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Research Report

Access and Engagement with services for Sexual Safety for children and young people with problematic and harmful sexual behaviour (AccESS Study)

Researchers:

Professor Jo Spangaro, Dr Kenny Kor, Professor Jason Payne, Dr Natalia Hanley, Dr Julaine Allan, Dr Summer Finlay, Dr Helen Simpson & Belinda Fabrianesi

School of Health and Society

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NSW Ministry of Health

Professor Jo Spangaro, Dr Kenny Kor, Professor Jason Payne, Dr Natalia Hanley, Dr Julaine Allan, Dr Summer Finlay, Dr Helen Simpson & Belinda Fabrianesi

School of Health and Society, University of Wollongong

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Glossary, Abbreviations & Acronyms

Glossary	
Problematic and harmful sexual behaviour	Problematic and harmful sexual behaviour (PHSB) is any sexual conduct by or between children or young people that is neither developmentally expected nor socially accepted and has profound negative developmental and social consequences (Hackett, 2014; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017) .
Risk of significant harm	A child/young person is at risk of significant harm (ROSH) if the circumstances that are causing concern for the safety, welfare or well-being of the child or young person are present to a significant extent. This is determined by Department of Communities and Justice (DCJ) using the information provided by the reporter and other available sources.
Field assessment	Following Child Protection Helpline reports, field assessment is a child protection assessment process which generally involves face-to-face meeting with the family and assessing the safety and risk of the child. A field assessment typically involves reviewing the family's history, sighting the child and possibly gaining more information from the reporter or other involved parties.
Joint Child Protection Response Program	The Joint Child Protection Response Program (JCPRP) is a tri-agency program delivered by the NSW Department of Communities and Justice (DCJ), the NSW Police Force (NSWPF) and NSW Health. The program operates state-wide and provides a comprehensive and coordinated safety, criminal justice and health response to children and young people alleged to have experienced sexual abuse, serious physical abuse and serious neglect.
Out-of-home Care	Out-of-home Care (OOHC) is defined in section 135 of the Children and Young Persons (Care and Protection) Act 1998 ('the Care Act') as the care of a child or young person by a person other than their parent at a place other than their usual home. Out-of-home Care may be provided through foster care; relative or kinship care, residential care or independent living.
New Street Services	New Street Services, NSW Health provide therapeutic services for children and young people aged 10 to 17 years who have displayed harmful sexual behaviours towards others, and their families and caregivers.
Integrated Violence	The Integrated Violence Prevention Response Services (IVPRS), Western Sydney Local Health District (WLSHD) encompass child

Prevention and Response Service	protection counselling service; crisis and medical sexual assault service; domestic violence counselling, JCPRP, children under 10s who have problematic sexual behaviours and Child Protection Education.
Domestic Family Violence & Sexual Assault Services (DFVSAS)	Domestic Family Violence and Sexual Assault Services, Illawarra Shoalhaven Local Health District (ISLHD) provide counselling to children, adults and families who have experienced sexual assault, abuse, or neglect; children under 10s who have problematic sexual behaviours; crisis and medical service for sexual assault and community engagement.
Rosie's Place	Rosie's Place, based in Mt Druitt Sydney, provides individual and family counselling for children, young people and families affected by sexual assault and domestic family violence including children under 10s with problematic sexual behaviour.
Waminda	Based on the South Coast of NSW, Waminda is a Women's Health and Welfare Aboriginal Corporation. It provides culturally safe and holistic services for women and their Aboriginal families including children under 10s with problematic sexual behaviour.

Abbreviations & Acronyms

AH&MRC	Aboriginal Health and Medical Research Council
BOCSAR	NSW Bureau of Crime Statistics and Research
CHeReL	The Centre for Health Record Linkage
DCJ	Department of Communities and Justice
DFVSAS	Domestic Family Violence & Sexual Assault Service
ISLHD	Illawarra Shoalhaven Local Health District
IVPRS	Integrated violence prevention and response service
JCPRP	Joint child protection response program
OOHC	Out-of-home Care
PHSB	Problematic and harmful sexual behaviour
ROSH	Risk of Significant Harm
WSLHD	Western Sydney Local Health District
YJ	NSW Youth Justice

Executive Summary

BACKGROUND

This research has been commissioned by NSW Ministry of Health, as part of their program of work to improve service system design and response to children and young people who have displayed problematic and harmful sexual behaviour (PHSB).

This program of work responds to the findings and recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse which found that PHSB by children and young people remains a serious but largely hidden concern.

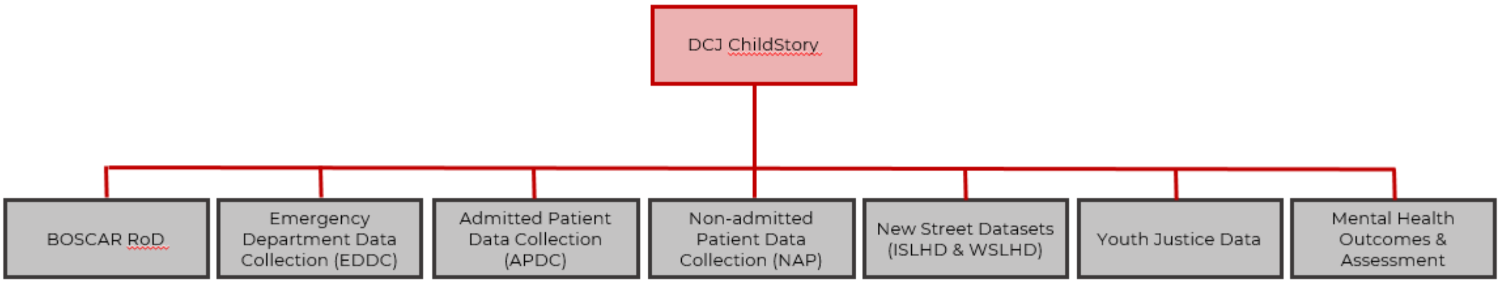
This research had two overarching objectives. First, it aimed to explore characteristics and services pathways of children and young people who have displayed PHSB. Second, it drew on the perspectives and lived experiences of young people, parents and carers to identify factors that support or hinder service accessibility and engagement.

METHODOLOGY

This research had two components: (1) data linkage analysis of over 5,000 children and young people who were reported to the child protection Helpline for PHSB; and (2) semi-structured individual interviews with caregivers and young people who have accessed services in response to PHSB.

The data linkage included seven administrative datasets from NSW Bureau of Crime Statistics and Research (BOCSAR), Department of Communities and Justice (DCJ), NSW Youth Justice and NSW Health.

The interviews included 31 caregivers and young people attending specialist services in NSW Health and Youth Justice.



Data linkage

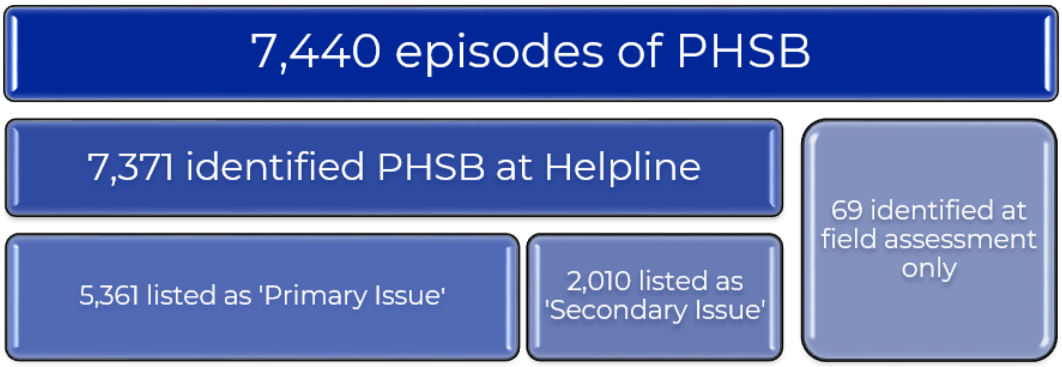
- The DCJ ChildStory data received by the research team contained information of Helpline reports made between 1 January 2018 and 31 December 2019. In total, 5,105 children and young people were identified by DCJ as having displayed PHSB, either as the primary or secondary Helpline assessed issue, or as a primary or secondary field assessed issue.

- For these 5,105 children and young people, there were a total of 33,726 unique ChildStory reports. Of these, 7,861 reports had PHSB listed.

- Some PHSB reports were made concurrently on the same day, often by different reporters of the same incident. Assuming all reports within a three-day window refer to the same 'episode' then the 7,861 reports pertain to 7,440 unique reporting episodes.

- Of the 7,440 unique episodes of PHSB, 7,371 (>99%) were episodes where PHSB was flagged as either the primary or secondary Helpline assessed issue. Of these 7,371 episodes, 5,361 episodes in which PHSB was recorded as the primary issue (69% of all episodes).

- There were 69 episodes where PHSB was not an issue reported to the Helpline but was later identified at field assessment.



- Of the 5,105 children and young people in the sample, almost 75 percent were male, with females accounting for 24.5 percent.

- When comparing different age groups and gender, the largest cohort of those reported in relation to PHSB were aged 10- 13 inclusive. Overall, females were a significant minority decreasing in prevalence as they age, from 36 percent under 10 years of age to 15 percent between 16 and 17 years of age. This contrasted sharply with males, increasing in prevalence as they age, from 63 percent under 10s to 84 percent between 16 and 17 years of age.

- Over 78 percent of children and young people had a disability status recorded in ChildStory. This comprised 70 percent of children and young people with no disability recorded and 8 percent with a disability recorded. Learning disorders were most common, followed by intellectual disability and autism.

- Additionally, 17.5 percent of those reported identified as Aboriginal and 52 percent as non-Aboriginal, whilst 21 percent were unable to be identified as either.

- For the 3,424 children and young people whose PHSB was listed as the primary assessed issue, 469 (13%) of them had a concurrent report of sexual abuse. Thirty-four had a concurrent report of physical abuse, 75 of neglect, 39 flagged problematic parental behaviour and 173 the problematic behaviour of that child or young person.

- For the 1,462 children and young people whose PHSB was listed as the secondary assessed issue, 1,288 (88%) had a concurrent report of sexual abuse and 135 (9%) had a concurrent report of physical abuse.

- Of the 5,105 children and young people reported, 45 percent were reported by Education, almost 20 percent by Police compared to just under 8 percent by Health.

- For this study, the analysis is framed within the context of each child's first report of PHSB recorded within the timeframe under review (between 1 January 2018 and 31 December 2019). It is important to note that this child's first report is not necessarily their first ever report but the first report within the study timeframe. This first report within the study timeframe becomes the temporal anchor point that delineates between pre-PHSB and post-PHSB events or activities, including those derived from other datasets.

- It is also important to remember that, as a cross-sectional sample, the analysis is limited to the study period between 1 January 2018 and 31 December 2019, hence, the analysis is limited in its capacity to speak to longer term outcomes or new reports that may have been lodged after 2019.

Pre-PHSB Report

Prior to the first Helpline report for PHSB, 53.3 percent of these children and young people presented in a hospital emergency department at least once.

55 percent of young people identified in ChildStory also had contact with other health services prior to their first PHSB report.

Of the 5,105 children and young people in the study, four percent had at least one admission episode with NSW Youth Justice. Almost 11 percent of the 5,105 children and young people identified in ChildStory, also had contact with the criminal justice system prior to their PHSB report.

PHSB Report

For the vast majority of PHSB report, a Helpline assessment outcome was finalised within less 24 hours. The median time between a Helpline assessment and the commencement of a field assessment was 32 days.

Approximately three quarters of the children and young people reported were assessed as meeting the statutory threshold of risk of significant harm (ROSH).

All ROSH reports are transferred to a Community Services Centre (CSC) and then during the triage process, some were allocated to a caseworker for further actions. Of the 3,878 ROSH reports, 25 percent were allocated to a caseworker. Over half of the ROSH Reports (63 percent) were closed due to competing priorities.

Of the 1,150 allocated for field assessment, 27 percent were substantiated, and 28 percent were not substantiated. Another 23 percent had not commenced field assessment but reviews of existing files only.

Post-PHSB Report

Following their first PHSB report, 48 percent of children and young people were again reported to the Helpline. Of these, most were reported on more than one occasion (68%) and 386 were reported on 10 or more occasions.

Of the 5,105 children and young people reported to the Helpline for PHSB, after their first PHSB reports, 41 percent presented at an emergency department, cumulating to a total of 6,540 visits. 40 percent were seen through non-admitted Health services. This compares with 45 percent prior to first PHSB reports.

Almost six percent of the children and young people who had a report for PHSB made about them were convicted of a crime. This compares with 11 percent prior to first PHSB reports.

Nearly seven percent recorded at least one episode of admission with NSW Youth Justice following first PHSB report. This compares with four percent prior to first PHSB reports.

Children and young people who received PHSB-related services after DCJ Field Assessment

- Of the 5,105 young people in this sample, 1,150 had their first PHSB report triaged to field assessment.

- Of the 440 who received a PHSB-related service, 63 were already engaged with the service before their PHSB report was received by DCJ. For these young people, it is unlikely that the service episode resulted from their contact with DCJ field assessment teams. It is the remaining 377 young people for whom we can be reasonably confident that a new service engagement occurred, most likely because of a referral from DCJ. This is approximately one in three young people whose cases are triaged to field assessment, but still, only seven percent of all (n=5,105) children and young people for whom a PHSB report was made.

- Young girls were more likely to appear for a new PHSB-related service than young boys, although for both boys and girls, younger children were more likely to appear in a PHSB-related service. Further, a new PHSB-related service episode was more likely to be recorded for triaged cases that involved concurrent reports of either physical or sexual abuse.

Children and young people who received New Street Services

- In response to the Royal Commission's recommendation, New Street has now been expanded to a statewide service. At the time of data collection, New Street was in operation in four LHDs including WSLHD, ISLHD, Western NSW LHD and HNELHD. The following findings are derived from the administrative data provided by WSLHD and ISLHD.

- Fifty-nine young people were identified from the data provided. Of the 59 young people, nearly 50 percent were 13 and 14 years of age, followed by 12 years (20.3%) and 15 years (13.6%). Fifty-five clients were males and four were females.

- Overall, almost 29 percent of these young people identified as Aboriginal, compared to 71.2 percent identified as non-Aboriginal.

- Of the 59 young people, almost 10 percent were identified as having trauma or stressor disorders and 10 percent with an intellectual disability.

- The primary form of PHSB was non-penetrative sexual touching (75%), followed by penetrative behaviour (50%).

- Females accounted for 59.3 percent of victims and males 39 percent.

- Of the 55 male clients, 20 of them had displayed PHSB against one male victim. Nearly half of the 55 male clients (45.5%) had displayed PHSB against one female victim. Of the four female clients, two of them had displayed PHSB against males, and two against females.

- The relationship between the 59 young people displaying PHSB and their victims was typically familial, with 22 percent sisters, almost 12 percent brothers, 10.2 percent cousins, and 10.2 percent a peer or an acquaintance. Only 3.4 percent of victims were strangers.

- More than half, 59 percent of the PHSB occurred at the victim's home. In over 67 percent of the cases, the behaviour was disclosed by the child who was harmed, 15.3 percent by an adult witness and 8.5 percent by a child witness other than the victim.

- Over 27 percent of young people had acknowledged their PHSB during the therapeutic process at New Street. Another 25.4 percent had 'partially acknowledged' which could mean that the young person admitted having committed aspects of the PHSB but had not acknowledged the full extent of the PHSB and its impacts. Nearly 31 percent were 'not stated'. It is noteworthy that, of the 59 young people identified in the dataset, only 15 had completed treatment. This means that, at the time of data collection, the work around acknowledgment was yet to be completed for those young people who were still in the therapeutic process.

Research interviews

- In total, 31 participants were recruited, comprising 20 caregivers and 11 young people from five different specialist services in public health and youth justice. Of the 31 participants, seven identified as Aboriginal people including three caregivers and four young people.

- In keeping with the research ethics approval, the interviews were designed to capture participants' perceptions and experiences of service accessibility and engagement, rather than the problematic and harmful sexual behaviour itself.

- Participants were asked about what they found helpful and unhelpful from services they had contact with, what they gained and needed from services, barriers they experienced when accessing services and how services can improve, and what they would want future potential service users to know about services.

- Key findings are captured in the following themes:

What were the service needs and contexts?

- Immediate support needs following disclosures:
  - Recognition of crisis
  - Prompt follow-up supports
  - Sensitivity and care
  - Specific needs in out of home care
- Diverse support needs and service contexts

"There are still a lot of families that would never have dreamt that would happen. So, approach it with a bit more compassion and a bit more understanding." (Caregiver)

What helps with service engagement?

- Being non-judgemental
- Being trustworthy
- Matching counsellors with clients' needs

"He's so justice-focused, he wants what's right for the kid, you don't feel like you need to lie or twist your words." (Young Person)

What have participants found helpful?

- Child-centred practice
- Involving caregivers
- Attending to multiple support needs
- Strengthened family relationships
- Improved capacity to reflect on consequences of behaviours

"I've opened up to my family a lot more. They're more realising about how I feel." (Young Person)

What have participants found unhelpful?

- Closed doors
- Unprofessional service response
- Reduced caregiver autonomy

"Well, we've got him booked in for a psychologist, but we booked that last year and his earliest appointment was for May this year." (Caregiver)

What were the barriers to service access?

- Service availability and capacity
- Service visibility
- Apprehension about help-seeking
- Care continuity
- More support for caregivers

"My fear was the stigma attached if our privacy wasn't respected, you know?" (Caregiver)

What can be improved?

- More support for caregivers

"There's not a lot of support for how it affects the carer because it floored us." (Caregiver)

- More accessible and timely supports
- More prevention and early intervention efforts

Chapter 1: Introduction

BACKGROUND

The New South Wales (NSW) Ministry of Health is leading a state-wide program to improve service system responses to children and young people who have displayed problematic and harmful sexual behaviour (PHSB herein). This program of work responds to the findings and recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017) which has identified PHSB by children and young people as a major concern, not only within institutional settings but also in the wider community. It estimated that there may be thousands of children harmed by other children's sexual behaviours in Australia each year. However, this issue remains largely hidden and under-researched.

In 2018, the NSW Government responded to the Royal Commission's recommendations and committed to establishing a cross-government framework that aims to reduce PHSB in children and young people, focusing on prevention, early intervention and improved access to specialist treatment services. The framework will be informed by research evidence, drawing on the perspectives and experiences of children, young people and their families.

Within this remit, The Program Delivery Office (PDO) of the NSW Ministry of Health has engaged the University of Wollongong to undertake a research project into service access and engagement for children and young people who have displayed PHSB. This research has two overarching objectives. First, it aims to identify service pathways within the child protection, public health and criminal justice systems for children and young people who have displayed PHSB. Second, it draws on the lived experiences of young people and their caregivers to identify factors that support or hinder service accessibility and engagement.

This research used a mixed-method design including: (1) data linkage analysis of over 5,000 children and young people across the child protection, public health and criminal justice systems; and (2) semi-structured individual interviews with 31 caregivers and young people accessing specialist services for PHSB within the Illawarra Shoalhaven Local Health District (ISLHD), Western Sydney Local Health District (WSLHD) and NSW Youth Justice.

DEFINITIONS

Disagreements among practitioners about what constitutes PHSB in children and young people are common (e.g., Haugaard, 1996). Resources such as the 'Traffic Light System' have been developed to provide a definitional framework to outline the differences between appropriate sexual behaviour and harmful sexual behaviour in children and young people (Child at Risk Assessment Unit, 2011). Similarly, Hackett (2014) places sexual behaviours of children and young people into a continuum, from (1) *normal* or socially accepted and developmentally expected sexual behaviour to (2) *inappropriate* behaviour that may be acceptable within a peer group, (3) *problematic* or socially and developmentally uncommon behaviours, (4) *abusive* or sexual behaviour that is coercive and has a victimising intent, and (5) *violent* or physically forceful and extremely intrusive behaviour. Whilst these definitional frameworks assist to separate problematic and harmful behaviour from developmentally appropriate behaviour, they may obscure the context and interpersonal dynamics in which the behaviour occurs and the victimising effects on the child harmed. Araji (2004) emphasises that, in addition to consent, power disparity and use of coercion, questions relating to how the behaviour has interfered with the child's development and caused long-term negative consequences should be considered.

Problematic and harmful sexual behaviour

In this research, PHSB is defined as sexual conduct by or between children or young people that is neither developmentally expected nor socially accepted and has profound negative developmental and social consequences (Cox et al., 2018; Hackett, 2014; Hackett et al., 2016; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017).

A range of behaviours can be described as problematic and harmful, from non-contact behaviours such as showing pornography to younger children, voyeurism and exhibitionism to non-consensual sexual contact, including fondling a child over the clothes, sexual touching or kissing a child and performing oral, vaginal or anal sex (Balfe et al., 2019; Meiksans et al., 2017; Shlonsky et al., 2017b).

Problematic sexual behaviour

Problematic sexual behaviours cause distress and disruption to a child's development but do not involve overt victimisation (Hackett et al., 2016). These behaviours could include self-stimulation and nonintrusive sexual interactions with other children that are more overt than exploratory sex play (Hackett et al., 2019; Hackett et al., 2016). These behaviours are also problematic because they continue despite the presence of directives to stop by adults or the child involved (Hackett et al., 2019; Hackett et al., 2016).

Harmful sexual behaviour

Harmful sexual behaviours, on the other hand, involve threat or coercive control within the dynamic of power imbalance because of differences in age, gender, social popularity, intellectual ability or physical strength. Since harmful sexual behaviour displayed by young people may or may not result in a criminal conviction or prosecution, defining it within the context of power imbalance is important because it recognises that harmful sexual behaviour is enacted through misuse of power, sometimes with bribery, coercion, intimidation or force (Hackett et al., 2016). It is, however, important to acknowledge that the harmful effects of the behaviour on victims and on the person causing harm, with or without convictions, are comparable to those children or young people who have been sexually abused by adults (O'Brien, 2010).

Children and young people who have displayed problematic and harmful sexual behaviour

There is growing awareness that terms such as ‘juvenile sex offender’ or ‘perpetrators’ are stigmatising and fail to consider the developmental levels of the child or young person and the complex environment in which the behaviour occurs. Hackett et al. (2016) have warned that ‘imprecise or vague terminology can lead to misclassifying children and young people or labelling them inappropriately’ (p.12). This echoes O’Brien’s (2010) recommendation that, ‘careful use of terminology is required to ensure that systems can respond appropriately, and with sensitivity, to the broad spectrum of sexualised behaviours and the conditions that are likely to have contributed to them’ (p.14). Eschewing the term ‘juvenile sex offender’ also recognises that many of the children and young people involved in this research have not been charged or convicted for the behaviour, either because they are under the age of criminal responsibility, or a child protection response has been deemed to be more proportionate to the severity of their behaviour. Nonetheless, it is important to acknowledge that PHSB causes negative long-term impacts on the victimised child, the child causing harm and their families.

In this research, the term ‘children and young people who have displayed problematic and harmful sexual behaviour’ is used[1]. This aligns with the terminology used by the Royal Commission (2017) and international literature (Barry & Harris, 2019; Hackett, 2014). This terminology also avoids using the age of criminal responsibility to differentiate problematic from harmful sexual behaviours, while still acknowledging the harm caused to victims. Using ‘harmful sexual behaviour’ rather than ‘sexually harmful behaviour’ also foregrounds victims’ experiences that the harm is more than sexual; its impacts have profound implications for physical, psychological, social and sexual development and spiritual health and wellbeing (Tolliday, 2021).

PREVALENCE

PHSB by children and young people has increasingly come into the spotlight (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017). This can partly be attributed to the rising number of child sexual abuse disclosures following the implementation of general child sexual abuse prevention programs (McKibbin et al., 2017).

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[1] References to ‘abuse’ and ‘offences’ have regardless been used throughout this literature review to ensure accuracy of reporting of cited literature.

However, the exact prevalence remains difficult to establish. Despite mandatory reporting of child protection concerns in some Australian jurisdictions, insufficient awareness and recognition of PHSB and its associated stigmatisation often results in under-reporting (Cox et al., 2018; Meiksans et al., 2017; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017). These undetermined rates of non-disclosure perpetuate the hidden nature of PHSB (Hackett, 2014; O'Brien, 2010).

Where disclosures or reports have been made, research suggests that young people under the age of 18 constitute a significant proportion of those who sexually harm other children and young people. In Australia, Ferrante et al. (2017) found that one in five of sexual assaults reported to the police between 2010 and 2014 were recorded as having both a victim and offender under the age of 18. Similarly, recorded crime data from the Australian Bureau of Statistics reported that one-fifth of all child sexual abuse offenses between 2019 and 2020 were committed by children and young people 10 to 19-years-old (Australian Bureau of Statistics, 2021a). The Royal Commission (2017) found that one in six of those who reported being sexually abused in institutional settings were harmed by other children and young people.

International research suggests 30 to 50 percent of those who commit sexual abuse are young people (Erooga & Masson, 2006; Finkelhor et al., 2009; Finkelhor et al., 2015; Hackett et al., 2013; McCartan et al., 2011; Vizard, 2006). A population-based study in United Kingdom found that 65.9 percent of sexual abuse reported by children and young people was committed by another child or young person (Radford et al., 2011). In the United States, over one-third of sex offences against children were committed by young people (Finkelhor et al., 2009).

CHARACTERISTICS

Children and young people who display PHSB are a heterogeneous group (Malvaso et al., 2020). Nonetheless, research has identified some common individual, familial and environmental characteristics.

Gender

Most children and young people identified as displaying PHSB are adolescent boys (Cox et al., 2018; Hallett et al., 2019; O'Brien, 2010). Hackett et al. (2013) reviewed 700 case files of children and young people referred to services for harmful sexual behaviour between 1992 and 2002 and found only 3 percent of the sample were girls. Similarity, Finkelhor, Ormrod and Chaffin (2009) reported that adolescent girls constituted only 7 percent of young people who committed sexual offences against children. However, girls who were identified as displaying PHSB were generally younger than boys; they were also more likely to have multiple victims and commit the behaviour against family members or boys (Finkelhor et al., 2009).

Age

Early adolescence between the ages of 12 and 14 is the age group during which the behaviour becomes known to services or justice systems (Allardyce & Yates, 2018). Finkelhor, Ormrod and Chaffin (2009) found that the number of young people whose behaviour became known to the police increased sharply at age 12 and plateaued after age 14 years. Similarly, Hackett et al. (2013) found that 54 percent of referrals to services were aged between 14 and 16. This is supported by Australian crime statistics. The Recorded Crime–Offenders data for 2019-2020 (Australian Bureau of Statistics, 2021b) shows that offenders aged 14-16 inclusive whose principal offence was a sexual assault or related offence account for almost 57 percent of all young offenders (12-17 years inclusive), and approximately 9 percent of all offenders, with a principal offence of sexual assault or related offence. Those aged 10 and 11 inclusive accounted for approximately 3.6 percent of overall youth offending for sexual assault or related offences. Consistent with earlier research (Finkelhor et al., 2009), the rate of sexual assault or related offence sharply increased at age 12 and peaked at age 14 (Australian Bureau of Statistics, 2021b).

Gathering reliable data about children under 10 years of age who display PHSB has unique challenges due to varied ages of criminal responsibility in different jurisdictions and a lack of specific treatment services from which they can be identified. The Australian Bureau of Crime Statistics reported that children under 10 years of age accounted for less than 1 percent of the total sexual offences by children and young people (10 to 17) between 2015 and 2016 (Cox et al., 2018).

Ethnicity

Internationally, information relating to ethnicity is generally lacking in reporting and research (Allardyce & Yates, 2018). Australia, however, has clear evidence that Aboriginal and Torres Strait Islander children and young people are over-represented as both victims and people causing harm (Ferrante et al., 2017). Factors such as intergenerational trauma, institutional racism and histories of mistrust associated with past government practices increase the difficulty for Aboriginal and Torres Strait Islander families to seek appropriate legal support and access culturally inclusive services (Meiksans et al., 2017, p. 7; O'Brien, 2010). Similarly, culturally and linguistically diverse children and young people who are newly settled or are refugees may have histories of trauma and different cultural understandings of what constitutes appropriate and harmful sexual behaviour (Ali et al., 2021). These factors, combined with other social and economic disadvantages may prevent them from receiving early support (Ali et al., 2021; Evertsz & Miller, 2012; Meiksans et al., 2017).

Disability and mental health

Hackett et al. (2013) found that 38 percent of the 700 children they reviewed had a learning disability. Similarly, a systematic review of 59 independent studies by Seto and Lalumière (2010) found that young people with harmful sexual behaviour had more learning difficulties than young people who committed non-sexual offences. Specifically, children with intellectual disabilities have been argued to be more likely to present with PHSB because of their difficulty with impulse control and exposure to others with disinhibited sexual behaviours in institutional care settings (Evertsz & Miller, 2012). Regarding mental health diagnosis, a meta-analysis of 21 studies into young people with mental health disorders who did and did not sexually offend, concluded that around 70 percent of young people with PHSB have at least one mental health diagnosis (Boonmann et al., 2015).

Childhood trauma

Past victimisation of child sexual abuse is commonly reported in children and young people who display PHSB. Seto and Lalumière (2010), for example, found that young people who display PHSB were 5.5 times more likely to have experienced sexual abuse than young people who did not. Malvaso et al. (2020) systematic review indicated that the prevalence of child sexual abuse in children and young people with PHSB ranged from 26 to 92 percent.

In addition to sexual abuse, Malvaso et al. (2018) noted that young people with sexual offending convictions are more likely to have experienced physical and emotional abuse than other young people who committed non-sexual offenses. Seto and Lalumière (2010), for example, found that young people with PHSB are 1.6 times more likely to have a physical abuse history than young people with non-sexual offenses. It is however important to highlight that not all children and young people who have experienced maltreatment develop PHSB. Allardyce and Yates (2018) note that no correlation between past victimisation and PHSB is reported in other research studies. The victim-to-victimiser correlation should therefore be interpreted with caution and understood in a wider context including other environmental factors including unstable family environment, domestic and family violence, parental substance abuse and mental health difficulties, economic and social disadvantages, inadequate sex education, excessive consumption of pornography, and lack of positive peer relationships and role models (Evertsz & Miller, 2012; McKibbin et al., 2017).

NATURE OF BEHAVIOUR AND PLACE OF ABUSE

Clinical studies documented diverse PHSBs, ranging from sharing pornography with younger children to fondling a child over the clothes, sexual touching of peers, performing oral, vaginal, or anal sex on a much younger child to date rape and gang rape (Finkelhor et al., 2009). Co-occurrences of these behaviours are common, for example, Hackett et al. (2013) found that, of 700 cases examined, 84 percent related to inappropriate touching, 52 percent involved penetrative abuse, 18 percent were physical violence and 50 percent related to non-contact behaviour. These findings are comparable to other juvenile justice studies which found that fondling (49 percent) is likely to be the most serious offence committed by young people (Finkelhor et al., 2009). However, it is important to recognise that sexual violence, including rape, constituted between 18 and 24 percent of the sexual offences committed by young people in both clinical and juvenile justice studies (Finkelhor et al., 2009; Hackett et al., 2013). These findings sharply contrast with a recent Australian study in which 75 percent of all reported cases to the police, where the offender was an older child were classified as aggravated sexual assault offences (Ferrante et al., 2017).

Most PHSB occurs in domestic environments including the family home or the homes of extended family members and friends. In Australia, 65 percent of PHSB reported to police occurred in the family home (Ferrante et al., 2017). School is the second most common place in which PHSB occurred. Finkelhor, Ormrod and Chaffin (2009) found that 12 percent of PHSB happened at school. The Royal Commission has also documented growing concern about PHSB in institutional settings, including out-of-home care. This resonates with other Australian and international research that children and young people in out-of-home care settings, particularly residential care, are more vulnerable to being victimised by PHSB (Euser et al., 2013; McKibbin, 2017).

