COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON SOCIAL POLICY AND LEGAL AFFAIRS

Family, domestic and sexual violence

(Public)

FRIDAY, 16 OCTOBER 2020

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON SOCIAL POLICY AND LEGAL AFFAIRS

Friday, 16 October 2020

Members in attendance: Ms Claydon, Ms Murphy, Mr Wallace, Dr Webster.

Terms of Reference for the Inquiry:

To inquire into and report on:

That the Standing Committee on Social Policy and Legal Affairs inquire into and report on family, domestic and sexual violence, including with a view to informing the next National Plan to Reduce Violence against Women and their Children, the following:

a) Immediate and long-term measures to prevent violence against women and their children, and improve gender equality.

b) Best practice and lessons learnt from international experience, ranging from prevention to early intervention and response, that could be considered in an Australian context.

c) The level and impact of coordination, accountability for, and access to services and policy responses across the Commonwealth, state and territory governments, local governments, non government and community organisations, and business.

d) The way that health, housing, access to services, including legal services, and women's economic independence impact on the ability of women to escape domestic violence.

e) All forms of violence against women, including, but not limited to, coercive control and technology-facilitated abuse.

f) The adequacy of the qualitative and quantitative evidence base around the prevalence of domestic and family violence and how to overcome limitations in the collection of nationally consistent and timely qualitative and quantitative data including, but not limited to, court, police, hospitalisation and housing.

g) The efficacy of perpetrator intervention programs and support services for men to help them change their behaviour.

h) The experiences of all women, including Aboriginal and Torres Strait Islander women, rural women, culturally and linguistically diverse women, LGBTQI women, women with a disability, and women on temporary visas.

i) The impact of natural disasters and other significant events such as COVID-19, including health requirements such as staying at home, on the prevalence of domestic violence and provision of support services.

j) The views and experiences of frontline services, advocacy groups and others throughout this unprecedented time.

k) An audit of previous parliamentary reviews focussed on domestic and family violence.

l) Any other related matters.

WITNESSES

HOOPER, Mr Russell, Head of Advocacy, No to Violence

TWISLETON, Ms Lizette, Head of Sector Development, No to Violence

WATT, Ms Jacqui, Chief Executive Officer, No to Violence

Evidence was taken via teleconference—

Committee met at 08:49

CHAIR (Mr Wallace): I declare open this public hearing of the House of Representatives Standing Committee on Social Policy and Legal Affairs for the inquiry into family, domestic and sexual violence. Today, the committee will wrap up this week of hearings by speaking with some organisations that work on men's behaviour change and others focused on women's health. In accordance with the committee's resolution of 23 July 2019, this hearing will be broadcast, and the proof and official transcripts of proceedings will be published on the parliament's website. I remind any members of the media who may be listening online of the need to fairly and accurately report the proceedings of the committee.

I now welcome representatives from No to Violence. Although the committee does not require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and, therefore, has the same standing as a proceeding of the House. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I now invite the witnesses to make a brief opening statement before we proceed to a general discussion with questions.

Ms Watt: I wish to begin by acknowledging this country and the lands that we all meet on today. I and my two colleagues are on Wurundjeri land in the wonderful state of Victoria. We wish to acknowledge all Aboriginal people past and present—those who may be on the call today—and leaders emerging. I'd like to thank the committee for inviting us to appear today. We understand this is the final day of these very important hearings, and, during that process, we note that there have seldom been conversations around the people who are actually using family violence. That's not a criticism of the process or the hearings. Rather it's an observation about the general discourse around family violence and particularly around the people who use it, who are generally men.

CHAIR: I might jump in there for a moment. The hearings are not being wound up today. This is just the last day of this week. We've got numerous days to go. That's just for your information.

Ms Watt: Thank you so much. I really appreciate that. The other bit about all of this, of course, is that we do recognise that a focus on victims-survivors is absolutely essential and extremely important. Perhaps what you're saying there is that we will get the opportunity to talk more about our specific work and how that can feed into whatever the committee's deliberations result in. We firmly believe that the rates of family violence will not reduce unless we address the core problem, which is the people who use violence. As I said, these are, disproportionately, men. These are the people that No to Violence and our members across Australia work with every day. We've been at this work for over 25 years—almost 30 years now. I'll say a little bit more about that in this opening speech, which will hopefully be quite brief because we do want to get into conversation with you.

Who are we and what do we do? Essentially, No to Violence has three functions. We are the largest peak body for organisations that works directly with men who use family violence. In fact, we're the only Australia-wide body that works with men directly. Secondly, we provide professional development and training to workforces that work with the men who use violence. This is about making sure that workers have skills and understanding to address this wicked problem, this complex issue. The work, as you've probably heard, is highly nuanced in how to approach this if we're serious about ending it. The third thing that we do is operate the men's referral service. The men's referral service is a specialist telephone and online counselling and referral service. As I said, we speak every day with men who use violence, so we have a bit of a take on what's happening, particularly in this COVID world that we're all currently inhabiting. I suppose you could think about our telephone line as being the yin to 1800RESPECT's yang. It's our intention that we make sure that all men in Australia get a consistent specialist response if they are using, have been using or are likely to continue to use family violence.

Our fundamental belief is that children are not born violent. Children do not need to turn into violent men. This is a learnt behaviour. Boys are not inherently violent or aggressive, and men are not born to harm and hurt their partners, in far too many cases leading to homicides. I hope that members would agree that men are not inherently violent and that these behaviours and actions, which are built in over time through social structures, expectations and, often also, men's own experience of violence and trauma. We all know, I believe, that there is a better way to this. We fundamentally believe that men who use violence can change. That's why we come to work every day and that's why our staff and our members across Australia do the work that they do.

But we recognise that hope is not enough. Approaches to respondent men's violence across the country are needed, and the fact is that across many parts of our country there's no support available. Of the support that is available, there is a lack of investment to enable innovation or to create the range of interventions and supports that are needed to respond to individual men's needs. The way we're currently expected to respond to men's family violence—and I know as a committee you've considered the role of men's behaviour change programs in this—assumes that perpetrators are a homogenous group. We know that this is not the most effective way of intervening in the process or, indeed, of creating the opportunity for personal and social change.

Like you and me, perpetrators have different life experiences. Men who choose to use violence have different trauma, different backgrounds, different upbringings and different cultural heritage, and they also pose different levels of risk. We basically need programs and interventions that are able to respond to these differences so that they are their most effective and they can prevent family violence into the future. We do need these programs to be effective, and I imagine that that might be one of the questions that you want to ask us more about and probe into, but it's really vital that these programs are effective, because it is about improving victims' safety—largely the safety of women and children.

For us, family violence must be considered core business not just for state governments, the federal government or territory governments but for everyone. I'm certain that you've heard the statistics countless times across these hearings and in all the submissions that there is a huge cost from violence in the budgets of police, social and health services and courts. This isn't just about the cost of small specialist services. We know that COVID-19 has already seen a rise. We saw some media from Tasmania this morning about how there are increases in family violence as a result of the COVID-19 pandemic and the social and economic costs of that. Even worse, I suppose, is the impact we can't put a price on: the long-term trauma of the victim-survivors and their families, their sense of safety and autonomy and their ability to live a full life—the time, the dreams lost and sometimes the lives lost. Last time we looked—I don't think it's changed during COVID—we know that every week in Australia a man is choosing to kill his current partner or ex-partner. That is the statistic that continues and endures despite all our best endeavours to intervene in better ways. I think what that shows is that this is a whole-of-community issue, and in order for us to realise that, governments do need to acknowledge that family violence is core business.

Our call to the committee is for the Commonwealth government to take this lead. We're calling for a national agreement or national partnership on family, domestic and sexual violence. We believe this can fall under the Intergovernmental Agreement on Federal Financial Relations, and that then puts it on the same benchmark as health, housing, infrastructure and other such agreements. We believe it's that important and we also believe that, as a mechanism, that can start to make the difference. Admittedly, that places a lot of faith in government and in instruments of government, but we believe, through these processes, every level of government can be properly defined and we can build accountability across the whole system across the whole of Australia.

The negotiations will be needed with all governments around coordination, but we must make sure governments are accountable for the parts of the system they are accountable for. Accountability is a big word for us because everything we do when we work with men and when we work one to one or in groups or in families is about building and strengthening that accountability.

How can we actually work together to have a coordinated system focused on improving the lives of people who experience family, domestic and sexual violence? The current national plan is primarily a Commonwealth document and it doesn't necessarily demonstrate intergovernmental coordination. It's endorsed by state and territory governments, but, in reality and in our experience, they have their own responses and they aren't heavily engaged in the implementation of the action plan. Again, this is not meant to be a criticism of the national plan because we think the national plan has had an incredible impact. Rather, it's an indication that the sector and the community have moved on since the first national plan commenced, and so too must the national plan. Again, I come back to the point that we believe family violence must be elevated to core business.

Our vision is one in which funding is agreed, there's transparency around funding levels and baseline responses, there's monitoring of the impacts and long-term research into the impact of our programs and how we can continue to eradicate the scourge of family violence in every suburb, town and community in Australia. To do this, we need to elevate to the levels of health, housing and infrastructure the family violence issue because it is core business for our nation. We need to pivot towards him and we need our sector to be engaged because we do know how to effectively engage men. One of the things about engaging men is that we know that, if we don't engage, they will disengage and that's when they often become the most dangerous and the most harmful. We can help with this. We can advise. We've been at this for almost 30 years, and, as I said, we talk with men almost every day.

I'm very proud to present here along with other members of my team. We've worked with men directly every day, our members who run programs across different states and territories talk with members every week and we represent organisations across the country who are working every day to make the lives of victims-survivors safer. So thank you for inviting us. We look forward to answering all of your questions today.

CHAIR: Thanks very much for your evidence, Ms Watt. I'll kick off with some questions and then I'll throw to my colleagues. I've really been very much looking forward to the opportunity to speak with you this morning, Ms Watt, because I think that, from my perspective—and I'm not speaking on behalf of the committee—I absolutely agree with your evidence that we need to concentrate in a much more significant way on men's behaviour and behavioural programs. We can spend—and we are spending—significant sums of money at the back end to try and assist women that are impacted by domestic, family and sexual violence, but we need to be stopping this before it even starts. The best way to do that is through men's behavioural programs and elevating the concept of respect, in my view. I really appreciate you coming along this morning. You've stated in your submission:

Like health, housing and education, the next National Plan should be established under the Intergovernmental Agreement of Federal Financial Relations, acknowledging family violence is core business.

Can you give us a bit more of an in-depth understanding of why that is so important and, in particular, why it needs to be part of the Intergovernmental Agreement on Federal Financial Relations?

Ms Watt: I'm happy to take off with this one. I think that's a fabulous question. We've made a clear pitch, and I can give you a few recent examples of why this becomes quite important. None of this is intended to take away the role or the power of state and territory governments in this, it's actually more about building on what we have learned in the different ways we've approach this. But if I look across—

CHAIR: Ms Watt, pardon me for interrupting. Whilst my name is Andrew Bruce Wallace, which is a good Scottish name, can I just ask you to slow your speech down a little bit because I am having a bit of trouble catching everything.

Ms Watt: Of course. I will do that and I appreciate the interruption. This is one of my life's challenges, because there's a lot to say, and I'm very mindful of all of your time.

Let me begin by giving you an example related to cross-border issues. We had an example from our colleague in the Mallee—you may wish to reflect on this—where someone is crossing the border between Victoria and New South Wales; they are on a charge in New South Wales, but also perpetrating abuse on the other side of the border in Victoria. Whilst there have been attempts made, I believe, to improve information sharing, what is getting in the way at the moment is the different ways that states approach this and that is actually putting women at risk. So that's maybe one very clear and detailed example about how the Commonwealth can lead and can encourage and support state and territory governments to work out arrangements that essentially put victims-survivors at the heart of the issue and also call men to account.

Mr Hooper: If I can add to Ms Watt's evidence: the Intergovernmental Agreement on Federal Financial Relations, which I believe is now transferred to the Council of Federal Financial Relations with the COAG transitions recently, is ultimately an instrument which requires a lot of agreement about a lot of specific sections of the service system between the Commonwealth and state and territory governments. There's a level of accountability around finance and a level of accountability around what's actually happening, which provides the transparency that is required across jurisdictions. At the moment, in jurisdictions across Australia, there are really inconsistent responses. In the case of men's behaviour change programs and perpetrator programs, most of the country, when you're outside of the cities, has very limited access to these programs. For example, members in Queensland have spoken to us about a waiting list of up to 18 months. In some places in remote Western Australia there is just no support available. Increasing this transparency, but also the expectations at different levels of government, is a way of making it clear what people are doing and holding them to account. Our hope is it increases the coordination of the response across the country.

CHAIR: I understand entirely the lack of services for victims and perpetrators outside of the capital cities; there are some, but there's a dearth. What will the establishment under the Intergovernmental Agreement on Federal Financial Relations do to fix that?

Mr Hooper: What it will do is create a conversation specifically around what is required to respond to family violence in every jurisdiction. That is a conversation that hasn't been had because each jurisdiction is doing things differently. But we think there needs to be at least a baseline response to men. At the moment it is very varied between different jurisdictions. So it is about having that conversation and the Commonwealth, for example, coming to the table to say: 'Well, we do this part. We do 1800RESPECT and we do primary prevention really

well. We expect you to do your part, and we think that needs to include perpetrator intervention.' That could be part of the discourse which cements what the system should look like.

In addition, I should mention the national plan. A lot of it is principle based, and it does receive Commonwealth funding, but ultimately it's a bit of a toothless tiger in its current state. Again, this is not a criticism of the national plan, because we've seen things like ANROWS and Our Watch come out of it, and we can't stress enough how excellent they have been in changing the sector. But really the states and territories do their own thing, and the national plan has very limited influence in the way things are happening on the ground. So we think a coordinated approach where people define their patch will be useful in producing that accountability and hopefully increasing service provision.

Ms Watt: I might just wrap that up a little bit as well. One of our intentions is to create consistency—not that everybody in every state and territory has to do the same thing but that men across Australia who are committing family violence receive a consistent response. We think that's really important, because there are a number of different human services systems and community organisations interfacing with this issue. We feel that that's important for best practice but also for innovation. We're not saying every state and territory has to do the same thing; we're saying there needs to be some innovation. Chair, you've identified remoteness and rurality as a critical issue. We think there are a number of different ways of doing this, but I think that we need to be consistent in our approach. We need to deliver consistent messages to men and have consistent, robust, safe approaches to engage in earlier in the piece to prevent further harm.

CHAIR: That's helpful. Thank you. I take you now to the touchpoints where we know, or at least the committee's received evidence from various groups, about heightened risk times in a man's life or a couple's life. We know, for instance, or we've been told, that one in three mothers experience intimate partner violence during the first four years of their child's life. We've heard from multiple witnesses that, in the first years after a child is born, that's problematic. Would you like to comment on the various touchpoints in a relationship or a particular individual's life and what your organisation is doing to reach out to them at that point in time?

Ms Watt: That's a great framing of the question chair, and I think this is what we really need to get into. I'll do my best with the short time available, but I think what this points to is that, again, this is a whole-of-service-system response. How able are our maternal and child health workers to identify the risks of violence and coercive control? What do we do to support new parents—not just mothers but fathers as well? So those are big questions about how the different bits of the service system interface. Again, as a small specialist organisation, we are very keen to get into these spaces, to train workers and to support them to know what they're looking at and know how and when to refer on. But equally I think what you've identified is having some basic provisions in a couple's relationships—when she gets pregnant, when they have the first kid—and also the red flags around controlling behaviours being spotted early enough. It's not just the government or the police who can deal with this. Again, I come back to the fact that we need a whole-of-community response. Lizette and Russell, you may have some specific examples you can offer to the chair and the committee.

Ms Twisleton: Coming from many years of practice working with men, I think one of the things that we see in the work is a lack of emotional literacy—so a lack of connection from men to their emotions and being able to express their emotions. So in those times that you're talking about, those times where there's additional stresses in the family, we've seen men becoming reactive and unable to process their own emotions and then express them. To me, that links very strongly to the primary prevention work, the early intervention work, as Jacqui was saying, where we're in there supporting right before this starts. Where violence and domestic abuse is already happening in the family, we want to work with him in that space for them to understand how they got to that point and what they need to be doing to creating safety for their families. We are having to unwind a lot of really complex issues for them. We need a joined up system where education starts very young, with children, around how to manage emotions and how to have respectful relationships. We need to connect with them throughout life and understand that different people have different abilities to deal with these kinds of stresses. As we said earlier, people who have experienced family violence and haven't had good role models are more at risk of perpetrating family violence.

CHAIR: Can I go back to the time around the birth of the first child. I'm 52 and I've had four children. When I was 24 years old we had our first baby. It was a huge shock to be very quickly dragged into the reality that I was no longer numero uno for my wife. As a young 24-year-old, that was hard to get used to. Even at the age of 52 today, I don't know how prevalent that is among young men. Am I the only person who felt that way at the age of 24, or does every bloke go through that? Is this something many men experience or few? I don't know. What sort of research has been done on this? If it is a significant problem, what should we be doing to reach out to young men?

Ms Watt: That's a great way of reflecting. If I may say, Chair, you are actually modelling what we need to do. I'm pretty sure most men go through that. There is research. Your next witnesses are Family & Relationships Services Australia and they will have some comment on this. I know that VicHealth did a project called Baby Makes 3. That was very much about the preparation we must do for the emotional impacts of a child: never mind the practical and financial impacts, how do we help men not just prepare for this but acknowledge it and deal with it? It's very real and I think we can do much more.

In Victoria, when we were having some discussions, we said, 'Why do we call it Maternal and Child Health?' It should actually be called Parental and Child Health if we're serious about asking men to be more engaged or more involved around the birth and the early months of the child. So I think you're onto something there.

Ms Twisleton: I think there is some fantastic work happening in the fatherhood project at the University of Newcastle. Backing in what Jacqui is saying, it is around how we are shifting responsibilities in the family. Often the men we are working with talk about finding out that they are going to become a father and feeling really ill equipped. For some men, that becomes a wonderful journey and a wonderful challenge to learn how to be the best dad they can be. For some men, that may plug into their own experiences of having a violent or absent father and really complex relationships with the men in their lives and plugging into a lot of trauma. It is a very complex place. When we are working with men, we are trying to unravel some of the additional barriers and drivers for men to be able to step into the roles in their life in a way that is loving and caring for the people they want to be with.

One of the things I've learnt over 12 years of sitting in men's groups is that when I ask them what kind of father they want to be, what they want to be for the people in their life they care about, they will invariably say that they want them to feel safe but they don't know how and they've messed up terribly. For some men, that messing up is really dangerous and incredibly harmful. For the men that we work with—and we are not shying away from the fact that there is incredible harm happening to those families—it's almost like a deep re-education needs to happen. That's why we believe in change. We believe that the change can happen, but we need to do an incredible amount of investment—from early childhood, where we're growing boys into young men who can face some of life's milestones and challenges and not be causing harm, not doing things that, even within themselves, they are not okay with.

CHAIR: Thank you so much. I'm going to hand over to the deputy chair. I could probably spend the rest of the day with you, but I'm conscious of the time. I now invite the deputy chair to take it from there.

Ms CLAYDON: Thank you, Chair, and thank you very much to the No to Violence crew for giving evidence this morning. You have asked for something that is not dissimilar to national agreements and national partnerships that exist in other sectors. You think this would elevate violence to a place that would be taken more seriously. Simultaneous with this inquiry we are running an inquiry on housing and homelessness in Australia. There is a national housing and homelessness agreement, which I'm pretty sure a lot of people in the sector would say has failed to be the accountability tool that I'm pretty sure you would like to see in the violence sector. What is it that you have seen working in other sectors that would give you confidence that there are not only agreed understandings about the way in which services and programs might be coordinated—particularly in the men's space, which is your specific interest—but accountability from all levels of government?

Ms Watt: Before I get into that, I would like to thank the chair for his comments and reinforce that we are very keen on accountability. I'm glad you have ended on that, because accountability is something that we live and breathe. When people ask us how we remain accountable in our work—and obviously that is very challenging—we have a couple of responses. One of them is to say that it's very hard to actually make somebody accountable; you can punish them but accountability is an internal journey. We can think of this in three layers: we have the person; we have the system they are operating in, which includes the family, the society and the community; and then we have the government, who are trying to make a change in this. What I would say to you is that we can make the system accountable for how it does its business. Part of that is people being clear about the different roles and responsibilities.

When we look at interventions or the lack of them, or the inconsistency or paucity of them in some parts of our country, we recognise that there is a common thread of having enough people who understand what is required but also then tapping into existing service systems. We don't have to deal with the spend in New South Wales as do in Victoria or South Australia or the Territory, but we do have some common threads around what will work as a web of accountability around that man and what the system can do.

In our role as experts, we are confident that, if we had the opportunity to have these conversations as part of a national agreement, we would come up with some really powerful and strong foundations from which this work could be properly evaluated, monitored et cetera. We don't think it's all about the dollars; I need to say that up-

front. The last funding announcement in Victoria shows that we are spending more money on family violence than the rest of the country put together. We are coming from a very uneven space in this. Part of an agreement is to try and equalise it—not say everyone is the same but at least have some basic standards, practices and approaches where we say, 'To enter these [inaudible], to make a difference to the trajectory of family violence in our country, here are some fundamentals that need to be in place.' As I said, No to Violence can help with that.

Before I finish, I want to send an invitation to the committee. At any point in time, if you get in touch with us we can arrange for you to observe a men's behavioural change program so you can see what actually goes on in these programs. Also, when we come out of this long, long lockdown, you can come and see the work of our call centres in action. I want to put that invitation to you before I forget.

In terms of accountability and the national agreement, Russell and Lizette might have something to say.

