TRANSCRIPT OF PROCEEDINGS

COMMISSION OF INQUIRY INTO THE TASMANIAN GOVERNMENT'S RESPONSES TO CHILD SEXUAL ABUSE IN INSTITUTIONAL SETTINGS

At Hearing Rooms 6A and 7A
Tasmanian Civil and Administrative Tribunal,
38 Barrack Street, Hobart

BEFORE:

The Honourable M. Neave AO (President and Commissioner)
Professor L. Bromfield (Commissioner)
The Honourable R. Benjamin AM (Commissioner)

On 3 May 2022 at 10.10am

(Day 2)

PRESIDENT NEAVE: Thank you, Ms Bennett.

MS BENNETT: Thank you, Commissioners. The first witness this morning is Ms Tammy Donohue. I'll ask Ms Donohue to come and take a seat in the witness box.

While Ms Donohue is finding her place, I'll just identify, Commissioners, that we've asked you to make some non-publication orders in relation to this matter and they concern the identification of a doctor and, in addition, while we'll be referring to Ms Donohue's daughter by her name today, and that reflects Ms Donohue's and her daughter's wishes, we will ask the Commissioners to make a non-publication order so that that name can't be published.

PRESIDENT NEAVE: Thank you, Ms Bennett.

Yesterday I explained that - I'm sorry, would you like to swear Ms Donohue first?

ASSOCIATE: You can read out.

PRESIDENT NEAVE: Yesterday I explained that it will sometimes be necessary for the Commission to make an order which restricts the publication of certain information. Sometimes the Commission will hear information in relation to people who are not accused of child sexual abuse but who may be part of a witness's evidence in other ways; in these circumstances it may not be necessary or appropriate for those people to be identified.

The next witness, Ms Donohue, has agreed to be identified. However, to protect the identity of a particular person the Commission has decided to make a restricted publication order in relation to that person.

In the context of the scope of this inquiry the Commission makes this order because it is satisfied that the public interest in the reporting on the identity of that person is outweighed by other considerations, namely their privacy.

I'll now briefly explain how the order will work and this is relevant to the media particularly, I think.

The order requires that the witness's daughter's name not be published other than by the Commission or by the

witness.

The order also requires any information in relation to the identity of the paediatrician who is treating the witness's daughter to be kept confidential.

This means that anyone who listens to or reads the information given by the witness to the Commission must not share any information which may identify that paediatrician. This information is not limited to their name and may include other information which may identify them.

I make the order which will now be published. I encourage any journalist wishing to report on this hearing to discuss the scope of the order with the Commission's media liaison officer. A copy of the order will be placed outside the hearing room and is available to anyone who needs a copy.

Yes, Ms Bennett.

MS BENNETT: Thank you, Commissioner.

<TAMMY ALICE MAY DONOHUE, affirmed: [10.14am]

<EXAMINATION BY MS BENNETT:

MS BENNETT: Q. Ms Donohue, thank you for giving evidence today to this Commission. You've made a statement to this Commission, have you read and signed that statement this morning?
A. Yes, correct.

Q. And its contents are true and correct?
A. Yes.

Q. Thank you. Ms Donohue, just to start, you've lived in Tasmania for most of your life; is that right?
A. Yep.

Q. And you have three children?
A. Yep.

Q. And you care for them on your own?
A. Yes.

Q. I'd like to ask you about the eldest of your children, [redacted], how old is she now?
A. She's 15 years old.

Q. She has some special needs, can you tell us about those?
A. [redacted] was born by emergency C-section and a result of that was quadriplegic cerebral palsy, yeah.

Q. Does that create some challenges for her to communicate with people?
A. Mostly when she was younger, but now that she's older she is a lot more content and happy with communicating, yeah.

Q. Tell us about how [redacted] communicates?
A. [redacted] communicates with yes/no gestures using hands and visuals, all visuals, a pod communication book and an eye gaze communicator also.

Q. Just so that we can understand, how would [redacted] say yes?
A. [redacted] would say yes if you give her hand gestures looking up, and a no would be to the side (demonstrates).

Q. She can also, can't she, tell you other things about how she's feeling, is that right?
A. Yes.

Q. Can you give us some examples? Can she tell you about when she's hungry and thirsty?
A. When she's hungry she'll make it very obvious, she will turn her head and yell at you until you give her the attention that she wants, yep.

Q. You've told her that you're coming here today?
A. Yes.

Q. And she knows that you're speaking on her behalf today?
A. Yes.

Q. Is she happy for you to do that?
A. She's happy but even though when I do mention it, she does get uncomfortable, but she knows very well, yeah.

Q. Can you tell us a little bit about how her

communication has changed over time. I think you said that she now communicates in this way, how has that evolved over time?
A. When [redacted] first started school it was a big battle of keeping her at school because no-one could communicate with her and she had separation anxiety, so I could be the only one that could look after her for a long time. But then, once she started using communication - ways of communicating, then it just became so much easier, and she loves school, she loves people, she loves groups, people, she loves everyone; she's a very people-person.

Q. And so, she used I think you said pod, is that right?
A. Yes, it's a pod book.

Q. Can you tell us briefly how that works?
A. It's a book with categories in it and you scroll through the categories to which conversation or what she wants to talk about and she says yes/no and we'll just make our way through that to get her conversation out.

Q. Did you find that people sometimes assume that they can't understand how --
A. Yes, definitely too often.

Q. Do you think that perhaps for someone who's nearly a 16-year-old young woman, they don't realise that there's this vibrant person inside?
A. Definitely, yep.

Q. How does that affect the way she's treated by the adults around her and the professionals around her?
A. How does that, sorry?

Q. How does that affect the way she's treated by other people?
A. Yeah, it's very poorly the way she's treated when she's not communicating with the person directly, and the same goes if someone's talking to me rather than her about her and she'll get very upset about that.

Q. She enjoys art and things, doesn't she?
A. Loves art, yeah.

Q. Commissioners, there's a confidential photograph that I've provided to you that shows [redacted] painting so that you are able to see [redacted], and again provided with permission

because [redacted] is not able to be here with us today. There's also a copy in front of you but we won't go to it now.

I'd like to talk about, so some of those special needs mean that [redacted] sometimes needs to seek some medical attention; is that right?
A. Yeah.

Q. And so, she's seen a range of doctors and medical professionals over the years?
A. We have but mostly in certain years because we're not the - we're not in and out of hospital all the time; [redacted] usually quite well most of the time, she doesn't often get flus or anything like that.

Q. And there have been times where she's needed medical assistance from the hospital near where you live?
A. Yes, definitely, yeah.

Q. Which hospital is that?
A. The LGH.

Q. That's the Launceston General Hospital?
A. Yep.

Q. She's been there as both an inpatient and an outpatient?
A. Yes, both.

Q. Can you tell us roughly how often she's visited LGH over her life?
A. Because she's an outpatient we have our usual appointments with our paediatrician every six to 12 months, or ranging in between, and yeah - I'm trying to get this out right. We're in and out for botox every now and then which isn't often now that she's older and she's looking at spine surgery coming up. Our biggest hospital visits were in 2018 when we went to the Royal Children's in Melbourne for a hip operation, and then we were in Hobart for PEG operation and then we were in and out of the LGH, like, a lot after that and, yeah, a lot.

Q. We'll come to the 2018 admission in a moment. Before that, you would usually stay with [redacted] when she was in hospital?
A. Yes, definitely. Before [redacted],

was born, I would always stay with [redacted] overnight.

Q. And then, you had another child and it became pretty difficult to do that?
A. Yes, because I'm not with the father of my second child, yes; single parent.

Q. And you have two children?
A. Three.

Q. Three children. When you've left [redacted] when you've had to go home to your other children and [redacted] left at the hospital --
A. My youngest is only just turning one, so she's very new, yeah.

Q. You're trusting the medical staff; is that right?
A. Yeah.

Q. Back before 2018 in the early days, tell me about how you felt about that trust; was it present for you?
A. Well, a lot of the time I didn't think I had to worry about it, but I've always had issues with trust in doctors from the start, from the start of [redacted] life really, yeah.

Q. You tell us in your statement that you found interacting with the medical world quite difficult; what do you mean by that?
A. Communication, yeah, everything - aspect of communication, everywhere.

Q. For you and for [redacted]?
A. Yep, anything and everything around it.

Q. Do any of the hospital staff working with [redacted], have they learned to communicate with her?
A. No, the paediatrician barely does.

Q. Was there anyone when you had to leave [redacted] at hospital, was there anyone there who could communicate with her effectively?
A. No, well, that's why I'd stay until she was partially asleep or going to sleep, and then I would leave because they would just check in on her every now and then and not treat her like she was - needed that care, and yeah.

Q. I think you tell us that she was incontinent and needed nappy changes at different times?
A. Yep.

Q. And was that something that you would do when you were there?
A. Definitely, yes.

Q. And when you had to be elsewhere you relied on other people to do that?
A. Yeah.

Q. Do you remember what ward she stayed on when she was staying at LGH?
A. 4K.

Q. I'd like to turn to the 2018 admission. So, can you tell us about when [redacted] was admitted to LGH in 2018?
A. Yeah. Well, the first time was the hip operation. We'd come back from Melbourne straight to the LGH and they weren't ready for us, they had nothing prepared, anything ready for us, so that was a bit of a downer. And then, after [redacted] PEG operation we had constant leaks and ongoing issues with the PEG, and I liaisoned with Hobart medical and they corrected me that things needed to be fixed up and so we went back to Hobart and got that fixed up. And then [redacted] PEG was ripped out here, there and everywhere, like school, after school care, just careless carers. It happens and it happened a lot, and then all of a sudden she came down with sepsis, and I didn't know the signs or symptoms of sepsis when it happened. So, the day before it happened, all I noticed was that she'd rubbed the side of her face on a pillow and she had a slight mark there but she was her usual self. And then the next day I woke up to her and she managed to get herself into a banana position in her bed and she was headbutting the wall all night. So, the infection has caused her to have a puffiness in her eye as well as her hand that she was hitting because she was constantly making this one movement. And then, so that next morning when I found her obviously I rang the ambulance and we were in there for a staph infection from the PEG and that's what it all was, yeah.

Q. So that was why you were admitted to LGH in 2018?
A. M'hmm.

Q. How long was that admission in the end?
A. It was three weeks nearly the last visit, yeah.

Q. For that three-week period was there anything set up to allow [redacted] to communicate with the people caring for her?
A. No.

Q. How do you feel about that when you reflect on it?
A. It makes me feel sick, yeah, and horrible, and angry, yeah.

Q. You were with her a lot of the time, I take it?
A. Yeah, always, yeah.

Q. How did she seem to you when she was on the ward?
A. Very distressed, like, I've - yeah, I've never seen her that distressed before and that's why it was so strange.

Q. What was she communicating to you about how she was feeling?
A. That something wasn't right and, yeah, she was uncomfortable, she wanted to come home, is what it was.

Q. There was someone you now know to be James Griffin at that hospital treating [redacted]. You were never introduced to him; how do you know it was him?
A. I've known him there over the years, like, you know, all the local nurses and that I know of, I don't know all their names but I recognise their faces, because we're not in and out all the time like, yeah.

Q. And he was a familiar face around the hospital?
A. Yeah, like, I was never friendly friends with that person.

Q. Did you hear people speaking about using his name to him and?
A. I only knew him as "Jimbo" because that's what I'd heard them calling him; I didn't know his name was James.

Q. Can you tell us about how he interacted with [redacted]?
A. So, yeah, things started - [redacted] started acting strangely around him and, when I asked him about a rash that had started, he wanted to see it, and then when I slightly pulled her nappy down and he's come over and he's

tapped her with his hand and said "she'll be right".

Q. Just to pause there, and I don't seek to cause distress, but he was touching her vagina, was he?
A. Yes.

Q. Did he pause to ask her about what he was about to do?
A. No.

Q. Make any attempt to communicate about --
A. No.

Q. Was it in a private space?
A. When I told him that she could use an eye gaze, he was very shocked that day.

Q. And was that something you mentioned afterwards?
A. Yeah, when I had that weird feeling come over me, I said, "Yeah, [redacted] will be able to tell me when she gets on her eye gaze", and he's gone, "Oh, she can communicate, can she?" I said, "Yes", and then over that next couple of days was when things got worse.

Q. Tell me about what got worse?
A. Well, after that day I turned up the next day and she was screaming in her bed, sweating. The blinds were all pulled down, and this was the room right outside the office of the ward; like, the office ward, straight across, and all the things were pulled down, the curtains, and I've just barged in there and seen her, and I've like got her up and gave her a cuddle and then I gave her a shower, and she had cream everywhere all over her vagina.

Q. Just pause there. Had you been responsible for [redacted] care since she was born?
A. Yes.

Q. And she was by this stage 15 years old - maybe slightly younger, sorry?
A. Yeah a little bit younger.

Q. How old was she around this time?
A. 11, I think.

Q. 11, sorry. Had she ever been prescribed any cream for her vagina in the past?
A. [redacted] never had a rash down there in her life, ever,

not once.

Q. Have you ever known of any need to treat her in that way?
A. No.

Q. What did you do when you were in the shower? What did you do then?
A. Well, I noticed that she had the injury there, she had skin off down the bottom of her vagina and, yeah, she was just really distressed and at that stage my mum was there with me, and yeah, I made her sit with me while I - I was running in and out of the hospital crying because I just could not understand what was going on with her, and the doctors would not listen to me, no-one was listening to me, no nurse was telling me what was going on, who was putting cream on her, nothing like that; it was all just - keep me out of that, yep.

Q. That was obviously distressing for you?
A. Very, yeah, that's why I called child safety, because I didn't know who else to call.

Q. Did you ask someone at the hospital to explain?
A. Yeah. Yeah, they - ah, they called me at one stage, "Oh, the girl with the Ugg boots", you know, that's how they treated me, yeah.

Q. Do you feel like they looked down on you a little bit?
A. Yes, because I'm a single parent.

Q. Now, you asked Griffin about the cream and that's the incident you described, is it?
A. Yeah, he just shrugged it off, like, they all shrugged it off. And even the [redacted] that wrote the notes down for me, and when I said, "No male was to change [redacted] from today", he, like, he seen all that, you know.

Q. Let's go back to that. So, you say that you asked that no males change her from today; tell us about --
A. Because she had skin off her vagina and lots of cream; like, it was plastered on there, it wasn't normal, it's not right.

Q. You didn't know what happened to her, so who did you go to to say you don't want men changing her any more?
A. The nurses. It was a [redacted] nurse at the time

and the head nurse as well, I complained to her, I pulled her over and took her into the kids' toy room and we spoke about the incident where he walked over and tapped her and I asked her, I said, "Have you got a daughter of your own?", because she didn't seem that fussed about it, and she said, [redacted], and I said, "Well, how would you like it if a male walked over to her and went like that on her?", and I did it, like, I acted it out. And she's like, "I can make a complaint but, you know, that's all I can do". And she said she could give me a form to put in and that's what she did, and she told me she was going to take complaints further, but whether or not it happened or not, I have no idea.

Q. Just to go back a moment again, you said that you saw someone write down that no men were --
A. Yes.

Q. -- to be changing [redacted] or treating her?
A. And no cream, not to put any cream on there any more and no males to be changing her.

Q. And you saw someone write that down?
A. Yes, yep.

Q. Do you know if that was a direction that got complied with?
A. Well, as far as I knew, but they still kept [redacted] for that extra week longer for no reason; like, she should have been home with me. I have no idea why they even kept her even longer than they should have.

Q. By about November of that year, of 2018, [redacted] went home with you after she was discharged?
A. Yep.

Q. Was there any further use of the cream after that that you saw?
A. No, no, uh-huh.

Q. So far as you observed, did you see any male nurses nursing her after you asked --
A. No, I didn't, nah.

Q. When you got home, did anybody speak to you about resolving your complaint or responding to your complaints?
A. No.

Q. Has anyone ever reached out to you since?
A. No, they've always been glad to see the back of us, for some reason, yeah.

Q. How did [redacted] seem to you when she got home?
A. She was very distressed; for a long time she was hating on me, it was really hard.

Q. Were you able to talk to her about what was upsetting her?
A. (Witness nods.)

Q. Can you tell us a little bit about what she tried to tell you? Sorry, if you need a moment.
A. Yeah. I just asked her if a man was bad, she said, "Yes".

PRESIDENT NEAVE: Are you all right? Would you like to go on or take a brief break?
A. No, it's all good.

MS BENNETT: Q. How did [redacted] progress after the months that followed?
A. So, the separation anxiety kind of come back again. Every time I left her she'd be just watching me like a hawk.

Q. Did that slowly abate over time?
A. Yeah, to an extent, but not fully; like, she's always gonna be like that now.

Q. It was about a year later --
A. I'll just mention, mainly in hospital setting, like, yeah.

Q. How is she now, if she needs to go to the hospital?
A. Yeah, she doesn't like going in there, she'll start yelling as soon as we go in through the doors, that's why I said I'd prefer to go to Hobart rather than up there, just for memory side of things.

Q. So, it's LGH specifically that she has an issue with?
A. M'hmm.

Q. Does she react differently to Royal Hobart?
A. She wasn't too bad the last time we went down, we had

to get dental work done, and it was pretty good, it was only for the day, yeah.

Q. It's a big trip for you though, isn't it, coming down from Launceston to Hobart every time she --
A. It is a little bit, yeah.

Q. Do you feel like you're less likely to access the medical assistance in your hometown because of all of this?
A. Yes.

Q. Does that make things harder for you?
A. It does, yeah.

Q. Does it make things harder for [redacted]?
A. Yeah, for sure.

Q. It was about a year after [redacted] came home that you read about the allegations against James Griffin in the media?
A. M'mm.

Q. Can you tell us how you felt when you read those allegations?
A. Well, it was a big reality check and it made me click onto everything and everything made sense from our last day. Yeah, I didn't know his name, so it was like a big shock; it was, yeah, messy.

Q. I'm sorry, I interrupted you?
A. A messy moment, that's for sure.

Q. What were your concerns after you heard about these allegations?
A. Well, everything that we assumed had happened, happened and, if not, worse.

Q. How does it affect you not knowing precisely what happened?
A. I feel like I failed [redacted], 100 per cent.

Q. Did anyone reach out to you about any of your complaints after all that had happened?
A. No.

Q. How does the uncertainty about what happened to [redacted] affect your anxiety about leaving her alone?

A. Massively, yeah.

Q. Tell the Commissioners how that's been for you?
A. Yeah, she's with me all the time. I can't let her go anywhere, apart from school.

Q. Do you feel like that's related to what happened?
A. Well, we were actually getting somewhere with school and stuff, but after all that - yeah. Sorry. Yeah, it's just too much. Even when she started - we attempted after school care again it was like, nah, the two hours and that was it, she'd be back home again.

Q. What about with your other children, has it affected you in relation to caring for them?
A. No, nah. Apart from, you know, they're always with me, you know, that's just the type of person I am now.

Q. I think you've said you're reluctant to take [redacted] back to LGH; that remains the case even though we know that Griffin's no longer there?
A. To stay there, yeah, I would forbid it, yeah.

Q. And that reduces your options for healthcare for [redacted] in Launceston?
A. Yeah.

Q. How do you feel about remaining in Launceston itself?
A. I only want to stay here for the next couple of years and then I want to take [redacted] somewhere else.

Q. And is that related to what's happened?
A. Definitely, and I believe [redacted] will live a happier life somewhere else with her sisters.

Q. What is it that you'd like to see come out of this Commission of Inquiry?
A. Change, yeah.

Q. What sort of change are you talking about?
A. Just more, you know, observant on who you're employing in hospitals, in after school cares, you know, all that, all round, everything.

Q. Do you feel like the communication and seeing people as being people capable of exercising autonomy is important to you?

A. Yeah. Well, that's a common sense thing to me, like, you know, I think all people who can communicate should be able to communicate with everyone regardless of how other people see them, because that's always been the issue with [redacted]; it's like, people are observant and they just assume that, you know, she's disabled so she can't do this, she can't think for herself when she can. She always has been able to since she was very young and that's why she was so frustrated when she was little, yeah.

Q. She can consent to who touches her body, can't she?
A. Definitely, yes.

Q. She can say yes and no?
A. M'hmm.

Q. And she wasn't given that opportunity that day you saw her?
A. No.

Q. You often speak for her; can you tell us what you think [redacted] would want to tell the Commissioners if she were here today?
A. That everyone's got a voice and, yeah, you just gotta listen; people have to listen.

