acknowledged and made
19 visible.

20 MR MOSHINSKY: Are you advocating that we need to broaden the
21 model? Are you also advocating that we need to change
22 definitions in the Act or is the focus more on the model
23 and the way we address matters such as policy, service
24 delivery and community education?

25 DR HORSLEY: I think it needs to happen across the board.

26 I think one of the key things that leads us to better
27 understand violence is recognising inequality and
28 dependence as key factors which make people vulnerable,
29 but also allow people to render violence against others
30 with some impunity. So that issue around inequality of
31 course can be gender based, but it also is based on other

1 socioeconomic and demographic factors such as disability,
2 class, ethnicity and so on.

3 So I think it's important to keep the focus on
4 women to a significant degree because we know women are
5 the people who predominantly suffer, and of course
6 children who witness violence if they are present, but we
7 also need to allow for the fact that the violence and the
8 perpetration of it and the experience of it is filtered
9 through a range of prisms. Gender of course is one, but
10 there are other factors that create inequality or
11 vulnerability to violence.

12 MR MOSHINSKY: Ms Brown, could I invite you to comment on the
13 breadth of the issue of family violence and also whether
14 the current definition in the Act is broad enough?

15 MS BROWN: We had a look at the current definition in our
16 submission, and this is in the Act, sorry, and the
17 definition appears to be expansive and non-exhaustive and
18 in fact gender neutral, so we are quite happy with it from
19 that respect because it appears to be inclusive of LGBTI
20 relationships and families.

21 But I'd agree with everything that Philomena says
22 about the need to broaden the way we look at this issue
23 and, without losing that focus on the gendered nature of
24 much of intimate partner violence and the experiences of
25 women, we still need to be inclusive of the diversity
26 that's existing within our society. So that's incredibly
27 important. I think given the legislation appears to be
28 okay, the policy framework and the way that we deliver
29 programs is utterly critical.

30 MR MOSHINSKY: Mr Aleksandrs, this is also a point you make in
31 your submission. Do you wish to add any comments?

1 MR ALEKSANDRS: Yes, I think it's reflective down to the
2 service provision level, that the definition of "family
3 violence" is very much around a heterosexual experience of
4 that violence. There's always been - through the hard
5 work of many family violence agencies there's been a very
6 clear establishment of a good, solid gender analysis of
7 violence and I would agree that, yes, a large proportion,
8 the highest proportion of people experiencing family
9 violence are women.

10 I think, though, as Philomena has pointed out, a
11 large part of feminist analysis also looks at inequality
12 as an issue and, given that the LGBTIQ communities are so
13 marginalised, that that fits within that analysis and
14 I think there's room for that. I think the gendered
15 spaces that the heterosexual view of family violence has
16 sort of created for refuge and for support I think has
17 made it very difficult for the LGBTIQ communities.

18 MR MOSHINSKY: Can I turn then to the topic of barriers to
19 people seeking access and support, access to services but
20 also support and assistance. Just starting sort of at a
21 broad level, what are some of the barriers that exist?
22 Perhaps if I could start with you, Dr Horsley. At page 6
23 of your submission you raise some of these issues. Would
24 you be able to speak to that issue?

25 DR HORSLEY: Certainly. I think at an individual level the
26 very basic barriers are people experiencing violence
27 thinking, "What is happening to me? Where can I go? Who
28 can I trust?" And that kind of opens up a whole range of
29 issues. We know, for instance, that concealment of
30 people's sexuality and gender identity is habitual in the
31 LGBTI community. At least 50 per cent, so half of people

1 really generally or occasionally conceal their identity
2 when accessing services. That becomes a habitual thing
3 because of the fear of negative responses.

4 That is underpinned in many ways by fundamental
5 distrust of services and what reception people might
6 receive, whether a service will be appropriate, whether a
7 service will be educated enough about the specific needs
8 of LGBTI people, and do they appear open and welcoming,
9 and does the model even fit.

10 So, for instance, a gay man who is experiencing
11 significant physical abuse in a relationship, he may be
12 thinking, "Okay, this is getting serious. Where do I go?
13 What do I do?" But then the whole discourse around
14 domestic violence is about a system that provides refuge
15 and support for women. So, in that sense he can feel
16 absolutely stifled or unable to actually think about where
17 he could go, including whether it's safe to approach the
18 police, let alone other services that specifically signify
19 themselves as providing family violence services.

20 So, there are issues there around individuals
21 being able to identify services. Then at the other end is
22 I think the services generally in family violence, but
23 also in broader mainstream areas such as aged care
24 services, community health and so on, are moving towards a
25 recognition that there are these barriers for LGBTI people
26 to access services, but also feeling unsure or unconfident
27 about how they might do that: what do they need to do,
28 what would be appropriate or inappropriate, and even does
29 the particular service model even fit the needs of that
30 community?

31 So we have barriers at the individual level or

1 the friendship network of somebody in terms of where can
2 we go, what would be safe, appropriate and so on, and then
3 at the service level there are barriers there in terms of
4 their lack of preparedness or information or skill level
5 around dealing with these particular issues.

6 MR MOSHINSKY: Would either of the other panel wish to speak to
7 this issue of barriers?

8 MR ALEKSANDRS: Yes. Certainly resourcing has been coming up
9 throughout the Royal Commission and also definitely was an
10 issue when we spoke to family violence services and also
11 to an extent the LGBTIQ agencies during our consultations.
12 To a degree there was a hesitancy from agencies to start
13 to, I guess, promote a response to LGBTIQ intimate partner
14 violence and family violence, and this was due in part to
15 I guess a lack of faith that there will be enough
16 resources and capability within those agencies to meet the
17 needs of the increase of people attending or wanting to
18 use their services.

19 So, yes, you have that sort of push and pull
20 going on, and then the LGBTIQ community sort of don't know
21 enough about the pathways to those services as well, so
22 that came up for us.

23 COMMISSIONER NEAVE: Ms Brown?

24 MS BROWN: I agree with everything that's been said and would
25 also add that I think the stigma and discrimination that
26 LGBTI people face, an apprehension of experiencing that in
27 the service provider context, is a very real factor as
28 well, as well as I guess the general perception that these
29 organisations, as well as the risk of discrimination, just
30 simply won't understand their needs.

31 Some of the responses to the Coming Forward

1 survey cited heterosexism as a barrier and fear of hetero
2 male ridicule or having gender history revealed or just
3 embarrassment and ignorance among service providers. That
4 is not just the sector, but also police and justice
5 support agencies as well. I mean, I could go on for a
6 while.

7 We talked specifically around regional and rural
8 area issues and we do have some very limited specialist
9 LGBTI providers or mainstream providers with some LGBTI
10 understanding and competency in the metro areas, very,
11 very limited as set out in the submissions. But this
12 obviously is deeply lacking when it comes to regional and
13 rural Victoria and also in those areas that's coupled with
14 the real likelihood of higher rates of discrimination,
15 homophobia and transphobia and more likely that LGBTI
16 people will be in the closet and fearful of seeking help.
17 So those experiences are very much compounded in those
18 geographical areas. Obviously we can look at on-line or
19 more remote delivery of services from those metro areas,
20 but this is still quite difficult.

21 We also raise in our submission particular issues
22 around faith based or religious service providers, and
23 that is that the law in Victoria has exemptions for those
24 providers when it comes to discrimination and, whether or
25 not those providers do discriminate, the LGBTI people
26 still fear the risk of discrimination and that is a very
27 real barrier, in addition to all those other barriers we
28 mentioned, in their ability or their willingness to access
29 those services.

30 So we would strongly recommend that in this forum
31 we explore possible amendments to discrimination laws and

1 limiting or removing those religious exemptions when it
2 comes to these service providers, but indeed any service
3 provider that's delivering services to vulnerable
4 communities.

5 MR MOSHINSKY: Just on that point, do we have information
6 available which indicates when faith based organisations
7 are providing services to victims of family violence,
8 whether that exemption is being utilised to deprive LGBTI
9 people of services?

10 MS BROWN: No real data. We have anecdotal stories from
11 people, particularly, for instance, transgender women,
12 that have experienced difficulties and we know from work
13 we did around federal discrimination reforms that LGBTI
14 people experience discrimination from faith based
15 providers in a whole range of settings. So I would assume
16 that family violence is also there as a potential area of
17 concern, but I don't have any concrete data on that.

18 I think a really important point to make is that
19 it's the fear of discrimination. Even if faith based
20 providers are doing the right thing, and I think more than
21 often they are, it's that fear and apprehension that will
22 stop someone from accessing those services or indeed
23 disclosing the nature of their relationship and getting
24 the help that they need.

25 MR MOSHINSKY: Mr Aleksandrs, in your submission you have
26 investigated service provision and gaps?

27 MR ALEKSANDRS: Yes.

28 MR MOSHINSKY: And in particular at page 32 of the submission,
29 where you set out the key findings down the bottom of that
30 page, you summarise the service delivery and gaps. Could
31 you outline for the Commission, based on your work, what

1 are some of the examples of gaps in the system where there
2 aren't services available for LGBTIQ people?

3 MR ALEKSANDRS: My page is slightly different to yours as well.

4 MR MOSHINSKY: It's the section 1.2 "Key findings" and the
5 second bullet point is "Service delivery and gaps".

6 MR ALEKSANDRS: Sure. One thing that really came up for us was
7 people not knowing where to send LGBTIQ people for crisis
8 housing in the incidence of family violence, particularly
9 for transwomen and also gay men and intersex people.
10 Although there are housing services and homelessness
11 services, there are very few available in a crisis model
12 that weren't sort of a kind of gendered form of
13 accommodation, which obviously would make it quite
14 difficult for an intersex person or a trans person if it
15 is about how you are perceived.

16 Then I guess the other thing, too, is that
17 although some LGBTIQ people knew that there were family
18 violence services available, they were like, "Well, it'll
19 all depend on how I'm seen on the day and what staff
20 member I'm going to deal with." I suppose it is a very
21 valid concern. There was response from the family
22 violence agencies that we spoke with saying that they
23 didn't really have a specific policy and procedure for
24 LGBTIQ people attending the service. There were some
25 procedures and policies for one agency and sort of some
26 starting to be implemented for a second, but then the
27 thing was that everybody again was sort of lumped into the
28 one acronym and there wasn't really an awareness of what
29 the differences in service delivery might be for each
30 person under that umbrella.

31 Certainly another service gap was sort of even

1 during the processes of intake where people are sort of
2 first accessing the service and there is no sort of
3 discussions around relationship diversity or gender
4 diversity or staff might not even know an intersex person
5 would possibly come into the service, that was definitely
6 putting people off.

7 We also did hear from some organisations in the
8 LGBTI community stories about people sort of seeking
9 support with police, also incidents in the courts where
10 intersex status and transgender status became the focus of
11 the issue rather than the violence itself, and that was
12 something that was quite distressing for some people,
13 feeling, "I have to come out in that sort of situation".

14 There is also no systematic referral for LGBTIQ
15 people. A lot of family violence agencies might have
16 lesbian in their overarching diversity strategy, but what
17 we found is that some of the LGBTIQ organisations that we
18 spoke with, who are very underresourced and literally run
19 by volunteers, had had LGBT people referred to them from
20 family violence services. So some of those were only
21 operating in a volunteer phone line capacity and so the
22 lesbian status or homosexuality of the client was the
23 focus rather than the family violence issue and the LGBTIQ
24 community didn't have the resources obviously to deal with
25 that. They don't have social workers there and child
26 protection workers and that sort of thing. So they were
27 like, "Well, why are we getting it?"

28 So we sort of discovered there was this full
29 circle of people just going from one to the other.
30 Obviously those people, those victims and perpetrators,
31 too, maybe, are going to give up along the way and fall

1 back out through the cracks of the system.

2 MR MOSHINSKY: Are there any organisations that provide
3 specifically services for LGBTIQ people who are victims of
4 family violence?

5 MR ALEKSANDRS: There were minimal services. There's one
6 behaviour change program. But in terms of - - -

7 MR MOSHINSKY: I will come to that in a moment, perhaps, but
8 just in terms of victims at the moment, are there any
9 specific organisations in existence?

10 MR ALEKSANDRS: There was one that existed at one stage a
11 couple of years ago and then no one really knows what's
12 happened with that particular service. I have spoken to
13 people who have worked in the said service and they have
14 actually told me that they need more help understanding
15 the issues because it's been so long since they promoted
16 their service that way.

17 That gets down to another issue that was raised
18 for us as well, which is that a lot of family violence
19 services were saying, "Well, we hire lots of lesbian
20 women, so that means our staff are going to be quite
21 cognisant of the issues and so forth." Knowing how small
22 the community can be, I would sort of reflect and be
23 concerned that at some stages staff will know victims or
24 know perpetrators as well. So, that's one side of it.

25 But also it just means that, like I experienced
26 with this particular service who was meant to be a focused
27 lesbian service, that this sort of really depends on the
28 staff there and their awareness of the issues and how
29 willing they are to sort of take it up, but there wasn't
30 anything that was kind of really consistent and built in.

31 MR MOSHINSKY: So then, just picking up the behaviour change

1 point, what, if anything, is available for those who have
2 used violence who may be from the LGBTIQ community? Are
3 there any programs available?

4 MR ALEKSANDRS: There is one that has recommenced after a bit
5 of a hiatus. There isn't really a built-in perpetrators
6 program model for LGBTIQ people. The behaviour change
7 program that I'm aware of also is just for gay men, so it
8 doesn't cover everybody under the acronym, so to speak.
9 So, it's extremely, extremely limited and it's a metro
10 program, so there again we go and reflect on what people
11 outside of the inner city might have.

12 Definitely individual counselling is an option,
13 but then we miss I suppose the sorts of contexts and
14 understanding of family violence that Philomena has
15 already raised in terms of the inequalities and sort of
16 how to respond to that kind of offending and perpetrating
17 of violence.

18 MR MOSHINSKY: Can I invite the other panel to comment on what
19 are the main gaps in terms of what supports or services
20 are currently available?

21 DR HORSLEY: I think there are really significant gaps in terms
22 of specific focus on the diversity of the needs within the
23 LGBTI population, and then there are broader gaps. So
24 I think we kind of recognise that there are family
25 violence specific services, but then there's a whole outer
26 connected range of services such as social workers at
27 hospitals, counsellors at community health centres, people
28 in the aged care sector who pick up a lot of domestic
29 violence and family violence related areas.

30 So, we have no specific services really beyond
31 temporary and ephemeral, and then within the family

1 violence specific services I think it would be very much
2 seen and is very much seen as an optional extra if there
3 is time and if there are resources, as opposed to an
4 approach where we are all Victorian citizens, we are all
5 entitled to services of equal access and of equal quality,
6 and that just seems to be not on the table for a whole
7 range of complicated reasons, I understand that.

8 Then there's the issue around the broader
9 awareness. For instance, the last 18 months I have spent
10 around Victoria running training in the aged care sector
11 around LGBTI inclusiveness, and that's a sector that
12 people would regard as fairly conservative and certainly
13 had not a lot of access to this kind of inclusive practice
14 approach. That's really been taken up and people have
15 actually gone, "Wow, I'm more aware now than I was
16 before." We have certainly done a lot of work around
17 community health centre staff, drug and alcohol staff,
18 mental health staff such as the services for young people.

19 So I think it's a process of integrating those,
20 greater awareness among the broader support services in
21 the mainstream and then also bringing that awareness and
22 integrating that awareness within family violence or
23 domestic violence specific services. But it requires
24 leadership from the government and it also requires
25 resourcing of the sector, because I think nobody who has
26 any knowledge of this area would be unaware of the fact
27 that this is an area that is significantly underresourced
28 generally in the community and we need a whole range of
29 services to meet the current needs and the developing
30 needs. But within that there has to be an integration of
31 understanding of the needs of people who are sexually

1 diverse or gender diverse.

2 It's just a basic human right to be able to
3 access services that will support you and ensure your
4 safety or in fact, if you are an offender who wants to
5 change, that will support your desire to change your
6 behaviour.

7 MR MOSHINSKY: Can I ask each of the panel to reflect on this
8 question. What direction should we be moving in? You
9 have outlined very, very significant gaps in terms of
10 supports and services. Should we be moving to a model
11 where the existing family violence sector organisations
12 broaden their reach to include services and supports for
13 LGBTI people or should we be looking at specialised
14 services and supports which are dedicated towards LGBTI
15 people? Do you have reflections on that issue?

16 DR HORSLEY: I'm sure there will be a range of views,
17 hopefully, and that would be healthy, because I think what
18 we have seen in terms of other sectors such as drug and
19 alcohol and mental health, you need some specific services
20 where possible, but the key ultimate aim is always to have
21 accessibility everywhere, in all mainstream services. You
22 need services that are welcoming, that are well informed
23 and that are absolutely inclusive with all of the
24 integrity in the way those services operate, because
25 specific services will never meet a need.

26 They may in fact play a role in being able to
27 capture data that will really add to our very limited
28 knowledge in this area, so in that sense they would be
29 very useful. For some people who will never trust
30 mainstream services, they will be essential, but there is
31 a problem then around where you roll them out, as we have

1 indicated, and how you roll them out.

2 So I think the key thing is to actually start
3 consulting with the community, start having those
4 conversations, funding more research, so that we can
5 really drill down to a better sense of what the service
6 needs are in a specific sense and how those needs could be
7 met by a combination of specific services and broader
8 general services.

9 MR MOSHINSKY: Other reflections from the panel?

10 MR ALEKSANDRS: I think that, looking at the issue of family
11 violence and then looking at the experiences of LGBTIQ
12 people, I think that the thing is no one really owns all
13 of the expertise in this particular space. The LGBTIQ
14 community to me are struggling with both understanding the
15 issues and responding to the issues. It's an early
16 discussion, I think, in the community itself, as we have
17 already raised.

18 I think the LGBTI community really needs the
19 expertise of social workers, counsellors, child protection
20 workers, courts, police. The sector has been operating
21 for a long time and there are some very skilled workers in
22 there, but obviously the sector itself and some of the
23 related services that come into contact with family
24 violence, as Philomena has just mentioned, some of those
25 service providers are really struggling with understanding
26 the specific situations of LGBTIQ people.

27 So it would be a great benefit if government
28 could support the collaboration and working together of
29 both sides, so to speak, even though we know it is diverse
30 within the acronym, but just to make it simple, from both
31 sides and just sort of start it. Also from how are you

1 going to collect the data and do the research
2 appropriately? When you are developing your policy
3 frameworks and any legislative tools, who is on your
4 reference groups and your committees and is the government
5 also supporting, I suppose, those agencies or the
6 organisations from the LGBTIQ communities who are very
7 grassroots? Are they being supported and resourced to be
8 able to do all these consultations and be part of these
9 processes because they are all very volunteer run and very
10 stretched. So there needs to be some respect there too
11 offered to the community. Then hopefully that will
12 increase the possibilities of a really healthy dialogue.

13 I think we are on the cusp of this. There are a
14 lot of things that can be done through just simply a
15 consultative process and using an integrated model. We
16 have had regional family violence networks running for a
17 long time where we've got sort of all these agencies
18 getting together and sharing ideas, and I think if the
19 LGBTIQ communities are involved in those sorts of things
20 that would be really beneficial. So, that's where I think
21 the possibilities for a more positive future in this area
22 lie.

23 MR MOSHINSKY: Ms Brown, did you wish to comment on that?

24 MS BROWN: I agree with everything that's been said, really,
25 and would just emphasise the points that have been made
26 already about the need for research and data to inform
27 this process going forward and for collaboration between
28 the LGBTI community and the expertise that's there, also
29 recognising that we lack expertise as communities and we
30 particularly lack resources and funding. Whether it's
31 Transgender Victoria or the Gay and Lesbian Rights Lobby

1 or some other body, most of the organisations in the LGBTI
2 sector are completely volunteer run and this presents real
3 struggles if we are going to grapple with these issues
4 properly and it is a challenge for government to work out
5 how to do that properly.

6 I would also like to emphasise in our submission
7 we recommended specialist organisations and services and
8 LGBTI inclusive, working towards LGBTI inclusive
9 mainstream services as well, so I completely agree with
10 what Philomena said, and I think Gay and Lesbian Health
11 Victoria has developed some really good tools and training
12 around LGBTI inclusion, including the Rainbow Tick that's
13 referenced in their submission which could be a model for
14 government and for service providers to look to. So
15 there's lots of positive progress and I think learnings
16 that we can build on, but obviously there's a need for a
17 lot of work in this space.

18 MR MOSHINSKY: I might at this point see whether the
19 Commissioners have any questions they wish to ask.

20 COMMISSIONER NEAVE: No, we don't have any questions.

21 MR MOSHINSKY: I might then take up another couple of questions
22 with the panel.

23 COMMISSIONER NEAVE: Yes.

24 MR MOSHINSKY: One of the points that's raised in some of the
25 submissions is the prevention programs directed at the
26 population at large relating to family violence. I was
27 wondering whether any of you wish to comment on that and
28 whether they should be looked at differently?

29 DR HORSLEY: I think we need a combination of approaches.

30 I think the larger community based programs, whether it's
31 Respectful Relationships programs in schools or in

1 sporting clubs or whether it's broader, television ads and
2 broader kind of education of the community, it needs to
3 kind of start framing family violence and domestic
4 violence in broader ways. I know this is a challenge in
5 terms of those kinds of programs, but nevertheless it's a
6 really key aspect of it.

7 Secondly, I think we really need targeted
8 community education of the LGBTI community. We really
9 have had very little, if anything, in terms of helping the
10 community grapple with the issues, to even find the words
11 to name it within our community, to recognise the
12 struggles and the kind of barriers around naming it, and
13 then recognising that we lack even basic information
14 around referrals. If we're a friend of someone and we're
15 worried about them or they're fleeing an abusive
16 relationship, how can we as friends or workmates of LGBTI
17 people actually assist in that process.

18 So, I think it's a combination of things. It is
19 to actually open up the conversation more broadly in the
20 general community, but also to target our community so
21 that we have an opportunity to learn more, to actually see
22 that it really relates to us, to the lives of our friends,
23 our workmates, our partners, our children, and bring to
24 life a conversation. It will be a difficult conversation
25 because I think it's surrounded by secrecy and shame, but
26 it has to happen and it has to happen soon, and through
27 that process we really are starting to then spread that
28 information and knowledge in terms of the services sector,
29 whether it's maternal and child health services, hospitals
30 or family or domestic violence specific services.

31 MR MOSHINSKY: Do either of the other panel wish to add

1 anything on that point?

2 MR ALEKSANDRS: Certainly I agree with everything Philomena has
3 raised there, and most definitely not just approaching the
4 mainstream awareness programs and also creating, like,
5 campaigns aimed at the community, but definitely a
6 structured program perhaps with educative workshops for
7 people that are running the LGBTIQ organisations and
8 community groups. There's a lot of also support groups
9 out there where family violence has come up and I have
10 been made aware of a few instances where support groups in
11 the LGBTIQ community have been floundering around how to
12 respond to an intervention order when it came up amongst
13 one of their members, and also sort of the difficulties
14 that people have as well in terms of discussing the issue.

15 As a social worker I have been quite alarmed
16 sometimes when I have seen the responses, for instance, on
17 the internet around alleged offences and I suppose I have
18 been alarmed around that because I have been concerned for
19 the victims, the impact that it might have on a victim's
20 legal recourse because people have been naming and shaming
21 on the internet and also maybe compromising victims'
22 safety.

23 So I think there needs to be an awareness within
24 LGBTIQ organisations about what they can do, what
25 intervention orders mean, how people are meant to be
26 responding to them, how to take them out, that sort of
27 thing. I think that's a really fundamental thing that
28 could be learned for those people because they are still
29 getting it - because there's going to be this gap between
30 when the services do step up their culturally appropriate
31 service delivery to these communities, there will be some

1 time passing before that's fully implemented and rolling.
2 So the community in the meantime kind of has to juggle a
3 lot too. So I think it would be good to train both.

4 DR HORSLEY: Could I just add to that because we haven't really
5 mentioned very specifically the justice system, but I do
6 want to acknowledge the leadership of Ken Lay in terms of
7 bringing this issue to the fore in VicPol and the fact
8 that we are on a couple of committees with VicPol, the
9 LGBTI Portfolio Reference Group and the External Education
10 Advisory Group which is providing education for both
11 current and new police. I think that's been a really key
12 and supportive initiative on the part of VicPol.

13 I think it still leaves the issue around
14 prosecutors and magistrates and the need for education
15 there. We certainly hear of stories where people have had
16 very negative experiences with lawyers who have not taken
17 their experience of violence seriously, and certainly in
18 the court system it's been seen as a trivial issue.
19 I think that those areas, they are moving quite
20 considerably with VicPol, but I think the broader justice
21 system also needs some education and training around these
22 issues.

23 MS BROWN: I agree with all that's been said, and would also
24 add on the social marketing and awareness campaign front
25 that obviously there's been invisibility of LGBTI people
26 in those campaigns and it's not to say that we necessarily
27 lose the gender focus, as we discussed earlier, but just
28 having some visibility would be useful and send the
29 message to LGBTI people that this is an issue that speaks
30 to them.

31 Then, in addition obviously we need to do work

1 within the LGBTI community and there should be targeted
2 programs and initiatives for the community, not only
3 around family violence and domestic violence, but we made
4 the point in our submission that campaigns targeting
5 homophobia more broadly would actually assist the LGBTI
6 community in dealing with violence and hopefully reduce
7 the prevalence of violence more broadly.