Mr Hooper: Thanks for the question, Deputy Chair. I take your point about some other agreements, including housing and homelessness, potentially not being what they hoped to be. But they did start a conversation between the Commonwealth and state and territory governments around accountability. Another conversation that happened was around the National Disability Insurance Scheme, back in 2011 to 2104, around what they expected as a minimum approach across the country. Although there are obviously still teething issues with the National Disability Insurance Scheme, there is support which wasn't available before. So having that conversation about where the deficits in the system are is a really important part of moving to a system that is more optimal. There is a lot of faith in government processes but the conversation is the most important part to make sure we are clear on what we expect as policymakers and also as a community.

There is one other thing I want to add to that. In the submission, you will note, we also spoke about the report on government services. I speak bureaucratese quite fluently, having spent over 10 years in the public sector. In one of those roles, working in family violence at the Commonwealth level, when trying to determine the different levels of funding and service provision across jurisdictions, that information just wasn't available. It's hard to hold individual governments—Commonwealth, state or territory—to account when that level of transparency isn't available or able to be compared across different jurisdictions. That's really important for policymaking. What we would suggest—and I note that there has been some conversation across the committee around a national commissioner for family violence—is some form of oversight in terms of service delivery, rates of domestic violence and also, importantly, funding.

Ms CLAYDON: Thank you. I appreciate your insights as a former professional public servant. In my opinion, that's a very noble profession to have had. I would be interested in your thoughts about increasing transparency. If you want to supply that on notice, that is fine by me.

You've been working collectively in the space of trying to change men's behaviours for almost 30 years now, you were saying, and yet from everything we know about violence all the figures are trending in the wrong direction. Clearly, whether from an increase in reporting or it's an actual increase, we're seeing figures moving in absolutely the wrong direction in just about all the jurisdictions that we're aware of. This is no reflection on your program, everybody's trying to run their programs all across the country, but there have to be significant gaps in services. I'm interested in your observations and your experience of where these gaps are, both in terms of service delivery models and geographically. I'm not sure, if I were a man living in, I don't know, Coonabarabran, that I would have the same access to services as if I were living in Fitzroy, Melbourne. I'm interested to hear your experiences around gaps and what is needed.

I concur with the chair's observation that we absolutely need to change the behaviours of those using violence in their lives, but there's a big body of primary prevention work that's got to take place as well, I would suggest. Anyway, I'm interested in your thoughts about those gaps in services in the delivery model and the geographic reach of services and people's access to them.

Ms Watt: Fantastic. I'll try to talk slowly enough, but there's a lot I'd like to put to you in response to that question. It's very heartening that it's a question that the committee is asking at the macro level. This goes to the heart of a number of things. One is, in terms of the numbers going in the wrong direction that it's true to say that there's greater awareness now, and also that there's been huge investment in how the police, the courts and other services do their work in this area. Part of that is around the impact, more recently, of people like Rosie Batty and her advocacy, and how that brought a lot of things to the surface.

What we can also know, though—and this is the bit that I would encourage you not to be depressed about—is that we're still talking about the tip of the iceberg here. We're talking about something that is complex, that is wicked and that is probably far more prevalent than we even potentially know about at the moment. You're absolutely right to say that we have to allow prevention work. These things will take place over time. There will

be attitudinal change, but, in the meantime, we may see even more numbers. The reason I say that is because of the impact of COVID-19 on the social and economic situations families find themselves in. I hate to say it—

Ms CLAYDON: No, I totally agree.

Ms Watt: We need to brace ourselves and we're very grateful and appreciative of the fact that the Commonwealth government have supported us to take the men's referral service national. As part of preparing to do that, back in May we did a survey of a number of men and got about 500 men to respond to the questions, 'If you did think you were using violence, how would you know what to do? Where would you go?' We were shocked at how many people said they wouldn't know where to go. So a big part of our work in rolling out that time-limited COVID-funded service is to say, 'Here's the number, please call.'

That's one bit of it, but the other bit of it is that men have different help-seeking behaviours and, again, there is research that's been done on this. They will essentially do everything they can to avoid making that call, because, as Lizette was hinting at, there's a complexity of emotional responses: there's shame, there's guilt, there's fear. I think we have to do more in the service system to make contacting a service a normal thing. We can't do that on our own. We do need the connectivity of other bits of the service system. That's one gap, I would suggest.

I think another gap is that this is an area that we haven't necessarily talked about or engaged in fully across the country, so in some senses it's quite new. So even though we've been talking with men for the time mentioned and we have members running men's behaviour change programs every week, the men's behaviour change program is not something that's suitable for all men. That comes back to my earlier point that they're not a homogenous group and that we need a range of different things we can do with men one-to-one in community, in the criminal justice system, in the health system. So there are many gaps. I think our submission spoke to this, but we can always give you some more specific detail on that. But the service delivery model itself isn't yet built. What I've often said in our work is that we're sort of building the plane as we're flying it. And that's where, again, national leadership on this issue could be really helpful to say, 'Well, what is the evidence base that works for that type of man or this type of man?' Men's behaviour change groups wouldn't have been suitable for Rowan Baxter. He wouldn't have gone to it. He wouldn't have thought he needed to, so preventing that particular horror is going to require something different.

Geographically—I'll stop so my colleagues can get their opportunity—we believe that there is a lot of work that we're developing already in response to COVID and to take our work online. We're looking at what is possible in intervening with the men directly, with the family or with someone working in the service system, if you like, to support the whole family. What's possible in terms of pivoting our attention and our work towards what's going on for him? What's he up to? What's going to happen next? What is the best way of keeping her and the kids safe? And what is the optimum way of engaging him in some kind of engagement conversation about what's going on so that he knows the system's eyes are on him. We've got a number of ideas and we're building an evidence base around what we're learning from doing this work online as well. I'll stop there.

Mr Hooper: I am conscious of the time, but I just wanted to elaborate on Jacqui's point about technology facilitated intervention. In the global pandemic, particularly in Victoria, people haven't been able to abide by physical distancing restrictions for men's behaviour change groups, so we have seen a pivot online. It's been really interesting because, with our refinement, we've learnt that people need to see all members of the group, so what's the screen size? It's actually 16 centimetres. There are also reflections on glasses, and we have trouble figuring out body language through a screen. But, ultimately—we will be evaluating this approach going forward—its applicability across the country, across different jurisdictions is potentially quite significant. For example, for GBTI men it's hard in regional areas to get enough for a men's behaviour change group, but, if you were going across different jurisdictions or different towns, you could get a critical mass to deliver these programs. So there's also potential for innovation coming out of the current environment.

Ms CLAYDON: That's important information.

Ms Twisleton: I'd just like to add that I think we realise that, when a man turns up in any service and family violence has been identified, he's actually at the beginning of a life's work of change. He's got to where he is because of his life and all of the influences that have been in that. And that's everything from societal messages to his own family and personal messages. As Jacqui said, we know that men are not generally very good at help seeking, so it's important to have a range of interventions that are really well funded and that do meet standards. And it's important that there is consistency in that approach, but there needs to be incredible flexibility in being able to tailor responses to individual men. That can be reliant on whether he has other criminal history and his own history and patterns of using violence, as well as the other complex life factors which are feeding into his use of family violence, his choice to use a range of behaviours that are harming his family. So it is a really complex space.

I think that, for us to be able to turn those numbers back and see the numbers drop, it is going to take some time of the primary prevention work, the generational change that needs to happen there, seeing more gender equity, and also having that range of responses so that we don't think that, if we send him to a men's behavioural change program, he's going to come out at the end of that program and be a different man—he's going to be at the beginning of a journey. So the importance of ongoing work and that work being able to be tailored to that man is really important.

Ms CLAYDON: That is a very important point.

CHAIR: I just need to see if any of our other colleagues have questions. Does anyone else have any questions?

Dr WEBSTER: I'd like to talk about the cross-border material at some point.

CHAIR: Thanks. Deputy Chair, do you want to have one last shot or are you happy to leave it there?

Ms CLAYDON: I have many, many questions, but I am—

CHAIR: As did I.

Ms CLAYDON: You could perhaps take this on notice. I am interested in who, if anyone, is working on that range of wraparound services that are going to be required once somebody has completed your behaviour program. This is just the start of a journey. What happens next and what's required? I am also interested in funding, given the astonishing observation that Victoria is spending more money than the rest of the country altogether. You're the peak national body, as I understand it. Is that correct?

Ms Watt: That's right.

Ms CLAYDON: I'm interested in whether you've got a line of thought on what funding is required across the country. Was there anything in the budget that gave you some assurance that the concerns that you've been raising around the inconsistency of some of the programs are going to be addressed? Were there any measures in the budget that gave you heart on that front? If you need to take those on notice, I am fine for you to do so, or you can make some comment now.

CHAIR: No; I am going to cut you short there. Could you take those questions on notice, please, Ms Watt, because I have two other members who are keen to ask some questions.

Ms Watt: Sure.

Dr WEBSTER: Thank you so much for your evidence today. I really appreciated it. Ms Watt, as you raised a little earlier, the cross-border problems are incredibly complex and also relate, in a not unrelated area, to child protection, to the problems for policing. I've actually had conversations with the Department of Home Affairs for this very reason, about how, at a federal level, we improve policing so that it's not just filled with many barriers and difficulties and that communication between the departments of human services—whatever their names are—is also problematic. Do you think that it's actually possible, or are we trying to move a behemoth and that it is just unlikely to take place? If you do think it's possible, what do you think the steps are?

Ms Watt: Thank you for that question. This is right at the heart, again, of why leadership in the Commonwealth space to support certain types of interventions is so critical. It is big—there's no doubt it is big—and it does cut across many, many systems. But we do also believe that it's possible. As to that bigger systemic shift of pivoting towards him and what he's doing, there are programs out there in parts of Australia that do what's called the Sticking Together Program—you may know about it—in the child protection space. At its essence—and this is not to simplify it—it is about making sure that those child protection workers and staff are paying attention to what he's up to and are recording things that then can be seen as being either red flags or warnings. So you build up a pattern of how he is carrying out his use of either coercive control or his particular pattern of abuse with that family. So, it actually does come down to nitty gritty, rolling-sleeves-up stuff, as well as the need for political and legislative leadership. It's as basic as the worker knowing that he or she needs to also keep an eye on how the parent of these children, or the step-parent of these children, is conducting themselves, and what that pattern of abuse is doing to this family. That's basic training. We can provide that, our colleagues in other programs can provide that. I give you that as an example of how there is hope here.

I think the actual leadership that's needed to message it is important, and I think that the system can shift and change, but we're in it for the long game. It will come down to basic practices around how social workers look at the family, how child protection workers look at the family, how lawyers look at the men they're representing in court. There are a lot of things to be tackled. Russell and Lizette, did you have something more to say to that, especially about the cross-border issue?

Mr Hooper: Yes, thank you, Ms Watt. Information sharing is really hugely important to these coordinated responses across jurisdictions. I know that this has been done in different sectors. I grew up in Albury-Wodonga, and the health system between Albury and Wodonga has merged in recent years. It is possible, if you have the appetite to do it. I'm not sure if we provided this example earlier, but one of our men's behaviour change providers operating in Victoria, near the New South Wales border, recently told us that they had no way of telling whether their clients, who are New South Wales residents, are on corrections orders or intervention orders, or what the conditions might be. We need that harmonisation of information sharing.

I note you said in a previous action plan, I think it was the second action plan, there was work on a DVO-sharing scheme, which was being led, I think, by the Attorney-General's Department. That stopped at the interim level; it hasn't gone to automation. My understanding of the scheme is that a police officer needs to call a different jurisdiction in order to find this information, which takes a lot of time. As we all know, police are already stretched as it is, and any additional time restrictions reduce the ability to get that kind of information, so having some form of automation would be really useful for these cross-border issues that you mentioned.

I just want to flag that if there is an escalation in violence while he's enrolled in a program, it might not be communicated to a men's behaviour change provider. In Victoria there are more programs. We often find that New South Wales people, if they're associated with a Victorian person, are using those programs, and so that lack of communication, in itself, is also contributing to that increased risk to safety. We really do think that we need to improve that level of information sharing at the state level, and I think it can be facilitated through the work at the Commonwealth level. I think that work sits with Home Affairs, if I recall correctly from my time at DSS.

Dr WEBSTER: Thank you for that. I have a border community. I have two borders, South Australia and New South Wales, in my electorate. There have certainly been issues where perpetrators have been able to escape one state, go to another state and the police have effectively been stopped at the border and time is lost. And, also, the legislation is different. There are serious issues with regard to keeping people safe.

My other question has to do with the rate of success of these men's outcome programs. In the research that we have, of which there is very little, as you would know, evaluations are scarce. The international research would indicate that men's behaviour change programs have around a 10 per cent success rate, and it would depend on what the variables are, what the parameters are, what the outcomes are that you're measuring. I'm just wondering what you see as being key issues that need to be addressed in order for these programs to improve the rate of success. If we take the rate of success to be perpetration ceasing, that men can have positive relationships with their families—I'm not sure what other parameters there would be, but if you can give me some idea of that, that would be great. And what research needs to be done in this space?

Ms Watt: I'll kick off, and let my colleagues come in on the back of that. We understand that 10 per cent figure has come from a very limited survey of very, very high-risk men, and I think that comes back to my point about how these programs, these particular programs, are not suitable for all men. What we have to get better at is identifying levels of risk earlier on, and having the appropriate response. I would actually direct you to Project Mirabel in the UK. You maybe have already had it mentioned. That was a program that worked over six months with men, and with their partners, that demonstrated there was increased safety. My colleague Lizette will have some of the stats on that—they were much better than 10 per cent, let me say. But it does come back to not just funnelling everybody who goes through the court process into a men's behaviour change program. It is actually, again, about a more sophisticated earlier intervention that's required.

What we know about group programs is that when he's engaged and when he's able to take on board the concept that he's actually harmed his partner, and that her freedom and her ability to live her life is important, the program will have more success. So the longer the program, the more it will be able to re-pivot him. Now, I come back to—I mentioned going back [inaudible] already. That model of coercive control, the way that person was behaving, was not going to be able to be intervened in a program like a men's behaviour change program. There was a raft of other interventions required there, and I'm sure the coronial report has plenty to say about that. We've got to get more sophisticated. What do we mean by men who use violence? What type of violence are they using? How frequent is it? How advanced are they in their journey of using that violence? These are all elements of building a more accountable system that we're very interested to contribute to going forward.

Ms Twisleton: What Jacqui is talking about there is what we're calling a suite of interventions, that there's not a one-size-fits-all solution. It is about tailoring responses and it is about that long-term work. What we believe is that we need to build a really strong evaluation framework, and I think that's something that could be led nationally. It needs to be a framework that can evaluate men's behaviour change programs and a range of other responses—case management; one-to-one work; other programs that address fathering, like Caring Dads, the Safe

and Together model as it happens in child protection—so that we can actually start to look at and do some longitudinal studies.

One of the things that Project Mirabal highlighted, and what became really important for us in our work, was the voice of victim-survivors saying what they want: whether they want to remain in that relationship; whether they're on a journey of moving away from that relationship. What they're asking for is increased safety and an increased sense of personal agency, to be their own person, to make their own decisions and choices in life and not live in fear. Being able to have a framework, particularly for our program, and this was highlighted in one of the ANROWS studies, means that we need to build a really solid framework. That would really support us and our work to be able to help build that system that Jacqui is talking about. I think that's a really major piece of investment that could happen.

Mr Hooper: I would completely echo what my colleagues—

CHAIR: I'm sorry to interrupt you, Mr Hooper, but we're going to have to keep moving. If you have a response that you'd like to put on the record, I'll get you to take that on notice. Peta Murphy.

Ms MURPHY: I want to thank you all for your very long and thorough submission, which we've only been able to touch on some elements of in this oral hearing. As I read your submission, you put men's behaviour change programs, which are by definition an intervention after a man has engaged in some form of family or domestic violence, very squarely into that broader context of primary prevention as well, and the need to work towards better gender equality and gender norms in society. Correct me if I'm wrong about that. Having done that preamble, what I'm interested in hearing from all of you with all of that experience that you have in men's behaviour change and working with men is what you take from that that you think could be translated into primary prevention programs directed at young boys over and above the sex education and healthy relationships programs that we have. We've heard evidence, for example, about programs at the moment that are directed towards empowering young girls who come from either families where there's domestic violence or disadvantaged communities where violence levels are high which aren't, per se, talking about domestic violence or sexual equality but are trying to take the positive traits that are in the girls and empower them to have confidence in leadership. So I'm interested to know if that's the sort of model you think might translate to boys and, if not, what it is that you think the Commonwealth should be looking at supporting in that space. It was a long question, I know.

Ms Watt: I will happily go first and let my colleagues fill in. I'm very, very mindful of your time here. I think all of the things you've detailed need to happen. It's important that boys are emotionally developed as well as girls. It's also important we look at the social structures that get in the way of this. It's one thing for us to seek to educate our children in our families and in our schools about relationships and the best way to conduct themselves as adults going forward, but if they're absolutely bombarded by porn on their mobile phones at school each day it's hard. So, again, a number of things are required. I think continuing to measure community attitudes to this is important. I believe the Commonwealth supports the National Community Attitudes towards Violence against Women Survey and the work of the ABS and the Australian Institute of Health and Welfare. Let's keep looking at this and monitoring and measuring this, because I don't think we've got it right yet. We're making some progress, but also in some areas we're going backwards.

Ms Twisleton: We have a fantastic framework with Our Watch's Change the Story. When we're working with men, one of the things that we're doing is actually unpacking all of the things they've learnt about what being a man is that have really not served them and have actually led them to the place where they are, where they're sitting in that room talking about their harmful behaviours. So there's a huge amount of work to do in changing those norms and, as I've said earlier, helping to develop that emotional literacy for poor boys and men, that it's okay to feel vulnerable and afraid and it's okay to not have all the answers, that you're not called 'weak' because you're vulnerable and you're afraid. I think they are the massive changes that are really clearly articulated in Change the Story that would help that generational shift. That's going to take us time. This is a long haul. It's a long game. As I said, the work with individual men is a lifetime's work. I think that this needs to be a lifetime's work for all of us in how we change the broader stories that we all grow up in.

CHAIR: I'm sorry to cut you short, Peter, but I'm going to make an executive decision and ask No to Violence if you wouldn't mind coming back for a subsequent session. There's so much to unpack from your evidence that I just don't think we'll be doing it justice to limit it to one hour.

Ms Watt: We'd be absolutely delighted.

CHAIR: Alright. We have other witnesses waiting patiently, so you will hear from the secretariat and we'll see you next time. Thank you very much for your attendance at today's hearing. The evidence that you have

provided the committee has been exceptional. You will be sent a copy of the transcript of your evidence and you'll have an opportunity to request corrections to transcription errors. You have been asked to provide additional information. Would you please forward that to the secretariat within two weeks of receiving the *Hansard* transcript, and we will be in touch with you.

BRADY, Mrs Jacqueline, Executive Director, Family and Relationship Services Australia

CLOUGH, Dr Robyn, Manager, Policy and Research, Family and Relationship Services Australia

Evidence was taken via teleconference—

[10:00]

CHAIR: Welcome. Although the committee does not require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as a proceeding of the House. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I now invite you to make a brief opening statement before we proceed to a general discussion.

Mrs Brady: Thank you, Chair, for the opportunity to provide evidence to the committee today. I'd like to start by acknowledging the traditional custodians of the lands on which we meet respectively. I speak to you from Canberra and acknowledge and pay my respects to the Ngunawal people. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and the region.

I also note for the record that I am a member of Australia's National Research Organisation for Women's Safety's Practitioner Engagement Group. I know the committee has already heard evidence from ANROWS. My organisation's work is informed by some of the excellent research that ANROWS produces, but today I am speaking solely on behalf of Family and Relationship Services Australia and our members.

Family and Relationship Services Australia represents over 165 members throughout Australia, with 135 organisations directly delivering family and relationship services across Australia. These services include family law services, such as family dispute resolution, family law counselling, children's contact services and post-separation support services. Our members also provide a broad range of other Commonwealth funded programs for children, families and communities, such as family and relationship counselling, children and parenting programs, the Communities for Children program, find and connect services, royal commission services, intercountry adoption services, family mental health support services and specialised family violence services.

Surveys of our members have shown that for family law services members estimate that family and domestic violence is a factor in 60 to 80 per cent of cases. Across other family and relationship services, that estimate sits at around 50 per cent. Accordingly, a high proportion of Family and Relationship Services staff are specifically trained to support clients who are experiencing or are at risk of family and domestic violence, and risk assessment at intake and throughout service delivery is a high priority.

Our submission covers a range of issues, but there are two issues I would like to emphasise in particular. Firstly, we think that a public health approach for family and domestic violence is needed in order to focus on addressing all the key risk factors—for example, childhood trauma, poor mental health and poverty, along with gender inequality—by building protective factors in vulnerable groups and delivering population-wide prevention measures. We see a contributing role for family and relationship services in this approach. The potential of the family and relationship services sector to play a bigger prevention and early intervention role in relation to family and domestic violence exists. The sector has a number of strengths that lend themselves to a stronger role. These include well-developed expertise and resources for working with a range of families; national coverage and extensive community links; developing expertise in the delivery and evaluation of evidence based family programs and evidence-informed practices; engagement with families across key transitions in the family life course; and non-stigmatised services relative to tertiary services, such as child protection and correction.

Secondly, we do need to see a much greater focus on children and young people. We'd like to see stronger connections between the successor to the National Plan to Reduce Violence against Women and their Children and the next National Framework for Protecting Australia's Children. Research has clearly shown that children and young people who are exposed to domestic and family violence may suffer negative psychosocial and developmental outcomes, and there are limited services and supports for children and young people who are experiencing family and domestic violence in their own right.

