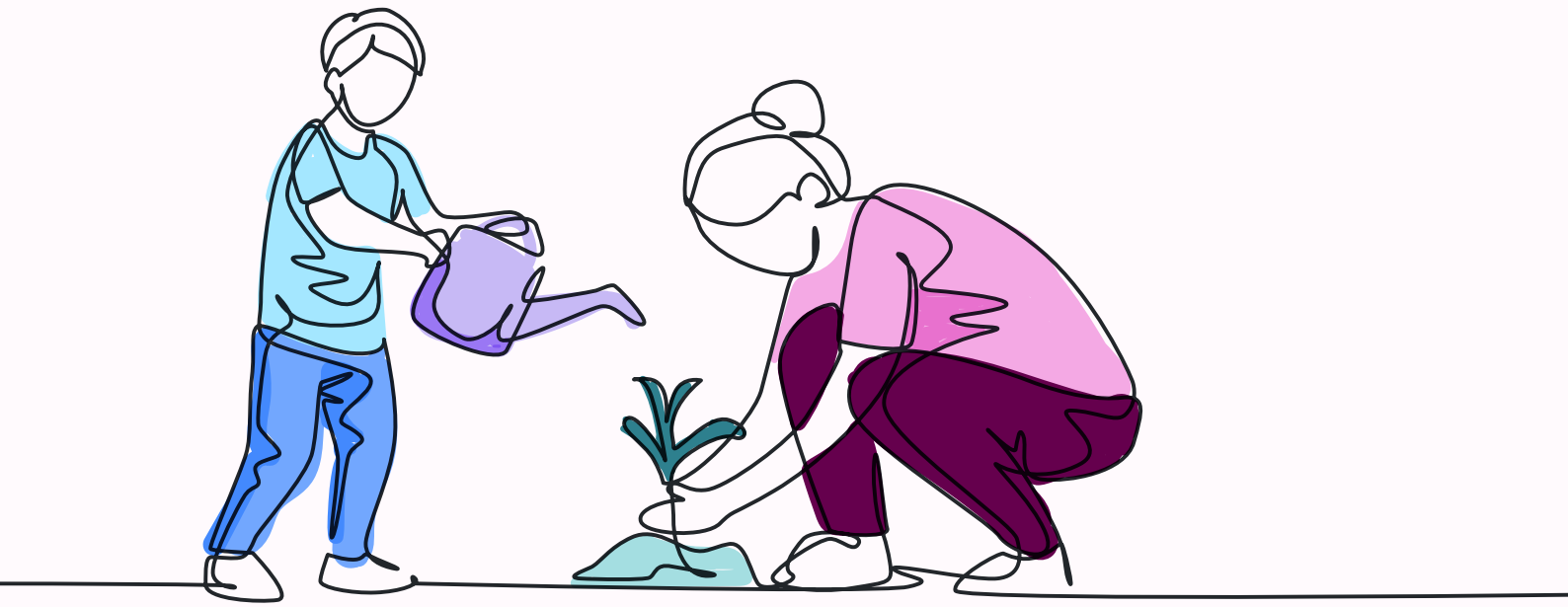
We can make a difference



A Case for Change – preventing and responding to problematic and harmful sexual behaviours by children and young people

NSW GOVERNMENT

Statement of commitment to safety, support, justice and healing for victims and survivors

The strength, resilience and courage of all children, young people, adults, families and communities with experience of violence and abuse, including by children and young people with problematic or harmful sexual behaviours (PHSB) underpins and drives the work described in this Framework.

The NSW Government acknowledges the lived expertise of victims and survivors and hopes that this Framework contributes to our collective vision for all children and young people to experience caring and respectful relationships and live healthy and safe lives free from violence, abuse and neglect.

In public hearings and private sessions, the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) heard from many survivors about sexual abuse they experienced as children by other children. Data also tells us in the general population, young people, particularly girls and young women, are most at risk of experiencing sexual assault and that this is often perpetrated by peers of a similar age.

The impacts of sexual harm by children and young people on others are often serious and long-lasting and can resemble the impacts of adult-perpetrated abuse, causing significant adverse effects on psychological, physical and sexual health, neurobiological development, interpersonal relationships, drug and alcohol misuse, sexual and gender identity, and connection to culture.

Substantial research also tells us children and young people who displayed or engaged in PHSB often have their own experiences of violence, abuse, neglect, and trauma. Breaking this cycle is critical. Evidence-based public health approaches that recognise and address the intimate links between prevention, early intervention and specialist tertiary responses for both children and young people with PHSB and children, young people, their carers, families and communities that are victimised or at risk of being affected or harmed, are essential.

Promoting treatment and support for children and young people who have harmed others, does not minimise the serious health and wellbeing impacts that harmful sexual behaviours and sexual abuse can have on victims and survivors, nor does it reduce the importance of accountability and responsibility.

Instead, the initiatives and objectives outlined in this Framework reflect the evidence that the best way to reduce the prevalence and detrimental impacts of sexual harm, abuse and assault in our communities is to 'stop it before it starts' and prevent repeated or future harm. This will be achieved through policies and programs that address the drivers of PHSB and seek to change and address the social norms, attitudes and individual circumstances that lead to harmful behaviours in the first place.

The safety, welfare, health and wellbeing of all children and young people is central to NSW Government's approach to preventing and responding to PHSB. The voice and views of children, young people, their families, carers and communities, must be respected and valued, and concerns taken seriously and acted upon.

Implementation of this Framework is underpinned by the NSW Governments commitment to upholding the NSW Charter of Victims' Rights, contained in the Victims' Rights and Support Act 2013. The Charter sets out how victims of crime are to be treated and what supports must be provided in NSW, including victims' rights to be treated with courtesy, compassion, cultural sensitivity and respect.

NSW Government recognises that no single service system or organisation can on its own ensure the safety and wellbeing of children and young people, and that it is our collective approach to healthcare, child protection, justice, and community wellbeing that will help us achieve our vision.

Everyone has a part to play in ensuring children and young people in NSW are healthy and safe.

Help and support

Children and young people's sexual safety can be a challenging issue and may bring up strong feelings for some people. The following services are freely available in NSW and can give you help and support:

- **If you or someone else is in immediate danger**, call
  Triple Zero: 000
- **For mental health support and advice**, call
  Lifeline: 13 11 14
  Kids Helpline: 1800 55 1800
  Beyond Blue: 1300 22 4636
  MensLine Australia: 1300 78 99 78
  or QLife: 1800 184 527
- **For sexual assault and domestic and family violence support and advice**, call
  NSW Rape Crisis: 1800 424 017
  NSW Domestic Violence Line: 1800 65 64 63
  or 1800Respect: 1800 737 732
- **For child sexual abuse support and advice**, call
  Blue Knot Foundation: 1800 657 380
  Survivors & Mates Support Network (SAMSN): 1800 472 676
  or NSW Sexual Violence Helpline: 1800 424 017
- **To find local support for adult or child sexual assault**, go to
  NSW Health's Sexual Assault Services directory:
  https://www.health.nsw.gov.au/parvan/sexualassault/Pages/health-sas-services.aspx
- **To find local support services for young people with harmful sexual behaviours**, go to NSW Health's New Street Services directory:
  https://www.health.nsw.gov.au/parvan/hsb/Pages/new-street-services.aspx
- **For victims of a violent crime,** counselling, financial support and a recognition payment may be available from the Victims Support Scheme. For information call:
  Victims Access Line: 1800633063
  Aboriginal Contact Line: 1800019123
- **Employee Assistance Program (EAP)** is offered by many workplaces. It is confidential and free and provides assessment, counselling and referrals for personal and work related issues.