8 The school programs, Respectful Relationships as
9 Philomena mentioned, I think provide a useful model to
10 expand perhaps for an adult context for LGBTI communities,
11 and other anti-violence campaigns could also be tailored
12 to our communities. So really again it is that
13 combination of strategies that I think would be most
14 successful.

15 MR ALEKSANDRS: Certainly somebody's opinion of LGBTI community
16 members impacts, I suppose, how they feel about violence
17 against members of that community. So when we have looked
18 at campaigns around violence against women and people sort
19 of evaluating the view of women in society, increasing the
20 respect of women obviously is going to increase people's
21 alarm at violence perpetrated against them and I think the
22 same goes with LGBTIQ communities and a lessening in all
23 the phobias associated with that acronym, that that would
24 play a really big role in making people aware of violence
25 perpetrated against them.

26 MR MOSHINSKY: Thank you. Do the Commissioners have any
27 questions?

28 COMMISSIONER NEAVE: I just had one question. Are there any
29 programs in schools that you consider effective that are
30 dealing with the whole question of equality and people
31 from an LGBTIQ background, the whole issue of sexuality

1 and sexual orientation and so on in schools?

2 DR HORSLEY: Our research over 18 years of young people and
3 schools, the non-heterosexual group and the group who
4 don't identify strongly as a binary gender have pretty
5 much all said that the sex education or the human
6 relationships education was next to useless, was
7 uninformative and really they didn't relate to it.

8 We do have within our centre input into a broader
9 national curriculum and I think there are different
10 aspects now that are relevant in terms of the ways that
11 this kind of inclusion could occur in schools' curriculums
12 or currently. But there is not an overarching sense of it
13 being a priority or a specific need, whether in the more
14 traditional notion of sexuality or human relations
15 education or in more broader areas around human rights
16 education.

17 MS BROWN: Yes, I agree, and I'm not an expert in education by
18 any means, but I would say that the Victorian Government
19 has through the Gay and Lesbian Health Victoria
20 established a very good program called Safe Schools
21 Coalition which is about developing safe environments for
22 LGBTI young people within schools and that program has
23 been funded to roll out to all government schools in
24 Victoria. It used to be just be voluntary, but now it is
25 going to be mandatory. Obviously there is still a gap in
26 the independent school system and there are also schools
27 where we might see attitudes promoted that are not
28 positive towards sexual and gender diversity.

29 COMMISSIONER NEAVE: So this is a program that is directed at,
30 for example, homophobia?

31 DR HORSLEY: It takes a whole of school approach around keeping

1 young people at school safe. So, it actually requires the
2 school as a whole community to take action to keep
3 students who identify as LGBTI or same sex attracted or
4 gender queer safe. We know from our statistics that it
5 has been so successful in Victoria that the levels of
6 violence and bullying that young people experience in
7 schools is lower in Victoria than in other states. As a
8 result of that, the Commonwealth Government just this year
9 has funded a national rollout of that program which is
10 overseen by FYA.

11 So, that's a really important thing. It doesn't
12 necessarily address some of the specific issues we are
13 talking about, but I think it does what Anna says, which
14 is essentially saying, "These children have a right to
15 feel safe at school. They have a right to respect and to
16 equality within the school environment." It's clearly an
17 evidence based program that has been shown to reduce the
18 levels of physical violence and verbal bullying that's
19 occurring in the lives of these young people, 80 per cent
20 of which has been occurring at schools from both students
21 and from staff.

22 COMMISSIONER NEAVE: Could you just tell me the name of that
23 program?

24 DR HORSLEY: It's called the Safe Schools Coalition of
25 Victoria.

26 COMMISSIONER NEAVE: That's the one that's being rolled out?

27 DR HORSLEY: That's being rolled out nationally. We have four
28 staff at Gay and Lesbian Health Victoria who are involved
29 in that program and they are doing a lot of intensive
30 support for schools generally, but also for families of
31 young trans children who are transitioning, and we are now

1 moving into and about to release in fact a manual around
2 how to incorporate these issues into curriculums in
3 schools. So that's a really welcome initiative. So we
4 are looking forward to that launch, which is just about to
5 be signed off by the Commonwealth.

6 COMMISSIONER NEAVE: Thank you very much.

7 MS BROWN: I might add also that Philomena is probably being
8 modest, but the Victorian model has been recognised as a
9 huge success and that's why it is being rolled out
10 nationally. There has actually been some mobilisation
11 within some fundamentalist Christian organisations against
12 the program, which I think is indicative in some ways of
13 its success, but obviously the campaigns and the work
14 that's being done in Victoria I think is really first
15 class.

16 COMMISSIONER NEAVE: Thank you.

17 MR MOSHINSKY: Commissioners, if the witnesses could please be
18 excused and could we now have a break for about 10 minutes
19 to about 11.05.

20 COMMISSIONER NEAVE: Thank you very much indeed. You are
21 excused.

22 <(THE WITNESSES WITHDREW)

23 (Short adjournment.)

24 MS DAVIDSON: Commissioners, the next panel is one in which we
25 will be exploring the issues that are particular for
26 people with disabilities. This of course is not the first
27 time in this hearing that we have been canvassing the
28 issues of the effects of disability on the ability to
29 access services and the experiences of people with
30 disabilities with respect to family violence.

31 I particularly draw the Commission's attention to

1 the evidence that we had from "Melissa Brown", who was a
2 victim of family violence. We heard her evidence on day 8
3 of the hearings and that was in circumstances where she
4 was a woman with a physical disability and she talked
5 about the impact that that had and her dependence upon her
6 husband as her carer and how that impacted upon her
7 experience of family violence and her ability to access
8 services.

9 I will ask that the witnesses be sworn, but we
10 have representatives from two agencies today; firstly,
11 Colleen Pearce from the Office of Public Advocate and is
12 in fact the Public Advocate. We also have two
13 representatives from the Women with Disabilities Victoria
14 agency who have also made a submission to the Commission.

15 I ask that they be sworn.

16 <COLLEEN GEORGETTE PEARCE, sworn and examined:

17 <KERAN ELIZABETH HOWE, affirmed and examined:

18 <JEN HARGRAVE, affirmed and examined:

19 MS DAVIDSON: Thank you. Can I perhaps start with you,
20 Ms Pearce. You are the Victorian Public Advocate?

21 MS PEARCE: Yes.

22 MS DAVIDSON: You have held that role since 2007?

23 MS PEARCE: Yes.

24 MS DAVIDSON: Can I just get you to outline the role of the
25 Public Advocate and the role of the office?

26 MS PEARCE: As Public Advocate I'm appointed by VCAT as
27 guardian of last resort for adults in Victoria with a
28 disability, a cognitive impairment, for people who are in
29 need of a decision being made in relation to their
30 personal circumstances, so such as accommodation,
31 healthcare or with whom they might have access to, people

1 they might have access to.

2 Other parts of my office concern the volunteer
3 program. We have around 900 volunteers who work in a
4 number of programs. We have the community visitor
5 program. Community visitors are volunteers who are the
6 eyes and ears of the community who visit closed
7 environments, so mental health facilities, residential
8 services for people with a disability, group homes, but
9 also supported residential services.

10 We have a volunteer program, the independent
11 third person program. Last year volunteers sat in on
12 2,700 police interviews for people who had an apparent
13 cognitive impairment. This was victims, witnesses, as
14 well as alleged offenders.

15 We have a community guardianship program and we
16 have a policy and research team. I should also say that
17 as part of the Guardianship and Administration Act my
18 staff also undertake investigations on behalf of VCAT
19 where a person may be subject to abuse, neglect or
20 violence or considered to be in need of guardianship.

21 MS DAVIDSON: Just in relation to cognitive impairment, what
22 sort of situations does that cover? I take it you are
23 talking about people with an intellectual disability, but
24 do you also cover older people who have diminished
25 ability?

26 MS PEARCE: Yes. In fact the majority of people under
27 guardianship in this state are people over the age of 65,
28 so around 60 per cent of people under guardianship are
29 over the page of 65, with the majority of those having
30 some form of dementia. But we also cover people with
31 mental illness, an acquired brain injury or an

1 intellectual disability. So there is a whole range of
2 cognitive impairments.

3 MS DAVIDSON: Thank you. You have made a statement for the
4 Commission in this matter?

5 MS PEARCE: Yes.

6 MS DAVIDSON: Are you able to confirm that that statement is
7 true and correct?

8 MS PEARCE: I am.

9 MS DAVIDSON: Can I move to you, Ms Howe. Can you just outline
10 the work that Women with Disabilities Victoria does?

11 MS HOWE: Yes. Women with Disabilities Victoria is a systemic
12 advocacy organisation and we are responsible for providing
13 advocacy on behalf of women with disabilities around
14 Victoria; that is, women from all walks of life and with
15 all types of disabilities and experiences. So that covers
16 women with physical, intellectual, other cognitive
17 disabilities, women with mental health.

18 MS DAVIDSON: You are the Executive Director?

19 MS HOWE: I'm the Executive Director.

20 MS DAVIDSON: You have held that position since 2007?

21 MS HOWE: That's correct.

22 MS DAVIDSON: You have made a statement together with
23 Ms Hargrave, who is beside you. Are you able to confirm
24 that that statement is true and correct?

25 MS HOWE: I can.

26 MS DAVIDSON: Can I move now to you, Ms Hargrave. You have
27 made a statement together with Ms Howe, and can you
28 confirm that that statement is true and correct?

29 MS HARGRAVE: I can.

30 MS DAVIDSON: Can you just outline what your role is with Women
31 with Disabilities Victoria?

1 MS HARGRAVE: My role is policy officer on violence against
2 women with disabilities. This role, like the work of
3 Women with Disabilities Victoria, is focused on systemic
4 advocacy, working to build up connections between the
5 family violence systems and the disability systems.

6 MS DAVIDSON: Perhaps we can just start with the topic of the
7 experience of violence for people with a disability.
8 I think, Ms Howe, you refer to women with a disability
9 experiencing a double disadvantage?

10 MS HOWE: That's correct.

11 MS DAVIDSON: Can you explain that?

12 MS HOWE: Yes. Part of our work as an advocacy service is
13 undertaking research and we have undertaken two
14 significant pieces of research around the issues for women
15 with disabilities who experience violence in Victoria.
16 What we find from our research and also from listening to
17 women with disabilities as our members is that women
18 experience the same kinds of violence that other women
19 experience. They experience violence from intimate
20 partners, but also from other family members. In addition
21 to that, we find women with disabilities experience
22 violence from a broader range of perpetrators of violence
23 than other women. So that can also take in paid carers
24 and service workers such as transport workers and can be
25 targeted in the general community.

26 In the same way that other women experience
27 violence from predominantly men as perpetrators, that's
28 also the case for women with disabilities. We also find
29 that women with disabilities experience disability based
30 violence. An example of that would be where a perpetrator
31 of violence wants to control a woman by removing her, for

1 example, wheelchair or another mobility aid or it might be
2 a communication aid, and also we have heard from women
3 about having their medications increased or decreased and
4 being socially isolated because they are more easily
5 controlled because of their disabilities.

6 So that violence that women experience, we find
7 women are at higher risk of violence because of their
8 disabilities because as women we experience the same
9 discrimination that all women experience on the basis of
10 gender, but we also experience high levels of
11 discrimination as people with disabilities. Research
12 that's undertaken here in Australia finds that young
13 people with disabilities are five times more likely to
14 experience disadvantage and discrimination than other
15 young people.

16 So, for women with disabilities we experience
17 poorer socioeconomic status, poorer economic and social
18 participation than both men with disabilities and other
19 women. So that gives us what we might call a double
20 disadvantage. If you are an Aboriginal woman, that's
21 again compounded and this disadvantage compounds itself
22 and significantly increases the risk that women with
23 disabilities, and particularly women from other
24 disadvantaged groups, experience.

25 MS DAVIDSON: I think you have also identified - I appreciate
26 that your service is for women with disabilities, but you
27 have identified that the area of men with disabilities
28 experiencing family violence is poorly researched.

29 MS HOWE: Yes, we think that the area of particularly
30 institutional violence against people with disabilities in
31 general is very poorly researched and we need to

1 understand more about the dynamics of gender within
2 disability services. Disability services have
3 traditionally not been particularly cognisant of the
4 issues for both men and women and the different needs that
5 men and women might have, but we do know that both men and
6 women experience violence because of their disability.

7 MS DAVIDSON: Ms Pearce, are you able to comment on that issue
8 as well, the general topic of the experience of violence
9 for people with a disability and how having a disability
10 might impact upon that experience?

11 MS PEARCE: Sure. OPA has done quite a lot of research just
12 into our own cases and of course there's our research with
13 Women with Disabilities Victoria, our Voices Against
14 Violence. We have been trying to establish, I guess, some
15 baselines around what might be the extent of violence in
16 the community against people with disability.

17 In 2010 we looked at 86 cases of violence and
18 abuse. We found that 66 per cent of those were women and
19 20 per cent of those were men and they had been subjected
20 to a range of violent and abusive acts, including physical
21 and sexual violence, emotional and psychological abuse,
22 including segregation and restraint and, as Keran said,
23 impairment related abuse, financial abuse and neglect.
24 The research found that the perpetrators included parents
25 or a parent's partner, a sibling, another relative, a
26 partner, a neighbour, a staff member, a co-resident or a
27 stranger.

28 So you can see there's a wide variety of
29 perpetrators for people with a disability. One of the
30 differences, of course, is the dependency on carers, so
31 both paid carers and unpaid carers, so we certainly see

1 many cases of that as well. In the 64 cases where the
2 perpetrator was characterised as a relative or a partner,
3 the actions could be categorised as family violence under
4 the Family Violence Protection Act.

5 MS DAVIDSON: Thank you. Just picking up on that issue of
6 where the perpetrator is a carer, we heard from the
7 witness "Melissa Brown" on day 4 who talked about the
8 impact that having a disability had and her reliance upon
9 her husband as her carer - I'm reminded it's actually
10 day 8 - how that impacted upon her ability or her reliance
11 upon him, the changes in the power dynamic and how she
12 felt unable to leave the relationship. Is that a sort of
13 fairly consistent issue for women who experience family
14 violence, and for men?

15 MS PEARCE: It is, and just when you were talking it reminded
16 me of a particular case where we were the guardian for a
17 woman. She had had a stroke. She was in hospital. She
18 told the guardian that she wanted to go into care because
19 her husband hit her. Now, she was in that relationship
20 for 40 years. It was a very difficult decision for her,
21 but her choices were very limited and she expressed the
22 desire to go into care rather than return home. But she
23 said, "Please don't tell him that I've told you that he
24 hits me."

25 The power dynamic continued when she was in fact
26 placed in care and he was continually at her bedside and
27 interfering with the care that was being provided to her,
28 and particularly around feeding time, insisting on - he
29 controlled even her feeding. So, this control that we see
30 is really a very common pattern.

31 MS DAVIDSON: Did you want to also add to that, Ms Howe and

1 Ms Hargrave?

2 MS HOWE: It certainly was affirmed in our research and many
3 women spoke about feeling trapped. They are trapped
4 because they have that dependence that Melissa experienced
5 for personal care and a belief that in fact there is no
6 other assistance that might be available, which is untrue.
7 They are also reliant on their partners for care of their
8 children sometimes and believe that there is no other
9 assistance available in that situation also.

10 So we need to be able to promote more effectively
11 the sorts of services that we do have. I might ask Jen to
12 talk a bit more about some of those services. But I think
13 that perpetrators of violence are aware of this power
14 dynamic and are aware of this dependency and are also
15 aware that they are more likely to be believed and that
16 their word carries more authority than the authority of
17 their partner. So, they play on this and women told us
18 about how partners threatened them that they would put
19 them into an institution if they tried to leave.

20 MS HARGRAVE: That's right. In Melissa's case she spoke about
21 different professionals from services such as police and
22 mental health asking her if she wanted to leave. In her
23 mind that wasn't an option because she couldn't imagine
24 who else might be able to assist her and her children. So
25 I think it points to a need for workers to be resourced
26 around having skills around asking questions; for example,
27 "What would you need in order to be safe?" or "I see that
28 you have a disability. What sort of things might assist
29 you?"

30 Although workers can feel very uncomfortable
31 about asking these questions, there is more danger in not

1 asking them. In fact, if women know why the question is
2 being asked and what's going to happen to the information,
3 the majority of the time they are really comfortable to be
4 asked.

5 The Disability Family Violence Crisis Response
6 Initiative is something that the Department of Health and
7 Human Services developed to replace this type of care that
8 partners may be giving for the family violence crisis
9 period to allow women and children a period of time to
10 leave the violence or for the perpetrator to be excluded
11 and for other alternative care arrangements to be made for
12 the longer term.

13 But it is important to note that there are three
14 important questions about the initiative. One is to look
15 at the eligibility criteria for the initiative, which at
16 the moment is in accordance with the Victoria Disability
17 Act, which actually excludes mental illness, injury,
18 preschool age children and people over 65. So, for
19 example, a woman that we know of who was driven over
20 during a family violence incident and was unable to walk
21 and required daily assistance with her disability was not
22 eligible because doctors weren't able to definitively say
23 that that injury was permanent.

24 Another issue which was raised through Melissa's
25 example was that while the initiative has lots to offer
26 those who are eligible, many workforces and workers still
27 don't know about the initiative. So, services such as
28 disability, child protection and police could be more
29 informed about the availability of the service.

30 Thirdly, this is the only initiative we know of
31 in Australia that provides this funding for disability

1 support, but the future for the funding is completely
2 uncertain with Victoria's transition over to the National
3 Disability Insurance Scheme and we are very concerned that
4 it might get lost in the national pool of funding and also
5 that those relationships across sectors between
6 disability, family violence and women with disabilities
7 that are integral to building the initiative and making it
8 work effectively would be lost in the national scale.

9 MS DAVIDSON: Ms Howe, you have talked about in your statement
10 the right of women with disabilities to be recognised as
11 parents and identified an issue in relation to how
12 services or the lack of them or the reliance upon family
13 members potentially reinforces or contributes to the
14 control that a perpetrator is able to exert over a woman
15 with a disability. Can you explain that issue and how you
16 see that being potentially addressed?

17 MS HOWE: Yes. This is a very real issue and again our
18 research found that women did have children removed from
19 their care. There are two aspects of this that we need to
20 think about. There is a strong belief in our community,
21 an unfounded belief, that women with disabilities are not
22 able to provide adequately for their children. In fact,
23 it's very common, when a woman reports family violence,
24 that the child can be removed from her care because the
25 belief is if the partner isn't around that she's not able
26 to provide adequate care.

27 There is nothing in the research that suggests
28 that women with disabilities are less able to provide
29 effective parenting and to be good mothers. What the
30 research tells us is that it is the appropriateness of
31 family support that's very important. So we need to be

1 able to tailor effective family support so that women with
2 disabilities are able to provide the support they need.

3 In my experience in my previous role as chief
4 social worker at the Royal Women's Hospital, I experienced
5 on a number of occasions where women had mild intellectual
6 disabilities that children were removed from the hospital
7 at the instigation of Protective Services without any
8 further follow-up, any further assessment of the woman and
9 her capacity to provide care and no intervention plan to
10 reunite the family. This was in my view based on
11 attitudes that were unfounded and without adequate
12 intervention.

13 So I think we need to look more carefully at the
14 ways we are protecting children, and of course it is
15 critical that we provide a caring environment for all
16 children, but there are ways that we can do that that mean
17 that women are not fearful that, if they come forward and
18 report family violence, that their children will be
19 removed.

20 Another way that we can I think address this is
21 with disability services who haven't traditionally seen
22 women in a caring role if they have a disability. So we
23 tend to think about people with disabilities as
24 individuals who might have families of origin that provide
25 care, but we don't tend to think about people with
26 disabilities who are providing parenting support to their
27 children.

28 So, disability services need to be open to the
29 idea that there is a role that they need to support
30 through disability service support. We have an instance
31 of one woman who told us about a disability worker that

1 was authorised to feed her and to assist with meal
2 preparation for herself, but wasn't allowed to give a
3 drink to her son who was there. There is no reason why
4 through policy that this should be the case, but in
5 practice disability services can have a very narrow view
6 of what's reasonable in providing support to parents.

7 MS DAVIDSON: What does that mean in terms of the woman's
8 capacity, a woman with a disability, her capacity to
9 contribute equally to a relationship and have that
10 equality within the intimate relationship? How do the
11 disability services deal with that?

12 MS HOWE: This is another aspect of how we view families within
13 the disability care system and we tend to see families as
14 partners, if you like, collaborators in providing care.
15 For example, if you were to apply for Meals on Wheels or
16 other family support through home and community care, the
17 first question to a woman is, "So, do you have a partner?
18 Okay, he can do that." We could argue that it's perfectly
19 reasonable for men to assist in and to contribute to
20 domestic duties, but in reality we don't recognise that
21 it's absolutely important for power balances within a
22 relationship that both are seen to be contributing and
23 have something that they can contribute in practical terms
24 to the relationship.

25 So one woman spoke to us about how she had to
26 insist with the new National Disability Insurance Scheme
27 that it was reasonable for her to have assistance in
28 preparing her husband's meal because she felt he did a
29 great deal for her in terms of personal care and in
30 reciprocating in that relationship and ensuring some kind
31 of balance in that relationship that she needed to be able

1 to provide for him too and she was successful in the end
2 in being able to advocate for her needs. But I think it's
3 very important across all disability service provision
4 that it's recognised that we have to be very aware of
5 power within relationships and to be respectful of the
6 need for women to be able to contribute equally to a
7 relationship.

8 MS DAVIDSON: Ms Pearce, do you have anything additional to add
9 to that?

10 MS PEARCE: Just in support of Keran, it's certainly our
11 experience that women with disabilities have their
12 children removed at a far greater rate than other people
13 in the community. If you look at Child Protection itself,
14 you will see that many of the families, but in particular
15 the women that are there, are women with some form of
16 disability, that they are significantly disadvantaged in
17 the justice system and that many of these people may have
18 been removed from families themselves, they may not have
19 an experience of what a family life might look like and,
20 as Keran said, they are not given any support in order to
21 equip them to be able to parent their children in an
22 effective manner.

23 So the first instance is whilst, like Keran, the
24 protection of the child is paramount, but also children
25 have a right to grow up in a family and people should be
26 supported to be able to exercise that right.

27 MS DAVIDSON: Moving on to another topic in relation to
28 attitudes towards people with disabilities, it's an issue
29 that you have all raised in your witness statements. How
30 does attitudes towards people with disabilities impact
31 upon their ability to access services and leave or get

1 away from family violence?

2 MS HOWE: With regard to disability services, we are concerned
3 that disability services do not have an adequate
4 understanding of family violence and more broadly in terms
5 of what women might need in providing an appropriate
6 quality service. So, one example I can give is a woman
7 recently brought to our attention - we will call her
8 Monica - who is in a supported accommodation service and
9 when she first went to that service checked whether in
10 fact they would provide intimate care, whether they were
11 able to provide the intimate care that she needed through
12 a female worker, and she was assured that that would be
13 the case.

14 As time has gone on, that has not transpired and
15 at the moment she is receiving care with her catheter and
16 care with showering and care with her menstrual care from
17 male workers. She is finding this extremely distressing.
18 She is going without showers. She is having all sorts of
19 health problems as a result of refusing the care of male
20 workers. There seems to be very little understanding by
21 the disability service that this is in fact quite a
22 violation of her human rights as a woman to dignity and
23 she is experiencing that as a very humiliating experience.

24 So women with disabilities who have that
25 experience of demeaning and degrading practices, they
26 often have talked about internalising this experience and
27 believing when they do experience violence that maybe it's
28 their fault and perhaps they deserve it. Women spoke
29 repeatedly in our research about that sense, and it again
30 was reinforced by partners and others, that in fact "This
31 is your fault."

1 So I think we have a real responsibility that we
2 provide empowering services to women, to all women, and
3 that the barriers to escaping violence are addressed. So
4 I think that example provides a very clear example to me
5 about the ways that we need to address this. We at Women
6 with Disabilities Victoria are working with disability
7 services to raise their understanding of women's rights to
8 gender-sensitive services and also raising awareness of
9 the existence of family violence and the critical
10 importance of disability services in identifying that and
11 making appropriate referrals.

12 MS HARGRAVE: If I may just add an example of how critical
13 family violence training can be for the disability sector.
14 I would like to point towards two recent examples that
15 I received that were actually both quite similar regarding
16 disability services, both involving women with
17 communication difficulties. So they didn't communicate
18 through speech, they communicated through gestures. Both
19 were appearing increasingly withdrawn in their disability
20 services and looking very reluctant to go home.

21 In one service the staff member was able to go to
22 her manager, who'd recently received an introduction to
23 common risk assessment training, and the manager was then
24 able to have a conversation with the woman using assisted
25 communication techniques to confirm, yes, she was feeling
26 unsafe to go home and then to call the Family Violence
27 Service who was able to send out an outreach worker who
28 worked with the communication assistant to develop a
29 safety plan and to give the woman important messages that
30 the violence she was experiencing wasn't her fault and to
31 look into options for the future.

1 In the other service the worker went to her
2 manager, who did what is common practice in disability
3 services and called the woman's mother. This in turn put
4 the woman and her mother at greater risk of the violence
5 they were experiencing and in fact resulted in a terrible
6 outcome where the woman became withdrawn from the service
7 and became more isolated and more exposed to the violence
8 she was receiving at home.