I understand that the committee is mindful that the parliamentary inquiry into Australia's family law system has yet to deliver its final report and the committee has therefore elected to limit its evidence-gathering on domestic and family violence to within the context of the family law system. However, it would be remiss of me not to bring to the committee for consideration the fact that insufficient attention is paid to the rights and needs of children within Australia's family law system. We do consider that that the family law system should adopt a more child-focused and child-inclusive approach that enables the child's voice and the child's needs to be front and centre of decision-making about that child. Too often children's voices are ignored and they are placed in damaging and unsafe situations.

Thank you for the opportunity to make this opening statement. I welcome questions from the committee.

CHAIR: Thank you very much for you detailed submissions. Once again, the submissions we've received have been excellent, and I want to congratulate you on your work.

Mrs Brady: Thank you.

CHAIR: First I'd like to take you to the first item you touched on in your submission, which is that the approach needs to be a public health approach. Can I get you to expand a little bit more on what you mean by that?

Mrs Brady: Certainly. A number of years ago we wrote a research report that was looking at strengthening prevention and early intervention services for families into the future. When we talk about a public health approach to service delivery, we are looking at where we have a three-pronged approach to service delivery: we have universal services that are broad and mainstream; we have secondary services; and then we have tertiary end services. So, for the likes of the services that are provided by Family and Relationship Services that we speak of, many of those would fit more within the band of the secondary stream within a public health model.'

I think often the real challenge is that there is a battle or a competition for funds. So, we really want to say that it's easy to get into an either/or situation. Tertiary services, especially in this time of uncertainty and high risk, are essential. And we know that these domestic violence services are working tirelessly to keep women and children safe. But prevention is a long-term investment, and, until we see material and positive changes that are sustained through significant decreases in DFV, we must give full support to those tertiary services.

That said, we do believe that there is an additional opportunity in which we're able to look at the sorts of services that are provided by our members. As I noted earlier in the introductory statement, people are coming into our service experiencing family violence. That provides us with a unique opportunity to work with them 'upstream', as we refer to it, before they get to the really pointy end and might be requiring the more tertiary-end service provision. We believe that, through systemic intake and assessment processes where risks are identified, we're able to work with people earlier in their experience of family violence, or even before they themselves have identified family violence. I think the key thing to note about our members is that, even through intakes and assessment processes, people don't necessarily identify, first off, that they are experiencing family violence. That may not come up through that initial process. It may be something that is disclosed to the practitioner they're working with as they—

CHAIR: Can I jump in there for a moment. I'm not sure if you've followed the evidence earlier today or in previous hearings, but we've received evidence that there are consistent touchpoints where men are most at risk of becoming perpetrators. Do you share that view? We heard and talked this morning about one of the touchpoints being in the first several years after the birth of a child, most significantly the first child. What are some of the other touchpoints in a man's life where things are likely to go off the rails?

Mrs Brady: From the experience of the services that we provided, yes, it's very clear that the birth of the first child is one such time in the life course. Another time, regrettably, is before that, during pregnancy; that is an area that's been identified in the literature. We also know that, when there is child neglect or abuse or where there's family and relationship conflict and breakdown, they are key areas where violence in those relationships can spike, often very close to the actual breakdown of the relationship, and not just before but after as well.

CHAIR: Are there any other times?

Mrs Brady: They would be the times most known to us. The other thing to point out, though, is that, when people are going through stressful experiences in their life, it would be fair to say that there can be a manifestation of behaviour that may lend itself to violent behaviour. In terms of actual age areas, I think that would be difficult to point to. What we do know is that when there is financial stress in relationships it can lead to family and relationship breakdown, and what we know about family and relationship breakdown is that there can be an increased prevalence of family violence around those times. So I think what we see is a causal or related impact that can occur during those times in people's lives.

CHAIR: We've heard in a lot of the evidence that we've received that part of the problem, which I know you've touched on, is that we don't have a really good, sound research evidence base of our experiences. A lot of it is anecdotal evidence from different organisations doing different things. That's part of the problem, and it's something that I hope this inquiry will address. But one of the other touchpoints that we've received evidence on is in times of natural disaster or other crises, like COVID-19, bushfires and things like that. I'll put aside COVID for a moment, because COVID is a little bit easier to understand in the context of domestic violence—it's certainly not permissible, but you can understand the stress that it causes. But, in relation to natural disasters, why do you think they spark an uptick in domestic and family violence?

Dr Clough: I know you're wanting to avoid talking about COVID, but I think we can put those natural disasters in with COVID in that they are incredibly unsettling. There can be a range of impacts on families, and certainly financial stress, as Jacqui just mentioned, is one of them. Clearly that's not an excuse for family and domestic violence, but we do know that when people are under stress their buffer is gone. Certainly high stress is something that will contribute to or escalate family and domestic violence. Obviously that won't be the case for everyone, but if there is already a vulnerability there then putting someone under stress is going to produce that behaviour.

Mrs Brady: Can I jump in there with a comment that might be helpful to you, and it points back to the public health model. One of the big issues around the assessment of people when they come in and are working with our services is this language around the identification of risk factors. What we know in the work that we do is that, through things like family and relationship conflict and breakdown, the family and relationship attitudes and behaviours that are exhibited and poor family management—if those risks are there then we know there can be the development of other health and social problems, which of course includes family violence. It also includes alcohol, tobacco and other drugs abuse, and it can include mental health problems such as depression and suicide. So there's a link between the two.

The key issue here, though, is that, where you have a risk factor, we know there are established means of assisting families in developing what we refer to as protective factors. Those mechanisms can assist families and individuals, even at the community level, to get through those periods. That's where we see a critical role for our services: we can assist with the identification of risk, but we're also well placed to assist with building those skill sets that are required. When you talk about the men in those particular situations, the sorts of things that you would be attempting to assist with are the development of skill sets within individuals to manage stress and to function well when faced with challenges, adversity and trauma. You help them to develop positive relationships that provide them with the emotional, informational and instrumental support that they need, when they need it, and ensure that they're able to reach out to the right community connections and family and individual connections that they need to be supporting them.

So, whilst there's a lot of talk about risk factors, one of the key issues for us in a public health model is the realisation that those factors can be mitigated to a large extent if we have the appropriate support services to build the protective factors that those children, families and communities require.

CHAIR: You may have heard, in the evidence from No to Violence, that they advocated for the next national plan to be established under the Intergovernmental Agreement on Federal Financial Relations, acknowledging that family violence is a core business of governments of all persuasions and all jurisdictions. Do you have a view on that?

Mrs Brady: I must confess that I didn't listen in to the No to Violence presentation or evidence this morning, so could I take that on notice? The only thing I would say is that it has certainly been beneficial to have the linkage through what used to be COAG. The mechanism that needs to support the ongoing work of the National Plan to Reduce Violence against Women and Children will require some sort of framework that can draw together the state, territory and Commonwealth responsibilities. But I would add that I think there's a necessity to also bring in a range of other not-for-profits and other services that are working to assist men, women and children.

CHAIR: Can I take you to funding. Where does Family and Relationship Services Australia get its funding from?

Mrs Brady: In terms of our members or us as an organisation?

CHAIR: Both you as the peak body and your members.

Mrs Brady: We are recognised as the peak by the Commonwealth government, and as a result we receive a stream of funding from the Department of Social Services to support us in that activity. That comes in at around $440,000 per annum for us. We also receive membership fees from those member organisations who are members of ours, and that comes to about $250,000 per annum. All of that is covered in our audited financial statements and so forth, so I can certainly provide that information.

For our members: our touchpoint with our members is through Commonwealth funded services. There are family law services that are funded by the Attorney-General's Department, and that at the moment comes in at around $160 million per annum. Then, from the Department of Social Services, the range of programs that sit under the Families and Children Activity is around $200 million.

The main source of Commonwealth funding for our domestic and family violence service provision is the Department of Social Services, and that amounts to, under normal circumstances, about $4.5 million per annum, which I note is a relatively small proportion of the overall funding. But I will add that in recent times additional

money was provided under the Fourth Action Plan, which came from the Women's Economic Security Package. That provided additional funding of $10 million over two years.

CHAIR: One of the things I'm struggling with—and I'm assuming that my colleagues are as well—is that many of the witnesses have provided evidence that what works in one organisation in one location won't work for another, and the importance of tailored programs. I'm talking specifically here about men's behavioural programs, intervention programs. I'm just putting this out there. It makes it very difficult for governments to fund these sorts of programs when we when we can't get a clear line of sight on which ones are working and which ones aren't. That's a whole evaluation problem that I think we almost universally agree is a challenge in this sector. Do you have a view on how, as governments, we can provide better targeted funding when there's such a disparate range of services that are being provided to men across the country by so many different organisations?

Mrs Brady: I'll offer an initial response, but I know that Robyn will have something to add to that. If I may be so bold, I'd suggest that there will be a necessity to find a way to provide funding for these services that allows a level of flexibility. I think that that is the nature of what we find in the delivery of the sorts of programs that we're talking about to children, families and communities throughout Australia. It is something that does need to feature and, I suppose, has been a point that we have various conversations with the Department of Social Services and the Attorney-General's Department in that you can have an overarching framework or guideline but having flexibility in how it's delivered. I know that that can be a bit challenging and I also know that we have room to develop better evidence and evaluation of those programs. But we have been working through that process in the family relationship services sector over the last six or seven years with a range of other program areas where there is a requirement to be evidence based, evidence informed, and clearly linked to very specific outcomes that the services and programs need to be measured against.

The final point I'll make before passing to Robyn is: one of the key areas here, though, is that the development of research, evaluation and evidence is also a cost to organisations. So I think that, in the pursuit of developing evidence and evaluation, we also need to be factoring in that there is a cost and ensuring that services are able to fund that sort of activity.

CHAIR: Thanks very much.

Dr Clough: I'll just add to that: something that the Department of Social Services has been looking at for a while and is moving towards is what is called an outcomes based framework rather than outputs. A true outcomes framework in practice means that providers get that flexibility, that they're focusing on the programs and working for their clients, rather than ticking boxes about how many clients they've seen, for example. It can be very difficult to agree on outcomes, but it enables that flexibility and service delivery, which is absolutely needed across different populations, different culturally and linguistically diverse groups who have different factors coming into play. So, it is important to be able to tailor those services.

CHAIR: Thanks very much. I'm going to leave it there.

Ms CLAYDON: Thank you to Family and Relationship Services Australia for your evidence this morning. I know we're pressed for time, so I'll try and get straight into it. In your submission, you refer to the link between financial hardship and family relationship challenges. Within the context of the pandemic, you said—and I'm quoting from page 20:

> The experience of FRSA members is that financial hardship can place considerable stress on family relationships, leading to interparental conflict and, in some cases, the onset or escalation of domestic and family violence.

Could you please talk the committee through that: what are your members seeing at this point in the pandemic; and what are they expecting to see over the next little while?

Dr Clough: Thank you for that question. We touched on this a little earlier, and what I want to emphasise is that financial hardship is not the cause of family and domestic violence, nor is it an excuse for family and domestic violence, but it can most certainly be a contributing factor. I must say that many people living in poverty or who are struggling financially have strong and respectful relationships. But we know that the links between financial hardship and family relationship challenges, including family violence, have been well established in empirical studies, looking at the impacts of unemployment, of recessions, et cetera.

During the pandemic, our members have certainly reported increases in couples and families presenting with family and domestic violence issues. We know there are a number of contributing factors to that. Obviously, family relationships are under strain when people are in lockdown, there's already family violence present and women don't have reprieve by going out to work and there's just a lot of tension. We've seen increases in consumption of alcohol and other substance misuse, which I think is all part of the uncertainty and the worry that

people are feeling during the pandemic. There are certainly job losses, financial worries and uncertainty. That all puts extra strain on already fragile relationships.

Something that our members have been saying to us over the last little while is that they're really concerned about JobSeeker being wound back in December and other measures such as JobKeeper ending. Our members are really expecting to see an increase in a range of issues impacting children and families in Australia. Domestic and family violence is one of those issues. As we said in our submission, we really think that addressing financial hardship is an integral precondition to reducing family and domestic violence. We think it is so important that government mitigate adverse consequences over the life of the pandemic and in the aftermath through adequate financial support.

Ms CLAYDON: Thank you. That goes to the other recommendation you made on the same page, that there not be any further cuts to the JobSeeker payment, I take it.

Mrs Brady: Yes.

Ms CLAYDON: Thank you so much for that. You've also argued that there's potential for a stronger role for Family and Relationship Services in the prevention and early intervention phases. We've received a lot of submissions. Some of them have argued for greater investment in services at the crisis end. A lot of the domestic violence services, refuges, crisis accommodation, and others, including your submission, propose that there should be greater investment in the prevention and early intervention phase. Could you explain to the committee what you mean when you say you see the potential for a stronger role for Family and Relationship Services in domestic violence early intervention? How does that fit with domestic violence, crisis-response type services?

Mrs Brady: Thank you for the question. I might have touched on some of this a little bit earlier. Once again, one of the challenges that we often see is that there is regrettable competition between what might be seen as tertiary and crisis support type services and secondary or even universal services. My reflection would be that domestic, family and sexual violence remains at such a heightened state in society that we need to ensure that we identify what is required and provide more adequate funding across the board, rather than making it an either/or situation. To the work of our members, they certainly are already providing educative and preventative programs. For example, they are also involved in the respectful relationships in schools type programs. Those programs are an important part of what's going on. When we talk about early intervention from a Family and Relationship Services perspective, our main focus is the capacity of our members to identify the domestic and family violence risk—which I was talking about a little bit earlier—when it may not have been disclosed elsewhere, or, to be honest, and this is one of the key factors, when it hasn't even been recognised as family violence by either the victim or the perpetrator. Often people affected by family and domestic violence who access our services initially present with issues that are not specifically about family and domestic violence. It is through that intake and assessment process that we do pick up on the fact that there is family violence present there. At other times, as I noted earlier, it's disclosed through the therapeutic services that are provided. But one thing that's really important is that we know that there is the prevalence of family violence in the families that we're working with, so we we're continually assessing for risks throughout that process.

As our services may pick up family and domestic violence issues before they escalate to the crisis end, which is where the police, tertiary services, hospitals and others may become involved, we know that a number of our members provide a range of services and are well connected to other providers, and they're able to refer to them in the way I'm sure that others have referred to as 'warm' referral points. But the key thing is that that relies very much on relationships between services. Whilst we certainly do know that our members are well connected in their local communities—you can't operate as a local community based organisation and not have those connections—the idea around a public health model is that what you are developing is a more systemic approach that doesn't just rely on those individual relationships between those providers but actively links services that would mean a much better outcome for the families. That's what we're referring to when we say we believe that there is a much greater role for our services.

Many of our members would also refer to the fact that there's potentially less stigma attached to our services. It's fair to say people are not coming to us necessarily because they're having a great time. There are certainly issues that have arisen in their relationships with one another or as parents, whether it's relationships between parents and children, whether it's challenges in parenting their children or whether it's issues around how they're managing looking after their children after they've separated. I think it's important to realise that there is the breadth of service delivery that can be very much involved in this process moving forward.

Ms CLAYDON: Thank you. I note your recommendation around the public health approach. We'll be hearing from a few other people working in that space later today, and we look forward to taking a bit more evidence on that. I will make one observation, and that is that I share your frustration around the inaction on family law

reforms. It was this committee back in 2017 that made a lot of recommendations—in fact, 33 of them—that would have put children at the centre of family law decision-making. Regrettably, they have not been implemented, and neither have the Australian Law Reform Commission's or those of any other number of others, and now the current committee is doing yet another inquiry. So I share your frustration.

Finally, I acknowledge that you are also running men's behaviour change programs. When it comes to perpetrator interventions, I'm interested to know what you think the best service delivery models are and what needs to be improved about the programs themselves. Also—and you can either answer this or take it on notice—was there anything in any measures to be delivered by the latest budget that gives you confidence that there is going to be a stronger investment in the services that you've identified as already lacking in this area?

Mrs Brady: You were breaking up a little bit when you were asking the first part of your question about that program. Were you asking about the actual construct of the men's behaviour change programs and whether there were gaps? Is that what you were asking?

Ms CLAYDON: Yes. When it comes to perpetrator interventions, what are the gaps in service delivery models and what needs to be improved about the programs themselves?

Mrs Brady: As our members are various and diverse, and as the chair has reflected in some of his questions around the types of men's behaviour change programs and that there are various models, I must concede that even amongst our own services there are variations in the way they are delivering their men's behaviour change program. I'm not sure that I can actually identify specific gaps, but I'm more than happy to go back to the members that are providing those services and seek out their advice on that particular question, if I may?

Ms CLAYDON: Certainly. That's fine. That probably actually goes to the broader point that a number of people have raised in that there isn't actually very good line of sight over the national level. There are issues around mapping out these services and issues around the evaluation process too. I'd be very interested to know what your members have to say on those fronts. Thank you for taking on that.

Mrs Brady: Yes. I'm happy to do that. I think the other question you asked was around the most recent budget.

Ms CLAYDON: Yes. You are the peak body for many family and relationship services. Were there measures in the budget that went to the kind of investment that you've already flagged with us and which is required across the board to really make some serious inroads into preventing violence against women and children in Australia?

Mrs Brady: In the previous budget there was one positive aspect for family and relationship services programs, which was a decision by government to—well, it's quite technical, but we have been in a situation where we've been receiving funding through two different streams. One stream of funding has been coming directly from departments, that being the Department of Social Services or the Attorney-General's Department. And then we've been receiving what's referred to as SACS supplementation line of funding, which has been coming through another stream of funding as a result of an ERO decision around fair pay for workers under what was a Social and Community Services Award. We were worried that that money would end and that we wouldn't see it again, but a decision of this budget was to increase baseline funding to services, increased to an amount that would replace that. That assures us that the services that they have currently funded will continue to be funded at the same levels into the future. Given that we were facing a funding cut of what we were anticipating to be about $43 million per annum across all the services, that was particularly troubling. However, I think that it's true to say that it would always be good to see greater investment in the types of services that we are delivering to be able to provide more of the risk identification and more of the protective factors that we do believe are absolutely critical to addressing issues around family and domestic violence in Australia.

Ms CLAYDON: Thank you. I put it to the other witness that we're not getting much heart from our observations around the numbers in terms of incidence and recurrence of violence. They're all trending in the wrong direction, despite lots of efforts being made.

What would your key recommendation to this committee be? I know to have one is always challenging—and it's probably a silly question in some respects—but we've got to try and turn this trend around. There are some very long-term goals that need to be addressed, and I totally appreciate the fact that behaviour change is a long-term and sometimes intergenerational project, but how do we get to a place where we really stop seeing one woman being murdered every week by an intimate partner and stop seeing the horrific increases in violence that we continue to see reports of on a daily basis?

Mrs Brady: It is the ultimate question, is it not? I can only speak from the perspective of FRSA. Regrettably, my response may seem somewhat self-interested. I think that there is still a great level of scope to be looking at when we know that there are heightened risks around violence and the potential for violence in relationships and

families, and what we're doing to support those people through those periods in their lives. Even looking at the breakdown of funding and the various measures that are under the fourth action plan—when we look at, say, a lot of the prevention or the things that are funded in the prevention space, a lot are absolutely critical, but a lot of them are very much at a universal level of service delivery, and then in the frontline of service delivery, which are critical. So I come back to my key points. There's a lot of contention about which part of this system we should be funding. Really, I think it is the middle ground, and, as I said, possibly sounding a little bit self-interested, I think that there is a great potential to tap into the sorts of middle area services that are being provided, so that we can make greater attempts to see, when we know that there is risk, whether we can provide those protective factors to the women and children and men, so that we don't see the full escalation into tertiary service delivery.

Ms CLAYDON: So it is your experience that we're simply not investing adequately into protection measures. Is that fair to say?

Mrs Brady: We believe that there is more that can be done, certainly at the Commonwealth level. I should also reflect that our connection is a Commonwealth or federal one, but many of our members are also funded to provide family violence services at the state level, as well, so they are very prominent in the family violence field at the state level that are funded by state or territory governments. But, yes, I would say that there is certainly more investment that could be made at the federal level.

Ms CLAYDON: Thank you very much. If there are any specifics you would like to share with the committee, please feel free to submit that in writing.

Mrs Brady: Thank you very much.

CHAIR: Can I ask colleagues to please send me their requests for questions early. That would be helpful. Otherwise, if no-one asks to ask a question, I'm going to let the deputy chair's question time run longer. If that's going to be abused, I'll have to take certain steps to make sure it's not abused. Ms Murphy has the call.

Ms MURPHY: There was no abuse there. I've been falling in and out of these witnesses—my apologies to the witnesses—in part because I'm in isolation and get phone calls to go and get checked by the police to make sure I haven't left my room.

Dr Clough: That's not good to hear, but it's also good to hear that we're not losing people on purpose.

Ms MURPHY: I'm very interested in your evidence and I'm sorry that I didn't hear all of it. There is one question that I particularly want to ask. If it has been covered, let me know if I missed it when I accidentally had to drop out. I would be interested in hearing your thoughts about services, particularly those around counselling and support in the Family Court, that assist children who have either been the direct victims of domestic violence, or victims of domestic violence by witnessing it, not only as the legal processes are navigated but in terms of support and trauma induced counselling, for their future wellbeing. What's your view about what's happening in that area? Is it enough? Could there be more or could there be better?

Dr Clough: I think across the board there needs to be greater investment and supports for children. I'd point you to submission 116. A recent research project undertaken in the ACT by the ACT Human Rights Commission in which they spoke with children and young people directly about their experiences as victims of family and domestic violence, either by witnessing it or with direct abuse, showed that children and young people feel like they're not receiving the supports they need. We know that at the point that it gets to the courts that support can be uneven. Some children might have a reasonably good experience but for other children their voices are not heard. We'd certainly recommend that there be much greater child-inclusive practice within the family law system. Jacqui, did you want to add anything?