Reporting concerns that a child or young person is at risk of significant harm

- **Child Protection Helpline:** 132 111

Any member of the community, including mandatory reporters, who suspect, on reasonable grounds, that a child or young person is at risk of significant harm should report their concerns to the Child Protection Helpline, 24 hours, on 132 111.

Mandatory reporters can call or make an eReport through the ChildStory reporter website: https://reporter.childstory.nsw.gov.au/s/

Statement of commitment to Aboriginal children, young people, families and communities

NSW Government recognises Aboriginal people as the First Peoples of Australia and the Traditional Custodians of the lands and waterways where we live and work. We pay our respects to Aboriginal Elders past, present and emerging and acknowledge that Aboriginal people are part of the oldest surviving culture in the world. We value Aboriginal people's history, culture, knowledges and deep connection to Country and the many ways that this enriches the life of all our communities.

More Aboriginal people live in NSW than any other state or territory in Australia. Improving the health and wellbeing of Aboriginal communities is a key focus for the NSW Government.

In July 2020, the NSW Premier signed the new National Agreement on Closing the Gap on behalf of the state. The National Agreement is underpinned by the belief that when Aboriginal people have a genuine say in the design and delivery of services that affect them, better outcomes are achieved. It commits governments to doing things differently – to working in partnership and sharing decision making with Aboriginal organisations and communities in the development, implementation, monitoring and evaluation of policies and programs to improve life outcomes for all Aboriginal and Torres Strait Islander people.

NSW Government recognises that the consequences of colonisation and subsequent inequalities in social determinants of health and wellbeing, including access to education, employment and housing, have had a devastating impact on Australia's First Peoples for over 200 years. The NSW Government also recognises the spirit, strength and cultural identity of Aboriginal families and communities, which has continued despite the impacts of colonisation.

The health and wellbeing disparities between Aboriginal and non-Aboriginal people and the significant over-representation of Aboriginal

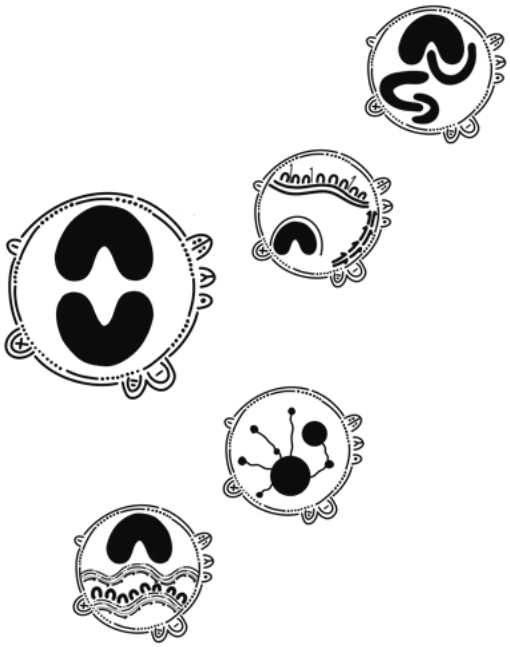
children and young people in the statutory child protection and criminal justice systems, must be understood and responded to with recognition of the impacts of colonisation, systemic disadvantage, forced removal of children, land dispossession, racism and discrimination, and the intergenerational trauma that these factors contribute to. This does not suggest that all Aboriginal children and young people would be represented within these systems but acknowledges that the over-representation of Aboriginal children and young people cannot be ignored and must be understood.

Aboriginal children and young people, like non-Aboriginal children, are vulnerable to the impacts of trauma, through direct experiences of violence, abuse and neglect and exposure to family violence or abuse. Adverse childhood experiences including violence, abuse, disadvantage and experiences of racism and discrimination, can increase risk of displaying or engaging in problematic or harmful sexual behaviours, as well as increasing risk of experiencing sexual assault, domestic and family violence and child abuse and neglect. As a result, Aboriginal children and young people are overrepresented in the population of children and young people who have engaged in problematic and harmful sexual behaviours.

The first NSW Closing the Gap Implementation Plan articulates the importance of this Framework for preventing and responding to children and young people with problematic and harmful sexual behaviours and a commitment to ensuring the needs of Aboriginal children, families and communities are at the forefront of implementation initiatives that aim to improve outcomes for Aboriginal people in NSW.

Although the effects of childhood trauma can be severe and long-lasting, NSW Government recognises that recovery can be mediated by initiatives and programs that nurture the spirit and cultural identity of Aboriginal families and communities. Genuine appreciation and understanding of the impact of power dynamics, the importance of Aboriginal worldviews, and the limitations of Western approaches in the assessment and treatment of trauma is central to demonstrating respect for the lived experiences of Aboriginal people.

NSW Government is committed to supporting the ongoing efforts of Aboriginal people and communities to reduce the impact of the social determinants of health, as well as the effects of individual and collective trauma legacies, to improve the health and wellbeing of Aboriginal families and communities in NSW. We are also committed to building the capacity of mainstream services to support Aboriginal children and families impacted by problematic and harmful sexual behaviours.



INYADOT ART featured in this document was created by Indigenous artist Jake Simon, proud Worimi-Biripi man living on Gadigal lands.

Artwork by Inyadot Art. Inyadot Art was engaged by Ministry of Health to translate the internal values and visions centred on children, young people and families and sets the priorities for how we, as a community, can support all children and young people in NSW to experience caring and respectful relationships and live healthy and safe lives.

Executive Summary

Purpose

The Case for Change has been developed to inform the NSW Framework for the Prevention and Responses to Children and Young People with Problematic or Harmful Sexual Behaviours. It builds on the findings of the Royal Commission into Institutional Responses to Child Sexual Abuse, provides a discussion of the evidence for a public health response to problematic and harmful sexual behaviours (PHSB) in children and young people and aligns this with the key strategic drivers and priorities in NSW.

Background

Change is needed now, at all levels, to prevent child sexual abuse and ensure appropriate advocacy, support and treatment for those impacted. This includes harm caused by children and young people.