9 So resourcing for disability service workers
10 around identifying and responding to family violence is
11 critical, both in disability services that are run in
12 Victoria and nationally, and of course mental health and
13 other associated services such as aged care.

14 MS PEARCE: If I could add to that and to say in support of
15 Keran and Jen that what we are seeing in disability
16 services, particularly in residential settings, is the
17 normalisation of violence against people with
18 disabilities. So we see that the tolerance is very high
19 and what I think any reasonable person would consider
20 violence is in fact tolerated.

21 I recently received a letter from the Department
22 of Health and Human Services in relation to a
23 notification. So, when I see a situation where I am very
24 concerned about the safety and wellbeing of residents in a
25 house, I notify the department. I got a response back
26 from the department that said that they did acknowledge
27 that what they called "episodes of behaviours of concern"
28 can be a cause of distress to other residents and they
29 then went on to say, "I have no evidence to substantiate
30 the concern regarding resident compatibility."

31 Yet in the very next paragraph they talk about,

1 in a 12 month period, "28 incidents of reports were
2 submitted relating to incidents involving physical
3 assaults directed towards staff and other residents and a
4 small number of incidents involving the attempt to pull
5 down the pants of the residents." Now, who here would
6 tolerate that? And would you describe that, if that was
7 happening in your house, as "resident compatibility"?
8 It's got nothing to do with resident compatibility. It's
9 got to do with violence.

10 One of the things that the family violence sector
11 has fought for for many years is to have violence and
12 abuse named as that. What we see in disability services
13 calling it "behaviours of concern" or "resident
14 compatibility" and not naming it as violence and abuse
15 means that it remains hidden, we are not getting the
16 cultural change or the policy change that's required to in
17 fact address what's happening in these houses, it remains
18 hidden and if it's not named and it's hidden, we can't
19 address it. I think the examples that Keran and Jen gave
20 are just very much examples of that.

21 MS DAVIDSON: Ms Pearce, you talk in your witness statement
22 about group homes and you make an argument that some
23 residents would be regarded as family members under the
24 Family Violence Protection Act. Can you explain what a
25 group home is for people with disabilities and why you say
26 that in some cases the violence that might occur between
27 residents would be regarded as family violence?

28 MS PEARCE: Group homes, they are houses in the suburbs, in the
29 community, when following de-institutionalisation it was
30 thought that people would have better outcomes and be more
31 included in the community if they in fact lived in the

1 community. So they are small houses with a home-like
2 environment as opposed to an institutionalised setting
3 where people live together. They can live together for a
4 very long time. It could be years where they could live
5 together.

6 In that same letter that I read from earlier, the
7 department describes the relationships in that household
8 as saying, in talking about an individual, that they had
9 "made friends" with the other residents. They go on to
10 say that they had "engaged in playful activity with other
11 men and has an especially good relationship with one man
12 who has taken on the role of 'big brother' towards him."
13 They also later in the letter describe two of the people
14 living in the house as siblings. So, there's a range of
15 relationships. Many of them are long-term; some of them
16 are more short-term. People don't have a choice about who
17 they live with, so it is an arranged relationship. But,
18 notwithstanding that, we know that in these relationships
19 people can form long-term relationships.

20 Just by way of an example, I was speaking to a
21 palliative care doctor recently who was talking to me
22 about her experience of helping a person with a disability
23 die at home because he wanted to be with what he perceived
24 to be his family and for them to all be able to grieve
25 with him. She said it's increasingly common that people
26 might choose to die at home if that's possible.

27 We know from the department's own material that
28 each of the residents will have what's called a "person
29 centred plan" and in that person centred plan there is a
30 description about the relationships with other people in
31 the house. They are not described as family members, but

1 nor are they described as people who are just simply
2 co-habiting in the house; they are more akin to family
3 type relationships.

4 While the aim of the group home is to improve the
5 quality of life of people who live there, part of the role
6 of the staff is also to foster relationships. So that's
7 why I think that they are in fact people's homes. They
8 live there for a long time. They are not a shared
9 household such as you might see in a university household.
10 They are completely different to that.

11 Can I also add that in some houses they might buy
12 white goods together. Historically that's happened in
13 some houses where they have ISPs, so the supported
14 packages. They might share that in terms of purchasing
15 food for the house. So there's a lot more interdependence
16 than there would be in a normal shared house setting.

17 MS DAVIDSON: In your experience, to what extent do residents
18 of those homes get a family violence response from
19 services in terms of a response that's been developed
20 under the Family Violence Protection Act?

21 MS PEARCE: In my view they don't. If I could just take you
22 through, and I have been using one household and I will
23 stick with that one household because I think it
24 characterises the relationships in the household, the fact
25 that 28 incidents of violence are just considered - not
26 even accepted as resident incompatibility, let alone
27 acknowledged as violence.

28 But, six months after I got that letter, the
29 community visitors were alerted there had been violence
30 going on in that house, so continually, unabated. I just
31 wanted to share with you an incident report, to just

1 illustrate the difference in the response that a person in
2 a disability service might receive to a person with a
3 disability residing in the community. I'm just
4 paraphrasing from this incident report.

5 So, we have a resident sitting on a chair in the
6 lounge area singing to himself. The staff can't see any
7 trigger, but he's then attacked by a resident who grabs
8 his shirt and his chest. The victim was screaming. The
9 staff tried to redirect the attacker verbally, but with no
10 impact. The attacker then proceeded to grab the victim by
11 the neck and shake his head so that the head banged
12 repeatedly on the hardwood of the chair backing. The
13 victim was screaming. The perpetrator could not be
14 redirected. Staff tried to block him from being
15 continually hit and scratched and banging the victim's
16 head against the wooden backing of the chair. The
17 victim's shirt was ripped open and a wound started to
18 appear on the victim's chest.

19 The victim was taken, rushed into the office and
20 they were all locked in the office. In the meantime other
21 residents were moved out of the lounge room. Somebody in
22 the shower was attempted to be protected. In the office
23 they sighted several bleeding scratches on the front and
24 the back, the most prominent being on the upper right side
25 of the chest. An ambulance was called in case of head
26 injury. The perpetrator wouldn't let them out of the
27 front door and so the staff locked the front door and
28 escorted the victim out of the back where he was treated
29 in an ambulance outside because the paramedics couldn't
30 get inside.

31 This is categorised as a category 2 incident, not

1 even a category 1, and no police were called. So what's
2 the difference? It's not recognised - I mean, that's a
3 terribly frightening situation for everybody. The
4 ambulance is called. We know this has been going on in
5 this house unabated for nearly two years. The police
6 aren't called. It's just simply another category 2. Then
7 I think the department has the hide to say that it's about
8 resident compatibility and not about violence and abuse of
9 people with a disability.

10 MS DAVIDSON: You talk in your witness statement about personal
11 safety intervention orders compared with Family Violence
12 Protection Act orders. What is the usual mechanism - you
13 have identified that these residents may be family members
14 under the Family Violence Protection Act. How often would
15 that Act be used by police to apply for an intervention
16 order for a resident in that situation?

17 MS PEARCE: I haven't found one case where the Family Violence
18 Protection Act has been used. To a certain extent,
19 whether you get an intervention order under the Personal
20 Safety Act or the Family Violence Protection Act, the
21 thing is people have got protection. But the issue is
22 what about those people who are residing in houses - so
23 let's just take the house that I have been concentrating
24 on, in that house.

25 In the first place police aren't called. So
26 where is the access to justice there? But in the second
27 case should police be called? There is the question: is
28 this a family violence situation or is it a question of
29 the Personal Safety Act? A lot of things flow from that.

30 So, for example, who will apply for the
31 intervention order? Where there's family or a guardian

1 from my office, we will apply. So a person can gain
2 protection in that manner. But a person with questionable
3 capacity, how is one of these residents without family
4 members going to be able to apply for an intervention
5 order?

6 Secondly, when the police come, if it was
7 considered to be family violence, there is the family
8 violence code of practice and a lot of things flow because
9 of that. But if it is not considered to be family
10 violence and it's merely the Personal Safety Act, police
11 have a choice about what they are going to do. They are
12 coming into a situation which is extremely volatile. They
13 may not be able to communicate with the residents. In
14 another case where police did come capsicum spray was used
15 against residents and one of the residents was charged.

16 But I'm very sympathetic to the police coming
17 into that environment. It's very difficult. They are
18 often relying on workers to intervene and to tell them
19 what has occurred. We know from the case that I have
20 cited it's only a category 2 . So in their minds it's not
21 particularly serious in any case. It's serious enough to
22 warrant a category 2, but not a category 1 nor to call the
23 police.

24 So you are often stuck with what you do. What do
25 you do in those situations? Many people do not have a
26 family member nor do they have a guardian. So it's what
27 flows for these residents. What is their access to
28 justice in a system where the only protection they have is
29 the personal safety intervention order and their ability
30 to apply for it? I should say also that if you are
31 applying for a personal safety intervention order then

1 your access to Legal Aid is somewhat more limited. So how
2 can they get an intervention order? What can they do?

3 COMMISSIONER NEAVE: I just need to understand that. It would
4 be helpful to the Commission for you to differentiate a
5 little bit more. The police safety notice procedure that
6 applies under the Crimes (Family Violence) Act does or
7 does not apply to personal safety orders? I don't think
8 it does apply, does it; that is, the police make the
9 application on behalf of the affected person?

10 MS PEARCE: I think they can. I'm not sure. I'll need to take
11 some advice on that. But they are less likely. If they
12 are able to do so, they are less likely to do that.

13 COMMISSIONER NEAVE: Because it's not covered by the code?

14 MS PEARCE: Because it's not covered about the code.

15 COMMISSIONER NEAVE: So this is as much about police practice
16 as it is about what the law might be.

17 MS PEARCE: It is indeed.

18 COMMISSIONER NEAVE: Thank you.

19 MS DAVIDSON: Can I move to another topic in terms of family
20 violence services and the availability of accommodation,
21 particularly for women or men with disabilities. This is
22 an issue that I think you have raised, Ms Hargrave, in
23 your statement. Can you identify what you see as barriers
24 for women being able to escape family violence given the
25 availability of accommodation?

26 MS HARGRAVE: Family violence response services, as we know,
27 are under enormous demand and they are faced with an
28 unenviable decision. As one service said to me and one
29 refuge said to me, "We could take one woman who has
30 disability support requirements or we could take five
31 other women." So we would argue we need to be putting in

1 place things that allow them to prioritise women who have
2 higher risks, because where else can that woman go?

3 In talking about disability access we should
4 recognise that there are many different types of
5 disability which require different types of access. For
6 women requiring, for example, ramps or handrails or wider
7 doorways we have on record from the Department of Health
8 and Human Services and Safe Steps that there are up to
9 nine refuges with those facilities across Victoria.
10 Appropriately three of those are for Aboriginal women
11 because nationally 51 per cent of Aboriginal women have a
12 disability.

13 But in looking at those refuges, which will often
14 not have availability and not all their beds will
15 necessarily have accessible features in that area, they
16 are not located in each region. So we can't guarantee
17 that there's a crisis accommodation response that's
18 accessible to women requiring universal access
19 accommodation in each region of Victoria. There's also
20 other types of access barriers that we need to talk about
21 that might be based on attitudes or other types of
22 resources.

23 MS DAVIDSON: In terms of longer term accommodation for women
24 you have identified issues regarding the building industry
25 and the lack of accommodation that would be suitable for
26 women with disabilities fleeing family violence.

27 MS HARGRAVE: That's right. I might hand over to Keran in a
28 moment to talk about the building industry, as she's done
29 some work in that area. But not only do inaccessible
30 housing options - so we know that housing options are very
31 limited for all women in terms of being affordable and in

1 the areas that they have their social and service
2 networks. But for women with disabilities that's even
3 lower.

4 So, in terms of family violence prevention, that
5 means that women with disabilities don't have housing
6 options to live independently as much as other women, but
7 also in terms of leaving short and medium-term crisis
8 accommodation it means there are fewer exit options. Some
9 refugees may intake according to what they see as the exit
10 options for women.

11 For these reasons putting women in short-term and
12 medium-term crisis accommodation isn't always ideal, and
13 it's really important to look at what other things we have
14 in place such as Safe at Home programs. These programs
15 are able to assist women to stay safe in their own homes
16 while maintaining their social and disability support
17 networks. It's unfortunate that the national funding for
18 the Safe at Home programs is continuously in doubt.

19 MS HOWE: If I go back to Monica for a moment, the woman who
20 was living in supported accommodation and was unhappy
21 about her care, she has said that she would love to move
22 out and has a friend who would also move with her into a
23 unit and she could then be eligible for personal care
24 through other packages. But there isn't any accessible
25 accommodation for her to move into.

26 So to address this we have to look more broadly
27 at how we are developing housing. In Victoria we have
28 looked at this. The previous Labor government looked at
29 building regulations and making changes to building
30 regulations so that there was a minimum standard of
31 accessibility for all new housing and apartments. That

1 was held up with the election and it was never taken up
2 again. I think this is a critical issue for us to take up
3 both nationally and within Victoria; that we catch up with
4 other countries where universal design standards have been
5 around for years with regards to new buildings. Unless we
6 do that, we are not going to deal with an ageing
7 population that requires accessible, basic universal
8 design standards and we are not going to address these
9 issues with regard to women with disabilities and people
10 with disabilities generally who need affordable and
11 accessible housing.

12 MS DAVIDSON: I take it that that issue would also arise for
13 able bodied women but who have got children with
14 disabilities.

15 MS HOWE: Correct. That's right. We are talking about anyone
16 with a disability, child or adult. If we look at the
17 incidence of disability it is very high in our community.
18 One in 20 people have a disability. It's higher if you
19 look only at the adult population. One in 16 to 17 have a
20 profound and severe disability . So we are not talking
21 about a small minority. We are talking about a
22 significant population that's at the moment excluded from
23 affordable accessible housing.

24 MS DAVIDSON: Can I move perhaps to another topic that you have
25 raised, Ms Pearce, about the independent third person
26 program and the extent to which it is utilised in a
27 consistent way by police. Can you identify, firstly, what
28 that independent third person program does and what you
29 have identified as being potential gaps in the way it's
30 implemented?

31 MS PEARCE: The independent third person program are

1 volunteers. They sit in on police interviews wherever
2 anybody has an apparent cognitive impairment. I say
3 "apparent" because it doesn't have to be a diagnosis. In
4 a police interview it's not possible of course to have a
5 diagnosis. So it's really up to the police to make that
6 determination.

7 Last year we sat in on around 2,700 police
8 interviews. We know if we look at the number of people
9 that are in our prison system who have either an acquired
10 brain injury or a mental illness or an intellectual
11 disability that there are many more than 2,700. So what
12 we think is happening is that there's an under-utilisation
13 of the independent third person program.

14 In part that's because it's not in law that it's
15 mandated; it's in the police manual that police are
16 required to have an independent third person attend the
17 interview. But we know when we do the analysis of where
18 we see police using independent third persons that there's
19 a great disparity across the state. So some stations,
20 such as Dandenong, are really outstanding in their use of
21 independent third persons. But you might see another
22 station, such as Sunshine, where one would think there's a
23 relatively similar demographic with significantly less
24 numbers of people interviewed by police with an
25 independent third person. So it's the station by station
26 analysis that tells us that there is a significant
27 under-utilisation. We have also looked at data from the
28 out court and we estimate that only 50 per cent of people
29 going through the out court have in fact had an
30 independent third person in their police interview.

31 MS DAVIDSON: That program would apply potentially to victims

1 and perpetrators and witnesses of family violence who
2 might have a cognitive - - -

3 MS PEARCE: Yes. If I could also just make the point that a
4 young person - so we would see young people - without a
5 cognitive impairment has what's called an independent
6 person, and that is in legislation. So it is there for
7 young people. But what about people with a disability?
8 Why is it that there is this choice?

9 MS DAVIDSON: Are you calling for it to be put into
10 legislation?

11 MS PEARCE: Yes, we are.

12 MS DAVIDSON: I will move to another topic which you have all
13 identified which is the possibility of an expansion of the
14 Office of Public Advocate's powers to conduct
15 investigations. Can I ask you to explain what you would
16 be seeking in relation to the conduct of investigations
17 and why you think it would be helpful in the context of
18 family violence?

19 MS PEARCE: This was an issue that was canvassed extensively by
20 the Victorian Law Reform Commission in its review of the
21 Guardianship Act in 2012. So it isn't just my office and
22 people like Women with Disabilities Victoria that are
23 calling for it. There has been a lot of thought that has
24 been put into this.

25 What we typically see is that the power of the
26 Public Advocate to investigate abuse and neglect in a
27 broader community setting is limited to cases where a
28 person might be in inappropriate guardianship or an
29 application for guardianship is likely to occur. There
30 are many cases of abuse in the community where a
31 guardianship order is not appropriate and the person is

1 not being held in appropriate guardianship.

2 If I just give you an example. The Aged Care
3 Complaints Agency has contacted my office on a number of
4 occasions where there is a person who is not in receipt of
5 Commonwealth aged services funding, so they don't come
6 under that scheme, but they hold significant concerns for
7 the wellbeing of this person with a disability in our
8 community. Their question is who and in particular is
9 there anything my office can do. And these people are
10 living at home.

11 So in one case we used my advocacy power and
12 simply knocked on the door, and we found the person was in
13 fact being very well cared for. But had the person or the
14 family not let us into the house then it would have been
15 very difficult for us to ascertain whether or not there
16 was any question of abuse of that person. Police could
17 have been called. But the question was around peg feeding
18 and whether inappropriate materials were being used in the
19 peg feed and whether the family understood how to care for
20 a peg feed. So it was something that was going to be far
21 more complex than I think the police could understand.

22 In my view we call it investigation, but perhaps
23 it's more akin to a preliminary investigation and referral
24 to an appropriate body, including guardianship should it
25 be warranted. But in many cases guardianship itself won't
26 be warranted.

27 MS DAVIDSON: That investigation power that you would be
28 calling for, it would cover family violence incidents?

29 MS PEARCE: Yes. But with the advent of the National
30 Disability Insurance Scheme and the Commonwealth
31 establishing safeguards, and these safeguards would apply

1 to people who are in receipt of those services, there will
2 be other mechanisms. So we wouldn't necessarily be
3 looking at group homes where there are other regulatory
4 environments. It's really for people with a disability in
5 the community where there is no other option.

6 MS DAVIDSON: I'm conscious of the time. Does the Commission
7 have any questions for these witnesses?

8 DEPUTY COMMISSIONER NICHOLSON: Yes. I would like to ask about
9 the implementation of the National Disability Insurance
10 Scheme where, as I understand it, it's creating a market
11 of providers, both for profit and not for profit. Central
12 to the whole scheme is this concept of consumer directed
13 care, which should empower people to determine the type of
14 care that they wish to receive. But it's also been put to
15 me that it opens up the opportunity for coercion from
16 family members about what sort of care is going to be
17 determined and that under this scheme there may not be
18 enough monitoring of that to be able to identify when it
19 occurs.

20 MS PEARCE: I wouldn't mind commenting first. My office has
21 had quite a lot of experience with the trial site in
22 Barwon, and that's right. The philosophy is empowered
23 consumers in a competitive market based environment. But
24 the people that my office works with are people with
25 cognitive impairments, particularly those with significant
26 cognitive impairments, and it doesn't matter which way you
27 look at it they are not going to be empowered consumers in
28 this new model.

29 I think around 60 per cent of people who are in
30 receipt of NDIS funding are people with cognitive
31 impairments. It's far higher than they thought. So

1 initially not enough thought was put into how that might
2 work. So, for example, the nominee provisions that are
3 there that are akin to those under the social security
4 system are not routinely being used because many people do
5 not have family members and the nominees are not paid
6 people.

7 So who is making decisions for people with
8 significant cognitive impairment? Often it's the planners
9 who are making those decisions. It's only recently been
10 recognised that a support person needs to sit in on a
11 planning session. People were left to their own devices
12 and didn't cover all of their care requirements such as
13 continence aids.

14 But I think NDIS is starting to recognise this
15 and does have a number of priority projects coming under
16 the NDIS Board where they are looking at the issues
17 related to cognitive impairment. But I think there is a
18 very strong disconnect between state based guardianship
19 laws and this legislation, particularly around nominee
20 provisions and who can make decisions.

21 MS HOWE: We also have concerns about the coming reforms and
22 the present reforms in the Barwon area, and the extent to
23 which the agency that's responsible for the National
24 Disability Insurance Scheme, which is the NDIA, are aware
25 of, for example, the issues of family violence and of the
26 importance of ensuring that the person that's to receive
27 support is comfortable with family members being part of
28 the planning process.

29 There's not really, that I'm aware of, real
30 attention being paid to the fact that not all families
31 have the best interests of the person with a disability in

1 the family at heart and there are opportunities for
2 exploitation. There are currently families where abuse is
3 occurring and it's not being picked up as part of that
4 assessment process.

5 So we think there is a very important role in
6 workforce development within the NDIA to make sure that
7 planners and anyone involved with the direct care planning
8 is aware of these issues and that there are practices and
9 policies in place so that these things are assessed as
10 part of the assessment process.

11 DEPUTY COMMISSIONER NICHOLSON: Perhaps if you have specific
12 ideas about the practices and policies you might like to
13 forward those to the Commission.

14 The second thing about the NDIS, I was unsure as
15 to what provision it makes for housing assistance, whether
16 that's modifying accommodation or whether it's simply
17 assisting a disabled person be competitive in a tight
18 rental market.

19 MS HOWE: I'm not sure that I can fully answer that question.
20 There was a housing strategy.

21 MS PEARCE: Which hasn't been released and we are all anxiously
22 awaiting that to understand what the relationship with
23 NDIS will be in relation to the funding of accommodation.
24 We do know that there has been a long, hard battle by my
25 office and many, many disability advocates to ensure
26 small-scale accommodation, a home like environment, the
27 group homes and for the closure of institutions. We need
28 to see the accommodation paper to understand what will in
29 fact NDIS fund. Will they fund large-scale congregate
30 care facilities? Is that part of the agenda? So we need
31 to understand that because there has been a long battle to

1 move towards people having the right to live in the
2 community in small-scale settings. But I do acknowledge
3 that some parents certainly do want their children to live
4 in larger scale settings.

5 DEPUTY COMMISSIONER NICHOLSON: It would seem that if the NDIS
6 doesn't adequately address the housing issue then the
7 whole notion of consumer directed care is a bit of a
8 nonsense.

9 MS HOWE: I think that's right, but I think also government has
10 a broader responsibility through housing to ensure that
11 housing - as I have made the point - is accessible because
12 sometimes we are using congregate care because we don't
13 have other options for accessible housing where you could
14 use a support package. So I hear significant numbers of
15 people who are in - - -

16 DEPUTY COMMISSIONER NICHOLSON: Would that be in terms of a
17 rental subsidy, for example?

18 MS HOWE: It could be. But it's also about the practical lack
19 of accessible housing, which I think needs government
20 leadership.

21 MS HARGRAVE: I might just add there very briefly too. In a
22 rental property you are not legally protected to make a
23 disability modification even if you pay for that to be
24 installed and removed at your own cost.

25 MS HOWE: Can I just add another area with the National
26 Disability Insurance Scheme is advocacy, and with the move
27 for all funding to go across from Victoria to the
28 Commonwealth, advocacy services in Victoria such as
29 ourselves could be at risk and in terms of the empowerment
30 of people with disabilities and women with disabilities in
31 particular this is a concern we have.

1 COMMISSIONER NEAVE: No further questions, thank you.

2 MS DAVIDSON: Perhaps these witnesses can be excused.

3 COMMISSIONER NEAVE: Thank you very much indeed.

4 <(THE WITNESSES WITHDREW)

5 MR MOSHINSKY: Commissioners, we may just change the order

6 slightly and we will call Mr Fonzi later in the day and we

7 will go directly now to Ms Blakey and Mr Chesterman. If

8 they could please come forward.

9 <JOHN HENRY CHESTERMAN, sworn and examined:

10 <JENNY BLAKEY, recalled:

11 MR MOSHINSKY: Ms Blakey, if I could start with you. You have

12 previously given evidence on Day 4 of the public hearings

13 in relation to the topics of financial abuse and financial

14 empowerment. Your statement on that occasion is also

15 before the Commission today.

16 MS BLAKEY: Yes.

17 MR MOSHINSKY: You indicate in that statement that you are the

18 manager of Seniors Rights Victoria.

19 MS BLAKEY: Indeed I am.

20 MR MOSHINSKY: In the interests of time I won't go over the

21 introductory matters that we canvassed last time in terms

22 of your position and the organisation.

23 MS BLAKEY: Yes.

24 MR MOSHINSKY: Mr Chesterman, you work at the Office of the

25 Public Advocate?

26 DR CHESTERMAN: That's correct.

27 MR MOSHINSKY: Could you briefly outline what your position is

28 and your professional background?

29 DR CHESTERMAN: I'm the Manager of Policy and Education at the

30 Office of the Public Advocate. I have been there now for

31 six years. Prior to that I was an academic at the

1 University of Melbourne where I lectured in political
2 science. I have a background in law and history.

3 MR MOSHINSKY: In terms of your work, is part of your work or
4 focus on issues to do with elderly people or older people?