Mrs Brady: I would add that, both in this submission and the family law one, part of the rationale for really asking or having greater attention to children's rights and needs is that, when we look directly at the family law services and what we are provided funding for within the family law services, the major focus around that is assisting the parents who are separating, to come to plans around how they're going to bring up their children, moving forward. We are now funded to do property, as well, but the main focus has always been on children. Therefore, the bulk of the funding has been provided around mediation and resolution of those parenting arrangements and not so much specifically around the children. Although, there are services within our organisations that provide—and we refer to it in our submission—what is referred to as child-inclusive practice, where the intention is for the mediators or the family dispute resolution people who are working with the parents to be speaking directly with the children, to be engaging with them, to be listening to them, to be feeding back to the parents what they are hearing and what the children are dealing with. Of course, though, family violence also brings heightened concerns around that information and how that's being dealt with—so, all sorts of measures around parental emotional regularity and all those sorts of factors have to be taken into account.

Having said that, there is a small program that's funded under the Attorney-General's family law services that is specifically focused on supporting children after separation. I don't have to hand how specific that might be in relation to any matters around violence, but I can certainly go out to our network and achieve a better picture of that, if I may take that on notice.

Ms MURPHY: Absolutely. Thank you, all of you, very much for your answers and for the work you do.

CHAIR: Thank you very much for your attendance at today's hearing. I found it to be very illuminating. And thank you so much for your detailed submissions, as well. You will be sent a copy of the transcript of your evidence and you'll have an opportunity to request corrections to transcription errors. If you've been asked to provide any additional information, could you please forward it to the secretariat within two weeks of receiving the *Hansard* transcript.

Mrs Brady: Thank you, Chair, and other committee members.

O'HARE, Mr Mark, Operations Manager, Stopping Family Violence Inc.

Evidence was taken via teleconference—

[11:03]

CHAIR: I welcome the representative of Stopping Family Violence to give evidence by teleconference. Although the committee does not require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as a proceeding of the House. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament.

I now invite you to make a brief opening statement before we proceed to discussion. For the assistance of my colleagues, I note that there are no written submissions made by Stopping Family Violence.

Mr O'Hare: Good morning and thank you very much for this opportunity for Stopping Family Violence to give you a brief few minutes around what stopping family violence is all about. Stopping Family Violence is a peak body in WA for perpetrator response work. Essentially what that means is that we are not member based and we are not a service provider. We are essentially supporting and working alongside those organisations that work in the area of domestic violence, particularly working with those who use abusive practices against family members or partners.

Stopping Family Violence does this work in a number of streams. The first stream is in the area of training in Western Australia. A key part of that training is to support organisations, government and non-government organisations, to really work as effectively as possible in the area, particularly in the area of working with perpetrators of domestic violence. We've got a number of training packages that may be delivered, anything from an hour to four-day training packages, with a key focus on the cause of the harm for the sort of violence of those that choose to use the violence against family members.

CHAIR: I'm having some trouble understanding you. Mr O'Hare.

Mr O'Hare: Would you like me to start again?

CHAIR: I think I think that's probably a good idea.

Mr O'Hare: Stopping Family Violence is a peak body in WA for perpetrator response work. What that essentially means is that we are not member based. We are an independent peak body providing support and improving capacity and capabilities and coordination of services within Western Australia to work as effectively as possible with perpetrators of family violence or those impacted by family and domestic violence.

There are a number of streams that we work in in that space. The first stream would be in training. We offer a number of different training packages in WA and actually nationally as well. They can range from an hour right up to four days. A key part of that training is to support organisations to really shift some of the focus—where a lot of the focus is often focussing or targeting in on those impacted by family and domestic violence to the cause of the harm. The language that we use around that is focusing on a perpetrator pattern based approach. That's really looking at shifting away from an incident based approach—just looking at the previous incident, which often is physical violence—to looking at the history, the background, the pattern of both violence and coercive control from the perpetrator or those that use violence against family members or their partners, and to use that as an umbrella over then looking at what some of the victims of violence behaviours may be in the context of the perpetrator's behaviours.

The training involved participants could be wide, from child protection, the Department of Communities in WA, police, men's behaviour change program providers, specialist workers, and also women's and children's specialist services as well. It is about really supporting, bringing together and recognising the importance of a perpetrator pattern approach and really focusing on the cause of the harm and the violence.

Another key part of Stopping Family Violence as the peak body is to facilitate and coordinate a men's behaviour change program network. These are organisations in WA that facilitate men's behaviour change programs and are actually coming together as agencies. There are not as many agencies, certainly, as over in the east. We'd have about six key providers in WA that provide men's behaviour change programs. So part of Stopping Family Violence is coordination and facilitation to really bring those organisations together to work as one, essentially, within the sector, as opposed to as individual organisations. The focus is on digging deeper around what success is in men's behaviour change program work. Obviously, somebody just sitting in a men's behaviour change program for 24 weeks is not a success. It's not only what behaviour change there is but also whether safety and wellbeing and quality of life has changed for the better, improved, for the survivors of these perpetrators of family violence. It's about coming together and looking at the best research and the most effective way of working in those programs.

The next component of Stopping Family Violence is the research component. That's partnering with universities in Western Australia, being part of a number of different research projects—in most recent times, with ANROWS, Australia's National Research Organisation for Women's Safety, which is focusing on perpetrator response and what's effective best practice work in not only behaviour change but creating safety for women and children in that area.

The third stream is policy. It's trying to influence what policy is potentially creating barriers to the safety of women and children, and, certainly, working closely with government to support them and focus in on what's going to be most effective and create safety for women and children.

Another key part is bringing organisations together. It's about shifting from a siloed approach, I guess. There are organisations doing some incredible work but often in silos, often not sharing information, key information, that could contribute and does contribute to the safety of women and children. So it's about bringing services together. And that's not just bringing specialist services together; that's really across the board, all the intersecting services that those that are using violence would be engaging in. It's about supporting a web of accountability in Western Australia so that, wherever a person using violence wants to go, they're going to get the same message—whichever agency they go to.

Also, if we're going to be collecting a true risk assessment of somebody who's using violence, we need to be pursuing information; we need to be tracking that person going through the systems and not just have information from one or two key agencies. We need to be identifying agencies such as alcohol and drug services or mental health services or health services, and what information they're gathering that could actually contribute to a risk assessment, ultimately, and contribute to holding those accountable for family domestic violence. That's a key piece, as well, in WA that Stopping Family Violence has continued to work to—the accountability of perpetrators of family and domestic violence. Systems often feel that they hold perpetrators accountable, but [inaudible] that may be more towards punishment and actually it may, ironically, end up as punishment and lack of safety for survivors and victims of family and domestic violence.

I can stop there and you can ask any questions, or I can keep going. There's a lot of content I'm putting in there.

Ms CLAYDON: Thank you, Mr O'Hare, for your evidence today. Due to phone connection and audio issues, I might have missed some aspects of your evidence. Firstly, we took some evidence yesterday from the Men's Outreach Service that operates across the Kimberley. Can you explain to me what's stopping family violence? Is there a relationship that you have with that organisation, for example? I'm just trying to get a handle on the men's behaviour program network in Western Australia and the connectivities, if any.

Mr O'Hare: Yes, we have certainly connected with men's outreach for some time now, and a large part of that is really supporting that with DV informed practice and DV informed training within the region. Stopping Family Violence has delivered quite a bit of training throughout the Kimberley. With a particular training model, we partnered with an organisation called Safe and Together. Really what that is about is supporting staff within organisations to what we call 'pivot to the perpetrator', to become DV informed when they're working in the area of family domestic violence.

The network is about sharing information and coming together. I was actually just talking to men's outreach the other day in regards to the network as well, which is a really important space for sharing both regional and metro practices. So it's not only sharing the knowledge within one's own organisation on men's behaviour change program work but actually coming together and sharing across all men's behaviour change program work as well. One of the key pieces there is really looking at the success of men's behaviour change programs. That means shifting from an output idea of success—how many people come to a program and complete the program—to asking: really, what is success for not only how that man within that program supports his own behaviour change but how is that impacting on his partner and those that he's being abusive to or coercively controlling?

Ms CLAYDON: Are you feeling any closer to a definition of success? We've been talking to people who have been doing these programs for decades, and there's such an apparent lack of national mapping of these services. Everybody is pointing to the problems around evaluations. I think you are flagging this issue too. What does success look like for a program? You're trying to shift us from an output focus to a success focus. Who is your model? Is there a jurisdiction in Australia, or internationally, that is providing a best practice model, in your view?

Mr O'Hare: First of all, the notion of success is so varied and so wide and is very different for each stakeholder, as you can imagine. So for a man often attending a men's behaviour change program, his idea of success is often about maybe getting his children back through that process, or getting back into the relationship or what have you. Whereas a victim-survivor's idea of success is obviously the reduction in violence, but it's often

many more things related to that around an increase in autonomy and quality of life, a reduction in feeling fear and an increase of feeling less controlled and safer. There are different degrees and levels of success. A practitioner would talk about successes that they see throughout a program on individual group members. It may be that they have a number of different successes within [inaudible]. I was talking to outreach the other day, with regard to this exact question as well, and was trying to evaluate what that success is even within the program. There is an array of different successes, even within the program. For example, even though it's not actually within a men's behaviour change program, a reduction in alcohol use in one of the participants allowed the group number to engage more, to be safer around his children and to engage at a high level with [inaudible] activities that were happening in the community. Consequently, his behaviours were less coercive. By the same token, there's still a lot of work to do with regard to his behaviours.

Ms CLAYDON: Given the complexities that you are trying to map out here—and I do appreciate that—what is the hesitance and delayed response to perpetrator interventions, and our evaluations and funding of them? In your view, what's going on? I don't know if my frustration is well-founded or not, but it seems to me that people have been struggling for decades in this area. There are no clear indications as yet—unless you've got something you want to point me to—about people who are doing this well. As we look towards the next national plan, what does the federal government need to do to support the work of men's behaviour change programs and other perpetrator interventions? Governments like to have an evidence base. It's good for governments to make evidence based decisions I'd suggest, but there's a complete lack of it in many, many respects. I'm going to ask you again: in your view and your experience, is there a jurisdiction that is doing this well that we should be looking to for some guidance or are we all just going to keep batting on for another few decades trying to figure out how to deliver complex, need-based, appropriate, safe programs and figure out some way still to evaluate them all in their efficiency and efficacy?

Mr O'Hare: You mean doing well with regard to men's behaviour change program work?

Ms CLAYDON: We've heard a lot about the lack of evaluation and consistency amongst men's behaviour programs. I don't understand why this remains the case. I'm trying to get you to help me understand this because we've got a very real issue. We have a national plan that is being developed. We are speaking to try and help shape and guide what that national plan might look like through this process. How on earth does the government look to support the work of men's behaviour change programs and other perpetrator interventions, if that's important? And a lot of people have suggested that is important work. Where is the guidance to ensure that the right sort of support and the best value for precious public dollars is invested?

Mr O'Hare: One of the main issues with evaluation of men's behaviour change programs, as you can appreciate, is the long-term evaluation. For example, we can have quite blunt instruments around recidivism. With regard to mandated programs, if somebody were to return to be charged again within two years, we can have those stats. But if he's not charged again or doesn't pop up in the system, that doesn't necessarily mean he hasn't actually engaged in perpetrating any family violence behaviours. So I guess there's a point. And there's a second point there as well: the more time passes for the evaluation piece, often victim-survivors actually don't want to engage, or they're difficult to track down, to continue those evaluation pieces with victim-survivors—even more so, I suppose, with perpetrators of family violence. So that long-term study, time and time again, really struggled to come up with a robust evaluation in that piece.

Ms CLAYDON: Would you be trying to steer us in the direction of investing in the non-mandatory kinds of programs? What's your advice to us from that front? You've got people who are compelled to undertake behaviour change programs because of court orders or whatever reason. Is that where we should act? I'm very interested to seek your advice about where the best investment should be. Do we look at the non-mandatory and preventative aspects? I'm all ears.

Mr O'Hare: I guess the simple answer is it's not one or the other. There will always be men who will need to be mandated to attend the program; otherwise they would simply never attend the program. Certainly that funding needs to continue, 100 per cent. But for those that attend programs or need availability or need space for non-mandatory programs, there certainly needs to be more funding channelled and funnelled into that area as well. One of the things that we need to be very mindful of is to make sure there are enough programs for both mandated clients and non-mandated clients. We know that the longer somebody is waiting to get into a program post-referral, the less successful that program is going to be for them. So at the time of motivation, at the time that they are motivated to attend the program, we really need to be getting them into that program as soon as possible. So I would say that we really need to be looking in the areas where there is a need and actually a demand. There are wait lists actually preventing these men from getting into the programs at that time.

There's another key piece that's actually with it as well. It's not just around the men's behaviour change program itself—in fact, I would argue that's actually a relatively small component with regard to the bigger picture that needs to fit around men's behaviours programs as well. That's, for example, the partner contact component that's attached to that program. Essentially, even if a man is mandated to attend the program and doesn't engage to the degree that we would qualify of him making any changes, there are still wraparound supports and engagement for victim-survivors around that program as well. That gets back to: what is success in a program?

Arguably, somebody might say, 'It's not a success unless he attends a program, unless he finishes a program and goes to the 24 weeks and the partner's safe and the children are safe,' et cetera. Well, actually, maybe success on the other side of the program is that, yes, he attends six sessions and he doesn't make any behaviour changes, but there is actually wraparound support and the victim-survivor actually gets the support that she needs. So there's another degree within the complexities of what measures success.

In addition to that, we often only measure the success of the program itself, in isolation of all the other services that really need to be coming together to not only support that service but really work along that men's behaviour program. That makes the difference, rather than a man just sitting in the program without supports outside of that program as well. And, really, as I mentioned before, without a web of accountability of that community, services can be really problematic. I certainly know from my time in government that, when a referring body—say, for example, a community corrections officer—referred a man to a men's behaviour change program, it made a huge difference if that community corrections officer was also working alongside the men's behaviour change program, was also connecting with other services, was also working alongside the drug and alcohol program to actually make sure that these services are working from the same page, if you like—what we call DV informed—so each service is in fact complementing the other service. So it's not—

Ms CLAYDON: I'm just going to interrupt, because I know other people will want to ask questions. You've identified wait lists and people's inability to actually get into programs. I heard from the men's outreach service yesterday that, even though, as you say, partner contact programs are critical and certainly are another measure of success, they were not funded to work with women. So I'm interested to know: are you, as the peak body for Western Australia, the group that is mapping the gaps in services, the gaps in funding? Are you in a position to recommend what it is that the federal government, for example, needs to do to support the work of these programs?

Mr O'Hare: Yes. That's a key part of the network of the men's behaviour change program, really to bring together—

Ms CLAYDON: So what recommendations are you going to put to this committee on that front?

Mr O'Hare: The funding is a key piece within that. Over the last 10 years with men's behaviour change programs, there's been a lot more research with regard to what creates, supports and promotes safety for women and children, but the funding has not actually changed to accommodate that. One of the big pieces of that is partner contact, and that's why men's behaviour change programs are continually being funded—I guess not funded enough, which accommodates the partner contact. It's not just men's outreach; it's the services across WA as well.

Ms CLAYDON: So a lack of recognition that that partner contact work is a critical component of the men's outreach programs—

Mr O'Hare: Correct.

Ms CLAYDON: or behaviour change programs, but the funding formulas just haven't caught up with that?

Mr O'Hare: Correct.

Ms CLAYDON: Thank you. I will hand back to the chair so that others have an opportunity to ask you questions. Thanks very much for your evidence today. I do appreciate it.

CHAIR: Thanks, Deputy Chair. Dr Webster?

Dr WEBSTER: Thank you very much for your evidence. I have some questions around the reproductive period of time in a couple's life. Specifically, we know that the first baby being born and even the pregnancy itself are heightened times for risk. I guess what I'm wanting to know is: how prevalent is reproductive coercion in domestic and family violence and are there particular predictive factors that make reproductive coercion more likely? I may have another question after that.

Mr O'Hare: Reproductive coercion is essentially another tactic of coercive control that we know. We know that we need to be getting a lot better at assessing perpetrator patterns, behaviours and coercive control rather than

assessing an incident base. If we're able to map a perpetrator's coercive control against his partner, then we can more accurately assess the risks if his partner were to get pregnant as well. That is a key risk factor in family domestic violence, during pregnancy. The reality is that it's another control tactic. The perpetrator can now say: 'Yes, disclose that I've done this. You're going to leave, you're going to be a single mum, and I'm going to harm your child if you do X, Y and Z.' So we know, certainly, that it is a risk factor in family domestic violence but it needs to be assessed within the coercive control and the patterns of those behaviours as well.

Dr WEBSTER: I'll just let you know that my background is working on the frontline, having developed an organisation to work with young pregnant and parenting women to support them and their children, particularly to re-engage in education and employment. So I have a little bit of experience, particularly in this area of coercive control around reproduction. One of the things that's come out through our public hearings, and the evidence that's been prepared, is that for gender equality or equity to be achieved, women need to be empowered to be able to make choices, manage their lives, earn an income and do all of those things that give people a sense of self. What are your comments or do you have any view with regard to the kinds of services that are being provided now in Western Australia for those young women, similar to the ones that I was working with? Just a little bit of understanding about what is being provided. Do you think that that is a legitimate component of being able to reduce domestic violence?

Mr O'Hare: Sorry, I got scattered with that with the echo, but you're talking about services available for young women in WA?

Dr WEBSTER: Yes. In this space of the reproductive period of time in a relationship, because that is a heightened risk period, do you think that there are enough services to support young women to give them the power to be able to manage so they're not as dependent on potentially risky relationships? That's certainly my experience. Often these young women are in relationships that are relatively high risk, and when it comes around to reproductive incidences—they're either pregnant or they want to get pregnant or whatever the issue might be—the risks are heightened but the support for women—from what I see and what I have measured across Australia, there is not enough support for those women at that time.

Mr O'Hare: I 100 percent agree that there are not enough supports. And even further than that, across the training, the language or understanding is around shifting from the cause of the harm to a failure to protect model. So, essentially, not only are the programs not available but there's even a model of failing to protect. Rather than recognising the cause of the harm, it's looking at, for example, what has this young lady done? Why is she with a violent person? Why is she making these decisions to be with a violent person?

Why has she not left the violent person? Why has she chosen to go back to a violent person? Why is she not taking a violence restraining order out? Why is she not going to a refuge?' So actually there needs to be a real shift in focus even for young pregnant women in this area, certainly in Western Australia, around that attitude, so that services recognise, 'No, hang on a minute, we need to shift the focus and pivot to the perpetrator,' and recognise his coercive control behaviours—and that's why essentially her decision-making [inaudible] those factors. Even shifting from a failure-to-protect model to a strengths based [inaudible] even under the perpetrator's behaviours she is able to make decisions that [inaudible] best interest for herself or for her child [inaudible] without [inaudible] of the perpetrator's coercive control may look like she is being [inaudible]. But actually putting in context we can start to look at some of the rationales for that. But in short, to answer your question, I agree, yes, there's [inaudible] a program [inaudible] available.

Dr WEBSTER: Thank you very much. I appreciate your input.

Mr O'Hare: Thank you.

CHAIR: Mr O'Hare, I don't think there are any questions from my colleagues. I just have one question for you and I'll just ask you to keep your responses as brief as you can. In response to a question from the deputy chair, you were talking about recidivism. You used the word 'recidivism'—and basically as a KPI. We know that we are moving more to outcomes based programs as opposed to outputs based. Isn't recidivism the ultimate KPI? It is all well and good to have programs that people may attend, may complete—they may spend more time with their kids, and they may do this, they may do that as a result of it, but the ultimate reason we are where we are is because there is too much domestic and family violence. I am absolutely on board with the deputy chair's frustration about this; there just doesn't seem to be enough insight into how we go about best resolving it. One of the issues I think is an almost reluctance to call out the recidivism as the primary goal.

Mr O'Hare: Yes. Recidivism should be one of the KPIs, for sure. I don't think we should discard it, but the risk around that, particularly because we are talking about family and domestic violence, is that recidivism is often around physical violence. What we know is that there are so many different elements to family and

domestic violence that are not visible. In fact, somebody might, for example, go to prison for physical violence and when he comes out he may never have to be violent to his partner again because he has pretty much given her the message that if she was to do anything that he was unhappy with then he has the ability to be extremely harmful to her and maybe to her children as well. So he may not technically pop up in the system as a recidivist, but actually his partner is living in fear for the rest of her life. As far as statistics go, if we're just looking at recidivism, he has not offended again. So we just need to be really mindful about what statistics can sometimes indicate. If we're looking at just that blunt instrument of recidivism, we may be fooled that family and domestic violence has [inaudible] when in fact it certainly hasn't and we're just not understanding it effectively.

CHAIR: Alright. Thank you for that. Thank you for your evidence. You will be sent a copy of the transcript of your evidence and you will have an opportunity to request corrections to transcription errors. If you've been asked to provide any additional information, could you please forward it to the secretariat within two weeks of receiving the *Hansard* transcript. Thank you once again for your time and you're now free to go.

CULLEN, Dr Patricia, Research Fellow, University of New South Wales

DAUNT, Judy, Chair, Illawarra Women's Health Centre

SALTER, Dr Michael, Scientia Associate Professor of Criminology, University of New South Wales

STEVENSON, Sally, General Manager, Illawarra Women's Health Centre

WILLIAMS, Dr Karen, Special Adviser, Illawarra Women's Health Centre, and Psychiatrist, Sydney Southwest Private Hospital

Evidence was taken via teleconference—

[11:54]

CHAIR: I now welcome representatives of the Illawarra Women's Health Centre and the University of New South Wales. Although the committee does not require you to give evidence under oath. I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as a proceeding of the House. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Thank you very much for your attendance today. I now invite witnesses to make a brief opening statement before we proceed to a general discussion. Representatives of the Illawarra Women's Health Centre, would you like to kick us off?