This strong recognition comes in response to the Royal Commission (2017) and the ongoing Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. The Royal Commission identified significant inconsistencies and gaps in Australia's approach to PHSB, noting that 'no state or territory has a comprehensive and coordinated policy approach for preventing, identifying or responding to children with harmful sexual behaviours' (Royal Commission, 2017, vol 10:9).

What do we mean by problematic and harmful sexual behaviours (PHSB)?

PHSB sits on a continuum of sexual behaviour from normal, inappropriate, problematic, harmful, abusive to violent (Hackett, 2014). The continuum acknowledges some behaviours are part of normal sexual exploration for children and young people, and that what is considered normal changes according to a child or young person's stage of development.

A shared understanding of what constitutes PHSB – versus sexual behaviours which are developmentally and age appropriate – is important to guide appropriate and proportionate responses.

Prevalence of PHSB

The Royal Commission found that there are likely to be thousands of children harmed by other children's sexual behaviours in Australia each year.

Research by the University of Wollongong identified that over a two-year period (1 January 2018-31 December 2019), more than 5,000 children and young people in NSW had PHSB incidents reported to Department of Communities and Justice, Child Protection (Spangaro et al., 2021).

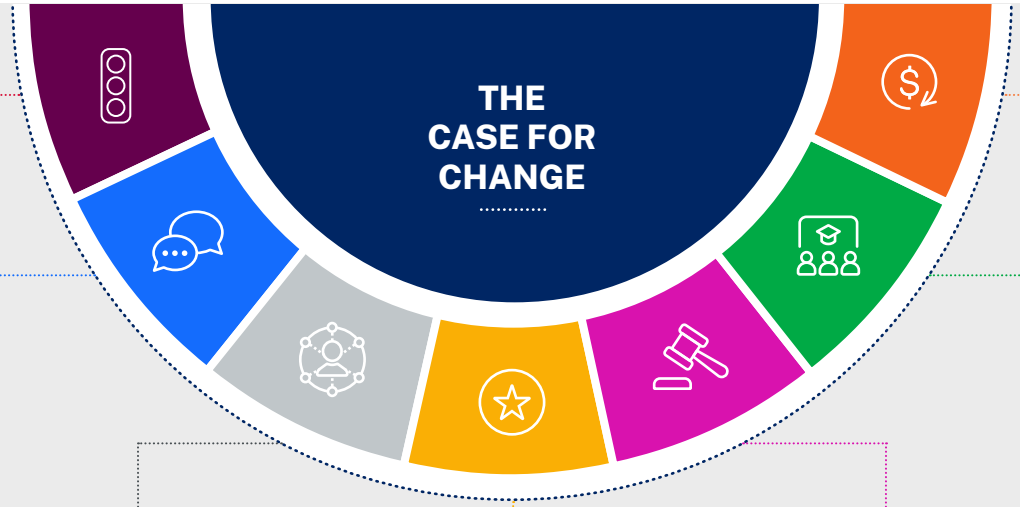
What needs to change and why: key arguments for change

PHSB by children and young people is a significant issue in NSW. We need to act now to prevent PHSB and avoid harm to our children and young people.

The case for change

Our vision is to create a whole of government and whole of community approach that supports all children and young people to experience respectful and caring relationships and live healthy and safe lives.

Our response to PHSB will achieve significant and measurable improvements to the lives of children, young people and their families. In line with the NSW Government Investment Plan for Human Services, we will build on the existing service systems through innovation and evidence-informed collaborative models of service delivery. This will ensure we are effectively supporting vulnerable children, young people and families.



1. A common understanding of PHSB will ensure consistent and effective responses

Shared language and understanding of what is normal and what is problematic or harmful behaviour

Targeting those at increased risk, strengthening key protective factors

2. We can prevent harmful sexual behaviour from occurring

PHSB has complex drivers that require an interagency and whole of community response

Whole of community education and prevention programs create better life outcomes for children and young people and can make a difference in preventing PHSB

3. Responding early prevents escalation and reduces harm

There are lifelong impacts of being sexually abused. The public health model helps prevent them and provides appropriate support when children and young people are sexually abused

The Team around the Child model, coordinate by a lead practitioner, can help us respond holistically to the child's needs and the range of issues in their environment

4. Specialist treatment services can prevent harmful sexual behaviours from re-occurring or escalating and help victims recover and heal

Treatment for PHSB reduces the risk of re-harming and helps reduce harms for the child or young person with PHSB

Timely access to high-quality support services including medical and forensic care and counselling services for children harmed by PHSB can minimise long-term physical and psychological impacts and support recovery and healing

5. Pathways into treatment can prevent re-harming

Intervening early can help divert young people away from criminal justice responses and rehabilitate them

We must address gaps in access to therapy for young people in contact with the criminal justice system

6. We need to build a confident and skilled workforce

Training helps professionals identify and respond to PHSB

With the right organisational supports, resourcing, training and professional development we can reduce vicarious trauma in workers

7. Committing vital resources now will deliver benefits and cost savings into the future

Prevention, diversion from criminal justice to treatment, holistic, early and tartgeted support and training created economic savings and social benefits

$24 billion each year
The estimated budgetary cost of unresolved childhood trauma and abuse in adults in Australia

$700 per Emergency Department presentation
Emergency department presentations for children and young people reported for PHSB are high

$27,000 to $41,000
Average annual cost for a child in out of home care

$500,000 per year
Average cost of holding a young person in juvenile detention per year

Contents

Introduction

Sexual abuse by children and young people is a considerable social problem (O'Brien, 2010; Hackett, 2014; Shlonsky et al., 2017). Available evidence suggests PHSB is prevalent in Australia[1] with the Royal Commission finding that there are likely to be thousands of children harmed by other children's sexual behaviours in Australia each year.

Research by the University of Wollongong identified that over a two-year period (1 January 2018-31 December 2019), more than 5,000 children and young people in NSW had PHSB incidents reported to Department of Communities and Justice, Child Protection (Spangaro et al., 2021).

These numbers are consistent with those from an Ombudsman NSW report showing 2,197 children had been reported to Community Services in 2010-2011 for issues involving an inappropriate sexual behaviour, and were assessed as at risk of significant harm (ROSH) (Ombudsman New South Wales, 2012). The number of children assessed as at ROSH is only a proportion of all reports for inappropriate sexual behaviour, with data over a 5-year period (2007-2011) showing 23,583 child protection reports that included inappropriate sexualised behaviours: an average of 4,716 per year (Ombudsman New South Wales, 2012). These figures suggest that, in addition to the more than 2,000 children requiring specialist child protection and therapeutic responses each year, there are just as many who require early support to prevent further harm and re-reporting to the child protection system.

A survey of the NSW workforce suggests the actual numbers of children displaying PHSB are much higher, a reflection that not all PHSB is reported. Respondents reported working with between 2,000 and 3,000 children and young people displaying PHSB over three months in 2020, and encountering between 700 and 1,000 more they were unable to respond to.