5 DR CHESTERMAN: I'm the manager of our systemic advocacy arm,
6 our policy and research unit, and we do have some
7 involvement in the elder abuse area. I'm also a member of
8 the Seniors Rights Victoria Council. In 2013 I was
9 fortunate enough to be on a Churchill Fellowship, which
10 looked at matters that are germane to the topic of elder
11 abuse. It wasn't focused just on elder abuse. It looked
12 at at risk adults and the adult protection system
13 generally.

14 MR MOSHINSKY: I may direct questions to Ms Blakey and if you
15 wish to add anything at any point in time please do so.

16 DR CHESTERMAN: Thank you.

17 MR MOSHINSKY: I also will just indicate that, given that the
18 focus of the questions with you, Ms Blakey, on the last
19 occasion was around financial abuse, I won't be focusing
20 on that so much today in the topic as we have covered that
21 to some extent already.

22 Can I start with this topic broadly, Ms Blakey.
23 Can you briefly encapsulate what we mean by elder abuse
24 and how that intersects with what is family violence?

25 MS BLAKEY: Yes. Elder abuse is a term which is defined by the
26 World Health Organization, and it's defined as an act
27 which causes harm to an older person and is carried out by
28 someone they know and trust, which might be a carer, a
29 family member or friend. It can take the form of a single
30 or repeated acts in that relationship where there's the
31 expectation of trust.

1 The relevance to this Commission is that we see a
2 lot of - we are an organisation that focuses on elder
3 abuse, but the people who contact us, a lot of it occurs
4 within the context of family. So we see that for the most
5 part our experience indicates that elder abuse occurs
6 within the family. In fact we have some statistics which
7 were produced over a two-year period which show that in
8 92 per cent of the cases the perpetrator is a family
9 member, and in fact of those approximately two-thirds the
10 perpetrator is the adult son or daughter. So it is very
11 clearly abuse occurring within the family.

12 DR CHESTERMAN: Can I contribute just a word on that and just
13 to say the only areas where elder abuse wouldn't be family
14 violence would be probably in two areas: one where the
15 abuse might not constitute violence, as such, and the
16 other one would be where the trusting relationship
17 wouldn't be seen as family-like. But largely, that's
18 right, most situations of elder abuse would be family
19 violence.

20 MR MOSHINSKY: What do we know about the prevalence of elder
21 abuse? In the Seniors Rights Victoria submission at page
22 15 there's a section dealing with the prevalence of elder
23 abuse. Are you able to indicate to the Commission the
24 extent to which there is evidence about the prevalence?

25 MS BLAKEY: Yes. There is very limited evidence of the
26 prevalence in Australia in that there haven't been the
27 appropriate prevalence studies undertaken. But there is
28 an estimate that it is 5 to 6 per cent of older people, so
29 over the age of 65, experience elder abuse.

30 Overseas studies are much more disparate in terms
31 of their estimates, but the World Health Organization says

1 that the estimate could be anywhere between one and up to
2 10 per cent of older people experience elder abuse. We
3 consider that it's highly underreported, and that is also
4 the reports from other research. So that may again be low
5 figures. There is a reluctance and difficulty to know to
6 what extent people may report elder abuse. In part that's
7 because people don't know what they are experiencing might
8 be considered elder abuse and therefore identified as
9 such.

10 MR MOSHINSKY: Ms Blakey, in your witness statement at
11 paragraph 26 you make the point that a distinction between
12 elder abuse in families and other forms of elder abuse is
13 this intergenerational aspect. Can you expand on that?

14 MS BLAKEY: Yes. A common conception of family violence is
15 that it is intimate partner violence and generally between
16 male and female. So therefore it has a very distinct
17 focus on the enormous number of women who are affected by
18 family violence.

19 Our experience is that the defining
20 characteristic is the difference in ages. So the person
21 who is experiencing the family violence is usually someone
22 in the age group of 70 to 84 years old and the perpetrator
23 is usually someone aged between 35 and 54 years old,
24 according to our experience. So we are talking about
25 people in their 70s and their 80s and sometimes older
26 experiencing the abuse at the hands of someone who is
27 younger, so someone in their 40s, 50s generally, and also
28 60s and 30s.

29 So whilst we also see the overlay of the
30 difference between genders in that approximately
31 62 per cent of the people who experience elder abuse at

1 our service are women, and that means about 27 per cent
2 are men, so still a high proportion of people who
3 experience it are women, but also a significant proportion
4 who are experiencing it are men as well. So the
5 distinctive characteristic is the age. So it is the
6 overlay of the age difference and the gender.

7 MR MOSHINSKY: I was wondering whether both of you may be able
8 to comment on a situation that was referred to quite a
9 number of times in the course of the community
10 consultations that the Commission has carried out which is
11 a situation of the adult child who is using violent
12 behaviour to an older parent, and that situation poses a
13 number of very difficult issues, particularly around
14 engagement of the police by the victim. I was wondering
15 if you are both able to speak to that situation and the
16 difficulties in accessing help in that situation.

17 MS BLAKEY: Yes, I will start with perhaps just explaining
18 there are different types of abuse for elder abuse. There
19 was the mention of financial abuse, which we talked about
20 last time, and then there is psychological or emotional,
21 physical, social, sexual and neglect. The foremost
22 experience that we see most of at our service are
23 financial, which we have covered, but also emotional and
24 psychological. So it can be the name calling, the abusive
25 language and those sorts of things.

26 To come to your question, the difficulty for
27 older people in seeking assistance is that it is a family
28 member, and it is frequently their son and daughter, and
29 so they are very loath to take action against that person.
30 They try to keep it within the family. So there's a sense
31 of saying, "I don't want to call the police on my son.

1 I don't want the police involved. I don't want it to
2 happen. I don't want my son to go to gaol", or they are
3 worried about, "If I engage in someone to take action in
4 this matter, what are the implications for me and my
5 relationship?"

6 So for some people they are prepared to tolerate
7 the abuse at the expense of themselves because they don't
8 want to lose the relationship. They are worried about
9 that being fractured, it being lost and that that may mean
10 that they are even further isolated. As someone ages,
11 it's because of their health conditions and also their
12 peers are dying, they have less social supports and
13 networks available to them or able to access, and they
14 become more reliant - they can become more reliant - on a
15 few key people, and that can be family members. So losing
16 those relationships can be very significant in terms of
17 increasing their isolation, their loss of those
18 significant relationships, particularly if they are sons
19 and daughters, and also the threat for them that they may
20 feel that they can't stay where they are and they may have
21 to move into care facilities.

22 MR MOSHINSKY: Mr Chesterman, did you have any comments on that
23 scenario that I have asked about?

24 DR CHESTERMAN: Sorry, I just missed your follow-up question.

25 MR MOSHINSKY: Do you have any comments about that scenario of
26 the adult child who is using violence, it may be physical
27 or it may be emotional or psychological or financial,
28 against an older parent and the difficulties confronting
29 the victim in that situation and who to turn to for help?

30 DR CHESTERMAN: Sure. The initial point I would make is
31 obviously where there has been clear criminal activity

1 then police should be the first port of call. But for the
2 reasons that Jenny has outlined sometimes the victim will
3 be the only witness to the behaviour and they may be
4 reluctant to call police.

5 One of the things that we have identified - and
6 Seniors Rights as well - is there is what we have called
7 an investigations gap at the moment where there's not
8 obvious criminal activity - so if we are talking about,
9 for instance, psychological abuse, even some forms of
10 financial abuse, which I know you have covered - who do
11 you call in that situation; who does the victim or others
12 who observe kind of worrying signals, who should they
13 call? In the absence of obvious criminal activity or an
14 obvious medical emergency, then emergency services,
15 police, ambulance officers are unlikely to be able to
16 assist.

17 This is why we have said that there is a need to
18 empower a statutory authority to conduct what we would
19 call a supportive intervention or supportive investigation
20 where they would go in and just assess what's going on,
21 link a person to services where that's appropriate, refer
22 matters to police where that's appropriate, but be able to
23 go in in a supportive way and identify further what's
24 actually going on.

25 MS BLAKEY: Can I add another response to that which fits with
26 what I was saying before. Parents can have this sense of
27 shame and not wanting to disclose what's happening and
28 there can be a sense of, "I haven't parented well enough,"
29 or there can also be the sense of, "I need to keep
30 trying," particularly where there may be issues with their
31 adult child which may relate to substance use or alcohol

1 use or mental health or gambling or whatever, there is
2 still this sense of wanting to be a parent and take care
3 of that person and try and resolve it in some way.

4 MR MOSHINSKY: Can I turn then to the topic of barriers to
5 seeking assistance if you are an older person who is
6 experiencing family violence or elder abuse. What are
7 some of the barriers that exist to reaching out to get
8 support?

9 MS BLAKEY: I think the first barrier again is identifying what
10 it is and knowing that such a thing as elder abuse exists;
11 so being prepared to then talk about it and if it's spoken
12 about with someone that they identify what it is as well.
13 So the importance is that if they talk about it with
14 someone that they trust, it might be another family member
15 or it might be a professional such as their GP or it might
16 be some other health worker that they have contact with,
17 that there is the ability again on that professional's
18 behalf to actually recognise it as elder abuse and be able
19 to respond.

20 So it's important that there is an awareness not
21 only within the general community and with older people
22 that this is something which exists and what it looks
23 like, but also with those parts of the service system that
24 people might come in contact with, and that might be the
25 banking system, it might be accountants, it might be
26 hospitals, it might be GPs or whatever, it might be the
27 support services that come into the house to help the
28 person with their housekeeping or their shopping or
29 whatever. So it's important that people are trained to
30 recognise elder abuse and be able to respond and then act
31 in some way.

1 The other barrier that I mentioned before is
2 about the disclosure, so the difficulty of the older
3 person actually disclosing and feelings of trust and
4 feeling a concern about how will it be responded to, will
5 they lose their relationship or will things be taken out
6 of their hands so they will no longer have control over
7 what they want and how they want their world and their
8 relationships to exist.

9 The other difficulty of course is the isolation
10 which I talked about before where people have less and
11 less contact with others and so therefore are not able to
12 have a place where they can go to and talk about it and
13 comment. That may be particularly the case for people in
14 rural and regional areas where there is a growing number
15 of older people because younger people are leaving to find
16 work and study elsewhere. So there's an isolation which
17 is geographical as well as these other barriers.

18 The other barrier which is probably worth noting
19 is for people of a different cultural background and their
20 ability to access information in a way which is
21 appropriate and culturally appropriate to them. So there
22 are pockets within our community who may have difficulty
23 having access to that information.

24 DR CHESTERMAN: Can I just add to that. I agree with
25 everything that Jenny has just said. I think that's a
26 good articulation of what the barriers are. One of the
27 things I would just add to is in looking at the limited
28 service responses we have currently available we have
29 really got some pretty blunt strategies in this area which
30 include a person losing control being moved into an aged
31 care facility, for instance, or having a guardianship or

1 administration order taken out against them where we
2 effectively remove their decision making authority. So as
3 protective mechanisms they are fairly blunt ones. What we
4 would certainly be proposing would be kind of more varied
5 service responses that support a person and listen to what
6 the person wants and support them better than we are
7 currently able to do.

8 MR MOSHINSKY: At this point we might just show a short video
9 which is not specific to family violence but what raises
10 some other relevant themes. If you might turn around and
11 watch it and then I will ask you to comment after we have
12 watched it.

13 (Video played to the Commission.)

14 MR MOSHINSKY: I should just note that I think we missed a few
15 seconds - - -

16 DR CHESTERMAN: There are some words at the start.

17 MS BLAKEY: I can tell you what that text is because I know
18 this well and it moves me every time I see it. What
19 begins is that you can see there's someone standing in
20 front, which you assume is an aged care worker or nurse,
21 saying, "What's this one's name? What do we call this
22 one?" Then the woman comes in to see him and says, "These
23 aren't your clothes. Where are your clothes?" I guess
24 for me it highlights very strongly how older people can be
25 regarded in our community as nameless objects, people who
26 aren't individuals, who are just treated as something to
27 be clothed and fed.

28 Then we go back through the richness of this
29 person's life and we then immediately start to think of
30 this person in a very different way and see him as a more
31 complete person and someone we accord rights to, who has

1 wishes and desires and who may want to be in control of
2 their life and be listened to and spoken to and speak. So
3 I find that that illustrates the point of ageism which
4 I guess underlies the point I was making before about the
5 power abuse occurring between different ages, and that's
6 the ageism that older people experience in the taking of
7 control and the abuse they experience.

8 DR CHESTERMAN: Everyone who I show that to thinks it's just
9 fantastic. I have shown it to my teenage children, who
10 are moved by it. They have a grandfather in aged care.
11 It is a very powerful rendition of the vulnerability and
12 the lack of respect that can accompany ageing in our
13 society.

14 MR MOSHINSKY: Can I move then to the issue of availability of
15 services or gaps in supports and services that are
16 available. What are some of the main gaps that you would
17 identify in terms of older people seeking help for elder
18 abuse within a family context?

19 MS PEARCE: I think again it comes back to services knowing
20 about elder abuse and being equipped and able to respond
21 to them. I have talked about that, so I won't go over
22 that again. But the other issue is appropriate
23 accommodation. So the family violence sector is set up
24 for women and children and there can be needs for
25 accommodation for people who are older. We are not
26 talking about aged care facilities. People who are still
27 very active and competent don't want to end up at that
28 point in time in a facility which is established for
29 different health needs. So accommodation is certainly one
30 of those issues.

31 MR MOSHINSKY: Are you referring to crisis accommodation, for

1 example?

2 MS BLAKEY: Crisis accommodation and maybe some longer term
3 accommodation. That can come up particularly where they
4 may have lost their accommodation. They may have lost
5 their home, going back to the financial abuse that we have
6 talked about at another time. Also it may be because they
7 have their adult child return home. Their adult child has
8 gone through some crisis. They have separated from their
9 partner. Maybe there has been family violence within that
10 relationship. Maybe there are alcohol and drug issues or
11 financial problems, they have lost their job, their
12 business has gone broke, and they turn up and they need
13 somewhere to live. So they return home.

14 There is no accommodation for them, and it comes
15 to the family and mum and dad to take them back. For a
16 lot of families that works really well; families manage
17 that. But for some families it's just not appropriate and
18 there is not alternative accommodation for the perpetrator
19 or the person who may become the perpetrator.

20 I think that there is a greater need for the
21 services for the perpetrator, and older people will
22 frequently say to us, "Can you fix him?" So it's about
23 services which are supportive to the family and the older
24 person in their situation, but also to the perpetrator.

25 Certainly one of the things that we were
26 interested in exploring and one of our recommendations was
27 how there might be appropriate sort of anger management or
28 appropriate sort of courses or programs perhaps is the
29 right word for the person who is the perpetrator to assist
30 them to change their behaviour and also to support the
31 older person in undergoing that sort of change.

1 MR MOSHINSKY: Mr Chesterman?

2 DR CHESTERMAN: Yes, there are very few service responses that
3 are geared towards supporting older people. If you remove
4 aged care from the equation - and we are talking about
5 situations of abuse and violence - there are very few that
6 are specifically focused on older people. Those that tend
7 to be utilised are, as I was suggesting before, fairly
8 blunt strategies where the decision making authority often
9 is removed or a person is moved into an aged care setting.

10 You would be familiar with the state's elder
11 abuse prevention and response guidelines, which the most
12 recent iteration of those was 2012 to 2014 which I have
13 here, and there will be we believe some new guidelines
14 drawn up. If you look at those, what we currently do is
15 largely draw on existing services and try and pool them
16 together in situations where there is elder abuse. We
17 would be liking to see more specific support mechanisms
18 geared towards, for instance, assisting older people to
19 stay in their home and be safe in their home and have the
20 recognition that they do often still have decision making
21 authority over most of their lives as they have had since
22 they have been an adult.

23 MS BLAKEY: Can I add a couple of other points that have come
24 to mind, and that is again to think about older people
25 from different cultural backgrounds and in terms of the
26 services that would be very useful for those communities
27 is of course around providing information in appropriate
28 language and written in a culturally appropriate way
29 because for some, for example, cultures the word "abuse"
30 may only talk about physical violence, so they may need to
31 use other language. Of course there are the other issues

1 around the roles within different cultures of family
2 members and particularly how money might be handled and
3 what the adult son's role is and how older people are
4 regarded, particularly older women. So there is a need
5 for the training of bicultural and bilingual workers and
6 providing information in the language which is appropriate
7 to them. For example, we gave advice to people from 49
8 different countries of origin over the last two years. So
9 it's really important.

10 The other area of course which we haven't really
11 explored in great depth and so we are not an expert to
12 talk about is the Aboriginal community. But we are very
13 aware that there are issues around the way older people
14 are regarded in Aboriginal communities, and again their
15 roles within those communities and how they are viewed by
16 the other members in their extended families, so making
17 sure that there is some resourcing to Aboriginal
18 organisations to deal with that issue.

19 We also think that it's an issue which crosses a
20 number of sectors so that there is the aged care sector,
21 the health sector, the family violence sector, the
22 accommodation sector and so forth. So what we are really
23 keen to see is that there is some work at a regional level
24 which brings together those sectors to respond to the
25 issues in the areas. There are examples overseas of
26 regional coordinators, and I'm thinking of New Zealand but
27 also in Canada and in a different way in the UK, although
28 the set-up there is a bit different because of the
29 different government structures than here, so something
30 which works across the services that exist in local areas
31 and for us to be able to coordinate and to act as a bit of

1 a clearing house to share that information across regions
2 so that we are not doing something in one area that the
3 others don't know about, that they can learn from each
4 other and actually leverage off each other in terms of
5 their knowledge and responses.

6 MR MOSHINSKY: Mr Chesterman, I'm not sure whether you wish to
7 make any further comments about the issue of investigating
8 elder abuse beyond those you have already made so far.

9 DR CHESTERMAN: Yes, the point really is who does one call if a
10 neighbour, for instance, appears to be at risk or
11 suffering harm but it's not obvious criminal activity,
12 it's not obvious that they are in a situation of medical
13 emergency, who do you call in that situation. That's a
14 question that confronts us, and that was the question that
15 I took overseas in my Churchill Fellowship and came back
16 with some responses to that. But both of our
17 organisations think there is an investigations gap at the
18 moment which could be cured by us doing in this state what
19 the Victorian Law Reform Commission recommended in its
20 guardianship final report in 2012 which was to empower in
21 this case the Office of the Public Advocate to undertake
22 investigations where people are at risk.

23 MR MOSHINSKY: Are there any other responses that you saw
24 overseas through that Churchill Fellowship that would be
25 relevant here that you might be able to refer to?

26 DR CHESTERMAN: That was the main one because I went and
27 examined some quite interventionist adult protective
28 service systems and I don't think they would translate
29 well here. In large part they are kind of modelled on
30 Child Protection. I don't think they have the balance
31 right in terms of respecting the wishes and autonomy of

1 the people they are investigating.

2 Also there was quite a problem with the extent to
3 which adult protective services would go and investigate
4 and make a finding. They were then quite unable to link
5 in appropriate services. So there was nothing that I saw
6 from those interventionist systems that I would
7 immediately adopt.

8 One of the things, though, that I did see
9 particularly in Scotland, and this draws very much on what
10 Jenny was saying, where they have adult protection
11 committees which are cross-disciplinary local committees,
12 I think there are 29 of them in operation in Scotland with
13 a population of about the same as Victoria, and they meet
14 locally and discuss individuals who are at risk in the
15 community with a range of service providers and emergency
16 services. So I think that works well in Scotland and
17 that's an idea that I think we could draw from, especially
18 not just in the elder abuse area but obviously family
19 violence more generally.

20 MR MOSHINSKY: Ms Blakey, in your statement at paragraphs 40.3
21 and 40.4 you deal with the issue of training or education
22 of GPs and also Victoria Police. I wonder if you might be
23 able to expand on that.

24 MS BLAKEY: Yes. I'm aware that both of those areas have some
25 information and training already, but I think it's fairly
26 limited. Our experience is there is a lack of consistency
27 in terms of GPs and their response and understanding, and
28 I think there could be a lot more training that occurs.
29 I'm aware that there could be particular questions that
30 could be asked by GPs which may prompt and explore the
31 condition of the elder person and it may be simply like,

1 "Have you noticed a change in your ability to pay your
2 bills," which might then lead to a discussion. So there
3 are some things that could be done. There can also be
4 importance around training GPs to ensure that they make
5 appropriate referrals and good referrals and good
6 assessments around the capacity of older people and their
7 ability to make decisions.

8 In terms of the police, our experience has been
9 quite disparate. We have had instances where the response
10 from the police has been excellent in dealing with a
11 situation where we have called them to an elder abuse
12 situation and other situations where it's been very poor.
13 In fact we have had one situation where the police was
14 called because an adult grandchild called them and they
15 spoke to the adult children, who were the perpetrators.
16 The older people were Vietnamese and couldn't speak
17 English and weren't spoken to, and the police left. But,
18 as I said, there have been other instances where the
19 police have been very good.

20 So there needs to be some greater training and
21 consistency across the police force to respond to these
22 issues and, like us all in the community, to have a
23 greater awareness of how we work and speak to older people
24 and include older people in the conversation and hearing
25 what they have to say.

26 DR CHESTERMAN: Just a footnote on GPs, people may be aware
27 that medical practitioners from 1 September are one of the
28 authorised witnesses for the powers of attorney that can
29 be executed under the new powers of attorney legislation
30 which means that they are attesting to the capacity of the
31 person to complete the instrument. Often times we know

1 that when a person is at risk or is suffering some
2 cognitive decline but there is some concern about their
3 financial affairs in particular they will be encouraged to
4 complete an enduring power of attorney. So this is of
5 relevance, I think, that GPs will have this enhanced power
6 and role to play.

7 MS BLAKEY: We think it also is important for other professions
8 like accountants and within the banking industry that
9 there is a greater awareness of elder abuse and more
10 readiness to ask again some of those exploratory
11 questions, particularly where there has been a
12 relationship of trust. Also with lawyers. Lawyers might
13 be involved in transferring assets and property. Again
14 there's been training in that area but our experience is
15 there has been different levels of response. We have had
16 some situations where lawyers have not really made sure
17 that the older person has had independent advice and has
18 just treated as the son's come in and asked them to do
19 that, they have brought mum along and they do it. So
20 there has been a transaction which has occurred which has
21 been to the detriment of the older person.

22 We would like to see greater emphasis, possibly
23 within law, that if there is a transfer of significant
24 assets and money at a point where someone is older that
25 it's not necessarily an assumption that it's a gift - that
26 can be the assumption that's occurring within that
27 situation between the generations - but there might need
28 to be more greater consideration about it being a loan or
29 at least making sure that there are some clear
30 arrangements about what the expectations are of this
31 money, what will happen if something goes wrong and how it

1 might be repaid in future.

2 MR MOSHINSKY: I'm not sure if the Commissioners have any
3 questions.

4 DEPUTY COMMISSIONER NICHOLSON: Yes, I did. We heard earlier
5 about the introduction of consumer directed care in
6 disability. Of course that's happening in aged care
7 driven by the Commonwealth and the introduction of a more
8 competitive market of service providers, and of course
9 that opens up I think the potential of coercion of people
10 receiving care by family members, particularly where
11 there's now greater transparency around how many - the
12 level of funds available to that person et cetera. Do you
13 have any views about what sort of safeguards are required?
14 Are there safeguards? Are they adequate?

15 DR CHESTERMAN: We have given this a lot of thought in the
16 context of disability as well about which you will have
17 heard. I think it's very important that the consumer
18 choice philosophy is not being implemented to the
19 detriment of those who have some decision making
20 disability which can be something that's lifelong or it
21 can be acquired through an injury, through an accident or,
22 for instance, with dementia. So the question is - - -

23 DEPUTY COMMISSIONER NICHOLSON: Even where they don't have
24 impaired decision making ability it's been said that the
25 potential is for family coercion in determining what sort
26 of care they get, the level of care et cetera.

27 DR CHESTERMAN: In that case I think a range of safeguards are
28 needed. The availability of advocacy is one about which
29 I think you have probably heard in the last session and
30 monitoring of how money is being spent. It depends on the
31 situation in which the person is living what monitoring is

1 appropriate. If they are in a private home it's more
2 difficult. But in any supported residential setting we
3 would say there needs to be monitoring.

4 DEPUTY COMMISSIONER NICHOLSON: The vast bulk will be in
5 private homes receiving care packages.

6 DR CHESTERMAN: We won't go into the area of financial abuse,
7 but that's in my view likely to be the most significant
8 danger. So we would be recommending greater kind of
9 police ability to monitor financial abuse and recognise it
10 and respond to it.

11 DEPUTY COMMISSIONER NICHOLSON: Do you have any specific
12 recommendations about the sort of safeguards that are
13 going to be required in this new environment?

14 MS BLAKEY: The only recommendation I can make - and you have
15 posed a great problem and we have the dilemma of how we
16 respond to it - is if there is an independent case worker,
17 so there's someone which is standing outside the family
18 who has a role to work with the older person around the
19 choices they are making and again maybe more attuned then
20 to picking up where there is undue influence on the older
21 person and decisions being made which perhaps are not
22 representing the person's needs and then having the
23 ability through that relationship to have the discussion
24 separately with the older person about what they want and
25 how they manage the difficulties which are occurring
26 around perhaps other needs within the family. That would
27 be my suggestion.

