JOINT STANDING COMMITTEE ON THE COMMISSIONER FOR CHILDREN AND YOUNG PEOPLE

REVIEW OF THE FUNCTIONS EXERCISED BY THE COMMISSIONER FOR CHILDREN AND YOUNG PEOPLE

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 28 MARCH 2018

Members

Hon Dr Sally Talbot, MLC (Chair)
Mr K.M. O'Donnell, MLA (Deputy Chair)
Hon Donna Faragher, MLC
Mrs J.M.C. Stojkovski, MLA

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Hearing commenced at 9.45 am

Mr BASIL MARTIN HANNA
Chief Executive Officer, Parkerville Children and Youth Care, examined:

Mrs AMANDA JANE PATON
Clinical Psychologist; Director, Therapeutic and Advocacy Services, Parkerville Children and Youth Care, examined:

The CHAIR: On behalf of the committee I would like to thank you for agreeing to appear today to provide evidence in relation to the committee's review of the exercise of the functions of the Commissioner for Children and Young People. I am Sally Talbot, member for South West Region, and I am chair of the Joint Standing Committee on the Commissioner for Children and Young People. I might just get the other members of the committee to introduce themselves, although I believe you have all met in my absence quite recently.

Mr K.M. O'DONNELL: Kyran O'Donnell, Deputy Chair.

Hon DONNA FARAGHER: Donna Faragher, member for East Metro.

Mrs J.M.C. STOJKOVSKI: Jessica Stojkovski, member for Kingsley.

The CHAIR: It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything you might say outside of today's proceedings. Today is a public hearing. If, during the hearing, you feel that the evidence you are about to give should be taken confidentially, please let us know so we can respond to your request appropriately.

Before we begin, do you have any questions about your attendance here this morning?

The WITNESSES: No.

The CHAIR: Did you want to make any sort of opening statement to the committee?

Mr HANNA: No. We are very pleased to be here. They are very important issues. I think that the recommendations that have been handed down by the royal commission in terms of our work, volume 9, are a great step forward and can be a catalyst for great change. We are looking forward to that.

The CHAIR: We were going to jump straight into that, as you know from the information we provided to you. Not many people got honourable mentions in the royal commission report, but you and your centre certainly did. Can you tell us: what are the implications of this endorsement of your service? Have you spoken to government about the way that endorsement may change or expand or spread the information about what it is that you do at the George Jones Child Advocacy Centre?

Mr HANNA: We have certainly spoken with the royal commission. We have not spoken to the department for child protection. It is essentially in chaos at the moment. I have got a meeting with the minister in relation to the centre and in relation to the second centre that we are building. We have never formally presented an argument to the government for money for the centre, but we have hoped that the centre would support services within it. For example, our tertiary service is completely funded by Parkerville under what we call deficit funding. Our secondary service is funded by the government. What we want is both the police and child protection to stand by us and walk

with us on this journey. That particular issue has oscillated over the seven years that we have had the centre open. For the first few years it was very challenging. Indeed, we were classified as an organisation with a head full of steam, and we had quite a fight on our hands to get people to recognise the value of it. In the latter years, and particularly while Amanda has been in charge of the centre, things have shifted, aligned to our research we have done with the University of South Australia and aligned to our growing reputation with the police. Things have got really good. We still continually have to encourage the department for child protection that this is really important. Even with the good stuff—the royal commission's recommendations; the fact that the research identifies it as international best practice—even with those really strong, positive things, we still have to coax them along. We are happy to do that. In time we think that we will prove ourselves right. In our arguments for building this second centre, we appeared before Lotterywest for some funding. Amanda pulled some figures out for us. We have had 15 700 children who have had tertiary or secondary services through that centre in the last seven years, which I think is really significant.

The advocacy model is an ongoing issue for us to promote and market. I do not really care what you call it—whether you call it a child advocacy centre, an ISVA, a Barnahus or whatever you call it—it is that integrated, seamless model that is so important. I think we will still be putting that forward for years to come, but we have people behind us now. I know we are going to talk about this later, but the Barnahus—what is happening in Europe—is quite significant. Some of the results we are getting are very, very promising, but I do not think this will be an overnight trip. We will be fighting this and Amanda will be fighting it for some time to come. We will continually have to prove that this is working.

[9.50 am]

Hon DONNA FARAGHER: Can I just clarify: you mentioned at the beginning of your response the term "chaos"—that we are in chaos. Can I just get some clarification: in what context are you referring to chaos? Is that in terms of the department or in a general sense? I am just wanting to get some clarity around that.

Mr HANNA: I am referring to the department. If we go back to 2008—10 years ago—the department started an out-of-home care reform. The whole idea around it was that it was to improve services for children. The whole of the not-for-profit sector and government aligned and started working on this. There were lots of subcommittees; lots of papers were put up. As the decade passed, things slowly began to change, until it was clearly evident about two years ago that this really was not about changing the world for the better for kids; this was about how we could save money. Then we began to get into some conflictual status. I am talking not about us but about the sector. Really, this is a complex world that we work in with these kids who are traumatised. We are talking about out-of-home care, because now this reform had extended to every single contract in community services. Our view was that you are not taking into account the complexity of what happens. This is costly—like it or not. The investment that this state makes into traumatised children I believe, personally, is not significant enough to deal with the complexity of the cases. Child protection has had immense upheaval in the last year to 15 months. If you consider that in the last 12 months every single executive of the seven who were there in the department for child protection has gone—every single one, top down, has been replaced by new people. Those people are good people but they do not have the history, and the rules have changed and the goalposts have changed, so it is very, very hard. The community sector really does not know what is going on, because tenders are being put off; tenders are being delayed. The out-of-home care tender itself, as an example, has now been delayed until January 2019. All the other tenders and the results are not going to be released until the middle of this year. When I refer to it being in chaos, that is a pretty good example

of chaos to me. If you were to talk to any single not-for-profit that has a contract with the department now, they will tell you the same story. It is not just about us; this is a community sector thing.