Sally Stevenson: Thank you, we would. I'd like to thank you and the committee for the invitation to present this morning. We certainly all very much appreciate the opportunity. I'd also like to pay my respects to the Aboriginal people upon whose land we all live and work. I'll make some brief opening remarks and then I'll hand over to Michael, Trish and Karen to do the same.

Firstly, I'd like to let you know that I have a background in finance and community development and have, for example, worked with Arnhem Land communities to establish the first Aboriginal owned and managed credit union. I also have qualifications and extensive experience in public health and emergency humanitarian medical responses, having worked for organisations such as Medecins Sans Frontieres, MSF, the World Health Organization and the World Bank. I have been, however, the general manager at the Illawarra Women's Health Centre now for almost seven years.

Our centre is community based and has been operating for over 30 years. We're nationally accredited and offer a range of services, including many innovative primary prevention and domestic and family violence programs. As we all know, domestic and family violence is a complex, multilayered and deeply entrenched issue. The rates have not materially improved over many years, and with the impact of COVID they've deteriorated significantly. In our area alone, BOCSAR reports that domestic and family violence rates are up 27 per cent, year on year, from June 2019 to 2020, and sexual assault is up 33 per cent.

We of the centre have had no new resources to cope with this increasing and overwhelming demand for the support services that are requested of our centre. We cannot, for example, provide any counselling support until January 2021 at the earliest, and we've got over 40 women on our waiting list. There are so many—

CHAIR: Sorry, was that for financial counselling?

Sally Stevenson: No, that's for mental health counselling.

CHAIR: Domestic violence—

Sally Stevenson: Yes.

CHAIR: mental health counselling?

Sally Stevenson: Domestic violence and mental health, yes.

CHAIR: Thank you.

Sally Stevenson: There are so many statistics that illustrate the devastating impact domestic and family violence has on women and children and on our community more generally, but statistics don't paint the personal picture. I'd like to bring the urgency of the situation into sharp relief by drawing on my own experience. That's what is at the heart of our submission—that is, to note that the trauma experienced by women that I've personally seen in war and conflict zones when working for Medecins Sans Frontieres is exactly what I see in the women who come to our centre for support. I see resilience, strength and resistance to violence. I also see in the Illawarra the same trauma and harrowing psychological injury that I've seen in Somalia, Ethiopia and South Sudan.

I can tell you that in homes in our community there are personal and sometimes inescapable private war zones. The picture is very grim. There are very few wins in our sector. Not only are we seeing women and children

continuing to be murdered but also we know that the impact on women's and children's physical and mental health can last for years, decades and, for many women, a lifetime. Indeed, we know that the psychological injury for women lasts well after they leave an abusive relationship, especially if they are untreated and unsupported. We know this from the data and we know that it's unequivocal.

Our submission references evidence and statistics that reflect the multisectoral nature of domestic and family violence from the criminal justice system to intergenerational cycles of violence. Between us I'm sure we could talk for hours on a whole range of challenges and potential solutions, but we decided to focus our submission on one proposal—a women's trauma recovery centre. That is because day in and day out, year in and year out women come to our centre suffering from the long-term impacts of domestic and family violence. They come to us because there is nowhere else to go. There's a huge gap in services provided to women, and that's the support to recover from the long-term impacts of violence.

Over decades at our centre we have seen literally thousands of women who could not access long-term support services, usually because they simply don't exist, because they can't afford them, because they're excluded from them or because they're time limited. We've had the privilege of listening to their stories and supporting these women and they all tell us that a wraparound centre that provides safe, free health, wellbeing, legal and psychosocial support would have changed their lives.

These women's stories are complemented by the evidence and research and point to an innovative and Australia-first solution—a women's trauma recovery centre. Such a centre doesn't exist, but were it to it would be a game changer, not just in the Illawarra but as a replicable model across Australia. This is why we recommend that the Commonwealth government include it as a model in the next national plan to prevent violence. A trauma recovery centre would be a win. I have to emphasise that it is needed now more than ever because of the impacts of COVID through domestic and family violence will, without exaggeration, be felt for decades. I will now hand over to Michael.

Dr Salter: Thank you, Sally. I also thank the chair and the committee for the chance to speak to you today. My research over many years has focused on trauma, particularly on women's trauma, as a common impact of family, domestic and sexual violence. It has included direct research with survivors. Very frequently I've engaged service providers in research as well. This has uncovered the unavailability of mental health care in particular for women to recover from the impacts of family, domestic and sexual violence. There are actually very few services nationally that are funded to provide long-term mental health care for women in the aftermath of abuse and violence. As a result, the impacts of that abuse and violence can stay with women in the medium to long term—with depression, anxiety, self-harm and suicidality. It has impacts on parenting and on their economic security and workforce participation. When left untreated, this complex trauma can perpetuate intergenerational cycles of trauma, violence and disadvantage, and children grow up in traumatised, unstable and unsafe environments, despite the best efforts of their mothers and other caregivers.

That's why today I'm really proud to be working with Sally and her amazing team advocating for the establishment of a women's trauma recovery centre. The research evidence very strongly supports this model. It indicates that a holistic service of the kind that Sally is envisioning to pilot will promote women's health, safety and recovery in the aftermath of violence and abuse so that they're not living with lifelong injuries of abuse and are supported and able to live a healthy and safe life. Undoubtedly this will also improve the lives and safety of the next generation. This is the kind of intervention that we've been waiting for for a very long time. I thank the committee.

CHAIR: Thank you very much. I'll kick us off with some questions and then I'll throw to my colleagues. From a federal government perspective whenever we're looking at programs or systems we need to look at replication. It's all well and good to look at setting up an individual trauma recovery centre—and I appreciate that you're looking at this as a pilot—but almost every group that has appeared before us in this inquiry has said that there are challenges they face, whether they be cultural or gender based. Their circumstances and the circumstances of those they look after, whether they be victims or perpetrators, are very specific—instance specific or geographically specific. Indigenous people want their own tailored programs run by Aboriginal community controlled organisations. Members of the LGBTIQ+ community want their own programs written for people within their own communities. You understand that that replicates across the whole gamut of this sector. How much of this trauma recovery centre is truly going to be able to be replicated if money weren't an issue—and of course it always is? What may work in the Illawarra may be entirely different to what's going to work in Arnhem Land, Tasmania or the Sunshine Coast. I'm keen to get your responses about that. Sorry it's a very longwinded question.

Sally Stevenson: I'm going to hand this to Dr Cullen because she is leading the research on the design of the centre and she can explain how we are incorporating multiple views across multiple sectors that will allow it to be replicated.

Dr Cullen: Thank you for that very important question. It is certainly something that we have considered extensively through this process. In my research I've looked at how women impacted by violence and abuse access support. We know that some women receive excellent care and support, but for many women this isn't the case. In terms of access to services, the barriers can be quite profound for women with limited financial means, without transport, or with a disability or a chronic health issue. This is particularly for women who live in regional or remote communities. Aboriginal and Torres Strait Islander women face additional barriers in accessing culturally safe support. I certainly agree with you that, in terms of access to care for Aboriginal and Torres Strait Islander women and communities, Aboriginal community controlled health services are leading the way and they're the most appropriate services to be funded to deliver that care.

In the design of the trauma recovery centre we're working, firstly, with survivors. We want to make sure that this is an inclusive space for all women. Given the diversity within women as a collective group, it's important that all women's voices and experiences are heard, so we're working with Aboriginal community controlled services, we're working with the LGBTQI+ community and we're also working with services that provide support to women with a disability. In addition to this we're reviewing evidence, both from Australia and internationally, to understand what's most effective in supporting recovery from trauma and making sure that that takes into account that breadth of diversity that we want this centre to be able to service.

Dr Williams: I'm a practising psychiatrist at South Coast Private Hospital in the Illawarra and I also advise on mental health policies at the Illawarra Women's Health Centre. I'm also on the committee for the development of this program. I'm in a fairly unique position. One of the reasons that drives my passion is that I work in a private hospital and the vast majority of patients that I have are from the Defence Force. I've got police, Defence and a lot of first responders who I treat for PTSD and other trauma-like syndromes. I also have an outpatient clinic, and that's what brings me here today. What I do in my outpatient clinic is in complete and direct contrast to what I can provide for the soldiers and first responders who come back from war. As Sally said, what you see in terms of psychiatric and psychological impacts of family violence is very similar, but it's not just the psychological and psychiatric impacts that are observable when you talk to people. When you actually look at neuro-imaging scans, you can see that there are physiological changes that occur for women who have been in domestic violence situations and children who have grown up in those situations as well.

We offer a service for Defence, and it's an excellent service with excellent results. I love what I do there. The questions aren't raised about whether or not we should have those services available. We have nothing similar for women and, whilst I understand that we need to be able to address every community, every minority and every single person, I don't think that should be getting in the way of the fact that there are currently no services that offer specialised treatment for this particular patient group.

CHAIR: That's a really interesting perspective. Thank you very much for that perspective. I'm throwing this open to the five of you. You're talking about a $10 million cost over three years to run the pilot. I don't mean to sound negative—I'm not and, if I do sound negative, I apologist; I guess I'm trying to play devil's advocate. The establishment of a trauma recovery centre in the Illawarra as a pilot sounds well and good, and let's hope that it works terrifically, you get funding for it and we're on our way to reducing the amount of trauma, but how is that going to help someone in the Kimberley who can't walk in off the street even if one were established in every state in the country?

Sally Stevenson: It goes back to your question of replicability. As our public health system is not the same, we're not able to respond to everybody everywhere all the time. There are limitations; I understand that. But, if you're trying to make that comparison, I would like to draw an analogy to a medical equivalent, which might be, for example, a cancer clinic. Cancer clinics provide wraparound services of specialised physicians and operate in hospitals across Australia. The model would have started somewhere and has been replicated across Australia. There's no reason to think that that principle cannot be applied to a domestic and family violence service.

Recently, I broke my finger and I went to the fracture clinic at Wollongong Hospital. I have to say it was a world-class response. I had input from orthopaedic surgeons, physios, radiographers et cetera and I got that for free. When I commented on just how good it was—because it was a small break in my little finger—they said: 'We take hands really seriously because it can affect your function for the rest of your life if you can't do a grip.' That was free, and it's available across Australia, and it's a clinic that provides a wrap-around service.

Now, the psychological injury that is perpetrated on women through violence has an immensely and profoundly greater impact on their lives and the lives of their children, and there's no reason to think that we can't

replicate something that we do here in the Illawarra across the public health system in Australia under those very principles. Karen, I think you wanted to add something?

Dr Williams: Just that it goes back to doing good for as many people as you possibly can. We've also got to think that if we can show that this service is successful and we've got the support of the college of psychiatrists—and I'm a member of their Family Violence Psychiatry Network Committee—and if we can show that we provide similar types of therapy to those available to our Defence Force and our first responders, then that would be able to be used as evidence to bring it to other communities, with, obviously, adaptations to suit the individual needs of each of those communities. I don't think that it [inaudible] a barrier to actually starting something within our communities.

CHAIR: We heard earlier evidence—

Sally Stevenson: Sorry—Trish would like to jump in.

CHAIR: Go ahead, Dr Cullen.

Dr Cullen: I'd just add that, within the research process, one of the stages would be to demonstrate the cost effectiveness and benefit, and, in doing this, we'd need to consider the multiple costs and burdens to the public health, justice, education and welfare systems that domestic and family violence currently cost the economy, and I don't need to tell you how much that is; I'm sure you know it's in the order of $22 billion a year. But we also need to consider the cost of inaction—the human cost—and we believe that this model is a model of community reinvestment that will deliver substantial savings over the long-term, both financially and in terms of the health and wellbeing and the lives of women.

CHAIR: We heard evidence earlier this morning from Family and Relationship Services Australia that there were, in effect, three models of care or work in the domestic and family violence space: the primary prevention space, the secondary area and then the tertiary. So I'm assuming that this model for your trauma centre would be a tertiary centre—would that be correct?

Dr Salter: In terms of splitting up the response into those three categories, it would fit at the tertiary end, but it's quite important to recognise the very high risk of re-victimisation faced by women after domestic violence. It's quite common to be working with women who have been in multiple abusive relationships, because, if women aren't supported to recover from the trauma of one abusive relationship, they're quite vulnerable to being targeted by an abusive man the next time around, and they haven't been then supported to understand the dynamics of abuse and violence such that they can identify it ahead of time. So it's quite important to understand that a comprehensive, holistic, tertiary response to women who have experienced family, domestic and sexual violence is preventive—it prevents them from entering into or being targeted again for abuse the next time, and it also ensures that their children are not being exposed any further to ongoing abuse and trauma.

A comprehensive response to family, domestic and sexual violence of the kind that's being proposed here would support women in their parenting. It would support children who have been exposed to domestic violence. We know, unfortunately, that children with early exposure to DV, particularly girls, are at higher risk as adults of being sexually assaulted and more subject to domestic violence. Unfortunately, we know that many male domestic violence offenders have childhood histories of exposure to domestic violence. We see this holistic response as really fundamental to interrupting the intergenerational transmission of trauma and ultimately bringing down the community prevalence of family, domestic and sexual violence. It undoubtedly has an important preventative role to play.

Dr Williams: I'd like to second that as a psychiatrist. Absolutely, treating somebody who has PTSD, the impact on the treated patient [inaudible] will definitely deliver preventative impacts for subsequent generations. Knowing that a mother with mental illness is a lot less able to parent effectively compared to if she is well supported and given lots of treatment, but the PTSD has socioeconomic impacts for that family, so again poverty relates to that as well. The high rates of fear within a household definitely impact children. We know that children who are experiencing domestic violence at home are at much greater risk of developing mental illness themselves as children, so the kind of conditions that you've all heard of, ADHD and all of those things, are higher in children who have got domestic violence at home. Once again, when they grow up the risk for them of becoming a victim again is higher. I think that it is both tertiary and preventative as well.

CHAIR: As part of your cost estimate of $10 million over three years, how many women and children do you think that you would be able to treat in that time?

Sally Stevenson: Those costs are preliminary. We've been funded by the minister for health in New South Wales to undertake the design process, which is what Dr Cullen is leading. Once we have the operational framework which has been informed by our professional advisory group, women with lived experience and

stakeholders, that will create the core of what we're going to do. From there, we'll be building the business case with our partners. So that's an estimate, the $10 million, but it is based on working with 400 families over a three-year period.

CHAIR: For the sake of the pilot, how will you triage the people who are coming to you?

Dr Williams: What was the question? I think I was trying to unmute myself.

CHAIR: It's the saying of the year: 'are you on mute?' If the trauma recovery centre is going to care for around 400 families, how will you triage those families as to who would fit the pilot model and who wouldn't?

Dr Williams: I think we'd be looking at people who have got recognisable syndromes initially because we're going to have therapies that are targeted and have been already proven in other populations. Trauma therapy is quite specific and we'd be wanting to see the patients meet the criteria for PTSD. But the centre is going to have a range of services. Depending on what the issues were for each individual and what we're able to provide—it's a difficult question because it's so broad. Ultimately it would depend on how much money there is. We talked before about the Defence Force, where there is unlimited money. Soldiers get individual therapy, group therapy, exercise physiology, yoga, mindfulness, relaxation groups, treatment for their addictions and trauma dogs. We'll be starting from scratch. We don't have any of those kinds of things within the trauma centre.

Sally Stevenson: Just to clarify: the $400 million is not $400 million at the same time. The way that it works is that it comes in as needed. We expect $400 million over a three-year period but there will be some movement through as the therapies start to take hold. Again, this is hypothetical at the moment, because the centre doesn't exist, not only in Australia but around the world. It really is dependent on the design model that we come up with through the research process. Having said that, and to add more to this, because we are working with the university from the beginning, we will be integrating monitoring and evaluation processes and principles from the very start. We'll be able to have a role in understanding the impact that it's making and we'll be able to adjust accordingly. I don't know if you want to add something to that, Trish.

CHAIR: Can I jump in there. When do you expect to be able to firm up the model that you're advocating for?

Sally Stevenson: The funding that we've been given by the ministry is 12 months. We expect to have the business case for that model by April or May next year.

CHAIR: I'll hand over to my colleagues, I could spend some time with you but I'm sure they're keen to ask you some questions as well.

Ms CLAYDON: Thank you to the Illawarra Women's Health Centre and the University of New South Wales witnesses. It has been terrific to hear about the development of your proposal for the women's trauma recovery centre. It actually looks like, from all the letters of support that you've received, this has been a project in the making for some time. I want to check on that front. I appreciate you're still working on that proposal, but have you pitched to government yet, to be blunt? Have you had applications before government for funding of this centre?

Sally Stevenson: We've certainly worked as closely as we can with the New South Wales government, which is why they funded us to do the co-design of the centre. That was for $50,000. We've talked to a number of federal representatives but we haven't yet made a formal proposal to the Commonwealth government. We did get a commitment from the federal Labor government to invest $1½ million at the last election. Obviously that didn't come to bear. No, we haven't put in any formal funding requests for the $10 million. We have initially sought support to undertake the design, because, as I say, that's a core element of how we can build our business case. We definitely see it as a staged approach. We need to work with women with lived experience and technical experts to design it and then, upon that, we will build the business case which we can then present to the government for a fully funded pilot.

Ms CLAYDON: Is there any particular funding stream or measure that you are aware of that you would submit your application to? I'm quite conscious that this is a big gap that has not been met to date. You've really made the case, I think very strongly, that there is a very, very clear connection between women with experience of family, domestic and sexual violence and their increased rates of poorer physical health, mental health and ongoing trauma. You're filling an incredible void that currently exists with this proposal for a women's trauma recovery centre. Have you had an opportunity to have conversations with government about where that funding might even come from?

Sally Stevenson: Not at a Commonwealth level. We've certainly talked across all departments at a New South Wales government level: Communities and Justice, mental health, prevention of violence and the Ministry of Health. This is a complex sector, as we've talked about, and it cuts across so many jurisdictions that it's difficult to gather them all together in one place. That is why we hope, and this is our recommendation, that it goes into the

national plan as a model and can be funded as a discrete project which could then be replicated by the state government public health systems. We fundamentally believe this is a service that needs to be affordable and accessible by women across socioeconomic demographics. Therefore, it needs to be embedded as a health service within the public health system. That's fundamental to ensuring it is sustained and appropriately funded and accessible to all women. We're seeking support from the Commonwealth government to demonstrate the model through the national plan. Having said that, I don't know the particular modalities or grant applications that we would need to put in. We haven't got that far yet.

Ms CLAYDON: You've given me a good sense of where you see the Commonwealth's role in providing leadership to, first, demonstrate the efficacy of the model, by funding the services as the first in the nation, perhaps. Your longer term view, if I'm correct, is that it would really become a part of our public health system, which currently does not offer adequate or appropriate support to women who experience family and domestic violence. Is that a fair assessment of where you see this sitting in the long term?

Sally Stevenson: It's fair and absolutely accurate. Thank you.

Ms CLAYDON: Given your long-term commitment and work in this area, you would have had hopes like everybody working in this sector around what might be in the most current budget, for example, about measures or responses that could help address what appears to be continuing escalating levels of family, domestic and sexual violence in Australia. Was there anything in the budget that you thought would be of use to the sort of model or service that you're trying to provide?

Sally Stevenson: No. I have to say there was not. To be frank, we were very disappointed with the budget. There's been a lot of public commentary and public awareness-raising in traditional and social media around the impact that the budget is going to have on women. We know it was gendered. We know that it didn't support women on a whole range of levels. In particular, there was no additional funding for domestic and family violence that I'm aware of. I also have to say that the $150 million that was committed by the Morrison government in March has not been fully rolled out yet. I find that really disappointing because the impact of COVID on domestic and family violence rates was predicted. It was absolutely known that the rates would escalate. I referenced those rates even in our area in my opening remarks. We know it's the shadow pandemic. We were very disappointed that the budget in general did not support women, who are disproportionately affected by COVID and are disproportionately affected by economic stress. We know those are contributing factors to domestic and family violence. There are nowhere near enough resources being put into the sector. It is a shadow pandemic. It does cost the Australian community at least $22 billion a year. You would have seen those figures from KPMG. That was from 2015. We know it's gone up; we know that's a conservative estimate. So, yes, we were disappointed.

Ms CLAYDON: In your clinical experience and your decades of work in women's health, I really want to go to what you understand to be the consequences of that delayed funding of frontline services, particularly during COVID. I also want to draw a parallel between a lot of the First Nations evidence that has come before this committee. We certainly talk about the intergenerational trauma that Aboriginal and Torres Strait Islander people have been experiencing for a couple of centuries, which has always had a very strong focus around a healing component. It really struck me that your model recognises both of those critical aspects about the intergenerational nature of the trauma and the absolutely critical need to have a healing component at the centre of the response. Are you working with First Nations people in the design and fine-tuning of your model?

Sally Stevenson: Yes. I'll answer, and then I'll ask Dr Cullen to continue. Firstly, in talking about a delay or the lack of funding for domestic and family violence services, talking from the Women's Health Centre experience, I mentioned that we now have 40 women on our waiting lists who we cannot see until at least January, because we've had no new funding at all throughout this pandemic to respond to that overwhelming need. That need comes from women who self-refer to our centre because we are both highly regarded and deeply trusted within the community. But we're also getting a significant amount of referrals from other government services and agencies, whether it's FACS, health or the police. So the burden is being placed on community services without additional resources. There is currently a funding round for additional funding through the New South Wales government, but it's a competitive tendering process. So we've had to engage in that. It's a deeply inefficient process—it's not just our time but also the time of the government—and is costly to women not getting those services during that time. Trish talked earlier about the cost of inaction. Women are bearing the brunt of not having sufficient resources, that's without question.