28 DR CHESTERMAN: Can I just quickly add. The safeguards would
29 be both preventative and responsive. The preventative one
30 would be education about what is appropriate and what is
31 inappropriate in that kind of setting, because some family

1 members do think that they have an entitlement that they
2 actually don't have. So that can lead to situations of
3 abuse. In terms of responding, I would say again the idea
4 of having an agency that could be phoned where there is a
5 situation of concern to a neighbour or another family
6 member who could then go and look at what is happening in
7 that situation.

8 DEPUTY COMMISSIONER NICHOLSON: I had two other quick
9 questions, if I may, counsel. Are you aware of any
10 training given to people that are delivering care packages
11 into the home, personal care attendants et cetera, that
12 would enable them to identify or understand the risk of
13 family violence?

14 MS BLAKEY: Yes, there is training. The State Government
15 funded Victoria University to run training for home and
16 community care workers, and there was a substantial amount
17 of training that occurred over the previous two years.
18 That funding to Victoria University has ceased and there
19 is now an on-line training program which the State
20 Government runs. There is also - I'm not quite sure of
21 the right word - licensing or recognition to two agencies,
22 two registered training organisations to deliver training,
23 and that is fee based training. I'm not really convinced
24 whether that's sufficient and whether there needs to be
25 more that's done because I think that care workers who
26 enter into the home are a key point to identify issues
27 that may be of concern.

28 DEPUTY COMMISSIONER NICHOLSON: Is there any requirement upon
29 service providers funded by the Commonwealth who are going
30 into the home to have any training?

31 MS BLAKEY: Not that I'm aware of. I think the initial vision

1 was to have it incorporated into mandatory training, so
2 particular diplomas and certificates, so it became a
3 module that people had to undertake as part of their
4 training.

5 I think there is also a need, though, for
6 training to continue because once you have had the
7 training that then becomes more and more distant with
8 time. So there needs to be refreshers in terms of
9 training and, I guess, the services that deliver that
10 training. There was one service, Aged Care Channel, which
11 we explored some time ago about delivering some training
12 on-line which goes out to care facilities. But I think
13 that's just residential. I'm not sure that would reach
14 workers who would then go into people's private homes.

15 DEPUTY COMMISSIONER NICHOLSON: My other question was about the
16 care packages that are delivered into the homes, because
17 that's the bulk of the people, as I understand. There are
18 far more receiving care in that way than in residential
19 settings. Are those packages able to be easily and
20 quickly adjusted or redeployed in circumstances of family
21 violence; for example, perhaps enable someone to travel or
22 to purchase temporary accommodation?

23 DR CHESTERMAN: I'm not sure.

24 MS BLAKEY: I don't have experience in that so I couldn't
25 answer it.

26 COMMISSIONER NEAVE: I have no further questions, thank you,
27 counsel.

28 MR MOSHINSKY: If the witnesses could be excused and if we
29 could adjourn until 2 o'clock.

30 COMMISSIONER NEAVE: Thank you very much indeed for your
31 evidence.

1 <(THE WITNESSES WITHDREW)

2 LUNCHEON ADJOURNMENT

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1 UPON RESUMING AT 2.00 PM:

2 MR MOSHINSKY: Commissioners, before the next witness is called

3 I would like to indicate to the Commission that some of
4 the evidence this morning during the panel relating to
5 people with a disability went beyond the evidence
6 foreshadowed to the State. In the circumstances, the
7 State would like the opportunity to consider whether it
8 wishes to put on any evidence or make a submission in
9 response and arrangements will be made in this regard.

10 COMMISSIONER NEAVE: Thank you, Mr Moshinsky. That's
11 appropriate.

12 MR MOSHINSKY: The next witness is Mr Fonzi. If he could
13 please be sworn in.

14 <ROCCO FONZI, sworn and examined:

15 MR MOSHINSKY: Mr Fonzi, could you please state your current
16 position?

17 MR FONZI: I am the Director of the Client Outcomes and Service
18 Improvement branch of the East Division of the Department
19 of Health and Human Services.

20 MR MOSHINSKY: Have you prepared a witness statement for the
21 Royal Commission?

22 MR FONZI: Yes, I have.

23 MR MOSHINSKY: Are the contents of your statement true and
24 correct?

25 MR FONZI: Yes, it is.

26 MR MOSHINSKY: Your statement deals with the disability family
27 violence crisis initiative and you explain in the
28 statement how the fund came about and how it operates.
29 I just want to ask you a few specific questions about the
30 fund.

31 In paragraph 14 you indicate that the primary aim

1 of the initiative is to provide immediate disability
2 support when required to women with a disability who are
3 experiencing family violence or children with a disability
4 who are experiencing family violence with their mother,
5 and then in paragraph 15 you indicate the initiative is
6 designed to achieve certain objectives. Perhaps if
7 I could just ask you to sort of encapsulate briefly what
8 sort of gap was this initiative designed to address?

9 MR FONZI: The initiative was designed to address the gap of
10 where a woman with a disability or a woman caring for a
11 child with a disability was experiencing family violence
12 and the specific disability that she had or the disability
13 needs acted as a barrier for her escaping the family
14 violence. This initiative provides resources and funding
15 in an immediate and flexible way to allow the woman to
16 receive those supports, to basically supplement the
17 support that she's providing so that it no longer acts as
18 a barrier. I think the previous panel gave quite a
19 detailed and good example about a woman who is relying on
20 an intimate partner who is also the perpetrator.

21 MR MOSHINSKY: In terms of the criteria for being eligible to
22 access this fund, you indicate in paragraph 16 that there
23 are three criteria. I won't read them all out at the
24 moment, but is one of the criteria that the person has to
25 have a disability as defined by the Disability Act?

26 MR FONZI: Yes, it is.

27 MR MOSHINSKY: Is one of the implications of that criteria that
28 the person needs to be assessed as having a permanent
29 disability?

30 MR FONZI: Yes, that's right.

31 MR MOSHINSKY: So is one of the gaps in terms of this fund

1 that, if one isn't yet assessed as having a permanent
2 disability, one would not be eligible to access this fund?

3 MR FONZI: That's correct.

4 MR MOSHINSKY: We had some evidence this morning, I think you
5 have been in the hearing during the day, from Ms Hargrave
6 who gave evidence of a situation of a woman who was driven
7 over, was unable to walk, the doctors were unable to say
8 definitely that her disability was permanent and therefore
9 wasn't able to access the fund. Is that a situation where
10 someone wouldn't be able to take up this initiative?

11 MR FONZI: Without hearing more about the specific case, if it
12 wasn't determined that it was permanent, then they
13 wouldn't be eligible. But I would just like to add that
14 in situations where - we can show some discretion in some
15 situations and if there was no other available funds to
16 assist a woman to escape the family violence, we could
17 show some discretion in that situation.

18 MR MOSHINSKY: But in terms of discretion, are you able to
19 exercise discretion in terms of whether they meet a
20 disability within the definition of the Act?

21 MR FONZI: No, that's pretty fixed. But I guess the point I'm
22 trying to make is that where we are faced with a woman who
23 has a barrier to escape family violence and if there is no
24 other way of supporting that, then we would do all that we
25 could to assist her to escape the family violence.

26 MR MOSHINSKY: Are you referring to perhaps drawing on other -
27 - -

28 MR FONZI: Initially, yes, we would look at what other supports
29 were available, yes.

30 MR MOSHINSKY: I think this has been drawn to your attention
31 that the lay witness who gave evidence on day 8 was a

1 woman with a disability and she had been subject to
2 violence from her partner who was also her carer. The
3 police took out an intervention order which precluded him
4 returning to the home and Child Protection were also
5 involved. But, notwithstanding the police involvement and
6 the Child Protection involvement, for a period of eight
7 weeks there was no-one else provided as a carer and she
8 didn't have a shower for some eight weeks. Is one of the
9 issues communicating the message that the initiative is
10 available to relevant people such as police and Child
11 Protection?

12 MR FONZI: I think that's the case. From what I heard of the
13 case, I think that's what happened in that instance. We
14 do quite a bit of promotional activity. There's a
15 full-time liaison officer and more and more of her time is
16 spent visiting agencies and promoting the initiative and
17 providing information about it. It was one of the issues
18 that was identified in the independent evaluation that was
19 undertaken after the pilot and so the promotional
20 activities were significantly increased.

21 MR MOSHINSKY: The last question I wanted to ask you was about
22 what will happen, so far as you are able to say, under the
23 NDIS. You deal with this towards the end of your
24 statement, but what's the bottom line in terms of will
25 this initiative continue after the NDIS commences?

26 MR FONZI: The service type and the funding for this initiative
27 are in scope to transfer to the National Disability
28 Insurance Agency. So what that means is that, upon full
29 implementation, the State Government would not provide
30 this service. So what we are doing in the transition
31 process is that we are advocating very strongly to the

1 National Disability Insurance Scheme about the need for
2 this kind of response to continue. My understanding is
3 that the NDIA are aware of that and they are doing some
4 work to look at how they deal with crisis response across
5 the whole of the population that's eligible for the NDIA,
6 not just for this specific group. But we are certainly
7 making it clear that this is a keen need that's required
8 and needs to continue, and in the interim we will continue
9 in the State Government to provide the service right up to
10 the transition period to make sure no one falls through
11 the gaps.

12 MR MOSHINSKY: What's the timing on finding out whether it will
13 be continued under the NDIS?

14 MR FONZI: The bilateral agreement has to be signed or is
15 planned to be signed later in August. It will give quite
16 a bit more information about what the timing and the
17 phasing will be. The full implementation is in June 2019,
18 so it will be some time between August and that period and
19 we will need to work with the NDIA about how we transition
20 this particular function. So, I don't have any sort of
21 more definitive dates other than that particular period.

22 MR MOSHINSKY: So is the position that it's as yet not clear
23 whether this sort of initiative will be able to be
24 available after the NDIS commences?

25 MR FONZI: My understanding is that crisis response will be
26 available and that will be a service that's provided by
27 the NDIA, and it will be provided so all of the clients
28 that are responsible, and that's the type of service that
29 will be able to take over from this particular initiative.
30 So, as best I can tell, it's something that would be
31 provided as part of crisis response, but at the end of the

1 day it will be up to the NDIA to decide how and when it
2 phases that in.

3 MR MOSHINSKY: Thank you. Do the Commissioners have any
4 questions?

5 COMMISSIONER NEAVE: I just have one. Will the crisis response
6 deal with a situation where the woman herself would not be
7 a recipient of support under the NDIS, but the child is
8 disabled and because the woman is escaping family violence
9 she has an issue about where she is going to go and how
10 she's going to manage?

11 MR FONZI: Under the current arrangements that would be
12 eligible. My understanding is that that should be
13 eligible under the new scheme and that's certainly
14 something we will advocate to because it is the same
15 eligibility as we require at the moment. As I said, the
16 NDIA will make decisions about that, but I would have
17 thought that that should be something that should be
18 covered.

19 COMMISSIONER NEAVE: Does any other state have an arrangement
20 of this kind, because if Victoria is the only one and an
21 attempt is being made to get the Commonwealth to pick it
22 up, it might be in a stronger position to do so if other
23 states had a similar sort of arrangement; do you know?

24 MR FONZI: My understanding is no other state has one of these
25 programs and that was identified in the evaluation.

26 COMMISSIONER NEAVE: Thank you.

27 MR MOSHINSKY: If the witness could please be excused.

28 COMMISSIONER NEAVE: Thank you very much, Mr Fonzi.

29 <(THE WITNESS WITHDREW)

30 MS DAVIDSON: I call the next panel of witnesses. We have

31 Ms Maya Avdibegovic and Ms Elizabeth Becker, both of whom

1 are from inTouch, and Ms Joumanah El Matrah.

2 <MAYA AVDIBEGOVIC, sworn and examined:

3 <ELIZABETH BECKER, affirmed and examined:

4 <JOUMANAH EL MATRAH, affirmed and examined:

5 MS DAVIDSON: Perhaps can I start with you, Ms Avdibegovic.

6 Have you made a statement for the Commission? Are you

7 able to confirm that your statement is true and correct?

8 MS AVDIBEGOVIC: Yes.

9 MS DAVIDSON: Can you just explain perhaps what the role of

10 inTouch is and the communities that it serves?

11 MS AVDIBEGOVIC: Intouch Multicultural Centre Against Family

12 Violence is a statewide agency that provides services,

13 programs and responses to culturally and linguistically

14 diverse communities around issues of family violence and

15 we have been around for more than 30 years and the work

16 that we do is across the whole continuum of family

17 violence. So we run prevention activities, early

18 intervention programs, multi-disciplinary crisis response

19 and post-crisis response, advocacy research and we do

20 provide training to the mainstream services around

21 cultural competency.

22 MS DAVIDSON: Can I turn to you, now, Ms Becker. You have also

23 made a statement for the Commission?

24 MS BECKER: That's correct.

25 MS DAVIDSON: Can you confirm that that's true and correct?

26 MS BECKER: It is.

27 MS DAVIDSON: You are also employed with inTouch. Can you tell

28 the Commission what your role is?

29 MS BECKER: I'm the Principal Lawyer at inTouch, so I run the

30 inTouch Legal Centre.

31 MS DAVIDSON: So you are in the inTouch Legal Centre?

1 MS BECKER: I'm the Principal Lawyer at the inTouch Legal
2 Centre.

3 MS DAVIDSON: How many lawyers does the centre have?

4 MS BECKER: We currently have four lawyers employed and a
5 number of volunteers.

6 MS DAVIDSON: I think the statement and the inTouch submission
7 identifies that you also have a registered immigration
8 agent; is that correct?

9 MS BECKER: We do.

10 MS DAVIDSON: You are the only service that has an immigration
11 agent within - - -

12 MS BECKER: A family violence setting, that's correct.

13 MS DAVIDSON: Can I turn now to you, Ms El Matrah. You have
14 made a statement for the Commission?

15 MS EL MATRAH: Yes, I have.

16 MS DAVIDSON: Can you confirm that that's true and correct?

17 MS EL MATRAH: Yes.

18 MS DAVIDSON: Can you tell the Commission what your role is and
19 what your organisation is involved with?

20 MS EL MATRAH: I'm the Executive Director of the Australian
21 Muslim Women's Centre. We are a nationwide service. In
22 Victoria we provide services, one-to-one support and also
23 information to Muslim women around ostensibly anything
24 that could be called the social welfare issue, and so we
25 do do a lot of work on domestic violence and we provide
26 training for service providers in Victoria.

27 MS DAVIDSON: Perhaps to begin with I will ask you,
28 Ms Avdibegovic, you are a migrant yourself; is that right?

29 MS AVDIBEGOVIC: Yes.

30 MS DAVIDSON: Can you tell the Commission from your experience
31 what the experience of a migrant is like, when does it

1 start and when does it finish?

2 MS AVDIBEGOVIC: Migration experience, and I'm talking about
3 this again in the context of family violence, so migration
4 experience on its own, it's a fairly important milestone
5 and a very traumatic experience even under the best
6 circumstances. But when you add other complexities to
7 that and experience of family violence, it becomes really
8 complex. Migration has a very big impact on
9 perceptions of how you experience family violence.

10 In terms of the migrants and newly arrived
11 communities, that whole journey starts pre-migration. We
12 have communities who have different pre-migration
13 experiences, and pre-migration experiences have big impact
14 on issues around family violence and when they happen once
15 families arrive to Australia. A lot of families, there
16 are families who have spent all their lives in refugee
17 camps, there are families who have had very traumatic
18 pre-migration journeys.

19 In terms of the settlement experience, that's
20 also another journey. Settlement is also not one point in
21 time. It's a lifelong journey for the first generation of
22 migrants and also experiences of settlement have a really
23 big impact on the experience of family violence.

24 MS DAVIDSON: Can I address the question perhaps to all the
25 panel members, but what is the role of culture and family
26 violence?

27 MS AVDIBEGOVIC: I might start and then I will pass it to you.
28 I think what we fairly often see when it comes to issues
29 of family violence in CALD communities is we quite often
30 hear the statement, "It's our family violence, but it's
31 their culture," and we quite often focus on some cultural

1 practices and some very specific forms of family violence
2 and very easily attach the label of culture to those forms
3 of family violence. I'm talking in particular about
4 issues such as honour killings, forced marriage, female
5 genital mutilation, dowry, those kinds of things. I'm not
6 saying they don't exist, I think that they exist, but they
7 are only the tip of the iceberg when you look at the
8 complexity of family violence issues in CALD communities.

9 I think what we really have to talk about is that
10 universal culture and that's the culture that excuses
11 violence and that's the culture of gender inequality, the
12 culture of male dominance, the culture of power and
13 control being perpetrated by men. So the causes of
14 violence are the same as in the mainstream communities and
15 we have to be very mindful of that. Saying that, where
16 culture plays a really big role is in how we provide
17 support and how do we develop and tailor the programs that
18 target CALD communities from prevention to post-crisis
19 support, that's where we need very a targeted approach and
20 that's where we need to take into account the role of the
21 culture.

22 MS DAVIDSON: Ms El Matrah?

23 MS EL MATRAH: The only thing I would add to that is that men
24 who are violent against their spouses or children or so
25 forth often themselves use the cultural defence. It's
26 really typical for men who are violent to have excuses for
27 their violence, anything else other than accepting
28 responsibility. So it's really important at that point
29 that people are well versed in exactly what violence is
30 about and that it's not about culture.

31 The other thing that I would add to really

1 reinforce Maya's point is that unless you attend to the
2 issues of culture when you are working on prevention and
3 shifting community attitudes and the way gender inequality
4 manifests itself in different cultures, you are unlikely
5 to actually be able to manage change and to eradicate
6 violence.

7 MS DAVIDSON: On the topic of accessing services and the
8 support and providing support to women and children from
9 culturally and linguistically diverse communities, we have
10 a slide in relation to some research that was done by
11 Dr Satyen which compares some of the reasons why migrant
12 women might - I might need to have one of these passed up
13 to you - not seek help relative to non-migrant women.
14 I think each of you deals with these sorts of issues in
15 your statements.

16 The first issue that often is discussed in
17 relation to migrant women is knowledge. How does the
18 knowledge of services differ within migrant communities
19 compared to within non-migrant communities and how does
20 that play out in terms of accessing services and support?

21 MS AVDIBEGOVIC: Talking about newly arrived communities, you
22 obviously have someone who has just arrived to the country
23 and they really do focus on what are the priorities for
24 them when they want to settle. So, finding out about
25 family violence at that point in the time might not be the
26 priority for the newly arrived communities.

27 You also have to understand that those newly
28 arrived families left everything behind and have come to a
29 country, to a completely different system. So, apart from
30 language barriers, there is also huge gaps in their
31 knowledge about how the system works and what is available

1 to them. The current Australian system might be
2 completely different from what is available in their own
3 country, if there is anything existing at all. So there
4 are a lot of those gaps, particularly in the first years
5 of migrating to Australia, that newly arrived communities
6 have to deal with.

7 On top of that there are some other barriers in
8 terms of accessing services and in particular to family
9 violence services but also to justice and legal services.
10 In 2009 we did a research called "Legal barriers for CALD
11 women experiencing family violence" and that research
12 report talks a lot about the range of barriers on two
13 different levels: first of accessing the services and
14 then, secondly, once they are in the court and justice
15 system, other barriers that they experience.

16 So there is a range of that, and I don't want to
17 repeat all of them because they are all in our submission.
18 But maybe Elizabeth wants to talk a little more
19 specifically about legal barriers.

20 MS BECKER: Yes. What we found at the inTouch Legal Service is
21 there are a number of steps that our clients fall through
22 the gaps in mainstream legal services. There is the
23 original issue of a lack of knowledge of the legal system,
24 of fear of authority, of language barriers, of social
25 isolation, but when they actually do try to engage a legal
26 service, any kind of referral is extremely difficult for
27 our clients. If they are referred to an alternative legal
28 centre or if they are just being given, like at court, a
29 brochure about legal services, they can't actually follow
30 through that next step of where to go. That's how we at
31 inTouch try to carry them through the continuum of the

1 legal issue.

2 MS DAVIDSON: Ms El Matrah?

3 MS EL MATRAH: I would support all those insights. I would
4 also add that for some women they do experience a range of
5 restrictions that are tied to their cultural entity. One
6 may be a generalised prohibition within their community
7 around not breaking the family apart and the blame that
8 targets women when they try to leave a violent situation.
9 Often their families actively try to restrict them from
10 accessing assistance and help. I'm sure you guys would
11 have had a lot of experience where women have come to
12 court, say, to get an intervention order or something like
13 that and have found not only the perpetrator there with a
14 community leader, but in fact not only his family, but in
15 fact her family as well, trying to prevent her from
16 getting an order. So, those things are really important.

17 The final thing I would say is that when women go
18 to religious leaders, this doesn't occur nearly as much as
19 people say, but where they do go to religious leaders,
20 often religious leaders use religion as a prohibition of
21 seeking outside help as well.

22 MS DAVIDSON: The data in the slide identifies that not knowing
23 that domestic violence is illegal is a much bigger issue
24 for CALD communities than non-migrant communities. Not
25 knowing how to get protection is also a much bigger issue.
26 How do you go about breaking down those knowledge gaps in
27 migrant communities?

28 MS AVDIBEGOVIC: Obviously prevention and awareness raising
29 plays a big part in that, but I also think what is even
30 more critical is provision of the crisis intervention
31 services at that end. So when you finally have a woman

1 that is brave and courageous enough to seek assistance and
2 disclose all the details of her personal life when she
3 comes to the service, and I will talk about our service in
4 this example, we have developed a model that is trying
5 really hard to overcome a lot of those barriers.

6 So, engaging bicultural, bilingual workers is the
7 first step. I know that we quite often talk about issues
8 around interpreters a lot and how to overcome those. I'm
9 not going to talk about it now, but I just want to say
10 that even in the case where you have a perfect interpreter
11 there, it's a third person between the case worker and the
12 client and that whole issue of establishing trust and the
13 relationship and enabling that client to disclose most
14 personal details is actually a huge barrier.

15 So we promote that use of bilingual, bicultural
16 workers and we developed a model in our service where we
17 have 12 workers who provide services in 25 different
18 languages and that makes a huge difference. In addition
19 to that, and Elizabeth mentioned that earlier, a lot of
20 our clients are women who don't have permanent residency,
21 so that is obviously a huge barrier and a huge sort of
22 risk factor for those women. We are the only service that
23 has an in-house registered migration agent, the only
24 family violence service, and she specialises in providing
25 support to women who are on spousal visa and accessing
26 family violence provisions under the Migration Act.

27 We supported 377 women in the last financial year
28 to access family violence provisions, but I have to add
29 there that that service has been provided by inTouch for
30 the last 15 years and it's an unfunded service.

31 In addition to that, we established an in-house

1 legal centre. So, legal needs are obviously huge and
2 access to legal system and to justice system is a huge
3 issue for our client. So we again have that in-house
4 legal centre which practices so-called therapeutic
5 lawyering model which is based on social workers and
6 lawyers working together. The clients are really
7 transitioned softly from their case workers to the
8 lawyers. There is ongoing communication between case
9 workers and lawyers and they are continuously working
10 together on client files.

11 In addition to that court support, we see a lot
12 of clients coming to the court, in particular after the
13 weekend, and the safety notice is being issued on the
14 weekend. In most of those cases they are police initiated
15 intervention orders; clients - it's not their will to be
16 there and they don't know what to expect. So, having case
17 workers at the courts is really important. That can make
18 the whole journey very, very different for the clients,
19 and really when you catch them at that early stages and
20 provide information about services available, that can
21 make a huge difference. At this stage we have case
22 workers at Sunshine, Dandenong and Heidelberg courts.

23 So, those are sort of the elements of the model,
24 I think, that is quite appropriate to meet the needs of
25 CALD women when they experience family violence and the
26 model that can support them and make sure that a lot of
27 those barriers - that we overcome a lot of the barriers.

28 MS DAVIDSON: Can I just take it back just a step. How do they
29 get to know, one, that it's illegal; two, that there is a
30 service out there that can help? How do they even get to
31 your service in the first place? What sort of things do

1 you think need to happen in the system in order to improve
2 the knowledge of women in the first place of what the
3 system can provide, that family violence is illegal, that
4 they can perhaps approach police officers, that they can
5 trust police officers potentially to do the right thing?
6 How do we get women to a service like yourselves earlier
7 in the piece? Do you have any ideas about that?

8 MS AVDIBEGOVIC: I think it's not only about how do we get them
9 to come to our service. It's also about how do we get to
10 them and how do we make ourselves more accessible.
11 Obviously a lot of work in the prevention, awareness
12 raising, providing information, that's quite important,
13 but it's only the initial step. A lot of our clients come
14 to us through the courts, so I think courts are a really
15 good place where you can access those clients quite early,
16 because we can see a lot of clients, even if there is an
17 intervention order and they come to the court, you see
18 them there and then they disappear. They either withdraw
19 the intervention order or they don't provide the
20 appropriate support and they just - they are lost to the
21 system. So for them to come back to the system again,
22 it's a real issue.

23 A lot of our clients come through other family
24 violence services, but a lot of them are also
25 self-referrals. About one-third of the clients that we
26 see are self-referrals. I would assume that would be
27 through specific agencies that we provide information with
28 and work through them, that would be through settlement
29 services that we also work with. So there are other ways
30 of providing information to the other services and raising
31 that awareness.