Let us talk about kids. The effect on services is significant. We do not know if we are going to be able to manage these kids as we move forward, because we have no idea where the department is heading. We have had lots of discussions. We have had discussions about, "You need to lower your price by 20 per cent if you want to be in the game. You need to consider that we may not have family group homes in the future." There is a lot of uncertainty. In 10 years, we built up a culture within the sector of cohesiveness—supporting each other; working together. That has gone in the last 18 months because of this uncertainty. If you even look at the staff situation, we would have 40 per cent of our staff on fixed-term contracts—40 per cent of our staff on fixed term! Why? Because we do not know if we will have a contract after this period of time. For someone looking into the sector from outside, they would go, "I don't want to work with those guys. I'm not sure if I can get a job for long enough."

Hon DONNA FARAGHER: A complete lack of certainty.

Mr HANNA: Absolutely. I know this is a slight digression, but it is great that the royal commission hands down these recommendations, but really they are handed down to a sector in trouble; they are handed down to a sector in chaos. That is just another thing that puts the pressure on. We already have, sorry, a touch of cynicism that we have lost sight of the kids in this and that this is not about kids; this is about money. We can get all the rhetoric we like from politicians, but when the rubber hits the road, we go, "You're talking about decreasing the number of kids or you're talking about decreasing the amount of money for the kids or you keep putting off tenders." It is a state of chaos—I am sorry, that is the fact.

The CHAIR: Can I ask you to clarify what you mean by tertiary and secondary services?

Mr HANNA: Sure. When we talk about tertiary, we talk about children who have been harmed in some way—the action has already happened. They are at the higher level of acuity, so they need to come in and they need pretty urgent assessment and care. That is how we classify tertiary. The type of tertiary work we get—in Amanda's case, there would be children and young people who will require a forensic assessment, they require safety and support, and they could require clinical intervention. In my other director Jo's area, those kids are taken out of the home and come into out-of-home care. We classify that as tertiary work. Secondary are children or families who are potentially at risk. Maybe they have not been harmed yet, but the family is in a state where the kids are at risk or the family is at risk. What we try to do is actually try to prevent them from going from that secondary status into tertiary.

The CHAIR: You talked about this developing crisis, essentially over the last decade.

Mr HANNA: No, the last decade has been this constant talk about reform. I think the last decade has been very good.

The CHAIR: That is what I was trying to match up.

Mr HANNA: We had the Ford report—you would remember the Ford report. Since the Ford report, we all worked together. Even not-for-profits that were kind of suspicious of each other and did not really want to work together actually came together because they had a common cause. We then developed really good collaborative relationships with the department, where there was a sense of trust. In the last decade, that has been the case. In the last—I do not want to be specific—let us say 18 months, that has gone by the wayside in many aspects because of this uncertainty, because every contract has been thrown in the pile. People are uncertain; organisations are uncertain too. Even the department itself is not clear. Its pathway has changed. What was the pathway a year ago is

now a different pathway. When you have a climate like that, when you have a culture like that, lots of things happen. There is a domino effect—it goes all the way down.

The CHAIR: You also referred to the fact that government does not provide overall funding for the George Jones centre—it funds individual services.

Mr HANNA: No; it funds a program called family secondary services. Armadale is the inaugural one. Amanda, has that been five years?

Mrs PATON: Six years now. The Armadale Family Support Network is the only one that it funds.

Mr HANNA: There are four family support networks that exist in Western Australia. Armadale was the first one and it was funded by the department. Then there is Mirrabooka and Fremantle. We have got one that we fund through philanthropy up in Geraldton. The plan when it was discussed between government and non-government was that there would be 16 of these rolled out.

The CHAIR: This was the plan six years ago?

Mr HANNA: Exactly right. We had lots of consultation with all the sector—lots of workshops at the zoo and all that type of thing to look at the model. It was a good collaborative exercise. Then the plan came that there would be 16 of these rolled out. In terms of government funding, there are three that are now in existence, but that has essentially stopped because of the situation we are in.

The CHAIR: The financial situation?

Mr HANNA: Yes. That is funded by government. The rest of the work—all the tertiary work that is done at the centre—is funded by us. I guess you could say the police are funded by government—we do not pay the police. They come along and they join with us, but they are very aligned to this model.

The CHAIR: I remember when we spoke a couple of years ago now, in a previous iteration of the committee, there were still some services that were not running out of George Jones. Is that still the case?

Mr HANNA: Yes. Quite a number.

The CHAIR: So health?

Mr HANNA: Yes.

[10.00 am]

Mrs PATON: We used to have a paediatrician on site, seconded from the child protection unit within PMH. The purpose of that was to do forensic medicals on site. We had funding, through grant funding, to actually have the medical equipment set up. The resource put into that, though, was later realised that it was not quite efficient given that the number of forensic medicals that actually occur in WA are very minimal and, when they do occur, it is often that the family are presenting through the emergency department at PMH and then they go straight through to child protection, which is absolutely where they need to be to have that forensic medical. So having that resource actually out in any of the centres is probably not ideal. He was then doing a lot of general screens, developmental assessments and categorising and assessing historical impacts of abuse on children who came into the centre. That had usefulness and merit, but probably did not need to be such a highly qualified specialist in terms of a paediatrician from the child protection unit. So when he moved on to take up a slightly different role, we diverted the grant funds elsewhere to something that was more required for the centre and the team. The police, child protection and Parkerville have strong links with the Department of Health, and families are still sent when they need to be sent to PMH for medicals or to local hospitals or GPs or whatever the medical requirements are,

rather than having that on site. It would be ideal to have a GP on site, but that is extremely expensive and not really on the cards at the moment with the rest of the deficit funding in the building.

Hon DONNA FARAGHER: I want to go back to one aspect. I know we have other things we want to talk about, but just in the context of your discussion about the department and your concerns with respect to the loss of experienced personnel. I also reflect your comment that we are not reflecting on the current personnel there, but the reality is that you lose significant experience when that number of senior executive staff go. I am interested in your views with regard to the amalgamation of a number of departments into what is effectively now a super department, of which child protection forms part. Do you have any concerns with respect to the fact that child protection now falls into a much larger department and perhaps the focus might be not as strong as it might have been when it was an individual department? I want to preface my comments by saying that this is not necessarily a reflection of the committee. I do have some concerns that a mega department is dealing with some of the most vulnerable people within our community. I have some concerns regarding that; I am just interested in yours.