The second thing I have to say is that the workforce is bearing the brunt. I'm trying to manage a team here that knows it is dealing with increased violence, an increased frequency of violence and an increased complexity of violence due to COVID. They know that they have a waiting list of 40 women and they know that there are women who aren't even bothering to be put on the waitlist. So the pressure of unmet need on the workforce is

going to inevitably lead to burnout and vicarious trauma. I think that's a huge risk that has been underestimated and we'll feel the impact of it in the future.

In terms of the healing process, I think that absolutely at the core of this is a safe, confident, healing culture. It's a trauma informed and client centred approach. I think we have so much to learn from that healing approach through First Nations and Indigenous people. If we can learn from them, we'll be well on our way around that culture of healing. And, yes, we are working with Aboriginal organisations in the Illawarra and the Shoalhaven. Waminda, a very well-regarded Aboriginal women's health service, has been with us from the beginning of this. I will now ask Trish to follow up on that.

Dr Cullen: Thank you for this question. I agree it's hugely important, and we have so much to learn from Aboriginal communities controlled approaches to addressing trauma and healing. In our design, one of the coinvestigators is a colleague of mine that I've worked with for a number of years, Dr Marlene Longbottom. She's a Yuin woman from the South Coast, and she is working with us on the design of the centre.

As Sally said, we're also working closely with Waminda Aboriginal Community Controlled Health Service. Ngarruwan has a long and very productive working history with Waminda. We worked on a project called First Response, which is about integrating trauma-informed care within health settings to support Aboriginal and Torres Strait Islander women who are experiencing violence. We've just published a paper together, Marlene and I, with Waminda around decolonising trauma-informed care across sectors to address the cumulative and intergenerational aspects of trauma. So absolutely, this is a priority for us in designing the centre, and we're going to be working very closely with Waminda and other Aboriginal leaders and elders in the Illawarra and Shoalhaven region.

Ms CLAYDON: Terrific. Thank you so much for that. I'll leave my questions there. I just want to thank the witnesses.

Dr Williams: Would I be able to comment also?

Ms CLAYDON: Of course; sorry.

Dr Williams: I want to talk about the fact that this shadow of secrecy around domestic violence is in every culture. It's something that we see in all communities, not any one individual community. The fact that we don't have a treatment option for that means that, as a system, we are actually adding to the trauma that women are experiencing. Children are growing up in families and people aren't talking about the domestic violence they're experiencing at school. It's not recognised as a trauma within the health system or anywhere within the health system. Somebody who might have asthma or diabetes can see a visible place to go. You go to the diabetes clinic or you go to the doctor or the GP clinic for a medical problem, but there's nowhere that is feasible where someone who has experienced significant family violence can go for treatment. Very often I'm the first person to tell my patients that they're traumatised, that what they've experienced is traumatising and is on par with what soldiers are experiencing. They'll often say, 'No, no, it's not as bad as that.' These are people who might have been raped at the age of five who would say to you that that trauma is not as bad. Our system is really adding to the invisibility, shame and embarrassment that our patients have because we don't acknowledge it and we don't think that they need any treatment for it. I think they do. But if the government doesn't show that by providing some sort of service—we are saying, 'Those things could happen to you, but you need to just pull yourself up and keep going.' I think it's really important to know that what we're doing is hurting people even further by our inaction.

Ms CLAYDON: Thank you so much. Your evidence has been terrific. Congratulations to you. I do note the level of support you have both locally from your communities and experts in the field. You've got cross-party political support, which is always terrific as well. I really look forward to following progress on your proposal for a women's trauma recovery centre. Thanks again for your evidence. Back to you chair.

CHAIR: I'd hate to see you folks labouring under a misapprehension, so I want to just point out a couple of things to you. In the federal budget, 700 new safe places for women and children escaping domestic violence will be built across the country under a $60 million program called Safe Places. Forty projects would be funded supporting about 6,000 women and children. I'd hate to think that you folks think that there's nothing in the budget, because that is fundamentally incorrect.

Ms CLAYDON: It is the subject of some debate, Chair.

CHAIR: It may be the case that your organisation is not getting any additional funding, but it's incorrect to say that there is no additional money going into this domestic violence space. I'm happy to provide—

Dr Williams: No, there's no additional funding going into trauma care.

CHAIR: Into trauma care.

Dr Williams: Yes, actually dealing with the trauma. It's one thing to put a family into a safe place. It's a different thing to actually deal with the consequences of being traumatised.

CHAIR: We're providing $150 million dollars and, in fact, we've already provided $130 million to the states as a result of the COVID crisis. This is not a time for argument, but the federal government has provided $130 million to the states to push that money out to community organisations, so I still don't accept your proposition that you're not getting any money in trauma care, because that sort of trauma care is being provided across the country by community organisations. Would you accept that?

Dr Williams: That's actually providing physical care that provides shelter, but it doesn't deal with the psychological and psychiatric impact of violence.

CHAIR: I can't remember whether it was Dr Karen Williams or Dr Patricia Cullen who said that the trauma centre that you're advocating for would be a world first, not just an Australian first. Is that correct?

Dr Williams: Publicly funded, yes.

CHAIR: Right.

Dr Cullen: Could I just add something? I want to make the distinction between what we're proposing and crisis support. I think the government has made substantial positive commitments towards domestic and family violence in the last 10 years; that's not up for debate. But a lot of the focus has been on crisis intervention, addressing perpetrator behaviour and changing long-held community attitudes. We want to make it clear that what we're proposing is different to that. It's a new approach and it's an approach that focuses on the long-term consequences—not just the health consequence but also consequences on women's lives in terms of their ability to access support that's legal, financial, health and housing related. It's a comprehensive approach that focuses on long-term healing, health and wellbeing.

CHAIR: Thanks for that, Dr Cullen. Whilst, to date, there has been a lot of attention on, and support for, those services that work with women and children who have been subjected to domestic and family violence, I think we would all agree—and I'm not trying to put words in your mouth, so correct me if I'm wrong—that we're better off to stop it before it even starts, before you need this trauma recovery centre. In that respect, in my view—and I'm not foreshadowing the views of committee—I think that there needs to be a considerable emphasis placed on primary prevention and working with perpetrators. That's not to suggest that, in any way, shape or form, I'm discounting the importance of dealing with the trauma that you've outlined so well this afternoon. I take particularly on point the views of Dr Williams. Dr Williams's evidence is that she's worked in trauma in war zones around the world and that, as a member of Medecins Sans Frontieres, she's seen that the sort of trauma that she sees in the Illawarra is similar to the sort of trauma that she's experienced in war zones. That evidence is not lost on me, and I think it's very, very pertinent evidence. So I'm not discounting in any way, shape or form the importance of dealing with the trauma; I'm just merely saying that we also need to try and prevent it from happening in the first place. I'm hopeful that you wouldn't quibble with that.

Dr Salter: If I may not quibble but just interject: I think it's important to recognise that family, domestic and sexual violence actually functions quite like an infectious disease. If we take the current circumstance of COVID, we need people socially distancing and wearing masks and so on to prevent COVID. But actually testing and treatment are crucial to the prevention of COVID, because people with COVID are infectious. If we don't want them to pass COVID on and create more people with COVID then we have to test and treat the people that have COVID. If we only focus on social distancing and masking then we cannot possibly crack this epidemic. And that's also true with family, domestic and sexual violence. It is incredibly difficult to work with damaged men who perpetrate domestic violence. And men's behaviour change programs in this country and around the world still are not the silver bullet for preventing deeply traumatised, wounded men who were exposed to domestic violence as children to stop passing on that domestic violence as adults. So we absolutely would not quibble at all with the focus of the inquiry and the committee on primary prevention. But I would just put it to you that trauma is infectious, violence is infectious, and we will never prevent family, domestic and sexual violence for as long as we ignore the burden of complex trauma in this country.

CHAIR: I'm not going to argue with that at all. Can I ask either organisation: I appreciate you're still in the infancy of putting this thing together but if you've got anything that would assist the committee, would you forward it to the secretariat, please?

Sally Stevenson: Certainly. Trish would like to speak to that point around recovery being a part of the prevention package of strategies, because, absolutely, we don't quibble with you; we need to stop it. But from a public health perspective, you always need a package of strategies to attack a problems. Look at it from a

smoking perspective: you need punitive measures such as the increased cost of cigarettes and fines but you also need positive pressures and incentives around it. It is the same thing with behaviour change. You need, from a public health perspective, if you want behaviour change, to have a strategy and a critical one to stop the intergenerational cycle to help women recover from the trauma. Tricia, do you want to say something.

Dr Cullen: I think Sally pretty much summed up what I was going to say, in the national fourth action plan that was released last year, we have acknowledged that there are not going to be substantial reductions in the prevalence of violence against women and children for the next 10 years. This means that, even though we agree with you on the focus on primary prevention, there's a backlog of women who have already experienced and continue to be impacted by this and it will be another 10 years before we see significant reductions. Given that we know the intergenerational impacts and the health implications of this abuse, it is unfathomable to me as a public health researcher that we are not investing greater resources in supporting women's recovery over the long term.

Ms CLAYDON: That's so disturbing but thank you for the reality check that we're looking at least another decade before we see a noticeable decline in violence against women and children. We're all keen to try and make that a shorter time frame, but I appreciate the reminder. I just want to check in with you to clarify, did the Illawarra Women's Health Centre get any of the funding? Did you get any additional dollars in funding during COVID-19 to deal with the added issues that you and many frontline services were facing? Was it sufficient for the need that you were experiencing at the time? I mean, I'm aware of your waitlist now, but could you just clarify for me if you got any COVID-19 funding?

Sally Stevenson: We've received no funding at all with regards to COVID, no additional funding. We get core funding through the Ministry of Health here and that's been maintained but no additional funding.

Ms CLAYDON: So no actual COVID-19 funding?

Sally Stevenson: No, none at all. The first tranche of the $150 million that was distributed through the states with New South Wales only went to communities and justice contracted organisations already, from which women's health centres and other health service providers were excluded because we have our contract with the ministry. The second tranche is now open under an open tender process and that allows for a maximum of $150,000 per organisation for a time limit of 12 months, which effectively means one to 1.2 full-time equivalent counsellors for 12 months. So the amount is inadequate compared to the deficit that we're now facing and the backlog that will continue to rise during that time. For the tender process, there's been no announcement as to who has won that.

Ms CLAYDON: You are all just part of a competitive tendering process?

Sally Stevenson: Yes, we are.

Ms CLAYDON: Sorry, I probably should know this, in the distribution of the second round of funding, is that a decision made by the state government or is it a condition of the federal funding? How do you arrive at [inaudible]

Sally Stevenson: I can't say definitively but I would suggest it is a New South Wales government decision.

Ms CLAYDON: I will follow that up myself.

CHAIR: Thank you very much for your attendance at today's hearing. You will be sent a copy of the transcript of your evidence and you'll have an opportunity to request corrections to transcription errors. If you've been asked to provide any additional information, and you have, could you please forward it to the secretariat within two weeks of receiving the *Hansard* transcript? And just to be clear, the question that I asked you, I don't think I communicated that very clearly. I meant, if you've got any additional information about the trauma recovery centre, if you could forward that to us via the secretariat within two weeks of receiving your *Hansard* transcript, that would be wonderful.

Proceedings suspended from 12:58 to 13:49

MICHELMORE, Mrs Janet, AO, Interim Chief Executive Officer, Patron and Board Member, Jean Hailes for Women's Health

RUSSELL, Ms Nicki, Public Health and Education Manager, Jean Hailes for Women's Health

Evidence was taken via teleconference—

CHAIR: Proceedings are now resumed, and for anybody who has been listening I apologise for the delay but we've had some technical difficulties. Welcome. Although the committee does not require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as a proceeding of the House. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I now invite the witnesses to make a brief opening statement before we proceed to a general discussion and questions. Over to you, Mrs Michelmore.

Mrs Michelmore: Thank you very much, Mr Wallace, and thank you for the opportunity to speak today. As I said, I'm the interim CEO of Jean Hailes for Women's Health, and Nicki Russell, who joins me, who is our public health and education manager, is also member of the advisory group for Our Watch's upcoming *Tracking progress in prevention* report. I'd also like to acknowledge that Nicki and I are both joining the hearing from the lands of the Wurundjeri people of the Kulin Nation and pay our respects to elders past, present and emerging.

So a quick summary of Jean Hailes for Women's Health: it's a national not-for-profit organisation dedicated to improving women's health across Australia through every life stage. We work in public health research, clinical services and policy. It's the integration between these four domains which has been the underlying principle for the past 25 years.

Our two medical clinics in metropolitan Melbourne are committed to excellence in women's health care and these clinics have unique insights into a range of current women's health concerns, which in turn inform our program of research and public health activities.

We produce a wide range of resources based on the best available research and medical evidence for our diverse national audience of community members and health professionals. These resources include videos, webinars, fact sheets, podcasts, brochures and booklets as well as accredited education resources for health professionals, including webinars and active learning modules. In 2008 alone, we had over 2.2 million visitors to our website.

In terms of our work in this area, we were very much involved in supporting the National Women's Health Strategy. At the start of 2019, the federal Department of Health launched the National Women's Health Strategy: 2020-2030. This strategy was the result of extensive consultation with the sector, and Jean Hailes led this process and development of the final strategy together with the Department of Health. As a result of the overwhelming feedback, through the consultation with the jurisdictions, health organisations and the public, 'Priority area 5—Health impacts of violence against women and girls' was included in the final version of the strategy.

I do want to note at this stage that the strategy uses the term 'violence against women' in order to be consistent with the language used in the current National Plan to Reduce Violence against Women and their Children as well as that used in international literature and frameworks. Although this inquiry has used the term 'family, domestic and sexual violence', we will generally be referring to 'violence against women'. as this encompasses family, domestic and sexual violence but also includes violence and harassment that can occur outside the home. This term also captures the gendered nature of the issue and points to common drivers shared by the different forms of violence.

I want to quickly draw attention to the impacts of violence against women—as I'm sure the committee has heard on numerous occasions. As this committee will have read through many submissions and heard from experts, the impacts of violence against women and the children who are exposed to it are profound and often include long-lasting or lifelong physical and mental health impacts. Intimate partner violence is the third-greatest health risk factor for women aged 25 to 44, and almost 10 women a day hospitalised for injuries perpetrated by a spouse or domestic partner. We know that women who experience violence also experience higher rates of mental health disorders as well as increased sexual and reproductive health issues and pregnancy and neonatal complications associated with reproductive coercion.

The Australian Institute of Health and Welfare estimated that eliminating violence against women would have reduced the disease burden in women aged 15 and over in 2015 by 41 per cent in homicide and violence, 18 per cent in early pregnancy loss, 19 per cent in suicide and self-inflicted injuries, 19 per cent in depressive disorders, 12 per cent in anxiety disorders and four per cent in alcohol use disorders. Interestingly, in 2015, as I'm sure you will know, PricewaterhouseCoopers estimated that the cost to the Australian economy is $21.7 billion each year,

with the majority of that cost being borne by the health sector. Of that, $10.4 billion constituted the cost of pain, suffering and premature mortality, and an additional $1.4 billion in government spending on health services. The overall cost was anticipated to grow to $323.4 billion by 2045.

With respect to the calls to action, like any other health issue, there are clear benefits in terms of both costs and outcomes by investing in a comprehensive strategy that addresses prevention, early intervention and response to violence against women. The intersectional nature of the drivers of violence against women also mean this approach will not only decrease the incidence of violence and it's direct health impacts but also offer broader health and societal benefits for women and men related to social determinants.

Jean Hailes as an organisation is not expert in matters of violence against women; however, like others in the health sector, we recognise the importance of this issue for women's and men's health and are committed to supporting work to address it. We look forward to the development of the second national plan and hope that it will follow a collaborative, co-designed approach with stakeholders and further invest in prevention, early intervention and response activities across various sectors and settings, including the health sector.

Nicki and I, and the organisation as a whole, want to thank you for this opportunity, and we will do our best to answer any questions that the committee has. Thank you, Mr Wallace.

CHAIR: Thank you very much, Mrs Michelmore. I'm going to invite Peta Murphy to start the questions off.

Ms MURPHY: Thank you very much, Chair. I'd be very pleased to. Thank you, both of you, for all the work that you do and for giving evidence today. Janet, I know that you essentially touched on this in your opening statement, but I'm wondering if either or both of you would like to elaborate a little bit more on some of the short-term and longer term health consequences for women of exposure to and being victims of what we'll call domestic violence.

Mrs Michelmore: Nicki, would you like to start? And then I'll add some comments at the end.

Ms Russell: Certainly the short-term impacts that come straight to mind are that there is an obvious physical impact for women who present at emergency or just to their GP and may have injuries sustained from physical assault. But obviously there are also a lot of mental health and emotional issues that can be both short term and longer term. You will have heard from Illawarra and the University of New South Wales earlier today about the sometimes multigenerational impact of ongoing trauma. Sometimes these mental health conditions, including PTSD, anxiety, depression and so on, can be lifelong. Certainly children who are exposed to violence or witness violence often will display similar symptoms, including anxiety and depression, but also cognitive delays and sometimes behavioural issues—antisocial behaviour and so on.

Thinking about the health impacts, the longitudinal women's health study found also that women who have experienced violence generally don't take part in cervical screening at the same rate and have higher rates of cervical cancer. Obviously, that's also to do with reproductive coercion, which often involves tampering with or withholding contraception or access to sexual and reproductive health services. There are direct sexual and reproductive health outcomes, including unwanted pregnancies. Sometimes women are forced to either continue with pregnancies or terminate pregnancies against their will as a result of that specific form of violence. So certainly there's a real gamut of physical and mental health impacts, both short term and long term.

I think there's really a need to address this within the health sector. I'm not sure whether Kelsey Hegarty's group from the University of Melbourne provided a submission to this inquiry. For the royal commission that was done in Victoria they did a good succinct overview around the real need to build capacity of health professionals in the primary health sector to identify and respond to family violence. I think something like 80 per cent of women experiencing abuse seek help at some point from health services, usually general practice, but there are very low rates of disclosure or even inquiry from GPs. Unfortunately, even when there are instances of inquiry and disclosure, evidence is that there's often an inappropriate response. So there's definitely a lot of work that we can be doing in that space.

Mrs Michelmore: I'd like to add a couple of comments to that, if I may. Professor Jayashri Kulkarni at Monash University has done some very interesting work on the effects of continually raised cortisol levels on hormones in women. She has found that a condition known as polycystic ovary syndrome seems to be more prevalent in women who have suffered abuse over a sustained period, and she relates that directly to these continually raised cortisol levels.

Your question highlights, though, that there is an ongoing need to increase the capacity of healthcare practitioners to recognise and address the physical and mental health impacts. As Nicki pointed out, it's about the ability to recognise that and ask the questions, particularly with women who are pregnant, women from culturally and linguistically diverse backgrounds and women with disabilities. It is in the teasing out, if you like, of the

problem that we have a chance or an opportunity to provide professional development to first-line or primary care physicians.

Ms MURPHY: Thank you both. There's a lot of useful information in those answers, and I thought of about five extra questions as you were speaking—of course, I won't remember all of them! But I might start where you both finished off, and that is, if I can just summarise it, the need for some further work to be done in the space of health professionals to help them identify signs that patients are experiencing violence and, I assume, in addition to that training, to have that primary health care linked up with specialist domestic violence services. My question on that has a few layers. Do you think it is something that is adequately addressed in the current and past iterations of national plans regarding domestic violence? Is it something that needs more emphasis in the national plan that's being developed? Is it something that you see the Commonwealth being well placed to at least be the driver of as part of a national scheme, or do you see it being state based?

Mrs Michelmore: I might start off there. I think it's a very good question. If you look at the National Women's Health Strategy, it is very clearly identified in the priorities and actions—that is, raising awareness of the health impacts of violence against women and girls by promoting peer education and also raising awareness of the physical and mental health manifestations. There's peer education of children, young people and adults, which has been identified and which I believe is crucial, but then there's also developing different models to address particularly those at greatest risk. I'm a firm believer in a multilayered approach. It can be driven by the Commonwealth, absolutely, but it must be supported at both a state and a local level and by the various groups, such as the College of General Practitioners et cetera, working together. That's where we'll get the greatest change.

It's that tandem approach of the professionals working together and government working together at all levels—and a tandem approach with the community. We must have greater awareness and greater acceptance at a community level as well. We also must have greater awareness of this issue across the lifespan. Nicki, I'm sure you've got something to add here.

Ms Russell: I would just say that I'm probably not as familiar with the national plan and subsequent action plans—the four action plans that came out of it—in terms of the level of commitment to the health sector and investment in the health sector. In some ways that answers the question about whether it goes far enough in engaging the health sector in that process. I definitely think that there would be a real opportunity with the second national plan to really think about engaging in and investing in activities for the health sector, not just in early intervention and response, and supporting women with the health impacts as well as supporting practitioners to identify and refer out safely—and also developing a model in prevention, as outlined in *Change the story*. There are a number of settings and sectors that haven't been looked at yet; health and community services is one of those settings. I think there's absolutely a lot of scope to develop a model and invest in trialling new actions and activities with the health sector.

In 2015 the last assessment was done on the national curriculum for health practitioners. There's no mandatory requirement at the moment. Some universities do require a few hours in the curriculum, but there's no mandatory curriculum at this point around family violence or identifying or responding to it, or any of the safety assessment tools that are currently used. RACGP obviously have the white book, and I think that there was some federal funding given to RACGP as well to develop some training. But at the moment it's very opt-in, and there have been some ad hoc initiatives. I think there have been lots of good examples of activities and initiatives within the health sector, but there certainly hasn't been, even at a state level and certainly at a national level, a consistent policy-driven approach. So I think that's a real opportunity.