Q. Tammy, thank you, we know it's been really difficult for you to come and do this today, we're grateful for your evidence and for your courage in speaking to this Commission. Those are all the questions I have for Ms Donohue today, unless I hand her over to the Commissioners?

PRESIDENT NEAVE: Thank you, Ms Bennett.

COMMISSIONER BROMFIELD: Q. Thank you so much for coming today and sharing your story, it's been very moving. I just wanted to come back to: you talked about making the extraordinary decision to call Child Safety Services to protect your child while they were in the hospital. Would you be able to tell us what happened when you called Child Safety Services?
A. Yes. So, before I called them my paediatrician at the time said that she wanted to see what support I had to go home with [redacted] as well, so I had all my teachers and staff organised and NDIS worker organised to come to a meeting. Well, when I rang Child Safety they said, "Okay, well,

we'll send someone along to your meeting that you're having", and they sent someone along, and yeah, she was present at the meeting and, yeah, when I was - during the meeting I mentioned about [redacted] injury on her vagina and it was completely dismissed by the paediatrician. [redacted] teacher and everyone else was shocked, but yeah, nothing became of that.

COMMISSIONER BROMFIELD: Thank you.

PRESIDENT NEAVE: Q. Thank you. Thank you so much. We are so sorry about what has happened to you, it's terrible, and we thank you very, very much for your courage in coming and talking to us and we hope very much that the evidence that we've heard from you and that we will hear from other people will make things better for other children.
A. That's it.

Q. So, thank you very, very much for your great courage in talking to us.
A. No worries.

COMMISSIONER BENJAMIN: Can you pass on our thanks to [redacted].

THE WITNESS: I will do, for sure. Thanks guys.

PRESIDENT NEAVE: Thank you. So, you're excused now and, yes, a short adjournment.

SHORT ADJOURNMENT

MS NORTON: Thank you, Commissioners. Before I call the next witness into the witness box may I just indicate, the original timetable for today contemplated a panel comprising both the next witness, Commander Sirec, and also Detective Chief Inspector Yeomans from the New South Wales Police. Unfortunately, Detective Chief Inspector Yeomans has become unavailable at short notice because of a court obligation as part of his duties.

So, although his statement is before you and can be read by you, I am not calling him today although I hope to be able to call him before you at a later time, but I am very grateful that Commander Hilda Sirec is available and I'll call her now to the witness box.

<HILDA SIREC, sworn: [11.28am]

<EXAMINATION BY MS ELLYARD:

MS ELLYARD: Q. Commander, please feel free to take off your mask now that you're in the witness box.
A. Thank you.

Q. I'll ask you first to tell the Commission your full name?
A. My full name is Hilda Sirec.

Q. And you're a Commander in the Australian Federal Police?
A. That's correct.

Q. What's the particular role that you hold in the Federal Police at present?
A. So at present I lead the Australian Centre to Counter Child Exploitation and Human Exploitation Operations for the AFP.

Q. And we can refer to that by the acronym, ACCCE?
A. Correct.

Q. How long have you been the Commander for ACCCE?
A. I have been the Commander of the ACCCE since November 2021.

Q. You have made a statement to assist the Commission of Inquiry which is signed by you and dated 28 April 2022.
A. That's correct.

Q. Are the contents of that statement true and correct?
A. They are.

Q. You refer in your statement to two exhibits, the first of which is a copy of your curriculum vitae and the second of which is the copy of an ACCCE research report from 2020 relating to online child sexual exploitation. Do you wish that to be part of your evidence today?
A. Yes, please.

Q. Thank you. Commander, may I begin by asking you, by reference to paragraph 6 and following of your statement, to summarise the experience that you've had prior to your current role that's relevant to the issues being considered

by this Commission?
A. Thank you. So, I joined the Australian Federal Police in 2001 and commenced general duties then doing uniform policing and across that experience came across various crime types inclusive of child abuse and child sexual abuse. In 2006 I commenced work in the Sexual Assault and Child Abuse Team where I spent a number of years investigating adult sexual assault and child sexual abuse and child sexual assault.

Following that, I worked in that role since 2010, and then worked in countering people smuggling in 2013, and then after that was deployed to Afghanistan to teach Afghan National Police various crime investigation techniques inclusive of homicides, domestic violence and sexual assaults.

Following that, I returned back to Australia and I worked in the joint Counter-Terrorism Team up until 2019 where I deployed to Pakistan where I performed the role as Australia's senior law enforcement officer to deal with law enforcement issues related to Pakistan, Afghanistan and the other Stans in the region and for Australian interests.

In November 2020, I returned back to Australia where I have commenced my role in the Australian Centre to Counter Child Exploitation.

Q. Perhaps by reference to paragraphs 14 and 15, how did the ACCCE come to be created and what is its remit?
A. So, in 2018 the Commonwealth Government provided additional funding to create the Australian Centre to Counter Child Exploitation. The ACCCE is predicated on the need to drive a collaborative response to deal with child online exploitation, bringing together multi-agencies across the law enforcement streams, also non-government organisations, Civil Service, academia, and other facets of those that are working within child protection to drive a coordinated national response to counter the issues around child exploitation.

Q. Some of the words that are used in your statement in relation to child exploitation as a form of offending are the words "prevent, disrupt and investigate". We can all understand that it's part of the role of the police to investigate crimes when it occurs, but am I right in understanding that an important aspect of ACCCE's work is

actually to stop crimes happening in the first place by either prevention or disruption of people who might otherwise be offenders?
A. That's correct. So, the ACCCE is predicated on four pillars: we prevent, we pursue, we protect and we make sure that we have all those elements involved in being able to identify the community needs in regards to the awareness around child exploitation, but also identifying those opportunities where we can prevent the crime and further victimisation at its core.

We engage with our prevention and engagement teams with multiple stakeholders to raise that awareness and provide techniques and investigative aspects to be able to intercept and interdict crime as it's occurring to disrupt the ongoing effects that's ongoing with crime.

We certainly foster a victim-centric approach to all our strategies within the ACCCE but also across our prosecutions as well.

Q. The work of this Commission is focused on responses to abuse in institutional settings and as part of that work the Commission's been made aware that there are cohorts of children in Tasmania, including the cohort of children who live in Out-of-Home Care, that are particularly vulnerable to and have become victims of sexual exploitation including online exploitation, and it's in that context that I want to ask you a bit about this issue.

Firstly, and I'm drawing your attention to paragraph 21 of your statement, when we speak about online child sexual exploitation, what are we talking about?
A. So, we're talking about the scenarios where there are either sexual images or children's genitalia, or situations where children have had sexually suggestive images taken of themselves, all the way up to individuals who are grooming children online to gain access to them. So, we classify child abuse material in its broader scheme for everything under the age of 18, and it relates to everything from procuring, producing, sharing, disseminating any child abuse images related to those children.

Q. You and I are both using the phrase "child exploitation" and "child sexual abuse material", there are other words that have been used in the past. You make it clear in your statement why the words we are using are the

preferred words, can you explain that, please?
A. Yes, so in the past and also in historical legislation it was termed "child pornography" and it's been changed in legislation as well that it is more appropriate to term it as child abuse material. Child pornography generally starts to conjure up a legitimacy across offenders, that it is consensual by the child and we make it very clear that any sexualised images or naked images of children are not consent, so we have moved away from the term child pornography and we work very hard with our stakeholders but also any of our media advice that we send out during prosecutions that we refer to the abuse of children; it's not pornography.

Q. You've made it clear in your statement that one form of online child sexual exploitation cannot just be the sharing of images that also exist, but also predators making contact with children through the internet to potentially persuade them to involve themselves in the creation of sexual images or to become victims to other kinds of sexual abuse. You talk from paragraph 32 of your statement about online grooming; can you tell us about that, please?
A. So, online grooming is a situation where we have offenders and predators out there targeting specifically children to be able to either have them coerced into producing naked images of themselves or undertaking sexual acts for their own gratification, or even to the extent of trying to arrange a meeting with that child for the efforts of doing contact child abuse offences.

It also relates to the fact that these individuals gain trust to these children, but also trust and manipulation to the families and parents and carers as well, so it can be quite sophisticated, people can take quite some time, days and weeks to weave themselves into these children's lives to the point where children initially think that it's quite innocuous to engage with someone, you know, their social friends, friends of friends online, this whole concept of being friends online is totally different to how we would assume friendships and people you trust are in the real world, let's call it. And then, through that process, they start to carve out that trust, remove these children away from their usual social networks and make their - you know, that relationship with an offender quite exclusive, and then to the point of creating some shame and some coercion towards these

situations where children feel trapped and feel like they need to comply to some of the offender's requests, such as sending another image or going to the bathroom and sending a naked image, and then that becomes a perpetuating problem for the children, which is very difficult for them to see a way out.

Q. You make the point in your statement at paragraph 36 that, given the two years that we've all lived through, children have been living even more of their lives online, including a lot of their schooling being done through the internet. What have been the potential implications of that for the potential for children to be groomed online in the way that you've described?
A. I think it's first good to acknowledge that, I'm sure we wouldn't have had a very positive society without the advent of technology and our ability to engage with each other online over the past two years, but it has provided an additional grounds for offenders to be able to target.

We have now children spending even more time online, children as young as 3 and 4 are gaining access to the internet and social media, our children are required to undertake all their schooling online as well and our offenders are very quick to identify vulnerabilities and adapt to that situation.

The issue that we're seeing is the increase in the reports that we received into the ACCCE, and we relate that to the additional time that children have been spending online and offenders being able to take advantage of that.

Q. Can I ask you to perhaps unpick a little more how offenders gain advantage, because one would have thought, if children are doing schooling online, well then they're interacting with their teachers, there shouldn't be any difficulty because their teachers will be safe. How is it that predators are able to insert themselves into what ought to be a safe online environment for children?
A. I suppose online, like I said, it's a fabulous advent, but I think it can be multi-faceted. You can have students obviously watching a tutorial or a lecture, and then with another pop up window they can have a chat function with their friends or their colleagues, and they can have their mobile phone device where they're engaging on different video apps, and they could probably also be gaming at the same time. So, I think children are excellent at

multi-tasking, but it's those multi-tasking avenues that I think the offenders are also taking advantage of. They are accessing the same social media sites that we think are age appropriate for young children, such as the 10 to 13-year-olds, and adult offenders can access those same sites as well, and they're very good at using the same language as what children are using to make themselves familiar to them.

So, as our students are obviously learning the critical work through the curriculum, they're also having that ability to engage on that social media side at the same time.

Q. And so, is there anything that schools can do in relation to the way in which they expect their students to make use of the internet to try and guard against the risk of children entering into spaces where predators might be present?

A. Certainly, I think there's opportunity for schools to certainly tap into the online safety resources that are available out there for a more holistic online safety that goes everything from respectful behaviours, to cyber bullying, all the way to child online exploitation. The eSafety Commissioner provides some great resources for that that the schools can access, and particularly for child online exploitation preventing grooming the AFP's ThinkUKnow program where we deliver tailored presentations to schools, teachers, carers and also students.

In the last year alone we were able to access almost 200,000 students across Australia within the pandemic to give those education presentations to children, but I think the schools can definitely, if they haven't already, is really tailor an ability to do the online safety parameters, you know, all the way through their education process from kindergarten all the way through and make that a focus.

Q. Some of the children whose stories the Commission has heard and are going to hear include children who are perhaps made vulnerable because of family circumstances and don't have present and actively involved parents or are distant in some way from people who might be keeping an eye on them. You mentioned the way in which predators use online media and social media to build connections with children. Would it be fair to say that children who don't

have parents who are watching closely who they meet and how they meet might be particularly vulnerable to the kind of attention that a groomer would offer?
A. Yeah, that's very fair to say. We certainly, as one of our first tips to give to parents and carers, is that supervision is essential; being able to see what your children are doing online all the time is really critical, but also I acknowledge the fact that sometimes that's an impossible task. Certainly being able to have an eye over the screen 24/7 is very difficult, but we certainly think that those online safety behaviours, the critical discussions that you have between parents and carers and children is really important to foster that because sometimes children might not see what is probably targeted behaviour from online offenders; they might not be able to recognise it immediately themselves, but a parent or carer might be able to say, "No, that doesn't seem right", so having that online dialogue is really critical.

But I think certainly our experience is that offenders have actively targeted those individuals who seem to be unsupervised online and in more vulnerable scenarios where that trust and that ability to inject themselves meaningfully into that victim's life happens a lot swifter than maybe in other settings where there's real strict parental controls over what children are doing online.

Q. Commander, you mentioned that in some cases those who groom children online will be grooming them, not just to try and get images, but to create the opportunity for what you referred to as contact offending, so that's actually meeting with the child and abusing the child in person.
A. Yes.

Q. Is that common?
A. Yeah, we would certainly see it's very common. We have a lot of situations where offenders are engaging with children online. We work very closely with some of our telecommunication companies and internet service providers and also social media platforms and they are able to identify that offending quite quickly, and we do a lot of proactive investigations to identify that kind of behaviour so we are able to routinely interdict those scenarios, but certainly it is our experience that it's not always trying to get some child exploitation material from the child, it is an effort to eventually meet up with the child to potentially commit other offences.

Q. You talked about interdicting, you mean disrupt, prevent the offending happening?
A. Correct, so disrupt the offending that's happened at the time, particularly so that the victim doesn't actually end up in the scenario where they're in an unsafe environment with the offender. And, of course, whilst we've disrupted the victimisation, there are still then prosecution aspects that we are able to pursue for the offending that's already occurred, but certainly a big part of our work is that disruption factor.

Q. Can I turn to paragraph 39 and following of your statement. Some research has been done by your organisation about parental attitudes which suggests that there's a substantial percentage of parents who would find it very difficult to even contemplate talking about this kind of topic with their children; is that right?
A. Yeah, absolutely. So, we commissioned some research through the ACCCE that was completed in 2020, and certainly we identified that at least 21 per cent of parents and carers find that it's too sickening to talk about or think about child online exploitation, and 15 per cent of parents and carers also are too embarrassed to talk about it if their child was exploited.

We've also identified that only 52 per cent of parents and carers are actually talking about online child sexual exploitation and safe behaviours online, so there's real criticality for us about reaching that awareness to those cohorts of individuals who don't either discuss it or don't think that it's a problem

Q. Am I right to say that one of the tools that offenders use is to create a sense of shame sometimes for children once they've been exploited to some extent that prevents them from feeling able to disclose that they've been victims?
A. Yes, certainly it's been our experience that some of the tactics that offenders use is that, you know, that coercion and that fear-based messaging to them. So, they've built the trust and they've got that one-on-one engagement with the child, and then all of sudden the content and the conversations starting to towards, "Well, if you don't send me this I'm gonna tell your parents and you're gonna get in trouble because you're talking to me", so they completely wrap every facet of the child's fear

around them so it prevents children to actually making those reports.

Q. And so, at paragraph 40 of your statement you describe a campaign called, Stop the Stigma that's intended to counter the fear and concern that people have. Could you tell us about that?
A. Yeah, so in 2021 we brought together some of the leading non-government organisations and personalities in relation to the Stop the Stigma campaign; it's really built around giving a voice to victim-survivors and making sure that they have the right avenues to make reports and that we want them to not be afraid or ashamed, that they will be trusted and they will be believed.

Some of the research that we did to identify the need through Stop the Stigma is that a lot of children, it takes them at least two decades to come forward and make a report about this, and a lot of children actually don't feel that they will be believed because they've already been told through offender grooming that they won't be believed. So, this is a way to create a voice to make sure that victim-survivors out there can be heard in a national campaign, that they have avenues to report, whether it's through law enforcement or support services, and making sure that their voice is louder than the offenders' voices.

Q. And so, you've mentioned a podcast series?
A. Yep. So, we also created a ten part podcast series Closing the Net. We interviewed over 55 experts within the child exploitation fields, from investigators to support areas to NGOs, all the way to international partners as well about highlighting the trends and issues that we found across child online sexual exploitation, but also some of the avenues of reporting that we've been able to identify.

The Closing the Net podcast had an amazing reach across the country and has also won awards in relation to its ability to shine a spotlight on what is often quite a difficult topic.

Q. You also mentioned the Australian Federal Police's ThinkUKnow program, can you tell us a bit about that?
A. Yes, the AFP's ThinkUKnow program is a collaboration between Commonwealth Bank, Datacom and the states and territories as well, state and territory law enforcement, and it's off a successful program from the UK that we

introduced in 2009, I believe, and it's all predicated on making sure that we build awareness and prevention techniques for children and also parents, carers and teachers.

So, there's a whole host of resource material on the ThinkUKnow website, and we deliver face-to-face presentations and awareness to our students. We've also trained state and territory police to be able to do that within their communities as well, so it creates a force multiplying reach to be able to work on the typical issues around child online exploitation and online grooming and it's complementary to some of the other broader online safety programs that eSafety deliver.

Q. Commander, I want to ask you some questions now about the way in which the AFP works with other enforcement bodies and other organisations.

At paragraph 52 and following of your statement you refer to the joint anti-child exploitation teams which is a taskforce bringing together the AFP and state and territory police departments. Can you tell us about how the JACETs work?

A. So, the JACETs were introduced identifying that there is a close correlation between Commonwealth online offending and the need to bring the local resources of all states and territories together to deal with these issues and these crime types. So, the concept of the JACET exists in all states and territories except New South Wales Police where we work very closely with the child protection agencies and law enforcement and New South Wales Police, but the construct of the JACETs is literally to collocate members. For instance in Tasmania we have Australian Federal Police and Tasmania Police. They collocate, they do joint operations together and joint investigations, and it brings the opportunity to bring not only the state resources but the Commonwealth resources to bear that we can gain access to across the whole of the Australian Federal Police but also other states and territory connections.

So, it's been a really critical way to make sure that we provide all the assets that we have to bear to deal with those Commonwealth offences.

Q. And so, does that mean that as well as the

Commonwealth offences which you've referred to, the joint taskforce is the opportunity to skill up, perhaps, state-based police forces who are investigating state criminal offences involving child abuse?
A. Yes, certainly. Through the coordinating role that the AFP gets to offer because we are within every state and territory, we are able to gain trends and techniques from other law enforcement agencies, particularly our international agencies who have been dealing with these crime types for a long time as well and we can bring all those in, those skill sets and those uplift of capabilities to the various state and territory agencies.

The Tasmania JACET has access completely to the ACCCE which is housed in Brisbane, it also has access to the child protection investigation workshops where we bring other state and territory agencies together to learn from each other.

Q. One of the things that you refer to in your statement later on is about funding that's been made available to the AFP through the National Strategy that's going to include additional funding for the AFP to work on some of these issues.

How might Tasmanians expect to see their own law enforcement capabilities improve through that funding? Is any of it going to resonate in the services and capacities in Tasmanian?
A. Yes, certainly, I believe so. So, under the National Strategy to prevent and respond to child sexual abuse which was Commonwealth and national action plans under that, the AFP received additional funding to uplift our law enforcement efforts across the country.

In the Tasmanian context we certainly see the additional access to victim ID specialists so that there will be actual resources that will be dedicated to work closely with the Tasmanian JACET to identify victims quicker and to be able to provide those capabilities that we have developed through the ACCCE in a faster way.

We also have access to technology detection dogs, so a specialist resource that we can deploy to search warrants to identify concealed electronic data devices, all the way from a SIM card to USBs, to be able to make sure that we don't leave any evidence behind in some of these search

warrants.

They will also have access to the Australian Victim Identification Database, or AVID. So, AVID has been created through the ACCCE to be able to download and harvest all the child abuse material that has been collected through seizures across the country and with Tasmania we will give them complete access to that, the training and the laptops required to do that so that through various search warrants any child abuse material that is located will go into this database. Anything that has been seen previously won't have to be re-seen by an investigator and our investigators here in Tasmania will be able to concentrate more on the unseen previously images to identify victims earlier, so they can spearhead their investigations and not have to worry about what has been duplicated in the past.