Mr HANNA: In theory you are right, but we have got no evidence to say yea or nay at this point in time. I would only say that with the current situation with child protection, we have some concerns that there is not as strong an emphasis as we would like on the vulnerability of children, but I do not know that I can give you objective evidence that says because of the change, this has occurred or that has occurred. Ask me in a year maybe. I could probably get back to you.

The CHAIR: We will make a date to have you back.

Mrs PATON: There have been lots of changes, so it is hard to pick out what it has been. We have had a change of government; we have amalgamated departments; we have had loss of executives; we have had tenders and reforms; we have had a royal commission; we have had complete changes to the structure of the way the department actually intakes reports of abuse, and is now moving towards a centralised model rather than a district level. We have had all these changes. From being in the sector, it is hard to pinpoint that it is that or it is that or it is that, because it has all happened within quite a tight time line.

Mr HANNA: That is absolutely right.

Hon DONNA FARAGHER: There are actually just too many changes that have occurred in a short period of time.

Mrs PATON: Too many changes that have happened within a short period of time.

The CHAIR: I wonder whether I could take you to the other side of that equation. What you have just described and what Hon Donna Faragher is pursuing with you is those kinds of administrative changes to the infrastructure of what you provide. Is it your observation that your—I hate to call them clients. The families and the children that you look after, have their situations altered in the last decade?

Mr HANNA: Yes, for the better they have. I think in the last decade it is my opinion that we have made some phenomenal improvements in the care of children in out-of-home care and the care of children within the sector—absolutely phenomenal. If I go back to 14 years ago when I started at Parkerville, the idea of trauma-informed practice did not exist. I think there was one psychologist at Parkerville when I started. How many have you got now?

Mrs PATON: There are 24 or 25 and then we also have some mental health–based social workers as well.

Mr HANNA: It is not just us; it is right throughout the sector. There is an understanding. If we went back prior to that 14 years, we would say, “All kids who have experienced trauma from abuse, if

they come into Parkerville and we give them a roof over their head, three meals a day, they will be sweet." But we know from research, only in the last 20-odd years or so, that this causes impairment of the development pathways of a child's brain. We all know that. So you have to do a little bit more than just give love and nurture; you have actually got to work with these kids to remove the plaques on the brain. You have actually got to do work. The improvements in the sector—not just us—have been an understanding of that, so we have moved towards creating this clinical milieu where we are not just caring and supporting kids, but we are treating them. That has been the best thing that has happened in the last decade. Our fear and why we refer to things in chaos is because we just do not know where we are going anymore, and because we have a real fear and a genuine fear that these kids will be funded in such a way that the ability to be able to provide the clinical expertise that is required to enable these children to recover will be taken away, and we will go back to the draconian days that we had. I say that with the greatest respect to my predecessors, who did not have knowledge around the research. So, yes, I think the last decade has been wonderful. We have all learnt and we have all tried to implement ways. The kids have certainly benefited from it. If you look back at what we used to do 14 years ago compared to what we do now, we were only talking about this prior to coming in here today about how safe the kids are: the steps that we put in place to make sure that no-one in our workforce is going to harm a child or, God forbid, if they did, it would be picked up pretty quickly. The clinical expertise that we give to these kids has exponentially changed. That has been positive. The last 18 months we are uncertain. I am not saying it is a fait accompli, but we are uncertain what the future holds for these children.

The CHAIR: Can you help us, who are not experts in this field, understand what is the basis of the observation that we have an increasing number of children with complex needs entering care? From what you have just said, I might be tempted to say that it is a different diagnosis; that there is a different categorisation of children and that that degree of complexity has always been there, but has not been recognised before. Can you help us understand that?

Mrs PATON: I think it is both. I think our system has gotten, as Basil said, significantly better. If I even think about when I started clinical practice 13 or 14 years ago, our treatment was good but not great from a trauma perspective. We have gotten to a place now where we are far better and holistic in terms of how we respond, but I think the incidence of abuse has increased. The type of abuse we are seeing has increased. Particularly for an organisation like Parkerville, which has improved and increased what we call clinical services and tertiary services, we are now referred far more complex cases than what we ever used to see. The level of acuity has increased. The drain on our mental health services has increased, which puts pressure down the line. The drain on out-of-home care services and child protection services has increased. We have child exploitation material, which we never had 15 years ago, which increases the impact of abuse and increases the incidence of abuse and the ongoing impacts and abuses that children experience. We now have children who are far more traumatised and far more impacted, and the incidence of that is far greater. We have an increase in family and domestic violence. We have an increase in neglect and kids coming into care. So whilst we have gotten better, I do not think we have kept up with the needs of the community.

[10.10 am]

If you look at even just something really simple like a tiny pocket of funding, we have what is called Child Sexual Abuse Therapeutic Service in WA. That was increased when mandatory reporting came in for WA under certain levels after the Ford report in about 2011. The funding in terms of quantity has not increased for that service in the last eight years. Before the Ford report and before the changes to mandatory reporting, it had not increased for the five to eight years before that, so you have a service that is meant to provide child sexual abuse services to children and young people and adults who have experienced or been impacted by child sexual abuse, and by children and young

people who are responsible for or at risk of offending against other children and experiencing sexualised behaviours. The funding has not kept up with the trend in terms of a significant increase in children experiencing those issues, so government has not kept up. It has provided CPI indexes, although that is slowing, but it has not kept up with wage growth. We used to be able to provide that service with psychologists. We now need clinical psychologists with substantial experience, so we are talking about a $30 000 or $40 000 difference just in salaries, but the funding has not increased. That is just a tiny little example, I suppose, of how the sector has gotten better, but the funding or the programs along with it actually have not kept up with the incidence and increase in terms of trauma and the impacts and just the sheer volume of cases that we are getting.