Young people in NSW are also telling us the numbers are much higher than reported and captured in our data and service system responses. Over 6,700 recent testimonies by young people, recorded in the Teach Us Consent petition started by Chanel Contos, raised awareness of the prevalence of sexual assault and sexual violence among children and young people. As a result, Government, Catholic and Independent School sectors signed a Statement of Intent (NSW Department of Education, 2021a) in March 2021 to strengthen the understanding of consent and harm prevention in schools.

1 Due to a lack of national data, low levels of community awareness and under-reporting by professionals and parents it is difficult to accurately estimate the prevalence of PHSB amongst Australian children. However, even when using conservative estimates, PHSB is a significant public health issue.

NSW journey to reducing problematic and harmful sexual behaviour

In 2018, the NSW Government responded to the Royal Commission's final report by committing to reducing PHSB in children and young people, with a focus on prevention, early intervention initiatives and improved access to specialist treatment services.

Since then, the NSW Government, led by NSW Health, has undertaken work to inform a *NSW Framework for the Prevention and Response to Children and Young People with Problematic or Harmful Sexual Behaviours* (the Framework).

This work contributes to and leverages a number of existing NSW Government commitments and drivers of policy change.

- NSW Government response to the recommendations of the Royal Commission.
- NSW Premier's Priorities
    - Decreasing the proportion of children and young people re-reported at risk of significant harm by 20% by 2023 by: educating parents and carers, equipping the workforce to understand, identify and respond to PHSB, and implementing a socio-ecological and holistic approach to addressing known environmental drivers of PHSB such as child abuse and neglect.
    - Doubling the number of children in safe and permanent homes by 2023 and reducing street homelessness in NSW by 50% by 2025 by: supporting parents, carers and out of home care (OOHC) workers in their role as carers in promoting respectful relationships and appropriate sexual behaviours and; enabling them to manage PHSB if it arises so that risk of family or placement breakdown is reduced.
    - Reducing the number of domestic violence reoffenders by 25% by 2023 by: educating the workforce and community that domestic violence is a risk factor for PHSB and; ensuring a joined-up and holistic system response to children and young people displaying PHSB who are encountering domestic violence.
    - Reducing the rate of suicide deaths in NSW by 20% by 2023 by: reducing the number of children and young people who are victims of PHSB, and therefore at higher risk of mental health issues and suicide and; by delivering effective and multi-disciplinary treatment for children with HSB, many of whom also have mental health difficulties and/or have lived experience of trauma.
    - Increasing the number of government services where citizens of NSW only need to 'tell us once' by 2023 by: implementing a common approach to screening and assessment including effective information sharing and collaborative support and safety planning.
- National Agreement on Closing the Gap to improve the lives of Aboriginal and Torres Strait Islander people – NSW Implementation Plan
    - Aboriginal and Torres Strait Islander young people are not overrepresented in the criminal justice system - By 2031, reduce the rate of Aboriginal and Torres Strait Islander young people (10-17 years) in detention by at least 30%. This program of work will contribute to this target through the development of an improved policy and legislation framework that will reduce the number of children with harmful sexual behaviour (HSB) from entering criminal justice system. Instead, where appropriate, they will receive specialist support in the community to change their behaviour.
    - Aboriginal and Torres Strait Islander children are not over-represented in the child protection system - By 2031, reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in OOHC by 45%. NSW specialist treatment programs – New Street and Safe Wayz are delivered within a child protection framework that promotes multi-agency and culturally safe responses to PHSB. Both programs work with the parents and/or carers to support them in providing safe and stable home environments and placements.
- New Online Safety Act: The new Online Safety Act 2021 (including new Restricted Access System) will commence on 23 January 2022
- Safe and Supported: the National Framework for Protecting Australia's Children 2021 - 2031
- The National Strategy to Prevent and Respond to Child Sexual Abuse 2021-2030
- Keeping Our Kids Safe: Cultural Safety and The National Principles for Child Safe Organisations, The Secretariat of National Aboriginal and Islander Child Care (SNAICC)
- NSW Sexual Violence Plan 2022-2027
- NSW Domestic and Family Violence Plan 2022-2027
- NSW Ombudsman Inquiry into the Operation of

the Joint Investigation Response Team Program 2017

- NSW Ombudsman 'Responding to Child Sexual Assault in Aboriginal Communities,' A report under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act 1993, December 2012
- Their Futures Matter. A new approach to child protection and family wellbeing
- NSW Aboriginal Family Wellbeing and Violence Prevention Strategy 2017-2022
- NSW Health's Integrated Prevention and Response to Violence, Abuse and Neglect Framework (2019)
- NSW Police Force, Youth Strategy: Prevention, Intervention, Partnership
- Domestic and Family Violence Youth Justice Strategy 2019-2020
- NSW Aboriginal Children's Early Childhood Education Strategy 2021-2025
- Future Health: Strategic Framework 2022 - 2032
- NSW Charter of Victims' Rights
- UN Conventions on the Rights of the Child.

The Case for Change informs the Framework. It synthesises existing research and consultations undertaken throughout 2020-2021, including:

- Literature Review on key findings from research on children and young people who display PHSB.
- Research on the training and resource needs of children, families and the workforce in NSW undertaken by Rosie's Place in collaboration with NSW Health's Education Centre Against Violence.
- Workforce Survey of government agencies, non-government organisations and education sector (ARDT, 2021).[2]
- Focus Groups with representatives from Department of Communities and Justice, non-government organisations working with children and young people, including:
  - children and young people with disability and from culturally and linguistically diverse backgrounds
  - Multicultural NSW
  - NSW Department of Education
  - Aboriginal Affairs NSW
  - Aboriginal organisations and services
  - Advocate for Children and Young People NSW
  - NSW Office of the Children's Guardian
  - NSW Health
  - NSW Police.
- Access and Engagement with Services for Sexual Safety (AccESS) study on children and young people with PHSB undertaken by the University of Wollongong (Spangaro et al., 2021). This included data linkage analysis of over 5,000 children and young people who were reported to the Child Protection Helpline for PHSB and quotes from qualitative research undertaken with parents, carers and young people accessing PHSB specialist services.
- Review of the NSW policy and legislation framework for responses to HSB by children over the age of criminal responsibility.

Key stakeholders told NSW Government about current challenges and opportunities

Following the Royal Commission, NSW Government commissioned the Nous Group to undertake co-design workshops with stakeholders to support the development of a NSW Framework for the Prevention, Identification and Response to Children and Young People with PHSB.

Stakeholders told us we need to strengthen, connect and coordinate existing PHSB policies and programs by providing a Framework with shared goals, defined roles and responsibilities, clear referral pathways and collaboration mechanisms for an integrated and consistent response.