Q. That will also, presumably, have ongoing benefits in not forcing people who might be in those images to be contacted again or in any way re-traumatised in relation to images that have previously been investigated?
A. That's exactly right. We found through the ACCCE as well a big pillar of what we do is the health and wellbeing of our investigators and our support agencies, so ensuring that our investigators only have to look at the minimum amount of child abuse materials means they're able to conduct more investigations, that they have a mental well-being that is more conducive to be able to do tailored investigations, and they're not spending excessive amount of time on looking at child abuse material that has already been categorised and seen before.

Q. At paragraph 63 of your statement you refer to an AFP-led investigation into an online network of child sex offenders which it did include, as I understand it, ultimately at least one arrest made in Tasmania. Can you tell us about that please?
A. So, Operation Arkstone began in February 2020 and it was as a result of one report from the National Centre For Missing and Exploited Children, and for context the ACCCE received last Year 33,000 reports. So, from one report in New South Wales they identified an online child sexual abuse syndicate that were also committing child abuse offences in the real world, and these individuals were connected to childcare centres as well, so they were gaining access to children in New South Wales for the

purposes of procuring child abuse material.

That operation went across the whole of the country and identified to date one of the largest child abuse syndicates within Australia and, as has been mentioned, there was one case, an arrest made in November 2021 here in Tasmania related to that as well.

So, over the course of the investigation and as of 28 January 2022 the investigation has resulted in over 1,340 charges being laid and 56 children victims identified and removed from harm.

Q. Thank you, Commander. You've made it plain in your statement that the ACCCE doesn't just collaborate with other law enforcement bodies, it's also part of your remit to collaborate and work constructively with other partners in the space of broadly child protection.
A. Yep.

Q. By reference to paragraphs 59 and following of your statement, can you tell us about how the AFP and ACCCE in particular works with other parts of the system that exist to protect children?
A. So, identifying that there were a lot of individuals that were working within child protection, the ACCCE in its creation to be that collaborative hub, that kind of gravity to make sure that there was somewhere where people who work and operate in child protection can go towards was critical.

We identified that a lot of the non-government organisations and the Victim Support agencies have been doing critical work for a large number of years, and we just needed to connect that work with the disruption and the awareness and the prevention awareness-raising work, and also the prosecution work that we were doing.

It's really identifying that there's a lifecycle of online child exploitation and if we can make sure that we target our resources and our efforts towards the prevention and the awareness-raising side, we can hopefully reduce and counter the actual victimisation and the offenders having that access to victims.

Q. I imagine there's a lot involved in trying to achieve complete coordination across the country at Federal and

state levels.
A. Certainly. Yeah, it is quite a voluminous environment and I think it's nice to see so many agencies out there trying to make sure that they are focused on protecting children and diverting efforts towards that; making sure that we plug into all those correctly can sometimes be a challenge.

We certainly work very collectively on it, we've worked very hard through the ACCCE over the four years that we've been there to harvest all that information and be able to make sure we collate all that together, but certainly we are constantly making sure that we reach out to those agencies that are doing some isolated work, and we certainly like to foster the notion that, you know, collectively we can create a fourth multiplier, we can amplify efforts rather than agencies doing things individually going forward.

I think the National Strategy, the Commonwealth and the National Action Plans will be another evolution of that coordination part, and we certainly work very hard through the ACCCE to make sure that we are aware of all the different avenues that people are fighting this crime and making sure that we plug into it.

Q. I wanted to ask you a more specific question about online exploitation before I take you to another topic. One of the case studies that the Commission's going to be considering here and it's by no means as we understand it an isolated incident, is offenders using the online environment to groom or predate upon children that they already know in the real world, so there might have been a connection made through some legitimate online contact whether as a friend or some holder of some office, but then the mode of exploitation is online. Is that something that you're familiar with?
A. Yeah, so we've had certainly cases where the online groomer has certainly been known to the victim, particularly around being a friend of a friend or a distant relative, or, you know, other associations and they've used the online exploitation as a way to introduce this child to, I suppose, innocuous ways to engage with this individual; you know, posing photos and things like that, and then slowly creeping them into more suggestive images, all the way to procuring sexualised images and using that as a way to then coerce the child. So, there are certain

circumstances where we know that the online offending that's been occurring is as a result of someone connected to the child.

Q. And so, once the connection's made with the child it sounds like the pattern of tricking the child into gradually participating in sexualised behaviour, it's the same modus operandi as that used by people who introduce themselves to children over the internet?
A. Yeah, certainly, because the internet offers a little bit more secrecy on connections. Instead of offenders having access to a child only at certain circumstances throughout a day or a week or the like, they can foster that connection with a child through direct messaging, or "here's my phone number, let's stay connected, let's stay in touch", or "here's my phone number in case you can't reach your parents so make sure you take this" and then that connection continues outside.

Certainly from my perspective we focused on the online connections that are occurring, but we can infer from what we see through the communication between an offender and a victim certainly there has been some connection outside the online world that has precipitated that first connection online.

Q. And in some cases would that mean that the offender has had quite a legitimate reason to know and have contact with the child in the real world, but then is misusing that legitimate connection in the online space?
A. Yes, certainly, that has been our experience, and equally to that extent offenders are grooming parents and carers and making sure that they're familiar and trusted with the parents and carers and offering a legitimacy to why they are then reaching out to children.

Q. You mentioned grooming the parents; is social media a means by which parents can find themselves perhaps tricked into believing that they know someone, when in fact they don't know them?
A. Yeah, absolutely. We find through social media and being able to glean some information about a family situation or a school that a child would go to. We've seen a situation where an offender has become a social media friend to the parents by citing that their child also goes to the school, so they create a familiar ground upon which they can communicate with each other; again, a legitimacy

around this offender saying that their child also goes to the school, so they bond on that sort of connection, and then through that complete trust by the family and carers by virtue of social media friendship that they've, you know, almost shared images and photos and then passed that and translated that trust down to the child.

Q. I want to turn now, Commander, to ask you some questions about one of your former roles and to ask you about some of the things that the Commission is also aware emerging from the evidence of Detective Chief Inspector Yeomans. You've indicated that between 2006 and 2010 you particularly worked in the ACT in the area of sex abuse offences, including child sex abuse offences.

One of the things that you say in your statement at paragraphs 46 and onwards is that over the time you worked in that environment you observed some improvements in the way in which what can be quite a brutal justice system operates to protect victims.

Can I ask you first perhaps to give a snapshot of an example of where perhaps earlier in your time the system didn't work well and wasn't particularly trauma-informed to protect a child who'd been the victim of child abuse?
A. Yes, certainly. In one of my early cases from when I worked in the child abuse and sexual assault team I interviewed a 5-year-old female girl who disclosed that her stepfather had been sexually assaulting her and this was done in front of - the disclosures were occurring in the interview in front of the mother, and there was sufficient information and corroboration there to take the matter to court.

However, the victim by that time was 7 years old and had to give evidence-in-chief physically in court at the ACT courts, which in person, in view of the offender, and also cross-examined to that extent. The difficulties around the cross-examination was, you know, around the memory recall, the specific details that the 5-year-old disclosed at the time and how they referenced that disclosure and corroboration versus to how they articulated themselves two years later was problematic for the courts, and there were no specific rules around the cross-examination and the way that the victim could actually have access to protections whilst giving their evidence.

Q. So that must have been a very difficult experience. It's trite to say it must have been horrific for that child?
A. It was to the extent where the mother who obviously had realised that she'd brought a person into their home that had sexually abused their child, but felt like she didn't - you know, at a lot of stages the mother didn't know she wanted her child to keep going, she didn't think it was going to be worth the prosecution outcome for the trauma that this was applying to the child.

Q. During the time that you were working in this area in the ACT did you see some improvements in the way in which the evidence of children and their treatment in court was managed?
A. Yes, certainly subsequent to that and then since the out years of my time there the process of evidence-in-chief interviews were introduced into the Evidence Act, where children are able to give their evidence under a video recording, however long it takes and how many times it takes, and that is now introduced through a - as long as the person taking the interview has done the appropriate training and is done to the standard that's required, that is the evidence-in-chief played to the court. And then cross-examination, not only the rules around cross-examination, that it needs to be done in a respectful and in a way not to continue the trauma of the victim, but it's done via CCTV, so the victim no longer - at least in the ACT - doesn't have to be within the same court arena as the offender.

Q. One of the things that Detective Chief Inspector Yeomans has talked about in his statement, and there's a trial of this as well in Tasmania at the moment, is the use of what's called a witness intermediary, so people who meet with a witness to try and get a sense of the best way to communicate with a child to encourage them to give their best evidence.

You touched in your anecdote earlier about the different ways in which a child expressed herself at age 5 and age 7 and the implications of that. From your own observation have you had anything to do with witness intermediaries yourself?
A. Not specifically witness intermediaries that are accepted through the court process, but certainly through

Victim Support individuals and child protection agencies, and we work very closely with child psychologists to be able to identify the best way to engage with the child for the evidence that they are about to provide. But certainly, the process of witness intermediaries and getting the best out of understanding the child and therefore the best out of the evidence is certainly a positive step forward.

Q. Because children, and thinking sometimes about quite young children, it's very different to question a child than to question an adult about anything, particularly sensitive things like sexual abuse?
A. Absolutely, and it's really critical to identify, you know, what is the child's background, how do they communicate themselves, how do they link what's happened to them with their communication style, and being able to provide those critical ways of different sort of cognitive abilities that children have and making sure that we are able to assess and get the best information from them.

Q. Thank you very much, Commander. Commissioners, those are the questions that I had for the Commander, noting that there's material before you from Detective Chief Inspector Yeomans, but you may have some questions yourself?

PRESIDENT NEAVE: Thank you, Ms Ellyard. Any questions?

COMMISSIONER BENJAMIN: Q. Yes, you talked about children being contacted by people they knew in positions of trust and using that trusted position to gain access to them through their technology. Do you have any suggestions or ideas how you can perhaps prevent that person from contacting - or first of all, should you prevent that person or people generally from having contact outside the scope of their profession? And, if so, what is the best way to do it? Say a teacher or a police officer or a doctor or somebody along those lines?
A. Yeah, and that's a very good question but a very complicated one. I suppose, you know, the whole notion of what we would teach generations of children about stranger danger and the like, and what is the concept of a trusted individual versus, you know, what is a friend is very difficult to navigate.

I suppose what I'd say around that is that we're always going to have situations where children are going to

have to have connection and contact to more than just their parents or their carers to be able to make sure that, if something happened to their parents and carers, they still have avenues to contact someone outside of that sort of circle, but critical it would be about the parents and carers who introduce these people of trust into their children's lives, that they know exactly to what extent that connection is, what conversations are happening.

I think it's probably responsible that, every time a trusted adult is making a connection to a child, that they inform the trusted carer or parent about that so that there is no isolated communication outside what the parents and carers know. And just also making sure that children have the best tools at their disposal to understand what is untoward contact versus what is accepted contact and who to report to when that's not within their understanding.

Q. Should there be some requirement in an employment contract or an employment relationship of that trusted person restricting their ability to contact the child outside the scope of that trusted area?
A. Yeah, I mean, there's certainly the opportunity for that. I know certainly within a policing context our connection to any child has to be done through a trusted adult to that child, a parent or carer; of course, in a classroom setting where you've got a kindergarten and the teacher that becomes a lot more difficult because they are in a trusted setting to do that. But definitely, if that connection goes towards online, making sure that there is a standard, I would suggest, that parents and carers are aware that there is to be no direct contact to children outside the accepted scope.

Q. Thank you. My second area, since you've opened the door I'll jump through, is you talked about the recognition, facial or whatever recognition it was. I take it from what you've said that that's really advanced over the last few years, and what happens if you've got a child from previous investigations or in some intelligence area and that face comes up again, your technology can match the faces rather than have individual police officers endeavouring to do that; is that the case or is that kind of stuff I picked up from the television and know nothing about?
A. No, it's certainly evolving, it's getting a lot better. At this stage we are still heavily reliant on an

investigator being able to identify victims and evidence within the background of a photo or an image. Certainly, as soon as we've identified that and can apply a hash value, basically a digital fingerprint, that is able to then correlate against other similar images that are brought up.

In terms of different images of the same victim, we certainly have some sophisticated algorithms and software to be able to identify that that is the same person, but the technology has to sort of continually evolve so that side-on images and dark and light images and the like are picked up.

However, what we're doing with the Australian Victim Identification Database is a lot of these images that are circulated online, as you can appreciate, are shared with other online sex offenders. They would procure images from 10 years ago and put them into series and they would share and create their own kind of language around, you know, this is the series of 5-year-old with a balloon or something, and there will be multitudes of images.

What we've been able to do is, all those images that have been seen before, if they are identified through a seizure of an offender, say tomorrow, we will be able to identify that that's already been seized and categorised; that investigator doesn't have to re-look at those images and they can concentrate on what hasn't been seen before in case there are additional victims that we aren't aware of.

COMMISSIONER BENJAMIN: Thank you.

PRESIDENT NEAVE: I've got a follow-up question on that before I ask Commissioner Bromfield.

Q. That would presumably mean that, even if there is no longer an offender who could be investigated, that if there were potential victims of that offender who had posted images online, it might be possible for the AFP to work out whether those were the same victims as in other photographs. Have I understood that correctly?
A. Yes, certainly. And, you know, as you can appreciate a lot of these victims don't get located around the world for many years, so unfortunately our victim identification specialists have actually seen victims grow up in these child abuse images --

Q. Yes, of course.
A. -- in these child abuse images from 5 to 10 years old. So, certainly even if there are no offenders anymore to locate that have procured that, we can certainly still focus on identifying victims and if they happen to come up, whether it's in other offender material or just through the dark web where you've got dark web forums sharing this material, we still target our efforts to identifying a victim.

PRESIDENT NEAVE: Thank you. I'll ask Commissioner Bromfield, I've got a couple of questions, but I'll ask her first.

COMMISSIONER BROMFIELD: Q. Thank you, Commissioner Neave, and thank you for your evidence. You mentioned Operation Arkstone, and I gather from that there were people who were in legitimate child-related employment in childcare centres who used their employment to gain access to children and produce child abuse materials.

In your view, is this a vulnerability that institutions that are serving children need to be alert to?
A. They should certainly be alert that that can actually happen. I think we haven't seen the prevalence of it to the extent that we would suggest under Operation Arkstone has given us quite a horrific understanding of that syndicate and what they were doing. I certainly see from the multitude of investigations that we are carrying out, that we aren't seeing, you know, childcare centres for instance targeted as a way to gain access to children, but it certainly is an avenue for offenders to gain access to children and exploit.

Obviously, there's a lot of rigor, guidelines and regimes around employment around childcare centres and schools and the like, but we'd certainly ensure that our engagement with that sector of the community is paramount so that they're aware of vulnerabilities that can occur through some individuals trying to gain employment through childcare centres to get access to children for sure.

Q. Would you consider that risk to be greater in institutions where perhaps there's less other staff present? So, for example, Out-of-Home Care where there may be one or two carers in a household?

A. Certainly potentially. I would suggest that any sort of avenues where there are vulnerabilities where there isn't the ability to oversight and gain those insights of vulnerable persons, yeah, every vulnerability like that that exists should be something that is considered.

Q. In an institution where this vulnerability is exploited and the worst does happen, what is the responsibility of that institution to work with ACCCE to help to identify victims?
A. If it's related to online sexual exploitation or online grooming that's translated we would work with either the relevant state and territory JACET that's working in there and the ACCCE would provide that back end support to make sure that they - not only we harvest all the evidence that's available and provide all the Victim Support that's needed, but also the awareness and education raising that's required so we can critically do that through ACCCE to make sure that, if they weren't aware of the online safety parameters and resources available to them, we'll make sure that they are.

Q. If through child-related employment child abuse - children are accessed and child abuse materials are made, those victims that are identified through that, should they or their families be contacted once they're identified?
A. Yes, so they are contacted through the investigation process and that's done by state and by territory and the requirements of connection to parents and carers and victims through that, but the local investigation team, be it through the JACET or other child protection agencies will make those connections and we will just make sure that, from the ACCCE perspective, that we can offer that support as required.

COMMISSIONER BROMFIELD: Thank you, that's all my questions. Thank you.

PRESIDENT NEAVE: Q. Thank you, Commander, I have a couple of different questions now. You've spoken about the role that ACCCE plays in terms of a collaborative hub and the relationship it establishes with a whole lot of different groups, including police forces, other organisations in states and territories, academics and so on.

I wonder if you could talk a little bit more about the

challenges that creating those collaborative relationships give rise to and how you've tackled that? I mean, are there structural ways of doing it or what's the best way? And I should say that I'm thinking particularly of having different government departments within a State, for example, which have responsibilities for some aspects of child sexual abuse, and one of the things we will obviously be looking at is how you get people to work together. So, any helpful comments on that we'd find very useful to us, I think?
A. Absolutely, thank you, it's a really good question. I think prior to the ACCCE there didn't seem to be that sort of central area where a lot of especially non-government organisations and other agencies such as the school industry or health or the like didn't know where to go nationally to be able to sort of coordinate their efforts on things.

So what we found was really critical was using individuals that are trained in that engagement piece, so our prevention and engagement team really offers that opportunity so that all the non-government organisations that we engage with have an opportunity to be heard, that they have a responsibility to also input their ideas and steer the way that they want the ACCCE to go.

We're also governed by a board of management which has all the different agencies involved in listening to how we're sort of developing strategies and also giving approval for some of those strategies and making sure that we are also there to provide assistance to some of these non-government organisations as they're trying to develop their own strategies, their own niche lines that they want to seek government support from and making sure that we're available to provide our experience through there.

I know that a lot of the non-government organisations particularly, they all vie for funding and it sometimes can be seen as quite competitive because, you know, funding is always a premium when it comes towards making sure that your advocacy and your agenda in that particular organisation has the right resources to perpetuate.

But what we do through the ACCCE is be able to bring those agencies together and they start complementing each other. So, if one agency is particularly doing like a support stream, then the other agency coming in can say,

okay, that's being done, we don't need to go down that line, how about we look at a niche capability such as looking at online services or looking at legislation advocacy, so we can almost divide and conquer by bringing these agencies in together.

We found that really successful to the extent where, whilst they are all vying for their own funding streams, they'd be far more successful in attaining those funding resources because of the complementary work that they've been able to identify, rather than having multiple proposals go forward with the exact same strategy and agenda.

Q. So you're saying a whole range of organisations are represented on your board and that encourages the dialogue?
A. Certainly. We have a stakeholder group and we have the stakeholder group come together three to four times a year where they join up on, not only the individual strategies but what they want to work collectively on, so it develops that sort of coordination and being able to look at some - you know, one particular organisation might have additional resources in a particular state that they can help another organisation that they don't have as much equity in and the like. And, it doesn't take away from the isolated work that they still have, you know, their board requires them to do, but their work in the ACCCE allows them to look at everyone's opportunities and enhance that.

I think the biggest challenge for us is that there are quite a lot of organisations out there that want to do work within child protection. We can't possibly bring everyone in on the same agenda otherwise, you know, you're crippled by the enthusiasm in the room, let's call it, but we certainly look for those right agencies that are going to be on board with the collaboration that's required as well; some agencies don't necessarily see the value in collaborating across agencies, they have a very niche requirement so they foster that on their own, which is okay, but we bring those like-minded individuals together and it helps us steer a complementary narrative so that agencies don't feel like they have to identify or come up with new ways to help protect children in the online world or whatever, so they have the access to all those resources.

And what we've also found as being really valuable is

that, again, resources are a scarcity for some of these agencies and whatever we can help build from the law enforcement side to help them connect them to schools, correct them to broader parts of the community, connect them to remote communities, we can foster that for them, so hopefully creating a false multiplication effect for them.

Q. That's very helpful, thank you. Now, my other question relates to something quite different. This is terribly difficult work for the people who are within your organisation, your centre. What are your policies about circulation of officers? Do you have people moving in and out? Because obviously people build up an expertise but you don't want people to be worn down by the work; if they do it for too long they may become less effective, so how do you balance those requirements of expertise and protection really?
A. It's a great question and to be honest, broadly law enforcement grapples with that all the time.

Q. Yes.
A. But what we've found is - first I'll start on with the fact that through the ACCCE we developed a world-leading health and wellbeing strategy to the extent that Interpol have asked for our health and wellbeing strategy and it's all predicated on certainly an opt-in only environment. So, it's one of the few areas within law enforcement, certainly within the AFP, where you can't be forcibly transferred to work in child protection, it's an opt-in, and so you're getting in people that want to be part of it.