Mr HANNA: One of the ways that Amanda's team gets around some of this is that they provide services to children under Medicare. In a way, the government is paying for that through the Medicare system. But Medicare gives 10 sessions. You are not going to finish with a child after 10 sessions. What we do is to say, "Okay once we engage with the child and those 10 sessions are over, we continue." But we continue at what we call deficit funding. We know the need is there. We feel that we are obligated, as an organisation that looks after children, to intervene. We intervene. We get some money from Medicare, but then the cost continues after that. I would hazard a guess that there are not many organisations that do that. The issue is out there. There is a great need for those services, but they are not funded properly.

The CHAIR: Amanda, you referred to child exploitation material. Can you explain what you mean by that?

Mrs PATON: We have an increase of children being used to create child pornography in both static visual images as well as movies. We have lots of clinical examples that we are working with currently where the children I do not think, as they are developing and growing, have fully understood the impact or longevity of images that are out there of them. The increase in child exploitation materials—whilst from a criminal justice perspective they are far easier cases to pursue if someone has the images in their possession, but from a trauma perspective for the child, it is so degrading and so long term—once the images are out there, you cannot get them back. It is far more impacting for the child and the young person and the family because when they begin to realise that and when they actually begin to fully understand what it means that they have had photos taken of their child in sexually explicit matters, or during the course of a criminal sexual act there has been video footage taken, the impacts of that are so devastating for the family and so devastating for the child. From a clinical treatment perspective, that is very significant.

This is probably a slight digression, but I do not think the people who are working in the area are probably being supported enough to view those. We are talking about hundreds of thousands of images that they are having to view for many, many cases and they are also having to trawl through multimedia devices, which is taking a long time. Again, I do not think we are keeping up with the way the crimes are changing and increasing. We are getting there, but it probably needs far more government, legislative and department support to keep up with the increase, because it is quite significant.

The CHAIR: Recommendation 9 of the royal commission talks about a new service system. Do you have any general comments to make about that model of new service system?

Mr HANNA: I have to keep reading that statement. I applaud it and I welcome it. The devil is in the detail. What is it going to be like? It would be very easy to say that we want 10 of these type services around the metropolitan area, but then you want to ensure that the fidelity and the integrity of each service is common. I do not think we are at that stage yet. Amanda and I were at a session only a couple of days ago with Lotterywest. We had a number of people around the table, all who allegedly have trauma-framed models that they work with. One of the great needs that we need to

do is to get some empirical evidence to support that these are valid. I come from a health background. In the health background nothing happens unless a randomised trial has been done and everything is researched-based. In our sector, nothing is research based—triple P has the tick, but nothing else. We are really behind in terms of researching what we believe is right practice. One of the things that we actually need to do is invest more money into research. The comment about having these services is a welcome one, a much-needed one but the devil is in the detail in terms of: How is it going to look? Where might these go? What is the expertise of the area or the individuals working in these facilities that might provide the proper services to the kids? In terms of the recommendation, I fully support it.

The CHAIR: We could spend the rest of the day talking about that aspect of things. What are your measurable outcomes? We know that George Jones works. We have known that in the state for some years now. It has now been recognised nationally as a model that works. What is it about the model that works?

Mrs PATON: The George Jones Child Advocacy Centre is a building. It is more about the services and the integration within the building and looking at those outcomes rather than a physical space itself and the name. Our secondary services are very—our family support network is measured based on the diversion from child protection in terms of the number of families. We have seen that in the Armadale area a significant number of families have been diverted from the child protection system, which we know helps in terms of the financials and the demand on resources and also diverts children from coming into care and needing those, quite intrusive, I suppose, child protection interventions. We know that connection and uptake of services in the area has been facilitated by the network. If we look at the psychological services, we look at things on a very basic client satisfaction level, but also then recovery from trauma and improvements and return to more improved functioning for the client—the child and the family. If you look at our multiagency investigation and support team, then that is very different again. For that we look at increased response times in terms of the interview of the child after a report of child sexual abuse has been made. We have an improvement in the time that the actual suspect is interviewed as well and charges referred and things like that, and we are also seeing child welfare assessments being completed in a more timely manner and then being closed off quicker. The evidence needs to be looked at in terms of that. As part of the three-year research, they looked at the interagency working and the perceptions of different key staff in the different agencies involved. They talk about increased collaboration and having a far more cohesive team environment. A prime example is a case that we had the other day where a further report was made. We have connections with the police now. We literally walk to the next door upstairs and we speak to the investigating officer and say, “Hey, we’ve had the child come in. They have now reported this. What do you think?” Then we go back straightaway and they bring them in for an extra forensic interview or whatever it may be. They are also doing great work in terms of the investigating officers and the police integrating with the children and families when they come in, far more than what they would have previously, where they would get a file and a brief once they have already had the interview. The outcomes are really about integration, and you have to look at them in terms of the individual services that are there, and they are being mapped, I suppose, on an individual program basis.

[10.20 am]

We do lots of surveys at the centre. Twice a year it is around safety in the building and whether children actually feel like they can talk to and report concerns to staff, whether they feel supported when they enter the centre, the timeliness of our responses and referrals and the treatment that they receive. But, as Basil said, more needs to be done. One of the flavours that I have seen through the royal commission, and not just volume 9 but the other ones as well, is that they are talking about

recommending funding for the service operation. Recommending funding for support, supervision and professional development of the staff providing them in recognition of the drain on professionals and the vicarious trauma. But the third one, which is really clear throughout, is that they are also recommending that research be done alongside all these things to make sure that we are continuously evaluating what we are doing to make sure that it is evidence based or evidence informed or that we are measuring impact, particularly talking about social impact problems and things like that.

Mr HANNA: One of the things that we do right across the organisation—not just the George Jones—but impacted by Amanda's team, is that we count very simple things for kids who are disregulated in terms of: How long have they remained regulated? How often are they going to school now compared with what we are doing beforehand? Those are things that we count in very simple terms. If a child has come to us and never been to school, and now we can get the child going to school for a whole term, that is quite significant.