1 But, as I said, it's also a matter of us going to
2 them and improving access for them. What I see from our
3 service, we are a statewide service that has a head office
4 centrally located, but what we try to do is to establish
5 outposts at the courts. We are now partnered with Maurice
6 Blackburn so we have access to their office space in
7 Dandenong and Sunshine and can provide outposts there.
8 From October this year we will have an outpost in
9 Dandenong Hospital. So, it's those places where those
10 women will come and seek the help.

11 I think that's something that we should think
12 about how to improve access for them, particularly in
13 those areas where we have a high CALD population, for
14 example Dandenong where you have 60 per cent of the first
15 generation migrants, and then it's the whole question of
16 what is the mainstream there. Should we only have CALD
17 services in Dandenong providing services to all the
18 population?

19 But in those areas, Dandenong, Sunshine,
20 Broadmeadows, it's really important to make sure that we
21 have outposts there where clients can access the services.

22 COMMISSIONER NEAVE: Counsel, I have a question about that. At
23 Dandenong and at Heidelberg there are applicant workers
24 and respondent workers who deal with the victims of family
25 violence and those against whom they are seeking orders.
26 There will be a duty lawyer. There will be various other
27 people. How does inTouch work with the other bodies that
28 are at those courts? Not at all courts, but at those
29 courts?

30 MS AVDIBEGOVIC: We are part of the court support network at
31 both Dandenong and Sunshine and Heidelberg. I think the

1 roles - we have been there for quite a while, so the roles
2 are quite defined and clear and they know which days we
3 are on. That was all done in consultation with the court
4 staff, that the magistrates and the court staff really
5 knew what were the most important days for us to be there.
6 So in Sunshine and Dandenong we are there on Monday and in
7 Heidelberg we are on Friday because it's now under - - -

8 COMMISSIONER NEAVE: Just as a practical matter, if somebody
9 goes to the registry at the court, they would be told,
10 "There is a worker from inTouch here who may be able to
11 speak your language," won't always, but may be able to and
12 at least will have some insights into the difficulties
13 that CALD women face.

14 MS AVDIBEGOVIC: Yes, the applicant workers would also refer
15 them.

16 COMMISSIONER NEAVE: So they'd work together with the applicant
17 workers, presumably.

18 MS AVDIBEGOVIC: Yes.

19 MS DAVIDSON: Ms El Matrah, from your perspective how do we
20 overcome or are there other points in the service system
21 where migrant women might make an early contact, health
22 services, those sorts of places where there are greater
23 opportunities, if we were to tap into them, to improve the
24 ability for women to know about services and access
25 services earlier?

26 MS EL MATRAH: I think there is always a lot of work that can
27 be done on the service sector itself, raising their
28 awareness how to engage with CALD women and specifically
29 Muslim women and I think work can be done there. In my
30 own experience, 20 years of working on violence, I find
31 that the best thing has been community education and going

1 out to women and consistently doing that to inform them of
2 what domestic violence is, the impact of domestic violence
3 on their lives, because a lot of women don't understand
4 that and, when they do, that can propel them forward, and
5 what are the services available.

6 When we have done that work over a five-year
7 period, one-to-one case work, the women who are accessing
8 our support for domestic violence jumped from 40 per cent
9 of our case work to 80 per cent of our case work, so this
10 is really a very powerful strategy that unfortunately we
11 have not rolled out very much. So, increasingly
12 government and services have relied on written material
13 about family violence. It just doesn't work in the way
14 that actually going out to women's groups and working with
15 them, getting onto the radio, getting community leaders to
16 do some messaging around family violence, not to do the
17 work but to do the messaging.

18 I think that to date we haven't made those
19 investments and I think if the investments were made, in
20 addition to work increasing the knowledge of the service
21 sector about how to respond to CALD and having people
22 present at the courts, that in itself I think would make a
23 substantial difference. The sort of work we have done for
24 the Australian community or the Anglo-Saxon community
25 around awareness raising is far greater than anything we
26 have done with CALD communities, so that needs to be done.

27 The final thing I would say is that I think a
28 shift in the culture for Muslim communities around family
29 violence and for women specifically would be greatly
30 assisted by if there was a refuge specifically for Muslim
31 women because we feel that that's the greatest barrier for

1 women wanting to leave a situation of violence. They are
2 just too scared about where they're going to go and the
3 consequences of that, and that's become a sort of cultural
4 impediment, really.

5 MS DAVIDSON: Is that the case for other CALD communities and
6 CALD women, not having access to a service that is
7 specifically for them? Is that an experience that you
8 would have observed?

9 MS AVDIBEGOVIC: Yes, definitely. In terms of the housing and
10 the crisis accommodation, definitely there are other
11 issues. We know the issues for Muslim women. We also
12 know the issues around large families who have a lot of
13 children. We know issues of the boys of a certain age not
14 being able to accompany their mothers and go there. But
15 also the women who don't have permanent residency, there
16 are issues there because they are not eligible for a lot
17 of other services like the financial support and because
18 of the process of applying for permanent residency under
19 the family violence provision, that whole process can take
20 up to a year.

21 So, if you have a woman in a crisis accommodation
22 and you don't actually have an exit plan for that client
23 and she can stay there for a year instead of what is an
24 average of six to eight weeks, it really creates a lot of
25 blockages in the system. So we have seen a lot of
26 refuges - I think they are doing their best to accommodate
27 those clients, but they really have to be mindful of how
28 many of them they can accommodate.

29 The other issue is also women on student visas.
30 It's really conflicting for them. If they need to go to a
31 refuge, most of the refuges are high security refuges.

1 They can't continue attending their university courses and
2 if they stop attending their university courses that has
3 immediate impact on their visa status. So they are really
4 in a very, very difficult position. So I think some of
5 the housing services and the crisis accommodation services
6 that meet specifically the needs of CALD women, that would
7 be really good.

8 MS DAVIDSON: We heard from a witness on the first day of the
9 hearings who had four children and was unable to find
10 accommodation for herself and four children. How much
11 accommodation is there, in your experience, that would
12 cater for large families?

13 MS EL MATRAH: It is not even 10 per cent, I think, of the
14 housing stock caters for families of that size, and women
15 have made choices about what children to leave behind, and
16 it's worked against them later on when they have sought
17 custody. It specifically disadvantages women.

18 MS DAVIDSON: Can I perhaps raise the issue of perpetrators, if
19 they are from a CALD community. To what extent are there
20 services available for men who use violence in a language
21 and that are culturally appropriate to their needs?

22 MS AVDIBEGOVIC: There are almost none. As far as I know,
23 there are few of them. We started, in partnership with
24 other services, in 2009 the first Vietnamese men's
25 behaviour change program. So that's been running for six
26 years now, with very sort of sporadic funding
27 opportunities and I think for the first two or three years
28 it was funded by the partners. We are also in the process
29 of establishing Arabic speaking men's behaviour change
30 programs.

31 So all of these programs are designed according

1 to No To Violence standards for men's behaviour change
2 programs. In addition to that we have three additional
3 weeks and those are the first three weeks of the programs
4 where we cover some specific issues such as pre-migration
5 experiences, torture, trauma, settlement, migration
6 experiences and their impact on family violence, and then
7 gradually start talking about it.

8 But still it's a program; at the end of the day
9 it's still a program that is designed for mainly Anglo men
10 rather than taking into account what would work for CALD
11 men. If you ask me what would work for CALD men, I don't
12 have an answer to that because we haven't done any
13 research on that. That's a huge gap.

14 Also there are some South-Asian programs designed
15 for the South-Asian group that are delivered in English,
16 but are taking sort of into account specific cultural
17 issues, and that's all that is there. So if you have a
18 perpetrator who is mandated to attend a program but he
19 doesn't speak English, there is nowhere for him to go. So
20 it's almost giving him again permission to continue
21 perpetrating violence because there is no punishment for
22 him.

23 So I think what we need to start looking at is
24 more CALD-specific men's behaviour change programs. We
25 also need to look into what are the other options and do a
26 bit of research and actually talk to CALD communities,
27 because I think that whole question about the difference
28 between individualist and collective sort of communities
29 has to be taken into account there, because the approach
30 is it might not be that CALD men feel comfortable sitting
31 in a group environment with 10 other men that they don't

1 don't know and talk about their most personal things.

2 There are also some other programs that we can
3 look at, programs that are focusing on fatherhood. That
4 might be an option. Some other early intervention
5 programs that are quite important, in particular for newly
6 arrived migrants. So, there is a whole range of
7 unexplored sort of territory there that we need to look
8 at.

9 MS EL MATRAH: I would agree with all of that and would add
10 that for Muslims there hasn't really been any engagement
11 in Australia, and actually not just for Muslims, but for
12 religious communities, spiritual abuse, which is basically
13 the use of religion to justify gender inequality and to
14 justify violence against women. A lot of that work is
15 happening in the US and it's happening in Canada and other
16 European countries, and in Australia we seem to be
17 completely silent about that and we focus on religious
18 leaders rather than tackling spiritual abuse.

19 So there needs to be a way of actually dealing
20 with that too. No sort of preventative program can be
21 developed or is going to be useful unless spiritual abuse
22 is actually looked at, because at the moment what you have
23 is that men who promote Islam have one particular view to
24 women and violence and western culture has another view to
25 women and experience of violence, and religious leaders
26 and men saying, "I'm not going to give up my religion just
27 to fit into Australia." So we shouldn't even allow men to
28 get into that sort of dichotomy. Any work with men has to
29 attend to that issue.

30 MS DAVIDSON: There has been often talk about faith based
31 approaches to preventing family violence. Do you have a

1 view on that issue?

2 MS EL MATRAH: The faith based approach was brought into
3 Australia because of some research that had been
4 done - some work that had been done in the US. That
5 literature and the work that was done in the US is not in
6 any way comparable to the sort of diversity of communities
7 we see in Australia. So I would dispute whether the work
8 done in the US has any relevance for us here in the first
9 place.

10 The second thing is that the vast majority of
11 faith based work that people have tried to undertake has
12 actually focused on religious leaders. There is no way
13 for us to make religious leaders accountable for their
14 conduct, accountable for what they say, and we cannot
15 monitor what they say to women and men when they are alone
16 with them. We also cannot police community leaders'
17 views. So it has been highly problematic, this sort of
18 I would say slightly naive approach to the issue.

19 It is important to recognise where religion plays
20 a role and most especially if you are undertaking
21 preventative work and to recognise that women do have a
22 religious identity that is important to them and must be
23 catered for and respected, but that doesn't mean you need
24 to work with religious leaders. It is more important to
25 work with organisations and experts who actually can
26 demonstrate their expertise, have undertaken work in the
27 area and perhaps are even registered to do the work, and
28 not with religious leaders who happen to be saying the
29 right thing to the right people and perhaps saying
30 something entirely different to their community.

31 The final thing I would say is that while

1 religious leaders may not agree with violence against
2 women, a great number of religious leaders do see men and
3 women as unequal and the idea of men being superior to
4 women is one of the lead contributors to violence against
5 women. Unless that shifts, no amount of support to them
6 to eradicate violence is going to work.

7 MS AVDIBEGOVIC: We haven't had a lot of experience in working
8 with the faith leaders. We mostly target community
9 leaders and work with them, and with our previous
10 prevention project we had some of our taskforces
11 established in four different communities. Some of the
12 members were faith leaders.

13 In terms of working with the faith leaders,
14 I think it's quite challenging work and it is hard work,
15 but I think some efforts need to be made in educating
16 those who are responsive, finding those who are responsive
17 in the right way. It's obviously quite challenging. I am
18 aware of the Jewish taskforce against family violence,
19 that they have done some really good work with rabbis and
20 teaching them how to respond to women and how to refer.
21 But it's getting that across sort of the whole community
22 is quite different.

23 I would say engagement there, because you have a
24 specific agency working with a specific community, it's a
25 lot easier rather than inTouch as a statewide agency
26 working with a huge number of different communities. The
27 engagement with the faith communities would be an issue.

28 MS EL MATRAH: I think that work was led by women, actually, in
29 the Jewish community.

30 MS AVDIBEGOVIC: Yes.

31 MS DAVIDSON: In terms of providing a culturally appropriate

1 response system and a service system that is responsive to
2 the needs of CALD women and their children, I think you
3 have talked about in your statement - I think you might
4 have all talked about this issue - but the idea of
5 workforce development in non-CALD specific agencies, so
6 more mainstream agencies and workforce development going
7 beyond being culturally appropriate but actually having an
8 intention to employ and develop bilingual workers. Can
9 I ask you to comment on that issue?

10 MS AVDIBEGOVIC: I think generally what we have in Australia
11 and in Victoria is 26 per cent of the first generation
12 migrants, 20 per cent of those speak languages other than
13 English at home, so we have this huge potential there of
14 the workforce, not only in family violence or community,
15 but across all of the industries where we are not tapping
16 in appropriately and using those resources.

17 But when it comes to family violence, I think
18 it's even more important. I talked about it before. When
19 you have an interpreter as the third person between the
20 case worker and the client, it makes a huge difference,
21 and we see that every day. Elizabeth can talk about it a
22 bit more because she works with the family violence
23 workers and the clients that are referred to her and what
24 is the difference that is made by service provided in
25 language.

26 I understand that we can't simply provide
27 services in all possible languages or have people
28 available who can support clients all the time in their
29 own language, but making that first initial contact with a
30 client, it makes enormous difference when it's done in a
31 language by someone who understands the culture and the

1 whole understanding of family violence in that culture.

2 We heard occasionally that some women don't want
3 to be supported by someone from their own community.
4 I heard about it. We haven't experienced it in our
5 service.

6 MS DAVIDSON: Ms Becker, perhaps you could identify how many
7 languages you do provide services in at inTouch?

8 MS BECKER: Our case workers speak 25 different languages,
9 which is an astounding amount. When we are seeing
10 clients we do utilise interpreting services, but my main
11 preference is to have our case workers present. The
12 bilingual and bicultural element that they bring is so
13 vital. The use of interpreters is obviously such an
14 important element to the clients giving their
15 instructions, to providing their story, and the ease at
16 which the case managers at inTouch can establish a rapport
17 with the client, allow them to feel that trust between the
18 two that they can then convey their story.

19 When the case workers aren't there, when we have
20 an interpreter, it takes so much more time to establish
21 that system of trust and also just ensuring that the
22 interpreters are actually interpreting the right
23 information. There's quite often such variations in legal
24 terminology that it's sometimes missed. It can be
25 confused for the client, especially using telephone
26 interpreters rather than on-site interpreters.

27 MS DAVIDSON: Ms El Matrah, is that your experience as well for
28 Muslim women?

29 MS EL MATRAH: Yes. I think there is a general problem in the
30 welfare sector around the homogenisation of the workforce.
31 There are less appropriately skilled workers around.

1 Mainstream services and their workers are not required,
2 there is no mandatory training for people who don't come
3 from relevant communities or people who are not bilingual
4 to make sure they undertake annual training and they keep
5 up their training around cultural diversity and culturally
6 appropriate practice.

7 The funding model that the government has gone
8 with, the mainstreaming model, it argues can sufficiently
9 service women. All the international research says that
10 doesn't happen. In fact, women do not get a service when
11 you mainstream, when you try to mainstream gender. So
12 when you try to mainstream gender, ethnicity and faith,
13 I think you are probably not servicing a whole variety of
14 women who need assistance. Sometimes the government
15 argues that it is a cheaper thing to do, but when services
16 are referring women to each other because nobody has the
17 exact skill base, that is not a more efficient way to run
18 things. That is exactly our experience.

19 I think that it is not as difficult as government
20 and organisations believe to employ a culturally diverse
21 workforce. All our employees at the centre, and we employ
22 eight, are multi-lingual. Sometimes people speak two or
23 three languages. It is possible to get that level of
24 expertise.

25 MS AVDIBEGOVIC: Can I just add to that that we don't forget
26 that, in addition to being bicultural and bilingual, that
27 those workers are actually accredited family violence
28 workers. So, focusing on just the language and the
29 culture skills, that doesn't mean that the service can be
30 provided by the volunteers, and that's our great concern.
31 We have seen a lot of small organisations coming up and

1 with the best intention of supporting the women, but not
2 working within agreed sort of frameworks and codes of
3 practice that are established within the sector, not being
4 able to do appropriate risk assessment and I think a lot
5 of them actually are putting clients at higher risk. So
6 the workforce, what we are recommending is the family
7 violence and culturally competent workforce.

8 MS EL MATRAH: Yes, I think you want a combination of
9 mainstream services and specialist services, but really
10 specialist services.

11 COMMISSIONER NEAVE: Counsel, I just wanted to follow up on
12 that point. All of you may want to respond to this. What
13 do you consider is the most effective means of providing
14 this training? So we have somebody who is bi- or
15 multi-lingual, but may not have any expertise in family
16 violence. What sort of qualification would they have to
17 do, or would it be based on their experience? How would
18 you train your workforce? What do you do?

19 MS AVDIBEGOVIC: We have experienced a lot of issues around
20 that where we employ our case workers, because I think
21 that the model we are building is based around that
22 bicultural, bilingual workforce. But you sometimes can't
23 find all of that in one person, so they might not have
24 enough experience or any experience here in Australia,
25 they might have different qualifications, which I have
26 seen with our case workers. I have case workers who are
27 psychologists, I have case workers who used to be
28 architects back home in their countries.

29 So what we are looking for is a range of issues,
30 is a range of skills and attributes that it's really hard
31 to find in one person. So what is not negotiable for us

1 is the language and the culture. What is also an added
2 bonus is that all of our case workers are migrants or
3 refugees themselves so they have that life experience and
4 added understanding of the issues around migration and
5 settlement. Other skills, which is the family violence
6 competence, they can learn that.

7 We have the basic standards, so most of our case
8 workers have qualifications either in community
9 development or welfare, some of them as I said are trained
10 counsellors, so it's a range of activities, and then once
11 when they start working with us, if they don't have any
12 family violence experience, there is a set of five modules
13 that we expect them to complete before they start working
14 with the clients and there's the training around risk
15 assessment, around family violence, family violence law,
16 case notes and then working with the database. So, those
17 are the sort of five basic modules and then we build up on
18 that.

19 COMMISSIONER NEAVE: Thank you.

20 MS EL MATRAH: I think the only thing I would add to that is
21 some of the attitudinal stuff around gender equality.
22 I have discovered you can't assume, you actually have to
23 train for that, because so much of that is not spoken. So
24 you do have to do some of the attitudinal training as well
25 around gender.

26 COMMISSIONER NEAVE: Thank you.

27 MS DAVIDSON: What about issues with interactions between CALD
28 women and police? What issues have you identified arise
29 for the Victoria Police and how would you see those being
30 addressed?

31 MS BECKER: One of the main things for our clients is that fear

1 of authority, that fear of the police coming to the door.
2 It prevents them from seeking assistance in the first
3 place and it also prevents them from giving a full picture
4 of the level of violence that they have faced when they
5 are questioned about a violent situation.

6 The police have been fantastically supportive for
7 a lot of our clients, but there remains a number of issues
8 that are of concern where - I'm just recalling instances
9 where the police will attend upon a residence for a family
10 violence situation and there will be no interpreter
11 present, obviously, they have just arrived at a scene and
12 they will utilise family members to interpret for the
13 client. That's always proving difficult.

14 Where the clients are completely confused, they
15 have absolutely no idea where to go, what to do from that
16 point once an intervention order or a safety notice has
17 been taken out, and they are just completely lost. So
18 they will quite often come to us as a result of being
19 directed from meeting a case worker at court on a Monday
20 and they will have no idea of what to do, where to go or
21 sometimes no desire to continue with that intervention
22 order because of the community influences that go from
23 there.

24 MS AVDIBEGOVIC: Can I just add some of the really positive
25 experiences with the police, because I think we deal with
26 them on a daily basis and if there are issues - and we
27 recently had an issue with a certain client and that was
28 resolved in a matter of days. We basically had a whole
29 team from that particular police station coming to our
30 service, talking to our case workers and resolving the
31 issues and there is now an ongoing relationship going on

1 there.

2 Also in terms of we do some post-crisis work and
3 mainly around therapeutic group work, but also when we
4 manage to get some funding we do family camps where we
5 take mothers and children for three days and it's a
6 combination of sort of a holiday but also a lot of
7 therapeutic elements in that work. Every time we do that,
8 we do it in partnership with the police. They normally
9 provide us with transport. We would have two police
10 officers coming with us, staying sometimes for the whole
11 duration of the camp, in their civil clothes, and then on
12 the third day they put their uniforms on, deliver a
13 session, engage with children.

14 So, I think there is a lot of willingness and
15 effort from the police to engage with CALD communities.
16 I have to say that there are issues, but we are working on
17 them and the partnership has been really good.

18 MS DAVIDSON: Is there any protocol in place to enable women
19 who are identified as being from a CALD community, is
20 there a protocol in place for them to be provided by
21 police with your details, for example?

22 MS AVDIBEGOVIC: I think that's a bit of issue how the system
23 works, and I think in particular with L17s, and L17s are
24 going to the regional local family violence services.
25 I know that they are under a lot of pressure to respond to
26 them. I'm aware of the numbers. But I'm also aware of
27 how many CALD women are not serviced appropriately at that
28 end.

29 I know that some of those services actually use
30 messages, text messages, to inform women. They receive
31 L17 and the first contact with the clients to follow up is

1 done through SMS. It is done in a region that has a very
2 high CALD population, which I find quite amazing, and then
3 thinking how many of those women would not have access to
4 the mobile at all, that might be sort of with their
5 abusive partner. The second thing is that they will
6 receive a message in English. We don't know whether they
7 can read in their own language, let alone in English, and
8 whether they will understand that.

9 The message on its own, it's probably not the way
10 how you would engage someone from CALD communities, that
11 they might receive that message, leave it. It's highly
12 unlikely that anyone from CALD communities - any CALD
13 women would respond to that message and contact the
14 service.

15 I think we were there when we talked about it
16 together, Commissioners, when we heard about the SMS
17 messaging being used as a sort of way of contacting
18 clients. I know that's the way how the system has been
19 set up, so basically we receive them, clients are referred
20 to us by those services. I think there is a gap there.
21 There is something that needs to be changed in the system
22 so that we are involved in that process a bit earlier.

23 MS DAVIDSON: What about data collection? How good is the
24 data? In relation to CALD communities in order to help
25 inform you about what services are required, the rates of
26 family violence, the kind of violence that might be being
27 experienced, how good is that data and what needs to be
28 done there?

29 MS EL MATRAH: Vic Pol or the service sector in general?

30 MS DAVIDSON: In relation to family violence for CALD
31 communities.

1 MS AVDIBEGOVIC: I think there is a lot of space for
2 improvement there. In terms of L17, I know that there is
3 a field that is labelled, I think, cultural - ethnic
4 appearance, and it's not mandatory, it is optional.

5 In terms of the SHIP data that we use, the
6 homelessness data, it's a database that's created for
7 homelessness primarily and then for family violence. It's
8 an issue of collecting all of these little - all of those
9 things that are quite important for CALD women, the issues
10 around permanent residency. There is a lot of data that
11 we don't collect on that.

12 There is a lot of data that we don't collect in
13 terms of the barriers. Even when we are assessing risk,
14 risks for CALD women are different than for women from the
15 mainstream communities, so in terms of that I think there
16 is a lot of space for improvement. So, not having an
17 appropriate data system is really disadvantaging this
18 whole sector and the organisations working with the women,
19 so we don't have evidence, we don't have appropriate data,
20 we can't respond then in an appropriate way and it can't
21 inform any of the programs and initiatives that we want to
22 deliver.

23 MS EL MATRAH: I think at the moment, to sort of get any sense
24 of what's happening from the sector, you have almost got
25 to go service to service and just get little bits and
26 pieces where you can. The Department of Human Services
27 doesn't make its data available, which would be really
28 important, for example, and there's other government
29 departments. But even services don't make - some services
30 won't give you their data even if you ring them and ask
31 them.

1 Added to that, we have tried very hard to get
2 data on Muslim women accessing services for domestic
3 violence and nobody collects them. There seems to be the
4 perception that Muslims would be offended if that was
5 asked of them. I'm guessing some might be, but I think
6 others would give the information if they felt that it was
7 handled appropriately. We are of the view that that
8 information is extremely important for service planning
9 and it is difficult to service plan unless you have the
10 data.

11 MS DAVIDSON: Those are all the questions I have. Do the
12 Commissioners have any additional questions?

13 DEPUTY COMMISSIONER NICHOLSON: Thanks, counsel. I have one.
14 The Commonwealth government funds settlement services.
15 I was wondering to your knowledge does it include any
16 information or education about family violence or about
17 the law in Australia?

18 MS EL MATRAH: The Settlement Grants Program has moved away
19 from civic and legal literacy, which it used to do about
20 three or four years ago, and that allowed you to shift
21 civic literacy to family violence and the Family Courts
22 because that was women's area of interest. They no longer
23 do that.

24 There is a new model, so to speak, in which
25 services can dictate to a greater degree what they would
26 like to do, but nobody knows what that looks like now.
27 Nobody knows what services will choose to provide and
28 nobody knows how the department will respond to that. So
29 the department is talking at length about providing
30 information that domestic violence is illegal in Australia
31 once people arrive here, but that's a very complicated

1 thing to do and they are doing that with I think
2 single-sided A4 pages. So I think domestic violence,
3 sexual assault, early enforced marriage, and perhaps
4 there's a fourth which I can't recall, but it's very
5 limited information.

6 DEPUTY COMMISSIONER NICHOLSON: In the first year of
7 settlement, in your view is that the best time to be
8 trying to alert people to the Australian law and how
9 family violence is considered?