We have in-house psychological and wellbeing support. Everything that was built within the ACCCE, its architecture and its internal design was all predicated on health and wellbeing of individuals, all the way to the extent where we have all the operational work happening on the top floor, and they don't even have a kitchen so they have to go downstairs and work and eat outside their work environment. So, we dissect them away so that there's no bad environments where they're eating in front of, you know, doing their work, so it's all about those little 1 per cent things that our psych and health wellbeing experts have told us to do.

Other aspects is about that really open and frank dialogue that we encourage our members to have with each other. It could be quite confronting for individuals

coming in and listening to when they talk about investigative techniques or when they've seen something horrendous online, but the building itself is built around the investigators and the specialists in mind, so they can feel free and discuss this without having to go to another area, you know, or take these sort of issues home or anything like that.

We have that really open dialogue where individuals who want to leave the area because of other factors, it is a no questions asked; we thank them for their extensive service and help place them moving on from the area, making sure that we're connected to them even post their work in the role so that they don't - so they're not continually affected by it.

But by and large I haven't seen any research to date that has indicated that actually looking and working within child exploitation material is the causational factor of people having to move on or have stress. Quite often it's all the extraneous factors involved, such as court matters, failed prosecutions, ongoing legislative questions and, you know, leadership bureaucracy which my job is to make sure that I minimise that for them. Often it's those issues that they can't pinpoint about what is affecting them that tends to be the broader issue.

Our investigators and specialists, they know when they see something horrific online or within a cache of an offender's material, that they don't like it, they don't feel well from it and they can understand why they don't feel well from it, so there's a cause and effect attribution that can happen immediately, but all the extraneous stressors that happen around them that they can't pinpoint about maybe why they don't feel so great that day, that can sometimes translate into additional stressors moving out.

In our experience, not only in Australia but also globally, people stay in this role for over 20 years. Some of our Interpol colleagues have been working in victim ID specialisation for over 20 years and for them it's making sure that they have the meaning of the work and every time that there's an opportunity to identify a victim or remove a victim from harm or find a perpetrator, it really sustains them. So, we certainly make sure that it's a case-by-case victim, not every individual is cut out for

this type of work, and we make no negativity towards people who can't do this role, even if they've joined the police, certainly it's not for everyone but those that are in it they're highly passionate and they do an extraordinary amount of work and we certainly build as much health and wellbeing around them as possible to make sure that it's done on their terms.

Q. In another context I have observed that sometimes people who are very good at this sort of work but have a whole lot of other pressures like children and all of those sorts of things have to leave because they can't be accommodated because of the other things in their lives, for example, flex time or being able to take time off to take your children on holiday and that sort of thing. How much flexibility is there in the working conditions?
A. Complete. We have a very flexible environment where we've got individuals that work, you know, split shifts, they work part-time, and because the online exploitation is truly borderless sometimes the timing of where individuals need to work actually serves us well, because we have our international community that, you know, whilst we're asleep they can pick up the slack and whilst they're sleeping we can do work. So, if we've got individuals that need to work between 10pm and 4am in the morning because that suits their family dynamic, go for it.

The only difficult thing is that a lot of the work around victim identification and child exploitation material can't be done from home, it needs to be done in the workplace, so that is the limiting factor. This whole evolution that we've had about the work from home concepts has really revolutionised some of the work that is happening outside the online child exploitation field, and certainly there's some work that our members can do from home when it allows for it, like doing up a statement or doing personal administration, you know, time recording and the like, but the actual critical work that they do must be done in the workplace.

PRESIDENT NEAVE: That's extremely helpful. Thank you very much, Commander, we've really enjoyed your evidence, it's been really interesting, thank you.

THE WITNESS: Thank you, I really appreciate the opportunity to come and give evidence.

MS ELLYARD: Thank you, Commissioners, I'll invite you to stand down until after the lunch break.

LUNCHEON ADJOURNMENT

MS NORTON: I'd like to call Jillian Maxwell and Kathryn Fordyce to give evidence.

<JILLIAN RUTH MAXWELL, sworn: [1.41pm]

<KATHRYN LOUISE FORDYCE, affirmed and examined:

<EXAMINATION BY MS NORTON:

MS NORTON: Thank you both for joining us to give evidence today. Ms Maxwell, I'll begin with you, can you state your full name, professional address and occupation for the Commissioners.

MS MAXWELL: The professional?

MS NORTON: Professional address.

MS MAXWELL: Jillian Ruth Maxwell, 31 Tower Road, New Town, and I'm the CEO of the Sexual Assault Support Service.

MS NORTON: Ms Maxwell, you've previously made a statement for the benefit of the Commission dated 22 April 2022; is that correct?

MS MAXWELL: That's correct.

MS NORTON: Have you reviewed that statement recently?

MS MAXWELL: Yes.

MS NORTON: Do you have any corrections you'd like to make to that statement?

MS MAXWELL: Just the one that was pointed out around the trauma informed principles.

MS NORTON: At paragraph 39 of the statement. Commissioners, I should say, Ms Maxwell's statement is at folder C, tab 10, and the correction is in relation to paragraph 39. What's the correction, Ms Maxwell?

MS MAXWELL: Just that, it's not in relation to harmful sexual behaviours, it's the BlueKnot Foundation trauma-informed principles.

MS NORTON: So, if we amend that first sentence in 39 to say:

> *When I say trauma-informed, I'm referring to the BlueKnot Foundation principles of trauma-informed practice.*
>
> Would that be accurate?

MS MAXWELL: Yes.

MS NORTON: Thank you. In every other respect is your statement true and correct?

MS MAXWELL: Yes.

MS NORTON: Ms Fordyce, can you now state your full name, professional address and occupation for the Commissioners?

MS FORDYCE: Kathryn Louise Fordyce, 112 Wilson Street, Burnie, and I'm the Chief Executive Officer of the North and Northwest Sexual Assault Support Service that's also known as Laurel House.

MS NORTON: Thank you. Now, you've prepared a statement for the benefit of the Commission as well. At this stage that's an unsworn statement, I understand.

Commissioners, the unsigned version of this statement is at folder C, tab 5, along with exhibits. Ms Fordyce, have you reviewed that statement recently?

MS FORDYCE: Yes.

MS NORTON: And is it true and correct in every particular?

MS FORDYCE: Yes.

MS NORTON: Would you like to, while you're sitting there, sign the statement so we've got a formal copy of it?

I might just get you to hand that to Ms Rolfe. Thank

you.

Ms Maxwell, if I could go back to you, would you like to tell the Commission a bit about your professional background relevant to your current role as CEO of SASS?

MS MAXWELL: Sure. Gosh, it was a long time ago now. I'm a former police officer. I joined in 1988 and left in 2001. I studied social work and psychology, two degrees. I worked in community development and education with Volunteering Tasmania and was their state manager for seven years, and then was lucky enough to get this position seven years ago with SASS.

MS NORTON: Thank you, Ms Maxwell. Ms Fordyce, would you like to give a similar history to the Commissioners, please.

MS FORDYCE: Sure. I'm a speech pathologist by trade and graduated in 2000, I think, and have worked almost exclusively in the disability sector as a speech pathologist, as a trainer, as a behaviour support practitioner and as a manager of an autism-specific early learning and care centre, and then northwest services that involved supported independent living, community support and Allied Health services. And then, most recently, approximately 12 months ago, took over as the CEO of Laurel House.

MS NORTON: Thank you, and Commissioners, you will see from Ms Fordyce's statement that she does speak to some of the insights that she has in relation to the particular vulnerabilities of people living with a disability in relation to the risk of child sexual abuse. We won't get to those matters today but it's a very worthy read and there will be a session on disability later in the week.

What I'd like to focus on to begin with with each of you is to get a sense and to draw out some more detail about the services that SASS provides in the north and the northwest - sorry, SASS in the south, Laurel House in the north and northwest, starting off in relation to the support services, and understanding that there are also primary prevention and there's an educative role as well.

So, perhaps if I start with you, Ms Maxwell, perhaps a silly question to start with, but where does the north end,

the north and the northwest end and the south begin?

MS MAXWELL: That's not a silly question. Basically, in terms of our counselling and support service which is funded through State Government, similar - well, the same as what Laurel House get, we service the 62 phone district. So, there's a 64?

MS FORDYCE: 63 and a 64.

MS MAXWELL: So, 62, so that's how the state's divided in terms of that.

MS NORTON: Thank you. That's not an answer I was expecting but it's very helpful. If somebody with a 62 phone number comes to SASS having experienced a sexual assault, what services can SASS offer to that person?

MS MAXWELL: Well, initially they come through our intake process and they're triaged, and depending on the wait list as to when they can access a counsellor, we work with the client and try and match them appropriately to an appropriate counsellor, then depending on their needs and the complexity of their trauma and the outcomes they want is to how long they engage with our service. But there's counselling involved and quite often some case management with other services; it could be mental health, alcohol and drugs, police, it could be basically a number of services, so we'll engage with those as well.

MS NORTON: Ms Maxwell, you say in your statement that SASS currently employs 48 staff, two of whom are full-time. Can you speak to the Commission a bit about the particular qualifications that you look for in counselling staff and any difficulties that you might experience with recruiting people with the right skill sets?

MS MAXWELL: Sure. I might have to get you to --

MS NORTON: Of course, one at a time.

MS MAXWELL: Basically, the counsellors that we employ, the essential qualifications is either a degree in social work, psychology or counselling, and usually they need, you know, a few years' experience in the field and be quite comfortable and knowledgeable around trauma-informed practice, so it's quite a rigorous interview and

recruitment process.

In terms of difficulty recruiting, probably about seven years ago, yes, but probably the last three years we actually have people approaching us from interstate and within the state wanting to work for us and our retention rate is extremely low. So, we've had staff there that have worked for over 10 years and it's not uncommon.

MS NORTON: Do you have any sense of why that has shifted in more recent years, the ability to attract staff?

MS MAXWELL: Yes. We've worked really hard on our culture internally. We're a very flexible workplace, hence the reason why most of the staff are part-time, given the nature of the work, and sometimes we've had staff that have worked for us for four days, then they need to take a little step back so they go back to two days and get some other work and then they're ready to step back in, so it's really important for us that we have a really flexible workplace around that.

We've worked really hard on building a framework where staff can see that there's options for progression and more experience and stepping up into leadership roles, and it's just a great place to work and the staff often comment, especially the new staff coming in and can see why there's lots of experienced staff there that don't want to leave, so we really pride ourselves on culture.

MS NORTON: Ms Maxwell, in your statement you say that an average caseload for a full-time employee, accepting that most of your employees are part-time, but an average caseload for a full-time employee is 30 clients. Can you give the Commissioners an idea of whether that's a manageable workload, whether it's high, low, in the scheme?

MS MAXWELL: Well, the average of 30 is manageable. At the moment we're asking them to have more than that because of our wait list. So, you know, there are tensions with that and we have to be aware that there are stressors placed on our staff as a result.

Quite often - we did some benchmarking interstate and other services usually have KPIs of four clients a day, whereas we only have three because of the case management and the complexity of the trauma and the stories the staff

need to hear. We made the decision a few years ago that three was more than enough and the extra work in terms of case management, notes, reports for courts, things like that, also take time.

And, I was really conscious early on in my CEO role that staff were staying back late catching up, so we felt it was really important that they did it in work time and not be expected to work longer hours.

MS NORTON: That sounds like a very employee-friendly policy; has it had implications for wait lists at SASS?

MS MAXWELL: Yes, it has. I think over recent years with our primary prevention work and the fact that we've spent a lot of time promoting our service, and Sexual Assault Awareness Month which has just finished, that's been running for three years, people know that we're out there now, and COVID's had a big impact on us.

So, for instance, over the last six years we've increased our referrals by 162 per cent, and in the last financial year, not counting this one we've almost finished, of that 162 per cent, 44 per cent was in that one year, and we've already exceeded that this year.

MS NORTON: You may not be able to answer this question, but can you give the Commissioners any idea about what your current wait list looks like and how long a priority or a less urgent referral might sit on the wait list?

MS MAXWELL: Sure. We prioritise children, so there's very few children on the wait list, and when I talk about the wait list, it's not like other services where they sit there until there's a counsellor. We have intake and crisis workers who are in constant communication with clients. We offer crisis appointments and help them regulate their trauma responses, and they can call us 24/7, so it's not like they're just sitting there.

But, to answer your question, we've probably got at the moment around 90 on our wait list, and depending on when we exit other clients, sometimes they're waiting six to eight weeks to access a counsellor - allocated to a counsellor.

MS NORTON: But in the meantime they will have access to

24/7 counselling that's available to anyone?

MS MAXWELL: Absolutely, and crisis appointments, yes.

MS NORTON: Can that present difficulties for somebody who comes forward who's dealing with complex trauma and would like to be allocated to someone to work therapeutically on an ongoing basis, can there be difficulties in having access to a one-off crisis appointment where you effectively open Pandora's box and you don't know what's going to come out?

MS MAXWELL: Yes, it can. I'm not a counsellor and I don't know what happens behind those doors in terms of a therapeutic response, but I do know that, you know, quite often I hear the counsellors talking that clients don't have to tell the whole story, they can just talk about how to regulate their responses, and the counsellors sit with them and do a case management plan on the outcomes that they want. So, it's very diverse and client-centric, but in terms of the crisis appointments, they're really about just helping them regulate and keeping them in a holding pattern until they're allocated.

MS NORTON: Thank you. And, forgive me, I should know this, but where are your offices based? I know you've got one in New Town; do you have other offices around the state?

MS MAXWELL: Yes. We have - our main office is in New Town and we have an office in Burnie, but that's for redress, and we have an office co-located with Mission Australia who are our partners in delivering the Harmful Sexual Behaviours Program where we have a worker located there.

MS NORTON: Whereabouts is that, sorry?

MS MAXWELL: In Launceston. We also have two workers co-located in the Community Health Centre at Huonville. We have outreach where we have counsellors from New Town going out to the regional areas.

MS NORTON: Focusing on the support services that you provide, not in relation to harmful sexual behaviours, I'd like to come back to that or the redress services, but therapeutic support services: is access relatively even

across the south of the state or are there people in some parts of the south that have greater access issues?

MS MAXWELL: In terms of access issues, I know that people struggle with transport, so we actually provide free bus tickets or taxi vouchers for them to come to our service. And, sometimes we work with other services that might be engaged with the client and our counsellor will actually go out to that service so the client can access support with our counsellors there so they don't have to travel in. But, I mean, that takes time. You know, when we've got a counsellor travelling, say, to the Southern Midlands, it might mean they only see two clients for the day and not three, so it does impact our service, but we feel it's really important that we go somewhere where the client feels safe and accessible.

MS NORTON: Thank you. Ms Fordyce, if I can come to you. So, Laurel House is to the north and northwest, what SASS is to the south. Can you talk about your services offering, whether it's comparable to that offered by SASS?

MS FORDYCE: Yeah. So, in lots of ways lots of the things that Jill has said apply in the north and the northwest. We have three offices, one in Launceston, one in Burnie and a small satellite office in Devonport, and similarly we have counsellors based in those locations that are providing specialist trauma counselling for victim-survivors of sexual assault, including victims of child sexual abuse, and the secondary victims, so family members and other people that have had victims disclose their sexual harm.

Our team, like Jill's, is comprised of degree qualified social workers, psychologists and degree qualified counsellors. We have, as a senior management team, determined that we may if an appropriate person approached us or applied would consider employing a mental health accredited occupational therapist to add to the kind of diversity of the counselling team, but at this stage occupational therapists and psychologists being in short supply, it's much more difficult to attract those people.

So, our team, similarly we're offering that counselling support both in our offices but also within outreach locations in a range of locations: George Town, Beaconsfield, Olveston, Smithton.

We have had some challenges at times accessing or offering outreach supports in some of the more remote locations, so on the West Coast in Circular Head on as frequent a basis as we would like it to be on the East Coast and on the islands, and certainly that's something that, as soon as we're having any challenges with an increase in referrals or some movement of staff, that it becomes more difficult to provide those outreach supports because, like Jill said, you might be travelling for two-and-a-half hours, three hours, if you're heading to the West Coast to see one or two clients; but obviously, we're really cognisant of the fact that people may have experienced sexual violence within the context of their home environment - not that that's relevant to this inquest - but they may not have a safe environment in which to participate in phone or online counselling, and so, outreach services play a really important role in that kind of local support.

Like SASS, we would offer support and counselling within environments where someone feels comfortable, particularly for children where perhaps ongoing access to counselling would be limited by having to come to our site for counselling. So, we have good relationships with a number of schools across the region where we might provide counselling on site in an appropriate location, which reduces the need for children to have their parents engaged in the process of participating in counselling, but also allows them to kind of not miss out on school in seeking support for the trauma they've experienced through child sexual abuse.

MS NORTON: Thank you. Are you able to comment on average caseloads? I don't think that's in your statement, you may not have that information to hand, but to the extent you're able to comment on how they might compare to SASS, that would be helpful.

MS FORDYCE: Sure. Certainly, like Jill, the majority of our counsellors work part-time and we do find that that's a really common experience because of the complexity of the caseloads, because of the nature of the work. Our counsellors often either work part-time or hold another position in perhaps a less challenging environment in their other days where they're not working for us.

Typically our counsellors would see between three and four clients per day, but then that would differ on other days where they might be doing outreach and seeing two clients per day.

I wouldn't be able to say specifically what that equates to in terms of the number of clients on a caseload for an individual person, but could come back if that needed to be.

MS NORTON: Thank you, that's been helpful. You say, Ms Fordyce, in your statement and it's consistent with Ms Maxwell's evidence, that Laurel House prioritises children.

MS FORDYCE: Yes.

MS NORTON: And as at 31 March of this year there were 44 people on your wait list: 30 in the northwest and 14 in the north. As an aside, is it fair to infer - that's a snapshot in time - but is it fair to infer that access is a bigger issue in the northwest than it is in the north?

MS FORDYCE: It can vary. So, the current data as at the end of April is 40, so not significantly different. The north, we have more demand for service, it's more population and we have more demand. We probably have had over time more difficulties with recruitment and retention in the northwest, and so, we've been through a period of recruitment over the last six months and that has then led to the fact that we've been a little under-staffed in the northwest comparatively to the north and have been providing support to the northwest from the north, so having staff travel up to provide support in Devonport from Launceston.

We've now got a number of new staff that are reaching capacity because, like Jill, we're really cognisant of not - this is a really difficult space to work in and providing people with adequate training and supervision and support, and slowly taking on a caseload in order to not burn them out, we want to retain people in this sector, people that are passionate about supporting victim-survivors, and so, that's very much the work that we've been engaged in and so we're seeing I guess the fruits of that now with the number of staff that we've put on in the last little while kind of reaching their

capacity. I expect in the next few weeks that that difference between the north and the south will level out - the north and the northwest, apologies.

MS NORTON: If we just take - so, you said it's 40 on the wait list presently. Do you know whether there would be any children on the wait list currently?

MS FORDYCE: There would be but, like Jill, we would prioritise children ahead of adults even if there were adults that had significant consequences as a result of their sexual violence, so the wait times for children are much less than they would be for adults.

MS NORTON: Are you able to give - you may not be, but are you able to give the Commissioners any idea of what you would expect an average wait time to be for a child on the wait list?

MS FORDYCE: No, I have overall, but I could get that information for the Commission. Overall our children are always prioritised as high, and at the moment with our April data, in the northwest the range of time that people have been waiting in the northwest is between 22 and 33 days, and in the north the range of people that have been prioritised as high is between 1 and 10 days that they've been on that wait list for counselling. All of those clients, like Jill's team, have had an initial appointment with an intake and assessment team, they've had ongoing contact from our team in terms of regular check-ins, and they're also able to, like Jill's team, seek a crisis appointment or to dial the 1800 number and get immediate support 24-hours a day.

MS NORTON: Thank you. You say in your statement, at paragraph 23, that the wait lists at Laurel House are much better now than they were a couple of years ago. Are you able to explain to the Commissioners why they've improved?

MS FORDYCE: I think, certainly one component of that is that the Department of Communities provided some additional injection of funding to Laurel House and also to SASS for the FY21 year. We also had received some additional funding in the year prior to that in relation to additional injections because of COVID and the recognition that during COVID there was an increase in sexual and family violence, so those additional staffing - additional funds to support

staffing is certainly part of the picture.