Ms MURPHY: I just want to make sure I clearly understand what you've both said—and for the benefit of the committee. This is not intended to be critical of any particular government at all, but it sounds as though there is a real gap at the moment in this area of health for women who are victims and a coordinated approach to the profession and to the services. As you say, there is an opportunity for that to be addressed in the national plan and there is perhaps a good role for the Commonwealth in terms of coordination and support for that approach. Is that a fair summary?

Mrs Michelmore: I think it's a fair summary. I think the intention has been to have an absolute focus. I think there's always a better way or a more productive way of doing things with greater coordination. So you're absolutely right.

Ms MURPHY: Thank you. In your opening statement, Janet, you mentioned the need to further invest in prevention and early intervention in the health sector in relation to domestic violence. Are you or Nicki able to give a concrete example of something that comes under that umbrella of health prevention and early intervention relating to women who have been victims of domestic violence?

Mrs Michelmore: Nicki, would you like to start on that?

Ms Russell: Yes. I think that there are good examples of early intervention, certainly. They would largely be around screening and referral for women at risk of or experiencing violence; a lot of that is done by health workers at the front line. There are lots of good examples of that work being done both in general practice and in the acute setting in hospitals. In terms of prevention, as far as I'm aware, no, there aren't any. That's what I mean when I say there isn't really a model for it. Addressing the gender drivers through structures, policies and the way that we are training and teaching our medical professionals as well as the institutions that they then work in, and the conditions that they reproduce in their practice, hasn't been done. That speaks to the really broad, transformative nature of prevention work; it is really big. As far as I'm aware, it hasn't been done. I think that Our Watch would be the natural go-to, to potentially help develop that model, and then funding services to implement it and drive that change would be the next step.

Ms MURPHY: Is that something that you would like or expect to see coming out of the national health plan that you contributed to, given that it does have a section about violence against women?

Ms Russell: I will just clarify the national strategy: it's a 10-year strategy and there aren't any action plans coming out of it. I think the idea was that a lot of this work was meant to intersect with the action plans and strategies of many other national plans and strategies that intersect with it, including the National Plan to Reduce Violence against Women and their Children. So priority area No. 5, in terms of the health impacts of violence against women and girls—there are a number of priorities and actions listed there that came out through that consultation, but by no means is that an exhaustive list of the kind of activity that could or should be done. Considering that it's an overall health strategy for all women for 10 years, those were just the high-level priorities that came out in the consultation.

Ms MURPHY: I have a question about targets. I take it with the health strategy, because, as you said, it's the high-level strategy, that the key measures of success don't dig down into the specific targets and numbers we'd like to see. Is that something from the public health perspective that you think would be useful in the national plan to reduce domestic violence—to have specific targets to be reached?

Mrs Michelmore: I don't think I'm qualified to answer that question. Nicki, what do you think?

Ms Russell: As you've mentioned, the measures are really high-level. A lot of them are largely general indicators around violence against women in a broader sense. If you are creating activities or action plans that have a specific focus on the health sector, then for the evaluation of that activity there should be more measurable indicators of success. I guess those would be developed in consultation and collaboration with the sector as you're developing the plan and the action plan.

Mrs Michelmore: The only thing I can add to that is that I was very involved with the department in the development of the National Action Plan for Endometriosis. In terms of that, specific targets were not mentioned but there were 'What would success look like?' comments. I think, as Nicki said, working with the sector to understand what success would look like would be a very good piece of work to do.

Ms MURPHY: Thank you for that. It's refreshing to hear someone say they might not have the expertise to answer; some people just answer! This may well be putting you on the spot, but if the committee wanted to have a short and easily understood explanation of what taking a public health approach to domestic violence is—so that people reading a report can say, 'Oh, that makes sense'—what would be the best way to describe it?

Ms Russell: You will have heard this from a number of people, and this isn't the first time I've said it either—and public health works the same way: I think the violence-against-women sector has divvied up different sections of the sector into prevention, early intervention and response. With any health issue, we're directly working with patients who present in front of us with a specific condition but also trying to engage in screening and identifying people who might be at risk of certain conditions as well as doing preventative health activities—healthy eating, increased physical activity—that have downstream positive effects to prevent later-life conditions and diseases. Violence against women, as we've discussed, has a really profound health and wellbeing impact on women, men and society at large. A public health approach to this issue would be the same as it is to any other health issue: investing in prevention, early intervention and response.

Ms MURPHY: Should we be looking at more opportunities for health professionals to speak to women, or to allow women to disclose to them if they feel comfortable doing so, about domestic violence? For example, we are quite good now at encouraging women over 50 to have regular mammograms. That's not something you would think would normally be an opportunity for a health professional to talk to a woman about domestic violence, but it's something women do regularly. Is there an opportunity to do some work on how to make that sort of interaction a safe space for women if they wish to disclose?

Mrs Michelmore: I think you've raised a really good point: we have to use opportunities to ask the leading question when women access services. This has come up on numerous occasions recently. There are various times in a woman's life when she accesses health services. One is, perhaps, to begin contraception. That is an opportunity. A pregnancy is another opportunity. Menopause symptoms are another opportunity. What we need to do is educate and support health practitioners to ask the next question. It may not be the direct question at that time, but you might bring them back for a second consultation.

An example of where this has worked really well—and it seems like an odd analogy to make—is in fertility planning. The work that's being done at the moment is if a woman turns up for anything at all, and it may be a sore shoulder or a sore knee, there is a tactful way to say, 'Are you thinking you may be considering pregnancy in the next little while?' If the answer is 'definitely not', then you offer them contraception. If it's 'maybe', then you talk about planning for fertility, and then you'd get them back to discuss that. Similarly, it's educating health practitioners—or any person who intersects with women on a health matter, or maybe not such a health matter—and it's training them with role-playing videos, with open-ended questions, so that you provide practitioners with the skills and confidence to address or broach these issues. It's been very well done, I think, in looking at depression and anxiety, and I think we can use some of those strategies in this space, too.

Ms Russell: I'll just add that there has been some really good work doing exactly that and trying to upskill clinicians to be able to safely facilitate disclosure. I think the Melbourne Research Alliance to End Violence Against Women and Their Children has done a bit of work on this. Certain hospitals as well, like the Royal Women's Hospital in Victoria, have done some work on teaching their clinicians to be able to screen and identify and to facilitate safe disclosure. So, it is happening, and there are lots of examples of good practice, but I wouldn't say it's consistent—certainly not in general practice. There's often still a perception that this is not a general practice issue, that it's not something that needs to be brought up or taught or done—that it's a social issue, something for the home and not a health issue. I think there's some work to be done to make the good work that's happening in small places more broadly known and to change the perception amongst clinicians themselves around where this issue lies.

Mrs Michelmore: Some very good work's been done in this area at Monash Medical Centre and Dandenong Hospital.

Ms MURPHY: Terrific. Thank you both. I don't want to hog all the time; I could ask you questions all day. Also, Janet, that explains why doctors sometimes ask me strange questions that I don't think are related to what I'm going to see them for!

That's fascinating evidence and an interesting direction for the committee to look at that perhaps hasn't had enough emphasis. I will hand you back to the chair and thank you for setting up Jean Hailes as well.

Mrs Michelmore: Thank you very much.

CHAIR: I'll just ask a few short questions in relation to coercive control. I'm wondering if you can tell the committee the sorts of health impacts that women are experiencing who have been subjected to coercive control, both physical and psychological.

Mrs Michelmore: Nicki, would you like to start on that?

Ms Russell: I'll start and I will preface it by saying that I'm certainly no expert in this area. I think that what I will be able to relate to you may be similar to what you've already heard. With coercive control and other forms of violence that are more insidious and not necessarily physical, you will see increased levels of mental health conditions and associated trauma. I would probably refer you back to some of the submissions that you would have already received from Illawarra, the Australian Medical Association and so on, regarding some of the more in-detail impacts in terms of specific conditions. It's probably not going to be anything contrary to that kind of physical and mental health.

CHAIR: No worries.

Dr WEBSTER: Thank you so much for your evidence today. The question I have is: how prevalent is reproductive coercion in domestic and family violence; and are there particular predictive factors that make reproductive coercion more likely?

Mrs Michelmore: I don't have the data on that, I'm sorry. I'm not sure whether Nicki does, but I can certainly provide you with it, Dr Webster.

Dr WEBSTER: That would be fabulous.

Ms Russell: Again, I believe that Marie Stopes have done a wonderful paper on reproductive coercion. One of the things—now I'm trying to remember it off the top of my head, so it might be better to actually refer to that

document; I can rustle it up and send it through to the committee afterwards. But my understanding is that there's pretty poor knowledge of the incidence of reproductive coercion. I think that that's one of the gap areas in terms of our knowledge on how often this is occurring. I think it's called *Hidden Forces*, and I'll see if I can find that paper.

Mrs Michelmore: Could you let me know who we should send that paper through to, Mr Wallace or Dr Webster?

CHAIR: You can send that straight through to the secretariat.

Mrs Michelmore: Fantastic; we will do that.

CHAIR: Thank you.

Dr WEBSTER: Following up on your point, Mrs Michelmore, in Mildura where I'm based, we have a collaborative pregnancy, maternal and child health network. When I was working on the front line as a social worker and running an organisation that worked with teen, pregnant and parenting young women, we specifically spoke about putting into the data that the maternal and child health nurses were using questions around what would effectively be levers or triggers around domestic violence. That was something that we were working on as a localised area. So I agree with you; I think that there's an opportunity for young women, when they are pregnant or they've just had their child, to be able to raise those questions.

Mrs Michelmore: I couldn't agree with you more, and I think maternal and child health nurses are one of the greatest assets in this area. They see women at a very vulnerable time, often where they may well be more likely to disclose this. They are a wonderful opportunity for us all to support women in a much more positive way and to identify a problem perhaps a little bit earlier than other professions might.

Dr WEBSTER: Yes, absolutely. I think the other thing about that particular profession is that they are already asking questions of that nature. They are about fundamental and personal social components that assist young women to be able to communicate.

Mrs Michelmore: Absolutely.

Dr WEBSTER: I don't have any more for the moment, but thank you very much for your evidence today.

Mrs Michelmore: Thank you very much. We'll send you through the article.

CHAIR: This is a broad, general question: do the maternal nurses that travel around—I'm harking back to the days when we had young kids—operate in all of the states? I know they operate in Victoria.

Mrs Michelmore: They do, absolutely. Each state has a different role for child health nurses. I have more a personal experience. I have worked with groups in Victoria particularly, but my personal experience is having a son with two children, one of whom was born in Western Australia and one of whom was born in Victoria. They have slightly different roles and purposes. The number of visits that a new mum has to these centres is much fewer than several years ago, but, post-departure from hospital, I think it's day 4 and day 12 they're visited—certainly in Western Australia. One of the problems is that there's not as much of a regular contact with these nurses and mothers as there used to be, but it is still an ideal opportunity. When they visit people in the home, in a sense, they can see much more in the home than they would if a mother brought the child to a particular centre.

Ms CLAYDON: Thank you so much for the evidence. Peta Murphy has captured most of my questions, but I just wanted to check in with you, given your preference for this public health approach. We heard a little bit this morning from the Illawarra Women's Health Centre, but, in terms of government reporting and strategic directions, would you ordinarily be aligning yourselves along with the National Women's Health Strategy? There's a new one that came out just last year for a 10-year period. And what, if any, interface is there between the Women's Health Strategy and the National Plan to Reduce Violence against Women and their Children?

Mrs Michelmore: Nicki, would you like to start on that?

Ms Russell: Yes. I would say that, certainly, being a health organisation, our work falls directly under the National Women's Health Strategy but that the implementation of that strategy is anticipated to be carried out through intersecting national strategies and plans, such as the National Plan to Reduce Violence against Women and their Children. So if there were dedicated work and funding for the health sector within the second national plan, we would hope or anticipate to support that work wherever appropriate. I hope that answers your question.

Ms CLAYDON: Yes, well, I'm now going to drill down a bit further about it. Are there clear pathways of connection between the two strategies?

Mrs Michelmore: I think there's always room to improve those pathways and room for greater collaboration. I've been involved in two workshops with the Commonwealth government and the Department of Health over the

last couple of weeks, looking at the national prevention strategy and its interface with other strategies. I think the very clear message from those workshops is that there has to be fewer silos, more collaboration and greater work between the various entities to ensure consistency of approach. So you've raised a very good point.

Ms CLAYDON: Are you feeling optimistic about the capacity for us to move beyond the siloed approach, which I have to tell you a lot of people raise with us!

Mrs Michelmore: I have worked in the field for 25 years and I live in hope for greater collaboration. I think there's a huge effort happening at the moment. If I didn't think there was hope I think I'd feel a bit despondent.

Ms Russell: Yes—

Ms CLAYDON: Yes, I do appreciate that. Sorry, I didn't mean to interrupt.

Ms Russell: Oh no, not at all. I was just going to add the fact that priority area 5—the health impacts of violence against women and girls—is in the National Women's Health Strategy for 2020-2030, and that was the result of extensive consultation, largely with the health sector. We did have consultations with organisations that you'd consider to be more traditionally the women's sector or the violence-against-women sector. But I think there's a real appetite and recognition that this is a real issue within the health setting. So I think that there are absolutely a lot of opportunities for collaboration—there's an appetite for it, I would say.

Ms CLAYDON: Is it something that ANROWS would have any involvement with? They've been a body collecting a lot of the research work around family violence, but I don't know if ANROWS ever sits down with the participants in the National Women's Health Strategy, for example—do you?

Mrs Michelmore: I can't remember the consultation that was held with ANROWS. Nicki, do you have any recollection of that?

Ms Russell: I actually don't know if they participated in the consultation—

Ms CLAYDON: Sorry, I'm probably just using them unfairly as an example of where—

Ms Russell: Yes.

Ms CLAYDON: In fact, where the points of connection might best be.

Ms Russell: I think that bodies like ANROWS, the George and other sorts of research institutes are absolutely a natural point, especially as they're developing evidence, frameworks and models for building this work in the health sector. In prevention there's Our Watch as well. They have a strong evidence base and policy foundation for their work. But, yes, I would say there are a few organisations we engage with around this issue, but I would say that you're right in identifying that in a lot of ways it's functionally two sectors.

Ms CLAYDON: I'm just trying to understand what might have been the historic reasons for that or the idea of carving violence against women and kids out into an area outside public health. In many ways, that's a little perplexing, given the intersections. Do you have any reason as to why there has been that resistance, perhaps, to date? I don't know if that's too strong a word, but why is it that we've not really considered this issue through the lens of public health policy, for example?

Mrs Michelmore: Nicki?

Ms Russell: This is just speculating, in my opinion, at this stage, but I would say that a lot of the separation between the sexes is because a lot of the violence against women sector was born out of crisis response, supporting women who were in crisis and fleeing, so the model has grown from there. In a lot of ways, it's a really good thing that we're now thinking about how we can broaden this out. Obviously this is an issue that affects women and children and all of society in many different domains and not just in this one crisis setting. So I think that it indicates that we're moving forward in the work that we're doing.

Ms CLAYDON: Kind of a more mature analysis.

Ms Russell: Exactly. We have started investing and working in this space, and it's an indication of the different areas that we're going to be moving into. If you look at the Change the Story framework, there are a number of different settings, including health, legal. And a lot of them we aren't working in yet, but I think that those are going to be the next frontiers. Certainly, for the second national plan, I would anticipate that these will be some of the areas that we'll start moving more into as we work.

Ms CLAYDON: Do you have opportunities to feed directly into that process of shaping the national plan? I accept you're giving evidence here and we are all trying to shape that national plan, but is there a network that you work through in order to have a seat at that table somewhere along the line?

Mrs Michelmore: Currently, the answer to that is no. But we consistently, on a more ad hoc and informal way, work with various groups, be it researchers who are absolutely looking at the physical and mental impacts of

family violence or violence against women. So it's more at an informal level, but I think it's possibly a challenge for us to become more involved in this. Because of the increasing awareness of the ongoing physical and mental impacts, it's an area where across the board there is greater awareness, and that's why there will be a greater drive towards involvement in this next plan.

Ms Russell: I would just add on to what Janet said and say that I'm not aware of the current process that's going into that scoping and development of the second national plan, but our organisation and others in the sector would be very keen to be, I'm sure, consulted. We would hope that that process would be as collaborative and co-designed with the sector as possible, to feed into that content and have some control or input over that process. I think that will also be really valuable when it comes to launch and implementation in terms of being able to engage with different settings and sectors to ensure uptake—and to make sure that it's valuable and relevant.

Ms CLAYDON: There are six national women's alliances that are funded through Prime Minister and Cabinet, if I'm not mistaken—that's where they used to be funded—and one of those alliances actually deals specifically with women: Strong Women Against Violence Alliance. I'm just interested in how much engagement all of these amazing organisations like yourselves, who are working on the frontline, on the ground, have. I'm wondering how you get to feed up into those alliances that then have a direct line into government policy making. I will continue to try and think that through a little more.

CHAIR: You'll need to leave it there, Deputy Chair.

Ms CLAYDON: I will happily leave it there. Thank you for your evidence this afternoon.

CHAIR: Thank you for your attendance at today's hearing. You'll be sent a copy of the transcript of your evidence and you'll have an opportunity to request corrections to transcription errors. If you've been asked to provide any additional information, could you please forward it to the secretariat within two weeks of receiving the *Hansard* transcript? Thank you very much for your appearance this afternoon, and I wish you good afternoon.

Mrs Michelmore: Thank you, Mr Wallace, for the invitation.

FORDER, Peta, Senior Statistician, Research Centre for Generational Health and Ageing; and Australian Longitudinal Study on Women's Health

LOXTON, Dr Deborah, Co-Director, Research Centre for Generational Health and Ageing; and Deputy Director, Australian Longitudinal Study on Women's Health

TOWNSEND, Natalie, Research Manager, Research Centre for Generational Health and Ageing; and Australian Longitudinal Study on Women's Health

Evidence was taken via teleconference—

[14:44]

CHAIR: I now welcome representatives of the Australian Longitudinal Study on Women's Health to give evidence via teleconference. Although the committee does not require you to give evidence under oath, I should advise you that this hearing is a legal proceeding of the parliament and therefore has the same standing as a proceeding of the House. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Do you have anything to say about the capacity in which you appear before the committee?

Dr Loxton: I'm a professor of public health at the University of Newcastle.

Peta Forder: I'm the senior statistician for the Research Centre for Generational Health and Ageing and the statistician for the Australian Longitudinal Study on Women's Health

Natalie Townsend: I'm the research manager for the Australian Longitudinal Study on Women's Health and the Research Centre for Generational Health and Ageing, based at the University of Newcastle.

Ms CLAYDON: Hello to fellow Novocastrians! It's great to catch up with you again.

CHAIR: I now invite witnesses from the Australian Longitudinal Study on Women's Health to make a brief opening statement, and then we'll proceed to a general discussion.

Dr Loxton: Thank you for having us this afternoon. I'll start with just a quick overview of the longitudinal study and then respond to each of the items that we provided in our submission.

CHAIR: Professor Loxton, before you go on, I'm going to ask you to go off hands-free, please.

Dr Loxton: We're actually unable to do that. What we might do is call in on a different phone.

CHAIR: Okay. I think that'd be worthwhile, because the quality is not good.

Dr Loxton: I agree. We're in a meeting room, so we'll call through on a private phone.

CHAIR: Will the three of you be calling in from separate lines?

Dr Loxton: Sorry, we're just trying to sort out the technology. We'll use a different speakerphone that shouldn't have this issue.

CHAIR: I'd rather you not use a speakerphone, because we do have issues with virtually all speakerphones. So, if you're able to go into three separate offices and call in on three separate phones, that's probably preferable, and, if you can not use your hands-free, that would be good.

Dr Loxton: Okay, we'll do that now.

Proceedings suspended from 14:48 to 14:49

CHAIR: We'll resume proceedings and hand it back over to you, Professor Loxton.

Dr Loxton: That is considerably better. I apologise for the technology.

The Australian Longitudinal Study on Women's Health is a longitudinal cohort study of over 57,000 women from across Australia, and is funded by the Department of Health. We first collected data in 1996 and continue to have women in four cohorts who are now aged 94 to 99, 69 to 74, 42 to 47 and 25 to 31. The participants complete surveys on a regular basis, and their data are linked with various datasets such as Medicare, hospital and cancer registry data. It is a very comprehensive and powerful dataset, and one of the few longitudinal datasets in the world to collect data about family and domestic violence and sexual violence.

In our submission we responded to two points, (f) and (i), so I'll speak briefly to those now. The inquiry is asking about the evidence base concerning the prevalence of domestic and family violence, and how to overcome limitations in this area, particularly with regard to consistent measurement, timely data collection and qualitative and quantitative data. The study has collected prevalence data since 1996 with regard to domestic and family violence. The initial focus of these data was on lifetime prevalence of violence from a partner or spouse, and sexual violence, but we later incorporated more nuanced measures of domestic and family violence to capture

types of violence experienced, and 12 months, as well as lifetime prevalence. Most recently, we have captured women's experiences of abuse in childhood, including physical, emotional and sexual violence.

With regard to consistency, about four years ago we were approached by the Department of Social Services to modify the way in which we captured domestic violence in the survey of our youngest cohort. The aim of DSS at the time was to encourage national longitudinal studies to compare prevalence across the studies that exist. And we did make those requested changes. As I've mentioned in the submission, the longitudinal study data have the potential to provide comprehensive information about women's experiences of violence and the outcomes of these. DSS has previously provided funding to examine issues to do with measuring domestic and family violence, risk factors for domestic and family violence and, last year, to map the prevalence of domestic, family and sexual violence across the country. This year ANROWS has funded us to examine the impact of sexual violence under the Fourth Action Plan and to look at this across the life course.