Allardyce and Yates (2018) note that whilst PHSB in community settings is relatively less prevalent, public indecency or peer-on-peer coercive sexual behaviour in places where young people congregate, such as parks is not uncommon. Yates et al. (2012) differentiate between four subgroups of young people displaying harmful sexual behaviour: (1) young people who have abused only siblings; (2) young people who have abused only in the community; (3) young people who have abused both siblings and in the community; and (4) young people who have abused family members other than siblings such as cousins, nephews or a child in foster care. Previous research found that between 15 and 25 percent of young people abused in both family and community settings (Worling, 2001; Worling & Curwen, 2000; Worling et al., 2010).Yates et al. (2012) found that this crossover group had generally started abusing at a younger age and at home before abusing in the community. They were also found to have experienced more extensive abuse themselves (Yates et al., 2012).

There is also growing awareness of technology-assisted PHSB, including compulsive use of pornography either independently or with younger children; creating, sending or distributing explicit sexual images online, viewing child sexual abuse material or coercing another person to perform sexual acts online (Allardyce & Yates, 2018; Hollis & Belton, 2017).

VICTIMS' CHARACTERISTICS

Victims of PHSB are predominantly girls. Although, Finkelhor et al (2009) found that where victims were boys, they were more often victimised by girls and were younger than female victims. It has been a consistent finding that most victims were known to the person causing harm (Allardyce & Yates, 2018). They were, however, not necessarily a family member or boyfriend/girlfriend (Ferrante et al., 2017) but acquaintances of the family (Finkelhor et al., 2009). It is however important to recognise that extrafamilial abuse was more likely to be reported compared to instances involving family members (Ferrante et al., 2017).

Overall, Finkelhor, Ormrod and Chaffin (2009) found that 59 percent of the victims were under the age of 12; the age range then dispersing widely, with only a small proportion of victims over the age of 16. Similarly, in Australia, nearly two-thirds of victims are under 10 years of age (Ferrante et al., 2017). In general, most victims are younger than the person causing harm. The average age gap between the young person causing harm and the victim is three years (Ferrante et al., 2017). More specifically, Finkelhor, Ormrod and Chaffin (2009) found that for young people between the ages of 15 and 17, their victims were typically two to five years younger. For children under 12, the PHSB is often found to be committed against children one to two years younger (Finkelhor et al., 2009).

SIBLING HARMFUL SEXUAL BEHAVIOUR

Sibling harmful sexual behaviour refers to a wide range of behaviour including 'intercourse, attempted intercourse, oral–genital contact, fondling of genitals directly or through clothing, exhibitionism, exposing children to adult sexual activity or pornography, and the use of the child for prostitution or pornography' (Caffaro, 2016, p. 544). Sibling harmful sexual behaviour is the most common form of familial sexual abuse (Krienert & Walsh, 2011). Research has found that it is three to five times more prevalent than parental sexual abuse (Caffaro & Conn-Caffaro, 2005; Stathopoulous, 2012; Stroebel et al., 2013). As with extrafamilial sexual abuse by young people, victims of sibling harmful sexual behaviour are predominantly females and those who harm are predominantly males (Wong et al., 2020). O'Brien (1991) found that sibling harmful sexual behaviour generally involves more intrusive behaviours than extrafamilial abuse, including penile penetration (46%), and occurs over longer periods of time.

A recent Australian study examined 30 sibling harmful sexual behaviour cases and found that the harming siblings, on average, were five years older than the siblings being harmed (Wong et al., 2020). Of the 30 cases referred to the Child Protection Units at the Children's Hospitals in NSW, nearly half were reported to the child protection statutory authority within 12 months following the sibling harmful sexual behaviour incident (Wong et al., 2020). In non-clinical settings, however, formal disclosures of sibling harmful sexual behaviour are less likely than abuse perpetrated by extrafamilial adults (Carlson et al., 2006). This may be due to parental concern about removal of their children as a consequence of reporting, coupled with shame and stigma about the abuse. The misconception that sexual behaviours between siblings are harmless and normal may also contribute to under-reporting (McDonald & Martinez, 2017).

Sibling harmful sexual behaviour creates unique challenges for parents and families. Disruption of family lives and destabilisation of family dynamics intensify parental distress. Sibling harmful sexual behaviour may lead to separation of the siblings, which often presents practical challenges for the family including financial stress. Protecting victims from further harm and holding the harming child/young person accountable is interlaced with multiple dilemmas when both the victim and the person who has caused harm are children and dependent on their parents care and protection (Tolliday et al., 2018). Parents may experience conflicted loyalties, feeling they need to choose between their children. Believing and supporting the victimised child may appear to be done at the cost of the other child's welfare because this may lead to long-term consequences including criminal conviction or removal of one or more children from the family home. Contrariwise, trivialising the abuse or supporting the child who has caused harm may be seen as allying with the child, aggravating the harm on the victimised child (Wong, 2020). Moreover, covert mother blaming in service delivery may also occur, preventing reporting and support seeking (Allan, 2004; Tolliday et al., 2018).

RECIDIVISM

A recent systematic review of 78 studies, including seven from Australia, concludes 'strong evidence demonstrating sexual recidivism rates amongst adolescent sexual offenders are quite low' (Malvaso et al., 2020, p. 55). However, research indicates that timely interventions and successful completion of treatment programmes are crucial to low recidivism. For example, Worling et al. (2010) examined 148 young people who completed offence-specific treatment and found a recidivism rate of five percent after ten years and nine percent after twenty years. In New South Wales, an evaluation of the New Street Services found that PHSB ceased in 89 percent of clients by the conclusion of the program, with three percent reporting they had engaged in PHSB three months following program completion (KPMG, 2014). Furthermore, research has found that recidivism rate for sexual offences is markedly lower than non-sexual offences. In one study, the recidivism rate for non-sexual offences varies from 30 to 72 percent, compared with a sexual offence recidivism rate of zero to 30 percent (Carpentier & Proulx, 2011).

Treatment dropouts is a significant risk factors for sexual recidivism (Laing et al., 2014). Consistent with the research evidence presented earlier, sexual victimisation during childhood, exposure to sexual violence, unstable family environments, disengagement from education and dual mental health diagnoses also increase vulnerability to sexual reoffending (Allardyce & Yates, 2018; Carpentier & Proulx, 2011). This research evidence highlights that reducing recidivism must also attend to these other support needs.

CURRENT SERVICE LANDSCAPES IN NSW

In New South Wales, New Street is the only public health service specifically for young people, aged between 10 and 17, who have displayed PHSB. Founded in 1998, the original New Street services in Parramatta, Sydney and Newcastle have since expanded to Western New South Wales (Dubbo, Orange and Bathurst), Illawarra Shoalhaven (Wollongong and Nowra) and Hunter New England (Tamworth), with additional services now operational in another seven Local Health Districts. This expansion was part of the NSW government response to the Royal Commission's recommendation. Given that New Street has only recently been established as a state-wide service, only the New Street services in Western Sydney Local Health District (WLSHD) and Illawarra Shoalhaven Local Health District (ISLHD) had relevant administrative data for this research.

For children under 10 years of age and their families, Hunter New England Local Health District (HNELHD) is the only LHD that currently operates a dedicated service for this client group, which is called Sparks Clinic. Service provisions in other Local Health Districts are shared between multiple services including Child Protection Counselling Services (CPCS), Domestic Family Violence and Sexual Assault Services (DFVSAS), Integrated Violence, Abuse and Neglect Services, Child and Family Health Services and Child and Adolescent Mental Health Services (CAMHS). These services, along with a small number of non-government organisations such as Rosie's Place in Mount Druitt and Waminda South Coast Women's Health and Welfare Aboriginal Corporation in Nowra, provide tailored counselling support to children and families affected by PHSB as an adjunct to their core services. Referral pathways to services overall are found to be inconsistent and limited by scarce service resources (Meiksans et al., 2017). In response to the Royal Commission's recommendation, the 'Safe Wayz' program is being implemented by NSW Health to centralise referrals and assessments for children under the age of criminal responsibility, currently 10 years of age, who have displayed PHSB.

NSW Department of Justice and Community (DCJ) have a small workforce of psychologists providing support to children and young people with PHSB. Within the justice context, Youth Justice NSW provide individualised, evidence-based and trauma-informed therapeutic services for young people with PHSB.

Overall, research has revealed that services for PHSB in Australia are underfunded (Nagy & Stathopoulos, 2016; O'Brien, 2010), siloed, inconsistent and uncoordinated. Information on available therapeutic services is provided to some families but not others (O'Brien, 2010; Quadara et al., 2020; Shlonsky et al., 2017b). Logistical challenges such as needing to cover large geographic areas has also left some young people and families in remote and regional areas without support, even when the behaviour has been substantiated during the term of a justice order (O'Brien, 2011).

Complex program eligibility requirements such as contact with the criminal justice system and specific age ranges have also excluded a significant number of young people from receiving suitable services (Quadara et al., 2020). Parents may be able to identify that their child is exhibiting or is a victim of PHSB but may be unaware of what can be done about it (Hackett, 2011). Misunderstandings of PHSB as 'normal experimentation' or 'developmental curiosity' also remain evident (O'Brien, 2008), leading to delayed identification and service provision.

RESEARCH AIMS

The challenges listed above have important implications. As noted previously, timely access to services and completing specialist treatment for PHSB is crucial to reducing recidivism and enhancing safety for families and communities. This research therefore aims to investigate where service pathways and gaps exist, and what young people and families have found helpful and would have found helpful when accessing and engaging with services. Using a mix-method design, this research consists of (1) linkage of administrative data from the child protection, public health, youth justice and criminal justice systems; and (2) semi-structured interviews with existing clients of specialist services.

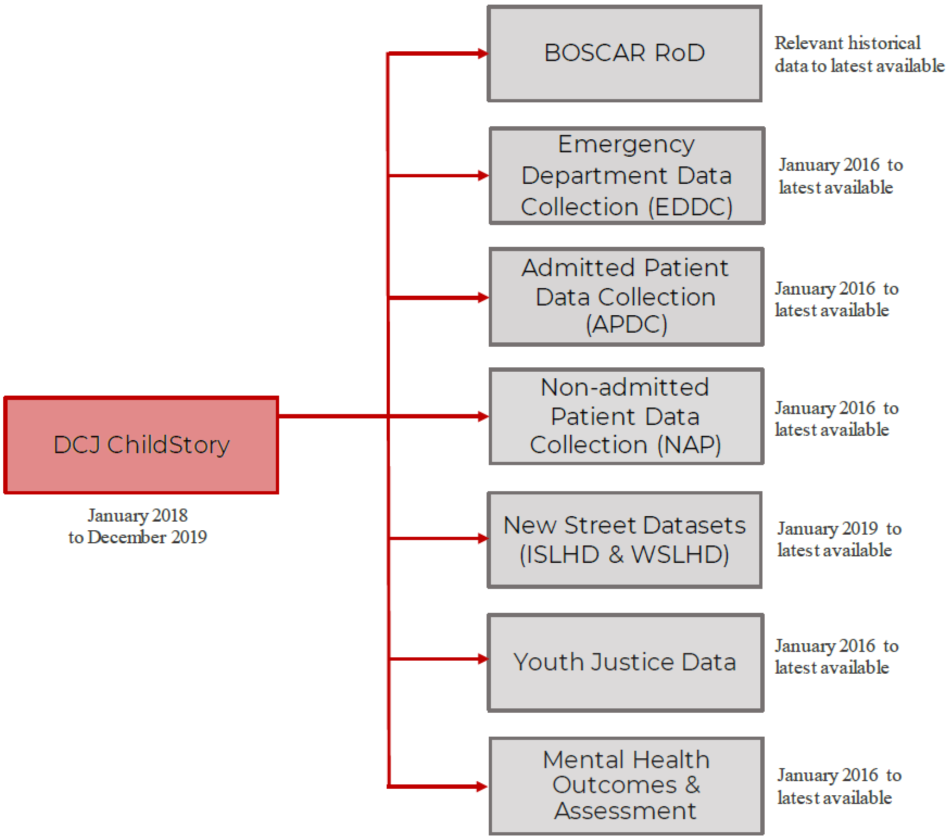
Following this introduction, Chapter 2 reports the data linkage methodology and its findings. The interview component including its methodology and findings are reported in Chapter 3. The quantitative and qualitative findings are integrated into four service journey maps, presented in Chapter 4. Discussion of key findings are reported in Chapter 5. This research report concludes with recommendations in Chapter 6.

Chapter 2: Data Linkage

This chapter outlines the data linkage methodology and presents a detailed analysis of the findings pertaining to children and young people in NSW who were reported as having displayed PHSB. To achieve this, a census of all reports of PHSB listed in the DCJ ChildStory database between 1 January 2018 and 31 December 2019 was extracted. This includes children or young people for whom a report of PHSB was made to the DCJ Helpline, as well as children and young people for whom PHSB was identified during a DCJ field assessment that was being undertaken for a different reason. In all, there were 5,105 unique children and young people in the study sample.

DATASETS INVESTIGATED

The DCJ ChildStory data received by the research team covers the period between January 2018 and December 2019. These data relate to children and young people (0 to 17 inclusive) reported to the child protection Helpline with the concern listed as ‘child/young person displaying sexually harmful behaviour’ either as the primary or secondary issue assessed by the Helpline and/or during the field assessment as reported in ChildStory. A cohort of children and young people was identified through this dataset and linked with the following datasets by the Centre for Health Record Linkage (CHeReL) for our data linkage analyses:



RESEARCH ETHICS

Ethics approvals were granted by the NSW Population and Health Service Research Ethics Committee (PHSREC) and the Aboriginal Health & Medical Research Council of NSW (AH&MRC).

METHODOLOGY

For the purposes of this study, the analysis is framed within the context of each child's first report of PHSB recorded within the database. This first report becomes the temporal anchor point that delineates between pre-PHSB and post-PSHB events or activities, including those derived from other datasets. Importantly, readers are to be reminded that as a cross-sectional sample of the DCJ ChildStory database, what is described here as a child's 'first recorded report of PHSB' may not be the first report made about that child, in particular if an earlier report of PHSB was made before 1 January 2018. Similarly, since the ChildStory reports are only available to 31 December 2019, analysis is limited in its capacity to speak to longer term outcomes or new reports that may have been lodged after 2019.

Counting PHSB - a technical note

Although uncommon, it is possible that multiple consecutive reports of PHSB can be lodged for a single child within a short period of time, typically by different reporters from different agencies, each with mandatory reporting obligations. Often these multiple reports will be treated as a single event for assessment and triaging purposes, even though the DCJ ChildStory data does not include a unique 'incident' identifier. Further, it is not always the case that investigation and assessment outcomes are recorded against each report of the same incident and the decision to allocate the case for field assessment may be tagged to just one of multiple reports received about the same incident. These are complex data collection systems which can result in a 'double counting' bias against those young people for whom multiple reports of the same incident are more likely. Without some adjustment, it would also adversely affect the estimation of time between multiple reports of PHSB if consecutive daily reports of the same incident were counted as if there were unlinked.

To address this, a counting rule has been applied to the ChildStory data which combines all consecutive reports of PHSB into a single 'episode' if they occurred within a three-day window. In other words, from the date of the first PHSB report, any other PHSB report received by the DCJ Helpline within three days is treated as a cluster and the outcomes of all grouped reports are considered as pertaining to the same incident. For 4,636 (of the 5,105) children and young people in this sample, the first PSHB report was the only report to be received within a three-day window of the first report. For the remaining sample (n=469), the first report was followed by at least one other consecutive report within three days. Non-PHSB reports are counted using the same rules as above.

One challenge when working with linked data from healthcare and justice databases is that information is collected in ‘real time’ and its collection is for operational, not research or statistical purposes. As a consequence, the data are vulnerable to other operational priorities and influences and can therefore be less reliable (Stewart & Davis, 2016). This may be for a variety of reasons including human errors (Maxfield & Babbie, 2011) and, at times, broad or misunderstood classification entry codes. Additionally, conditions may be misdiagnosed, or clients may not report (Stewart & Davis, 2016).

Criminal justice contact events are counted for any instance where the individual is known to have had contact with the police and where that contact resulted in a finding of guilt or conviction. Within this category of events, there are two distinct types of criminal justice contact which are reported separately. These are youth justice conferences or court appearances which resulted in a proven offence. To minimise the operational bias which can sometimes lead to a higher number of charges being applied in certain circumstances or against specific individuals, the decision was taken to aggregate multiple charges on a single day into a daily event of criminal justice system contact. This is an important mechanism used to mitigate the risk of over counting criminal justice system contact for those who might be subject to greater scrutiny by law enforcement (Payne, 2007). In terms of the Youth Justice data, contact events are counted for each recorded episode of ‘admission’ to a Youth Justice Order.

For Non-admitted patient (NAP) events, episodes of service are counted for all unique service delivery records irrespective of whether multiple records were recorded on a single day. Specifically, it is not unlikely that a person may receive multiple separate services at the same location or at different locations on the same day. For the purpose of this study, these are treated as separate episodes of service provision. One limitation of this is where separate services overlap, such as when one treatment begins at 1pm and finishes at 4pm and another service, for an unrelated matter, starts at 2pm.

Emergency Department (ED) presentations are counted for all unique instances of presentation to the emergency department irrespective of whether multiple presentations were recorded on a single day. While it is possible that two records are created for the same presentation, the more likely scenario is that a person will present to the emergency desk twice in one day, especially for chronic or acute issues. One limitation of this is where singular or multiple transfers occur between hospitals to facilitate service delivery access.

Admitted patient events, episodes of service are counted for all unique instances in which a person was admitted to a stay of any length in hospital, irrespective of whether multiple records were documented on a single day. Specifically, it is not unlikely that a person may receive multiple separate services at the same location or at different locations on the same day. For the purpose of this study, these are treated as separate episodes of service provision.

One limitation of this is where singular or multiple transfers occur between hospitals to facilitate service delivery access.

Developing client personas – a comment

A key objective of this project was to identify the differential experiences of different client personas with the intention of highlighting key groups which may have different and important policy and practice implications. The personas presented in this chapter are not wholly exhaustive nor mutually exclusive, meaning that some children and young people may be counted in multiple person groups. Given the considerable heterogeneity of the data, simple, higher-level clustering procedures cannot be mutually exclusive without using some form of hierarchical classification strategy. This might include counting rules which treat one persona as more or less important than another. Given that there is no clear preferential or importance hierarchy in the nature of service use or access, the decision was taken to develop the personas as whole groups, even if some young people are counted across multiple groups.

Further, the mostly categorical nature of the available data did not lend itself to statistical clustering techniques, since the range and variability of dichotomous and multinomial categories is limited. In our preliminary cross-tabulation analysis, the data evinced no obvious clustering and so the decision was taken to build personas based on service user types rather than statistically derived clusters. To be sure, statistical clustering techniques use mathematical algorithms to define points of frequency and numerical density across a set of available data. These techniques do not identify meaningful clusters where meaningful points of density do not exist and so we have erred on the side of creating clusters based on known service user types.

Personas, in this case, represent groups of children and young people defined by their different service contacts with the aim of identifying possible service pathways and explore their characteristics with regards to demographics, context and history of PHSB reports and their outcomes. Four personas were identified including: (1) children and young people whose PHSB reports were closed with no further service pathways identified; (2) children and young people received a PHSB-related service in Health (3) children and young people had contact with youth justice and criminal justice (youth and criminal justice hereafter) and (4) children and young people received a New Street service in ISLHD or WSLHD.

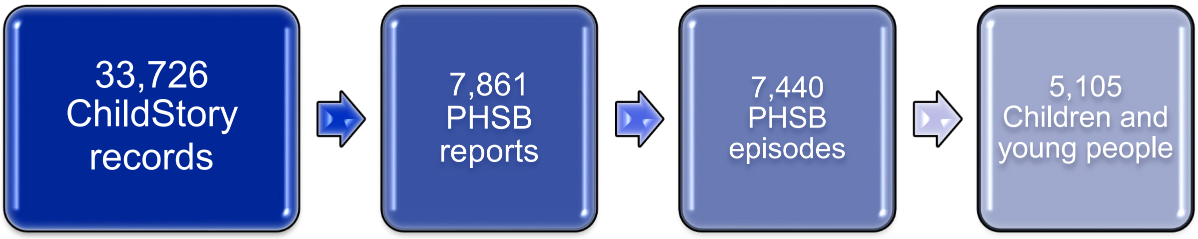
CHILDSTORY DATA: AN OVERVIEW

The DCJ ChildStory data received by the research team contained information about 5,105 children and young people who were identified by DCJ as having displayed PHSB, either as the primary or secondary Helpline assessed issue, or as a primary or secondary field assessed issue.

For these 5,105 children and young people, there were a total of 33,726 unique ChildStory reports. Of these, 7,861 reports had PHSB listed.

Some PHSB reports were made concurrently on the same day, often by different reporters of the same incident. Assuming all reports within a three-day window refer to the same 'episode' then the 7,861 reports pertain to 7,440 unique reporting episodes.

Figure 1: ChildStory reports and PHSB episodes

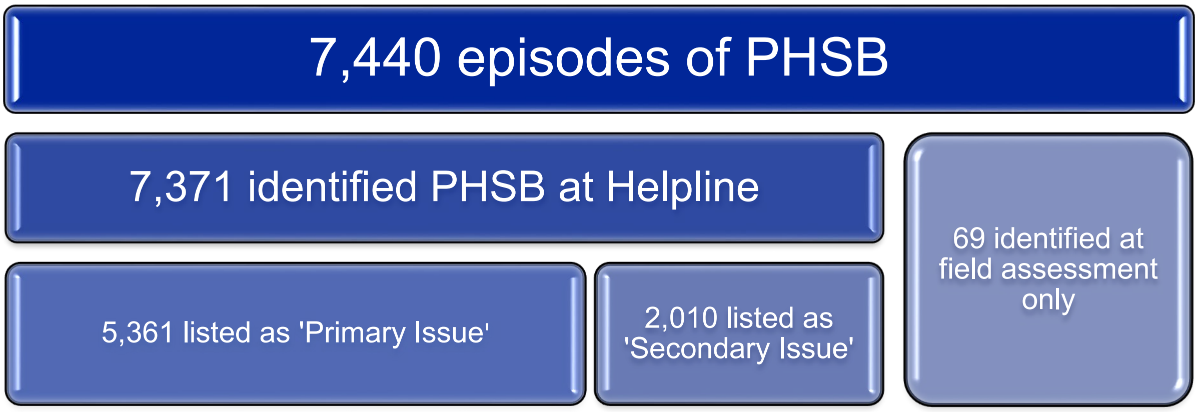


ChildStory data: PHSB identification

Of the 7,440 unique episodes of PHSB, 7,371 (>99%) were episodes where PHSB was flagged as either the primary or secondary Helpline assessed issue. Of these 7,371 episodes, 5,361 episodes in which PHSB was recorded as the primary issue (69% of all episodes).

There were 69 episodes assessed by the Helpline as PHSB but were later flagged during the field assessment as involving PHSB.

Figure 2: PHSB as either primary or secondary issue



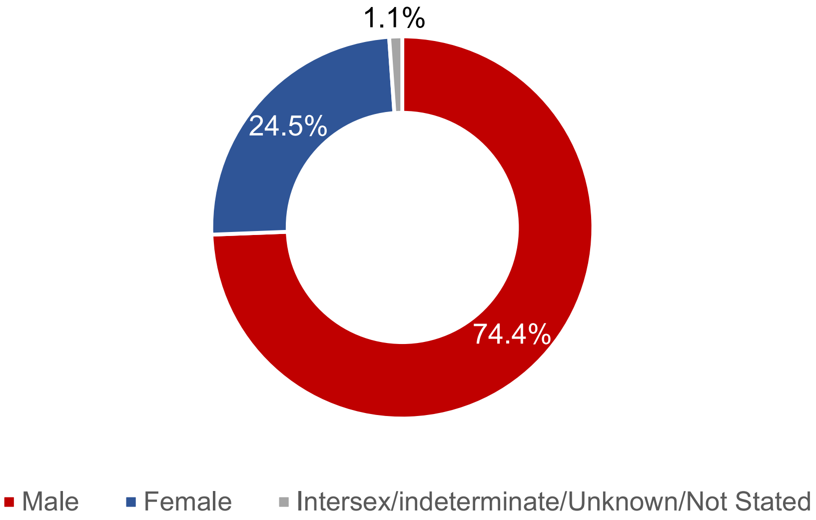
Analysis herein is conducted for the 5,105 children and young people.

Demographic characteristics

Age, gender and ethnicity

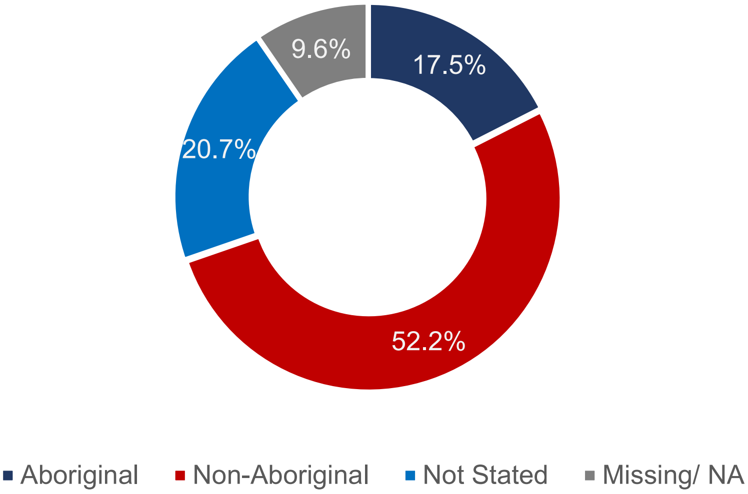
Results show that the majority, or almost 75 percent, of children and young people reported were male, with females only accounting for 24.5 percent (Figure 3).

Figure 3: Gender of children and young people



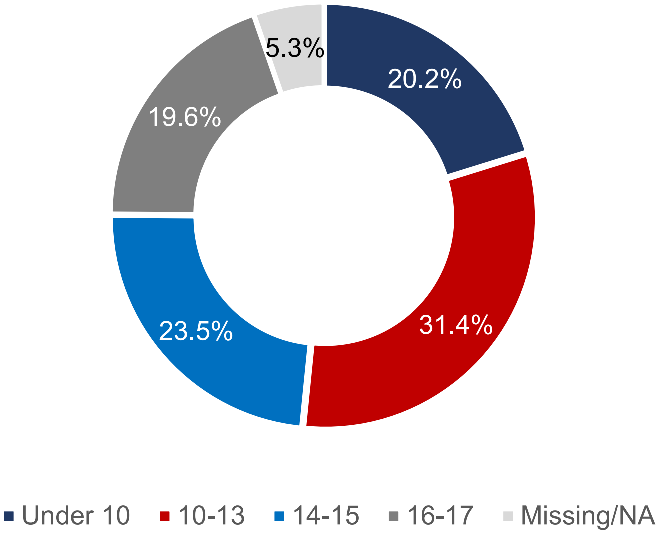
Additionally, 17.5 percent of those reported identified as Aboriginal and 52.2 percent as non-Aboriginal, although nearly 21 percent were unable to be identified as either (Figure 4).

Figure 4: Aboriginal Status of children and young people



As shown in Figure 5, there were also variations in the age groups PHSB was first reported. The 10-13 age group accounting for the highest number of first reports (n=1,601), followed by 14-15 and then under 10s (Figure 5).

Figure 5: Age of children and young people



Of the 5,105 children and young people, 4,785 of them had both gender and age recorded in the ChildStory dataset. As shown in Table 1, the 10-13 years old age group was most prevalent in both genders (37.6% for females and 31.7% for males). There was a larger proportion of under 10s in the female group (30%) than in the male group (18%). For the 16-17 age group, there was a larger proportion for males (23.6%) than for females (12.8%) (Table 1).

Table 1: Age and gender

Female	Unique Persons	% (of 1221)
Under 10	366	30.0
10-13	459	37.6
14-15	240	19.6
16-17	156	12.8
Male	**Unique Persons**	**% (of 3564)**
Under 10	639	18.0
10-13	1131	31.7
14-15	952	26.7
16-17	842	23.6

When comparing age and gender, females represented a lower proportion in all age groups (Table 2). Overall, females were a significant minority decreasing in prevalence as they age, from 36.4 percent under 10s to 15.6 percent between 16 and 17 years old. This contrasted sharply with males, increasing in prevalence as they age, from 63.6 percent to 84.4 percent.

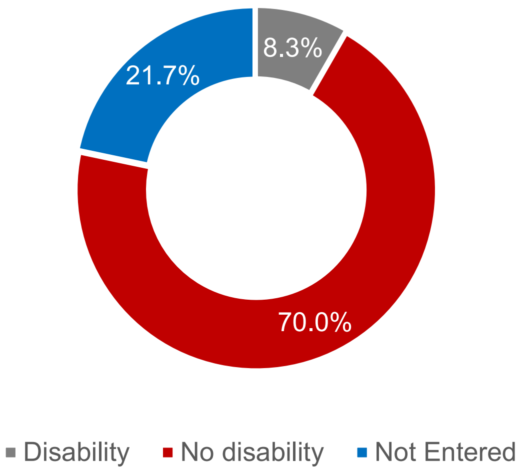
Table 2: Comparisons between age and gender

Age Range	Female	Male	Total	Female %	Male %
Under 10	366	639	*1005*	36.4	63.6
10 – 13	459	1131	*1590*	29.0	71.0
14 – 15	240	952	*1192*	20.0	80.0
16 – 17	156	842	*998*	15.6	84.4

Disability status

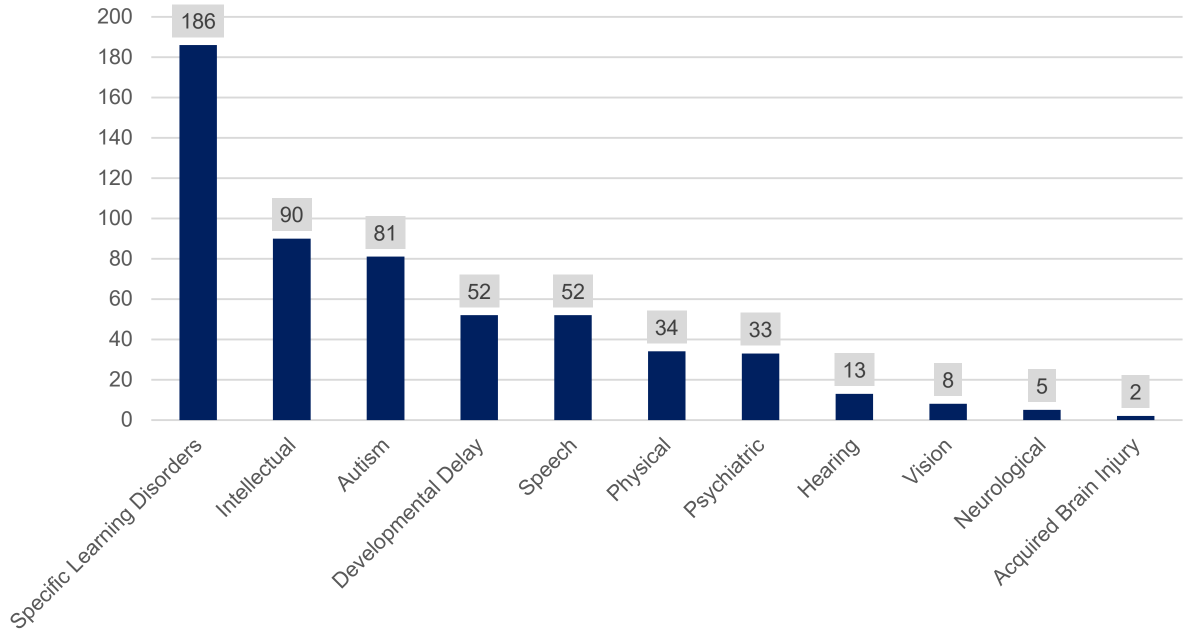
Just over 78 percent of children and young people had a disability status recorded in ChildStory. This comprised 70 percent of children and young people with no disability recorded and 8 percent with a disability recorded (Figure 6).