10 MS EL MATRAH: We really always go with where women are at, and
11 what we find is that they are interested in those issues
12 where they relate to their children. They are very
13 preoccupied with the welfare of their children and what
14 things are going to be like for them in the country. That
15 is the way we have used to start speaking about violence
16 in general and family and so forth, and in every situation
17 we have found women very open.

18 DEPUTY COMMISSIONER NICHOLSON: So under the new arrangements
19 for settlement grants, you think there is still an
20 opportunity to do some of those community education around
21 this issue?

22 MS EL MATRAH: It's unclear where the department is going to
23 go. It's upon services to run with what they think is
24 important. My experience of government is that there are
25 always limitations to that, so I'm not clear yet as to how
26 committed they are to services assessing what communities
27 need and then just providing it.

28 I should also say what hasn't shifted about SGP
29 funding is that they want the one-to-one work with women
30 to be very short-term and they want it to be more of a
31 referral service. So, if you are getting a woman who has

1 a domestic violence situation, according to the funding
2 rules you really can't spend enough time with her to do
3 that work and you really need to be referring her on.
4 Even if she comes back to you because she didn't get the
5 service she needed from another organisation, technically
6 you are supposed to refer her on again.

7 MS AVDIBEGOVIC: Can I just add to that? I think there are
8 different points in sort of journeys of migrant
9 communities where you need constantly to keep providing
10 information and to keep raising awareness, because the
11 responsiveness is not the same at all of those stages.
12 When you first migrate to a country you are focused on
13 employment, house, school for your kids, learning
14 language. Even if you experience family violence at that
15 particular point in time, you are so focused on keeping
16 your family together because that's the reason why you
17 migrate to a country, for that better life, for the better
18 opportunities for your children. Again it's all
19 responsibility again on women to - they simply can't make
20 that decision in early stages unless their lives are
21 really genuinely at risk.

22 So, I think at different stages we need to keep
23 providing different information. We are not one of the
24 settlement grant services providers, but I just want to
25 mention a really good program which is called Complex Case
26 Support and that's targeting migrants who have been in the
27 country for less than five years and who face complex
28 issues, so there is a whole range of issues. So we are
29 one of the providers of that program and that program
30 proved to work really well.

31 DEPUTY COMMISSIONER NICHOLSON: Thank you.

1 COMMISSIONER NEAVE: I do have one more question.

2 Ms Avdibegovic, what do you do about people in rural and
3 regional communities? How do you reach out to them?

4 There are people scattered all over Victoria from CALD
5 backgrounds. So is it a phone service?

6 MS AVDIBEGOVIC: There is a phone service and providing
7 secondary consultations to the workers from those
8 services, but that is really minimal. In terms, yes, we
9 are a statewide service, but the resources that we
10 currently have do not allow us to do any of that. We are
11 currently looking into means of using technology to
12 improve access, because I think there are great
13 possibilities there. But at the end of the day our
14 service is funded to provide support to 697 clients a
15 year. Last year we had 1,034 women, so stretching us to
16 beyond that is really hard.

17 But I agree with you that's something - on top of
18 that is another sort of barrier, another issue for CALD
19 women, if you have a woman experiencing family violence,
20 she is from CALD background and she is in rural and
21 regional areas where there is not that many services
22 available for them, it's genuinely a very complex issue.

23 MS EL MATRAH: Can I just add to that. We have been to a
24 certain area in Victoria where they must have had about 50
25 families located there from a country with a history of
26 war, long-term war, and none of the women in that area had
27 actually accessed any of the services there. The women
28 had been there for at least two, three years. The men
29 had, but not the women. So, those women weren't in any
30 way going to be able to access support without a targeted
31 sort of strategy.

1 The other thing is that some of the settlement
2 patterns can itself create sort of vulnerabilities for
3 women. So, for example, in Geelong we have the highest
4 sort of concentration of women at risk in rural Victoria,
5 women who came out on the women at risk category on their
6 own with children all concentrated in a certain area.
7 There's some funding towards that community, but the
8 challenges those women have are profound, to say the
9 least, and they do need not only additional support around
10 family violence, but also the impact of family violence on
11 their children which starts to become apparent a decade or
12 so later.

13 COMMISSIONER NEAVE: Thank you.

14 MS DAVIDSON: May these witnesses be excused?

15 COMMISSIONER NEAVE: Thank you all very much for your really
16 important and interesting evidence.

17 <(THE WITNESSES WITHDREW)

18 MS DAVIDSON: Commissioners, the next witness is joining us via
19 videolink from New South Wales. It's Stephen Lillie.

20 <STEPHEN JOHN LILLIE (via videolink), affirmed and examined:

21 COMMISSIONER NEAVE: There is a bit of an echo. I wonder if we
22 might try to deal with that before you give your evidence,
23 Mr Lillie. Is it possible to fix the echo?

24 MR LILLIE: I will just turn the volume down a bit. Is that
25 any better on my side?

26 MS DAVIDSON: It's a little bit better.

27 MR LILLIE: I will turn it down a bit more and see how we go.

28 MS DAVIDSON: You still need to hear us, that's all.

29 MR LILLIE: Yes, that will help.

30 MS DAVIDSON: Mr Lillie, you have made a witness statement for
31 the Commission?

1 MR LILLIE: That's correct.

2 MS DAVIDSON: Can you confirm that that's true and correct?

3 MR LILLIE: That's true and correct, yes.

4 MS DAVIDSON: Sorry, there is still a bit of an echo. I will

5 just ask our technical people. They are suggesting could

6 you turn down your speaker or use headphones. I think

7 there might be quite a significant delay, though, which

8 might be the problem.

9 MR LILLIE: We just have a laptop. There are a set of

10 headphones coming now. We will just see whether this

11 works. Is that any better?

12 MS DAVIDSON: Can you hear me now?

13 MR LILLIE: I can hear you now.

14 MS DAVIDSON: The echo has gone. We still have a bit of a

15 delay, but we will see how we go.

16 MR LILLIE: Okay.

17 MS DAVIDSON: Mr Lillie, you are a Men's Health Worker at the

18 Hawkesbury District Health Service?

19 MR LILLIE: That's correct, yes.

20 MS DAVIDSON: Can you just describe your role and the nature of

21 the hospital that you are in?

22 MR LILLIE: Hawkesbury District Health Service is a private

23 hospital that's funded to deliver a public service and we

24 are in Hawkesbury, which is about a 60 kilometre drive out

25 towards the mountains just above Penrith in the

26 Hawkesbury. Hawkesbury is about 65,000, is our

27 population, and we deliver the same services that all

28 other area hospitals deliver. It's just the contract is

29 run by Hawkesbury District Health Service to deliver that

30 service. So, it's no different to our counterpart, Nepean

31 Health.

1 MS DAVIDSON: Your role as a men's health worker, how common do
2 you see those sorts of roles in New South Wales?

3 MR LILLIE: As far as I'm aware, I'm the only full-time men's
4 health worker in the health system within Australia, and
5 definitely in New South Wales I can vouch that
6 100 per cent. In about 2009 the men's health policy was
7 withdrawn, so there is no funding for men's health inside
8 the health system.

9 MS DAVIDSON: You have been involved with the Yellow Card
10 system in New South Wales that was identified in an ARACY
11 research program as being an example of a program working
12 with men who were victims of family violence. Can you
13 describe what the Yellow Card system does?

14 MR LILLIE: Within the Hawkesbury, the Windsor area, local area
15 command, we are sort of semi-rural, so we have a lot of
16 contact as in most people that work in the Hawkesbury live
17 in the Hawkesbury. So we usually can get things done a
18 lot quicker because it is a lot more community focused.
19 The DV Yellow Card is throughout New South Wales, but in
20 the Hawkesbury, because of my position, all male victims
21 of domestic violence, that card gets faxed over to myself
22 and then I make the first point of call to the male victim
23 to engage with them.

24 MS DAVIDSON: How common is that sort of process in New South
25 Wales?

26 MR LILLIE: As far as I'm aware, Leslie, our domestic violence
27 officer at Windsor Police Station, they catch up I think
28 every three months with all the DVOs in New South Wales
29 and she believes we are still the only service that
30 actually offers support for male victims. All the other
31 areas will just offer the MensLine business card to the

1 client and it's up to the client to do something.

2 MS DAVIDSON: From your perspective, how important is it to
3 have a more proactive response to male victims?

4 MR LILLIE: Extremely high. A lot of the times people come to
5 counselling when they're stuck and it's no different to
6 what happens when they engage with the police service.
7 They're usually at a dead end in what's going on in their
8 life. So for them, even though I don't call them back in
9 a day or two, sometimes it might be a week or two weeks
10 because by the processes done, they feel validated that
11 they have been spoken to, that someone listens to their
12 concerns, and the majority of the time I'm giving either
13 education or resources of where to go to help resolve a
14 problem and I also make referrals into services like
15 Partners In Recovery or FamS to finalise and help things
16 and a majority of the time there are a lot of Family Court
17 issues around custody battles and relationship breakdowns
18 and family matters in that sense. But there are other
19 areas of elder abuse and also blended families which still
20 comes under the Family Law Act as well.

21 MS DAVIDSON: In the ARACY document a snapshot had been done of
22 the male victims who had been referred to you under the
23 Yellow Card program in 2011.

24 MR LILLIE: Yes.

25 MS DAVIDSON: That demonstrated one male victim of domestic
26 violence reported for every five female victims?

27 MR LILLIE: Yes, in Hawkesbury.

28 MS DAVIDSON: Yes. It had an initial statistical review of the
29 data showing 5.5 per cent of male victims of domestic
30 violence were under 18 years of age and were the victims
31 of their father's behaviour; 25 per cent of male victims

1 of domestic violence were the victims of their
2 ex-partner's behaviour; 25 per cent of male victims of
3 domestic violence were the victims of their son, grandson
4 or son-in-law's behaviour; 30.5 per cent of male victims
5 of domestic violence cited separation issues as the cause
6 of the incident; and 30.5 per cent of male victims of
7 domestic violence cited drugs and alcohol as the cause of
8 the incident or a major contributing factor. Are they the
9 most up-to-date statistics that you have?

10 MR LILLIE: They are currently the only statistics we have.

11 How those statistics came about is I actually went over to
12 the police station, we sat down and we went through every
13 Yellow Card and that information is only given by what the
14 general duties officer has written on the card. So there
15 is no formal evaluation or research going into that
16 process. The system is not that - it's very basic. This
17 is goodwill work, let me say it that way to you.

18 MS DAVIDSON: You have talked about in your witness statement
19 blended families being one of the more significant areas
20 in which issues for male victims of family violence comes
21 up. Can you explain what you have observed in relation to
22 blended families and family violence for men?

23 MR LILLIE: The research - I don't know the exact figures, but
24 a lot of the time when there are children to male victims
25 or perpetrators of domestic violence in blended families,
26 it's usually an introduced male into the family. So, a
27 lot of times I will also see the actual blood father who
28 has got concerns with his ex-partner's new boyfriend who
29 has moved into the house and the children or the sons or
30 the daughters are having relationship difficulties with
31 the new male within the system and that spends a lot of

1 time around, I suppose, setting structures back in the
2 family system and parenting issues and core values and
3 core beliefs of family roles.

4 MS DAVIDSON: What sort of services are available to assist men
5 in that situation and what kind of services do you see
6 being needed for men?

7 MR LILLIE: In the Hawkesbury, in my role I do a lot of anger
8 management work, I do a lot of stress management,
9 I support males to Family Law Court. My history is in
10 drug and alcohol as well, so I'm drug and alcohol trained.
11 In the other areas, the majority of the time is around
12 mental health or depression and anxiety, so sort of
13 moderate mental health in that area. There isn't anyone
14 to refer into from my service in the Hawkesbury. I have
15 no one to refer out to. Then I also get a lot of
16 referrals from other areas, so Penrith or Blacktown will
17 try and refer clients to myself, but due to areas we can't
18 pick these clients up.

19 I have been in this position since 2006, so I've
20 been around a long time. So my reputation has sort of
21 gone out into different areas because we used to do a lot
22 of health promotion, but that's been dropped over the last
23 couple of years as well.

24 MS DAVIDSON: In terms of the response that men need relative
25 to what women might need, you have identified and you have
26 talked in your statement about having a telephone response
27 and the sort of shorter length of the response that might
28 be needed for men and the different type of response that
29 you would provide to a man compared with a woman. Can you
30 explain to the Commissioners your views about the kind of
31 response that's needed for men and how you are best to

1 engage them?

2 MR LILLIE: I can comment on the men's health side. I don't
3 actually pick up any female victims. That goes to our
4 Women's Cottage. But the males, as I said, all I get is
5 their name, date of birth and 10 or 15 words of a
6 description of what's gone on. In my belief that first
7 phone conversation is quite important because when
8 I introduce myself and I try to engage with the client and
9 first of all I'm trying to build that rapport with the
10 client that it's not a legal system that's trying to get
11 to them. Then after that I look at what resources they
12 need or do they actually just need a conversation and just
13 to debrief the trauma they have gone through in their own
14 way.

15 MS DAVIDSON: You have talked in your statement about the
16 difficulty of engaging men on a long-term basis. How long
17 would you ordinarily engage a man for?

18 MR LILLIE: The males that come through - I will answer it the
19 other way. The ones that stay around for a long time are
20 males that either have mental health or Family Law Court
21 issues, purely because that old-fashioned case management
22 is something we still do in the Hawkesbury, so we look
23 after clients in not just a straight counselling format,
24 we also do case management.

25 When we get the brief interventions and that
26 follow-up, sometimes the males just need to know the phone
27 number for the Family Law Court or what's their rights,
28 what are they allowed to see when they see their children
29 or where can they go. They may not be seeing an
30 appropriate GP in the first place or the GP may not be
31 giving them appropriate help, so my suggestion to them is

1 to get a second opinion with another GP. A lot of it is a
2 common sense approach and very basic engagement with males
3 and probably solution focused in, "What's the problem,
4 let's resolve this and what can we work towards."

5 MS DAVIDSON: You have talked in your statement about where you
6 contact men, that you are more likely to contact them at
7 work?

8 MR LILLIE: Correct.

9 MS DAVIDSON: What does that mean? The information that you
10 are given through the Yellow Card system, what sort of
11 contact details does that seek? Does it get a home number
12 or a mobile or what sort of system - - -

13 MR LILLIE: I'd say about 90 per cent of our clients - sorry,
14 go ahead.

15 MS DAVIDSON: What sort of system is there to ensure that you
16 are at a practical level able to contact a man if, as you
17 say in your statement, they are more likely to be working?

18 MR LILLIE: I'd probably say about 90 per cent of our contact
19 is through mobile phones. We don't usually get home
20 numbers anymore. Then through - I'm not quite sure of the
21 statistics, but there would be easily 50 per cent work and
22 50 per cent unemployed. But the ones that are working,
23 I usually have a conversation with them in the afternoons
24 on their way home or I organise a time to call them back.
25 Sometimes they'll say "I can't talk" and I say "I'll call
26 you back at 2" and they just go "Yes" and we make a time.

27 One of the downsides for services for men is that
28 it is 9 to 5, five days a week. The time I work is the
29 same time they - - -

30 MS DAVIDSON: I think we've just lost your voice.

31 MR LILLIE: - - - work and there isn't services after hours for

1 males to actually engage on that direct issue.

2 MS DAVIDSON: Can you still hear me okay?

3 MR LILLIE: Are we back again? I can see it flashing on and
4 off.

5 MS DAVIDSON: Can you just repeat what you said about the fact
6 that men are more likely to be at work when you're at work
7 because the health system works around a 9 to 5 system?

8 MR LILLIE: Yes, that's correct. So, the time that I'm
9 working, they're working as well, so there isn't any after
10 hours services. After hours counselling in the Hawkesbury
11 is pretty hard to get as well, but even for after hours
12 counselling the majority of our counsellors in the
13 Hawkesbury are females as well, so they don't feel
14 validated or supported.

15 MS DAVIDSON: I think you have talked about this in your
16 statement, that your role actually didn't involve new
17 funding; it was just diversion of existing funding or use
18 of existing funding and creation of a role called men's
19 health worker; is that how it worked?

20 MR LILLIE: Yes, that's correct, and to sort of break it down
21 for you, there's one day from a drug and alcohol position,
22 there's two days from a generalist counselling position
23 and there is two days from a health promotion position.
24 It's just loose ends which Peter Blanchard, our GM, put
25 together to deliver a service that we should be delivering
26 in the first place, in my belief.

27 The reason for that, just to give you an example,
28 is even our generalist counselling team, when it comes to
29 couples work or a male comes in, the majority of our team
30 is female counsellors for the generalist team. When an
31 aggressive male comes in to a female counsellor, sometimes

1 it's good for the male just to say, "That's not
2 appropriate behaviour and let's talk about what to
3 expect." In that sense it changes that sexual gender
4 issue. I think we've just dropped out again, have we?
5 MS DAVIDSON: No, we could still hear you, just couldn't see
6 you.
7 MR LILLIE: Yes. So a lot of the times it's just standing up
8 as a strong male within the system and also protect,
9 inside the system, nurses. Even when I get called up to
10 the emergency department, just when sometimes the males
11 are up there aggressive, it's just having a male respond
12 to the situation. There's plenty of females in the
13 emergency department, but there are not many males and, if
14 they are, they're a doctor and that brings a lot of
15 perception that something different is going to happen
16 than what I would offer.
17 MS DAVIDSON: I have no further questions for you, Mr Lillie,
18 but the two Commissioners may have additional questions.
19 COMMISSIONER NEAVE: No, we don't have any additional
20 questions.
21 MS DAVIDSON: Thank you, Mr Lillie.
22 COMMISSIONER NEAVE: Thank you very much, Mr Lillie. I'm sorry
23 about the technical - - -
24 MR LILLIE: Can I just add something as well?
25 COMMISSIONER NEAVE: Yes.
26 MR LILLIE: That in men's health, how our role is set up, it's
27 an unusual model in that sense, that it's very client
28 focused but also it's quite assertive. So we don't
29 tolerate - when males ring up or are aggressive, we
30 actually deal with that behaviour in that moment. So
31 I think it's important that it's the role modelling within

1 the service, because you could set up another men's health
2 counsellor anywhere, that's not the issue, but I think the
3 value systems you need, what you are trying to push out is
4 also quite important to have within the system in the
5 first place.

6 One of the downsides, if you were to deal with
7 male victims in domestic violence, is having strong valued
8 males that are quite assertive and able to stand up and
9 educate the other male what is appropriate and not
10 appropriate behaviour. They are in the counselling
11 session, they are on the spot and I think that just brings
12 a lot of honesty, but it also shows this is how you can
13 perform in society but this is also teaching them
14 communication with healthy people at the same time.

15 COMMISSIONER NEAVE: Thank you very much for that. Can I just
16 clarify one point. You talk about the issue of blended
17 families and as I understand it that is mainly a situation
18 where the violence is by a child against the stepdad or
19 the partner of his mother. Did I get that right? Have
20 I interpreted your witness statement correctly?

21 MR LILLIE: Yes, in two ways. One example would be a
22 15-year-old boy, his mother has just introduced another
23 man into the house and he is moving in, and there is that
24 side. Then the other side is that the actual blood
25 parent, who hasn't got any control into the family where
26 his children live, is hearing what goes on in the
27 community and is helpless, so he tries to communicate, but
28 then the police are involved because of the conflict that
29 goes on.

30 COMMISSIONER NEAVE: Thank you very much. And thank you very
31 much for your evidence, Mr Lillie.

1 MS DAVIDSON: Thank you.

2 MR LILLIE: Thank you.

3 MS DAVIDSON: Perhaps we could have a five minute break.

4 <(THE WITNESS WITHDREW)

5 (Short adjournment.)

6 MR MOSHINSKY: Commissioners, the next witness is

7 Superintendent Charles Allen, if he could please be sworn

8 in.

9 <CHARLES THOMAS ALLEN, sworn and examined:

10 MR MOSHINSKY: Superintendent, could you please tell the

11 Commission what your current position is and give a brief

12 outline of your professional background?

13 SUPERINTENDENT ALLEN: Certainly. Superintendent leading the

14 Priority Communities Division with Victoria Police. My

15 immediate work history, my previous role was with the

16 Transit Safety Division implementing the Protective

17 Services Officers across the system. Prior to that I was

18 the Local Area Commander at Greater Dandenong for a period

19 of some four and a half years, and have a 33-year history

20 in policing across general duties, investigation,

21 supervision and leadership roles.

22 MR MOSHINSKY: You have prepared a witness statement for the

23 Royal Commission?

24 SUPERINTENDENT ALLEN: Yes, I have.

25 MR MOSHINSKY: Are the contents of your statement true and

26 correct?

27 SUPERINTENDENT ALLEN: Yes, they are. I would just like to

28 make one point of clarification, if I could.

29 MR MOSHINSKY: Certainly.

30 SUPERINTENDENT ALLEN: On page 24, paragraph 85, the paragraph

31 is referring to the Koori family violence protocols. The

1 paragraph states, "The ongoing commitment to the family
2 violence protocols and the rollout across the state will
3 be a key area of focus of Victoria Police in the short to
4 medium term." That is correct, but the statement "and the
5 rollout across the state" may be interpreted differently.
6 Certainly Victoria Police intend to continue to roll out
7 the family violence protocols where there is a need based
8 on priority.

9 COMMISSIONER NEAVE: Is that based on the fact that there is a
10 Koori community in the particular area or something, is
11 it?

12 SUPERINTENDENT ALLEN: Exactly. It's pointless establishing a
13 protocol if there is no Koori community or a very small
14 Koori community.

15 COMMISSIONER NEAVE: Thank you.

16 MR MOSHINSKY: Could you please explain briefly what is the
17 Priority Communities Division?

18 SUPERINTENDENT ALLEN: Yes. The Priority Communities Division
19 is a relatively new division. It came into being as a
20 result of a number of reviews, particularly reviews around
21 how we engaged with community, so our focus is engagement
22 both at the strategic level and at the local level with
23 priority communities. Priority communities are
24 communities we identify that are overrepresented as
25 victims or offenders or underreport in crime or have
26 over-representative contact with police.

27 So the communities we identify are Aboriginal and
28 Torres Strait Islander people, people living with
29 disabilities or mental health, including their families
30 and carers, LGBTI community, CALD community, faith
31 communities, seniors and youth.

1 MR MOSHINSKY: As I understand it, the division was established
2 in December 2013 following a review?

3 SUPERINTENDENT ALLEN: That's correct.

4 MR MOSHINSKY: Some of the key themes from that review you set
5 out in paragraph 19 of your statement. They include in
6 19.3 there was a need to strengthen Victoria Police's
7 policies and procedures in relation to field contacts and
8 to better recognise human rights principles in the
9 Victoria Police Manual, and in 19.5 you indicate
10 cross-cultural training for police officers provides an
11 important skill base.

12 One of the issues that you then take up in
13 paragraph 32 of your statement is the issue of low
14 reporting levels by some of the priority communities. Can
15 you expand on that? What is the sort of issue that you
16 are concerned about there?

17 SUPERINTENDENT ALLEN: Quite a few of those issues have been
18 borne out in the evidence today. So, underreporting of
19 family violence across CALD communities, Aboriginal
20 communities, LGBTI community and difficulty in reporting
21 for people living with disabilities or people living with
22 mental health.

23 MR MOSHINSKY: What sort of data is available to Victoria
24 Police about underreporting? Is it possible for
25 particular crimes to map whether there is underreporting
26 among each of the priority groups that you have
27 identified?

28 SUPERINTENDENT ALLEN: A lot of the data is anecdotal,
29 qualitative in nature as opposed to quantitative. So,
30 yes, it is very difficult.

31 MR MOSHINSKY: What about more specifically on family violence,

1 which is the subject matter we are concerned with for this
2 inquiry. There is the L17 process that the Commission has
3 heard many police witnesses give evidence about. Is it
4 possible to look at whether, because of the L17 data
5 that's available, there's underreporting from any of the
6 priority groups that the division looks at?

7 SUPERINTENDENT ALLEN: I don't think that's evident from
8 analysis of L17 data. Certainly we rely on external
9 reports, and those reports are cited in my statement, as
10 well as our engagement directly with community.

11 MR MOSHINSKY: So with the priority communities that you have
12 identified and you have read out the names of them, they
13 are listed in paragraph 13, is there a way - I'm not
14 suggesting you have it at your fingertips now - but is
15 there a way of analysing whether within one or more of
16 those groups there is underreporting of family violence
17 related matters?

18 SUPERINTENDENT ALLEN: Once again coming back to my previous
19 answer, certainly we are relying on anecdotes, from
20 engagement with community, from pieces of research that
21 are available, many of which I have cited in this
22 statement.

23 MR MOSHINSKY: In terms of that list of priority groups, to
24 what extent does the L17 process capture data about
25 whether either the victim or the perpetrator is in one or
26 more of those groups?

27 SUPERINTENDENT ALLEN: Not very well. Capturing data on
28 diversity is not well addressed by the L17. It asks two
29 specific questions: ethnic appearance, which is
30 predominantly relying on either the information that the
31 attending constable is able to glean by direct questioning

1 or their view. There is also another question which is an
2 open text question around country of birth.