Untapped information about the complexity of multiple experiences of violence exist in the data, as does the potential to untangle the various factors that exacerbate or mitigate the impact of violence on health. This is especially important since our data is showing a very long term deficit in physical and mental health that's associated with experiences of domestic violence. Similarly, we can see in the data the long term impact of abuse in childhood on women's health. As well as needing to understand this in more detail, the findings highlight the need for trauma recovery services in the long, as well as the short term.

With regard to other datasets mentioned, we already link with hospital data. We have spoken with the New South Wales Bureau of Crime Statistics and Research about linking our data with crime stats. It is certainly feasible, although to do this at the national level would require resourcing. We also note that there is a distinct difference between the number of women who report domestic violence to the police and those who experience domestic violence. And we'd be happy to investigate the feasibility of linking our data with administrative housing datasets. Even without this additional information though, our quantitative and qualitative data linked with administrative data collected over 25 years, provide an evidence base about domestic, family and sexual violence that could be further utilised.

The inquiry has also asked about the impact of natural disasters such as COVID-19 on the prevalence of domestic violence. We have collected information from our participants about their experiences of abuse during the pandemic as part of our fortnightly COVID-19 survey. We will also collect more detailed data in the future about women's experiences of domestic and family violence during this time.

You can see from our submission that our recommendations are focussed on making best use of existing data by funding analysis, supporting consistency in data collection across studies where possible, facilitating data linkage, recognising the long term health impact of violence against women, and the need to identify factors that can help improve women's lives where they have had these experiences. Thank you.

CHAIR: Thank you very much for those submissions. So it's fair to say that since 1996 you've built up a very extensive array of stats on the issue of family and domestic violence. Where have you got your funding from in the past? You've said the Department of Health and the Department of Social Services, but where else have you got funding from? And, in a perfect world, what do you need to be truly effective?

Dr Loxton: The study itself—collecting the data—is funded by the Department of Health and has been since 1996. To analyse data in depth on particular issues such as domestic and family violence, we apply for money from other funding bodies. In this case, we've had funding from the Department of Social Services. We have had funding in the past from the Department of Health to have a look at some aspects of domestic and family violence and we have a current grant from ANROWS to do that. What we would need to fully exploit the data would be a grant to really cover those analyses in full. The current grant from ANROWS does actually allow us to look in detail at what has happened for women who've experienced sexual violence. It would be good to be able to follow that up with some qualitative interviews with women to get a little bit more lived experience information within that space. The data from domestic and family violence, because it's 25 years worth of data, is highly complex, and doing the analyses requires investment in the statistical expertise that's needed in order to do those analyses. So, I guess, money. If I were to sum it up; it's investment in analysing the data.

CHAIR: And do you have any sort of idea of what that would cost?

Dr Loxton: Can I take it as a question on notice and get back to you with some accurate figures?

CHAIR: Absolutely, you can.

Dr Loxton: Okay, I would like to do that.

CHAIR: No problems. It seems to me that one of the common complaints and concerns that has been raised throughout this inquiry is the lack of data that we have in relation to the prevalence of domestic violence, but

more so the lack of data with the many and varied measures that have been taken to try and combat it or prevent it. I'm imagining—and correct me if I'm wrong—that your data will really be a matter of helping us to get a better picture of the extent of the problem and the connection between the impacts of domestic violence on women's health. Are there any other specific issues that you think we should be looking into?

Dr Loxton: I will add a little codicil to this in that obviously the questions that we can answer are limited by the women that we've collected data from. In that sense, I think that we probably can't speak to cultural and linguistic diversity. But, other than that, we can speak to women within these age groups from across the country, including rural and remote areas. No one study is ever going to answer all questions, but we can certainly answer a lot more questions than we have up to this point with the data that we've collected, particularly in light of the fact that we're linked with administrative data sets.

CHAIR: What questions do you think need to be answered?

Dr Loxton: For me, the most pressing question is: what are the things that help to mitigate the impact of domestic, family and sexual violence on women's health over the life course? When we look at our data you can see that the impact lasts at least 20 years. So women who've lived with violence have a deficit in mental and physical health that appears to last a lifetime. But that's not true for all women. With our data, what we hope to do is identify those factors that actually mitigate the impact of violence on women's health and wellbeing and those that exacerbate that effect, so we'll be able to identify those things that need to be augmented within service provision and in social support.

CHAIR: Right. Any other questions?

Dr Loxton: I don't have any questions off the top of my head. I'm just going to look at my colleagues—and they don't have any questions either. Do you have any more questions?

CHAIR: Sorry, I meant: are there any questions that you think should be answered as a result of the comprehensive 25 years of data that you've got?

Dr Loxton: I understand. Some of the things that we're currently looking at with collaborators include the healthcare costs that are attributable to experiences of violence. We would also be able to identify some of the other economic costs of violence on women's health and wellbeing by having a look at their employment data and raising children and so on. I'm aware that some years ago there was an Access Economics study that had a look at the cost of domestic violence, and it was in the billions of dollars. We would be able to contribute to the study along those lines if that was something that would be useful. From my perspective, I look more at the health of women than I do at the financial costs, but I think that it is important to note that, because of these increased financial costs, there is an investment that could be made in women's health in mitigating the impact of violence that actually would save the economy money in the longer term. So I think doing some economic analysis would also be useful.

CHAIR: I think you're referring to the PricewaterhouseCoopers report of 2016, which identified the cost to the economy as just a shade under $22 billion a year. Does that sound right?

Dr Loxton: Yes, you're right.

CHAIR: Anything else?

Dr Loxton: I'm just going to hand you over to Peta Forder, who's going to bring up a point with you.

Peta Forder: I think the Australian Longitudinal Study on Women's Health has got a broad depth of information in terms of population prevalence, and we can link that with administrative health data sets. What would be really good would be to link that with other data sets such as social security, housing, recovery services. That's something that is beyond the remit of our current study, but, if you wanted to look at a really broad integrated approach to domestic violence and family violence, you can't ignore other services that people need and are required to use to be able to recover.

CHAIR: So what's the data that you're looking to unpack, or what are you trying to find in relation to the housing connection with domestic violence?

Peta Forder: I think one of the things we'd be interested in is how families cope when there's a separation, what services they can access, how that impacts on them getting on with their lives. Does it change the trajectory? Because the Australian Longitudinal Study on Women's Health is about women's health, we don't have that kind of detailed information on other aspects of life. And, of course, it's not just health; it's where you live, what you do, how you work, how you pay your bills. As a health study, it doesn't have that information. But, from a population point of view and from an individual point of view, that's really important to how you go about planning what you're going to do now and how you extricate itself from the situation.

CHAIR: Alright. Deputy Chair.

Ms CLAYDON: Thank you very much for that evidence you just provided. There is an enormous wealth of data that you have—and there would possibly be endless possibilities if you were able to access additional funding to do the analysis work here. We had evidence earlier today from the Illawarra Women's Health Centre. And, I'm sure you're aware—I recall seeing a letter of support from yourself, Professor Loxton, for this project. I guess that report was born very much out of knowing that the impact of violence on women is substantial and long-lasting, as you've made clear in the evidence today. Are there opportunities through partnering with a trauma recovery centre like that, which doesn't yet exist in Australia, but they're trying hard to get up and running. What would be the value of a partnership between the Australian Longitudinal Study on Women's Health in collaboration with, for example, a trauma recovery centre?

Dr Loxton: I'll respond to that. We have actually spoken with Ms Sally Stevenson, as you might have gathered from the letter of support that we wrote. There are a number of ways that a partnership with a trauma recovery centre could value add—that is, for the longitudinal study working in concert with a trauma recovery centre. Firstly, the longitudinal data allows us to identify the factors that might help women recover from violence and abuse at a population level. These can be translated into trauma recovery programs and therapy in order to augment women's health and buffer against further health deficits that occur to women who have lived with violence. Secondly, we are able to bring the methods that we use in order to evaluate the efficacy of a trauma recovery centre. One of the things that I've noted in the sector over the years has been the—largely financially but also other—inability to do evaluations of services that have been rolled for women who've lived with violence. There are a number of reasons for this, and I certainly wouldn't blame the services concerned. I think there are resource implications and all sorts of things that are beyond my expertise. In a partnership with a trauma recovery centre from the very beginning, we'd be able to find those long-term longitudinal measures of evaluation, so you can use the longitudinal study data to not only identify those factors that will help the centre to be successful but also measure its success in the longer term.

Ms CLAYDON: Thank you so much for that. I know this is a tough question, because you've got twenty five years of data that is quite phenomenal, but, just knowing your research as you do—and you have highlighted some in your submission to us, but I want to give you an opportunity to put on public record—what are the statistics and trends that are most concerning for you and that you are seeing in terms of the data you've collected around the experience of domestic family and sexual violence in Australia?

Dr Loxton: I might start by listing some of the physical and mental health outcomes of domestic violence that we've found in our data. They include overall poor physical health and overall poor mental health. Physical health includes emphysema, bodily pain, respiratory conditions, allergies, breathing problems, eyesight problems, vaginal discharge, cervical cancer, low iron, bronchitis, hearing problems, bowel problems, fatigue and cardiovascular disease. For poor mental health it includes depression and anxiety, self-harm and suicidal ideation. With regard to health behaviours, it includes an increased likelihood of tobacco use and, according to some evidence, alcohol consumption, and, of course, overall psychological distress. We note that among all of our cohorts, between about 20 and 30 per cent of women have lived with a violent partner or spouse, and this increases for the first 30 or 40 years of life—that is, as women enter into relationships that are more stable in nature the likelihood of entering into a violent relationship increases. The percentage stabilises at around middle age, although there is still the onset of violence among middle-age and older age women. We note that some women who are reaching very old age experience the onset of domestic violence as their partners become unwell, in the context of dementia and other cognitive disorders.

Although we expect to sometimes see a reduction in domestic and family violence as it becomes more spoken about in the media and as awareness grows, sometimes what you see is a little increase as women become more willing to disclose their experiences of violence and abuse. The very long-term impact of violence and abuse I find personally frightening—that women can have these experiences, the violence can end and they can move on with their lives yet still experience mental and physical health deficits that are attributable to violence. That's something we've been focusing our attention on most recently.

Ms CLAYDON: I agree that the concept or knowledge that there is a lifetime deficit in mental health associated with domestic violence, which you made clear earlier on, is terribly frightening and that it remains so much, even after abuse has ceased. Is that something we are really only just beginning to understand more about? I appreciate that you're now very focused on that aspect. We heard from the Illawarra Women's Health Centre that it was an issue that led them to put forward a proposal around a trauma recovery centre, for example. Is it fair to say that it is a fairly recent area of work for people like yourself and indeed our public policy thinking?

Dr Loxton: I think that might be fair to say. It's a bit of a judgement call. Here on the study we have known for I guess the past five or six years that this is an issue that doesn't seem to change for women over time. And maybe because there's been such a focus on getting women out of violence, if you like, there hasn't been the time or the impetus to actually look at these long-term impacts, while we focus on what I suppose is secondary prevention in a public health sense—getting women safe. So, first of all: create safety. That will remain of prime importance, as is primary prevention—preventing violence from occurring in the first place. However, understanding that within the community in any particular age group you might have between 15 and 25 per cent of women who've had these experiences and that that proportion of the population then may be experiencing mental and physical health deficits attributable to that violence, I think it begins to dawn on people that this is indeed a public health crisis.

CHAIR: Deputy Chair, there are questions from other members, but—

Ms CLAYDON: I'm happy to allow other members to go, and if there's time over perhaps come back. But if I don't get time to return, I would really appreciate a sense of your priority areas now in terms of a deeper analysis of the data you've got. We didn't get to touch on the terrific data you collected through the fortnightly surveys that were undertaken during COVID-19. So, if we don't get a chance to talk about that now, I'd be very interested to know what you think the key messages are for this committee to understand from that body of work and also what your priorities would be in terms of funding to enable you to do a deep analytical dive of the data that you already have.

CHAIR: Thanks, Deputy Chair.

Dr WEBSTER: I have a question regarding the survey material and the data that you have collected. Obviously some significant benefit of Medicare is that you know where the data's coming from. I'm interested in the prevalence of reproductive coercion and whether you are collecting information about that. Perhaps I'll go with that first, and whether there are any predictive factors you might be able to provide from the information that you have gathered.

Dr Loxton: With regard to reproductive coercion, we'll be collecting this information next year. I heard earlier that Janet Michelmore and her colleagues were talking about the report by Marie Stopes. That would be my recommendation in the first instance, and we would hope to have data by the end of next year that might be able to shed some light on reproductive coercion.

Dr WEBSTER: Excellent. From the data that you've collected, are there particular stages in men's [inaudible] that are more likely to [inaudible] a prevalence of domestic violence?

Dr Loxton: I'm sorry, I'm having trouble hearing you. I think you asked whether there are particular events that precede domestic violence?

Dr WEBSTER: Yes. Obviously we've heard about pregnancy and that the first child can be a time of great stress and therefore an instigator, if you like, or a reason or a motivator for violence. But I'm just wondering if there are other times—ages and stages? You've spoken briefly about dementia.

Dr Loxton: The prevalence that seems to go along with dementia has been one of the clearest things to come from our qualitative dataset, and it's something that really does need some more attention quantitatively to be able to make some sort of population statements about it. It's something that would be really nice to be able to follow up on. With regard to events, yes, certainly the increase of domestic violence around times of having children has been documented in other studies. One of the things that form a longitudinal analysis would be, in fact, to identify those things that do occur prior to experiences of violence—taking a more longitudinal sort of analytic approach. I might ask our senior statistician to respond in a little bit more detail with regard to that.

Peta Forder: With regards to where our focus is, we have collected data on both adverse childhood experiences as well as domestic and family violence during the course of the survey. One of the things that we would like to focus on—which we currently haven't got the resources for, but we're trying to fit it in—is to look at the cumulative effects of what happens in childhood, along with what happens as you go through your life and how that adds together and whether or not it multiplies effects or if it's an additive effect. And there's what people are at risk for, in terms of what they've had exposure to. That's probably where we would like to go with some of the work that we would like to do, in terms of analysing the data—to try and add some of those things together instead of having them as separate entities.

Dr WEBSTER: One of the other things that has been raised today is the similarities between women who have experienced domestic violence with someone who's come back from war—I assume combat war—where there is PTSD present. Do think that more data will provide greater insight into that? Can it do that, and should we have a broader approach to domestic violence, as we do with our veterans, and acknowledge PTSD?

Dr Loxton: I think that's an interesting approach and certainly something that's worth looking at. In our data. we don't specifically measure post-traumatic stress disorder, so it would be hard for me to answer that with accuracy. But, while you were talking, I was thinking it would be very interesting to do a comparison study and see if, indeed, what we suspect is true and that these things are comparable. Basically, you're talking about two groups of people who live in fear of their lives, potentially for a very long period of time, and who are periodically injured psychologically and/or physically. So there are definitely parallels that can be drawn. When you look at the depression and anxiety and some of the things that women report when they've lived with violence, they're not that dissimilar to what returned veterans report.

Dr WEBSTER: Yes, and probably the unknown component, too—vulnerability and the unknown future. I think that will do from me. Thank you, witnesses. I really appreciate your input today.

CHAIR: Thanks very much, Dr Webster. Back to you, Deputy Chair.

Ms CLAYDON: Could I perhaps follow up on the questions that I was leaving you with—just in case we didn't get time then. One is: what would be your priority areas for additional support to do analysis of data? Where would you think would be the most profitable areas—and I mean profitable in the sense of delivering the best public good for precious dollars. Where would you focus, in the analysis of the data that you've got? You mentioned earlier, for example, that you thought we should be linking with other data sets but there's an issue of analysis of the huge amount of data that you've got now. Have you been able to do analysis of the COVID-19 surveys to the extent that you would like, for example?

Dr Loxton: Thank you for the question. With the COVID-19 surveys, we have been sending those out once a fortnight. And, no, we have not yet analysed the data from those to any extent. This was a study we pulled together on a shoestring budget because it's not part of our core work, although we felt that it was very important to try and measure the impact of COVID and of policy changes on women's health and wellbeing over the pandemic. We have this week just sent out the 13th of those surveys. They're quite short in nature. One of them asked women about their experiences of violence during the pandemic. So we hope to be able to analyse those in more detail, moving forwards. But again, as I said, funding is a bit of an issue in that. To answer your question about priorities—

Ms CLAYDON: Just before you leave that—so, that was an initiative of your own, really. You saw a need to have these surveys out there in the field, and you've got that incredible access to thousands and thousands of women. So that was your own initiative, to do that? You weren't requested by government to start tracking anything in particular during COVID-19?

Dr Loxton: That was our own initiative. Things were moving very rapidly, as everybody knows, in March. And so we pivoted—I think that's the new word—and managed to get the first of those out in April.

Ms CLAYDON: Fantastic. But then, of course, as you've identified, the challenge then becomes what you get to do with that data if you don't have additional staff and resources to do the analytical work. So that would be an area worthy of investigation, so that we know that we are, as policymakers, for example, responding in the best way we can to help with the recovery process. What about other areas of research? If you were the Minister for Women or the Minister for Health, where would you be directing those dollars to—whether it's filling current data gaps or whether there's a really rich vein of research that you know is there but you just haven't had the resources to get to? Where would you go?

Dr Loxton: I think my top priority would be doing the longitudinal examination that identifies the factors that improve women's health after they've had experiences of violence and fully understanding why it is that women who have one experience of violence are more likely—not 100 per cent likely, but more likely—to end up in other situations that put them at risk of further abuse. That's been something that we have had on our list of things to do for some time now. And now that we have 25 years worth of data, I think the time is certainly right that we would be able to do that. Part of that would be to identify the things that help women to recover from abuse, and the flip side of that is to identify those factors that make things worse for them. Sometimes those are modifiable factors and sometimes they're not. But, at the moment, we actually haven't identified them, and we would be able to do that with sufficient investment. I will backtrack a little bit to the COVID surveys. If anybody's interested in looking at the very basic results, they are available on the ALSWH website. I think the first six survey summaries are up there, and we'll have the others going up over the next few weeks.

Ms CLAYDON: Terrific. Thank you. Do you get approached by government agencies or departments? Who reaches out to you for the data that you're collecting? How is it most frequently used?

Dr Loxton: It's a combination of many different things. We have a lot of collaborators across the country who use the data, because the data themselves are freely available. It's just a small matter of putting in an expression of

interest, and anyone with the right sort of expertise can access the data and analyse that. That means that it is used worldwide. But, in order to focus on this particular area, I think that some investment is needed in actually getting the data ready for that.

With regard to stakeholder engagement, we have from time to time been approached by different sections of different government departments, usually at the Commonwealth level. We also reach out to different sections of government departments, so it's a bit of a two-way street. We know the people at the Department of Social Services who are working in this area to put together the next national plan and who've been working on the last one. We've certainly been able to do some direct work through the Department of Social Services as well as ANROWS. It's actually been really useful to be able to answer their priorities using the longitudinal study data.

Sometimes we manage to put things together without funding, so we have provided data to the Institute of Health and Welfare, and of course we provide a major report to the Department of Health every year as part of our core deliverables. The topic is chosen in that regard in consultation with the needs of the department at the time.

Ms CLAYDON: Terrific. Thank you. It is incredible foresight, I have to say, to have begun longitudinal domestic and family violence data back in 1996. I am wondering whether there are any other jurisdictions that would have comparable data. Do you have sister organisations around the world that likewise have 25 years worth of data to work with, or are you utterly unique?

Dr Loxton: I don't know if we're utterly unique. Certainly there are a lot of other longitudinal studies around the world, and we've been doing some work with quite a few of the studies. The longitudinal studies are quite well known at University College London. They've been collecting longitudinal data from one of their cohorts since 1946, which is fairly amazing. They don't, though, necessarily collect information about people's experiences of violence and abuse. I have yet to find another study that's comparable in that way. That doesn't mean it doesn't exist; it just means I haven't found one.

Ms CLAYDON: Well, congratulations. I am sure you are world leaders. I'm not going to be shy about calling that. Thank you enormously for your evidence this afternoon and for such a rich body of work, which really should be utilised to the max to help us decision-makers and guide us in the best ways to shape policy and have input.

I asked my final question of the previous witness too. You have an annual reporting mechanism back through the Department of Health. Do you get to help shape any of those strategic documents—the national women's health strategy, for example, in which a new 10-year strategy was just released last year? Of course, we're about to come up to the renewal of the National Plan to Reduce Violence against Women and their Children. Are there any formal pathways in which you participate in that level of strategic discussions and policymaking?

Dr Loxton: Very much so. As part of the national women's strategy our major research report that year was actually a suite of policy briefs around all of the pertinent areas that had arisen from our data in order to inform the development of that policy. We welcome that opportunity whenever it arises.

Ms CLAYDON: That was the National Women's Health Strategy?

Dr Loxton: That's right, yes. It was the National Women's Health Strategy. We submitted a series of policy briefs to help form the evidence base for the development of that policy. We welcome the opportunity to overtly provide evidence whenever it's useful across state and federal governments.

Ms CLAYDON: Thank you, and thank you very much to the fabulous researchers at Newcastle university.

CHAIR: Witnesses, thank you for your attendance at today's hearing. You will be sent a copy of the transcript of your evidence and you'll have an opportunity to request corrections to transcription errors. You have been asked to provide additional information. Could you please forward that to the secretariat within two weeks of receiving the *Hansard* transcript. Thank you to all of the witnesses for their participation in today's hearing and, in fact, the hearings for each day of this week. I thank my parliamentary colleagues for their diligence in attending these hearings and, of course, the ever-so-faithful secretariat and Broadcasting. Thank you for your efforts. I now declare this public hearing closed.

Committee adjourned at 15:31