The CHAIR: That is exactly what I was thinking of in terms of indicators.

Mr HANNA: We count all those things along the way and there is a list of those in terms of their cognitive ability, how often are they going to school, how regulated are they in the home and how regulated are they in the school. Those things are all counted. Each one of them might appear to be small, but in the of realm of this child's life they are quite significant.

The CHAIR: If I were to attempt to summarise, particularly with what you have just said Amanda, it is a very impressive story. We all accept that this model works; we want to see more of them. Is there a sense in which it is about the relationships between the professionals in the building—you said George Jones is just a building, so it is the relationships within the building that make it work.

Mrs PATON: We go and represent both sides. We will speak to anyone who will listen about the centre and the way it works. People say, "These agencies are co-located over there so that is the same isn't it?" Co-location is not integration. You can be in the same building, and we have seen prime examples of that around the sector over the last five to 10 years where different department agencies or teams will co-locate and be in the same building, but they do not know one another. They do not integrate. The model works on the premise of the relationships and the integration. It is not easy. We have a building with psychologists, social workers, occupational therapists and police officers. Some of those are detectives and some are forensic interviewers. We have child protection forensic interviewers and child protection case managers. That is an extreme mix of staff and to have them all coming from very different cultures and perspectives, having them actually integrated and communicating and being a whole team is not a simple thing. It is something that we all continually work on all the time, but when it is working it works really well and it works to benefit the child and the family, and without it you have a very fractured service system. It does not matter if you are all in the same building. It is absolutely about those relationships both formal in terms of agreements with police, and higher up in terms of the commissioner and things like that, but also on-the-ground relationships as well.

Mr HANNA: When we were at the round table in August in Sydney with the royal commission, and there were members from all other states, that was the differentiating factor for the commissioner, who said, "I think you other states need to go over to Western Australia and have a look at what they're doing in terms of what integration means." It is really hard. It is not just, as Amanda says, about plonking different disciplines in the building; it is about them working together.

The CHAIR: Do you have any research or data relating to the way the staff do their jobs? We have seen evidence from other jurisdictions to say that when these silos are broken down, people have a sense of being more effective professionally.

Mr HANNA: We have not got research, but anecdotal —

Mrs PATON: Yes, there was a qualitative part of the three-year research where it actually spoke about the value that staff were actually getting out of that and the changes.

The CHAIR: Is that research a public document?

Mrs PATON: Yes.

Mr HANNA: We have a copy.

The CHAIR: We might have a look at that, thank you. Can we take you straight to the Barnahus?

Mr HANNA: Yes.

The CHAIR: You referred to that earlier. We are very interested to hear you speak to that to us if you would.

Mr HANNA: If we go back a bit, the first child advocacy centre in Europe was formed in Iceland in 1998 and was referred to as a Barnahus, which means "house child". The next one was in 2005 in Linköping in Sweden. From that, Scandinavia was always known as the leader in child advocacy centres, but they refer to them as Barnahus. There are 10 standards for a child advocacy centre that emanated out of North America when the first one was established in 1986. In Scandinavia, they have picked up those same principles, so there is a consistency. In Scandinavia, they have been going for quite some time. As we speak, there is a commitment by Europe—it is called the European promise—that there will now be 14. They have not actually decided on a name but they said that children do not like the Barnahus interpretation, so they have not decided on a name, but it does not matter what you call a child advocacy centre—Barnahus; it does not matter—as long as the principles are the same. There are 14 about to be launched throughout Europe.

The CHAIRMAN: So there were 10. Is that the same, founded on 10 principles?

Mr HANNA: I am sorry. There are 10 principles that every child advocacy centre must have. There are 14 new child advocacy centres being opened up in Europe. In England there are three—two in London and one in Durham. As I speak, they are about to be opened. We were kind of proud that the people from the UK came over, had a look at ours, benchmarked ours, took it back and now that is extended. One of the differences that we are a bit jealous about, of course, is that they are funded in England, and we have not moved to that sphere yet.

The CHAIR: That is what recommendation 9 recommends is it not—full funding?

Mr HANNA: Yes. If we think about it, when we first started doing research on this model, there were 750 child advocacy centres globally. There are now 1 200 globally, and Europe is the latest to emerge into this area. A Barnahus is a name, in a sense—a different sort of name for a child advocacy centre. The principles of what is done there are exactly the same as what was created in America in 1986.

The CHAIR: Is the model in Europe the same as George Jones?

Mr HANNA: There are some slight differences. Probably the most significant difference in Europe is that Iceland is leading the way. They have done some research, and we are quite happy to send you the article around it. They have done some research that says children recover better, heal better and get better assessments when they are done by clinical psychologists. From their perspective, clinical psychologists are the ones that are doing the forensic interviewing. Our legislation does not allow that. Our legislation says that is must be the police that do that. You are talking to two clinicians here. We are always going to have a bias. As much as we love the police, we are always going to say, "Give it to a clinician. Have the police with you, but give it to a clinician." I hope, in my work time, that we might see that we follow the Iceland model, because it is now spreading throughout Europe.

The CHAIR: In the Iceland model, what is the involvement of the police?

Mr HANNA: The police work alongside the psychologist in the same way that the psychologist works alongside the police here. The fundamental difference is that the clinician psychologist sits down with the child and does the interview. Over here, the forensic police interviewer sits down with the child and does the interview. That is the only difference. When they have done the interview here, the police talk to Amanda's team, the child and family advocates, and they work as a team. In Iceland, the clinical psychologist comes out and talks to the rest of the team. In Poland, they take one step further. A judge, a prosecutor and a defence sit behind a window and the questions will be asked of the child, but they then stream questions in. The court case is happening right there, so the child never has to appear in court.

[10.30 am]

The CHAIR: That is very interesting. I would ask you to let us have the link to that article; that would be very useful.

Have you spoken to the police? That unit that deals with child sexual abuse in the police currently is quite well-regarded, is it not? It has implemented an enormous number of reforms.

Mr HANNA: Absolutely.