To gain insights about the current service system, NSW Government commissioned:

- the Education Centre Against Violence to undertake targeted workforce and consumer interviews to inform the program of work including the development of resources.
- the University of Wollongong to research current

2 The Workforce Survey, conducted between 2020 and 2021 collected responses from 1,941 staff across NSW, with 44% of respondents residing in the Greater Sydney Metropolitan area. Respondents included staff at NSW Health, the Department of Education, the Department of Communities and Justice, Catholic and Independent schools and a range of non-government organisation staff working across child protection, community services, health, family and child support, disability, housing assistance, homelessness, and youth justice.

pathways children and young people with PHSBs take through the NSW system and gain understanding of the experiences of children/young people and their carers.

- ARTD Consultants to undertake a survey of the government and non-government workforce groups across relevant sectors who are operating throughout the three tiers of a public health response to PHSB. The purpose of the survey was to understand NSW system gaps and service challenges in responding to PHSB presented by children and young people and to identify promising practice and initiatives that could be learnt from or built upon.

From these stakeholder consultations, several key challenges and opportunities were identified for the Framework to address.

Challenges for the Framework to address

A more consistent and State-wide approach to prevention, improving general understanding across the community and among service providers about what constitutes normal, problematic and harmful sexual behaviours, and addressing common drivers.

Development of multi-agency models of working with clearly defined roles and responsibilities of government and non-government organisations to support collaboration and make best use of resources, across the three levels of a public health model.

A consistent approach to assessments and understanding of children and young people's needs.

Clarity on what early intervention and tertiary treatment responses involve to help reduce the discrepancies between different agencies' practices and knowledge.

The current legislative and policy frameworks create barriers to accessing treatment and support for some young people, which can lead to continued or escalated behaviours, school exclusion and family or placement breakdown.

Demand outweighs capacity of treatment and counselling services for children with PHSB and children who have been harmed. Additional resourcing is required to provide timely access to assessment and counselling/treatment and to enable safe restorative justice processes, particularly in non-metropolitan areas.

Early support services are needed to respond to children who do not meet the criteria for 'tertiary' services – this would ensure that problematic behaviours do not escalate to cause harm.

More effective responses for children at higher risk of experiencing common contributing factors of PHSB, of being harmed by PHSB or who are likely to experience additional service access barriers, including Aboriginal and Torres Strait Islander children, children with disability, children from culturally and linguistically diverse backgrounds, and children in OOHC.

Training and development appropriate to workforce responsibilities and roles.

Specific support and training to meet the needs of carers in the OOHC system including detailed information on PHSB for children in their care, increased involvement in safety planning, and the offer of respite care when dealing with a child who displays HSB.

Opportunities for the Framework to build on

Expanding the capacity of effective specialist counselling services to meet demand and prevent recurrence of HSB. Stakeholders have a high level of confidence in New Street Services, which is known to reduce re-offending and have positive wellbeing outcomes, however stakeholders reported that it needs additional resourcing to meet the current or likely future demand.

Stakeholders are also supportive of the Office of the Children's Guardian decision to strengthen the Child Sexual Offender Counselling Accreditation Scheme to make it could be more effective in the area of PHSB by children and young people.

Capacity building NSW Health Sexual Assault Services to ensure access to counselling for children who have been sexually harmed by another child or young person. Stakeholders reported Sexual Assault Services (SAS) and Violence Abuse and Neglect services (VAN) services work well as referral pathways for children who have been sexually assaulted and flagged better resourcing would help meet demand and specific community needs.

Build on the small number of early support services to ensure problematic sexual behaviours do not escalate to cause harm to others. Stakeholders identified the lack of early intervention services for children and young people and their parents/carers as a crucial gap in preventing harm and escalation into the tertiary service system. Building on these early support services would also be the more cost-effective approach.

- Health and education, as universal services, are well placed to provide targeted responses and identify and address these needs.

    - Stakeholders suggested the benefit of providing additional training to school counsellors, pastoral care workers and behaviour specialists to provide support to children and families.
    - NSW Department of Education provides annual mandatory Child Protection training for all staff and publish an annual Child Protection Update centred on a key issue of focus. The 2022 Child Protection Update guides staff to identify indicators where children and young people may be displaying problematic and/or harmful sexual behaviour and to respond in a positive and supportive manner that puts the child or young person's wellbeing at the centre while meeting reporting obligations.
    - NSW Health is rolling out Wellbeing and Health In-Reach Nurse positions in state schools to help facilitate access to relevant health services for vulnerable children and young people and their families.
    - NSW Health is rolling out 25 'Safeguards' – Child and Adolescent Mental Health Response Teams – across NSW to provide services to children and teenagers with moderate to severe mental health issues and their families and carers.
- NSW Health Youth Health Services could be resourced for a specific remit to provide counselling and support to address problematic sexual behaviours and other wellbeing needs, however these services are not available in all parts of the State, with a particular gap in rural and regional areas. Non-government organisations reported workforce capacity building would help them immediately support the families they are already engaged with when problematic sexual behaviours are identified. Access to specialist case consultation and specific training was seen as essential.
- Stakeholders identified Youth on Track as an early intervention program that could be expanded to meet the needs of young people with PHSB. Youth on Track is a Department of Communities and Justice funded early intervention program delivered by non-government organisations. It is a voluntary scheme for 10 to 17-year-olds that identifies and responds to young people at risk of long-term involvement in the criminal justice system through multi-agency collaboration.

Improve early identification of PHSB by implementing consistent screening and strengthening existing pathways for professionals to access case advice.

- The NSW Health and NSW Education Child Wellbeing Units were described as effective pathways for accessing case advice and as trusted sources of support for their respective workforces. The education sector also valued the Child Wellbeing Unit's support in raising awareness of PHSB for those who make contact with the service.
- Family Support and Connect (formerly Family Referral Services) were identified as an important avenue for advice, support and capacity building for non-government agencies.
- Children displaying PHSB are often reported to the Child Protection Helpline for other primary child protection concerns including abuse and neglect, creating an opportunity for routine PHSB screening, assessment and prevention in relevant VAN and other non-government organisations. They were also shown to frequently present at hospital emergency departments (53.3% had presented at emergency at least once), providing another opportunity for identification, assessment and referral (Spangaro et al., 2021).
- The workforce is interested in more comprehensive and targeted training, including a focus on opportunities to train workforces together to build a common understanding of PHSB, roles and relationships. The Workforce Survey showed a correlation between undertaking training and understanding of and confidence in dealing with PHSB.
- The traffic light model was reported to be an effective tool for PHSB identification/screening across workforces and there was strong support for developing and adopting a specific NSW version of a traffic light tool, alongside more comprehensive assessment tools and guidance.

Enable coordinated responses for children and families through collaborative multi-agency models. Interagency collaboration was identified as an essential component of effective responses to PHSB. School communities were seen as an appropriate location to coordinate and deliver supports for children. Stakeholders described in-reach models such as Health workers coming into or being based within schools to support children, in collaboration with teachers, principals, school counsellors and pastoral care workers.