I think there would potentially be some - there's been quite a bit of movement in the Laurel House team and I think it takes some time for people, like I was mentioning before, to be at their capacity and to be being able to move through caseload in a way that addresses the wait list. So, I think in the last - since I've been the CEO we've done quite a lot of recruitment and the expectation is that we'll be able to kind of keep those wait lists as low as possible, assuming that we don't see dramatically more increases in referrals, but sadly that seems to be the pattern and, like Jill, we've seen considerable increases in referrals year-on-year over the last five years.

MS NORTON: Can I ask you - I'll just throw this question open to both of you - can you speak to the Commissioners about the importance of timely access to support services for survivors, and in particular survivors of child sexual abuse?

MS FORDYCE: I guess we know that victim-survivors, that that first contact that they have or after their first disclosure, the need to provide support and to help them understand what they're experiencing can help to set them up to be successful in their interactions with police, with the medical fraternity, with their family, and a lot of what our team do is support victim-survivors, whether they're children or whether they're adult victims of historic child sexual abuse, has helped them to normalise their experience and to help them understand through psychoeducation that their experience is to be expected when they've experienced something that is not normal.

And so, I think that that support that's provided in those early days that helps them realise that, however they're responding is okay, however they're responding is normal, and that there are people here to help, can just set them up to be much more successful through the course of their recovery.

MS NORTON: Do you have anything you'd like to add, Ms Maxwell?

MS MAXWELL: Yes. I would add that, given that we were a service delivery during the Royal Commission as well, that one thing we noticed, and we still have clients as a result

of that, that over the years if they're adults now and they've been victims of institutional sexual abuse, that the stories that we hear of the amount of times they try and seek help and disclose and either feel not heard, believed or silenced, if they're seeking support from a service like ours and they can't access a counsellor for some time, it's just another story they have of delays and feeling unheard and unsupported, so I think it's really important that they have access quickly.

MS NORTON: I suspect that you would both ideally like not to have wait lists at all. What would it take to reduce your wait lists to zero? Is it just a matter of funding or is it more complex than that?

MS MAXWELL: For us, we've got a budget submission in, so fingers crossed for the budget later this month, but in that we outline the extra funding we need. We haven't had an increase in core funding that I know of, particularly over the seven years I've been there and even prior to that. Given that our referrals have gone up 162 per cent, I think it's really important that that budget submission is treated seriously. We've outlined that we can get the wait list down to below 10 with the extra increase that we're asking for.

But I personally feel that the impact that, if we are really serious about primary prevention, and our mission at SASS is to eliminate sexual violence in Tasmania, we'll only do that through education and having a community that feels comfortable talking about consent and talking about sexual violence, but I guess the other end of that means - and we've seen this - that our statistics go sky high because people that haven't been able to talk about that or haven't been able to access a service or know that there's a service there to support them do and they access it, which is really, really important.

So, I think in the short-medium term we'll see increases, and I think it's important that we collect that data in a way that we represent that to government and they're responsive to that, but in the long-term hopefully with investment in primary prevention we will see it go down

COMMISSIONER BENJAMIN: Ms Maxwell, just to help me out, you've talked about the figures. You've said there was no

increase in core: do I take it that it increases in accordance with the 2.5 per cent or whatever government does each year, but whilst your numbers increased by 160 per cent, the core remains pretty well as it is; is that the effect of that?

MS MAXWELL: Yes, correct, yes.

COMMISSIONER BENJAMIN: And then you get special funding for other bits and bobs?

MS MAXWELL: Correct.

COMMISSIONER BENJAMIN: But it may dry up at the end of the period.

MS MAXWELL: Yes, well, there's a lot of work to be done approaching the three-year contracts to ensure that we still have funding to deliver services and keep our qualified staff, so there's a lot of work involved.

COMMISSIONER BENJAMIN: Ms Fordyce, I note you're nodding your head as well; does that apply?

MS FORDYCE: Yes, Jill's been in her role longer and understands the history of the funding. Similarly I imagine our funding has been the same in terms of no increase in core funding, but these last few years we've had this top up one-off funding given to us by the State Government that has allowed us to address - and Jill got some of that funding as well - has allowed us to address kind of part of the increases that we're seeing, but yeah, we definitely, like SASS, would like an increase in our core funding.

COMMISSIONER BROMFIELD: Just to follow up from that, I believe that there were some challenges in terms of staff attraction and retention when it is annual one-off funding.

MS MAXWELL: Well, I mean, you know, while we're appreciative of any money we get, and the one-off funding we got last year from State Government was great and it hugely helped, but staff - until the budget's released and we know whether that's continued, staff worry about their roles, yeah.

MS NORTON: Thank you. I'd like to now ask you some

questions about institutional child sexual abuse which is, of course, the focus of this Commission of Inquiry, and I do so appreciating that your clients presumably, your institutional clients, comprise both children who have made recent reports of child sexual abuse and adults who have come forward as adults to report child sexual abuse during their youth.

Are you able to each give the Commissioners a sense of the proportion of your clients who come from a background of institutional abuse as opposed to another type of sexual abuse or setting?

MS FORDYCE: I can certainly make some very basic assumptions.

MS NORTON: Thank you.

MS FORDYCE: So, I guess implementing a trauma-informed approach, we sometimes don't - or quite often don't ask for the specifics of the perpetrator or the location of the abuse; the focus, I guess, of the trauma-based counselling is really to support the sequelae of consequences of the abuse, so sometimes that means we don't have the specifics of who was the perpetrator.

The data that we have for people that are currently accessing our counselling is that we only have data about the perpetrator in 53 per cent of the cases, and only a small subset of those have indicated perpetrators that are from institutional settings. So, we could certainly do a lot more analysis and get to more detailed figures, but it is a much smaller subset than sexual abuse of children that is occurring by known perpetrators that are within family settings or within other contexts.

MS NORTON: Thank you, and Ms Maxwell, is it a similar picture at SASS?

MS MAXWELL: Yes, it is, yes.

MS NORTON: Can I ask you both to speak, to the extent you are able to, about the particular impacts that institutional child sexual abuse can have on a child both as children and through their lives and comparing it, to the extent the comparison is available, comparing it to abuse in other settings?

MS MAXWELL: I think that's difficult because it doesn't matter what type of sexual abuse somebody experiences, it's extremely traumatic and the trauma that they experience, whether it's high or low, is right for them. But in terms of the child sexual abuse particularly in institutions, I know for our service over the years we provide a service to Risdon Prison and we started off with a counsellor just visiting part-time over there and it's grown so much we've got three counsellors almost full-time going to the prison to provide services to prisoners that have been victims of child sexual abuse in particular and, as a result of that abuse, they're finally seeing that the choices they've made in their lives have resulted in where they're living at the moment. So, it has a huge impact on their lives and quite a lot of the ones that we've seen were victims of child sexual abuse within Ashley historically. So, there's a lack of trust with institutions, a lack of - high dependency on drugs and alcohol to cope with their trauma, and hence the life of crime, so yeah, it has a big impact.

MS NORTON: Ms Fordyce, anything to add, and in particular in relation to that idea of institutional betrayal and the compounding effect that that can have on a victim-survivor?

MS FORDYCE: Yeah, certainly I think any victim of child sexual abuse has an experience that somebody that should have been caring for them, that somebody that was an adult and that should actually have the best interests of children at the heart of their interactions has betrayed them and I think that for the victims of child sexual abuse within institutional settings, I guess there's sometimes some solace in that it wasn't a family member; you know, it wasn't somebody that you necessarily have to maintain an ongoing relationship with, which in some cases in familial child sexual abuse that may need to be the case.

Whereas, I guess, the distrust in institutions, the distrust then, I guess, in how that institution handled the sexual assault and then the confidence in any further systems that might proffer to offer support is, I guess, much more impacted and so that confidence that the victim-survivor may have in any institution, whether it's government or otherwise, that they will act in the best interests of that person is really damaged and can have all of the consequences that Jill has talked about.

MS NORTON: Ms Maxwell, in your statement you talk - I'd like to talk about some issues that arise in particular institutional contexts, and you mentioned before Ashley Youth Detention Centre. In your statement, at about I think it's paragraph 55, you talked about the need for community-based organisations to have in-reach, if you like, to provide therapeutic treatment to young people in institutions like Ashley. Can you talk about the reasons why that's particularly important?

MS MAXWELL: An example is how we've developed over time a working relationship with, say, the prison, and that took, you know --

MS NORTON: Sorry, Ms Maxwell, I'll stop you there. This is the program in relation to Risdon, the adult prison?

MS MAXWELL: Yes, that's correct, and that took several years of developing trust, not only with the staff there and establishing our credibility, but also with the inmates themselves, and most of our referrals from there now are through word-of-mouth.

Over the years we've had clients come to us as a result of being victims of child sexual abuse within Ashley, and that can be historically or, you know, as recent as the past five years. And, I can't see why a detention centre for young people can't work in a similar model as to one for adults, where they allow specialist organisations like us in to work therapeutically with the survivors in there, and that way they're developing that rapport and relationship with our counsellors, so when they're released from the centre they've already got that and they're not having to wait until they're released to engage, because it just doesn't happen. So, I just feel quite strongly that there should be specialist services being able to access and having the young people referred to those services and going in and supporting that.

MS NORTON: It sounds like you can't see an in principle reason why that in-reach model couldn't be available through Ashley or indeed one of the new centres that's due to replace Ashley?

MS MAXWELL: Correct.

MS NORTON: You say in your statement that you've offered

in-reach services to Ashley over the years but those offers haven't been taken up. Do you have any insight into why?

MS MAXWELL: No.

MS NORTON: Ms Fordyce, do you have any comments you'd like to make about provision of services within Ashley? I know that you talk in your statement at paragraph 66 about a program that Laurel House recently ran at Ashley in relation to harmful sexual behaviours; would you like to tell the Commissioners about that?

MS FORDYCE: Yeah, sure. I think, in relation to Ashley and any Out-of-Home Care setting and, you know, potentially youth detention in the future, I think what needs to be recognised is that children often don't disclose sexual abuse until they're older, and I think that there needs to be a focus - I know that Michael Salter talked about this yesterday - around secondary prevention and recognising that there is a subset of members of the community, young people, that are at higher risk of having either experienced sexual violence, sexual abuse, or likely to experience sexual abuse in the future either in an institutional setting or from their peers in an institutional setting, or in future relationships, and I think that it's really critical that that therapeutic support is offered to address the range of needs of young people.

I think the program that we offered was not specifically about harmful sexual behaviour, it was more about kind of exploring consent, exploring inappropriate sexual behaviour, talking to the young people about, you know, how they may best interact with their peers and with others; more of a primary prevention focus than specifically addressing, you know, developing a plan about harmful sexual behaviour in the sense of how other harmful sexual behaviour programs would be addressed.

I think in that setting the feedback was really positive, that the staff appreciated the opportunity to have other people provide perhaps some of the same encouragements and coaching that they may have been offering around appropriate interactions with peers and with staff, and I think that openness that members of our team, and I imagine Jill's team, in being able to talk frankly and fearlessly with young people about their rights

about consent, about what's okay and what isn't, as well as then doing that in a trauma-informed way that provides them with pathways to support, that that kind of holistic wrap-around support that's not only addressing the support needs of the young people but it's supporting the other people that are supporting the young people, so every opportunity throughout a day is a learning opportunity or an opportunity to reinforce those good messages about consent, because that kind of sheep dip approach of going in and providing a program and then leaving, and then not building the capacity of the people within that service, whether it's a school or Ashley or any service, is having everybody talking from the same song sheet and supporting children and young people and the staff around the expectations, is what I believe is really critical.

MS NORTON: It sounds like you would agree then that there's certainly scope for more interaction between external services and Ashley Youth Detention Centre?

MS FORDYCE: Absolutely.

MS NORTON: Can I ask you both about conflicts of interest in small communities; this is possibly a bigger issue in the north and northwest, though I'm sure it comes up in the south as well. How do services like yours deal with - I'll just give you a hypothetical. We'll be hearing later in the Commission's hearings about James Griffin. Now, he was a very well-known person within the Launceston community. If, say, at Laurel House you had somebody come forward, a victim-survivor come forward to one of your counsellors and disclose, and that counsellor happened to know Mr Griffin, or indeed any perpetrator, how would that be dealt with at Laurel House?

MS FORDYCE: Because all of our counsellors are degree-qualified and typically they're registered with their professional organisation, they're all bound by Codes of Ethics in relation to how they may declare conflicts of interest, and then we obviously have within our own organisation conflict of interest policies that make it clear that people need to disclose in an intake meeting.

So, typically we would receive a referral. What would happen is, the nature of the victim-survivor, you know, who they are and who their parents are and what details we know would be talked about with our counselling team. If people

know that particular victim or their family or have got some kind of association with the perpetrator, they would not be allocated to that client.

So, often as much information as we can have at that intake point is really critical because, particularly in northwest Tasmania, and we've got a number of counsellors that have been lifelong northwest residents, so they are connected to the community and know lots of people, so there's lots of very careful monitoring of that.

Also then, as the therapeutic relationship emerges we may get more details about a perpetrator or other relationships that become, as the victim-survivor feels more comfortable to share details, we may become aware that a conflict of interest exists and at that point our counsellors would use their judgment as to whether that moment is an appropriate time to have that disclosure; they would typically try and wrap up a conversation and then they would seek support from the seniors in the team as to how we're then going to manage that moving forward. And then that most often would then involve a discussion with the client about the conflict of interest but in a way that's kind of managing the level of distress and providing reassurance around our role and our professional responsibilities in relation to being confidential and not sharing any information that has happened in counselling.

Our counsellors would provide information at that initial stage in terms of what the limits of confidentiality are as well, particularly I guess when we're working with young people, children and young people, where we have mandatory reporting obligations. Those conversations are had with young people very early in the interactions or with parents of children very early on so that they're aware that there may be times that we need to share information that has been talked about in a session, but certainly that that would not involve engaging with sharing any information with perpetrators that they might disclose in an appointment.

MS NORTON: Thank you, and Ms Maxwell, anything you'd like to add about conflicts of interest?

MS MAXWELL: Well, I support what Kathryn said. We're pretty clear at SASS that the client is our focus. So, we have safeguarding children and safeguarding adult client

policies. Counsellors have case reviews regularly with their senior practitioner. Similar with intake, you know, the more information we get, we try and allocate to the appropriate counsellor. So, we have a pretty rigid process in terms of, what we do is for the client. So, if we saw a conflict of interest, we would act in the best interests of the client rather than anybody else.

MS FORDYCE: If I may?

MS NORTON: Yes.

MS FORDYCE: I guess some of the challenges that we've experienced in regional and remote locations often relates to the challenge that we have in terms of trying to create access to service, so by having, say, outreach at a location that would be accessible to clients, but then maintaining the confidentiality of those victim-survivors.

So, [redacted] one of our counsellors engaged with a man who was Aboriginal. We indicated that we might be able to offer outreach services in a location that would be more culturally sensitive for him, and he indicated that that wasn't something that he wanted because there was, you know, I guess a risk in that, that people may be alerted to his experience of having experienced child sexual abuse. So, there's a really fine balance around that, and I guess in regional and remote areas that experience in reporting to police as well, in terms of, often police, you know, they're connected.

You know, when somebody parks their car outside the police station in the small regional and remote locations, people know whose car's whose, and so some of those things are not as anonymous as victim-survivors may want them to be initially, and I think there's also a real balance for us around wanting to create an environment where victim-survivors know that it's not their fault and that they don't have to be ashamed to come to a service that has Laurel House on the door or is about them seeking support for the sexual harm they've experienced, but also maintaining their anonymity while they need and want that anonymity. So, yeah, the regional aspects are much more complicated in that regard.

MS NORTON: Understandably. That probably leads in quite nicely to another topic that I wanted to discuss, which was

Multi-Disciplinary Centres. It strikes me in what you're saying that having a one-stop-shop to access a range of services might be one way to overcome some of those barriers concerned with anonymity.

I know, Ms Maxwell, you talk about the importance of Multi-Disciplinary Centres in your statement, would you like to elaborate for the Commissioners?

MS MAXWELL: Sure, it's a little bit redundant now given the recent announcements by government, but they've agreed to establish two centres at this stage here in the south and the north. We've been advocating for this for probably six out of my seven years in SASS. I was fortunate enough to go and look at some of the centres in Victoria many years ago, and so, government have now committed to the Multi-Disciplinary Centres.

There are so many advantages as you're probably aware, but for me it's how a survivor can walk through the door accessing our service and, working with a counsellor - and sometimes, you know, it's taken us several years for a person to be ready and want and choose to report to police and seek justice through that process, and to navigate separate buildings, separate suburbs, different people all involved retelling stories; that doesn't happen in a Multi-Disciplinary Centre, that all happens with ease - well, that's the idea of it. So, we are huge fans of this.

My only concern is that the funding for the Multi-Disciplinary Centres, if they're going to be state-of-the-art and house the appropriate services, I'm not sure the funding allocated at the moment will do that, but hopefully through the pilot that will highlight where more money needs to be spent; but, yes, that's already been announced, so very excited.

MS NORTON: I'm sure. One potential model as I understand it that's being considered would see a single Multi-Disciplinary Centre for victims of sexual abuse, child abuse and family violence: do either of you have any comments or concerns about the co-location of services for people in those different cohorts?

MS MAXWELL: No, I don't, no. You know, the centres on the mainland, all the Sexual Assault Service, the Support Service, is co-located. I'm not sure that will happen here

given that the money committed, we might not be able to do that, which is a concern for me, but I'll go with what I've got. But on the mainland they've got all their service. So, for instance the one in Geelong, they've got the whole Sexual Assault Service in there, and then they merged with Family Violence, they've got police, Child Safety, so I don't see any issue with that at all.

PRESIDENT NEAVE: There is one issue that I perhaps might ask you to comment on in relation to that, and I'm familiar with the MDC in Geelong.

One concern is that family violence can swamp the sexual assault area because there's more family violence than there is sexual assault, or at least child sexual assault; did you want to make any comments on that?

MS MAXWELL: Sure. I think it's going to be really important that we're aware of the learnings. For us, it's really important that we are seen as a specialist service outside of family violence.

PRESIDENT NEAVE: Yes.

MS MAXWELL: We've got probably a quarter of our clients that experience either currently or historically family violence where sexual assault's been intertwined in that, but there's so much external, so I think it's going to be really important that we work and be conscious of that up-front.

PRESIDENT NEAVE: Right, okay. Thank you.

MS NORTON: Ms Fordyce, I wanted to ask you a question. You said Multi-Disciplinary Centres are one way in which trauma-informed practices can be used. You also give an example in your statement of a great example of trauma-informed policing. You don't need to worry about getting all the detail right because, of course, it's in your statement, but if you could give the Commissioners an overview of that particular interaction and why it was so beneficial for your client?

MS FORDYCE: Sure. I guess that the circumstance happened in the northwest Coast, and I think that the nature of small numbers of staff in our team, small numbers of police, we're able to establish really strong working

relationships in a way that means that it is very common that police will come and take statements at our building when, like Jill has mentioned, you know, after considerable contact with our counsellors a victim-survivor is ready to do so.

And so, in this particular instance I had a previous knowledge of this particular client and the counsellor was absent, so I sat in on this police interview, which would be quite unusual given my role usually. But the experience that I had was that this particular police officer offered choices throughout, you know, spent a lot of time engaging with this particular individual who had a disability around their interests throughout requested consent, to where the police officer sat, just at every point the principles of trauma-informed care were being undertaken.

The police officer was really clear about their choices, really clear about their role, and did so in a way that immensely respected the person for their bravery, told them that they believed them, that they were going to investigate this further, and created an opportunity for that particular victim-survivor to disclose some historical sexual abuse that the counsellor was not aware of, you know, so the nature of that exchange was incredibly powerful to see, somebody who is working within the constraints and the processes of the police system but doing so in a way that is bringing all of that learning into how to really create a trusting and respectful relationship and a relationship that gives the power back to the victim-survivors where they, through the abuse, have lost some of their power.

MS NORTON: Ms Maxwell, I'm interested to get your comments on that, particularly having regard to your experience, your past experience as a police officer. Do you have anything you'd like to say to the Commissioners about the importance of trauma-informed policing and perhaps, you know, what the dangers are where a trauma-informed approach isn't taken by police.