Figure 6: Disability status



Where disability status was recorded, learning disorders were most common, followed by intellectual disability and autism (Figure 7).

Figure 7: Disability status by type



Note: Multiple disabilities may be recorded for a single child – estimates reflect the total number of children with each disability, not the number of times each disability was recorded.

Location

Reports came from 67 of the 128 New South Wales local government areas. The most substantive number were from Sydney (n=763), followed by Central Coast (n=462), Campbelltown (n=249), Penrith (n=201), Blacktown (n=181) and Newcastle (n=150).

Table 3: PHSB reports by top Local Government Area (top 10)

Internal Business Unit LGA	Unique Persons	% (of 5,105)
Sydney (C)	763	14.9
Central Coast (C) (NSW)	462	9.0
Campbelltown (C) (NSW)	249	4.9
Penrith (C)	201	3.9
Blacktown (C)	181	3.5
Newcastle (C)	150	2.9
Parramatta (C)	147	2.9
Canterbury-Bankstown (A)	134	2.6
Lake Macquarie (C)	127	2.5
Shellharbour (C)	118	2.3

Note: Each Internal Business Unit was coded according to the LGA region of its physical location. This may not always reflect the location of the child. However, it is the best available.

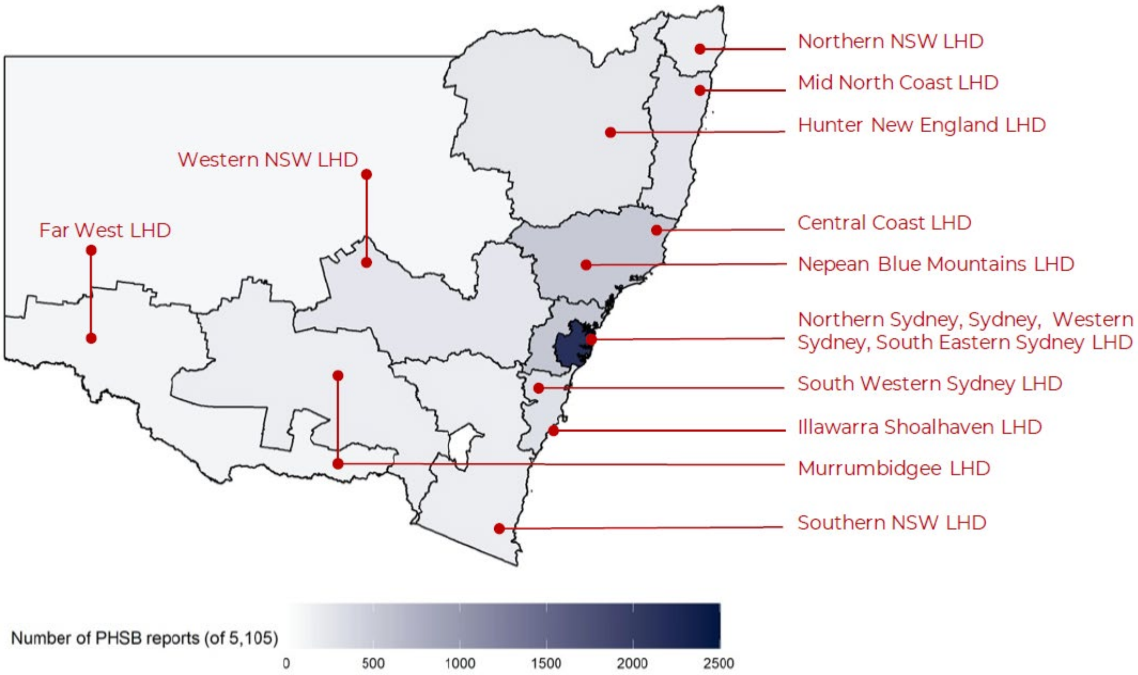
When this is aggregated into regions, 42.4 percent of those identified as displaying PSHB originated from the Greater Sydney area (n=2,164), followed by 10.4 percent from Sydney Surrounds (n=531), 10 percent from Greater Newcastle (n=512) and 5.7 percent from Illawarra (n=289).

Table 4: PHSB reports by regions

Internal Business Unit Region	Local Health District	Unique Persons	% (of 5,105)
Greater Sydney	Northern Sydney, Sydney, South-Eastern Sydney, South-Western Sydney	2164	42.4
Sydney Surrounds	Western Sydney, South-Western Sydney, Nepean Blue Mountains, Central Coast	531	10.4
Greater Newcastle	Hunter New England	512	10.0
Illawarra	Illawarra Shoalhaven	289	5.7
Mid-North Coast	Hunter New England	266	5.2
Central West	Western NSW	241	4.7
Northern	Northern NSW	238	4.7
Richmond-Tweed	Northern NSW	180	3.5
South-East Region	Southern NSW, South-Western Sydney	176	3.4
Riverina	Murrumbidgee	170	3.3
Murray	Murrumbidgee	104	2.0
North-West and Far-West	Hunter New England, Western NSW	78	1.5
Missing/NA		26	0.5

Note: Each Internal Business Unit was coded according to the LGAs region of its physical location. This may not always reflect the location of the child. However, it is the best available geographical indicator. There is overlap where some LHDs cross into more than one region, in these cases the larger area is denoted.

Figure 8: Number of PHSB reports by region and LHD



Note: Each Internal Business Unit was coded according to the LGAs region of its physical location. This may not always reflect the location of the child. However, it is the best available geographical indicator. There is overlap where some LHDs cross into more than one region, in these cases the larger area is denoted.

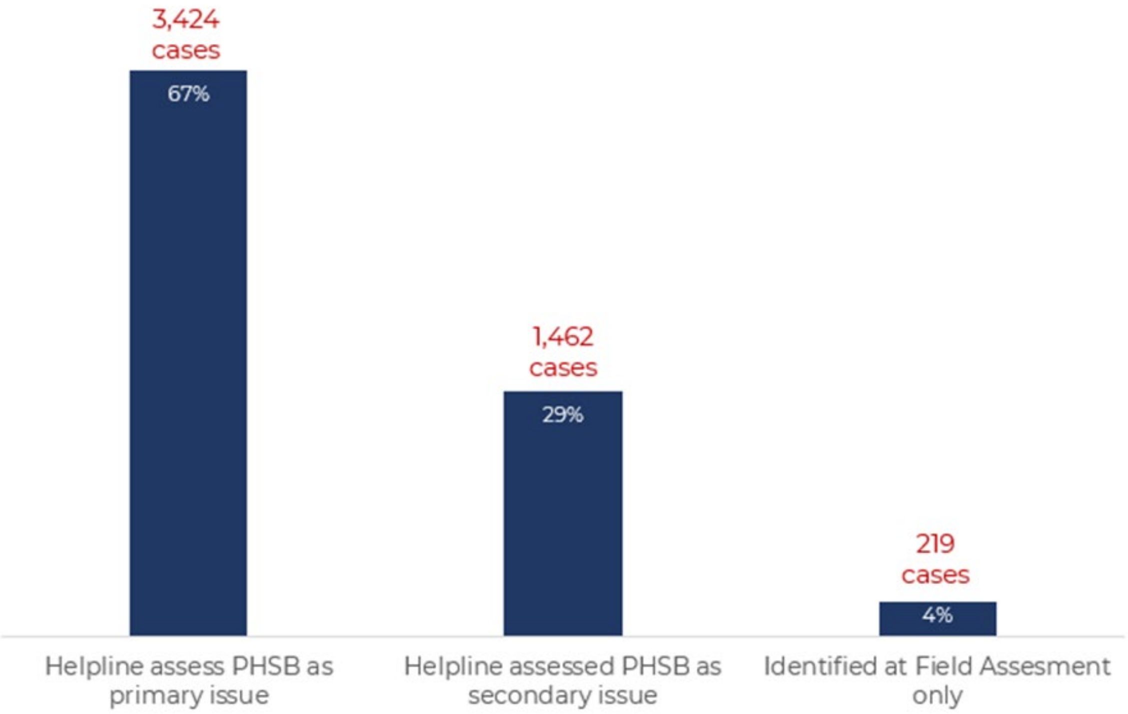
PSHB Report Context

Report type

As previously mentioned, a child or young person is included in this study if PHSB was recorded either by the DCJ Helpline or during a field assessment. In both instances, PHSB can be recorded either as the 'primary assessed issue' or one of any number of 'secondary assessed issues'. This means that there are three locations where PHSB may be recorded in the database. Figure 9 disaggregates these data depending on where in the relevant ChildStory record PHSB was first reported. The results show that:

- Only 4 percent (n=219) of PHSB cases were identified during a field assessment. The vast majority (96%) of PHSB were reported directly to the DCJ Helpline.
- Of the cases where PSHB was reported to the Helpline, PSHB was recorded as the 'primary assessed issue' in 67 percent (n=3,424).
- One in three (n=1,462) PHSB reports to the DCJ Helpline were for other 'primary' reasons and PHSB was listed as 'secondary assessed issue'.

Figure 9: Point of notification

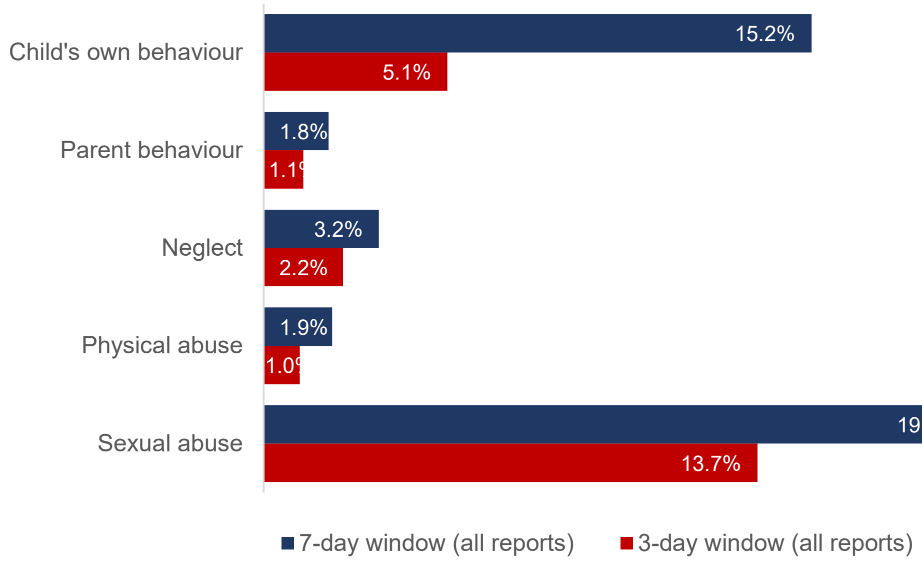


Concurrent reports

In addition, some reports of PHSB are accompanied by consecutive reports of other issues. These may be listed in the same report as the PHSB, or as separate but consecutive reports.

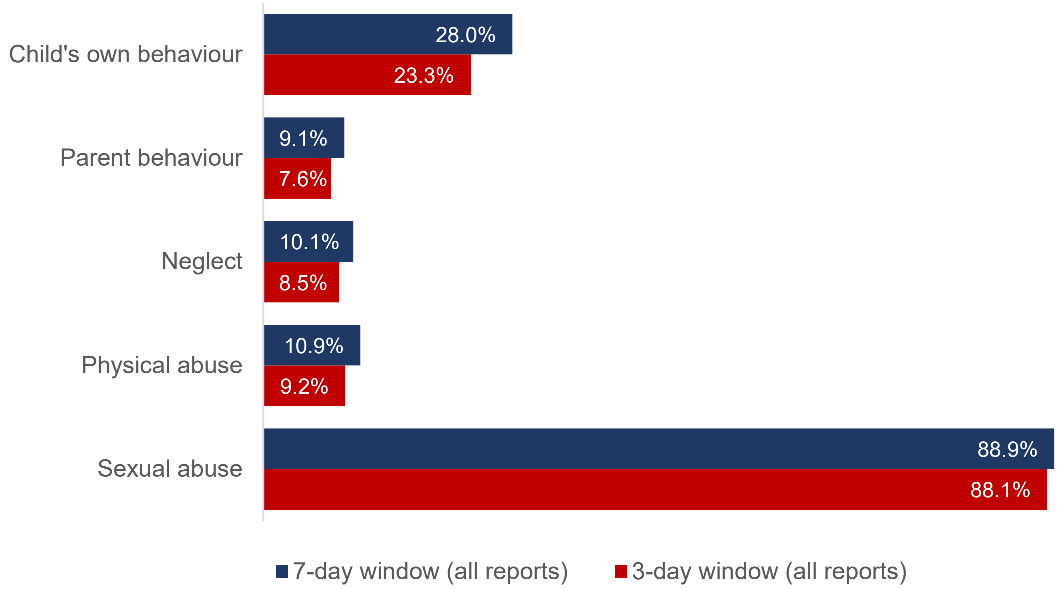
For the 3,424 children and young people in this data, whose PHSB was listed as the primary assessed issue, 469 (almost 14%) of them had a concurrent report of sexual abuse within a prospective three-day window. Thirty-four had a concurrent report of physical abuse, 75 of neglect, 39 flagged problematic parental behaviour and 173 the behaviour of that child or young person. If the window is increased to seven days, to include the three days before and after the PHSB report, then the estimates increase to sexual abuse (676), physical abuse (666) and neglect (110) (Figure 10).

Figure 10: Other Helpline assessed issues for 'primary' PHSB reports



For the 1,462 children and young people whose PHSB was listed as the secondary assessed issue (Figure 11), 1,288 (88%) of them had a concurrent report of sexual abuse within a prospective three-day window, 135 had a concurrent report of physical abuse, 124 of neglect, 62 flagged parental issues and 519 the child or young person's own behaviour. If the window is increased to seven days, to include the three days before and after the PHSB report, then the estimates increase to sexual abuse (1,300), physical abuse (159) and neglect (147).

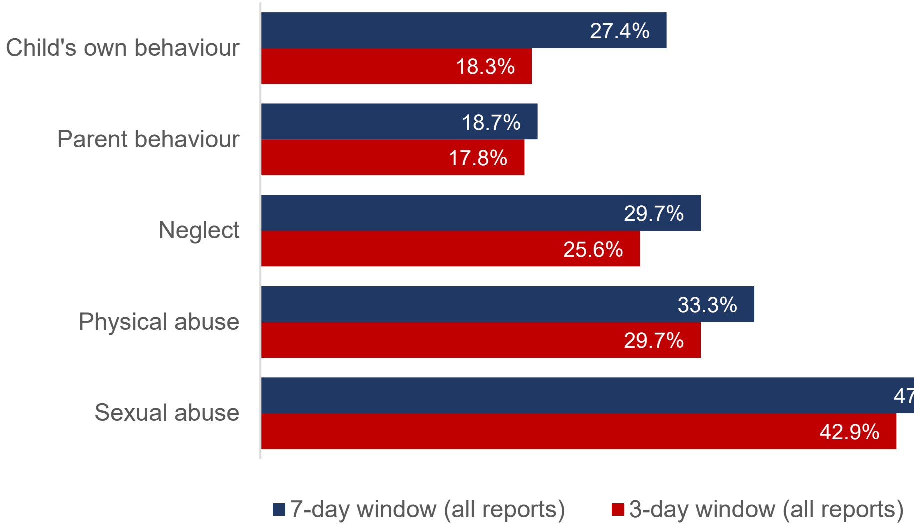
Figure 11: Other Helpline assessed issues for 'secondary' PHSB reports



For the 219 children whose PHSB was first identified at field assessment within a prospective three-day window, all were recorded as having at least one non-PHSB issue of concern (the issue which led to the conduct of the field assessment). Of these children, 94 (43%) had been reported for sexual abuse, 65 for physical abuse and 56 for neglect (Figure 12).

Where the window is increased to seven days, to include the three days before and after the PHSB report, this figure increases with 105 recorded in relation to sexual abuse, 73 physical abuse and 65 for neglect (Figure 12).

Figure 12: Other Helpline assessed issues for PHSB identified at field assessment



Reporter

Of the 5,105 children and young people reported, 45 percent (n=2,298) were reported by Education (identified by position e.g., Principal, including private schools), almost 20 percent (n=1,010) by Police compared to just under 8 percent by Health (n=404). Family, as informal rather than mandatory reporters, were close to this figure accounting for 6.3 percent (n=321) of reports (Table 5).

Table 5: Source of PHSB report

Source	Number	% (of 5,105)
Education	2298	45.0
Police	1010	19.8
Other	909	17.8
NGOs	738	14.5
Health	404	7.9
Family	321	6.3

Note: A child may be reported by multiple 'contactors' for the same or for other reports that were concurrent to the first report of PHSB. Where appropriate, multiple contactor types are recorded for each child.

There appears a relationship between reporter type and whether there are concurrent issues identified. The largest category of reports (26%) was those made by Education for PHSB only. In other words, a report was made without any other identified or assessed issue. This was followed by reports, again from Education, but where the report was for multiple issues including sexual or physical victimisation. The category of reports with the smallest overall number were those made by Health where PHSB was reported concurrently with sexual or physical victimisation, or neglect. Generally, there is a 60/30 split between reports made solely for PHSB and PHSB reports made concurrently with other assessed issues. The exception was for reports made by family members where more than half involved allegations of other forms of victimisation and neglect (Table 6).

Table 6: Cross-classification of report context personas

	EDU	Family	Health	NGOs	Other	Police
Number						
PHSB report only	1332	140	237	425	483	482
PHSB report concurrent with Sexual, Physical or Neglect	871	142	129	230	339	281
Count	*2203*	*282*	*366*	*655*	*822*	*763*
Column %						
PHSB report only	60.5	49.6	64.8	64.9	58.8	63.2
PHSB report concurrent with Sexual, Physical or Neglect	39.5	50.4	35.2	35.1	41.2	36.8
%	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Percent (% of 5,105)						
PHSB report only	26.1	2.7	4.6	8.3	9.5	9.4
PHSB report concurrent with Sexual, Physical or Neglect	17.1	2.8	2.5	4.5	6.6	5.5

WHAT IS KNOWN ABOUT THE CHILDREN AND YOUNG PEOPLE *PRIOR* TO THEIR FIRST HELPLINE REPORT OF PHSB?

Helpline reports

Prevalence and frequency

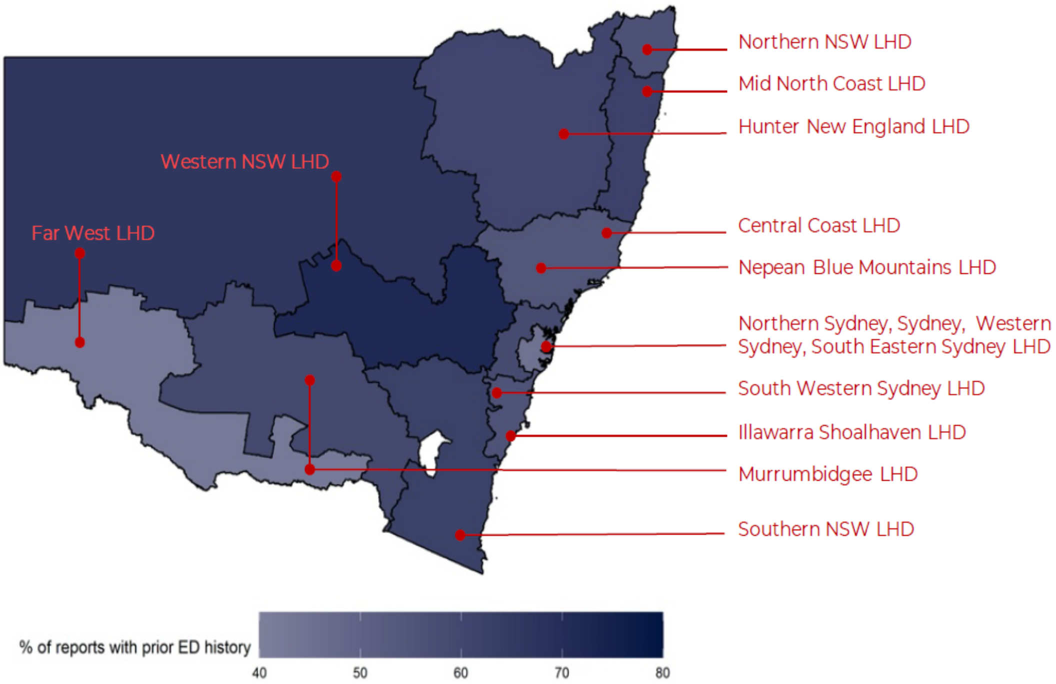
The Children and Young Persons (Care and Protection) Act 1998 enables any person who has "reasonable grounds to suspect that a child or young person is, or that a class of children or young persons are, at risk of significant harm" to make a report to the Helpline. Under the Act, reporting is mandatory for "a person who, in the course of his or her professional work or other paid employment delivers health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly, to children" and their managers or supervisors within these services. Mandatory reporting also applies to any person in religious ministry (or person providing religion-based activities to children) and registered psychologists. Given that all concerns regarding potential or current risk of harm to a child should be reported to the Helpline, it is to be expected that some children would have had multiple reports of risk. As shown in Table 7, there was a total of 11,001 Helpline reports involving 2,151 children and young people. Amongst this cohort, almost 33 percent were flagged once (n=708), approximately 19 percent twice (n=400) and 13 percent 10 or more times (n=279).

Table 7: Helpline reports by number of reports, prior to first PHSB report

Number of Helpline Reports (11,001)	Unique Persons	% (of 2,151)	% (of 5,105)
1	708	32.9	13.9
2	400	18.6	7.8
3	236	11.0	4.6
4	139	6.5	2.7
5	136	6.3	2.7
6	92	4.3	1.8
7	65	3.0	1.3
8	64	3.0	1.3
9	32	1.5	0.6
10+	279	13.0	5.5
Any	2151	100.0	42.1

Note: The available data was for reports listed in the DCJ Child Story database for a two-year period between 1 January 2018 and 31 December 2019. In this case, prior reports are those that were recorded in the database from 1 January 2018 until the date of the first PHSB report. Caution should be exercised when interpreting these data, since those children who were reported for PHSB early in 2018 will not have a much ‘prior’ time for reports to have been identified.

Figure 13: Helpline reports by region and LHD, prior to first PHSB report



Note: There is overlap where some LHDs cross into more than one region, in these cases the larger area is denoted.

Emergency Department presentations prior to report

Prevalence and frequency

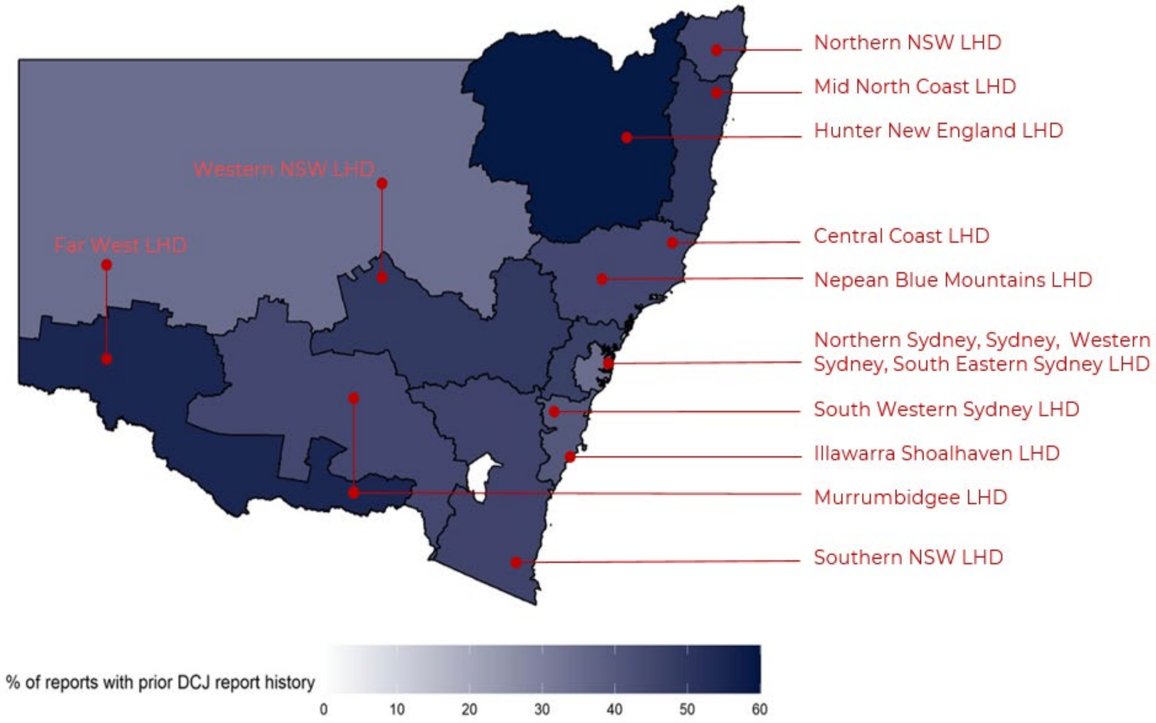
Prior to the first Helpline report for PHSB, 53.3 percent of these children and young people presented in a hospital emergency department at least once, with around 18 percent attending on one occasion, 10.7 percent on two and almost 3.8 percent on ten or more occasions (Table 8).

Table 8: Emergency presentations by number, prior to first PHSB report

Number of Visits (n=9,153)	Unique Persons	% (of 2,719)	% (of 5,105)
1	936	34.4	18.3
2	545	20.0	10.7
3	362	13.3	7.1
4	234	8.6	4.6
5	158	5.8	3.1
6	102	3.8	2.0
7	81	3.0	1.6
8	67	2.5	1.3
9	42	1.5	0.8
10+	192	7.1	3.8
Any	2719	100.0	53.3

As a percentage of young people in each region, those in the Central West were most likely to have at least one presentation to an emergency department. Those located in the southwest region of the Murray were the least likely to have a history of presentation to the emergency department (Figure 14).

Figure 14: Emergency presentations by region and LHD, prior to PHSB report



Note: Prior ED presentations are more common in rural areas where other primary care options are limited and are therefore likely to reflect available healthcare rather than increased injury or illness. There is overlap where some LHDs cross into more than one region, in these cases the larger area is denoted.

Type and referral source for emergency department presentations

Of these presentations, the majority (53.2% n=9,498) were seeking emergency assistance, with a small number for a pre-existing condition (2.5%), return visits (2.3%) and small number for a variety of other prearranged admissions. Most referrals (n=8,728) were self-made or from family and friends, with 6.3 percent (n=411) from general practitioners and dentists (Table 9).

Table 9: Emergency presentations by visit type and referral source, prior to first PHSB report

	Unique Episodes	Unique Persons	% (of 2,719)	% (of 5,105)
Visit type				
Emergency presentation	9498	2715	99.9	53.2
Unplanned return visit for continuing condition	185	126	4.6	2.5
Return visit - planned	154	119	4.4	2.3
Outpatient clinic	132	55	2.0	1.1
Pre-arranged admission: with ED workup	17	17	0.6	0.3
Disaster	5	5	0.2	0.1
Pre-arranged admission: without ED workup	5	5	0.2	0.1
Privately referred, non-admitted person	4	2	0.1	0.0
Dead on arrival	1	1	0.0	0.0
Person in transit	1	1	0.0	0.0
Referral source				
Self, family, friends	8728	2605	95.8	51.0
General Medical Practitioner or Dentist (not hospital based)	411	320	11.8	6.3
Missing	220	152	5.6	3.0
Other hospital in Area Health Service	135	116	4.3	2.3
Other Community Service, other than Health	175	104	3.8	2.0
Other	126	101	3.7	2.0
Other hospital outside Area Health Service	43	34	1.3	0.7
Prison or Justice Health	42	26	1.0	0.5
Hostel/group home	38	26	1.0	0.5
Department of Community Services	15	13	0.5	0.3

Recent ED presentations

Most ED presentations occurred more than 12 months prior to the report of PHSB, with only 5.1 percent (n=260) taking place within 30 days prior, 15.1 percent (n=772) within 6 months prior and 11.6 percent (n=590) within the year beforehand (Table 10).

Table 10: Emergency presentations by time since last presentation, prior to first PHSB report

Time	Unique Episodes	Unique Persons	% (of 2,719)	% (of 5,105)
< 30 days prior	260	260	9.6	5.1
< 6 months prior	772	772	28.4	15.1
< 1 year prior	590	590	21.7	11.6
Longer than one year prior	1097	1097	40.3	21.5

Of those emergency presentations within the prior 6-month period, just over 20 percent were seeking emergency services (Table 11).

Table 11: Emergency presentations by visit type (6-month episode only), prior to first PHSB report

Visit Type	Unique Episodes	Unique Persons	% (of 1,036)	% (of 5,105)
Emergency presentation	1891	1033	99.7	20.2
Return visit - planned	41	37	3.6	0.7
Unplanned return visit for continuing condition	51	29	2.8	0.6
Outpatient clinic	15	11	1.1	0.2
Pre-arranged admission: with ED workup	3	3	0.3	0.1
Disaster	1	1	0.1	0.0
Pre-arranged admission: without ED workup	1	1	0.1	0.0

When considering emergency department presentations in the 30 days prior to the PHSB Helpline report, there was some notable regional variability. For example, the proportion of young people with an emergency presentation in the past 30 days was highest in the Central West and Northern regions and lowest in the Murray region to the southwest.

Admitted patient episodes prior to report

Prevalence and frequency

The number of children and young people admitted to hospital, prior to their first report for PHSB, was lower, with 20.6 percent (n=1,053) in total hospitalised, 12.8 percent on one occasion (n=655), 4.3 percent twice (n=218) and less than 2 percent three times (n=83).

Table 12: Hospital admissions by number and frequency, prior to first PHSB report

Number of Visits (n=2,067)	Unique Persons	% (of 1,053)	% (of 5,105)
1	655	62.2	12.8
2	218	20.7	4.3
3	83	7.9	1.6
4	31	2.9	0.6
5	22	2.1	0.4
6	15	1.4	0.3

7	6	0.6	0.1
8	7	0.7	0.1
9	2	0.2	0.0
10+	14	1.3	0.3
Any	1053	100	20.6

Visit status and reason

Almost 14 percent of those admitted to hospital were listed as emergency status (n=1,185), comparative to 8.3 percent for non-emergency (n=667), although 12.3 percent had no emergency department involvement (Table 13). Overall, mental illness accounted for 2.3 percent of diagnostic categories (n=320), injury, poisoning and drug related toxicosis accounted for 2.8 percent (n=187) and substance induced disorders 0.2 percent (n=19).

Table 13: Hospital admissions by emergency status and major diagnostic categories, prior to first PHSB report

	Unique Episodes	Unique Persons	% (of 1,053)	% (of 5,105)
Emergency status				
Emergency	1185	712	67.6	13.9
Non-Emergency/Planned	667	425	40.4	8.3
Urgency Not Assigned	215	163	15.5	3.2
Emergency department status				
Episode with no ED involvement	1035	630	59.8	12.3
Episode includes ED (for Level >=3) and ward	848	574	54.5	11.2
Entire episode within ED (for Level >=3) only	146	107	10.2	2.1
Episode includes ED (for Level 1 or 2) and ward	26	21	2.0	0.4
Entire episode within ED (for Level 1 or 2) only	11	11	1.0	0.2
Not assigned	1	1	0.1	0.0
Major diagnostic category				
Musculoskeletal System and Connective Tissues	220	174	16.5	3.4
Ear, Nose and Throat	172	147	14.0	2.9
Digestive System	188	143	13.6	2.8
Injury, Poisoning and Toxic Effects of Drugs	187	145	13.8	2.8
Unspecified	143	119	11.3	2.3
Mental Diseases and Disorders	320	118	11.2	2.3
Nervous System	142	87	8.3	1.7
Respiratory System	121	82	7.8	1.6
Factors Influencing Health Status & Other Contacts with Health Services	105	75	7.1	1.5
Skin, Subcutaneous Tissue and Breast	85	74	7.0	1.4

Note: Top 10 major diagnoses only.