NSW Government's commitment to a public health approach

A public health approach was central to the Royal Commission's recommendations to support children with PHSB.

To support this, the final report of the Royal Commission (2017) recommended:

- the issue of children's HSB should be included in national strategies to prevent child sexual abuse (10.1)
- timely expert assessments are available for children, so they receive appropriate responses (10.2).
- specialist and general therapeutic services are adequately funded and resourced to ensure the needs of all children with harmful sexual behaviours are met (10.3).
- there are clear referral pathways for children to access expert assessment and therapeutic intervention, regardless of whether the child is engaging voluntarily, on the advice of an institution or through their involvement with the child protection or criminal justice systems (10.4).
- therapeutic intervention for children with harmful sexual behaviours should be based on the best practice principles (10.5).
- therapeutic staff receive professional training and clinical supervision (10.6).
- funds should be available to evaluate services providing therapeutic interventions for problematic and harmful sexual behaviours by children (10.7).

The NSW Government has committed to implementing a public health approach to PHSB, as recommended by the Royal Commission. This supports a socio-ecological model that seeks to understand PHSB and the underlying risk factors through the interplay of individual, relationship, community and societal factors (World Health Organization, 2021a). It enables a proportionate, coordinated and person-centred approach that recognises PHSB, like other forms of violence, abuse and neglect are public health issues (Letourneau et al., 2014).

> *'We are of the view that Australia should adopt a public health approach as an overarching framework for preventing and responding to children with harmful sexual behaviours, both within institutions and in the broader community. Children with problematic and harmful sexual behaviours need access to interventions that align with the public health model (spanning primary, secondary and tertiary intervention) so that the response they receive can be tailored to the behaviours they have exhibited, their situation and background, and the institution in which the behaviours occurred.'*
>
> (Royal Commission, 2017, vol 10:113)

The socio-ecological approach to a public health framework allows us to consider underlying causes of behaviour beyond individual risk factors. It recognises common drivers that can contribute to children and young people presenting with PHSB, including societal expectations about gender norms, experiences of violence, abuse and neglect and other adverse life experiences, and early or extensive exposure to pornographic material. It allows us to understand PHSB as a problem that can be addressed, with multi-layer, complementary and coordinated initiatives across individual, relationship, community and societal levels. Tackling PHSB through this multi-level approach is more likely to achieve sustained change and helps focus investments, policies and energy instead of duplicating efforts.

A public health approach operates at three levels: primary prevention across the whole population; secondary prevention targeting those at higher risk and; tertiary prevention responding to harms after they have occurred.

The public health framework for PHSB includes:

Universal prevention activities inclusive of all children and young people and their parents/carers to prevent PHSB.

Targeted prevention activities for at-risk cohorts and those with specific needs.

Early intervention responses for children and young people displaying problematic sexual behaviours or attitudes who have not sexually harmed others.

Tertiary responses for those who have sexually harmed, delivered as a multi-agency approach within a child protection context. Public health approaches are trauma-informed and consider the developmental and eco-systemic context for the child or young person. Therefore, they typically focus on positive behaviour change through specialist counselling, alongside broader wellbeing support and often in combination with parent education and support activities. The needs and safety of children harmed or at risk of harm are at the centre of responses which include restitution/restorative justice processes and may also include criminal justice responses in some cases.

While a public health approach involves health agencies and institutions, it is not the exclusive domain of health. Everyone has a role to play to prevent, identify and respond to PHSB to keep children and

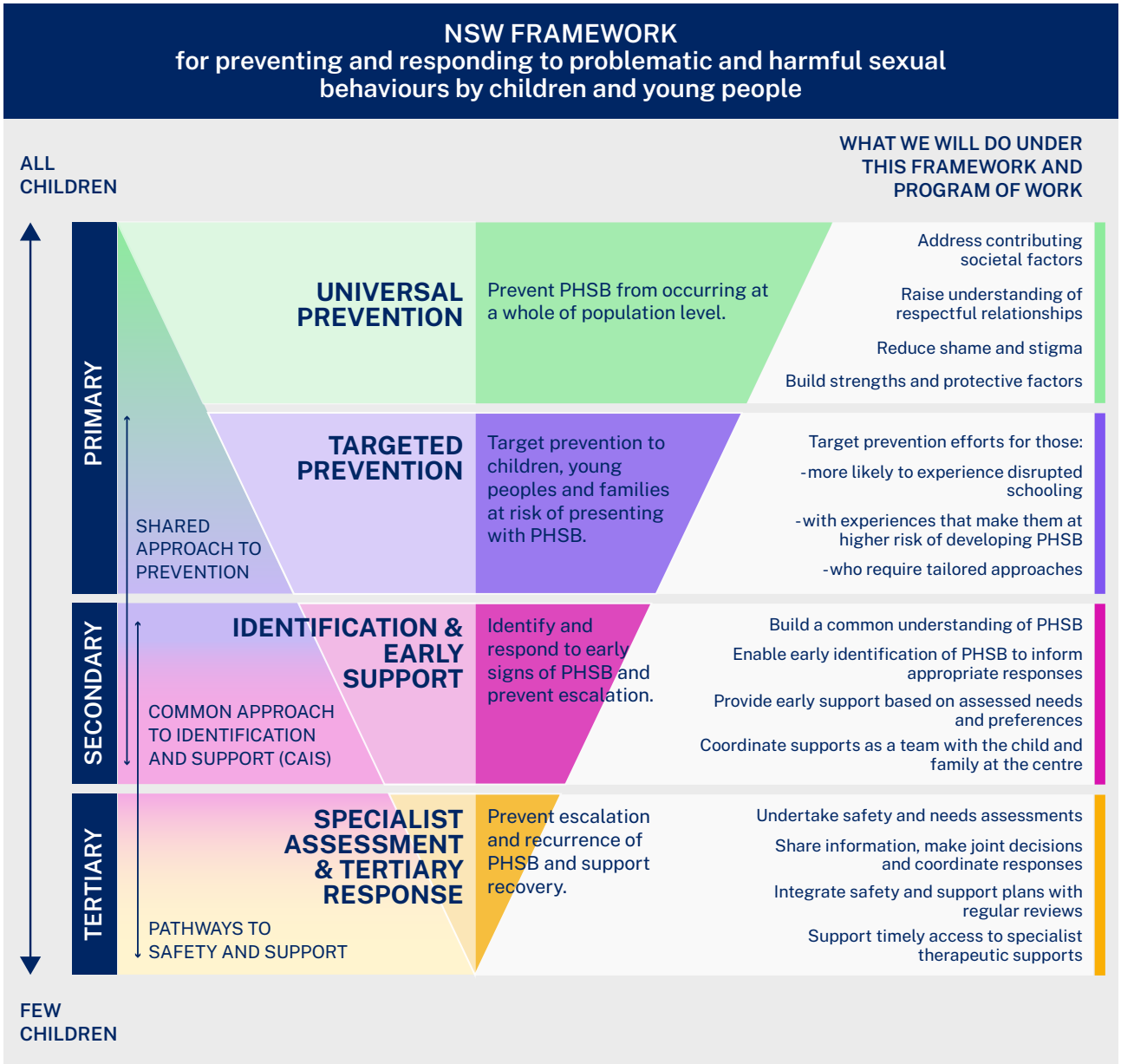
young people safe and healthy. This includes our schools, community and sports groups, religious institutions, primary and community healthcare providers, the justice system, the child protection system, OOHC providers, non-government sector, parents and families.