MS MAXWELL: Oh, that story warms my heart. I mean, I know that, given my background, I've worked with our staff to talk about how when we're present with interviews with police that we can support that trauma-informed process, and the majority of the time it's a similar experience.

You know, in my experience as part of SASS, not part of my previous occupation, is that police are so committed to justice for the victims, they just have a different role to play to our service and our staff and when it's done well, which is most of the time, the survivor feels empowered to tell their story; whether it's the outcome down the track that they may expect or not, I feel it's really important that those relationships between our staff and police - it could be Child Safety, it could be anyone involved in the story of that survivor - works collaboratively for that survivor and in my experience that happens most of the time.

MS NORTON: Thank you. I'm conscious of the time. I'd just like to ask a few questions about therapeutic interventions for harmful sexual behaviours.

Commissioners, we will be having another session on this next week with Ms Maxwell's colleague, Ms Pepper, so I'll leave a lot of the content for that, but I would just like to understand a bit about the delineation of service provision in the state currently.

As I understand it from your statement, Ms Maxwell, SASS recently, a year or so ago, received funding for a two-year pilot whereby you funded to provide therapeutic interventions among other supports in relation to harmful sexual behaviour statewide. Is that correct?

MS MAXWELL: That's correct.

MS NORTON: How does that differ from your service offering for therapeutic interventions prior to the funding being provided?

MS MAXWELL: Prior to the tender for harmful sexual behaviours as a stand-alone program we were funded to provide a program for children up to the age of 11 that were impacted by either problem sexual behaviour or harmful sexual behaviours, but we increasingly saw that those from 12 to 17 impacted by the harmful sexual behaviours had nowhere to go, or the ones committing or perpetrating those behaviours, had no treatment program and we felt it was really important and advocated for some time.

We probably over the last four years had our staff trained under the AIM Project which Ms Pepper will talk at

length about no doubt, and it's the best practice model from the UK, in anticipation that there would be a program eventually for those up to the age of 17. And, thankfully there was.

For us, we've got a whole program that delivers that statewide. We can't advertise that fact at the moment because it's a set amount of funding and we're at our capacity with that now. And, we've only got until April next year before we know whether that's continued, so it's a similar funding model; it's difficult when, you know, it's short funding. We set up programs like this not knowing whether they continue, but fingers crossed, there's certainly a need for it and we're really proud of the work that we do with it.

MS NORTON: Can I ask you: having a statewide remit obviously allows you to provide continuity of service throughout the state, which is a positive. Do you have any concerns about access issues for people in more remote areas? If you have a young person in Stanley on the northwest coast, do they have access to the same sorts of therapeutic interventions as a peer in Hobart, for example?

MS MAXWELL: Yes. We have a worker that's based in Launceston that travels across the coast, and I know she does home visits and visits with other services and meets young people. But, like I said, we're just relying on the fact that people are aware and the referrals are coming through. But, if the referral's picked up, there would be issues with access, yes.

PRESIDENT NEAVE: How many young people in that 12 to 17-year-old age group, how many are you able to include in that program?

MS MAXWELL: Ms Pepper would be able to answer those questions, because she's the one that actually oversees and directs that program.

PRESIDENT NEAVE: Thank you.

MS NORTON: I'd just like to give you an opportunity to comment, Ms Fordyce. I understand from your statement that Laurel House also provides therapeutic interventions to children and young people in the north and northwest; how does your service provision interact with the offering that

SASS provides?

MS FORDYCE: Yeah so, like Jill said, historically the funding has allowed us, I guess, to a certain extent to provide support for children under 12 who exhibit harmful sexual behaviour or problematic sexual behaviour. I guess there are circumstances where we might engage with that funding, may still be providing support to slightly older children or children with a disability who perhaps have significant delays and where we've got a therapeutic relationship, so we may continue to engage with them in delivering support in relation to their harmful sexual behaviour and in relation to providing support and education to the people around them, the parents and teachers and others.

Certainly with the introduction of the new funding that SASS was successful in receiving, you know, it does address a gap that was really significant, and our team's experience was that the support was really ad hoc for children aged 12 to 17; you know, people didn't get the support - young people didn't get the support they need, teachers and families didn't get the support they needed in order to feel that the children's needs were being addressed and the needs of their peers were being addressed.

I guess, because the program is new, the SASS program is new, there's still some interface challenges that we're still trying to work out and work through because, you know, some children who are exhibiting harmful sexual behaviour at 14 may be clients of Laurel House or they may, through the harmful sexual behaviour program it may be identified that they've experienced sexual harm and ongoing support might need to be offered by Laurel House, and so, there's still some work to do which is not a surprise. When any new program that comes into an existing service system is, how do we do those referrals and how do we work out the interface.

I mean, I certainly would be keen to see, and we're working to have our team trained in the same AIM model and to build some consistency across the state, that a lot more funding be offered across the state and that Laurel House too would be able to offer services in this space, I guess in particular because we know that delivering services in the regional and remote parts of the state are already

difficult enough, so being able to develop relationships with schools, with the communities, us being able to when we're already in Smithton delivering services be also able to do some of the other supports, I think, would be really advantageous and would benefit the community and particularly teachers and families and the young people.

MS NORTON: Thank you. Commissioners, that concludes the questions I had for Ms Fordyce and Ms Maxwell. If there's anything you'd like to ask?

PRESIDENT NEAVE: Thank you.

COMMISSIONER BENJAMIN: Very briefly, Ms Maxwell, you told us about the arrangements and the trouble you had to get - not trouble, that's the wrong word - but the negotiating you had to get into Risdon. If and when the State Government sets up the two new Ashleys, excuse the expression, is it your view that access by you and Laurel House, entitled access, would offer another and better level of protection for the young people in those institutions?

MS MAXWELL: I'm not sure about better level of protection; I think Child Safe Organisations, we all have a responsibility if we're engaging with children no matter what, so I don't think that would be up to SASS to say to another organisation they're not fulfilling those obligations. I think, having --

COMMISSIONER BENJAMIN: I think you misunderstand my question, I'm just thinking that there might be another level or another degree of protection; they would have their own protection, but having someone independent going there, would that be advantageous to those young people?

MS MAXWELL: I think our role would be to go in if there was a young person that needed our support in relation to experiencing either harmful sexual behaviours or sexual assault, so I think that's what our role would be.

PRESIDENT NEAVE: So, it would be to offer trauma-informed counselling to children who are in those places that needed the help, yeah?

MS MAXWELL: Absolutely and, you know, as with any client, if there's advocacy and other work to be done, we would

engage other stakeholders in that, but yes.

MS FORDYCE: If I may? I think that, with respect to Jill, I think that it is bigger than that. I think that there is a role for SASS and for Laurel House to play in creating environments where children are able to disclose and that the visibility of people that are trusted, either being in there delivering consent education or being in there, you know, consulting and advising and training, or just being visible - not on the basis of a referral but being present and being on site, so that almost I guess it's kind of professional loitering, is kind of the term that we used to use as speech pathologists; you know, you would be at a child and family centre and you would just professionally loiter in the hope that you would be there to catch a moment.

And so, I think that that visibility helps to promote children and young people to disclose, but it also then allows I guess a level of, not oversight, but it's sunlight, I guess: that, you know, you're there and things that may happen where there's not an outsider present may not happen if there's an outsider present, and so, I think that there's a role that we as our services could play in those kinds of services moving forward.

PRESIDENT NEAVE: What about a role in educating staff?

MS MAXWELL: Yes.

MS FORDYCE: Absolutely, without question.

COMMISSIONER BROMFIELD: Actually, on the topic of education: Ms Fordyce, I believe it was you who used the sheep dip analogy about consent, education and respectful relationships education, and you noted the importance of being able to really follow up and reinforce the learning. I just wanted to ask and, Ms Maxwell, you may want to comment on this as well, whether your current funding for primary prevention in schools allowed you to do more than the sheep dip approach?

MS FORDYCE: Absolutely our funding does not allow us to do anything more than that, and in fact, it doesn't even really allow us to do the sheep dip. And I guess what happens for Laurel House is that, as soon as we've got any kind of increase in referrals, we're kind of very quickly

diverted to responding to the immediate need of the victim-survivors who have disclosed, which is certainly not where we want to be placed but it is kind of the reality of where we're placed.

So, yeah, that whole being able to work with - and I've had some really great conversations in the last little while with senior members in the Department of Education about how do we create whole-of-school cultures that help children and help parents and teachers to better understand consent and respectful relationships and people's responsibilities for, you know, how to respond to a disclosure in a trauma-informed way, how to then, you know, direct people, supporting people in relation to their mandatory reporting responsibilities, but also just in terms of ensuring that young people and children and young people get the follow-up care that they need.

So, those conversations are really fruitful and positive that we're talking about whole-school approaches rather than a sheep dip approach; that, while it may be useful for individual children and they get a lot of benefit out of that, those every day conversations are just so critical, that every interaction that adults are having with children are reinforcing their rights to their bodily autonomy and their right to articulate their consent, and addressing importantly the drivers of sexual violence which are, you know, gender inequality and addressing other inequality and really challenging those things when they occur as well.

MS MAXWELL: I guess a great example for us is that I guess about six years ago we piloted our own primary prevention consent as a conversation, unfunded with a high school down here in the south, and then used their feedback from the students and teachers to refine it and we got funding, and so, our funding allows us to go into four schools a year and that's been going for five years, five, six years. It's been hugely successful and it's one where we go in, and there's about six modules. We teach all the students and we give the teachers and health staff located at those schools a session as well so they are equipped to deal with disclosures and understand the content when we step out, and we also offer that to parents as well.

But with that particular high school, we've been going back sort of as a thank you for road testing it at the

start; we've been going back every year and doing that unfunded and the staff often comment that they've seen quite a cultural change with us going back and topping up the knowledge for those that have undergone our program, but then the new students coming in, the Grade 7s, go through the full program, so it's been really useful but it's resource-intense if we were to do that. Like, our goal would be to be in every school, but it's resource-intense.

PRESIDENT NEAVE: Did you say four schools per year?

MS MAXWELL: Yes. Under the consent is a conversation; under the harmful sexual behaviours one, there's extra schools that we do under that funding, yes.

PRESIDENT NEAVE: Thank you very, very much indeed, that was really a very helpful session, thank you, and you're excused now.

MS FORDYCE: Thank you.

MS MAXWELL: Thank you.

SHORT ADJOURNMENT

MS ELLYARD: Thank you, Commissioners, the next session is a panel involving Professor Brett McDermott and Dr Catia Malvaso, I'll ask them both to come into the witness box and take the oath or affirmation.

<BRETT MICHAEL CHARLES MCDERMOTT, affirmed: [3.22pm]

<CATIA GAETANA MALVASO, affirmed:

<EXAMINATION BY MS ELLYARD:

MS ELLYARD: May I invite you both to take off your masks now that you've been sworn in for the ease of understanding the evidence you're going to give. May I begin with you, please, Professor McDermott, can I ask you to tell the Commission again your full name?

PROF McDERMOTT: Brett Michael Charles McDermott.

MS ELLYARD: And you are, by profession, a psychiatrist and a Fellow of the College.

PROF McDERMOTT: That's correct.

MS ELLYARD: Your current roles include the role as the Statewide Specialty Director for the Child and Adolescent Mental Heath Service in Tasmania.

PROF McDERMOTT: That's correct.

MS ELLYARD: And you're also a Professor of Psychiatry at the James Cook University and the University of Tasmania.

PROF McDERMOTT: That's correct.

MS ELLYARD: You've made a statement in response to a series of questions that were posed to you by the Commission and that statement's dated 11 April 2022. Do you have a copy of that statement with you?

PROF McDERMOTT: I do.

MS ELLYARD: Are its contents true and correct?

PROF McDERMOTT: They are.

MS ELLYARD: Thank you. May I turn to you, please, Dr Malvaso, and ask for your full name?

DR MALVASO: Yes, Catia Gaetana Malvaso.

MS ELLYARD: And you're an academic and Senior Research Fellow at the School of Psychology and School of Public Health at the University of Adelaide?

DR MALVASO: That's correct.

MS ELLYARD: Your background is in psychology and you also have a doctorate; is that right?

DR MALVASO: That's correct.

MS ELLYARD: You've made a statement to the Commission dated 29 April 2022. Do you have that with you?

DR MALVASO: Yes, I do.

MS ELLYARD: Are the contents of it true and correct.

DR MALVASO: Yes.

MS ELLYARD: And you've included amongst the annexures, as indeed has Professor McDermott, a copy of your full curriculum vitae?

DR MALVASO: Correct.

MS ELLYARD: Thank you. I want to begin - and I should finally note on that point, Dr Malvaso, you've included as annexures to your statement a number of articles in which you were an author or a co-author which are relevant to the matters that the Commission is considering?

DR MALVASO: Correct.

MS ELLYARD: May I begin with you please, Professor McDermott. Some of the questions that you were asked by the Commission to answer and have answered relate to the Child and Adolescent Mental Health Service, or CAMHS, and I'm drawing your attention to page 12 and following of your statement in which you make it plain that there's a current structure but there's also a proposed structure from CAMHS that's going to include a number of improvements following a review which you recently conducted. Can I invite you to speak in summary form to the changes that are proposed arising from your review?

PROF McDERMOTT: So, Commissioners, the review found that the local Child and Adolescent Mental Health Services were significantly underfunded, and because of that under-funding and some other reasons weren't really servicing young people with complex and severe mental health problems, and there were several areas which were outstanding in their omission. One was a youth Mental Health Service, so that's individuals generally aged from 12 to 25 years, and important because that was a major transition point from the Child and Adolescent Services to the adult services, and that was a point where some people were very much lost, you know, in that transition. That's the first one.

The second one was a Forensic Adolescent and Youth Mental Health Service, and although there was the perception of the service, if you look closely it was more like one individual who did some sessional time from

Melbourne. The importance of that service is that, if you don't intervene early with people clearly on a trajectory to prison, then many of them will go to prison when there are clearly things that you can do to prevent that and put them back on a somewhat more normal trajectory.

The other major admission was a service specifically for Out-of-Home Care children, and we know from population-based research around the world that this group have very high rates of mental illness and very high rates of the outcome of - one of the worst outcomes of mental illness, that's completed suicide.

So, the main reform is to create a statewide service to make the three regional teams have the same model of care, to have a statewide leadership structure, to change the culture into one that's more empirical and evidence-based, and to bring on these three major services. There are some other smaller things like eating disorders but they're the major reforms.

MS ELLYARD: Thank you, Professor, and I'll come to ask you some more questions about some of those reforms again in a little while. Can I turn to you, Dr Malvaso, to begin the discussion. At paragraph 9 and following of your statement you refer to the concept of adverse childhood experiences, something that Professor McDermott touches on in his statement as well, and you draw a distinction between an experience which is adverse which might relevantly include child sexual abuse and trauma. Can I ask you to explain the distinction that you're drawing?

DR MALVASO: Sure. I think the simplest way to understand this distinction is to think of the adverse childhood experience as the event and the trauma as the response to that event and that response can be multi-faceted, it can be physical, it can be neurobiological, it can be expressed emotionally, behaviourally; that's the main distinction.

MS ELLYARD: And so, it doesn't necessarily follow then that a particular adverse event will necessarily have a particular consequence in the form of trauma being experienced?

DR MALVASO: That's correct. There are, you know, multiple definitions of adverse childhood experiences. Typically they refer to ten distinct life events that occur

before age 18 that include all different types of child maltreatment, physical, sexual, emotional abuse and neglect, as well as indicators of household dysfunction, so that's exposure to domestic and family violence, parental separation, exposure to parents with mental illnesses, substance abuse and incarceration, and we've seen researcher, policymakers, practitioners and the like arguing for a broadening of these experiences to include other events like experiencing living or being born into poverty, experiencing precarious housing conditions, homelessness, bullying, racism, as well as experiencing the death of a close friend or family member, and there's been some practice in terms of just adding up the number of adversities that a child has experienced and an assumption that, well, some researched evidence to suggest that a higher number of adverse childhood experiences results in poorer outcomes in health, in behaviour, especially in terms of contact with the justice system. However, we also know from research that the vast majority of children and young people who experience adversity in childhood never go on to have contact with the justice system and I think trauma and the response to these events has been used to try and understand - has been used as an underlying mechanism perhaps that is responsible for some of the increased risk associated with experiencing these adversities and engaging in things like offending behaviour.

MS ELLYARD: And so, what you say in paragraph 11 of your statement, doctor, is that one of the issues is to consider the extent to which adverse childhood experiences can be identified as the causes of clinical levels of symptoms, which is the point at which a child might come to the attention of Professor McDermott's service or a similar service?

DR MALVASO: Yes, correct, and so, there's obviously multiple ways to measure trauma and my knowledge is really around some of the instruments and tools that have been used in Youth Justice populations to measure trauma and some examples of that, trauma symptoms, checklists for children, but to the best of my knowledge none of these tools have been validated on an Australian population of children of different ages, different genders or from cultural backgrounds, and there is a lot of discussion around whether these tools are adequately capturing the consequences of developmental or complex trauma, and this

is really important because when we're thinking about treatment options it might be that we're overlooking some symptoms or some behavioural indicators that are developing as a response to trauma as being perhaps fixed or arising from more fixed or non-modifiable traits. And, of course, you know, then the risk of that is that we're responding inappropriately to some of these symptoms and not providing the appropriate treatment response for some of these children.

MS ELLYARD: Thank you, doctor. Turning to you again, Professor McDermott. One of the questions that you were asked to answer from your perspective as a clinician and experienced psychiatrist was what's understood to be the short, medium and long-term effects of child sexual abuse on survivors, and you were asked to identify this in terms of short - biology brain development, executive function and psychology. Can I ask you, you've given us a great deal of detail, but perhaps to summarise at a higher level, what are the key areas where one would reasonably expect to see impacts on children who'd experienced child sexual abuse.

PROF McDERMOTT: One of the inherent difficulties in the area is, the answer is invariably is, it's complex, and I don't say that in any demeaning way at all. The more you study it and the more, you know, I know about it, the more complex it is.

So, there are fundamental biological changes and, by the way, all of this is likelihood, it's, there is an increased likelihood of, it's a probability kind of matrix.

There is an increased probability that you will actually have some structural brain damage. An example is a famous Japanese study in girls 18 years of age who are able to give consent for an MRI scan of their brain. If you had sexual abuse under the age of, I think 16, you had lost on average 18 per cent of the grey matter of your visual cortex was not there, okay. 18 per cent is nearly a fifth: wasn't there.

And there are now a series of studies that show that there are fundamental brain alterations in - you know, that are correlated, their increased likelihood from sexual abuse and they are in various parts of the brain. There are studies that show a relationship with the frontal lobe

which is all about executive functioning. There are changes in the hippocampus, in short-term memory areas and also in emotional regulation areas.

So, one area is actually brain structure. A second area is, there has been a revolution in genetics in the last 20 years; we thought genetics was, if you like, a factory with one speed: DNA program was read by RNA which led to protein synthesis, it was just a linear factory. Now we know that you can speed up and slow down genes, genes can work faster and slower, and we know that sexual abuse and other forms of trauma are a fundamental way of doing this. And there are things now called heat maps where you can look at the methylation of someone's genome, and the last time I checked, you know, over 12,000 genes were susceptible to change based on trauma.

So, right from an early age you might have a different brain, you might have a different genetic response, and from there, you know, the next layer - so that's the biology - the next layer is psychology related, and my learned colleague is probably better to talk about that, but we know that there can be changes in your attachment behaviour, you can have anxious or anxious avoidance attachments. We know that the very early kind of relationships around temperament can change.

And then, of course, there's secondary deficits. If you are, you know, biologically impulsive and your stress response is less sophisticated, and you have temperamental issues, you don't make friends with children who are highly emotionally regulated, you make friends with children like you, and you have problems sitting in your seat in school, so then you develop issues in primary school. Your friendships and peers influence, you know, the way you deal with pro-social events and your development of schema, cognitive schema and social mores, it has effects in your high school. You might learn to self-medicate with drug and alcohol, you might develop a mental health issue.

So, there is this for some people - not everybody - this cascade of events that follows you through life, certainly through the developmental parts of life, the early years up to, you know, the early 20s, that are all responsible, that all have their nubbin in trauma.