Visit types and units of admission

Resultingly, 19.2 percent of these admissions were for acute care (n=1,781) and around 2 percent for mental health (n=196). The leading type of admission was emergency at 12.3 percent (n= 1,028), followed by paediatric at 3.6 percent (n=216). Child and Adolescent Mental Health Services (CAMHS) accounted for a further 0.8 percent of admissions (n=74), acute psychiatric care for 0.4 percent (n=22) and obstetrics (n=7), acute psychiatric (n=4) and intensive psychiatric care (n=4) for 0.1 percent respectively (Table 14).

Table 14: Hospital admissions - visit type and referral source, prior to first PHSB report

	Unique Episodes	Unique Persons	% (of 2,719)	% (of 5,105)
Episode of care type				
Acute Care	1781	982	36.1	19.2
Mental Health	196	95	3.5	1.9
Newborn Care	74	68	2.5	1.3
Rehabilitation Care	12	1	0.0	0.0
Maintenance Care	4	4	0.1	0.1
Unit type of admission				
Emergency Department - Level 4 & above	1028	628	23.1	12.3
Paediatric	216	182	6.7	3.6
Missing	144	120	4.4	2.4
General-Mixed	143	82	3.0	1.6
Same Day Not Elsewhere Classified	124	60	2.2	1.2
CAMHS Acute	74	39	1.4	0.8
Bassinet	65	62	2.3	1.2
CAMHS Non-Acute	65	8	0.3	0.2
Same Day Surgical	59	53	1.9	1.0
Emergency Department - Level 1 & 2	37	31	1.1	0.6

Note: Top 10 reasons only.

Non-admitted patient service episodes prior to report

Prevalence and frequency

Forty-five percent (n=2,299) of young people identified in ChildStory also had contact with a number of Health services prior to their first report for that behaviour (Table 15), with 14.3 percent (n=730) attending these services on 10 or more occasions, 7.5 percent (n=383) once and 5.4 percent twice (n=275).

Table 15: Non-admitted patient service by number prior to first PHSB report

Number of Visits (n=28,923)	Unique Persons	% (of 2,299)	% (of 5,105)
1	383	16.7	7.5
2	275	12.0	5.4
3	207	9.0	4.1
4	190	8.3	3.7
5	125	5.4	2.4
6	128	5.6	2.5
7	97	4.2	1.9
8	88	3.8	1.7
9	76	3.3	1.5
10+	730	31.8	14.3
Any	2299	100	45.0

Contact with Police prior to report

Prevalence and frequency

Almost 11 percent (n=545) of the 5,105 children and young people identified in ChildStory, also had contact with the criminal justice system prior to that report (Table 16). This includes 3.2 percent who had contact on one occasion (n=161), 2.2 percent who had contact 10 or more times (n=111), 1.8 percent who had contact twice (n=93) and 1.2 percent, trice (n=60).

Table 16: Criminal justice system contact by conviction number, prior to first PHSB report

Number of Convictions (n=3,394)	Unique Persons	% (of 545)	% (of 5,105)
1	161	29.5	3.2
2	93	17.1	1.8
3	60	11.0	1.2
4	27	5.0	0.5
5	32	5.9	0.6
6	19	3.5	0.4
7	15	2.8	0.3
8	17	3.1	0.3
9	10	1.8	0.2
10+	111	20.4	2.2
Any	545	100	10.7

Offence type of conviction

Consequently, 5.2 percent (n=819) of these young people were convicted of acts intended to cause injury, 4.4 percent (n=655) with property damage and environmental pollution and 4 percent (n=537) with theft and related offences (Table 17).

Table 17: Criminal justice system contact by offence type of conviction, prior to first PHSB report

Type of Conviction	Unique Episodes	Unique Persons	% (of 545)	% (of 5,105)
Acts intended to cause injury	819	267	49.0	5.2
Property damage and environmental pollution	655	225	41.3	4.4
Theft and related offences	537	202	37.1	4.0
Public order offences	313	148	27.2	2.9
Offences against government procedures	895	132	24.2	2.6
Unlawful entry with intent/burglary, break and enter	164	82	15.0	1.6
Sexual assault and related offences	153	80	14.7	1.6
Illicit drug offences	88	63	11.6	1.2
Prohibited and regulated weapons and explosives offences	70	53	9.7	1.0
Traffic and vehicle regulatory offences	117	45	8.3	0.9

Note: Top 10 offence types only.

Contact with the Youth Justice system prior to report

Of the 5,105 young people in this study, 206 (4%) had at least one admission episode with NSW Youth Justice Services prior to their first report of PHSB. There were 736 admission episodes in total. Multiple admission episodes were not uncommon with 61 percent of these young people having had at least two admission episodes prior to their first PHSB report. In all, there were 15 young people (0.3%) of the total sample who had 10 or more YJ admission episodes in the period preceding their first PHSB report to DCJ (Table 18).

Table 18: Episodes of admission to YJ by number and frequency, prior to first PHSB report

Episodes	Unique Persons	% (of 206)	% (of 5,105)
1	80	38.8	1.6
2	31	15.0	0.6
3	24	11.7	0.5
4	11	5.3	0.2
5	16	7.8	0.3
6	10	4.9	0.2
7	7	3.4	0.1
8	10	4.9	0.2
9	2	1.0	0.0
10+	15	7.3	0.3
Any	206	100.0	4.0

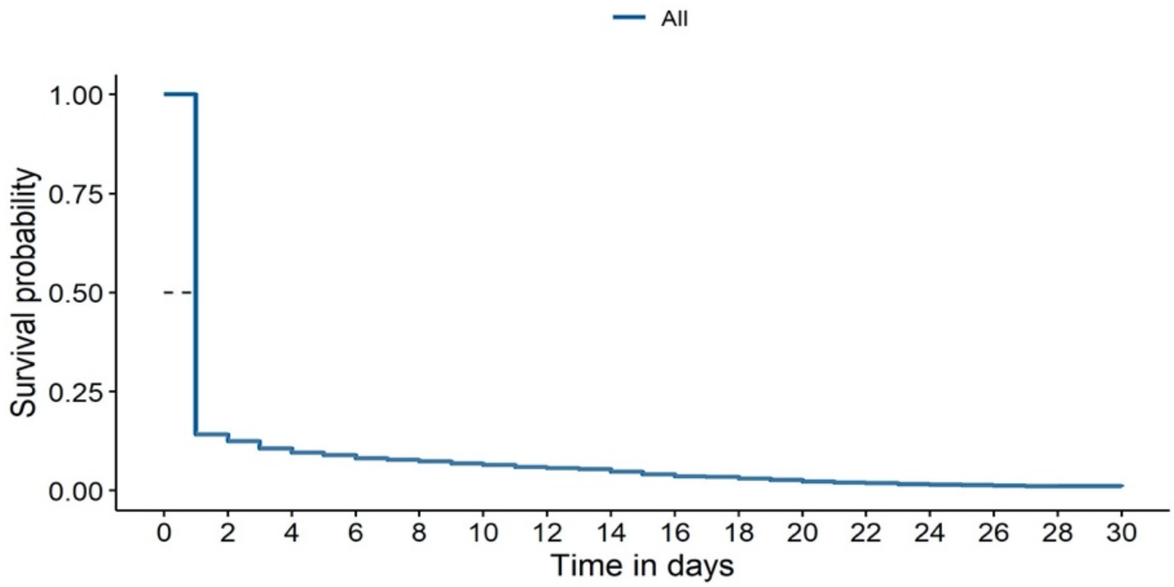
HOW DID THE PHSB REPORTS *PROCEED* THROUGH THE SYSTEM?

Helpline Assessment

Time to completion of Helpline Assessment

For the vast majority of reports of PHSB, an assessment outcome was finalised within less 24 hours. For only a small number of reports, the assessment was not completed within 24 hours (approximately 15) and for a very small fraction the assessment processes were still 'open' after 15 days. The most likely explanation here is that DCJ was managing several incoming reports about the same child, and assessment outcomes were not recorded immediately, or were not retrospectively completed once other concurrent reports had been progressed (Figure 15).

Figure 15: Time to completion of DCJ Helpline assessment (survival % by day), during first PHSB report



Note: This survival curve plots the proportion of the sample whose Helpline report had not been assessed by the number of days which had passed since the report was first made. The data are provided as whole-day dates, without timestamps, so the minimum interval is one-day.

Helpline assessment outcomes – ROSH categorisation

Approximately three quarters (n=3,878) of the reports were assessed as meeting the statutory threshold of risk of significant harm (ROSH) in comparison to 19 percent (n=979) who did not meet this benchmark (Table 19).

Table 19: Helpline assessment outcomes by ROSH classification, during first PHSB report

Helpline Assessment Outcome	Number	% (of 5,105)
ROSH	3878	76.0
ROSH duplicate	246	4.8
Non-ROSH	979	19.2
Not screened	2	0.0

Note: 'ROSH Duplicate' is where the Helpline caseworker noted that the report meets the ROSH threshold, but the report was made by the same reported with the same information. 'Not screened' occurs when the alleged victim is over 18 years, the incident occurred outside NSW the child/young person is not currently living in NSW, other matters not covered by the legislation or that the report relates to requests for other assistance (e.g., food vouchers).

Helpline assessment outcomes – Response Time

Of the 3,878 reports classified as having reached ROSH, 35.5 percent (n=1,375) of reports were allocated a priority response within 24 hours and 22.9 percent (n=888) within 72 hours (Table 20). A further 40.1 percent (n=1,554) were prioritised for action within 10 days.

Table 20: Helpline assessment outcomes by response time during first PHSB report

Response Time	Number	% (of 3,878)
<24 Hours	1375	35.5
<72 Hours	888	22.9
<10 Days	1554	40.1
N/A – CYP added at field assessment	12	0.3
Missing/NA	49	1.3

Triage outcomes

Triage decisions

All ROSH reports are transferred to a Community Services Centre (CSC) and then during the triage process, some were allocated to a caseworker for further actions. Of the 3,878 ROSH reports, 25 percent (n=979) were allocated to a caseworker. Over half of the ROSH reports (63 percent, n=2,455) were closed due to competing priorities (Table 21).

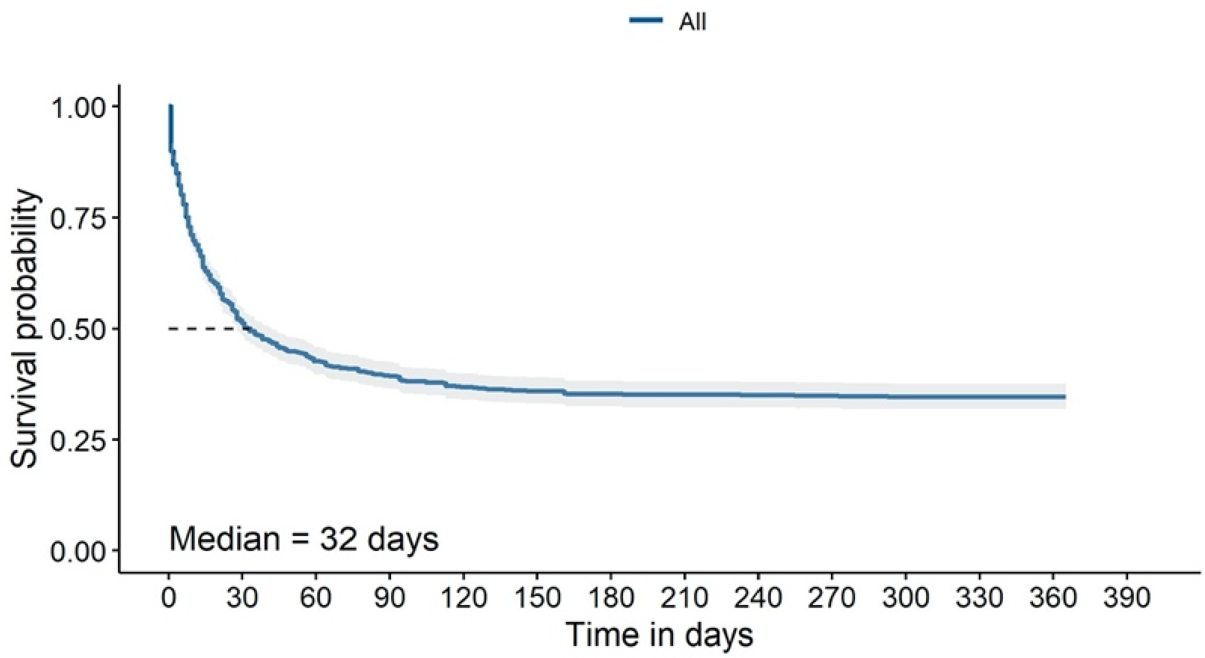
Table 21: Triage outcomes of ROSH Reports

Triage Outcome	Number	% (of 3,878)
Triage decision to allocate	979	25.2
Triage decision pending	229	5.9
Triage decision to close: competing priorities	2455	63.3
Triage decision to close: subject not located	6	0.2
Triage decision to close: other	202	5.2
No Triage: Closed at Helpline	4	0.1
Triage decision Pending - No transfer record	3	0.1

Time taken to commence Field assessment for allocated cases

The median time between a Child Protection Helpline assessment and the commencement of a field assessment was 32 days for reports that were triaged to allocate (Figure 16), with the survival probability of cases plateauing below 40 percent from under 170 days or 5 and a half months. Importantly, this plateau indicates that for about 30 percent of all allocated cases the field assessment does not commence before 365 days. This suggests that either some allocated cases are simply never progressed to field assessment, or that field assessment commenced but the date of commencement was not retrospectively recorded in the DCJ database. This confounds the measurement of field assessment outcomes because missing dates are quantitatively treated as cases yet to be assessed.

Figure 16: Duration from completion of Helpline assessment to the commencement of field assessment for reports triaged to allocate (survival % by day), during first PHSB report



Field assessment outcomes

Of the 1,150 reports allocated for field assessment, 26.8 percent (n=308) were substantiated, and 28 percent (n=323) were not substantiated. Another 23.3 percent (n=268) had not commenced field assessment but reviews of existing files only (Table 22).

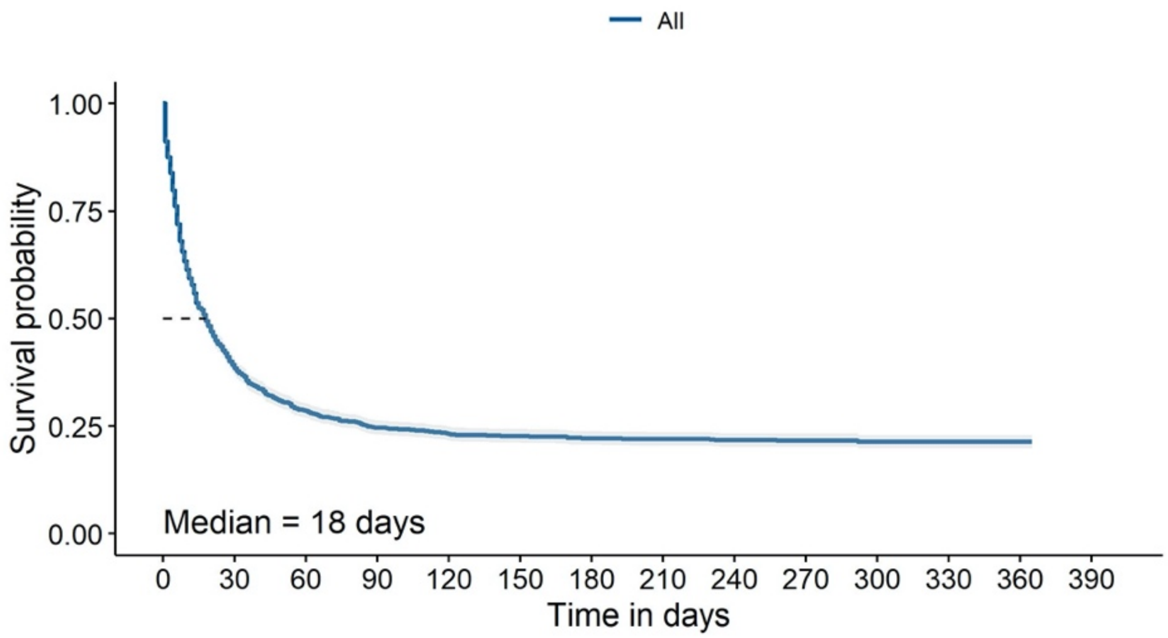
Table 22: Field assessment outcomes during the first PHSB report

Field Assessment Outcome	Number	% (of 1,150)	% (of 5,105)
Field Assessment Complete: Substantiated	308	26.8	6
Field Assessment Complete: Not Substantiated	323	28.1	6.3
Field Assessment Complete: Not assessed	28	2.4	0.5
Pending: No field assessment commenced, triage allocation purpose is review existing open case or other	268	23.3	5.2
FA Pending: No field assessment commenced, triage allocation purpose is Field Assessment (response)	98	8.5	1.9
FA Pending: A filed assessment linked to the report	78	6.8	1.5
Closed: Field assessment not completed	47	4.1	0.9

Time taken to 'close' cases that are not allocated for field assessment

Cases which are not allocated to a field assessment are typically closed within 18 days (Figure 17) while 25 percent of 'closed' cases are not given a 'closure date' even after 365 days.

Figure 17: Duration from completion of Helpline assessment of closure of reports not triaged to allocate (survival % by day), during the first PHSB report



WHAT HAPPENED TO CHILDREN AND YOUNG PEOPLE *AFTER* THEIR FIRST PHSB REPORT?

Helpline Reports

Following their first Child Protection Helpline report for PHSB, 47.8 percent of children and young people (n=2,439) were again reported to the Child Protection Helpline (Table 23). Of these, the largest percentage, 31.6 percent (n=771), were reported on more than one occasion and 15.8 percent (n=386) were reported on 10 or more occasions.

Table 23: Helpline reports by number and frequency following first PHSB report

Number of reports (n=15,675)	Unique Persons	% (of 2,439)	% (of 5,105)
1	771	31.6	15.1
2	430	17.6	8.4
3	265	10.9	5.2
4	161	6.6	3.2
5	112	4.6	2.2
6	112	4.6	2.2
7	84	3.4	1.6
8	65	2.7	1.3
9	53	2.2	1.0
10+	386	15.8	7.6
Any	2439	100.0	47.8

Of the 2,439 children and young people who had a Helpline Report made after their first PHSB report, 983 (40%) had reports related to PHSB and 1, 456 had reports related to other harm types.

Emergency department presentations following report

Prevalence and frequency of attendance

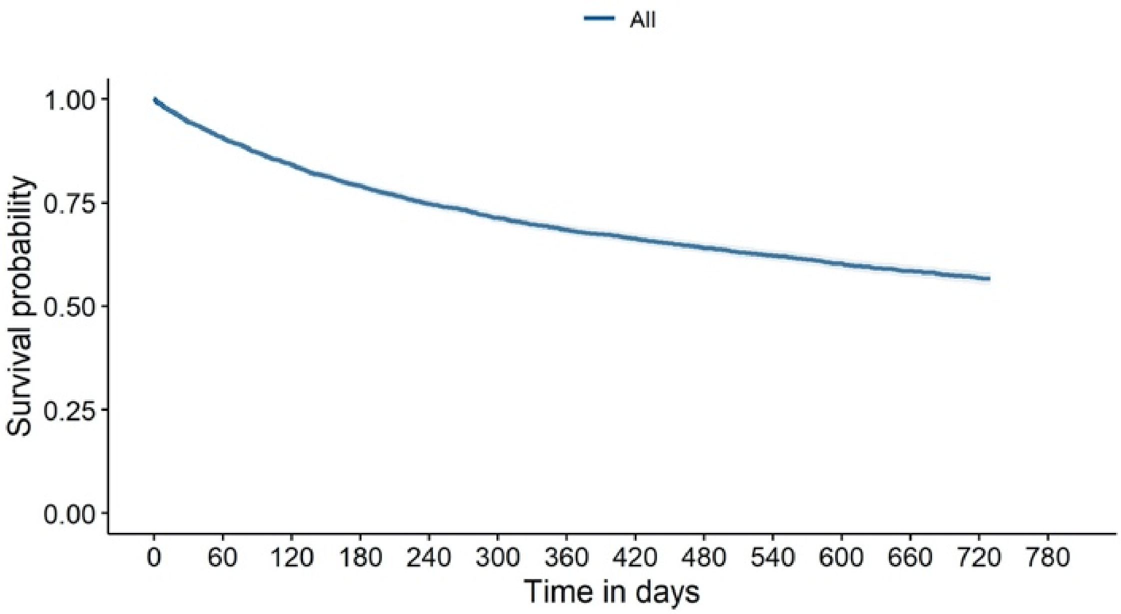
Additionally, of the 5,105 children and young people reported to the helpline for PHSB, following that lodgement, 41 percent (n=2,093) presented at an emergency department, cumulating to a total of 6,540 visits. Almost eighteen percent (n=896) presenting on one occasion, 8.4 percent (n=427) twice and 5.1 percent (n=259) three times (Table 24).

Table 24: Emergency presentations by number and frequency, following first PHSB report

Number of Visits (n=6,540)	Unique Persons	% (of 2,093)	% (of 5,105)
1	896	42.8	17.6
2	427	20.4	8.4
3	259	12.4	5.1
4	160	7.6	3.1
5	94	4.5	1.8
6	56	2.7	1.1
7	38	1.8	0.7
8	31	1.5	0.6
9	21	1.0	0.4
10+	111	5.3	2.2
Any	2093	100.0	41.0

The probability of a child or young person displaying PHSB having an emergency presentation at a hospital decreasing by around 25 percent at 240 days and by a further 20 percent by day 720 (Figure 18).

Figure 18: Emergency presentations by probability of presentation following first PHSB report (survival % by day)



Reasons for visiting the ED

Regardless, around 41 percent of children and young people displaying PHSB (n=2,083) had an emergency presentation at an emergency department, following first PHSB report, accounting for 6,651 emergency presentations. A further 1.5 percent (n=132) presented for an unplanned visit regarding and existing conditions and 1.4 percent (n=94) in relation to a planned visit (Table 25).

Table 25: Emergency presentations by visit type following first PHSB report

Emergency Presentation	Unique Episodes	Unique Persons	% (of 2,083)	% (of 5,105)
Emergency presentation	6651	2083	99.5	40.8
Unplanned return visit for continuing condition	132	77	3.7	1.5
Return visit - planned	94	72	3.4	1.4
Outpatient clinic	50	34	1.6	0.7
Pre-arranged admission: with ED workup	14	12	0.6	0.2
Dead on arrival	3	3	0.1	0.1
Disaster	2	2	0.1	0.0
Person in transit	1	1	0.0	0.0
Pre-arranged admission: without ED workup	1	1	0.0	0.0
Privately referred, non-admitted person	1	1	0.0	0.0

Admitted patient episodes following report

Prevalence

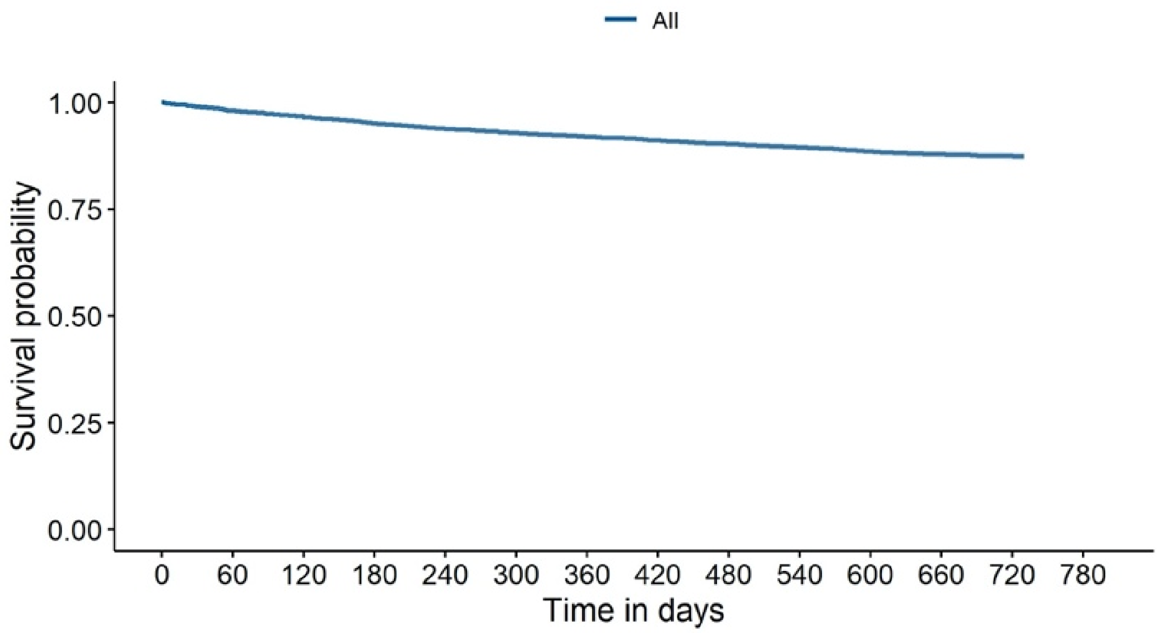
Furthermore, 12 percent of the 5,105 children and young people displaying PHSB (n=613), were admitted to hospital, 8.4% on one occasion (n=428) and 2 percent twice (n=101) (Table 26).

Table 26: Hospital admissions by number, following first PHSB report

Number of Visits (n=1,111)	Unique Persons	% (of 613)	% (of 5,105)
1	428	69.8	8.4
2	101	16.5	2.0
3	44	7.2	0.9
4	10	1.6	0.2
5	6	1.0	0.1
6	9	1.5	0.2
7	2	0.3	0.0
8	2	0.3	0.0
9	1	0.2	0.0
10+	10	1.6	0.2
Any	613	100.0	12.0

The probability of admission to hospital remaining above 75% by day 720 (Figure 19).

Figure 19: Probability of admission to hospital (as an admitted patient) following first PHSB report (survival % by day)



The most significant reason for hospital admission for the 613 children and young people who were hospitalised was an emergency, with 70 percent (n=429) presenting for this and accounting for 687 unique episodes (Table 27). Additionally, 37.2 percent of admissions were non-emergency presentations (n=228), across 346 episodes, 23.7 percent (n=145) were for injury, poisoning and the toxic effect of drugs and 19.2 percent (n=118) were regarding mental health.

Table 27: Hospital admissions by emergency status and major diagnostic following first PHSB report

	Unique Episodes	Unique Persons	% (of 613)	% (of 5,105)
Emergency status				
Emergency	687	429	70.0	8.4
Non-Emergency/Planned	346	228	37.2	4.5
Urgency Not Assigned	78	54	8.8	1.1
Emergency department status				
Episode with no ED involvement	1035	630	102.8	12.3
Episode includes ED (for Level >=3) & ward	848	574	93.6	11.2
Entire episode within ED (for Level >=3) only	146	107	17.5	2.1
Episode includes ED (for Level 1 or 2) & ward	26	21	3.4	0.4
Entire episode within ED (for Level 1 or 2) only	11	11	1.8	0.2
Not assigned	1	1	0.2	0.0
Major diagnostic category				
Musculoskeletal System & Connective Tissues	220	174	28.4	3.4
Mental Diseases and Disorders	320	118	19.2	2.3
Ear, Nose and Throat	172	147	24.0	2.9
Digestive System	188	143	23.3	2.8
Injury, Poisoning & Toxic Effects of Drugs	187	145	23.7	2.8
Unspecified	143	119	19.4	2.3
Nervous System	142	87	14.2	1.7
Respiratory System	121	82	13.4	1.6
Factors Influencing Health Status & Other Contacts with Health Services	105	75	12.2	1.5
Newborns/Neonates with conditions originating in perinatal period	85	68	11.1	1.3

Note: Top 10 major diagnoses only.

Non-admitted patient service episodes following report

Prevalence

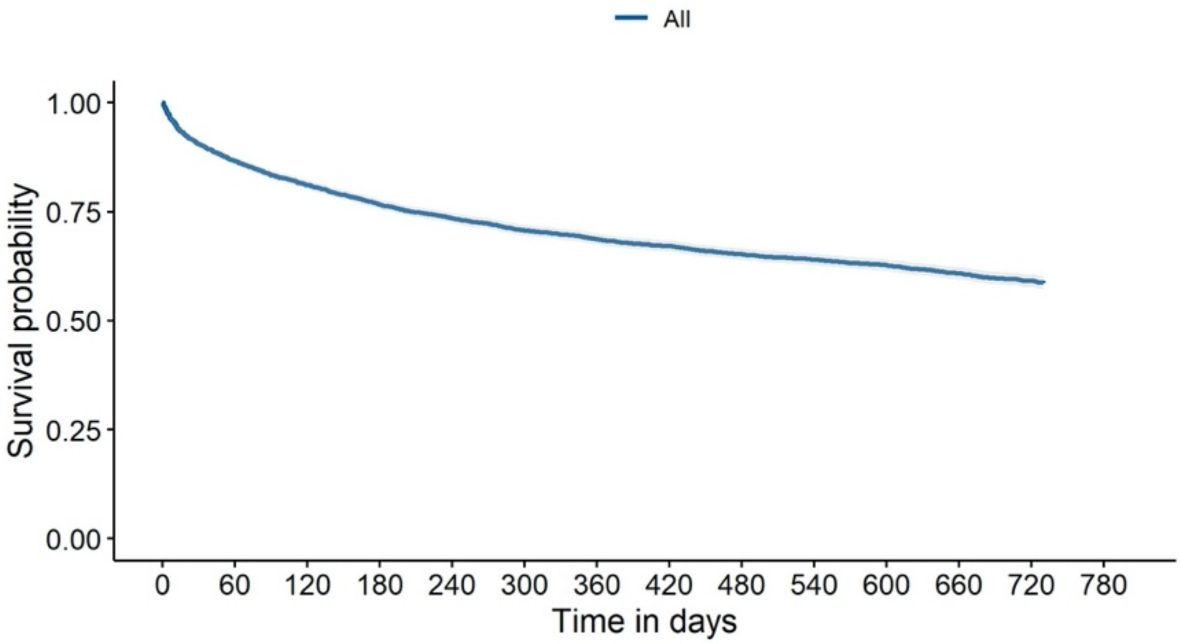
Following the report for PHSB, 40.2 percent of these children and young people (n=2,054) were also seen through NSW Health for non-admitted patient services (Table 30). This compares with 45 percent (n=2,299) of children and young people prior to their first PHSB Helpline report (Table 17). Of the 2,054 children and young people, almost 31 percent (n=629) of these were individuals seen on 10 or more occasions, 23.6 percent (n=485) once and 13.1 percent (n=269) twice (Table 28).

Table 28: Non-admitted services by number and frequency following first PHSB report

Number of Visits (n=28,157)	Unique Persons	% (of 2,054)	% (of 5,105)
1	485	23.6	9.5
2	269	13.1	5.3
3	183	8.9	3.6
4	126	6.1	2.5
5	106	5.2	2.1
6	76	3.7	1.5
7	65	3.2	1.3
8	69	3.4	1.4
9	46	2.2	0.9
10+	629	30.6	12.3
Any	2054	100.0	40.2

The probability of individuals attending a non-admitted patient service following a Child Protection Helpline report decreasing by around 25 percent by day 240 and a further 20 percent by day 720 (Figure 20).