Identification and early support responses aim to prevent escalation at the 'inappropriate' or 'problematic' end of the spectrum. Tertiary responses are for those behaviours that have harmed others, and are provided within a child protection and/or criminal justice framework in recognition of the harm caused and/or offence committed.

Across the public health continuum, it is important to note the various aspects of effective responses to PHSB, including therapeutic treatments, assessment

'Multi-agency collaboration should be at the heart of a public health approach to children with harmful sexual behaviours. Child protection, police, health, therapeutic treatment services, juvenile justice and institutions where a child has exhibited harmful sexual behaviours will all have expertise and particular insight that can inform interventions for the child. Information sharing is key to achieving the best possible outcomes.'

(Royal Commission, 2017)



practices or worker roles, are often fluid and not exclusive to one level of intervention. Often workers can be engaged in activities across the continuum with different levels of intervention supporting and/or reinforcing each other.

The elements of this approach work together to change the culture of silence about PHSB, to support children and young people displaying PHSB to address their behaviours, support children who have been harmed in their recovery, and promote healthy relationships for children and young people in NSW.

Key argument 1

A common understanding of PHSB will ensure consistent and effective responses

The call for a common understanding

Most sexual behaviour in children and young people is a typical and healthy part of their development. Some sexual behaviour, however, is not within the typical expected range of behaviour for the child or young person's level of development. Some behaviours may harm the child themselves or other children. When sexual behaviours are not in the typical expected range, we know that children, young people and their families benefit from early advice or support. We know, from the evidence, that early support can prevent inappropriate sexual behaviour from progressing into something harmful.

Understanding of sexual development and the continuum of normal, problematic and harmful behaviours – and how these change throughout a child's development – is key for confident and effective identification of PHSB (Martin, 2014). A limited societal understanding of normal versus problematic and harmful sexual behaviours is negatively impacting children and young people through overreaction to sexualised behaviours (McKibbin et al., 2020).

The Royal Commission identified the lack of a common understanding and definition of PHSB as having the potential to cause significant harm to children and young people through minimisation of serious behaviours or disproportionate, ineffective or stigmatising responses. The sector wide Workforce Survey (2020-21) in NSW confirmed this, with numerous respondents raising concerns that differences of understanding led to inaction on cases.

- One professional stated that 'concerning behaviours suggestive of exposure to pornography or even being the victim of sexual abuse,' that they had seen in young children were described as 'normal child experimental behaviour' by inter-agency colleagues.
- Another professional raised concern that children with PHSB often have multiple challenges in their lives, which can include living with a disability or mental health difficulties, however it was a struggle to achieve a shared assessment, understanding of needs and

collaboration across agencies and services. They observed that this can lead to a lack of engagement with the young person and 'labelling (of the) child/young person as "too hard basket" – just ceasing services' with no information and support provided for the child and family.

- A third professional was concerned about children under the age of 10 years with PHSB being seen 'as a 'perpetrator' and it can result in the carers requesting the child be moved or results in a placement breakdown.'

This was echoed by NSW stakeholders who were consulted to inform the development of a NSW Common Approach to Identification and Support for PHSB.

> *'There is often inappropriate language used when children are being discussed across agencies – we need to do more to destigmatise PHSB.'*
>
> Consultation participant

What we need to know for a shared understanding

A shared understanding of the continuum of sexual behaviours across agencies and workforces is essential to designing and implementing effective collaborative responses to PHSB.

As outlined in Figure 1, PHSB sits on a continuum of sexual behaviour from normal, inappropriate, problematic, harmful to abusive (Hackett, 2010). The continuum acknowledges that some behaviours are part of normal and appropriate sexual exploration for children and young people, and that what is considered normal changes according to a child or young person's stage of development.

The following definition of PHSB is adapted from Hackett's (2014) definition of 'harmful sexual behaviour':

> *Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult.*

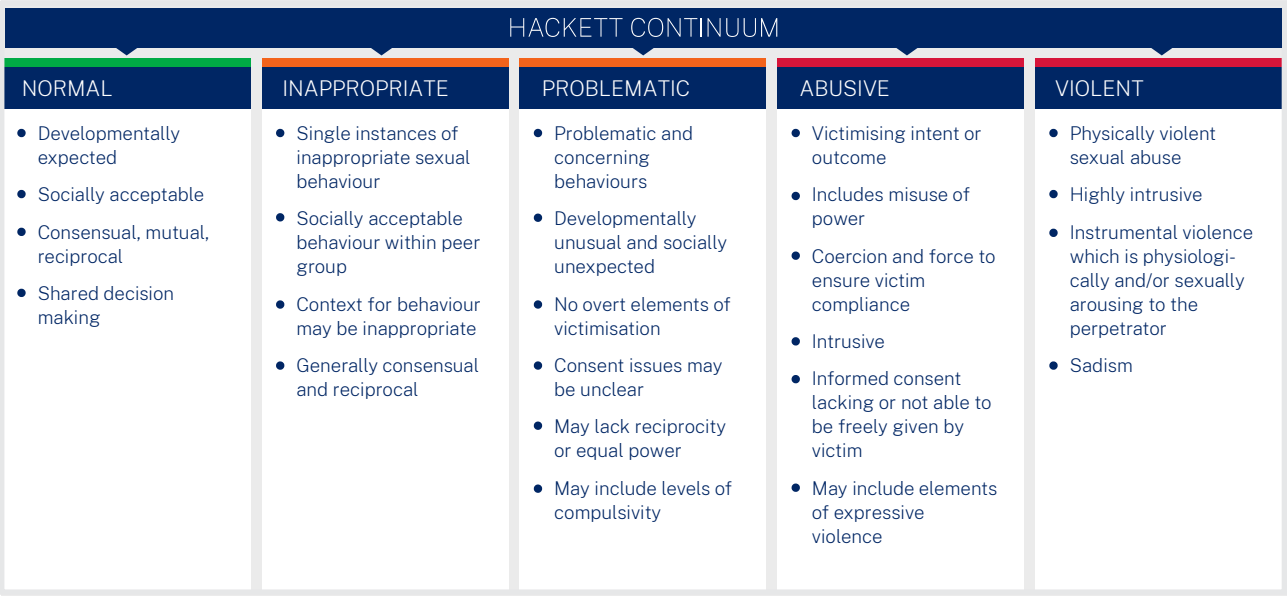


Figure 1 Hackett continuum of sexualised behaviours[3]

3 Hackett, S (2010). Children, young people and sexual violence. In Barter, C and Berridge, D (eds) Children behaving badly? Exploring peer violence between children and young people. London: Blackwell Wiley.