MS ELLYARD: Thank you, professor. Dr Malvaso, you

identify at paragraph 12 and following of your statement, and you've said some of this already, that the question of complex trauma, what has been described by Professor McDermott is, as he said, this cascade of impacts that can arise, none of them might be diagnosable as a clinical condition, but nevertheless they all potentially combine as a trauma response to the abuse; is that right?

DR MALVASO: Yes, I would agree with that.

MS ELLYARD: But you also go on to say, as you've already touched on, that it's important to work out that these things are abuse responses and not just innate and unchangeable features of a person?

DR MALVASO: Absolutely, and I can speak to some of the research finding that have been developing over the last couple of years specifically in regards to callous-unemotional traits or a lack of empathy; these characteristics and symptoms can be quite common among young people especially in the youth justice system. There's of course a school of thought that suggests that these traits are biologically based and they're not modifiable. However, there is some research demonstrating that these traits can develop in response to significant adversity and as a trauma response, as a coping mechanism for children and young people who perhaps are emotionally detaching due to those distressing events that they've experienced, and so, of course that's really important from the treatment perspective because it provides us with these new opportunities to provide more appropriate responses for these children and young people.

I think the key is that we really need to understand, you know, the drivers of these symptoms and when, how and for whom adverse childhood experiences and trauma leads to offending behaviour so that we can respond appropriately.

MS ELLYARD: One of the things you say thinking about responses, Dr Malvaso, at paragraphs 45 and following, you identify again, picking up this distinction between the event and the trauma response, that ideally if you can't prevent the difficult event happening, what you want to try and do is intervene as quickly as possible before it can have any of the cascade of consequences that Professor McDermott has been discussing.

DR MALVASO: Yes, absolutely. I mean, in research terms we think about them as mediators, so obviously we want to prevent the exposure, the cause potentially of the trauma or the associated outcomes, whether that's contact with the criminal justice system or another negative outcome like a suicide. But if we identify these risks and these experiences later in the life course then there may be other opportunities to prevent and intervene early to reduce the chances of these negative outcomes, so focusing on trauma might be one of those opportunities.

MS ELLYARD: Thank you. Professor McDermott, one of the questions that you were asked to answer and you've answered at page 8 of your statement is the therapeutic responses that are most effective for addressing or minimising the impact, so thinking about therapies that can be offered. You've identified that what will be appropriate will be dependent on a range of factors, including the nature of the abuse. Can I ask you to speak to that?

PROF McDERMOTT: Yeah. So, abuse is, as Commissioners are well aware, is an incredibly non-specific term and some people have a single event of a single type of abuse. Often people with complex mental health presentations have many different forms of abuse over many years and, although these are still, if you like, research models, it would seem that sexual abuse as a form of adverse childhood experience is incredibly damaging. Of course parental separation is a much more normative experience of Australian children, so not all abuses are the same.

There is also an issue about critical periods. For instance, an example is, if you don't have binocular vision at a certain time of childhood your brain will never ever for the rest of its life have binocular vision and it will actually choose one eye and actually the other eye will be functionally blind. There are critical periods where you have to develop speech and language, social development, where you have to learn to regulate your sleep and your eating, where you have to learn to develop friendship. So, not all abuse is the same.

At its most simple, if you have complex abuse that generally includes multiple forms over a long time, but it also might include parents who have their own challenges and help and that needs a multidisciplinary response with a team who all bring different skills to the challenge who

might see the person over a protracted period of time.

If you have a single abuse in an otherwise normal development, something like cognitive behaviour therapy trauma focused cognitive behaviour therapy might be all you need, so it's highly variable.

MS ELLYARD: And the question of working with the family, you've identified that as one of the potential limbs; can I ask you to explain a little bit more the significance of working with a family where a child has experienced abuse?

PROF McDERMOTT: So, and I want to again be very broad, in that some people with complex abuse don't actually have what we would say is a nuclear biological family, so some people actually don't have a family and you need to work with their system.

But if you are with two carers in what we would conceptualise a family - there is an issue, by the way, that some of the family responses to abuse do need their own guidance. So, for instance, if you have a single episode of abuse and are never allowed to go to a party again for the rest of your childhood, many of my patients would look me in the eye and say, "That was highly problematic", they wouldn't say "problematic", but that was very difficult and got in the way of their development, so often families also need guidance to, you know, help the family to return to a normal way of being as well as the child who's been abused.

MS ELLYARD: One of the key cohorts of children whose interests the Commission is concerned with are children in the Ashley Youth Detention Centre and in other cohorts children in Out-of-Home Care. There's material available to the Commission and I think each of you in your different ways have touched on in your statement the fact that those cohorts of children appear to be at increased risk of child sexual abuse and at perhaps increased risk of suffering some of the traumatic consequences of that abuse.

But I wanted to turn to you, Dr Malvaso, because I think you've identified in your statement that, although it might be the case that many people who go on to have contact with Youth Justice have an experience of childhood abuse, the inverse is not true, it's not the case that merely having an experience of childhood abuse inevitably

sends you down the Youth Justice path; is that right?

DR MALVASO: That's right. So, I think one of the best ways to explain this is thinking about different research designs and studies. So, cross-sectional studies which provide us a snapshot of a population in time. So, if we take, for example, the Youth Justice population and we look at how many of the children involved in the Youth Justice system have experienced maltreatment or who have been placed in Out-of-Home Care, we see that it is a high proportion of those children have had these experiences.

This research is really important because it tells us something about the characteristics of these children and young people and something about their needs, and this information is critical for informing planning, especially of rehabilitative services and interventions.

However, in terms of planning for preventative interventions across the life course it matters for prevention when we know about these experiences when they occur, and to understand this better we need prospective or longitudinal studies. These studies are studies where you're able to follow the same individuals over time; they provide insight into different pathways and trajectories for children, but they also, depending on whether they include comparison groups, enable us to differentiate children who will develop the outcome, so who will end up having contact with the justice system, from those who won't. So, it tells us a little bit more about perhaps the when and the how and the for whom experiences of adversity or placement in Out-of-Home Care might lead to Youth Justice system and contact and this is really critical for planning our prevention and intervention services across the life course.

I think one of the most important points to make is that there won't be one magical intervention that will disrupt these pathways and promote a more pro-social pathway, but that we need a series of these interventions targeted at different opportunities across different developmental periods across different contexts so that there are multiple opportunities for us to intervene.

MS ELLYARD: Thank you. Thinking about the links between the cohort of children who have contact with the Out-of-Home Care system and the cohort of children who have

contact with Youth Justice, Dr Malvaso, at paragraph 21 and following of your statement you've made some comments about that link, and again it's, as I understand it, although it might be that there's a higher content of children in Youth Justice who have had an Out-of-Home Care experience, it doesn't necessarily follow that most children in Out-of-Home Care enter the Youth Justice system; is that right?

DR MALVASO: That's right. I think we know from research from around the world, from Australia, that it's well-established children in Out-of-Home Care are more likely to have contact with the Justice System. Our most recent research in South Australia using population level data suggests it's one in seven young people who have been placed in Out-of-Home Care were experiencing Youth Justice system contact by age 18, but that means six out of seven won't, so the association is not deterministic, not all children placed in Out-of-Home Care will end up in the Youth Justice System, and again I keep bringing that back to the importance then for understanding, you know, the reasons behind or underlying that increased risk for those children in terms of being able to plan and target our prevention, early intervention initiatives.

I think one of the biggest challenges is the difficulty in disentangling the impact of Out-of-Home Care placement experiences from the reasons that a child and young person ends up in Out-of-Home Care and, you know, the cumulative adversity and disadvantage that we've already spoken about. Out-of-Home Care itself is not one thing, so children can be placed in different types of care at different ages for different periods of time; some will be reunified with their families, others will come back into the system time and time again, so it makes it really challenging to understand which cohorts of children we should be focusing on and what are the suitable interventions for those cohorts.

MS ELLYARD: At paragraph 26 of your statement, Dr Malvaso, you talk about some research that's being done that really speaks to this being a very big picture whole-of-society issue but can I ask you to speak to the matters in that paragraph and the potential complexity of predicting what children are more likely to end up in these environments.

DR MALVASO: So this is referring to some research that I've conducted with my colleagues in BetterStart at the University of Adelaide using whole-of-population administrative-linked data, so that's where we can see everyone born from 1991 to 1998 in South Australia and understanding their contact with different systems, specifically focusing on child protection and Youth Justice.

I guess what some of this research is demonstrating is that patterns of socio-economic disadvantage are evident for these children before they're even born or at birth, which means that we're seeing these indicators or picking up - we're potentially able to pick up these indicators from birth, and that's, I guess, one of the advantages of using administrative-linked data. So, it's not necessarily about that particular risk factor, you know, whether it's mum smoking during pregnancy, but it's about what travels along with those risks and those opportunities for providing prevention and intervention initiatives.

We've also used the link data to see if we can identify groups of children who are placed in Out-of-Home Care early, so before aged 10, which ones are more likely to end up having contact with Youth Justice, and so we've used formal risk prediction methods which I won't go into the detail of today, but essentially this requires some nuanced judgments of model predictive performance.

And the conclusions from that research is that, while the potential for prevention is large, there are some major ethical and practical considerations that we need to think about; we need to define our interventions in order for us to truly understand the costs of the inevitable false positive and false negative predictions that we might make, so thinking about the stigma of labelling a young person in Out-of-Home Care at high risk of entering the Youth Justice system.

And something that I believe is really important, which is, there's no point in screening for risk if we don't have the effective interventions to offer those children. I might leave it at that, if that answers it.

MS ELLYARD: Thank you. Can I turn then to the question of where to get help and the kinds of help that's available and the potential barriers to children who have experienced

child sexual abuse and where that's revealed while they're still children.

Turning to you, Professor McDermott, in answer to a question at page 13 of your statement you've given a summary of the programs and services that CAMHS currently delivers, including a list of the mental health difficulties that services can be received for. As one looks at that list and thinking about the discussion we've already had, it's possible, is it not, that some of those mental health difficulties might be properly understood as themselves the sequelae of adverse childhood experiences like child sexual abuse?

PROF McDERMOTT: I think the research says very clearly that abuse is a non-specific risk factor to different outcomes. So, for instance, abuse or trauma, and especially sexually-related trauma, will increase your likelihood of, for instance, post-traumatic stress disorder by six times, but personality disorder by six times and substance abuse disorder by six times and psychosis by two times and depression by three times, so it is a non-specific. There is no one particular presentation from a mental health point of view that says, this is because they were abused.

MS ELLYARD: But if it's a mental health presentation that's found to coexist with a history of sexual abuse, does that mean that understanding that is relevant to the way in which the child's treated then with that condition?

PROF McDERMOTT: Stronger than that: I would say that any individual who presents with a child and adolescent mental health presentation should be asked about abuse, should be very clearly and professionally and developmentally appropriately questioned about whether abuse happens, and I think the finding of that is always influential in your formulation and treatment of the case.

MS ELLYARD: Can I ask you about the answer that you gave to a question about CAMHS offering trauma-informed care. You've answered that question on page 15 and you've made the observation that there was a limited ability and expertise to provide trauma-informed care to consumers with severe trauma-related presentations.

May I ask you first just by matters of definition,

what do you mean by trauma-related presentations, what's the distinction that you're drawing?

PROF McDERMOTT: So, as opposed to - I mean, if you follow the logic of my last answer, everything is potentially trauma-related.

MS ELLYARD: Indeed.

PROF McDERMOTT: But some are much more clear. Post-traumatic stress disorder by definition links to a particular event, and complex trauma, you know, links to a series of particular events. So, complex PTSD, some anxiety-related things like phobia can specifically be related to a traumatic event. In little children some attachment presentations like reactive attachment disorder are specifically related to trauma. In young adulthood I would say that borderline personality disorder and in fact bulimia as well have very, very high rates of individuals who have trauma experiences.

MS ELLYARD: I take it from the answer that you've given here that, compared to the way in which CAMHS presently is able to respond to children with other kinds of presentations, there's a limited capacity to meet the needs of that cohort where their presentation is trauma-related?

PROF McDERMOTT: Yeah, and it's more than that. I mean, to, you know, force society to actually intervene appropriately, there are many, many, many filters before you get to CAMHS. CAMHS is, if you like, at the top of a pyramid and we should be identifying the possibility of trauma at multiple levels of that pyramid.

So I would have said that, in a society that was truly going to take on this issue, you know, workers in child cares, workers in primary school, workers - and I say workers broadly - workers in high school, everybody should have some ability to identify what's potentially a trauma response.

MS ELLYARD: You've said in part of your answer to that question that historically, and I'm conscious that you're giving this in the context of a review which is proposing changes for the future, historically CAMHS has apparently conveyed the view that severe trauma-related mental health illness is not a matter that CAMHS can help with. Taking

up your answer about CAMHS being at the top of the tree, that seems incongruous if indeed that has been the view, that the children with the most complex trauma-related presentations were not suitable for the adolescent Mental Health Service.

PROF McDERMOTT: I made that statement, it's in my report, I stand by that statement, and I think there are various reasons why that can be understood, these are reasons that I don't particularly accept, but there are some views that, you know, complex trauma cannot be treated by a clinic-based service. These individuals are so disregulated and have so much difficulty, you know, sitting in a clinic-based service that they can't be helped: that's one thing, that's a barrier.

Another barrier is that, if you run a service that overwhelmingly has a family therapy and a family orientation - I mean, a lot of these kids don't have families; you know, a lot of these young folks - and related to that is that, you know, for some types of therapy and child and adolescent you need some placement stability and unfortunately some individuals with severe and complex needs have multiple placements, and some CAMHS teams find this highly problematic.

The reform is all about changing the way this business is being done to account for those barriers.

MS ELLYARD: Thank you, and I'll come to ask you about some of those specific programs in a moment. Can I turn to you Dr Malvaso. In the particular context of children in the youth justice space who might have crossed over from the Out-of-Home Care or child protection system, you've identified in your statement the way in which sometimes the Justice System becomes a de facto provider or organiser of services to children who might have needed various forms of support for their trauma but haven't got it. I'm drawing your attention to paragraph 27 and following of your statement. Can you tell us about your observations in that area?

DR MALVASO: Yes. There's been a fair amount of research especially from the eastern states looking at the reasons why some children in Out-of-Home Care are over-represented in the Youth Justice system and some of the, I guess, system process or bias that leads to that

over-representation, and so, some of these matters are around criminalisation of behaviour that wouldn't normally be criminalised in a family home, so calling the police for property damage or aggressive behaviour, assaults against workers in Out-of-Home Care placements.

And then, once these matters progress to court sometimes the courts are limited in terms of their options for bail in terms of, if there's no fixed address for a young person or Out-of-Home Care placement, it doesn't have the capacity to accommodate that young person due to their behaviour - just checking to see if there's anything else I'd like to say.

MS ELLYARD: In paragraph 30 you've raised the question of the courts perhaps stepping in where it perhaps ought to have been a child protection response but somehow it doesn't happen.

DR MALVASO: Yeah, I think it's really challenging because sometimes when you think about the children who end up in the Youth Justice System, I don't want to use a word as strong as "has been a failure", but we can think about it in that sense of other systems to pick up some of the issues and some of the behaviours and some of the experiences that these young people have gone through that have led them up to this point of being involved in the Justice System.

And so, courts, I guess, the statement is in context around courts trying to link these children and young people up with services that can respond to their needs; whether the Justice System response is the most appropriate response for that or, you know, it's happened so far down the line that it's come to that response is questioned. Whether it's Child Protection's remit is also questioned because we know that the Child Protection system is overwhelmed, we know that demand on Child Protection Services is growing, it's unsustainable, and adolescents in particular aren't always the focus of those, I guess, Child Protection responses, and so, if we do think about it as a Child Protection response there are some concerns around whether these children will actually get any response at all.

MS ELLYARD: Professor McDermott, picking up what you said a little while ago about the systems as they existed until

now depending to some extent on some assumptions about stability of placement and functional supportive families, it sounds like then that the cohort of children that Dr Malvaso is describing are precisely the cohort who, up until the changes that you're proposing, might have found themselves too complex to get services from CAMHS.

PROF McDERMOTT: I also think CAMHS made decisions based on how best to use the money and, if you are faced with an individual who has, you know, 14 placements in different parts of the state, then you know, I can completely understand their decision process that the money might be best used somewhere else. So, there is some very reasonable decision-making around, you know, model of care fitting with complexity of the presenting challenge, and again, hopefully we will be able to remediate that.

COMMISSIONER BROMFIELD: Sorry, excuse me, Professor McDermott, in that circumstance where a child has been removed by the State, do you feel that it's reasonable that across Tasmanian Government services there is some consideration to a duty of care to that child?

PROF McDERMOTT: Always, yes. You know, there is an extension of, it takes a village to raise a child; I mean, different departments should always cooperate in the best interests of the child.

COMMISSIONER BROMFIELD: In the scenario you gave though, we would have had a child who had experienced multiple placements while in the care of the state and another state service determining that, because of that, they were too difficult to treat, they are wicked problems.

PROF McDERMOTT: Again, I think that these are serious systematic issues and they have been, you know, the cause of significant contention and they've been the cause of significant consumer concerns, but also practitioner concerns. Practitioners would love the degree of information about a child's past to follow them very seamlessly between placements and that often doesn't happen. The placement would love the clinician to follow the patient across placements, and that doesn't happen. So, I think, you know, there's no particular one culpable entity, but all entities could do much better.

COMMISSIONER BROMFIELD: Thank you. Sorry, Ms Ellyard.

MS ELLYARD: Not at all, Commissioner. Professor McDermott, you've made the point fairly in your statement that CAMHS is not a sexual assault service, and as I understand it even under the new models that are proposed you would still see there being a role for specialist sexual assault services to respond to the particular needs of children who have experienced child sexual abuse. Assuming that they're a child who is otherwise presenting in a way that makes them eligible for CAMHS services, that does seem to suggest a bifurcation of the child's experiences and needs that would either create duplication or the potential for some dislocation in how the child can be cared for.

PROF McDERMOTT: Sure. I think the way to conceptualise this is a stepped care model. So, if you think of a pyramid with different kind of levels, I think that CAMHS, because it's funded arguably the most and it has the most experienced practitioners, is at the top of the pyramid and it should see complexity, and that complexity, if it is sexual abuse, it is sexual abuse plus substance abuse plus depression plus suicidality plus parents might be struggling with drug and alcohol, but it is inherently with school refusal and presentations to accident and emergency, and it is incredibly complex and that's where CAMHS should sit.

If you have an unfortunate person who has sexual abuse but in the context of an otherwise normal educational experience and family experience and they're not suicidal or they don't have other things, then a sexual abuse service is extremely appropriate and in fact a good model of care because they can develop profound expertise in that area, and best practice in that area.

So, when I say CAMHS is not a sexual abuse service, CAMHS should see everything that's complex, but there should be, I think, also a sexual abuse service.

MS ELLYARD: This really in part raises a question of service design and system design. Dr Malvaso, at paragraph 49 you've identified what you see as some issues within your areas of interest relating to the way in which government services are siloed with different criteria for different eligibility and so forth, can I invite you to speak briefly about those matters.

DR MALVASO: Yes, I think the structure and design of our service systems, and this is not unique to Tasmania, this is not unique to Australia all the time, but it's not always conducive to the needs of families and children, particularly those with complex needs that we've been speaking about this afternoon and some of those barriers exist at the system level in terms of agencies operating in silos, and that's partly driven by really strict funding models. There are barriers at the system level around strict eligibility criteria, who's viewed as appropriate or not appropriate for a particular service or agency, as well as challenges in terms of information sharing and, when there are multiple agencies involved in terms of coordination and who is responsible for leading that coordination, often the responsibility will fall to statutory systems like Child Protection or Youth Justice. Then, of course, there's individual barriers around the complex needs of children and families not always being aligned with the way these services are run or designed.

MS ELLYARD: You've raised the question of multidisciplinary responses being appropriate for children who have the complexities often associated with Out-of-Home Care and Youth Justice. That's on paragraph 55.

DR MALVASO: Yes, I guess that's speaking to some of what we might think of as strategies or facilitators to break down some of these barriers, and of course there are other barriers that arise like I've mentioned around, you know, who will be the lead agency when multiple agencies are involved, and sometimes it might just be the agency or a practitioner who has the best relationship with that young person or with that family, and it doesn't necessarily have to be a professional either; in some of our research we found it could just be a trusted adult or another support person who won't play a role in delivering therapy, for example, but they will get the child or young person or parent to that service and will vouch for the service so that they can engage more meaningfully and successfully with those services.