Figure 20: Non-admitted service by probability of attendance following first PHSB report (survival % by day)



Contact with police following report

Concomitantly, almost 6 percent (n=303) of the children and young people who had a report for PHSB made about them were convicted of a crime (Table 31). This compares with 10.7 percent of children and young people prior to first PHSB report (Table 16). Of the 303 children and young people, 35 percent (n=106) attained one conviction, 19.1 percent (n=58) two and 11.9 percent (n=36) ten or more convictions (Table 29).

Table 29: Criminal justice system contact by number of convictions following first PHSB report

Number of Convictions (n=1,410)	Unique Persons	% (of 303)	% (of 5,105)
1	106	35.0	2.1
2	58	19.1	1.1
3	35	11.6	0.7
4	22	7.3	0.4
5	16	5.3	0.3
6	9	3.0	0.2
7	8	2.6	0.2
8	9	3.0	0.2
9	4	1.3	0.1
10+	36	11.9	0.7
Any	303	100.0	5.9

Within this group the most common conviction type was acts to cause injury, with 45.9 percent of the 303 individuals receiving convictions across 320 incidents (Table 30). This was followed by 32.3 percent (n=98 across 251 incidents) for theft and related offences and 31 percent (n=94 across 168 incidents) for property damage and environmental pollution.

Table 30: Criminal justice system by conviction type following first PHSB report

Conviction Type	Unique Episodes	Unique Persons	% (of 303)	% (of 5,105)
Acts intended to cause injury	320	139	45.9	2.7
Theft and related offences	251	98	32.3	1.9
Property damage and environmental pollution	168	94	31.0	1.8
Offences against government procedures	281	76	25.1	1.5
Public order offences	112	60	19.8	1.2
Traffic and vehicle regulatory offences	57	31	10.2	0.6
Unlawful entry with intent/burglary, break and enter	42	29	9.6	0.6
Illicit drug offences	42	30	9.9	0.6
Prohibited and regulated weapons and explosives offences	43	25	8.3	0.5
Sexual assault and related offences	23	18	5.9	0.4

Note: Top 10 offence types only.

Contact with the Youth Justice system following report

Of the 5,105 young people in this sample, 351 (6.9%) recorded at least one episode of admission with NSW Youth Justice following their first PHSB report. This compares with 4 percent (n=206) prior to the first PHSB Helpline report (Table 18). More than half of these young people recorded two or more episodes and 23 young people were admitted to YJ on 10 or more separate occasions following their first PHSB report (Table 31).

Table 31: Episodes of admission to YJ by number and frequency following the first PHSB report

Number of YJ Admission Episodes (n=1.248)	Unique Persons	% (of 351)	% (of 5,105)
1	140	39.9	2.7
2	69	19.7	1.4
3	29	8.3	0.6
4	23	6.6	0.5
5	22	6.3	0.4
6	13	3.7	0.3
7	13	3.7	0.3
8	8	2.3	0.2
9	11	3.1	0.2
10+	23	6.6	0.5
Any	351	100.0	6.9

DIFFERENCES BETWEEN AGE, GENDER, ENTHINCITY AND REPORT CONTEXT

Age and gender

This section describes the results of the analysis by age and gender of unique individuals (n=5,105). As reported previously, the largest cohort of those reported in relation to PHSB were males aged 10 to 13 inclusive (n=1,131), followed by males aged 14 and 15 (n=952) and then males aged 16 and 17 (n=842). Whilst females were reported at lower levels, again the age group which was most reported was those aged 10 to 13 inclusive (n=459). However, the next highest prevalence was in those under 10 (n=366), followed by 14 and 15-year-olds (n=240).

As shown in Table 32, females and males under 10 years and 10 to 13 years of age were more likely to also have concurrent reports of sexual or physical abuse and neglect compared to older young people. Males aged 14-17 years were the least likely of all age groups to have concurrent reports in the DCJ system. However, a quarter of 14 to 15-year-old males and one fifth of 16 to 17-year-old males still had concurrent reports of other concerns.

Nearly half of all reports were made by Education. There were more Police reports to DCJ about males aged 14-15 and 16-17 than for other age groups. Health made less than 10 percent of all reports for any age group except for females 14-16 years (11.7%). Family made 256 reports of PHSB (11% of all reports).

Half to two thirds of females had one or more prior reports to the Helpline. Half to one third of males had prior Helpline reports. Older males were less likely to have had prior Helpline reports compared to younger males and all female age groups.

Approximately three quarters of PHSB reports reached the risk of significant harm threshold. Males aged 10-13 years was the largest group in the data set to be assessed as at ROSH (16.8% of all reports).

Half of the younger age groups (males and females under 10 and aged 10-13) were more likely to be prioritised for a response within 24 hours with the prioritisation time getting longer for older age groups with 75 percent of males 16-17 years listed for response within 72 hours (20.4%) to 10 days (54.4%). Of all 5,105 young people, 34.4 percent were prioritised to be responded within 24 hours. At least half had attended an Emergency Department prior to their PHSB report with 67.9 percent of females 14-15 years represented in the ED data set (Table 32).

Table 32: Comparisons between age and gender (percentage of the total cohort)

	Females > 10	Females 10-13	Females 14-15	Females 16-17	Males >10	Males 10-13	Males 14-15	Males 16-17
Concurrent Helpline reports	73.2	61.1	47.1	40.4	56.9	40.3	24.3	18.7
Most frequent mandated reporter source	Education 46.4	Education 44.7	Education 44.2	Education 43.6	Education 48.5	Education 46	Education 43	Education 40.4
Least frequent mandated reporter source	Health 6.6	Health 5.4	Health 11.7	Health 9	Health 4.9	Health 5.3	Health 7.1	Health 8.1
Reported by family	9.0	6.5	3.3	0.6	8	6.7	4	2.3
1 or more prior reports to helpline	52.2	51.9	57.5	59.6	46.6	45.4	37.6	33.1
Assessed as ROSH	70.8	68.1	64	61.3	67.6	72.2	72.1	76.1
Response time	<24 hrs 53.8	<24 hrs 48.7	<10 days 34.6	<10 days 41	<24 hrs 45.4	<24 hrs 41.1	<10 days 46.4	<10 days 51.4
One or more ED visits prior to PHSB report	53.6	50.8	67.9	62.2	55.4	54.6	57.0	57.0

Aboriginal and Torres Strait Islander children and young people

Aboriginal and Torres Strait Islander children and young people are overrepresented in ChildStory compared to the general population of NSW (17.5% and 3.4% respectively) even though Indigenous status was not identified for 20.7 percent of young people represented in the dataset (total n=5,105). Data recorded as not stated or missing is excluded from this section of the report.

Nearly half of the 891, Aboriginal and Torres Strait Islander children and young people identified in the DCJ dataset had concurrent reports for sexual or physical abuse or neglect (Table 33). A similar proportion as non-Aboriginal children and young people. Education was the most frequent source of the report for both groups but 10 percent more reports were made by Education about non-Aboriginal young people. NGOs made reports about 20 percent of Aboriginal and Torres Strait Islander children and young people compared to 12.5 percent of non-Aboriginal children and young people. This is a considerable difference and also a different result than the age/gender comparison where NGOs made fewer reports compared to other mandated reporters. More Aboriginal and Torres Strait Islander children and young people than non-Aboriginal and Torres Strait Islander children and young people had 1 or more prior reports to the Helpline, with 67.5 percent Aboriginal and Torres Strait Islander children and young people having one or more prior reports as compared with 47.6 percent for the non-Aboriginal cohort.

Two thirds of reports about Aboriginal and Torres Strait Islander were assessed as at ROSH and only one third were allocated to a 24-hour response priority. This is a similar proportion to the non-Aboriginal young people and both groups had a similar proportion of young people who were allocated to 10-day response priority.

More Aboriginal and Torres Strait Islander children and young people (70.4%) made one or more prior visits to ED compared to non-Indigenous young people (58.3%). Within the criminal justice context, more young people who identified as Aboriginal and Torres Strait Islander had at least one prior conviction, comparative to those who identified as non-Aboriginal with at least one prior conviction (Table 33).

Table 33: Comparison between Aboriginal and Torres Strait Islander and non-Aboriginal people (percentage of the total cohort)

	Aboriginal and Torres Strait Islanders	Non-Aboriginal and Torres Strait Islanders
Concurrent reports in DCJ	44.4	43.8
Most frequent mandated reporter source	Education 36.6	Education 45.1
Other mandated reporter source	NGO 20.0	NGO 12.5
Least frequent mandated reporter source	Health 6.7	Health 6.4
Reported by family	4.8	5.9
1 or more prior reports to helpline	67.5	47.6
Assessed as ROSH	72.4	69.9
Response time	<24 hrs 27.6	<24 hrs 29.1
One or more ED visits prior to PHSB report	70.4	58.3
Prior conviction history	19.8	12.0

Report context

Prior DCJ Helpline reports

This section examines the datasets by report type – PHSB only, PHSB with concurrent other reports and the report source (Education, Health, Family, NGOs, Police and Others).

For 3,118 children and young people, their first PHSB reports were for PHSB only. For the remaining 1,987 children and young people, their first PHSB reports came in with other child protection concerns (Table 34).

Table 34: Prior DCJ Helpline reports

	PHSB Report Only	PHSB Report Concurrent with Sexual, Physical or Neglect
Number		
None	2017	937
1 or more reports	1101	1050
Total (N)	*3118*	*1987*
Column %		
None	72.3	81.7
1 or more reports	27.7	18.3
Total (%)	*100*	*100*

The reports were consistently spread across the report sources. However, Education and Police were slightly more likely to make a first report of PHSB whereas NGOs were more likely to be reporting PHSB when there were already concurrent reports (Table 35).

Table 35: Prior DCJ Helpline reports by reporting agency

	Education	Family	Health	NGOs	Other	Police
Number						
None	1377	151	221	282	457	466
1 or more reports	828	132	151	373	370	297
Total (N)	*2205*	*283*	*372*	*655*	*827*	*763*
Column %						
None	62.4	53.4	59.4	43.1	55.3	61.1
1 or more reports	37.6	46.6	40.6	56.9	44.7	38.9
Total (%)	*100*	*100*	*100*	*100*	*100*	*100*

Helpline assessment outcomes – ROSH categorisation

Regardless of whether there was a single report of PHSB and other types of abuse, the majority of young people were assessed as at ROSH. However, PHSB reports with concurrent concerns appeared more likely to be assessed as ROSH (82% vs. 72%) (Table 36).

Table 36: ROSH categorisation

	PHSB Report Only	PHSB Report Concurrent with Sexual, Physical or Neglect
Number		
CYP is at ROSH	2255	1623
CYP is not at ROSH	863	364
Count	*3118*	*1987*
Column %		
CYP is at ROSH	72.3	81.7
CYP is not at ROSH	27.7	18.3
Total	*100.0*	*100.0*
Percent (% of 5,105)		
CYP is at ROSH	44.2	31.8
CYP is not at ROSH	16.9	7.1

Most of the ROSH PHSB reports were made by Education (30.2%), followed by Others (12.1%), Police (10%) and NGOs (9.5%). Only 5.4 percent of Helpline reports by Health were assessed as ROSH (Table 37).

Table 37: ROSH categorisation by reporting agency

	Education	Family	Health	NGOs	Other	Police
Number						
CYP is at ROSH	1715	232	308	537	690	570
CYP is not at ROSH	755	116	104	209	182	262
Count	2470	348	412	746	872	832
Column %						
CYP is at ROSH	69.4	66.7	74.8	72.0	79.1	68.5
CYP is not at ROSH	30.6	33.3	25.2	28.0	20.9	31.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Percentage (% of 5,105)						
CYP is at ROSH	30.2	4.1	5.4	9.5	12.1	10.0
CYP is not at ROSH	13.3	2.0	1.8	3.7	3.2	4.6

Helpline assessment outcomes – case prioritisation

Concurrent reports in which PHSB was a concern appeared more likely to be prioritised (<24 hours) than PHSB report only (44.1% versus 13.4%). About 12 percent of the 'PHSB report only' were prioritised for 72-hour responses, with the majority (41.1%) assessed after 10 days (Table 38).

Table 38: Case prioritisation by PHSB report context

	PHSB Report Only	PHSB Report Concurrent with Sexual, Physical or Neglect
Number		
<24 Hours	465	978
<72 Hours	417	549
<10 Days	1422	194
Unspecified	1137	498
N/A - CYP added at field assessment	19	1
Count	*3460*	*2220*
Column %		
<24 Hours	13.4	44.1
<72 Hours	12.1	24.7
<10 Days	41.1	8.7
Unspecified	32.9	22.4
N/A - CYP added at field assessment	0.5	0.1
Total	*100.0*	*100.0*

The majority of prioritised reports (<24 hours) were made by Family (32.5%), followed by Other (29.6%) and then Education and Police (both 24.9%) (Table 39).

Table 39: Case prioritisation by reporting agency

	Education	Family	Health	NGOs	Other	Police
Number						
<24 Hours	615	113	98	152	258	207
<72 Hours	388	56	83	153	171	115
<10 Days	716	62	119	231	243	245
Unspecified	749	116	111	208	186	265
N/A - CYP added at field assessment	2	1	1	2	14	0
Count	*2470*	*348*	*412*	*746*	*872*	*832*
Column %						
<24 Hours	24.9	32.5	23.8	20.4	29.6	24.9
<72 Hours	15.7	16.1	20.1	20.5	19.6	13.8
<10 Days	29.0	17.8	28.9	31.0	27.9	29.4
Missing/NA	30.3	33.3	26.9	27.9	21.3	31.9
N/A - CYP added at field assessment	0.1	0.3	0.2	0.3	1.6	0.0
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

ED presentations prior to PHSB

Half of all young people regardless of single or concurrent reports attended an ED prior to the first PHSB report. Regardless of the source of the report, half of all young people made one or more ED presentations (Tables 40).

Table 40: Emergency department visits prior to PHSB report - by report type

	PHSB Report Only	PHSB Report Concurrent with Sexual, Physical or Neglect
Number		
None	1473	911
1 or more prior visits	1626	1081
Total (N)	*3099*	*1992*
Column %		
None	47.5	45.7
1 or more prior visits	52.5	54.3
Total (%)	*100.0*	*100.0*

Young people represented in NGO reports made slightly more ED presentations than those from other groups (Table 41).

Table 41: Emergency department visits prior to PHSB report - by reporting agency

	Education	Family	Health	NGOs	Other	Police
Number						
None	1017	137	180	261	430	361
1 or more prior visits	1188	146	192	394	397	402
Total (N)	*2205*	*283*	*372*	*655*	*827*	*763*
Column %						
None	46.1	48.4	48.4	39.8	52.0	47.3
1 or more prior visits	53.9	51.6	51.6	60.2	48.0	52.7
Total (%)	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

CHILDREN AND YOUNG PEOPLE WHO RECEIVED PHSB-RELATED SERVICES AFTER FIELD ASSESSMENT

Of the 5,105 young people in this sample, 1,150 had their first PHSB report triaged to field assessment. Of those whose cases were further investigated, 440 (approximately 40%) later appeared for a Non-Admitted Patient (NAP) service that was likely related to their field assessment. A PHSB-related service was defined as any of the following service categories in NAP Dataset:

- Adolescent / Youth Health
- Alcohol and Other Drug
- Child and Family and Child Health
- Child Protection and Child Protection Counselling
- Child Wellbeing
- Counselling – General
- Sexual Assault
- Specialist Mental Health; and
- Social Work

It should be noted that New Street services are not included in the NAP dataset (New Street data are reported in the next section). Of the 440 who received a relevant NAP service, 63 were already engaged with the service before their PHSB report was received by DCJ. For these young people, it is unlikely that the service episode resulted from their contact with DCJ field assessment teams. It is the remaining 377 young people for whom we can be reasonably confident that a new service engagement occurred, most likely because of a referral from DCJ. This is approximately one in three young people whose cases are triaged to field assessment, but still, only 7 percent of all (n=5,105) children for whom a PHSB report was made.

Young girls were more likely to appear for a new NAP service than young boys, although for both boys and girls, younger children were more likely to appear in the NAP database.

Table 42: Post-field assessment NAP service status, by age and gender

	Female >10	Female 10-13	Female 14-15	Female 16-17	Male > 10	Male 10-13	Male 14-15	Male 16-17
Number								
New NAP service	53	68	24	12	63	91	44	20
Continued existing	12	14	7	5	17	27	12	11
Ceased existing	23	14	8	8	40	39	20	18
No service	50	57	23	12	79	140	76	45
Count	*138*	*153*	*62*	*37*	*199*	*297*	*152*	*94*
Column %								
New NAP service	38.4	44.4	38.7	32.4	31.7	30.6	28.9	21.3
Continued existing	8.7	9.2	11.3	13.5	8.5	9.1	7.9	11.7
Ceased existing	16.7	9.2	12.9	21.6	20.1	13.1	13.2	19.1
No service	36.2	37.3	37.1	32.4	39.7	47.1	50.0	47.9
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

Further, a new NAP service was more likely to be recorded for triaged cases that involved concurrent reports of either physical or sexual abuse (Table 43). Finally, reports from

Education, even if triaged for field assessment, were less likely to end with a referral to or appearance at a NAP service (Table 44).

Table 43: Post-field assessment NAP service status, report context/concurrent reports

	PHSB only	Sexual Abuse	Physical Abuse	Neglect
Number				
No service	185	254	23	26
New NAP service	137	194	26	16
Continued existing	50	42	9	5
Ceased existing	75	87	7	5
Count	*447*	*577*	*65*	*52*
Column %				
No service	41.4	44.0	35.4	50.0
New NAP service	30.6	33.6	40.0	30.8
Continued existing	11.2	7.3	13.8	9.6
Ceased existing	16.8	15.1	10.8	9.6
Total	*100.0*	*100.0*	*100.0*	*100.0*

Interestingly, there was a sizable number of children who had been having contact with the relevant NAP service prior to their report for PHSB, but then did not re-appear in the NAP database after their field assessment. We have classified these cases as those where an existing service connection ceased (at least within the timeframe of this analysis). Service cessation was highest among older girls (21.6% for girls aged 16-17 years), higher where the PHSB report was made without any concurrent allegations of sexual or physical abuse (Table 42), and highest where the reporting agency was an NGO (Table 44). This latter finding may indicate those young clients who became frustrated, at the suspicion or information that the agency was the source of the report to DCJ. Alternatively, the agency may have terminated contact with the child or young person on discovery of the PHSB, if they deemed themselves not to be an appropriate agency to respond to this type of issue.

Table 44: Post-field assessment NAP service status, by reporting agency

	Education	Police	NGOs	Health	Family	Other
Number						
New NAP service	97	46	81	28	35	90
No service	227	57	66	23	34	85
Ceased existing	62	13	45	11	12	31
Continued existing	23	7	35	11	10	21
Count	*409*	*123*	*227*	*73*	*91*	*227*
Column %						
New NAP service	23.7	37.4	35.7	28.4	38.5	39.6
No service	55.5	46.3	29.1	31.5	37.4	37.4
Ceased existing	15.2	10.6	19.8	15.1	13.2	13.7
Continued existing	5.6	5.7	15.4	15.1	11.0	9.3
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

CHILDREN AND YOUNG PEOPLE WHO RECEIVED NEW STREET SERVICES

Context

As noted previously, in response to the Royal Commission's recommendation, New Street has now been expanded to a state-wide service. At the time of data collection, New Street was in operation in four LHDs including WSLHD, ISLHD, Western NSW LHD and HNELHD. The following findings are derived from the administrative data provided by WSLHD and ISLHD.

Client characteristics

Amongst the 5,105 children and young people reported to the Child Protection Helpline in relation to PHSB, 59 could be linked to the two New Street services at Illawarra Shoalhaven and Western Sydney Local Health Districts, who provided data for the project. Of the 59 young people, 55 were males and four were females. Nearly 50 percent were aged 13 and 14, followed by aged 12 (20.3%) and aged 15 (13.6%) (Table 45).

Table 45: New Street clients - age

Client age	Number of Clients	%
10	3	5.1
11	5	8.5
12	12	20.3
13	15	25.4
14	13	22.0
15	8	13.6
16	1	1.7
17	2	3.4
Total	*59*	*100.0*

Overall, almost 29 percent of these young people identified as Aboriginal, compared to 71.2 percent identified as non-Aboriginal (Table 46).

Table 46: New Street clients - Indigenous status

Client Aboriginal Status	Number of Clients	%
Aboriginal	17	28.8
Non-Aboriginal	42	71.2
Total	*59*	*100.0*

Nearly 8.5 percent of this group identified as culturally and linguistically diverse (Table 47).

Table 47: New Street clients – cultural and linguistic diversity

Cultural/ Linguistic Diversity Status	Number of Clients	%
None	52	88.1
Not Stated	2	3.4
Chile	1	1.7
China (excluding Taiwan)	1	1.7
Italy	1	1.7
Samoan Western Tonga	1	1.7
Turkey	1	1.7
Total	*59*	*100.0*

Of the 59 young people at the two New Street services, almost 10 percent (n=6) were identified as having trauma or stressor disorders and 10 percent (n=6) with an intellectual disability. Just over 8 percent were identified as having a ‘disruptive’ disorder (n=5) and 6.5 percent (n=4) having issues relating to impulse control, conduct disorders, anxiety and/or attention deficit disorder respectively (Table 48).

Table 48: New Street clients - psychological, physical, or emotional disorders

Psychological, Physical, and Emotional Disorders	Number of Clients	%
Trauma and stressor related disorders	6	9.7
Intellectual disabilities	6	9.7
Disruptive	5	8.1
Impulse-Control	4	6.5
Conduct Disorders	4	6.5
ADHD	4	6.5
Autism Spectrum Disorder	4	6.5
Obsessive-Compulsive and Related Disorders	1	1.6
Anxiety Disorders	1	1.6
Specific Learning Disorder	1	1.6
Genetic Conditions resulting in impairment	1	1.6
Vision Impairment	1	1.6
Total	*36*	*100.0*

To access the New Street services, 50.8 percent (n=30) of young people and their families travelled less than two hours (Table 49). The distance travelled for just over half was under 25 kilometres (Table 50).

Table 49: New Street clients – travel time to service

Time to Travel	Number of Clients	%
Less than 2 hours	30	50.8
Not Applicable	4	6.8
Not Stated	25	42.4
Total	*59*	*100.0*

Table 50: New Street clients - travel distance to service

Distance to Travel	Number of Clients	%
0-25 KM	30	50.8
Not Stated	29	49.2
Total	*59*	*100.0*

Over 27 percent of young people had acknowledged their PHSB during the therapeutic process at New Street. Another 25.4 percent had ‘partially acknowledged’ which could mean that the young person admitted having committed aspects of the PHSB but had not acknowledged the full extent of the PHSB and its impacts. Nearly 31 percent were ‘not stated’ (Table 51). It is noteworthy that, of the 59 young people identified in the dataset, only 15 had completed treatment. This means that, at the time of data collection, 44 young people were still in treatment. This could mean that the work around acknowledgment was yet to be completed.

Table 51: New Street clients - client acknowledgement of their behaviour

Client Acknowledgement	Number of Clients	%
Acknowledged	16	27.1
Partially Acknowledged	15	25.4
Not Acknowledged	10	16.9
Not Stated	18	30.5
Total	*59*	*100*

Referral source

The largest percentage, 37.3 percent (n= 22) of the 59 young people at New Street were referred by the Joint Child Protection Response Program (JCPRP), followed by DCJ (32.2%) (Table 52). The high referral rates from JCPRP and DCJ reflect the fact that confirmation of PHSB is the primary referral criterion to New Street.

Table 52: New Street client - referral source

Client Referred By	Number of Clients	%
JCPRP	22	37.3
DCJ	19	32.2
Parent/Carer	6	10.2
NGO	5	8.5
Community Health Service	3	5.1
Dept of Ed/School	1	1.7
New Street /Rural New Street	1	1.7
Not Stated	1	1.7
Other	1	1.7
Total	*59*	*100.0*

Client’s PHSB characteristics

Of the 59 New Street clients, over 61 percent (n=36) had harmed one victim, 22 percent two victims and 10.2 percent three victims (Table 53).

Table 53: New Street client – number of victims

Number of Victims	Number of Clients	%
1	36	61.0
2	13	22.0
3	6	10.2
4	1	1.7
5	2	3.4
Missing	1	1.7
Total	*59*	*100.0*

Females accounted for 59.3 percent (n=35) of victims and males 39 percent (n=23) (Table 54).

Table 54: New Street clients – gender of most recent victims

Victim Gender	Number of Clients	%
Female	35	59.3
Male	23	39.0
Not Stated	1	1.7
Total	*59*	*100.0*

The largest percentage of victims, 11.9 percent were 4-year-olds, 10.2 percent were 10-year-olds and 11 percent were 5-year-olds respectively (Table 55).

Table 55: New Street clients – age of most recent victim

Victim Age	Number of Clients	%
2	1	1.7
3	2	3.4
4	7	11.9
5	6	10.2
6	4	6.8
7	3	5.1
8	3	5.1
9	4	6.8
10	6	10.2
11	5	8.5
12	5	8.5
13	2	3.4
14	2	3.4
15	2	3.4
16	2	3.4
Missing/not stated	5	8.5
Total	*59*	*100.0*

As noted previously, of the 59 clients, 55 were males and four were females. Of the 55 male clients, 62 percent had displayed PHSB against one victim, and 22 percent against two victims (Table 56).

Table 56: Number of victims by male clients

Number of Victims	Male Clients	%
1	34	61.8
2	12	21.8
3	6	10.9
5	2	3.6
Missing	1	1.8
Total	*55*	*99.9*

Of the four female clients, two of them had one identified victim, one had two victims and another one had four victims (Table 57).

Table 57: Number of victims by female clients

Number of Victims	Female Clients	%
1	2	50.0
2	1	25.0
4	1	25.0
Total	*4*	*100.0*

Of the 55 male clients, 20 of them had displayed PHSB against one male victim (Table 58). Nearly half of the 55 male clients (45.5%) had displayed PHSB against one female victim (Table 59).

Table 58: Number of male victims by male clients

Number of Male Victims	Male Clients	%
0	31	56.4
1	20	36.4
2	2	3.6
3	2	3.6
Total	*55*	*100.0*

Table 59: Number of female victims by male clients

Number of Female Victims	Male Clients	%
0	17	30.9
1	25	45.5
2	9	16.4
3	3	5.5
4	1	1.8
Total	*55*	*100.1*

Of the four female clients, two of them had displayed PHSB against males (Table 60), and two against females (Table 61).

Table 60: Number of male victims by female clients

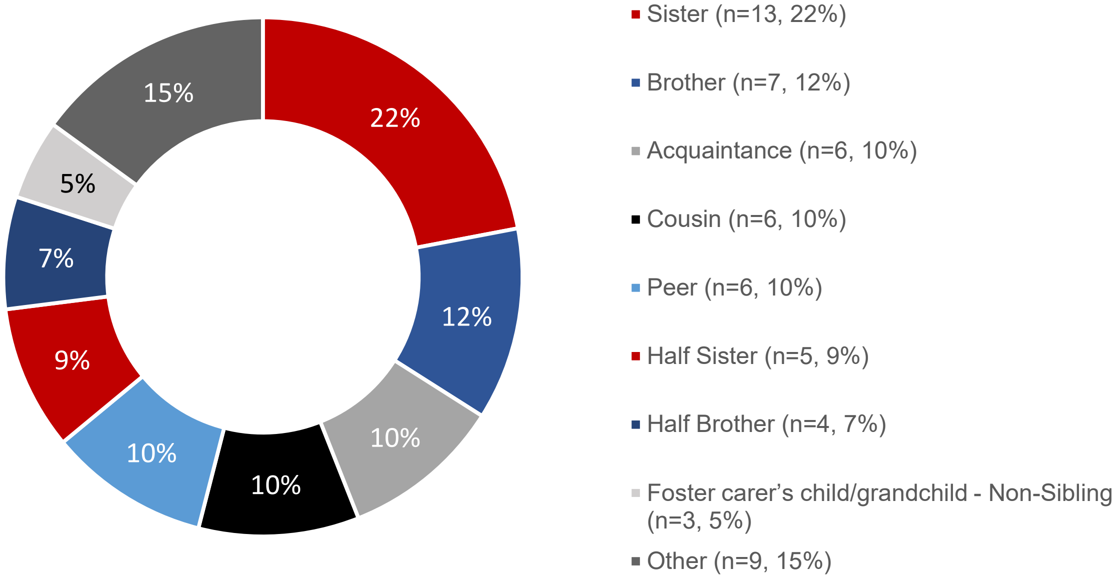
Number of Male Victims	Female Clients	%
0	2	50
1	2	50
Total	*4*	*100*

Table 61: Number of female victims by female clients

Number of Female Victims	Female Clients	%
0	2	50
2	1	25
4	1	25
Total	*4*	*100*

The relationship between the 59 young people displaying PHSB and their victims was typically familial, with 22 percent sisters, almost 12 percent brothers, 10.2 percent cousins, and 10.2 percent a peer or an acquaintance. Only 3.4 percent of victims were strangers (Figure 21).

Figure 21: New Street clients - relationship to most recent victim



Note: Other includes: Other child living in the same residence (3%); Stranger (child) (3%); Co-resident in residential care (2%); Foster sibling LT (2%); Friend (2%); Not stated (2%), and; Other relative (2%)

Client's PHSB behaviour type

Young people at New Street services presented with a range of PHSB. Some young people engaged with more than one behaviour and some young people had more than one victim.

In total there were 122 PHSB reported. Of these 122 PHSB, 75 percent were non-penetrative sexual touching, followed by penetrative behaviours (50%) (Table 62).

Table 62: New Street clients - PHSB behaviour type

Behaviour Type	Number of Clients with Behaviour	Incidence of Behaviour	% of all Incidence (n=122)
Sexual Touching (non-penetrative)	50	57	75.2
Penetration	32	38	50.2
Technology-assisted harm of a person	9	11	14.5
Inciting sexual behaviour	7	7	9.2
Sexual harassment	1	4	5.3
Exposure of self	3	3	4.0
Underwear theft	2	2	2.6
	Total	*122*	

Note: A young person may be reported for multiple behaviours and multiple victims. ‘Penetration’ includes vaginal (n=18), oral (n= 12) and anal (n=8).

More than half, 59 percent of the PHSB were reported to have occurred at the victim’s home, 8.5 percent occurred at the home of the young person displaying PHSB and 8.5 percent at an educational facility (Table 63).

Table 63: New Street clients - location of PHSB behaviour

Location of PHSB	Number of Clients	%
Harmed Child's Home	35	59.3
Not Stated	6	10.2
Own Home	5	8.5
School/TAFE	5	8.5
Own Home (where different from the CH's home)	3	5.1
Other Private Residence	2	3.4
Residential Care House	2	3.4
Public Transport	1	1.6
Total	*59*	*100*

In over 67 percent of the cases, the behaviour was disclosed by the child who was harmed, 15.3 percent by an adult witness and 8.5 percent by a child witness other than the victim (Table 64).

Table 64: New Street clients - person who disclosed the behaviour

Person Who Disclosed	Number of Clients	%
Child Harmed	40	67.8
Other Witness Adult	9	15.3
Other Witness Child	5	8.5
Not Stated	4	6.7
Young Person	1	1.7
Total	*59*	*100*

Client PHSB during treatment

Amongst the 59 young people at New Street, 32.2 percent had not displayed further PHSB during counselling at New Street, compared to 18.6 percent who had. Nearly half of the 59 clients were not recorded (Table 65).