Mrs PATON: That is who we have in our centre.

Mr HANNA: They work in our centre.

Mrs PATON: We have a child abuse squad. It is one of the teams that is integrated in the multiagency investigation and support team. That child abuse squad, child protection and Parkerville work together and respond to all the child sexual abuse reports and serious physical injury that occur within the south east metro corridor. They all come to the centre. We have great connections with police in that area and there are also police that are taking it one step further and really looking at both the training of their detectives in terms of making them more trauma informed, more aware of child abuse and the impacts on the victim, and witness statements. They are also looking at and having initial and earlier discussions around how they can better support victims in the forensic interview process around witness intermediaries and a few things like that.

The CHAIR: So your relationship with the police is collaborative?

Mr HANNA: Yes, it is very good.

Mr K.M. O'DONNELL: From all my background in policing, police are not keen on change at times. However, in this instance, our department is always working collaboratively with you—same thing in Kalgoorlie with child protection. I daresay the police would have no issue if it was allowed that a clinician talks to the child. It is similar to here: we have the chair talking to you and then at the end a question could possibly come out from police, but that would be a great way to go if it is shown that it is better for the victim.

Mr HANNA: We are laughing. I think you would have a few hurdles to jump.

Mr K.M. O'DONNELL: Yes, you cannot just do it overnight.

Mrs PATON: I think it actually has a lot to do probably with not just police, but also the DPP and the same. For us, certainly, in the next three-year research that we have agreed to, we are looking into how they actually need to come around the table for some of this stuff because there have been changes to forensic interviewing in WA—some say for the better, some say for the worse—in terms of child protection not taking the lead on cases and that it is now the child abuse squad interviewers. The DPP is the one that takes the cases forward. If they were to say that the evidence is better when they get it from a clinical psychologist or someone with that background—for example, it might be

someone with my credentials but with policing overlaid on this credential rather than interviewing overlaid on a police credential. It does not matter how you do it or what background, as long as they have the right training and expertise to know how to talk to the child and support them.

The CHAIR: Is it the quality of the evidence that drives the change in places like Poland?

Mrs PATON: Yes, absolutely, the quality of the evidence has been the driver for change. In criminal justice findings and criminal justice outcomes, what is probably most evidenced in the child advocacy centre models is that it is easiest to go: "That child went through that system and there was a charge and a conviction and that is the evidence." It is simple from a research perspective and it probably is the greatest outcome.

Mr HANNA: If you look at North America and Canada, you will find that you can be a police officer, psychologist, social worker or any of those disciplines provided you have had training in forensic assessment. Their legislation is quite open. The research that is interesting out of Iceland is that they are claiming that a clinical psychologist gets better results. You are always going to get a bias from us too. We are always going to come from the child perspective that says, with the greatest respect to the police, that clinicians will get a better result on it. But I think the important thing is to let us look at this open-mindedly. Let us get the police around the table with the clinicians. Let us look at the research and say, "Are we doing this at the best for the sake of the child and the family?" Then, if it needs to change, let us change it.

The CHAIR: In terms of successful prosecutions, I know that one of the concerns of centres similar to yours in other parts of Australia was the pursuit of further criminal charges that were as a result of a child's disclosure. So the child talks about what is happening to its siblings, for example. How do you work with that at George Jones?

Mrs PATON: Do you mean if the child continues services with us and then they further disclose?

The CHAIR: Yes.

Mrs PATON: I suppose it actually goes back to the integration. For example, we had a case just the other day where the child had previously disclosed but not with enough particularisation to allow charges to be laid against the offender. We had lots of information in the system that the offender had actually also sexually abused the mum in this case and also a cousin. So there was lots of anecdotal corroborating evidence, but not enough to lay charges so that the family could go on their way. We have done clinical work with the child. Unfortunately, the child did not come through the George Jones Child Advocacy Centre at the time for their initial forensic interview, so they were not linked in with advocate support, which, from a personal perspective, would have changed things in the beginning. Through the clinical intervention and through the work with the clin psych, the child has now particularised a lot in therapy. We have been able to take that directly in—essentially only an hour after the child's session—to talk to one of our investigating officers in the building and say, "What do you think about this? Can you look it up in the system? Is it actually more particularisation than what she has previously given? What do you want to do with this? Here's the evidence." We do that in consultation and support with the child and the family. The information that we got from the investigating officers was, "Yes, absolutely. That's more than what they disclosed in the first place. Let's talk to her about if they want to go forward and do another forensic interview and what that might look like." We have also got the luxury of the interviewer being able to meet the child beforehand. They can say, "This is where you would do it. This is the room." Then they are familiar with the centre. So the information is passed on, the evidence is preserved and it is reported to the police verbatim. When it comes to it, we receive multiple disclosures quite often in our team at the centre with the advocates and the psychologists. We then do an affidavit and attach those documents and pass all that information along straightaway and the child is re-interviewed with the

advocate support and the treating psychologist or the advocate who received the disclosure. They support them during the breaks and we support the police to do their job, to get the interviews and to do that, and we are able to offer extra information to the interviewers or the police at that time to say, "Look, we have been working a lot on emotional regulation, so let's do some stuff before the interview to make sure that the child is really well regulated and that they're really comfortable in the space", and those types of things. It is a really clear process that we have. We keep to our role; they keep to theirs, and we are really cognisant of that—that we are not disrupting evidence or anything like that

The CHAIR: Who is that advocate support?