MS ELLYARD: May I ask you now, Professor McDermott, about a couple of the specific changes that you've touched on already and which are particularly relevant to the Commissioner's terms of reference. At page 18 and following of your statement you answer some questions about

the Out-of-Home Care Intensive Support Team which, perhaps picking up on the discussion that I've just been having with Dr Malvaso, as I understand it it's proposed that there's going to be a referral panel that's going to include representatives from a number of different agencies; can you speak to us briefly, and I'm conscious it's early days yet, about what's proposed for that and what gap it's intended to meet?

PROF McDERMOTT: Sure. And a 20 second statement to start off with: "If I had the chance to change one thing, it would be 'never again here' did not meet criteria." Okay, it is the most exclusionary comment ever made by any professional, it's unbelievable.

Okay, so I think what we are looking to do is institutionalise, in the best possible way, people to surround the best interests of the child, and that means a referral panel has to have on it someone from Child Protection, someone from Police, someone from Education, someone from Health, someone from Youth Justice. In Queensland we have someone from Housing, we have someone from Transport, and that group of - anyone from that group of people can bring a name to the panel.

Now, the panel, the caseload in this team will be low, they'll only see six to eight - one clinician will only see six to eight young people, so it's quite an expensive resource. We have to put that resource in its best possible place, and so, we have to see people with extremely complex needs, and it's interesting that Housing or Transport or Police might actually know the person with the most complexity. Anyone from all those areas can refer into that team, we think that would be incredibly helpful to stop these, you know, these kind of service disagreements; that group will have to make a decision on who the next person is into the service.

Once you're in the service we think it needs to be truly multidisciplinary because if you have complex needs you might have speech and language problems, you might have neuropsychological issues, you might need medication, you might need psychology. A lot of these kids, occupational therapists are wonderful to help them regulate their mood, so it will be an interdisciplinary panel to get in and the service you'll be offered will be multidisciplinary.

MS ELLYARD: One of the key barriers and challenges to this great improvement that you've described, you've identified as being a potential shortage of the people to do the work, can you talk to us about that?

PROF McDERMOTT: So, a wonderful thing in Australia at the moment is the collective and the political interest in mental health: you can't go through an election without some funding on mental health, which is a wonderful and beautiful thing, but it does mean that at the same time as huge reforms in Victoria, we are trying to recruit 60 new clinicians to CAMHS in Tasmania. I know that New South Wales are starting to have a reform, so it's going to be problematic to get people into these positions. I think we need to take a longer view and I think we need to provide the best training scheme in Australia to train our own; it'll take a bit longer, but I think we need to have - you know, the risk to the CAMHS reform is actually our workforce strategy.

MS ELLYARD: And so, what you've identified at page 22 of your statement is a centre of excellence to be established in association with the University of Tasmania, so as you've said you're going to train up within Tasmania the cohort of additional specialists that you're going to need?

PROF McDERMOTT: Yeah, so one example is occupational therapists; I've already noted there the importance of this cohort. We don't train OTs in Tasmania. So, the Centre for Mental Health and Innovation is all about the changing the culture to something more empirical, something more inbuilt evaluation and, you know, creating a larger workforce in this area.

MS ELLYARD: Dr Malvaso, at paragraph 67 of your statement you've drawn the Commission's attention to the Exceptional Needs Unit as an example of a multi-agency response to children with complex needs. Can you tell us about that?

DR MALVASO: Yes, so the Exceptional Needs Unit is a multidisciplinary service that sits within the Department of Human Services in South Australia, and this team works with systems and services, I guess, to help coordinate support for individuals across the life course, so that can be children and young people, it can be adults as well who have multiple and complex needs, and so, obviously they're children that we've been talking about today. My

understanding is that's quite unique to South Australia, although there are some other similar types of coordination-type government services in other jurisdictions as well.

I'm unfortunately not aware of any formal evaluations of these types of models or services within our context, but in terms of reducing some of these barriers around the idea of, to use more colloquial language, passing the buck between agencies, that you can then take that lead role and assist in that co-coordination.

MS ELLYARD: So a bit like, as Professor McDermott said, not saying doesn't meet our criteria, off you go to the next door?

DR MALVASO: Correct.

MS ELLYARD: Professor McDermott, can I ask you then about the proposed youth forensic unit which you've dealt with at pages 22 and following in your statement and ask you to summarise, as you did in relation to the proposed team for Out-of-Home Care care, what's this unit going to do and what's the gap that it's meeting?

PROF McDERMOTT: There are two aspects to the Youth Forensic Service: one aspect is a community-based and one aspect is in-reach into detention-like facilities.

The community aspect is something called multisystemic therapy. Multisystemic therapy is an American product that has been around for at least 25 years, it has been run successfully in New Zealand and Western Australia. It's an incredibly intense service where you get six months of therapy seven days a week with availability of your therapist 24/7, which is incredibly intensive, and you're expecting to see your therapist three to four times a week. You're not allowed to have an office, so multisystemic therapy therapists will see you in your front yard, if it's safe in your living room. They will intensively work to support parents and caregivers to give more sort of evidence-based and responsible and impactful parenting, as well as work with the young person on a multiple of - you know, a range of interventions to change their trajectory from prison. A lot of it's incredibly practical, increasing their coping set, increasing their alternatives to medication and drugs and alcohol. Actively breaking

relationships with other dysfunctional peers, who I've been with MST teams and we've gone up to gangs and said, "You promise not to meet with this gang?" And the young person said, "I did", and hopped in the car and we drove away, so it's an incredible service that has many, many randomised controlled trials that shows that it will decrease the recidivism rate to prison, and some states of America have actually adopted MST because one day you're more likely to pay taxes. Now, although I say that somewhat facetiously, if you're more likely to pay taxes it means you're more likely to get a job and you're more likely to have a meaningful life. So, the community offering will be multisystemic therapy. There will be a team, there will be three teams in Tasmania.

The other offering will be an in-reach into the replacements to Ashley Detention Centre to provide assessment and treatment services, and we anticipate they will be not only traditional mental health but also neuropsychological. For instance, the rate of things like foetal alcohol syndrome in detention populations is actually very high. The rate of some types of genetic presentation are actually very high. The rates of, you know, speech and language issues and the need for remedial education are high. So, the input to the prison will be sort of neuropsychological as well as psychiatric, and hopefully the two arms of this service will talk to each other.

For instance, you could get some assessment and work in detention and then be discharged to an MST team.

MS ELLYARD: What about if the opposite happens, a child is on an MST program in the community and falls foul of the law and finds themselves remanded to Ashley, is the system going to be able to cope with --

PROF McDERMOTT: The one team leader and one consultant will be responsible for both arms of the service; they will be a truly integrated service. So, the knowledge, the treatment plan, should follow seamlessly the young person into detention.

MS ELLYARD: You've said that the MST program isn't going to be intended for people who are themselves engaged in sexual offending where sexual offending occurs in the absence of other delinquent or anti-social behaviour - I'm

quoting from page 24. What's the reason for excluding sexual offending as a basis? It's pretty anti-social behaviour, one would have thought.

PROF McDERMOTT: We are very constrained by the MST model of care. We actually sign a contract with MST. They provide supervision and training, so that's actually a contractual part of our obligations.

I think that the group who are of themselves sexual offending, my firm position is that they are of increased likelihood to have abuse histories themselves, and they should be seen in other aspects of the service.

What we hope is these new teams will actually be highly influential to our existing community CAMHS teams and will more likely for those teams take serious and complex as well. I would hope that those individuals would be seen by community CAMHS.

MS ELLYARD: Dr Malvaso, Professor McDermott's just referred to the contractual nature of the process by which any organisation can use the MST model. You've made some comments about your understanding of the way in which the MST model has been reviewed at paragraphs 68 and following of your statement. Can you tell us please about that?

DR MALVASO: Yes. So, MST's originally developed to help support or rehabilitate young people with anti-social behaviour, with conduct problems. As Professor McDermott has talked about, it is a community-based model intended to work with families, holistically and therapeutically, so work with the individual young person as well as their families or their Out-of-Home Care unit, their school, their community and now there are various adaptations of MST, including MST-CAN which is child abuse and neglect which I guess is intended more as a family preservation program. There are specific MST programs for children with harmful sexual behaviours as well but that's not the mainstream program I suppose, and MST-CAN itself excludes families in which sexual abuse has occurred as well.

Much of the evidence base has been generated by studies conducted in the US and there's been a recent meta-analysis published last year, so meta-analysis combining the results from multiple randomised control trials have concluded that the evidence for MST is actually

quite mixed; the majority of studies used to support its effectiveness were assessed as having a high risk of bias. So, these authors actually, I would say, went through the randomised control trials, quasi-experimental studies with a fine tooth comb to assess risk of bias. So, when I'm talking about risk of bias I'm talking about things like issues with the randomisation process, so with trials; there's random allocation of individuals to receive the treatment, so to receive MST, and then random allocation to a control group which might be treatment as usual or another intervention. And so, they identified a high risk of bias due to issues with randomised process which can lead to base line differences between the groups which makes it really difficult to reliably estimate the effects of the program.

High risk of bias in terms of measuring outcomes, missing data on those outcomes, attrition, deviations from the intended intervention, so that's transportability issues as well in terms of what's intended to be delivered as well as selective reporting and conflicts of interest in the studies that have been conducted in the US.

There are of course trials that have been conducted outside of the US; recently there was a trial in the UK and the conclusion from that research was that there was no evidence of long-term superiority of MST over treatment as usual, and so, I guess this body of more recent knowledge casts some doubt over how well MST can be transported to other jurisdictions and how effective it is. That's not to say that it can't achieve positive outcomes, but I think we need to think really carefully about the programs and the interventions that we are trying to implement in an Australian context, especially those from the US, and acknowledging that our context does differ in some cases quite significantly from the US, particularly when it comes to the Youth Justice System.

So, our Youth Justice System in Australia tends to be more informed by a welfare approach to responding to young people who commit crimes, which is a contrast to some of the more punitive-driven models in the US. We have a lot more emphasis placed on diversion, which means there's multiple opportunities to divert children and young people from the Justice System, whether that's through police formal or informal cautioning, whether that's through the courts with family conferencing.

The reason I guess I'm saying this is because the children and young people that we see in our Youth Justice systems in Australia might not look the same, and indeed in South Australia they certainly don't look the same as children in the US, in the sense that we're seeing a much higher prevalence of adverse childhood experiences of trauma, and I think that we really need to take these differences into account and ensure that we're, I guess, implementing and designing interventions that are based on the needs of our population, and the really important point of recognising the over-representation of Aboriginal and Torres Strait Islander children and young people in Child Protection and Youth Justice and considering the legacies of colonisation and entrenched disadvantage that leads to their over-representation in these systems.

MS ELLYARD: Thank you, doctor. How are you going to --

PROF McDERMOTT: I think it's really important that I respond to that.

MS ELLYARD: How are you going to be measuring this, any comment that you'd like.

PROF McDERMOTT: I think it's really important that I respond to that. I think a researcher could say that about any intensive intervention from a methodological point of view.

If you look at the methodologies of looking at complex and severe, there's always biases, there's always differences across jurisdictions, there's always methodological issues; these are the typical things that a researcher would find problematic about a system - first thing.

The second thing: it's been successful in New Zealand for, you know, 12 years or so, and I would suggest that, similar to us, it's now successful in Western Australia for many years, which I would suggest is fairly similar to us.

We've done extensive stakeholder discussions with First Nations people; they find the MST approach, which is non-clinic based, which is strongly family affirming and strongly, you know, in the home and in the community, their choice, their system of choice. And, of course, MST is not

our only offering.

The last thing I was involved in, the first international study of MST CAN in the world, and it's really important that we continue to try evidence-based interventions in this area, it's crucial. And, although that wasn't a very successful study, we learned a huge amount about running an MST service in the Child Protection environment.

I think we will be - because, you know, I have a Doctorate in Science - I can assure you that we will be looking assiduously at outcomes and those outcomes will include wellbeing and community connectedness and a whole level of functional improvements, including uptake of work, uptake of education, recidivism rates, those kinds of things as part of this intervention.

MS ELLYARD: Thank you, professor. Can I ask you, in the context of the identified limitations that you were asked about in relation to the Youth Forensic Unit you've identified a couple of things and one of them is that, as I understand it, part of the design of the MST program is that it assumes a degree of family involvement and indeed it can't work without that. Thinking about the possibility of some of the children who might otherwise be good candidates for it not having a stable family or indeed any family at all, and you've identified that; are there going to be alternative offerings for those children?

PROF McDERMOTT: Yeah, but also MST is actually aware of that and the family, again, is broadly defined. If you have a member of kin, you know, broadly defined, who is going to be with you for six months; if you have a foster parent or someone who's going to be with you for six months, if you have some adult carer who's going to be with you with for six months, they will accept that.

MS ELLYARD: The last topic I want to raise, conscious of the time Commissioners, is what I'll call broadly the topic of culture, and I'll start with you, Dr Malvaso. The final comments that you've made in your statement were about your observations of past enquiries which might make a lot of small recommendations which are given effect, but somehow the overall system doesn't seem to change and you have some reflections on what is required. Can you talk to me about that?

DR MALVASO: That's, there's no one answer to that and it's really challenging, and I think a lot depends on major social and political reform, long-term investment and commitment in evidence-based programs and initiatives to drive our reforms; this means that politicians and decision-makers and to some extent the public need to be willing to make these investments while accepting that we may not see the returns or the returns may not be realised for years, decades, sometimes even generations.

We need to invest in research and methods that help us understand which interventions are most appropriate, which ones are evidence-based, and evidence has many different meanings and is not always created equally, so we need to think about, for the children who are already in contact with Child Protection and Youth Justice, our legal, our moral and ethical obligation to them to ensure that we don't do any more harm to these children.

And so, of course, I would argue we need the objective and rigorous research, but we also need to listen and learn and really value the evidence generated through lived experience as well.

MS ELLYARD: Professor, can I turn to you. It's clear from --

PRESIDENT NEAVE: Sorry, I just had one quick question on that. Did the MST program evaluations to which you've referred provide any opportunity for children who'd been through those programs to express their views? To what extent did they make use of children's voices?

DR MALVASO: Off the top of my head these are mainly based on randomised control trials and quasi-experiments, so they can be some self-report in terms of outcomes, but in terms of any sort of in-depth qualitative investigation, I'm sure there are studies, but I would have to take that on hand.

PRESIDENT NEAVE: Professor McDermott, can you...?

PROF McDERMOTT: I don't know.

MS ELLYARD: The final question to you, Professor McDermott. It's clear from your evidence and your statement that there are a lot of changes coming proposed

by you in your review of the CAMHS model and a lot of need for additional investment in resources, but also perhaps more fundamentally as I see potentially a change of culture, if I can use that expression, attitudinal changes within the service or amongst clinicians about the way in which to respond to some of those issues, and I'd be grateful for your reflections on how that culture shift is going to happen in addition with the various specific proposals that you've described.

PROF McDERMOTT: Sure. Commissioners, I graduated in 1984. We could have had this Commission of Inquiry in 1985, 1995, 2005, 2015. And I think you have an interesting task to try to - and a challenging task - to try to create enduring change, and my view is that system recommendations won't do it, service recommendations won't do it, and I'll just give you the example of Beyond Blue.

I was a board member of Beyond Blue for 10 years, so I'm actually biased towards Beyond Blue. But, if you were a fella, you couldn't go into a toilet in any pub in Australia for 15 years without seeing a Beyond Blue sticker, and you couldn't sit down and have a beer without having a Beyond Blue coaster, and there was a national conversation about depression, and a national conversation about stigma.

We still do not have a national conversation about child abuse. It is still something that people would prefer not to talk about, not to acknowledge, not to think about, not to realise that the prevalence is ridiculously high. And I think, until we have a national - Tasmania could champion it - Tasmanian ongoing entity like Beyond Blue that, in a regular and profound way uses, not people like me, but uses marketing experts and using national leaders and national experience - you know, people that are known through media or politics or whatever, that on a weekly fashion encourages people to face these issues and encourages things like, you know, a whole bunch of issues like people to delay - you know, wouldn't it have been nice if you delayed having a child until a husband and wife got their ice addiction under control; that'd be kinda nice, that'd be nice, and the only way to do that is not a systems response from a health professional, it's actually a national body or a state body reminding you in a weekly fashion that you need to nurture your child's brain in utero in the first five years to provide them the best

chance of life.

So, I don't see any change - with respect - until we have those things which are way above service providers.

MS ELLYARD: Thank you, professor. Commissioners, those are my questions. Are there any --

PRESIDENT NEAVE: May I just make one comment? I think one purpose of this Commission is to encourage precisely the conversation that you're talking about.

PROF McDERMOTT: I know, I was being rhetorical, yes.

PRESIDENT NEAVE: And that both of you I think have raised as important. Any questions?

COMMISSIONER BROMFIELD: I wanted to acknowledge your final comment, I think it's an excellent point and I thank you for it, my question now seems quite micro in that context. But, Dr Malvaso, I noticed your research, you've really utilised linked data; you've used that tell us more about populations, to do prospective analysis, and you talked in your statement about, I guess, some of the power of linked data or of data systems that tell you about systems, about referral pathways and about outcomes.

Really, it's a question for both of you as to whether you think that there is a role for the use of linked data in Tasmania, both to inform our service system responses but also potentially to evaluate and continue to monitor how we're performing?

DR MALVASO: Yes, I think there definitely is a role, I think linked administrative data gives us the best population-wide view of different contact patterns with different agencies and services; it tells us something about where children have come from and where they go; it tells us something about their trajectories, and importantly, it's the type of data that is really valued by policymakers, by decision-makers in terms of informing service planning. It can be really powerful thinking about how we can use the linked data to evaluate studies.

So, Professor McDermott pointed out some of the biases that we're always going to see in research when it comes to complex interventions with families with complex needs in

this area and whether we can use linked data for quasi-experimental studies that don't rely on randomised control trials.

I don't know the number of children who have come through MST programs in Australia, but I can't imagine they would be very large, and so we could be waiting years and years for data to be able to evaluate the effectiveness of MST in the randomised control trials. However, we can use linked data to, I guess, bring in service data providing we're collecting that and we're investing in collecting the right type of data that we need to answer questions around effectiveness. Bringing that in with linked administrative data allows us to construct comparison groups of children and families with similar characteristics who haven't had that intervention.

I will add to that, while population level, linked administrative data will give us that best population-wide view, it's not always very detailed, so we do need to supplement and augment that data with psychologically meaningful data with service data, and importantly, that point around actually talking to children and young people and families and those with lived experience, and in particular adhering to principles of indigenous status sovereignty, ensuring that we're not just perpetuating the same negative stories using this type of data but that we're also using indigenous methodologies and knowledge to inform what we might view as an evidence base.

COMMISSIONER BROMFIELD: Thank you.

PROF McDERMOTT: Can I just add that a lot of people don't know that some of the work on sudden infant death syndrome, SIDS, and the relationship of the positioning of a baby in a cot and death was actually Tasmanian-linked data, and it's probably saved millions of lives: this was back in the 90s.

Tasmania is perfect for linked data, it's an island, a lot of people, you know, live here and don't go for good reasons, and a lot of the linked data studies in Dunedin and Christchurch and Western Australia are all from places where, you know, people stay for many, many, many years, so it's actually perfect for that.

COMMISSIONER BROMFIELD: And would that have utility, in

your view, Professor McDermott for service planning?

PROF McDERMOTT: I agree with everything my colleague said, I think it's incredibly helpful, you know, you need to look at multiple ways of evaluation. That is one way and, you know, there's other ways of doing it. Different methodologies and designs are better for answering different parts of the jigsaw, so it's one powerful way.

COMMISSIONER BROMFIELD: Thank you.

PRESIDENT NEAVE: Thank you very, very much, that was really a fascinating session, we learnt a lot from it. Thank you.

MS ELLYARD: Thank you, Commissioners.

AT 4.40PM THE COMMISSION WAS ADJOURNED TO WEDNESDAY, 4 MAY 2022 AT 10.00AM

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