Table 65: New Street clients - client displayed further PHSB while at New Street

Further PHSB	Number of Clients	%
No	19	32.2
Yes	11	18.6
Not Stated	29	49.2
Total	*59*	*100*

It is unclear when these further PHSB occurred during counselling at New Street because over 80 percent were not recorded in the dataset. Just over 15 percent of these further PHSB occurred during intensive phase (Table 66).

Table 66: New Street clients - stage of PHSB while at New Street

Stage of Further PHSB	Number of Clients	%
Assessment Phase	2	3.4
Intensive Phase	9	15.3
Not Stated	48	81.4
Total	*59*	*100*

Client experience of harm during treatment

During their New Street service access a small number (n=8) of the young people displaying PHSB were harmed (Table 67).

Table 67: New Street clients - child harmed during period of intervention with New Street

Client Harmed During Treatment	Number of Clients	%
No	23	39.0
Yes	8	13.6
Not Stated	28	47.5
Total	*59*	*100*

Of these young people, half (n=4) were harmed by a parent, and one was harmed by a co-resident in residential care, one by another adult relative and one by their parent's partner (Table 68).

Table 68: New Street clients - alleged perpetrator of harm against the child while at New Street

Person Causing Harm	Number of Clients	%
Parent	4	50.0
Parent/Other Relative	1	12.5
Parent's partner	1	12.5
Co-resident in Residential care	1	12.5
Not Stated	1	12.5
Total	*8*	*100*

PERSONAS

A key objective of this project was to identify the differential experiences of different client personas with the intention of highlighting key groups which may have different and important policy and practice implications. The personas presented in this section are not wholly exhaustive nor mutually exclusive, meaning that some children and young people may be counted in multiple person groups. Given the considerable heterogeneity of the data, simple, higher-level clustering procedures cannot be mutually exclusive without using some form of hierarchical classification strategy. This might include counting rules which treating one persona as more, or less important than another. Given there is no clear preferential or importance hierarchy in the nature of service use or access, the decision was taken to develop the personas as whole groups, even if some young people are counted across multiple groups.

Personas, in this case, represent groups of children and young people defined by their different service contacts with the aim of identifying different possible service pathways and exploring their characteristics. Four personas were identified: (1) children and young people whose PHSB reports were closed with no further service pathways identified (over 70% of the sample); (2) children and young people received a PHSB-related service in Health (11% of the sample); (3) children and young people had contact with youth and criminal justice system (nearly 10% of the sample); and (4) Children and young people received a New Street service in ISLHD or WSLHD (1.2% of the sample). This section compares these four personas in relation to demographics, the context of their first PHSB report, their prior history of contact with Health and Helpline outcomes. The findings presented in this section will be integrated with the qualitative findings into four different journey maps, presented in Chapter 4.

Personas characteristics - gender, age and ethnicity

As shown in Table 69, children and young people who received a New Street service or had contact with youth and criminal justice were predominantly males. Nine in ten clients in New Street were males, and eight in ten in youth and criminal justice were males. PHSB-related services in Health had the largest proportion of female clients (37.5%) compared with only 6.8 percent in New Street and 16 percent in youth and criminal justice.

Within our study period (January 2018 to December 2019), over 60 percent of the New Street clients had their first PHSB reports when they were between 10 and 13 years of age. This compares with 41 percent in other PHSB-related services in Health. In youth and criminal justice, over 40 percent of the clients had their first PHSB reports when they were between 14 and 15 years of age, followed by the 16 to 17 age group (32%).

It is alarming that Aboriginal and Torres Strait Islander children and young people were over-represented in the youth and criminal justice system. Aboriginal and Torres Strait Islander children and young people constituted only 6 percent of the youth population (10-17 inclusive) in NSW in 2019 (AIHW, 2020), yet 32 percent of them in our sample had contacts with youth and criminal justice. This means that Aboriginal and Torres Strait Islander children and young people were 8 times as likely as non-Aboriginal children and young people to have contact with youth and criminal justice (32 per 10,000 compared with four per 10,000).

Table 69: Personas by gender, age and Aboriginal status

	Persona 1 (Closed Reports)	% (of 3,691)	Persona 2 (PHSB-related)	% (of 549)	Persona 3 (Y&C Justice)	% (of 502)	Persona 4 (New Street)	% (of 59)
Gender								
Male	2832	76.7	340	61.9	417	83.1	55	93.2
Female	816	22.1	206	37.5	82	16.3	4	6.8
Intersex or indeterminate	3	0.1	0	0.0	1	0.2	0	0.0
Unknown/Not Stated	40	1.1	3	0.5	2	0.4	0	0.0
Age at first PHSB								
Under 10	653	17.7	155	28.2	3	0.6	0	0.0
10-13	1071	29.0	227	41.3	118	23.5	38	64.4
14-15	915	24.8	105	19.1	211	42.0	17	28.8
16-17	810	21.9	61	11.1	164	32.7	3	5.1
Missing/NA	242	6.6	1	0.2	6	1.2	1	1.7
Aboriginal Status								
Aboriginal	485	13.1	187	34.1	156	31.1	15	25.4
Non-Aboriginal	1838	49.8	332	60.5	286	57.0	38	64.4
Not Stated	959	26.0	25	4.6	35	7.0	5	8.5
Missing/ NA	409	11.1	5	0.9	25	5.0	1	1.7

Personas characteristics - History of Health service contacts

As shown in Table 70, over 70 percent of New Street and other PHSB-related service clients had a prior Helpline report unrelated to PHSB. Similarly, 60 percent of clients in youth and criminal justice had a prior Helpline report unrelated to PHSB. Of the four persona groups, children and young people in youth and criminal justice had the highest rate of ED presentations (37%) and admitted patient episodes (15.5%). Nearly four in ten children and young people in the PHSB-persona group had prior contacts with a PHSB-related Health service, followed by children and young people in youth and criminal justice (30%) and New Street (23.7%).

After the first PHSB report, over 80 percent of clients in a PHSB-related Health service had new Helpline reports followed by New Street (79.7%) and youth and criminal justice (77.3%). Again, children and young people in youth and criminal justice had the highest ED presentations rate and admitted patient episodes. Over half of the New Street clients also had contacts with others PHSB-related services after PHSB reports.

Regarding mental health, only 30 to 40 percent of clients in Health and the youth and criminal justice systems had received a mental health assessment. Only one in ten children and young people had a mental health assessment if their PHSB reports were closed after Helpline or triage.

Table 70: Personas by service contacts prior and after PHSB report

	Persona 1		Persona 2		Persona 3		Persona 4	
	(Closed Reports)	(% of 3691)	(PHSB-related)	(% of 549)	(Y&C Justice)	(% of 502)	(New Street)	(% of 59)
Prior to PHSB report								
Prior ChildStory Reports (since 1 Jan 2018)	1268	34.4	397	72.3	310	61.8	42	71.2
Emergency Department Presentation (lifetime)	1877	50.9	379	69	387	77.1	35	59.3
Emergency Department Presentation (past 12 months)	720	19.5	171	31.1	184	36.7	16	27.1
Admitted Patient Episode (lifetime)	708	19.2	181	33	166	33.1	15	25.4
Admitted Patient Episode (past 12 months)	260	7	87	15.8	78	15.5	3	5.1
Non-Admitted Patient Episode (lifetime)	1460	39.6	411	74.9	323	64.3	38	64.4
Non-Admitted Patient Episode (past 12 months)	537	14.5	209	38.1	151	30.1	14	23.7
After PHSB report								
New ChildStory Reports (before 30 Dec 2019)	1429	38.7	476	86.7	388	77.3	47	79.7
Emergency Department Presentation (post PHSB report)	1372	37.2	363	66.1	364	72.5	35	59.3
Admitted Patient Episode (post PHSB report)	396	10.7	116	21.1	121	24.1	7	11.9
Non-Admitted Patient Episode (post PHSB report)	1219	33	549	100	343	68.3	40	67.8
Any time before/after PHSB								
Mental Health Assessment	431	11.7	173	31.5	170	33.9	23	39

Personas characteristics - PHSB Report Outcomes

Clients in the New Street and other PHSB-related service groups were more likely to be assessed as ROSH, although the rates for ROSH were consistently high across all four Persona groups (over 70%).

Table 71: Personas by Helpline assessment outcome

	Persona 1		Persona 2		Persona 3		Persona 4	
	(Closed Reports)	% (of 3,691)	(PHSB-related)	% (of 569)	(Y&C Justice)	% (of 502)	(New Street)	% (of 59)
Helpline Assessment Outcome								
ROSH	2677	72.5	463	81.4	384	76.5	51	86.4
ROSH-D	182	4.9	23	4.0	34	6.8	4	6.8
Non-ROSH	832	22.5	61	10.7	83	16.5	4	6.8
Helpline flag								
CYP is at ROSH	2677	72.5	463	81.4	384	76.5	51	86.4
CYP is not at ROSH	1014	27.5	86	15.1	118	23.5	8	13.6

Note: ROSH-D refers to ROSH Duplicate.

Regarding response time, clients in the New Street and other PHSB-related services group were more likely to be prioritised within 24-hour. Clients in the youth and criminal justice group received the lowest response priority, with over 35 percent over 10 days.

Table 72: Personas by response priority

	Persona 1		Persona 2		Persona 3		Persona 4	
Response Priority	(Closed Reports)	% (of 3,691)	(PHSB-related)	% (of 549)	(Y&C Justice)	% (of 502)	(New Street)	% (of 59)
<24 Hours	806	21.8	217	39.5	111	22.1	25	42.4
<72 Hours	575	15.6	133	24.2	102	20.3	11	18.6
<10 Days	1263	34.2	113	20.6	176	35.1	15	25.4

Clients in the PHSB-related services group had the highest ‘triage to allocate’ rate (85.1%), followed by New Street clients (55.9%). This suggests that allocation is an important factor for service access. Over 45 percent of reports in the youth and criminal justice group were closed due to competing priorities, suggesting not being allocated and subsequently not having access to services may be a risk factor for contacts with youth and criminal justice.

Table 73: Persona by triage decision

	Persona 1		Persona 2		Persona 3		Persona 4	
Triage Decision	(Closed Reports)	% (of 3,691)	(PHSB-related)	% (of 569)	(Y&C Justice)	% (of 502)	(New Street)	% (of 59)
Triage decision to allocate	0	0.0	484	85.1	142	28.3	33	55.9
Triage decision pending	11	0.3	62	10.9	43	8.6	10	16.9
Triage decision to close: competing priorities	2681	72.6	0	0.0	229	45.6	12	20.3
Triage decision to close: subject not located	8	0.2	0	0.0	1	0.2	0	0.0
Triage decision to close: other	295	8.0	0	0.0	40	8.0	0	0.0
No Triage: Closed at Helpline	696	18.9	0	0.0	46	9.2	4	6.8
Triage decision Pending - No transfer record	0	0.0	3	0.5	1	0.2	0	0.0

Chapter 3: Research Interviews

This section reports the research methodology for the qualitative component of this study and the findings from the interview data. The qualitative findings complement the data linkage results by drawing on participants' experiences to identify enablers and barriers to service accessibility and engagement. It provides further insights into participants' service experiences across the child protection, youth justice and public health systems. The qualitative data were collected from 31 interviews, addressing six key research questions:

1. What support was provided by services in response to the PHSB?
2. What have participants found helpful or unhelpful from services?
3. What are the perceived positive impacts of services and negative consequences of unhelpful services?
4. What helped with service engagement?
5. What were the barriers to service access?
6. What can be improved?

RESEARCH ETHICS

Ethical approvals were granted by the Human Research Ethics Committee of the Sydney Children's Hospitals Network (SCHN) and the Aboriginal Health & Medical Research Council of NSW (AH&MRC). Specific site approvals were granted by the Illawarra and Shoalhaven Local Health District (ISLHD), the Western Sydney Local Health District (WSLHD) and Youth Justice, NSW (YJ).

PARTICIPANTS

Recruitment of caregivers (parents and carers) and young people (aged 14 to 17) took place in relevant services that provide counselling and treatment to children and young people who have displayed PHSB, and to their families. These services included:

Services for children and young people between 10 and 17 and their families:

1. New Street Services in ISLHD and WSLHD.
2. Youth Justice (Blacktown, Burwood, Campbelltown, Penrith and Wollongong).

Services for children under 10s and their families:

3. Domestic Family Violence Sexual Assault Services (DFVSAS) in ILSHD.
4. Integrated Violence Prevention and Response Services (IVPRS) in WSLHD.

5. Child and Family Allied Health Service in WSLHD.
6. Rosie's place.
7. South Coast Women's Health and Welfare Aboriginal Corporation in Nowra.

Meetings were held with each service to explain the scope and purpose of this study. Each service was provided a recruitment script, recruitment posters and a QR code which linked to a 5-minute animation video for recruiting young people. Staff from each service approached clients who were eligible for this study. Interested clients either passed on their contact details to the research team to discuss the project further or organise an interview appointment. Alternatively, interviews were arranged through their counsellors or support workers.

Recruitment took place between March and May 2021. In total, 31 participants were recruited, comprising 20 caregivers and 11 young people. Of the 31 participants, seven identified as Aboriginal people including three caregivers and four young people. As shown in Table 74, the participants were from three of the seven recruitment sites (New Street in ISLHD and WSLHD, DFVSAS and YJ). Small numbers of eligible participants in under 10s services were cited as the primary reason for their low participation rate.

Table 74: Interview participant demographics

	Young People Aged 14-17 (n=11)	Caregivers (n=20)
Gender		
Males	10	4
Females	1	16
Recruitment		
ISLHD New Street	4	13
ISLHD DFVSAS	n/a	2
WSLHD New Street	2	4
Youth Justice	5	1
Relationship to young person		
Biological parents	n/a	13
Foster/kinship carers	n/a	7

DATA COLLECTION

Caregivers and young people participated in semi-structured interviews lasting between 30 minutes and one hour. In keeping with research ethics approval, the interviews were designed to capture participants' perceptions and experiences of service accessibility and engagement, rather than the PHSB. Participants were asked about what they found helpful and unhelpful from services they had contact with, what they gained and needed from services, barriers they experienced when accessing services, how services can improve and what they would want future potential service users to know about services.

Research interviews took place between March and May 2021. All interviews were conducted face-to-face in services from which the participants were recruited, except for one in which the interview was conducted remotely from the participating service. All interviews were audio-recorded after participants provided their consent. All participants received a $40 voucher for their contributions to this research.

DATA ANALYSIS

Data analysis was assisted by NVIVO 12 software. Thematic analysis (Braun & Clarke, 2006) was employed. A coding tree was developed deductively by research questions then inductively by attributing short phrases to common perceptions or experiences reported by participants in research interviews. This process enabled themes within research questions to emerge from the data. It also facilitated the identification of other pertinent information that participants had shared with the research team which may not have directly reflected the research questions. Focused inductive coding involved reading and re-reading the interview transcripts and collating codes into potential themes. Analytical coding involved checking and reviewing to ensure that the coded extracts fit with the potential themes and the dataset (Braun & Clarke, 2006). Themes were further refined in the writing process including selecting quotes that were illustrative of the themes.

In keeping with ethical research practice, research participants have been de-identified. Given the low numbers of participants from some services, we have aggregated participants into one of two cohort groups: caregivers and young people. 'Caregivers' refers to parents, kinship and foster carers. 'Young people' refers to participants aged between 14 and 17. Results are presented thematically. The proportion of participant concurrence within each theme is not included. There are two key reasons for this approach. First, these data are not representative of clients, and indeed, were not designed to be. This means that providing quantitative data about the extent to which participants 'agreed' with a theme is not reliable. Second, there are small numbers of participants in some groups and disaggregating themes by small numbers of participants' risks identifying individuals or families.

FINDINGS

This section reports five broad themes across the qualitative dataset. These themes capture common perceptions and significant experiences of participants in relation to the research questions set out below.

Table 75: Themes identified from qualitative dataset

What were the service needs and contexts?

- Immediate support needs following disclosures
    - Recognition of crisis
    - Prompt follow-up supports
    - Sensitivity and care
    - Specific needs in OOHC
- Diverse support needs and service contexts

What helps with service engagement?

- Being non-judgmental
- Being trustworthy
- Matching counsellors with clients’ needs

What have participants found helpful?

- Child-centred practice
- Involving caregivers
- Attending to multiple support needs
- Strengthened family relationships
- Improved capacity to reflect on consequences of behaviours

What have participants found unhelpful?

- Closed doors
- Unprofessional service response
- Reduce caregiver autonomy

What were the barriers to service access?

- Service capacity
- Service visibility
- Apprehension about help-seeking
- Care continuity

What can be improved?

- More support for caregivers
- More accessible and timely supports
- More prevention and early intervention efforts

What were the service needs and contexts?

Immediate support needs following disclosures

Participants identified some immediate support needs following disclosures. These needs are summarised below.

Recognition of crisis

Caregivers reported the need for service providers to recognise that they were at a crisis point following disclosures of PHSB. Caregivers, particularly in instances of sibling sexual abuse, were confronted with the pressure of needing to make important decisions in haste. They cited examples where they had to decide whether or not to press charges against their child, how to separate the siblings and where to find alternative accommodation. Caregivers identified different challenges during this crisis point, from fear of being blamed, having difficulty with understanding complex legal information, worrying about their children's safety, to coping with the emotional impacts.

> *"There are still a lot of families that would never have dreamt that would happen. So, I think sometimes they just need to remember that… approach it with a bit more compassion and a bit more understanding…even though the police or FACS are very familiar with the process and the situation, the rest of the population isn't. And we're already scared and frightened. We don't need to be bewildered as well."* (Caregiver 15)

> *"I just, you know, kept on bawling my eyes out. As soon as I heard the news, I, sort of, started to grab my keys and run to the car and you know, [my family members] were trying to stop me and they were like, 'give yourself some time and some space to breath'…so I did sit there, and you know, cry."* (Caregiver 8)

Prompt follow-up supports

A small number of caregivers reported that their needs arising from this crisis were met. These included child protection and police maintaining regular contact, providing clarity on legal information and making referrals to appropriate services.

> *"[JIRT] explained things to us which was really good. Because even when they sort of set out the AVO, I'm like, 'I have no idea about an AVO. Like, what does that mean?' and she said, "I will phone and I will talk to [your child] over the phone with you as well". So, we sat there with the phone on speaker and she just really clearly explained everything as much as she could within that legal boundary of what we were allowed to say and what we couldn't. So, that was very helpful."* (Caregiver 15)

A few other caregivers noted that service responses to their support-seeking after investigations were lengthy and lacked continuity from one organisation to another, particularly during the transfer from JCPRP to local child protection offices.

> *"Nothing happened for ages. And then, like, surely something should be happening. So, I started making some phone calls and leaving messages, and got called back after a few days… 'here's some numbers, ring them up', sort of like deal with it yourself."* (Caregiver 16)

Sensitivity and care

Non-blaming approaches to caregivers during the investigation and safety planning processes was seen as crucial.

> *"They [the investigators] were really good. It was just really hard to process. They were really understanding and really caring and didn't put the blame on us, which was good. There was no, "Where were you?, what were you doing?," type of thing."* (Caregiver 14)

A small number of participants felt they did not have opportunities to tell their side of the story.

> *"They refused any sort of answering from me. They had made their decision and without – before they'd even spoken to [the child] or anything, they had made their decision. That was their decision, that was final and they wouldn't listen to any of our concerns whatsoever. They just kept shutting me down. Shut me down, shutting me down."* (Caregiver 2)

Some caregivers wanted a more sensitive approach, citing incidents where young people's privacy and confidentiality were not safeguarded.

> *"Two police officers were on their way to the school to pull [the child] out of class and handing him with an AVO but I stopped everyone and said, "I don't think that that's the wisest and safest option for [the child]."* (Caregiver 9)

Young people described the process following disclosure and investigation as "stressful", *"I thought my heart was going to break or something. I thought it was going to like pop out of my chest"* (Young Person 9). They noted that the process was often lengthy and somewhat confusing as multiple people in the system were involved. Needs identified were clear information about what would happen to them following disclosures and adequate care and comfort while being detained in police stations.

Specific needs of young people in out of home care

In situations where young people were placed in out-of-home care (OOHC) following disclosures, caregivers found themselves needing to alter family and work schedules and meet the new demand of caring for a young person or a child who has complex support needs. Caregivers in this situation identified a range of additional needs relating to clarity around family contact, safety of other children visiting the household and financial support.

> *"[my partner] is having to cancel or decline shifts at work so [my partner] can be available to give [the child] the care and supervision…just managing all of the appointments is almost like a full-time job. Financially, we're really struggling."* (Caregiver 9)

> *"What are the risks?... My granddaughter lives in the property in a granny flat. The other children in the house, how old they were, what was the likelihood of… What I had to look out for."* (Caregiver 3)

Diverse support needs and service contexts

Participants were asked about their experiences with services and organisations they had contact with across different systems. In addition to DCJ, JCPRP and Police, participants reported a range of other services and organisations including Schools, GPs, Youth Justice, OOHC agencies and public health services including hospitals, mental health and other specialist services for children and young people with PHSB. The number of services with which participants had contact varied, depending upon needs, participants' roles and at what point they became involved in the child's life. For example, some caregivers only became involved in the child's life as OOHC carers after the behaviour had occurred, hence, had relatively limited contact with DCJ and police.

The qualitative data suggest, in addition to the specialist services specific for PHSBs, participants had contact with other services for myriad reasons, with PHSB being one of the related concerns in some, but not all, situations. For example, some caregivers reported having contact with mental health services because of young people's aggressive or suicidal behaviour. Some of these service contacts were associated with PHSB, for example, at the point of disclosure, the young person felt suicidal and was sent to the emergency department. Other caregivers reported seeking support from schools to address their children's learning and social difficulties. Some young people also spoke about finding support from schools to manage bullying incidents.

These qualitative data cannot determine to what extent these service contacts were directly related to PHSB. The data, however, indicate that children and young people who have displayed PHSB have multiple needs across various developmental domains and service systems. Therefore, their experiences of services should be understood in this broader context where not all contacts will be primarily about PHSB. The findings reported below capture participants' experiences across these different services.

What helps with service engagement?

This theme relates more broadly to participants' experiences of how staff build relationship and trust, to enable them to feel informed, heard and work towards their goals in generalised and specialist services.

Being non-judgmental

Participants noted that they perceived staff as non-judgemental when they refrain from making assumptions about them, listen and validate their emotional experiences and concerns. The importance of this is particularly evident in the context of participants feeling they have no one to turn to because of the fear of stigmatisation.

> *"[the staff] answered the phone and I've never felt like I spoke to someone who understood what I was going through and it was just like, cause it's not the sort of thing you can just go and talk with your friends about or anybody about. I was protecting my child's story and so to actually have someone else on the end of the phone who actually could see how desperate I was to get my child some help."* (Caregiver 5)

> *"They support every step of the way. Literally [the counsellor] has made it feel like it's not even a counselling session when I go there. It's like I feel like I'm just going there to talk to a friend. She has made it that comfortable…I can swear my head off if I need to, I can do what I need to and there is no judgement whatsoever."* (Caregiver 20)

Young people perceived a non-judgemental attitude as being willing to consider their point of view and respect their need for autonomy without "forcing" them into talking before they feel ready. Some young people noted that this makes them feel 'safe'. They also added that staff being interested in not just what they have done but who they are as a person, and looking after their best interest makes them feel they can be honest and open.

> *"If they [the staff] weren't so respectful and so patient and so non-judgmental, I don't think I would have been able to do it. I think I would have refused to even talk about it…[Lawyer] is honestly the best lawyer ever…He always explains everything to me where I know what's going on and I understand everything and I'm not left thinking 'what are they saying?'… he's so justice-focused, he wants what's right for the kid…you don't feel like you need to lie*

> *or twist your words, you just tell him exactly what you done."* (Young Person 9)

Being trustworthy

Some participants spoke about their initial apprehension with the service, but staff gained their trust through either extending their support beyond the immediate service setting or being reliable by following through on promises. These participants cited instances in which staff provided strong advocacy and emotional support in meetings with other services such as schools or child protection.

> *"Because of my apprehension, I'm kind of, "I'll wait and see and meet the counsellors and see what they're like." I really probably was more stand-offish when we started…until I saw their responsiveness and how they bent over backwards. They genuinely care about us. I've got no doubt that this isn't just a job for them. We're not just another family. They take vested interest in our story."* (Caregiver 13)

> *"I can't fault them in our case…They called back when they said they'd call back, they were brilliant."* (Caregiver 2)

> *"She's excellent. I saw her yesterday. She came around because she's going on leave for a week, she's got a week's holiday, she actually came around to check on us, make sure we're okay, if there's anything we needed before she went away, anything I wanted to talk about. She's very good like that."* (Caregiver 19)

Matching counsellors with clients' needs

Some participants appreciated the considered approach to matching staff with clients based on developmental needs and gender. Caregivers observed the strategic thinking behind the matching, noting that counsellors who could relate to young people were assigned to work with the child whereas parents were assigned to counsellors who were skilled in working with adults. A few participants cited examples where the services were willing to change counsellors to meet their needs.

> *"They realised that I needed somebody else and after that, they've changed me over to [a different counsellor] and – yeah, me and [the new counsellor] clicked... So, I think they're really good at that, knowing and seeing that you need somebody else."* (Caregiver 1)

> *"[the counsellor] is a lot younger she understands more how I'm thinking 'cause my last counsellor she was like my grandma's age."* (Young Person 5)

What have participants found helpful?

Participants reflected on three service approaches they have found helpful: (1) child-centred practice; (2) involving parents and carers; and (3) attending to multiple support needs. In some cases, participants reported positive impacts of these service responses including strengthened family relationships and improved capacity to reflect on consequences of behaviours. These findings are included in this section.

Child-centred practice

When participants were asked to describe the work they did in counselling, they provided some common responses such as "talking", offloading heavy emotions, learning alternative communication or problem-solving strategies, and viewing counsellors as their sounding board for advice. Some participants cited examples which indicate that therapeutic work was not modelled on a prescriptive or manualised approach, rather it was centred on the individual needs and interests of young people. For example, a caregiver spoke about the counsellor using her child's interest in sports as a metaphor to engage him in discussion about social support networks and protection. Other caregivers found value in children using photo books and drawings to makes sense of their life story and work through emotional experiences. Specific needs of young people were also attended to through therapeutic tools that helped them feel settled in counselling sessions:

> *"Because she does have ADHD. They brought a basket of fidget toys and things like that in for her …There was a bit of drawing that she could sit there and do while she listened and learnt things so that she was able to feel comfortable in her environment to do the things that were needed."* (Caregiver 18)

Caregivers also found that counsellors were responsive to young people's developmental and emotional needs.

> *"One time, [my child] was just no, not doing it…not even coming in, not even sitting down for this... So, [the counsellor] actually just went and sat outside with him and chatted to him and – on a 13-year-old grown up level."* (Caregiver 1)

The child-centred practice extends to sensitive and careful pacing of counselling. Both caregivers and young people appreciated that the therapeutic work was not imposed upon young people, rather, they felt having a sense of control in deciding the timing and pace of therapy.

> *"They always ask him, it's not just, "We're doing this today." They ask him. They give him options, they make him feel valued, and help him realise that*

> *this is for him…to be able to come here and he has those options, and he has a voice."* (Caregiver 2)

This approach is particularly important to young people during various pressure points when they felt the need to take a breather and reset the pace.

> *"Every time we complete one of the focuses we will have a two session break to get my mind ready. That was actually [my counsellor's] idea as well as mine. My idea was, no, I said I would need a little bit of breaks to get myself ready for the next sessions and everything and then [my counsellor] was, "Maybe two sessions' break."* (Young Person 3)

Involving caregivers

In services where caregivers were involved in therapy, the involvement was reported to include having a dedicated counsellor and doing joint work with the young person in counselling sessions. Multiple benefits of this approach were noted by participants. Some caregivers found that being involved in counselling meant they could offer direct assistance to their children in counselling, helping them understand the work involved.

> *"When [the counsellor] is sitting there telling her something and she's going, "Yep. Yep. Yep." I'm reading her going, "You're not getting any of that." Then I'll stop them, and I'll be like, "Do you understand what was just said?" She'll be like, "No." I'm like, "Okay. Here we go" …I don't think their work would have as big an impact or work as well if there isn't an icebreaker, somebody in the room that can understand what's being said on the other side and can help relate it better to the child's needs or ways of understanding."* (Caregiver 18)

Other caregivers noted that having dedicated counsellors for them and for the child provided flexibility to meet their individual needs and the needs of the family.

> *"Having us all here at the same time, we all get a little bit of whatever it is off our chests. [My child] feels like he can be heard, because he gets the option of starting the meeting separately. He'll go off with one counsellor whilst the other counsellor stays with me and my wife. We all can vent away from each other…There is that flexibility that they can stop or they can start with separate, if everything's looking a bit tense."* (Caregiver 13)

A few caregivers also noted that their involvements provided invaluable reassurance to their children that they were not alone in working through the issue:

> *"I think for us all coming together as the three of us, that was good for [my son] because it was we were here together, so it was that real visible, 'We're here to support you and to help you through this."* (Caregiver 15)

> *"Our relationship has gotten a lot better because I think [my child] feels that I understand, I'm being supportive, I'm here every week, I'm doing it with [my child] and we're on the same page."* (Caregiver 18)

From young people's perspectives, having caregivers attend counselling with them during the initial period was particularly crucial as it provided a sense of safety and comfort.

> *"I'm more like not scared or anything with [my parents] around…talking about things and being with like people I'm not really used to. Like, I'm used to them now but like when I first came."* (Young Person 6)

Attending to multiple support needs

Whilst participants accessed or were brought to the service as a result of PHSB, they reported a range of other support needs, from education, housing, employment, mental health, sexual health, legal aid, family dispute resolution and culture. Participants cited instances in which practitioners supported them to meet these needs either through warm referrals to relevant services or provisions of practical support such as helping young people write job applications.

One common need expressed by caregivers relates to education and behaviour support from schools. Whilst determining the prevalence of learning and social difficulties was not the focus of the research interviews, many caregivers noted that their children faced additional challenges at schools such as ADHD, autism, prolonged suspension, expulsion or being victims or instigators of bullying. Within this context, caregivers reported that having counsellors to coordinate and participate in school meetings helped them obtain valuable resources. These included schools providing circuit-breaker activities such as time-out cards to help children with their emotion regulation, referrals to after-school activities or school counselling services.

> *"Having the service go to the high school, contact them, explain the situation and what [my child] got going on, trying to help with support within the school environment. Just knowing that all around she's getting extra support has been helpful."* (Caregiver 18)

The limited data suggest that allowing young people and their families to engage in cultural activities, regardless of how much they knew about Aboriginal Culture was seen as a positive. For many Aboriginal people, their connections to Culture can vary significantly due to processes relating to colonisation such as child removal and assimilation policies, as well as interpersonal and systemic racism. Some people know little beyond knowing they are Aboriginal while others may be immersed in Culture. Regardless of how much people feel connected, allowing them to explore or express Culture within the services is seen as positive.

> *"Yes. It definitely – before going to supervision I didn't really care about my Aboriginality and I was kind of like – I was kind of like not embarrassed by it but I was kind of like it's not something that's really interesting or that I really want to tell people…But now it's I want everyone to know I'm Aboriginal, like I'm so proud of it and like I have so much pride in my culture and I love it so much now."* (Young Person 9)

One of the factors that appears to enable cultural expression based on the limited data are Aboriginal staff.

> *"The school has a really good lady. She's an Aboriginal lady. She advocates for the kids, but she was gone for, like, three terms and the second she was gone, so much happened to my boys. So much. They were – everything was stopped, like, no. They refused to do the TAFE for [Young person, that's when [Young Person] had those two incidences. Both the boys were getting suspended for walking through corridors at recess and lunch and things like that. And, it was as soon as she was gone, because she would advocate for the kids and now they had nobody."* (Caregiver 1)

Strengthened family relationships

Through the support received, participants appeared to have experienced two main positive impacts. Firstly, services assisted participants to strengthen family relationships. Participants reported that the support they received from services allowed them to spend quality time together.