Mrs PATON: At the centre we have three child and family advocates. Two of them are senior and we are training and developing one of them. They are extremely experienced senior social workers with experience in family violence, child protection, mental health and a whole range of other things. One of them—Lisa, our most senior—has been working with us for 16 years at Parkerville. We split the child advocate role into two styles, I suppose. One is what we call the duty child and family advocate and that support on the day is about supporting the family and supporting the child between interviews. We make sure that if the child or the family needs to be taken to the hospital to have a forensic medical or if the child needs to be supported while the police are doing a witness statement with the parents or whatever, then we make sure that that is supported. We do a lot of psycho-education and acute response with the family. Quite often, the family only finds out that day, or moments before that their child has actually been abused. As you can imagine, for parents, the horror that that actually is, and so that advocate is there to support the adult too. When the child comes out of their forensic interview, during the breaks, the adult is there to welcome them and support them and we can maintain that relationship. Then we have the ongoing role of the advocate that we call the therapeutic advocacy service—the child and family advocate. They do ongoing work with not just the family, but the extended family as well. Quite often there will be grandparents, uncles and aunties who need to come on board to support the child. They will do ongoing work with the child and make referrals to secondary and other tertiary services as needed. In WA we have long waiting lists for specialist services. They will support the child until they are allocated to a specialist to do mainly clinical therapeutic intervention, but some of the kids and some of the families are not ready for that level of support, so the advocate will work with them until they are ready to engage in that. It is a very holistic service and all the time they are working with the police and child protection, particularly if there are child protection concerns and it might need to be looked at that from perspective as well.

[10.40 am]

The CHAIR: I guess there is a sense in WA—I want to say that we almost pre-empted the royal commission, but there can be no such thing. The Blaxell report gave us an early warning about what was coming. Of course, one of the things that Blaxell talks about that that individual advocacy and support, and that is something that you know very well that the commissioner has been very interested in exploring. Can you give us your views about the provision of individual advocacy and support in WA? You would be well familiar with the commissioner's views. He reiterated them after the royal commission reported.

Mr HANNA: Do you mean the commissioner of children?

The CHAIR: Children and young people.

Mr HANNA: I read the commissioner's report and, from what I can see with his report, he has a different definition of advocacy to what we do. For me, I separate it into three areas. The first is about oversight and compliance and the sector has something in place for that, which I do not think

is good enough. One of the things that is incorrect in the report is where it talks about how the department put together this oversight compliance system. They did not. It was actually a joint venture between the department and the non-government sector. In actual fact, we were at the forefront, ourselves and Wanslea, and wrote the first ever standards, "Better Care, Better Services". What we had hoped from that in 2005 and the vision put forward was that there would be a number of clinicians throughout the non-government sector and a number of clinicians within the government sector that would audit compliance for these standards wherever there was a contract. That never got up for a number of reasons, which, really, we do not have the time to go through. Partly, it was the non-government sector's fault as it did not want to commit funds to it, and it was partly the government that wanted to keep control. At the end of the day, there were only two not-for-profits that were aligned to it, which was Wanslea and ourselves. At the end of the day, we even fell away. But one of the things that we constantly argued was that this is not right. If you look at every other caring system that we have—health, mental health, child and adolescent mental health, disability, aged care—when we talk about compliance, there are standards that are required to be kept by those organisations, which are audited by an external body. They call them accreditation and stuff like that. We are the only system that does not have that. We have gone down a different path. We had a difference of opinion with the department. We said, "Not good enough." We have an internal QMS, so we went out and got an external organisation to audit us.

So we then became a child safety–accredited organisation. This is where I have a disagreement with the commissioner's report—that it cannot be internal. When he talks about the child advocate at the department, he quite rightly points out that there is a conflict of interest in having your child advocate working for the department, which may have a complaint about it. I completely agree with that. In terms of complaints, we need to have a system that is an independent organisation that comes and accredits, or audits, compliance. The next thing, as I read the commissioner's report, is that he talks about a number of advocates who would hear complaints. That is not how we define an advocate. You can call them an admin person if you want, because they hear complaints. Our definition of an advocate is, as Amanda has described them, far more holistic. For us, an advocate is someone who is the linchpin between the child and the family and the professional people. That is crucial to any work that we do with these people. So, I applaud the commissioner's report, but there is a difference that we actually see. We do not think the definition, from our perspective—the way that we talk about a child and family advocate is different to what the commissioner talks about in his report.

The CHAIR: Are you talking about the oversight report?

Mr HANNA: Yes, I am.

The CHAIR: He has, in different contexts, referred to the "child's friend" when he talks about advocacy. Is that more in line with what you are talking about?

Mr HANNA: We do not refer to it as the "child's friend". We look at anything that will assist them as a systematic thing, so we talk about child and family. We do not necessarily use the term "friend". In clinical terms, that can displace boundaries. But certainly we are aligned to the principle that a child and family advocate is someone who is there to look after and interpret the needs of this child and their family to make sure that they are more comfortable and they are supported.

Mrs PATON: I think some of the royal commission stuff talks about a slight case management, or call it what you want—case engagement or case support—kind of element to the child and family advocate. They are highly specialised, particularly in child abuse and child sexual abuse. They are working with not just the child, but the entire system, so sometimes we talk about that system advocacy. But then there is also individual advocacy making sure that the child's voice is heard, making sure that the child has the right supports and making sure that everyone around the child is

actually equipped and able, and in a space where they can provide that support to the child—working with other agencies and navigating that. There is the acute kind of responses that are required, particularly within our system, working in that forensic space and child sexual abuse. But the ongoing work is really varied. One day they might be supporting a family because the child is yet to have medical intervention, so they might be, "Come on, mum, let's get you to the hospital" because they do not have transport or they do not have those supports. Or they are fearful of child protection, so we might go with them to a Signs of Safety meeting or we might sit down with the department and help the family understand why the department is involved and looking at those. So it is a really varied response.

The CHAIR: Is this partly to do with the confusion between advocacy and oversight?

Mr HANNA: Yes.

Mrs PATON: Yes.

The CHAIR: I think what I hear you say is that you agree with the commissioner's views about oversight deficiencies —

Mr HANNA: Absolutely.

Mrs PATON: Yes.

The CHAIR: The word "advocacy" needs to be used with a bit more subtlety, from what I understand.

Mr HANNA: Yes.

Mrs PATON: Yes.

Hon DONNA FARAGHER: Particularly in the context of individual advocacy.

Mr HANNA: Yes.