3 MR MOSHINSKY: What about Aboriginal and Torres Strait
4 Islander?

5 SUPERINTENDENT ALLEN: It also asks the standard Indigenous
6 question and a large percentage is reported as unknown.

7 MR MOSHINSKY: Apart from ethnic appearance, country of birth
8 and Aboriginal and Torres Strait Islander, in terms of the
9 list of priority communities there is no field which
10 requires any of that identification to be entered; is that
11 right?

12 SUPERINTENDENT ALLEN: That's correct.

13 MR MOSHINSKY: Is there any plan to address that, that you are
14 familiar with?

15 SUPERINTENDENT ALLEN: Not that I'm familiar with. Having said
16 that, part of our division is certainly getting better
17 visibility of offending and victimisation across priority
18 communities. One area of interest for us is certainly the
19 standard Indigenous question getting better data capture
20 on DSIQ.

21 MR MOSHINSKY: So there is a focus on improving data on the
22 Aboriginal and Torres Strait Islander question?

23 SUPERINTENDENT ALLEN: Yes.

24 MR MOSHINSKY: But currently, as far as you are aware, no plans
25 to try to capture data about the other priority groups?

26 SUPERINTENDENT ALLEN: That's correct.

27 MR MOSHINSKY: Can I turn then to the topic of liaison officers
28 that you deal with at paragraph 34. You list there the
29 different types of liaison officers. Just at a general
30 level, can you explain what a liaison officer is? What's
31 their role?

1 SUPERINTENDENT ALLEN: There's a number of different
2 categories. I think the easiest way to distinguish
3 between the categories are those that perform the role
4 full-time and those that have it as a portfolio
5 responsibility. So, starting with those that have a
6 portfolio responsibility, they are the police and
7 Aboriginal liaison officers, the gay and lesbian liaison
8 officers and the mental health liaison officers. They are
9 all portfolio responsibilities. Those liaison officers,
10 their full-time role would be generally a general duties
11 role within Victoria Police, but also have portfolio time
12 to deliver on their portfolio responsibilities. So,
13 relationship building, working with community across
14 projects and programs, and being a point of entry into
15 Victoria Police for the particular community. It's
16 similar with the YROs and the MLOs - - -

17 DEPUTY COMMISSIONER NICHOLSON: Can I just ask about that. In
18 these portfolio categories, what proportion of time
19 typically is devoted to the specific portfolio and what
20 proportion to the general policing duties?

21 SUPERINTENDENT ALLEN: It varies . The resources are owned by
22 the local area commands, usually at station level. So it
23 depends on the depth of resource at a particular area and
24 priorities at a particular area. So, to answer your
25 question, it could be from a couple of days a week to
26 grabbing moments when there's opportunity, and that's sort
27 of the full range.

28 COMMISSIONER NEAVE: I have a follow-up question. Who were the
29 officers who were not portfolio officers? Just the YROs?
30 Have I got that right?

31 SUPERINTENDENT ALLEN: Yes.

1 COMMISSIONER NEAVE: So the YROs are the only non-portfolio
2 full-time, is that right?

3 SUPERINTENDENT ALLEN: No, the full-time liaison officers are
4 the youth resource officers and the multicultural liaison
5 officers who are sworn police officers, but also the
6 Aboriginal community liaison officers and the new and
7 emerging community liaison officers are full-time liaison
8 officers but public servants.

9 MR MOSHINSKY: So the first four that you have listed are
10 full-time as liaison officers and then the last three, the
11 police Aboriginal liaison officers, the gay and lesbian
12 liaison officers and the mental health liaison officers
13 it's a portfolio role. They have other duties as well.

14 SUPERINTENDENT ALLEN: That's correct.

15 MR MOSHINSKY: Just following on from those questions, if
16 someone is in the last three categories and it's a
17 portfolio role, what are their other duties? Are they
18 front-line police who go out in a van or do they have
19 other roles?

20 SUPERINTENDENT ALLEN: They do have other roles, and it would
21 depend on their rank, predominantly either general duty
22 officers or general duty supervisors. Some station
23 managers take on the role also.

24 MR MOSHINSKY: What rank are the full-time liaison officers?

25 SUPERINTENDENT ALLEN: You are looking at a range of constable
26 through to senior sergeant.

27 MR MOSHINSKY: You have indicated some of the duties of the
28 liaison officers in terms of a point of contact with the
29 community, building the relationship with the community.
30 I was just wondering if you could explain a bit further
31 what's the interaction between the liaison officers and

1 the actual front-line police members?

2 SUPERINTENDENT ALLEN: Once again it varies from site to site.

3 General duty liaison officers will be interacting very
4 much in the day-to-day process because they are embedded
5 within general duties. The full-time liaison officers, it
6 will depend. All regions or all divisions are tasked by a
7 tasking coordination process, which sort of makes the
8 decision about how we use our resources. Resources will
9 often be tasked to similar concerns. So liaison officers
10 and general duty officers are working on similar issues.
11 They are situated within police stations. Good general
12 duties police officers will use their LOs as a resource.

13 MR MOSHINSKY: Is it fair to assume that the liaison officers
14 are located where it is most relevant for the particular
15 priority community that they are associated with?

16 SUPERINTENDENT ALLEN: Yes.

17 MR MOSHINSKY: They are geographically located in stations
18 where, if we are talking about an ethnic community, there
19 would be many members of that community in that area; is
20 that a fair assumption?

21 SUPERINTENDENT ALLEN: Yes. Generally, yes.

22 MR MOSHINSKY: Just at a sort of macro level, what's the
23 process of communicating to the front-line police members
24 the messages that you want to impart in terms of how to
25 deal with a particular community, some of the
26 sensitivities that might arise, some of the particular
27 practices or policies that pertain to that priority
28 community?

29 SUPERINTENDENT ALLEN: A number of ways. I guess first of all
30 there's our education and training processes, and I talk
31 to our cultural community and diversity education strategy

1 in my statement. The approach there is to use a golden
2 thread, as we like to explain it, through training
3 processes, so from foundation through to development and
4 promotional programs.

5 There's also a wide variety of resources that we
6 maintain around priority communities. So they are
7 available on our intranet, so for officers who go seeking
8 the information, the cultural awareness guidelines is an
9 example, and also we will communicate via email, via other
10 sources, whether it's the Police Gazette or Police Life
11 around specific issues as they emerge.

12 MR MOSHINSKY: Is there some way of measuring success in terms
13 of whether the messages are getting through and actually
14 being adopted as matters of practice by police members?

15 SUPERINTENDENT ALLEN: As to the efficacy of the LO program, is
16 that the question?

17 MR MOSHINSKY: No, I'm really focusing more now on the
18 front-line police who are actually perhaps being called
19 out to a family where there is a family violence incident,
20 how they deal with it, when it might be from one of the
21 priority communities that you have identified here. Is
22 there a way of measuring success, whether practices have
23 changed, whether members have taken on board the
24 principles in your program, for example?

25 SUPERINTENDENT ALLEN: One measure is the complaints process.
26 That certainly gives us an indication of where we're
27 getting it wrong. Another process is feedback directly
28 from community. I was very buoyed to hear some positive
29 feedback today from some of the communities that are
30 represented. So our priority reference groups, priority
31 community reference group, which I also talk to in the

1 statement, a strategic way where we are able to gauge
2 feedback directly from community at strategy level. So,
3 what we are hoping to pick up there are issues, systemic
4 issues across our service system, but also at the local
5 level we are supporting good engagement processes at the
6 local level, and once again through the feedback
7 mechanisms of engagement at the local level.

8 MR MOSHINSKY: So one method is the complaints process. One
9 method might be the reference groups where you meet with
10 priority communities. I appreciate the priority division
11 hasn't been going for that long, it was set up in December
12 2013, but are you able to comment on what feedback you've
13 had so far?

14 SUPERINTENDENT ALLEN: I can certainly comment on feedback from
15 the reference groups because I sit on all of them. Once
16 again, some of the reference group members were actually
17 represented in the witnesses here today, so we have worked
18 very hard at connecting people who are attached to peak
19 organisations representative of their communities.

20 We certainly don't feel we will get it right at
21 first blush and we have just gone through our first
22 12 months of reference groups and part of the process I'm
23 undertaking is having conversations with how we can
24 improve those reference groups. The feedback I'm getting
25 is about that two-way feedback process where we are
26 feeding back on operational issues and communities are
27 able to feedback to us on systemic issues they are seeing
28 across their communities.

29 MR MOSHINSKY: Has it been positive feedback, negative
30 feedback, concerns? What's the nature of it in general
31 terms?

1 SUPERINTENDENT ALLEN: It's positive that the conversations are
2 happening, but there's a long way to go for a lot of
3 communities. Elder abuse was spoken at depth today.
4 I think we are very early in that journey of how to deal
5 with elder abuse and that's a conversation that we have
6 within the seniors portfolio reference group.

7 MR MOSHINSKY: You get some feedback from the reference group.
8 How do you then impart the message to the many, many
9 front-line police members, because I don't think that's
10 part of the liaison officer role, is it?

11 SUPERINTENDENT ALLEN: No. We can use the liaison officers as
12 a resource and certainly we conduct development sessions
13 with the liaison officers to share learnings and
14 understandings around issues. But another part of the
15 Priority Communities Division is the service delivery arm,
16 so the service delivery arm have their relationships into
17 operational policing. So it's their responsibility to
18 meet either proactively or reactively in response to a
19 particular issue at either a regional level, divisional
20 level or local area command level, which is happening.

21 MR MOSHINSKY: Have there been any attitude surveys of
22 attitudes held by police members, for example, to any of
23 the priority groups?

24 SUPERINTENDENT ALLEN: Interesting; we are in the process of
25 trying to - sorry, the community survey. We have finished
26 a survey recently which was internally focused around the
27 Globe program. We have also joined Pride in Diversity and
28 through that Pride in Diversity process surveyed our
29 people around attitudes with the LGBTI community.

30 MR MOSHINSKY: So you have done some survey of police member
31 attitudes towards LGBTI people?

1 SUPERINTENDENT ALLEN: Yes.

2 MR MOSHINSKY: Do the results of those indicate concerns for
3 you in terms of your program?

4 SUPERINTENDENT ALLEN: No. Results are relatively positive.
5 I'm very conscious we have a lot of people working for us
6 with wide-ranging views and biases. All of those
7 wide-ranging views and biases we have to deal with as an
8 organisation.

9 COMMISSIONER NEAVE: So you had an internal attitudinal survey
10 relating to police attitudes to LGBTI people. Did you
11 also say you had a CALD one or not? Did I mishear you?

12 SUPERINTENDENT ALLEN: No, not a CALD one.

13 COMMISSIONER NEAVE: So the sort of question - I'm just
14 interested in the kinds of issues that you pursued in
15 relation to the LGBTI community. What sort of attitudinal
16 issues were you pursuing within the police?

17 SUPERINTENDENT ALLEN: We joined Pride in Diversity some
18 18 months ago, which is a national initiative. I think we
19 were the first Victorian Government agency to join. Pride
20 in Diversity have a standard survey that they use within
21 organisations. We returned - 1,000 of our people
22 responded to the survey, which was a very pleasing
23 outcome. The questions were wide-ranging around LGBTI and
24 contact with LGBTI community. The responses for our
25 organisation were certainly pleasing. I wouldn't suggest
26 that we haven't got work to do; we certainly have got work
27 to do.

28 COMMISSIONER NEAVE: Thank you.

29 MR MOSHINSKY: Is there any consideration given to doing
30 similar internal attitudinal surveys for any of the other
31 priority groups?

1 SUPERINTENDENT ALLEN: Yes, it's a consideration.

2 MR MOSHINSKY: Do you think that would be a useful step?

3 SUPERINTENDENT ALLEN: Yes, I do.

4 MR MOSHINSKY: Is there any process to do surveys of attitudes

5 within the priority communities of police, because one of

6 the themes that you will have heard through the evidence

7 today is that within some of the groups that we have heard

8 evidence from I think it's accepted part of the issue is

9 not necessarily police practices, but also perception of

10 police. So has any thought been given or has this

11 occurred of doing attitude surveys of members of the

12 community and what they feel about the police?

13 SUPERINTENDENT ALLEN: Yes.

14 MR MOSHINSKY: It has been done?

15 SUPERINTENDENT ALLEN: No, it hasn't been done, but I think

16 your question was is there consideration. We are actually

17 pursuing a project at the moment to survey the LGBTI

18 community.

19 MR MOSHINSKY: Any thoughts of doing surveys for the other

20 priority communities?

21 SUPERINTENDENT ALLEN: Considerations, but we are actively

22 pursuing that project around the LGBTI community. Seeing

23 as we have a baseline about our internal attitudes, it

24 would be complementary to have that community view.

25 MR MOSHINSKY: Because is it fair to say that one of the issues

26 that the Priority Communities Division looks at, is

27 concerned about, is the perceptions of police held by

28 members of the particular priority community?

29 SUPERINTENDENT ALLEN: Yes.

30 MR MOSHINSKY: And in that light it might be useful to gauge

31 what are the perceptions and then baseline them and then

1 do it again a couple of years later, perhaps. Do you
2 think that would be a desirable thing to do?

3 SUPERINTENDENT ALLEN: Absolutely. I should also mention that
4 there is a lot of material out there and a lot of other
5 survey material that we can rely on. Once again, some of
6 those I have referred to in my statement. Also our
7 reference groups are another window into community
8 attitudes. But would surveys be of use? Yes, absolutely
9 they would be.

10 MR MOSHINSKY: Can I turn to the topic of recruitment.

11 COMMISSIONER NEAVE: Just before you do, Mr Moshinsky. It
12 would be interesting to compare internal police attitudes
13 with those of the general community. I don't know whether
14 there are any surveys on LGBTI people. I know there are
15 certainly surveys on things like community attitudes to
16 gay marriage and so on, but I'm talking about something
17 that's broader than that. It would be interesting to
18 compare what attitudes the community generally hold with
19 attitudes of police. Has any thought been given to doing
20 that?

21 SUPERINTENDENT ALLEN: I agree it would be very interesting.
22 The preface is that police are the community and community
23 are the police. So, it would be nice for police to hold a
24 mirror as to where they stand against the rest of the
25 community. Hopefully we would be comparable or better,
26 given our roles.

27 COMMISSIONER NEAVE: But at the moment nothing like that has
28 been done.

29 SUPERINTENDENT ALLEN: No.

30 MR MOSHINSKY: Can I turn then to recruitment. Is there any
31 policy to encourage recruitment of police members from the

1 priority communities?

2 SUPERINTENDENT ALLEN: Yes.

3 MR MOSHINSKY: Could you tell us about that?

4 SUPERINTENDENT ALLEN: Certainly. There's a diversity plan
5 which is very focused on improving diversity from across a
6 range of communities. There is a specific Aboriginal and
7 Torres Strait Islander employment plan which has a
8 specific target of - I think it's 1.6 per cent of police
9 officers by the completion of the plan. There is a number
10 of initiatives under way to support both of those plans.

11 MR MOSHINSKY: Does the plan extend beyond Aboriginal and
12 Torres Strait Islander people?

13 SUPERINTENDENT ALLEN: Yes. There is a general plan, which is
14 a diversity plan that's owned and managed by our human
15 resource department, but certainly we contribute to that
16 plan, so that's looking at diversity across the board.
17 There's probably a focus there on recruitment from CALD
18 communities, LGBTI and disability; also our accessibility
19 action plan which is not far off launch has a focus on
20 recruitment of people living with disability, but there is
21 also a specific Aboriginal employment plan which is part
22 of our Aboriginal Justice Agreement undertakings to
23 improve representation of Aboriginal and Torres Strait
24 Islander people within Victoria Police.

25 MR MOSHINSKY: In terms of where things stand at the moment, is
26 there still work to be done in terms of improving
27 diversity amongst some of the priority community groups?

28 SUPERINTENDENT ALLEN: Yes.

29 MR MOSHINSKY: Can I turn next to some of the evidence that we
30 have heard today. In the session on elder abuse Ms Blakey
31 gave an example of a situation where an adult grandchild

1 called police; the police came to the home; they spoke to
2 the adult child, so the parents of the person who called,
3 who in fact was the perpetrator. They didn't speak with
4 the older person, who was of a Vietnamese background and
5 was the victim. One infers there were language barriers.
6 Can you perhaps comment on that scenario in terms of not
7 obviously the specific case but just as a matter of proper
8 practice what should occur?

9 SUPERINTENDENT ALLEN: Yes, you are right; I can't comment on
10 the specific details of the case. It's certainly less
11 than best practice that the police officers have spoken to
12 the perpetrator as opposed to the victim. I suppose the
13 question was hanging there for me, "Did they have a
14 consciousness of who was perpetrator and who was victim on
15 attendance?" If there was some doubt about that, then
16 certainly the use of an interpreting service to get a full
17 sense of the scenario as well as considering some
18 isolation of the victims from the offenders so they can
19 speak confidently in a safe location.

20 MR MOSHINSKY: This issue of interpreters, how is that managed
21 in a family violence context? So the police are called to
22 a home, they arrive, the family members don't speak
23 English. How are police sort of instructed to deal with
24 that situation?

25 SUPERINTENDENT ALLEN: Very difficult; difficult to get an
26 interpreter on their feet at a scene in a timely manner.
27 So second best is telephone interpreting services or
28 reliance on networks, which is less than best because that
29 could be bringing another community member which could
30 create a barrier to a safe place to have a conversation.

31 MR MOSHINSKY: Police, do they have numbers available to them

1 or should they have numbers available to them to contact
2 interpreting services?

3 SUPERINTENDENT ALLEN: Yes.

4 MR MOSHINSKY: One of the other points that was mentioned
5 I think by Ms Becker was the issue of police using family
6 members to interpret. Is there a practice or guideline
7 around that issue?

8 SUPERINTENDENT ALLEN: Once again it's not ideal and either an
9 interpreter or a telephone interpreting service - the
10 complexity there, if the situation is very dynamic, police
11 need to be able to draw out information quickly to be able
12 to deal with the dynamics of a situation, hence why on
13 occasions other approaches will be taken to try to get a
14 sense of the issues at play.

15 MR MOSHINSKY: Can I turn to the topic of people with
16 disabilities. As you will have heard referred to today,
17 the lay witness who was called on Day 8 of the public
18 hearings was a woman with disabilities. At one point in
19 the violent relationship the police took out an
20 intervention order, which in hindsight she was thankful
21 for. But she was sent home and there was no-one to care
22 for her because her husband was her carer and he had been
23 excluded from the home. Again, I can't expect you to
24 comment on the specific case, but what's the proper
25 practice around that scenario in terms of the police's
26 role?

27 SUPERINTENDENT ALLEN: You are right; I can't comment on the
28 specifics of the case. I was provided with a copy of the
29 statement, which I read. My interpretation of the
30 scenario was a little bit different in that the husband
31 was excluded after he had been charged, which was after

1 the issuing of the intervention order, was my
2 understanding.

3 MR MOSHINSKY: Yes, I think that's right.

4 SUPERINTENDENT ALLEN: The case was handled by a SOCIT unit, as
5 you would expect, because there were allegations of sexual
6 assault. The SOCIT units are certainly very victim
7 focused. I found it unusual that the victim had been
8 released to return home without appropriate levels of care
9 and it certainly seems a system breakdown there at some
10 point. I don't know what that is.

11 It did concern me that there would have been an
12 initial referral via the L17 process, but there would have
13 been some distance between that initial L17 referral and
14 the later charging of the husband. So I don't know if
15 that created the system failure. Having said that, the
16 SOCIT unit should have been conscious of the care needs
17 for that individual.

18 MR MOSHINSKY: In evidence today from Ms Pearce, the Public
19 Advocate, and in her statement, which I think you have had
20 available, she refers in paragraph 71 to an issue of
21 whether police are using, where they should, an
22 independent third person. She quotes from the Victorian
23 Police code of practice for the investigation of family
24 violence and quotes the section dealing with people with
25 disabilities. Could you just explain what the code of
26 practice says about using an independent third person?

27 SUPERINTENDENT ALLEN: I haven't got the code of practice
28 before me, but I certainly have the Victoria Police
29 manual, our procedures and guidelines before me in
30 relation to interviews of vulnerable people.

31 MR MOSHINSKY: What is an independent third person? In general

1 terms when should they be used?

2 SUPERINTENDENT ALLEN: If it is a young person, first of all,
3 then there is a legislative responsibility for us to have
4 an independent third person, which is identified as
5 parent, guardian or if they are not available then an
6 independent third person via the referral process, which
7 is the YRIPP referral process. If it is a young person
8 with a cognitive impairment then the independent third
9 person is to be an ITP trained via the Office of Public
10 Advocate.

11 MR MOSHINSKY: Can I just interrupt you there. You have
12 provided through your counsel an extract from
13 the Victorian Police manual. Could I just pass forward to
14 you and to the Commissioners copies of the extract you
15 have provided.

16 SUPERINTENDENT ALLEN: Sure.

17 MR MOSHINSKY: Is this the set of guidelines in the manual for
18 dealing with interviews with vulnerable people?

19 SUPERINTENDENT ALLEN: That's right.

20 MR MOSHINSKY: What is the status of these provisions in the
21 manual? Are these things that the police officers are
22 bound to comply with under the code of practice?

23 SUPERINTENDENT ALLEN: Yes, is the answer.

24 MR MOSHINSKY: When dealing with vulnerable people in these
25 categories this sets out the guidelines of when an
26 independent person needs to be present?

27 SUPERINTENDENT ALLEN: That's right.

28 MR MOSHINSKY: The independent third person system for people
29 with disabilities, I think the suggestion was that that's
30 not always adhered to. Is that something you are able to
31 comment on?

1 SUPERINTENDENT ALLEN: I have also seen the Public Advocate sit
2 on our reference group that provides us with the data
3 which is referred to today about the use of ITPs.

4 I certainly agree with the witness Colleen Pearce that
5 there appears to be inconsistency across police stations.
6 I think that data needs a greater depth of analysis.

7 The independent third person does not necessarily
8 have to be from the office - or ITP trained by the Office
9 of Public Advocate. There are occasions when it must be,
10 as in a young person with a cognitive impairment or for a
11 person with a cognitive impairment who is involved in a
12 bare interview. So there's a number of variables there.

13 Another variable is trained ITPs, independent
14 third persons, are not always available, particularly in
15 rural and regional areas. We are relying on a volunteer
16 workforce. I get the difficulties in managing that, but
17 they are not always available.

18 MR MOSHINSKY: So this issue of variable practice, which
19 I think you have indicated may in fact occur - - -

20 SUPERINTENDENT ALLEN: Yes.

21 MR MOSHINSKY: Is there any plan to look at that of trying to
22 improve the system?

23 SUPERINTENDENT ALLEN: Yes. So there's a ready reckoner which
24 we have out there which provides advice and guidance to
25 police officers. We are actually working with the Office
26 of Public Advocate to re-work that ready reckoner. So the
27 preference is that we are using a Public Advocate trained
28 independent third person for individuals with a cognitive
29 impairment.

30 COMMISSIONER NEAVE: So that ready reckoner, just to clarify,
31 as I understand it what it does is provides the member

1 with some guidance as to whether the person might have a
2 cognitive impairment, because that's not always
3 immediately obvious; do I understand it correctly?

4 SUPERINTENDENT ALLEN: That's correct, and also refers the
5 member to the forensic medical officer if they have some
6 doubt to seek some advice.

7 MR MOSHINSKY: I have just been handed a sheet on a
8 confidential basis which I understand to be the ready
9 reckoner that you are referring to. Perhaps if I could
10 just pass forward that to you and to the Commissioners.
11 If you could just confirm that that is the document. Is
12 that the ready reckoner that you are referring to?

13 SUPERINTENDENT ALLEN: This is the existing document. We are
14 in the process of redrafting this.

15 MR MOSHINSKY: I see. Thank you.

16 SUPERINTENDENT ALLEN: But that's still a live document, having
17 said that.

18 MR MOSHINSKY: Commissioners, those are the questions that
19 I had for the witness.

20 DEPUTY COMMISSIONER NICHOLSON: I just had one question.
21 Throughout the hearings the Commission has heard of
22 circumstances where a young person is violent towards
23 their parents in the family home. What are the
24 circumstances if a young person is a 15-year-old and the
25 police are called to the home to intervene with a
26 situation where that young person was being violent
27 towards a parent?

28 SUPERINTENDENT ALLEN: There are a lot of variables in that
29 scenario. Certainly police would look at any criminal
30 aspects, first of all. So it would be following the code
31 of practice effectively; so looking at either criminal

1 remedies or the civil remedies, an intervention order, or
2 looking at referral pathways is another option.

3 DEPUTY COMMISSIONER NICHOLSON: Would they be required to bring
4 in an independent person?

5 SUPERINTENDENT ALLEN: If the young person was taken into
6 custody for interview by the police then there would be a
7 responsibility for police to contact an independent third
8 person, which would be via the Centre for Multicultural
9 Youth, CMY, who provide the service for YRIPP; unless the
10 young person had a cognitive impairment, then it would be
11 an independent third person via the Office of Public
12 Advocate.

13 DEPUTY COMMISSIONER NICHOLSON: Thank you.

14 MR MOSHINSKY: If there are no further questions, may the
15 witness please be excused.

16 COMMISSIONER NEAVE: Thank you very much, Superintendent.

17 <(THE WITNESS WITHDREW)

18 MR MOSHINSKY: That completes the evidence for today.

19 COMMISSIONER NEAVE: Thank you, Mr Moshinsky.

20 ADJOURNED UNTIL WEDNESDAY, 12 AUGUST 2015 AT 9.30 AM