> *"There're two younger siblings. As a unit, as a mum, I'm always with all of them but having that just one-on-one time, just doing us for a drive out here every week has also been a positive impact on [my child]."* (Caregiver 18)

> *"It's been really good, and it's actually brought us closer, which I didn't think was possible, because he's pretty much forgotten that the umbilical cord was cut, but it's brought us closer."* (Caregiver 3)

Relatedly, through counselling, family members developed an increased understanding of each other, providing opportunities to learn new communication strategies to reduce tension within the family. The improved communication and relationships were not limited to parent-child relationships but between siblings and other family members:

> *"Just hearing my children being a little bit more open about how they find me has made me stop and think a little bit clearer about what I'm going to say to my children…Just thinking about choice of words, it's helped me with my choice of words with my younger children in particular."* (Caregiver 10)

> *"I've opened up to my family a lot more. They're more realising about how I feel. Because, before I came to [this service], I didn't even open up to them about anything. Even when I was sad, I would put a fake smile on…But, now I express my feelings when I walk into the house."* (Young Person 3)

> *"I do think they're a bit more open with me about some things. And, they don't approach me the way they used to. So, if I did something wrong or if one of my brothers was complaining about me, my dad doesn't come out effectively yelling at me anymore... I think it might have pulled myself and my dad and my mum closer since we're more open to each other about things."* (Young Person 12)

> *"Huge. [my child] goes to [his brother] now if he needs to talk about any boy things, and he goes to his older brother and is happy to just sit and chat, or he goes and he speaks to my brother. Him and my brother are really close. It's changed the whole family."* (Caregiver 2)

Improved capacity to reflect on consequences of behaviours

More specifically, perceived positive impacts on young people were that some of them found themselves having greater capacities to manage anger and to reflect upon personal values, consequences, and accountability.

> *"I can also control my anger a bit better as well. Because I've had anger issues in the past where almost anything could set me off really badly, really quickly. I think it's because I've come here and I've learnt I can control it a bit better."* (Young person 12)

> *"Before, I was so impulsive and I was so oblivious to consequences and I feel like going to these sessions have really made me step back and think to myself, 'is a life of crime a life I want'…I feel like they've not only made me realise it's not the life I want for me, but they've helped me to value myself and put worth in myself."* (Young person 14)

> *"The best part was when [my child] apologised…over that course of the whole lot, we got to a point where there was never really an admission of what he'd done, but he apologised. And, it sounded quite genuine and heartfelt. So, I think that was a really – it was, like, a wow moment."* (Caregiver 16)

What have participants found unhelpful?

Participants responded to a range of prompts designed to identify opportunities to improve access and engagement with services for PHSB. One set of prompts asked participants to reflect on negative, difficult or challenging experiences with services that may have occurred once, or on multiple occasions. Three themes emerged from these data on unhelpful service experiences: (1) closed doors; (2) unprofessional service responses; and (3) reduced caregiver autonomy. In some cases, participants reflected on the consequences or impact of their experiences and, where possible, those data are included below.

Closed doors

Some participants were not able to receive services and therefore experienced 'closed doors'. The reasons for the lack of service were twofold. First, there were unavailable services resulting from long waiting times to access support:

> *"Well, we've got him booked in for a psychologist, but we booked that last year and his earliest appointment was for May this year."* (Caregiver 1)

Second, there were service eligibility criteria that prevented participants from accessing available services. Criteria that resulted in ineligibility included the sexual nature of the behaviour, the age of the child, their level of needs, and/or their complexity.

> *"We wanted to know what options there were and they basically said that they couldn't help us because of his harmful sexual behaviours."* (Caregiver 12)

> *"I was getting shoved from place to place, is because they didn't know what category to put him in, one, because of his age and the other one because of what he'd been through and experienced. So, I think there was a lot of, he might be able to go here, he might be able to get there and a lot of people said to me, "No. We won't take him because he's too young." Or, "We won't take him because the problem's not bad enough" or, "He's not bad enough for our services." I got shoved around a little bit."* (Caregiver 7)

> *"There is nothing for his age group. He's 12. So, back then just 11. And, even at one stage to get us in quicker [someone] actually recommended I took him to the emergency department and so we actually did that as well just to try and get him, because he might have got seen a bit quicker if we got him triaged."* (Caregiver 3)

The consequences that participants reported because of their experience of closed doors ranged from a perceived increased risk of harmful behaviours to advocacy on the family's behalf by other services. The perceived increased risk of existing harmful behaviours included PHSB, physical violence, and self-harming behaviours such as food refusal and attempted suicide. Risks were to the young people experiencing PHSB and to the wider family:

> *"Well, how do we wean him off some meds? Are you telling me I have to wean him of meds in my own home when we know that behaviours can escalate?"*

> *And he’s like, “Yeah, you’ll have to do it at home,” with two young children.”* (Caregiver 12)
>
> *“…cause he was going to commit suicide, so we went up to [Redacted] Mental Health there and they couldn’t help him because he’s not the right age, which is totally stupid.”* (Caregiver 17)
>
> *“…when computers are thrown at windows and holes punched in walls or chairs thrown across the room, you’ve got to think of the other kids too.”* (Caregiver 12)
>
> *“The only solution that we have that she responds to is going to the hospital. They try and encourage us to go home. Often, when she has her meltdowns, she doesn't eat.”* (Caregiver 9)

In some instances, parents and caregivers developed their own informal ‘response plans’ to manage the child’s behaviour. Informal response plans included utilising 24-hour emergency services such as hospitals and police, organising private services such as psychiatry, and adopting techniques of hyper-vigilance such as technological and parental surveillance and monitoring:

> *“That’s why I've called the police. That’s why I've asked police to take him away. It’s because he can literally not be in this house because he unsafe.”* (Caregiver 13)
>
> *“She feels really comforted being at the hospital, and more often than not, it's so busy and she doesn't actually get to see anyone from the mental health team or talk to anyone. Just being there calms her down a little bit, as much as it is a bit of a strain on the system, especially when they're so busy and they don't have beds.”* (Caregiver 11)
>
> *“I rang the Mental Health Line, and they told me that he didn’t qualify for services. And so, I ended up finding a psychiatrist in Sydney.”* (Caregiver 12)
>
> *“I just wanted [my child] to get help, and we were just sat at home, and then it was on me to watch him all night, make sure nothing – he wouldn’t harm himself. And, it was like that for months, just on watch, taking – there was no sharp knives around, make sure there’s no scissors, pacing up and down the hallway all fricking night. I don’t know. Didn’t get no sleep that – those couple of months.”* (Caregiver 13)

Parents and caregivers reported increased feelings of stress as a result of the closed doors that they had experienced. In some cases, there was significant strain on the family and increased risk of family breakdown both in parental and caregiver families:

> *"I told [child protection], "We get zero respite. We get no break from it. This is 24-seven." I told them, "I'm ready to give him up and not be his parent if that's what I have to do to get a break and to make sure my little ones are safe in the same house."* (Caregiver 13)

> *"Ultimately, if it's going to be a permanent thing or much longer than three months, I think we probably will need to say no and figure out another solution because we're not doing very well."* (Caregiver 11)

Perhaps a more positive consequence of the closed doors that participants experienced was advocacy on the family's behalf by other services:

> *"…just to get a meeting with [mental health], we have one tomorrow, but that's only because [STAFF) and [STAFF] go on that phone, and they're saying, "This family is in crisis. They need your help." But, as parents, we wouldn't have been able to be heard. So, very, very negative."* (Caregiver 12)

Unprofessional service responses

For participants, one unhelpful aspect of their experiences related to a variety of unprofessional service responses. Participants reported feeling judged, silenced or not listened to, threatened, labelled or name-called, and engaging with disinterested practitioners.

> *"The other two that we'd had, they were very factual not personal, if that makes sense? They were more about this is the job but they didn't look like they were passionate in their job, that they liked their job. It was more that it was just the job because it showed when they moved to another department that they didn't like where they were, and it showed within their work and the way they were."* (Caregiver 18)

> *"We explained the situation, and she still wrote in her referral that [my child] had predatory behaviour…but, it was extremely unnecessary language, the way she was, and the way she was with [my child] verbally in that appointment, I've never been back to her, and I will not."* (Caregiver 2)

> *"She comes into our house and says, "I don't like your chances. There's usually a five-year waiting list." She goes, "I couldn't stand to live like you." What did she call us? Hillbilly hicks."* (Caregiver 9)

> *"It was more so like trying to get me out of bad habits of thinking and I don't think she – she failed to understand, I like to play video games in my spare time, so she couldn't understand why or why I liked them and stuff like that, like why that helps me cope."* (Young Person 7)

Some participants extended these data by reflecting on the consequences of unprofessional service responses. The consequences were serious and impactful, ranging from difficult feelings and emotions to increased risk of harm to other children in the home. Feeling judged and not being heard could resulted in unwillingness to continue to seek service, for example from the family General Practitioner (GP), as well as unwillingness to engage with the referral offered by the service:

> *"She didn't listen, and she put that in his thing, so I've never taken him with that referral because I will not have somebody else read those words and think that that is what happened."* (Caregiver 3)

Increased anxiety and for caregivers and children in the family was another reported consequence of the unprofessional service responses:

> *"It's an awful organisation. They haven't helped with our family, trying to get our family together. They've made my mental health worse; my anxiety has gone through the roof. His as well, and my two children."* (Caregiver 8)

Reduced caregiver autonomy

The final theme exploring unhelpful services responses documents caregivers' feelings about their reduced autonomy in decisions relating to their child and other children for whom they are responsible. Contrary to the data presented previously, these data highlight the uneven practice by services around involving caregivers. Participants referred to their experiences of coercive interventions, feeling excluded from decision-making, not receiving sufficient information, and matters moving at a fast pace that felt confusing.

> *"I hadn't spoken to anyone from [child protection] until we had that face-to-face meeting in March because I requested it. I felt like decisions were being made about my life, taking on a child, not really having a choice in that matter."* (Caregiver 9)

> *"…I think it may have been why I was so scared to come here, because they basically said, 'You have to do this."* (Caregiver 2)

One of the consequences was the lack of informed decision-making by caregivers:

> *"I love [the child], and [the child] a great kid, but it really has been a big burden. Sorry. We just felt like we had no choice in this arrangement. It was just dumped on us so fast."* (Caregiver 9)

In situations where caregivers were tasked with protecting young people from engaging in further PHSB, some noted they lacked information to assist with safety planning, leading to disruptions in family life and potentially, harm to a child.

> *"They didn't give me the reports. They told me that there'd been a sexual incident, and that [the child] had harmed his sister …without going into detail… It wasn't really helpful… So, it really put me in a rather awkward position, because I used to have my grandchildren, sometimes I'd have them for the day, sometimes I'd have them for an overnight stay, and I couldn't do that anymore."* (Caregiver 3)

> *I didn't have a handle on all the sexual activity that had been going on. His little brother come into care for a couple of weeks and it was through finding them together that I'd actually seen what had happened. [The department] do tell you just the basics, they weren't allowed to be alone with brothers and sisters, they had to be supervised. There was drug and alcohols involved. But they don't actually say that he was being abused, they say that he is traumatised."* (Caregiver 19)

What were the barriers to service access?

Participants were asked to identify the challenges they experienced when accessing services for problematic and harmful behaviour. Four barriers emerged: (1) service capacity; (2) service visibility; (3) care continuity; and (4) apprehension about help-seeking. These are reported in this section as both barriers and opportunities for improvement as they point to where service gaps are and how they can be addressed. In addition, the key finding that caregivers needing more support is included in this section, not as a barrier to service access but an opportunity for improvement.

Service capacity

Services were perceived by some participants to lack capacity at two levels, regarding practical capabilities (the physical ability of services to provide assistance) and practitioner specialisation.

The limitations cited by caregivers in relation to regionality was a key obstacle to access services, albeit somewhat less prohibitive than the 'closed doors' experience reported in the section above.

> *"I don't want there to be a need for support down here but there is and we should get it. And, just because we're a bit more regional up – and I'd hate to think that people out west and things like that who –those little country towns that might have similar needs who – who just can't get this kind of support. Like, it's sort of heartbreaking, really."* (Caregiver 15)

> *"It took a while. Someone rang me from [the service] because I rung other places and then eventually [the service] got in contact with me. They just told*

> *me that they deal with this sort of problem and that they're based in [another regional city] but the good news was that they came to [here] once a week. So, I booked in that way."* (Caregiver 7)

The constrained ability for services to meet clients' needs due to their regional location and how that may be further exacerbated for those in rural or rural remote locations. Regardless, the ability for practical ability for services to meet the needs of children and young people who have displayed PHSB and their families is just one aspect of service capacity that limited their access, the ability of services to address PHSB is suggested to be equally restraining.

In this study, service specialisation was seemingly brought into question by participants regarding both the competency of services in relation to PHSB and their flexibility in meeting perceived individual client and family requirements. Young people and caregivers perceived the inability of some services to tailor their responses to their individual needs to be problematic. This occurred in three ways. First, because they lacked specialisation with regards to PHSB.

> *"I don't think I would've been as happy with just a psychologist who doesn't deal in this particular area because I think this team has a niche of knowledge that when you're just a general psychologist, that I don't think you have that expertise in."* (Caregiver 15)

Second, some services were perceived to have overlooked aspects of the client's situation that they viewed as important:

> *"They organised a young lady in their department to counsel [the young person], but I don't think – she didn't target the area he needed the help in."* (Caregiver 3)

Last, some services were seen to have expected the family to fit into their working models rather than accommodating to the needs of the family:

> *"We had one service who actually just said to us like, "Look, it's not working because he's not engaging, so there's not much point you coming back,"…I'm like, "Well, if the way I'm teaching in my classroom isn't working for a kid, I change what I do, I don't try to change the kid" most of the time. And I would think that service would be better to approach things like that as well because not every model is gonna work."* (Caregiver 15)

Service visibility

Some services were described by participants as both hard to find and difficult to access information on the assistance available.

> *"even though the things are put there, they say there's all these places that can help you, to try and evaluate which place you need is the hard part. …Really just numbers and names. So, there's these counselling places, but they don't identify what they're counselling for. So, I think if you know what they're counselling for, what type of – then it would make it a little easier to decipher what you need. Because I've got all of the children from that family."* (Caregiver 4)

A complexity that was said to be further complicated where specialised funding, such the NDIS, delineated pathways.

> *"I eventually asked Centrelink, and a lovely gentleman at Centrelink gave me some numbers to ring and he said, "You actually need a coordinator." I said to him, "I have no idea what I'm doing, and I have no idea how to access any of the facilities that are available under this package."* (Caregiver 3)

Participants offered a range of suggestions to improve service visibility:

> *"A directory or something that you could look up and say, "Okay. This fits here." So, I'll call here first. This department. It was just hard to know what to do. At times I felt like there was actually no one that could help. Where do we take him?"* (Caregiver 7)

> *"Really just numbers and names. So, there's these counselling places, but they don't identify what they're counselling for. So, I think if you know what they're counselling for, what type of – then it would make it a little easier to decipher what you need."* (Caregiver 3)

> *"Schools need to be aware this service is available. The parents. Put it up in Centrelink, for Christ sake. Like, just places where parents are."* (Caregiver 2)

Apprehension about help-seeking

Relatedly, participants noted that fear of stigmatisation led to apprehension about help-seeking.

> *"I get really embarrassed. Like, if someone would start talking about it, I will change the subject. I'll be, like, "Guess what happened – guess what happened at school today," I'll change the subject 'cause I don't – I won't want to talk about it."* (Young Person 10)

> *"My fear was the stigma attached if our privacy wasn't respected, you know? And the fact that he was so young when it occurred, it's not something that I wanted to follow him for the rest of his life."* (Caregiver 2)

> *"I don't want to admit it, there's like shame behind it, like you don't want your kids doing stuff like this. It gets embarrassing to an extent, like my kids displaying these behaviours that are just so out of control."* (Caregiver 20)

Care continuity

Discontinuity of services was noted by participants at both intra- and inter-service levels. In particular, the continued need to repeat traumatising narratives and build relationships with new caseworkers was associated with intra-organisational staff changes, information siloing and a lack of coordination between services.

> *"Pretty annoying. Even though they had all the documents and all that in front of them to say what happened, I still had to go over everything again."* (Young Person 1)

> *"They spend a year or two, or a year or six months, and you get a different caseworker…You've got to then build a relationship with another worker, and you've got to explain everything, and then they've got to start a relationship with [my child]."* (Caregiver 4)

Other participants experienced service discontinuity due to lack of coordination within services when changes of workers or transfers from one office to another occurred.

> *"It was a bit disjointed after they left, and I think there was a bit of time before [the local] FACS got involved and we got a case manager from there. So, there was a bit of a gap."* (Caregiver 9)

> *"We were just told from [one local office] that, "Yes. We're handing you over to [another local office]. This will now be your contact person". They actually, from memory, didn't contact us for some time and…I rang…I think them being a little bit more proactive about setting up maybe a meeting with us first or even perhaps if [the two offices] could've worked together."* (Caregiver 15)

A corollary of this was service delays. Few participants pointed out that improving service coordination and reducing waiting time present greater opportunities for early interventions.

> *"If you can nip it in the bud, get these kids the support and help…when they needed it rather than waiting, then perhaps there'd be a whole group of people who don't need your support into adulthood."* (Caregiver 15)

> *"There needs to be something, especially with children-victims or perpetrators. They need the counselling there and then…not a year later, because it just creates so much torture for the families to deal with."* (Caregiver 17)

What can be improved?

Participants were asked to provide advice or recommendations on what services could do to better meet their needs and to draw on their experiences to consider what would be helpful for other young people and families affected by PHSB. Three common recommendations were provided including (1) more support for caregivers; (2) more accessible and timely supports; and (3) more prevention and early intervention efforts.

More support for caregivers

Caregivers expressed a strong need for more support, to reduce social isolation and help them cope with the emotional intensity involved in caring for young people who have displayed PHSB.

> *"There's not a lot of support for how it affects the carer because it floored us and you're feeling floored from the incident and then you've got to do the right thing not making him feel shame and some more support around that would have been really, really helpful."* (Caregiver 5)
>
> *"You've got friends that come over and want to spend time with you and then the children display things like that, and they're like, 'that's too much, I'm not going back there', so you just feel even more alone because you've got no support services for them, no support from friends because they're too embarrassed to come over, so really you've got no one."* (Caregiver 20)

Some caregivers, both biological parents and OOHC carers, suggested that respite could be provided to mitigate carer fatigue.

> *"When you live something 24/7, I don't know. More respite maybe. There's no respite from [the child] except for that three-hour on a Saturday. I think it's getting harder and harder to get respite through an agency, and for them to put it in the funding. I think their funding's cut."* (Caregiver 4)
>
> *"Give us a break. Give us something that lets us breathe, because then we get the energy to deal with the hard stuff. The break is literally taking the problematic child, taking the family, and moving them apart. It doesn't have to be long. It can be two days, three days, but just to allow that space for things to deescalate with feelings in the home, things to deescalate with the child... The parents get the chance to maybe sleep, so that they are replenished, so that they can tackle what they need to tackle."* (Caregiver 13)

As reported previously, social stigmatisation hinders help-seeking. A caregiver recognised this and suggested that support groups that bring parents and carers together may reduce stigmatisation and isolation, allowing them to provide mutual support for one another.

> *I know this is a very, very touchy, sensitive subject, and a lot of families do not want anyone to know they have a kid who has sexualised behaviours, but some way that we could maybe to bring people together…because I don't want to go tell my workmates, "I've got a kid who has sexualised behaviours." I don't want to tell my family that, but to be able to be around people and know that they're going through the same thing, and perhaps we can share a story or two here or there, I think helps shore up a person when they identify they're not alone."* (Caregiver 13)

More accessible and timely supports

Whilst all participants in this study had access to services for PHSB, many reflected on some of the service access issues they previously experienced. This prompted their recommendation for more specialist services to meet the demand.

> *"Having more people that can actually see children, because it is very hard to get into see somebody, there are so many people out there at the moment that are needing services badly. They're just not available. There's a lot of people missing out because there's just no one to see. So, what we really need is more people that can help."* (Caregiver 3)

More specifically, caregivers suggested that more trauma-informed knowledge and skills is needed in services to support children with complex mental health needs:

> *"there's no support for parents that have children that have complex needs like these kids. And, there's so much aggressiveness with the spectrum and there's just nothing. And then, you take the kids up to the hospital when they are aggressive or they're having a meltdown or an episode and the hospital say, 'We can't help you because it's all behavioural,' and it's, 'Where do you go?'."* (Caregiver 12)

> *"[the psychologist] even said, 'I can't help you anymore, I don't know what to do here'. I've been to eight different psychologists to try and get her help. So many of the reports are trauma background, 'not much we can do' kind of thing."* (Caregiver 20)

Both caregivers and young people also advised that access to counselling support should be timely and take priority over bureaucratic processes.

> *"That counselling needs to start as soon as possible, and that needs to be stated, and it needs to be put in motion. Not just something that needs to be addressed once we get all the paperwork organised and we get all down the track, once we get everybody situated, because they never get you situated where you're meant to be anyway. That's never, ever going to happen."* (Caregiver 3)

> *"Like only now coming, I've got good support, I've got good people around me, but I wish I had that a lot earlier."* (Young Person 5)

Some caregivers suggested that having an advocate or a care coordinator to help families feel empowered and provide practical support to navigate multiple service systems would be beneficial.

> *"When you first sit with a child that's got a problem, or children that have been removed, especially if you're a family member, you don't have the mind space to be thinking, "What is the best thing for me to do right now for that child?" You need someone to tell you, "You need to have counselling organised for that child. Here is the people that we feel are the best people for you to contact. We'll help you contact them. If you tell us who you want, or if you think you need that, we can arrange that."* (Caregiver 3)

> *"A lot less mistrust would happen if [families] could have an advocate for them, you know. Because a lot of families just feel lost and unsure."* (Caregiver 8)

More prevention and early intervention efforts

A few participants spoke about the importance of prevention, specifically around raising awareness of PHSB in education settings.

> *"They always say prevention is better than cure. If [there] was actually a class lesson or something like that, there would be a lot less issues and problems occurring. Imagine getting a flat pack from Kmart or wherever…If you've been given the right tools, you have the right information, you've got the right stuff in front of you, you've just got to put all the pieces together, it will work. Same goes for kids. If they're given the right tools, they're given the right environment, the teachers are trying to build rapports, relationships with kids then kids will grow, kids will learn, kids will do all the right things."* (Caregiver 18)

Recognising that PHSB often occurs within the context of childhood trauma and other co-occurring mental health issues, few participants noted that more concerted efforts in providing early identification and intervention are needed to support at-risk families and young people.

> *"Why do families break down? What is happening in parenting and children that are causing the issues? Do we go to domestic violence, do we do the drugs and alcohol? What is it we can do to help make it better for families in Australia?"* (Caregiver 4)

"I think just picking up the signs of a mental health crisis would be a really good thing…They need to check in more …My workers were seeing me…like behaviours and all these things I was doing and starting to do, and they weren't telling anyone, they weren't putting it in the notes or anything, they were just like kind of brushing it off as like not serious or like they can fix it or you know, like they would just take the razor blade off me or they would take the lighter off me or the bong or whatever I had, and then they would just be like 'we confiscated it, the situation is over, nothing needs to be done about it'."

And, so it kind of got progressively worse but they weren't saying anything, but I was starting to do more, and it started to become too much for them to handle to the point where when they told somebody like '[this young person] got a problem', like it was like I already had too much of a problem. I was too far where like I didn't give a fuck anymore, like I want to do whatever I want. And I was actually at a point where I was like I'm going to do whatever I want, and I was doing whatever I want, you know." (Young Person 9)

Chapter 4: Journey Maps

This chapter integrates the key data linkage findings and research interviews into four clients' journey maps to services. Journey maps visually summarise service experiences over time, capturing clients' likely thoughts, feelings and actions, from their point of views, for the duration of their interactions with different services (NSW Agency for Clinical Innovation, 2021). Journey maps also help to identify service users' characteristics, service strengths and opportunities for service improvement (NSW Agency for Clinical Innovation, 2021).

The journey maps presented in the chapter draw on aggregated quantitative and qualitative data to represent some of the distinctive characteristics and experiences. *Italicised* texts embedded in the journey maps are direct quotes from research interviews. As indicated in the interview findings, participants' experiences of services varied between services and contexts. The gain and pain points described in the journey maps highlight what participants have found helpful and unhelpful from their experiences; they are not representative of all clients and services.

Consistent with earlier research, our study found that children and young people who have displayed PHSB are heterogeneous with myriad overlapping characteristics and interlocking service needs. Therefore, the journey maps presented in this section are neither exhaustive nor mutually exclusive. Assuming so would run the risk of over-simplification of a complex problem. As our participants clearly indicated in their research interviews, addressing their needs requires multi-agency efforts including engagement with specialised services to tailor their responses to individual needs and circumstances whilst ensuring that services are accessible to all families in need.

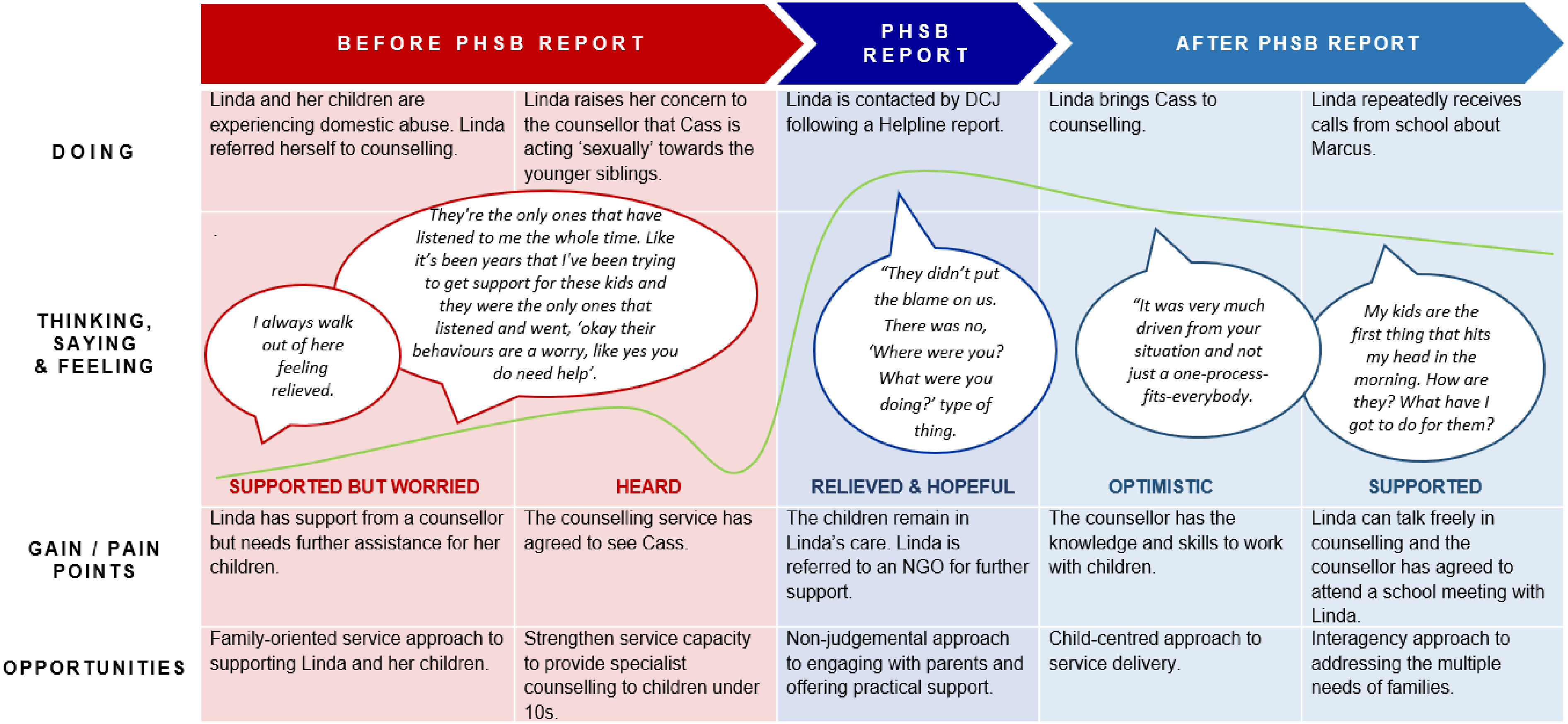
Journey map 1 – PHSB reports were closed at Helpline or after triage with no further service pathways identified (over 70% of all the sample)

Justin is **12 years** old. He has a **language delay** but his **ongoing learning and communication difficulties** remain undiagnosed. Justin lives with his parents and is witnessing **family violence** perpetrated by his father against his mother. Justin attends a mainstream school with intermittent support from a teacher aide.

	BEFORE PHSB REPORT		PHSB REPORT		AFTER PHSB REPORT
DOING	Justin is finding it hard to make friends at school.	Justin is also struggling with learning but having very limited support.	Justin is displaying PHSB at school. 5 reports were made, all reached ROSH but closed due to 'competing priorities'.	Justin is told by teachers that his behaviour was wrong, but he doesn't know why and how to stop.	Justin is receiving repeated school suspensions. Parents are told about PHSB and are given information about different services but they don't know who to call.
THINKING, SAYING & FEELING	*I have to legit try to force myself to get out of bed and just get to school. I just go 'Well, I know today's going to be a crap day.'*	*If I don't know it, try and teach it, not just try to get me to answer without knowing it.*	*It seems like every time I go to this school it just makes a chain reaction that brings stuff up.*	*I just see it as a miserable place.*	*My fear was the stigma attached. Also, there're these counselling places, but they don't identify what they're counselling for. Where do we take him*
	ISOLATED	**FRUSTRATED**	**OVERWHELMED**	**HELPLESS**	**CONFUSED & WORRIED**
GAIN / PAIN POINTS	Justin lacks positive peer relationships at school.	Justin falls further behind from his peers academically and starts to disengage from learning.	School has identified Justin's PHSB and reported to the Helpline but no concrete support offered.	School has continued their attempts to correct Justin's PHSB but he remains at risk of harm with no specialist support.	Justin is experiencing disruptions in education. Parents' support needs are not met.
OPPORTUNITIES	Early intervention to reduce Justin's vulnerability.	Access to mental health assessment, additional resources for school to provide learning support.	Interagency response to enable referrals to specialist services.	Training and supervision support to teachers in response to PHSB.	Specialist support for both Justin and parents.