Hon DONNA FARAGHER: What you are saying, with respect to, I suppose, an example of a child and their family and all that goes around that in terms of accessing support and providing that support is quite different from being there for the child as such in a more general sense in quite a different role perhaps than what currently occurs within the children's commissioner's remit. It would be a complete—not a role reversal, but a completely new role for them and that would obviously require the resources that you currently have in order for it to be effective. I would put to you: do you think that without that level of resourcing that you have—it is quite extensive—and that integration, would it perhaps not be as effective as what —

Mr HANNA: Yes.

Hon DONNA FARAGHER: That would be a reality.

Mr HANNA: We have often said that the child and family advocate within our system is fundamental to the success of the system because it forms that linchpin between professionals and the family.

Mrs PATON: If you look at—call them child houses, Barnahus, child advocacy centres or whatever they are—they all have a child and family advocate role within them. For some of them, they are filled by the clinical psychologist or the therapist. For some of them, they are filled by the social worker or the child protection worker, but they have that person who sits alongside the child and the family through their journey, which in our system can take two years from start to finish. That one person makes sure that they are supported, that they are able to get to the end of their journey and that they are able to actually recover through and after that journey.

[10.50 am]

We have here what is called the child advocate, I suppose, which is very different from what the commissioner is talking about in oversight. That type of advocacy is very different from the child

and family advocate role within child advocacy centres and Barnahus all over the world. This over here, in terms of that child and family advocate role that sits alongside the family and supports them, they have independence as well. That is absolutely crucial to the model, but it is resource intensive. We have three at the centre who deal with about 400 to 500 individuals a year. It is intensive. If we could have an extra advocate, we would welcome it because we actually need it. There are a lot of cases where we have to sit down—we have a multidisciplinary team meeting every week—and I get to be the bad guy and say, "Can you really afford to dedicate your time to this family? I know they need it, but we actually have five other families that are far more acute and far more concerning, and you actually need to spend your time with them." We have to prioritise because it is that intensive, but it is required. It is significant.

Hon DONNA FARAGHER: I suppose, picking up on that, at the end of the day the very sad reality of all of this is that this issue is not confined to one area. You are obviously dealing with a large group, but it is confined to a relatively certain area across the state. From a general perspective, with regard to if there were to be an "overarching individual advocacy" aspect, from the commissioner's perspective that would be very large indeed. Whether it is the commissioner's role or another organisation that would take on that role, it could become completely overwhelming and the outcomes —

Mr HANNA: It could become overwhelming. The commissioner, in his report, talks about the number of people coming on board to be advocates in terms of hearing complaints. Again, that gets back to the oversight. It is the semantics, is it not, about what you call an advocate and what the definition of an advocate does? I do not disagree with what the commissioner says about the oversight; we just want to make the differentiation of what ours are. Certainly, when the royal commission talks about these services going out in the community, we would argue vehemently that if they are to be successful, every single one of them needs a child and family advocate situated there.

The CHAIR: The other area in which the commissioner has done a lot of work is child safe organisations. You talked quite specifically about your organisation being child safe. What is it that you have been able to do that other organisations have not?

Mr HANNA: It is very simple. I am not saying that other organisations have not done it, but we have always thought that we were a child safe organisation. We have always had that view. All we have actually really done is gone out to an external body and said, "Come in and have a look at us. We will follow your standards of accreditation, and tell us whether we're doing it right or not." That happened 18 months ago. They came in and said, "You are a child safe organisation; you are accredited." But it is important for us. If you just take the area of recruitment, we spend a lot of time to make sure that if you want a job at our organisation, we want to make sure that you are safe to look after children. There are the simple things—the police checks, the department checks and the child safety checks. But then we take you another step further and we say, "Okay, whether you want to work as a staff member or as a volunteer, you need to complete this online training. When you've done that, guess what? We're going to introduce you to Amanda's team and there's going to be more training about abuse and trauma and stuff like that." We know that 100 per cent of our staff undergo that—it is mandatory. We know that there are repeat sessions. So when we talk about a child safe organisation, we talk about having a set of policies and practices that people have to follow around child safety; we have incident reports that are recorded. If, for whatever reason, someone speaks in a disrespectful way to a child, it becomes a type B incident report. It comes down the line and we have to investigate it. Sometimes it is like a tap on the knuckles for the person; the person has been exhausted and has lost their temper and told the child to go away in a fairly aggressive manner. We bring them back in and we refocus them and we retrain them, but to

that level we are a child safe organisation. Everything that we do, we are always thinking "child safe" first. It is very simple things, but it is throughout the culture of our organisation.

The CHAIR: Do you think that there is a need to change the statutory framework around child safe organisations?

Mr HANNA: Yes, I do. I think that if you are working with children—what has happened in the last four or five years has proven this—you need to be able to provide some surety to the community, to government and to anybody that you are safe. That contains doing lots of practices. I would say that there needs to be some sort of system that comes into place that you are measured by someone independent to you and that you get the tick of approval or not. If you do not get it, you do not practice with children. I think we have to be that tough. Look at our system in health, our hospitals and our aged care—you do not practice as an aged-care provider unless you have the tick of approval. We can see what happens when you do not have that. It is the same with children; it is too easy to lapse into this apathetic state of, "Well, we do it all the time." You need to have someone independent to come in and view what you do.

The CHAIR: Do you think the commissioner and his office have a role in considering changes to the statutory regulatory framework?

Mr HANNA: Yes, I think they certainly do. I guess I had a difference of opinion with the department in the use of the Ombudsman. No disrespect to the Ombudsman, but they are still government. I think we have to distance ourselves, because the community views what we do. We have to distance ourselves to make sure that we have true independence and that that is properly assessed. Having said that, I think the commissioner certainly has a role in enabling us to get documentation up to change legislation—most definitely.

The CHAIR: That brings me to the end of the questions that the committee had prepared. Thank you very much for coming in today and giving evidence before the committee. A transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional evidence or elaborate on particular points, please include a supplementary document for the committee's consideration when you return your corrected transcript of evidence. Thank you very much.

Mr HANNA: Can I confirm: our actions are that we will send you the research article from Iceland? Is that all we need to do?

The CHAIR: I think so, yes.

Hearing concluded at 10.58 am

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