Journey map 2 – Receives a PHSB-related service in Health (11% of the sample)

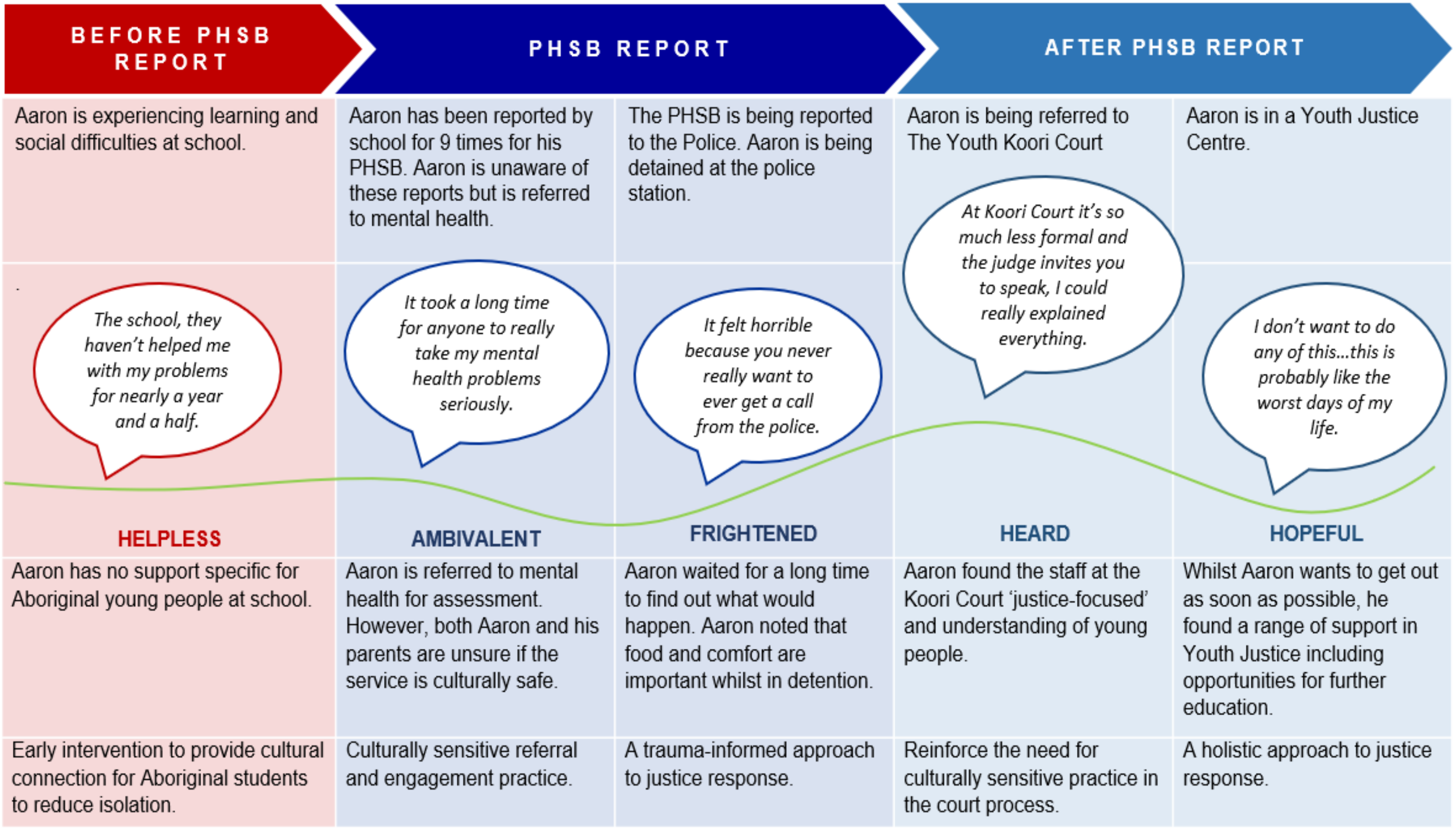
Linda is a **single mother** of 3 children, Cass (9), Marcus (8) and Tommy (6). Linda is a **victim of family violence** perpetrated by her former partners. Linda has sought support from GPs and other services for her **own mental health needs** and her **children's developmental challenges**. However, Linda felt misunderstood and judged by these services.



	BEFORE PHSB REPORT		PHSB REPORT	AFTER PHSB REPORT	
DOING	Linda and her children are experiencing domestic abuse. Linda referred herself to counselling.	Linda raises her concern to the counsellor that Cass is acting 'sexually' towards the younger siblings.	Linda is contacted by DCJ following a Helpline report.	Linda brings Cass to counselling.	Linda repeatedly receives calls from school about Marcus.
THINKING, SAYING & FEELING	*I always walk out of here feeling relieved.* **SUPPORTED BUT WORRIED**	*They're the only ones that have listened to me the whole time. Like it's been years that I've been trying to get support for these kids and they were the only ones that listened and went, 'okay their behaviours are a worry, like yes you do need help'.* **HEARD**	*"They didn't put the blame on us. There was no, 'Where were you? What were you doing?' type of thing.* **RELIEVED & HOPEFUL**	*"It was very much driven from your situation and not just a one-process-fits-everybody.* **OPTIMISTIC**	*My kids are the first thing that hits my head in the morning. How are they? What have I got to do for them?* **SUPPORTED**
GAIN / PAIN POINTS	Linda has support from a counsellor but needs further assistance for her children.	The counselling service has agreed to see Cass.	The children remain in Linda's care. Linda is referred to an NGO for further support.	The counsellor has the knowledge and skills to work with children.	Linda can talk freely in counselling and the counsellor has agreed to attend a school meeting with Linda.
OPPORTUNITIES	Family-oriented service approach to supporting Linda and her children.	Strengthen service capacity to provide specialist counselling to children under 10s.	Non-judgemental approach to engaging with parents and offering practical support.	Child-centred approach to service delivery.	Interagency approach to addressing the multiple needs of families.

Journey map 3 – Contact with Youth and Criminal Justice (nearly 10% of the sample)

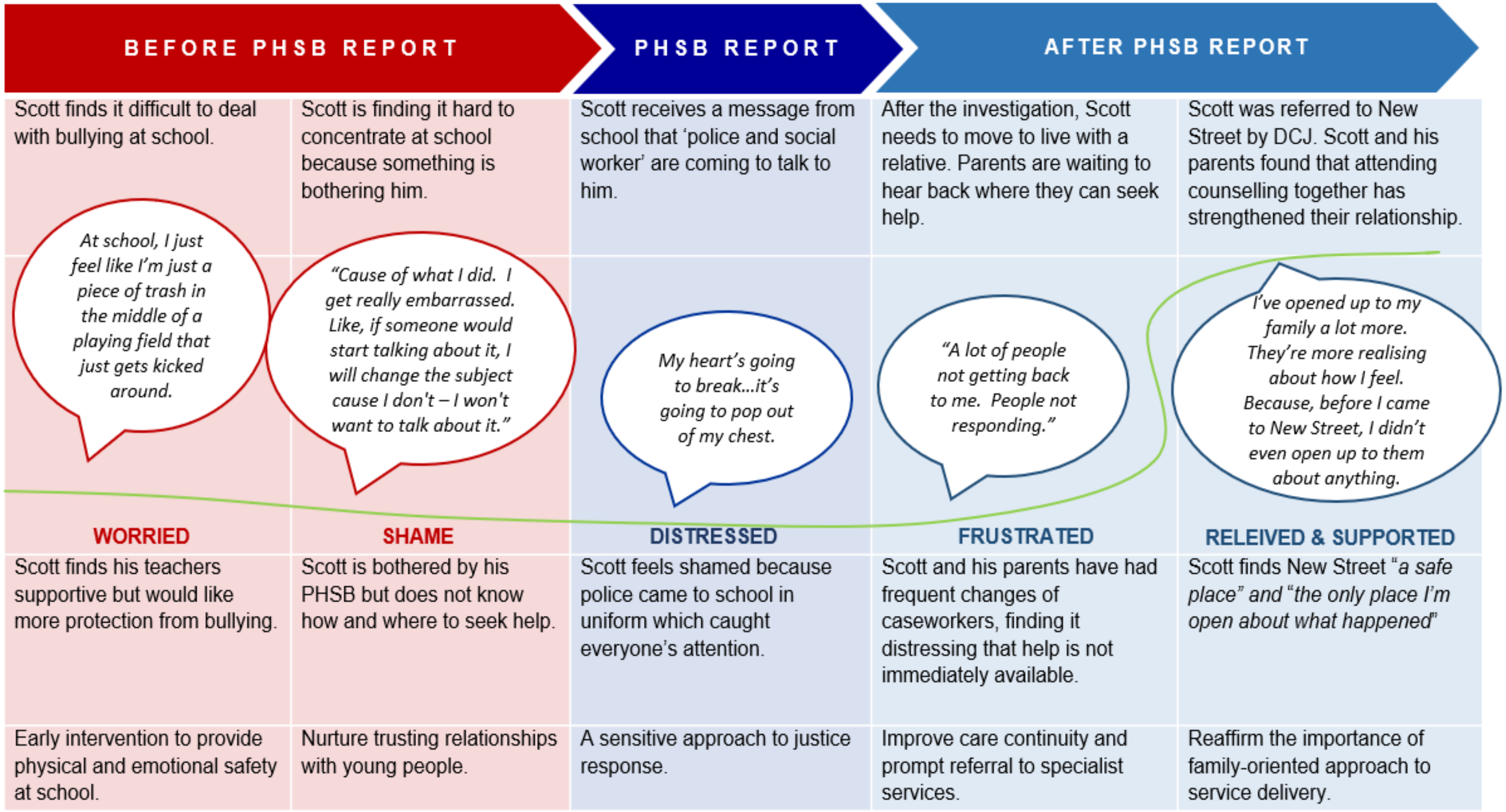
Aaron is a **15-year-old Aboriginal** young person. He experiences **multiple social and economic disadvantages**. Aaron attends a mainstream school and struggles to make friends. Aaron has an **undiagnosed mental health issue**. Aaron wants to learn more about his culture. Aaron **lacks positive peer relationships** and wanders around the neighborhood with a group of young people after school.



	BEFORE PHSB REPORT	PHSB REPORT		AFTER PHSB REPORT	
DOING	Aaron is experiencing learning and social difficulties at school.	Aaron has been reported by school for 9 times for his PHSB. Aaron is unaware of these reports but is referred to mental health.	The PHSB is being reported to the Police. Aaron is being detained at the police station.	Aaron is being referred to The Youth Koori Court	Aaron is in a Youth Justice Centre.
THINKING, SAYING & FEELING	*The school, they haven't helped me with my problems for nearly a year and a half.* **HELPLESS**	*It took a long time for anyone to really take my mental health problems seriously.* **AMBIVALENT**	*It felt horrible because you never really want to ever get a call from the police.* **FRIGHTENED**	*At Koori Court it's so much less formal and the judge invites you to speak, I could really explained everything.* **HEARD**	*I don't want to do any of this...this is probably like the worst days of my life.* **HOPEFUL**
GAIN / PAIN POINTS	Aaron has no support specific for Aboriginal young people at school.	Aaron is referred to mental health for assessment. However, both Aaron and his parents are unsure if the service is culturally safe.	Aaron waited for a long time to find out what would happen. Aaron noted that food and comfort are important whilst in detention.	Aaron found the staff at the Koori Court 'justice-focused' and understanding of young people.	Whilst Aaron wants to get out as soon as possible, he found a range of support in Youth Justice including opportunities for further education.
OPPORTUNITIES	Early intervention to provide cultural connection for Aboriginal students to reduce isolation.	Culturally sensitive referral and engagement practice.	A trauma-informed approach to justice response.	Reinforce the need for culturally sensitive practice in the court process.	A holistic approach to justice response.

Journey map 4 – Receives New Street Services (from ISLHD and WSLHD data)

Scott is a **13-year-old** young person. He has been **diagnosed with autism**. He attends a mainstream school and finds it hard to communicate his **learning and social needs**. Scott lives with his parents and a younger sister Christy (8). Both parents work full-time. Scott spends time alone with Christy after school.



	BEFORE PHSB REPORT		PHSB REPORT	AFTER PHSB REPORT	
DOING	Scott finds it difficult to deal with bullying at school.	Scott is finding it hard to concentrate at school because something is bothering him.	Scott receives a message from school that 'police and social worker' are coming to talk to him.	After the investigation, Scott needs to move to live with a relative. Parents are waiting to hear back where they can seek help.	Scott was referred to New Street by DCJ. Scott and his parents found that attending counselling together has strengthened their relationship.
THINKING, SAYING & FEELING	*At school, I just feel like I'm just a piece of trash in the middle of a playing field that just gets kicked around.* **WORRIED**	*"Cause of what I did. I get really embarrassed. Like, if someone would start talking about it, I will change the subject cause I don't – I won't want to talk about it."* **SHAME**	*My heart's going to break…it's going to pop out of my chest.* **DISTRESSED**	*"A lot of people not getting back to me. People not responding."* **FRUSTRATED**	*I've opened up to my family a lot more. They're more realising about how I feel. Because, before I came to New Street, I didn't even open up to them about anything.* **RELEIVED & SUPPORTED**
GAIN / PAIN POINTS	Scott finds his teachers supportive but would like more protection from bullying.	Scott is bothered by his PHSB but does not know how and where to seek help.	Scott feels shamed because police came to school in uniform which caught everyone's attention.	Scott and his parents have had frequent changes of caseworkers, finding it distressing that help is not immediately available.	Scott finds New Street "*a safe place*" and "*the only place I'm open about what happened*"
OPPORTUNITIES	Early intervention to provide physical and emotional safety at school.	Nurture trusting relationships with young people.	A sensitive approach to justice response.	Improve care continuity and prompt referral to specialist services.	Reaffirm the importance of family-oriented approach to service delivery.

Chapter 5: Discussion

EXTENT AND NATURE OF PHSB

The analysis of ChildStory data identified 5,105 children and young people who displayed PHSB from 7,440 Helpline reports made within the two-year study period (January 2018 to December 2019). Approximately three quarters of the children and young people reported were assessed as meeting the statutory threshold of risk of significant harm (ROSH). Of the 3,878 ROSH report, only a quarter of them were allocated to a caseworker. Field assessment outcomes indicated that around eight percent of the total ROSH reports were substantiated. This represents approximately three percent of the total substantiated cases of sexual abuse (9,513) within the financial years of 2018 to 2019 in the entire ChildStory cohort (Department of Community and Justice, 2021). Whilst drawing on only one dataset is not a reliable estimate of the prevalence of PHSB, the three percent is markedly lower than previous Australian research which indicates that children and young people accounted for around 17 to 22 percent of people committing sexual abuse nationally (Shlonsky et al., 2017b). This seems to suggest that under-reporting of PHSB exists, leaving a significant proportion of children and young people with PHSB and their victims without a service response.

Approximately three quarters of the children and young people reported with regards to PHSB were assessed as meeting the statutory threshold of risk of significant harm (ROSH). It is noteworthy that when PHSB was reported in conjunction with other child protection concerns, it seems more likely to be assessed as ROSH (82%) than when PHSB was reported as a single issue (72%). This reflects previous research findings that experience of victimisation is common among children and young people who display PHSB, although it should only be understood as correlation rather than causation.

Although 76 percent of PHSB reports were assessed as ROSH, only 25 percent of children and young people were allocated to a caseworker. This indicates that a substantial proportion of children and young people did not receive a child protection response to their PHSB. This might have contributed to the 40 percent recurrent report rate, which is higher than the general re-report rate in the ChildStory cohort (37%) in 2018 and 2019 (Department of Community and Justice, 2021). Relatedly, over 40 percent of the children and young people were reported to the Helpline for other child protection concerns prior to their first report of PHSB. These prior reports, whilst unrelated to PHSB, could have provided opportunities for prevention or early intervention.

Consistent with existing research, a sizeable proportion of children and young people in the study were also reported for other child protection concerns including sexual abuse, physical abuse and neglect. Concurrent reports of these child protection concerns were particularly high for children and young people whose PHSB was listed as the 'secondary issue' in the Helpline. Our findings support the existing research evidence that the majority of children and young people with PHSB are also victims of child maltreatment. Whilst the victim-to-victimiser correlation needs to be cautiously interpreted with considerations of other contextual factors such as lack of positive relationships with family and peers, the accumulative evidence indicates that trauma-informed responses to children and young people with PHSB is warranted.

Our study identified that nearly half of the reports made to the Helpline were by Education (40.4-48.5%). This strongly resonates with the finding of a recent Australian study that over 40 percent of educators had observed children displaying PHSB in education settings including primary schools, preschools and after school care (Ey & McInnes, 2018). Whilst there was some concern of over or inaccurate reporting of PHSB from education settings, earlier research indicated that educators' descriptions of PHSB were largely accurate (Ey et al., 2017). The high reporting rate from Education therefore adds weight to the call for education staff to have greater access to specialist support (McInnes & Ey, 2020) and more multi-agency collaboration to enable integrated prevention and response including addressing harmful gender norms in education settings (Firmin, Lloyd, & Walker, 2019; Llyod, 2019).

CHARACTERISTICS OF CHILDREN AND YOUNG PEOPLE WHO HAVE DISPLAYED PHSB

Nearly 75 percent of children and young people reported were male, aged between 10 and 13. This is similar to earlier studies which found that early adolescence between 12 and 14 years of age was the most common demographic profile known to child protection and justice systems (Allardyce & Yates, 2018; Finkelhor et al., 2009). Notably, one in four were identified as female in our study which is higher than previous research in which one in 70 were identified (Finkelhor et al., 2009; Hackett et al., 2013). The vast majority of females identified in our study were between the ages of 10 and 13. This age group is older than previously reported (Finkelhor et al., 2009; Hackett et al., 2013). However, our study also shows that the proportion of under 10s is larger in the female cohort (30%) than males' (18%). This somewhat confirms earlier research that the onset of PHSB is often younger for girls (Finkelhor et al., 2009). More importantly, girls who have displayed PHSB are more likely than boys to have experienced sexual victimisation by multiple perpetrators and at an earlier age (Hickey et al., 2008; Mathews et al., 1997). These additional vulnerabilities, along with the higher number of girls identified in our study suggest that there may have been significant delays in identifying and responding to girls who have displayed PHSB.

In relation to disability, only 8 percent of children and young people in our study cohort were identified as having a disability, with the largest proportion of that group (3.6%) listed as having specific learning disorders. Whilst the overall number is lower than earlier research (Hackett et al., 2013), it is similar in the sense that most children and young people who have displayed PHSB were found to have more learning difficulties than other young people involved with non-sexual offenses. Notably, only 11 to 30 percent of children and young people in our study had received mental health assessments. This indicates a significant unmet need in light of the research evidence that around 70 percent of young people with PHSB have at least one mental health diagnosis (Boonmann et al., 2015). In fact, many caregivers in our qualitative study reported having sought support from mental health services, schools and NDIS for social, behavioural and learning difficulties including attention-deficit/hyperactivity disorder (ADHD) and Autism. These findings suggest that more children and young people who have displayed PHSB may be affected by different forms of disabilities and mental health difficulties. Lack of information regarding disability and delayed assessments and diagnoses may have obscured the extent to which children and young people who have displayed PHSB are affected by disability and mental health issues.

Indigenous young people are overrepresented in the study cohort compared to the general population of NSW (17.5% and 3.4% respectively). Interestingly, NGOs made more reports about Indigenous children and young people than they have about non-Indigenous counterpart. This is striking in light of another finding that NGOs ranked fourth overall in reporting PHSB in this study and in child protection matters more generally (Australian Institute of Health and Welfare, 2021a). It may be that Indigenous children and young people and their families have more regular contacts with NGOs than other government departments due to the general mistrust against governmental services or the high proportion of children in OOHC. Whilst no marked differences were found in this study between Indigenous and non-Indigenous children and young people in terms of ROSH, it is important to note that more Indigenous than non-Indigenous children and young people had one or more prior reports to the Helpline (67.5% vs 47.6%).

CONTACTS WITH SERVICES

Although available data cannot confidently establish that children and young people were referred to a suitable service as a result of a Helpline report or field assessment, there are a few notable findings. First, approximately one in three children and young people who were triaged to Field Assessment had a new service contact reported in the PHSB-related Health services within the NAP dataset. Although the number is alarmingly small (377/1,150), the finding indicates that young girls and those who had concurrent reports of other child protection concerns were more likely to be identified in the NAP data for a PHSB-related

Health service following field assessments. Given that the analysis of the NAP dataset targeted PHSB-related services such as sexual assault and child protection counselling, children and young people might have been referred to these services for PHSB and other child protection concerns following field assessments. However, further research is needed to examine this.

Second, contacts with police decreased from 11 percent prior to the first PHSB report to 6 percent after. The number of convictions also dropped from 3,394 prior to the first PHSB report to 1,410 after, particularly for sexual assault and related offences, there was a considerable decline from 14.7 percent prior to the first PHSB reports to 5.9 percent after. However, contacts with Youth Justice increased from 4 percent prior to the first PHSB report to seven percent after. Youth Justice admission episodes also increased from 736 prior to 1,248 after. These findings appear to suggest that Helpline reports of PHSB may have an effect on reducing policing responses by diverting PHSB matters to the youth justice system in which young people are more likely to receive treatments that are more oriented towards their developmental needs. However, further research is required to confirm this finding.

It is important to note that, whilst New Street is now a statewide service, at the time of data collection, only the New Street services in WLSHD and ISLHD had available data. In total, there were 59 children and young people included in the data linkage analysis. Of these 59 children and young people, over 70 percent were referred by DCJ or JCPRP which clearly shows the referral pathway for this cohort. Caregivers in the qualitative study revealed mixed experiences with accessing New Street services, some reported having waited for a lengthy period of time to be referred whilst others reported that they were referred and accepted within a relatively reasonable timeframe, often as a result of their own persistence or at the goodwill of individual workers. The key message from these mixed experiences is that lack of service visibility and unmet demand for specialist services such as New Street were key barriers to service access.

Our study found that 53.3 percent of children and young people presented in ED at least once prior to the first Helpline report for PHSB. Compared to the overall rates for children and young people aged 0-14 inclusive in NSW in 2019-20, 38 percent attended ED (Australian Bureau of Statistics, 2021a; Australian Institute of Health and Welfare, 2021b). A few participants in our qualitative research also reported bringing their children to ED for a range of mental health issues including suicidal thoughts. This indicates the vulnerability of children and young people who display PHSB and suggests that, as with other interpersonal violence, ED may be a crucial early point for identification and intervention for people who experience trauma (Spangaro et al., 2020). Further research is needed to understand the extent to which the ED presentations of the PHSB cohort are related to PHSB or other associated concerns and how ED staff may play a role in early identification and assessment.

SERVICE NEEDS AND EXPERIENCES

The qualitative findings indicate that young people who have displayed PHSB had diverse needs across various developmental domains, and consequently, had contacts with multiple service systems. This is consistent with practitioners' experiences that service needs of children and young people who have displayed PHSB intersect in complex ways across different service systems, therefore, they cannot be adequately addressed in isolation by a standalone intervention (Quadara et al., 2020). Within this context, participants considered it crucial for generalist services such as GPs or other child-focused departments such as Education to understand their specific needs and challenges. Addressing these needs require firstly, sensitivity to the fear of stigmatisation many participants experienced and secondly, prompt follow-up supports and strong coordination between services.

An ecological-oriented approach to therapy involving caregivers and attending to multiple support needs was appreciated by many participants. This finding adds to the growing research evidence that treatment for PHSB needs to shift away from adult-centric, manualised and individualised service delivery to a family-oriented approach that are tailored to family's needs and circumstances (Allardyce & Yates, 2018). The qualitative findings extend this research evidence by identifying the need to recognise families are at a crisis point following disclosures and to provide clear information and tangible assistance to OOHC caregivers who are tasked with providing safety and care for children and young people affected by PHSB.

Similar to earlier research (Quadara et al., 2020) the qualitative findings suggest inadequate provision of information and limited understandings of support services, combined with insufficient specialist services, particularly in regional areas, are key barriers to service access. Existing research on PHSB services largely focuses on service providers' experiences (e.g., Quadara et al., 2020) and young people's perspectives (e.g., McKibbin et al., 2017), caregivers' perspectives are relatively less attended to. Caregivers who participated in this study provided important insights into their experiences and needs. Some caregivers experienced closed doors from services either due to long waiting times or restrictive eligibility criteria. These negative experiences, coupled with feeling judged and silenced by services led to impactful consequences, from adding overwhelming pressure to caregivers, reducing their autonomy to increasing risks of harm to other children in the home. Caregivers expressed a need for much stronger support to mitigate carer fatigue and isolation including respite and support groups, along with other broader recommendations which will be embedded in the next chapter.

LIMITATIONS

Under-reporting of PHSB is common. Children and young people who were reported to DCJ which is the starting point of this analysis, likely represent a particular group who have drawn the attention of people around them, possibly due to their social-economic backgrounds and other contextual factors such as family and domestic violence or Aboriginality. Furthermore, PHSB is not necessarily understood the same way by all reporters. Lack of fields regarding the nature and context of PHSB within the ChildStory dataset (e.g., sibling sexual abuse or abuse in OOHC) also limited the breadth and depth of the analysis. The lack of fields within ChildStory for referrals made and referral outcomes limits what can be reported in relation to outcomes from a report to DCJ and so referral pathways to services. It should be noted too, that data for the New Street services, the key statewide specialist service for young people aged over 10 years engaging in PHSB was only accessed for two Local Health Districts, limiting the size of the data pool for this key group.

Record keeping of public health care and justice is largely a social process. For this reason, the breadth of data available from each source is affected by the record keeping and data entry practice of staff or system processes. Also, specific events may not have been counted due to the longitudinal nature of the data. This occurs when recent events have not yet been recorded into the data due to their ongoing processing, for example when PHSB is recently recorded but not enough time may have passed for the incidents to have appeared in the data, for example, length of time to go to court.

Similar to other data linkage research, for data security reasons, linkage of personal identifiers was performed by a third party, CHeReL. This privacy measure for data linkage projects is important, however, it has also been recognised as a significant limitation in terms of assessing the quality of the linked dataset (Harron et al., 2017). In this study, the mostly categorical nature of the available data did not lend itself to statistical clustering techniques since the range and variability of dichotomous and multinomial categories is limited. In our preliminary cross-tabulation analysis, the data evinced no obvious clustering and so the decision was taken to build personas based on service types rather than statistically derived clusters. Nonetheless, the personas delineated four possible service access pathways for the development of the journey maps, providing important insights into clients' experiences at various points of their service contacts.

Regarding the qualitative research component, whilst we included seven services in our recruitment, most of the participants were from New Street Services and Youth Justice. The research team made significant attempts to recruit participants from under 10s services, however, participating agencies indicated there was a lack of eligible participants during the research period. This means that the qualitative research findings cannot fully capture the experiences of clients in under 10s services.

In light of the sensitivity of identifying this target group, we relied on service providers to introduce the research to potential participants. It is therefore important to acknowledge the possibility of selection bias in this approach. Furthermore, the majority of the young people we interviewed were males. Whilst this largely reflects the gendered nature of PHSB, it is important to recognise that girls constitute a noticeable proportion in the cohort. Given the additional vulnerabilities and needs of girls, specific research into their service experiences is warranted.

Despite the over-representation of Aboriginal and Torres Strait Islander children and young people in the cohort, less than a quarter of our interview participants identified as Aboriginal people. Although our team included Aboriginal researchers and interviewers, due to scheduling constraints, none of the Aboriginal participants were interviewed by Aboriginal researchers. Although all Aboriginal participants agreed to be interviewed by non-Aboriginal researchers, this may still have constrained them from sharing their experiences as openly. The qualitative data pertaining to their experiences were therefore limited. Relatedly, the service experience of other culturally and linguistically diverse client groups is not strongly represented in this sample.

In keeping with research ethics requirements, we focused on service engagement and experiences, rather than specific details of the PHSB. Given the social stigma attached with the issue, asking specific questions about the behaviour would have created further challenges in recruitment. However, it is important to recognise that there may be some important contextual information or nuanced experiences missing from the data which would deepen the understanding of clients' service journey.

Chapter 6: Recommendations

Prevention and early identification

Findings	Recommendations
Over 70 percent of Helpline reports were assessed as ROSH. Over 60 percent of the ROSH reports were closed due to competing priorities. On average, it took 32 days for Helpline reports to progress from allocation to field assessment.	NSW Government to deliver the Royal Commission's recommendation for timely and specialist response, including: Review decision making tools and update guidance on required responses to Helpline referrals that include PHSB and those that meet the ROSH threshold. Consider a pilot of designated caseworkers to assess and provide case management to address the safety and wellbeing needs of children and young people with PHSB and are screened at ROSH.
Education had the highest reporting rate of PHSB. Participants spoke about the importance of prevention, specifically around response to PHSB in education settings.	Design and implement PHSB prevention programmes to be delivered by all schools. Build the capacity of early education providers and schools to provide effective early responses and interventions where a child protection and specialist response is not required.
Participants noted the importance of GPs having a strong understanding of PHSB and specific needs and challenges faced by children, young people and families.	NSW Health implements a strategy to raise GP awareness of PHSB including about pathways for children, young people and families to access support.

Findings	Recommendations
For children and young people whose PHSB was listed as the secondary assessed issue, 88 percent had a concurrent report of sexual abuse.	Establish routine PHSB screening and early support assessment tools and capacity build Violence, Abuse & Neglect (VAN) services and NGOs to implement them and respond to presentations of PHSB.
Over 50 percent of children and young people presented in EDs at least once prior to the first Helpline report for PHSB, indicating an opportunity to address the multiple vulnerabilities of children and young people with PHSB.	Ensure social work capacity in EDs to respond to ambiguous presentations, which may mask abuse or trauma issues including PHSB.
Health made less than 10 percent of all Helpline reports nearly for nearly all age groups.	Increase Health workforce awareness of PHSB and ensure appropriate reporting.

Service response

Findings	Recommendations
Participants had multiple needs across different service systems.	The NSW Framework should include clear responsibilities and guidelines to enable information sharing, collaboration between agencies and joint support and service provision planning.
Delayed or ‘closed door’ responses from services such as mental health due to restrictive eligibility criteria and significant delays in accessing services.	NSW Health should establish clear pathways into support services that specify eligibility criteria and implement collaborative case allocation meeting (when the most appropriate service is unclear). NSW Health raise awareness amongst mental health clinicians about the co-existence of PHSB and mental health issues.
Insufficient specialist services for PHSB, particularly in regional areas.	Ensure existing New Street Services are fully recruited to. Undertake demand modelling for New Street Services that considers any policy changes proposed as part of the new NSW Framework and expand services where demand or service needs outweigh service capacity. Introduce an early intervention service stream for children 10-17 years who don’t meet the threshold for accessing New Street. This is to prevent escalation to specialist services when not needed.

Findings	Recommendations
Lacked integrated services for younger children including under 10s.	Expedite the implementation of SafeWayz program and undertake demand modelling to consider current need and forecast future demand. Enhance capacity of SafeWayz based on the result of this modelling. Capacity build other relevant service providers to deliver early intervention and specialist supports for children under 10s.
Participants felt judged, blamed or silenced by non-specialist services.	Upskill non-specialist services workforce to increase understanding of PHSB and the context in which it occurs and build capacity to deliver trauma-informed care for families affected by PHSB.
OOHC carers felt they lacked information for safety planning and practical support.	Capacity build OOHC service providers to provide timely information and support to children and young people with PHSB and their carers.
Caregivers experienced social isolation and carer fatigue.	Ensure current and future initiatives are tailored to meet the social, physical and emotional needs of carers.
Nearly 22 percent of children and young people did not have disability status recorded in ChildStory. Where disability status was recorded, learning disorders were most common, followed by intellectual disability and autism.	Review assessment tools and recording practice in relation to disability. Capacity build NSW Health and NGO services to provide assessment and appropriate NDIS support for children and young people displaying PHSB.

Aboriginal and Torres Strait Islander families

Findings	Recommendations
Over-representation of Aboriginal and Torres Strait Islander children and young people in PHSB Helpline and more broadly child protection and justice systems.	Ensure Aboriginal and Torres Strait Islander communities are fully involved in designing and implementing culturally safe policies and programs including in the design of any pilots and evaluations. Ensure PHSB prevention efforts are tailored to meet the needs of Aboriginal and Torres Strait Islander people.
Insufficient data to fully explore the service experiences of Aboriginal and Torres Strait Islanders children, young people and families.	Commission further research to examine the service experience of Aboriginal and Torres Strait Islanders children, young people and families when accessing PHSB services. When commissioning research projects, provide sufficient time and resources to fully engage with Aboriginal and Torres Strait Islanders in the project as set out in the NSW Aboriginal Health Ethics Guidelines (AH&MRC).

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