Terminology

Harmful sexual behaviour (HSB) describes sexual behaviour outside of the normal range for children and young people which causes harm to the child or young person themselves or emotionally, physically or psychologically harms other children or young people subjected to this behaviour. In the past, other terminology has been used to describe this group, including 'juvenile sex offender', however, this term has been criticised for encouraging the stigmatisation of children and young people with HSB and presenting a barrier for accessing therapeutic responses for what is now known to be a very vulnerable cohort.

Problematic Sexual Behaviour (PSB) includes sexual behaviours displayed by a child or young person that are inappropriate, harmful to the child or young person themselves, but do not involve the immediate victimisation of another. However, it is also used by some researchers to describe sexual behaviour that falls outside the normal range for children and young people below the age of 10.

The term **problematic and harmful sexual behaviour (PHSB)** is used as an umbrella term to account for the broad range of sexual behaviours outside of the normal range for children and young people that a public health response framework should seek to address.

PHSB can take many forms, such as physical peer on peer abuse that involves non-consensual touching, hugging or kissing of others, public self-stimulation, coercion and/or sexual assault (Meiksana et al., 2017). PHSB can also take place through digital media, such as:

- the possession, making or distribution of indecent images of children, including sexting
- the use of pornography that is developmentally
- inappropriate[4]
- sexual harassment
- grooming
- exposing other children and young people to pornography (Hollis and Belton, 2017)[5].

Sexual behaviour can be considered inappropriate if it falls outside a child or young person's normal stage of development, or if a behaviour that is appropriate in certain contexts is performed in an inappropriate context.

The ages and developmental stages of the children involved, and the behaviour itself must be considered alongside the legislative context. In NSW, the Crimes Act 1900 includes provisions and thresholds for dealing with sexual offences and the age of consent for sexual intercourse. If developed, a NSW screening tool should align with the legislative definitions and provisions.

NSW stakeholders reported that a NSW specific "traffic light tool" with age based examples, building on the Hackett continuum and tailored to the NSW context would support a consistent understanding and response. The True Traffic Lights framework (insert footnote number and add this reference to the footnote list: https://www.true.org.au/traffic-lights) and the Brook Sexual Behaviours Traffic LIght Tool (insert footnote number and add this reference to the footnote list: https://www.brook.org.uk/training/wider-professional-training/sexual-behaviours-traffic-light-tool/) are examples of this approach.

Sexual behaviour requires further investigation if it (1) falls outside of a child or young person's normal stage of development and (2) if any of the following criteria are met:

- the inappropriate behaviour persists
- the child or young person does not stop the behaviour when asked
- there is an inequality in age or development with other children (if involved)
- there is a lack of reciprocity between those involved; or
- the behaviour is compulsive.

4 The Royal Commission's Final Report (2017, vol 10) identifies the viewing of materials such as online pornography for sexual pleasure as an expected behaviour as part of sexual development, stating 'We can determine whether a child's sexual behaviours are harmful by considering how much they differ from these healthy developmental expectations, as well as by examining the context of the behaviours, their severity and the impact on other.' In Appendix B (vol 10), identifying existing guidance on children's sexual behaviours, True Relationships and Reproductive Health's Traffic Lights Tool highlights a 'Preoccupation with sexually aggressive or illegal pornography' for 14 to 17-year-olds as a 'red light behaviour'.

5 Accessed at https://learning.nspcc.org.uk/research-resources/2017/children-young-people-technology-assisted-harmful-sexual-behaviour

Sexual behaviours are considered abusive and violent if they victimise others (intentionally or unintentionally) or if they involve coercion, force, or if informed consent cannot be given (Hackett, 2014).

Not all PHSB includes victimisation of others. It also includes sexual behaviours that are harmful to the child or young person themselves or puts them at risk of harm.

Key protective factors that can prevent harmful sexual behaviours

The known key protective factors that prevent HSB and decrease the risk of reoffending sexually are: connection to parents, peers and community; living in a safe environment where the risk they pose is managed; and receiving specialised treatment (NSW Department of Family and Community Services, 2016). Culture is a central protective factor against family violence: 'Preventing and responding to family violence starts with a recognition of individual, family and community strengths' (SNAICC, 2017).

We also know parental or caregiver involvement is an important part of effective treatment programs, and involving and engaging parents/carers in prevention programs can be effective.

The University of Wollongong study identified multiple benefits to involving caregivers in therapy. Participants who underwent sessions with dedicated counsellors doing joint work with their carer noted it helped them not feel alone in working through issues, ensured they understood what the counsellor was saying, and provided a feeling of safety (Spangaro et al., 2021).

There are also strategies that can be implemented in institutions to create safety for children:

'Institutions should have clear policies on how to deal with harmful sexual behaviours in children. These policies should support adults within institutions to react to these behaviours when they occur and respond to incidents in an appropriate, informed and calm manner, while prioritising the safety of all children involved.' (Royal Commission, 2017, vol 10:14)

Having protective strategies in place is important in preventing situational risk factors such as unsupervised time between children in particularly risky environments.

The Royal Commission recommended 10 child safe standards, drawing on its findings, research and consultation about what makes organisations child safe. The Office of the Children's Guardian has published a Guide to the Child Safe Standards (Office of the Children's Guardian, 2020).

Common contributing and contextual factors and priority populations

A child or young person's sexual behaviour should always be analysed in context—what is considered appropriate or inappropriate sexual behaviour can change depending on the social or cultural norms of a child or young person's community (Hackett, 2014).

A widely shared view across many researchers is that PHSB is often a behavioural indicator of multiple underlying or contributing issues that a child or young person may be experiencing (Meiksans et al., 2017). While there are common risk factors, there is no 'all encompassing' behavioural or developmental pathway that precedes PHSB.

Like other young people engaging in socially unacceptable and/or criminal behaviours, inappropriate sexualised behaviours in childhood are closely associated with:

- experiences of childhood trauma
- compromised educational outcomes
- adverse socio-economic conditions
- homelessness or an unstable home-life (including alternate care)
- intellectual impairment or developmental delays
- social isolation and/or difficulties engaging with peers at school, and
- exposure to drug or alcohol misuse (O'Brien, 2010).

Children and young people with PHSB and their families and carers often have intersectional needs beyond PHSB. Many are already connected to other services such as the National Disability Insurance Scheme (NDIS), VAN support services, child protection and OOHC services.

> *'We need to build into systems an acknowledgement of the very high degree of complexity... and therefore resource service responses with people who have the training and expertise to do this work'*
>
> Consultation participant

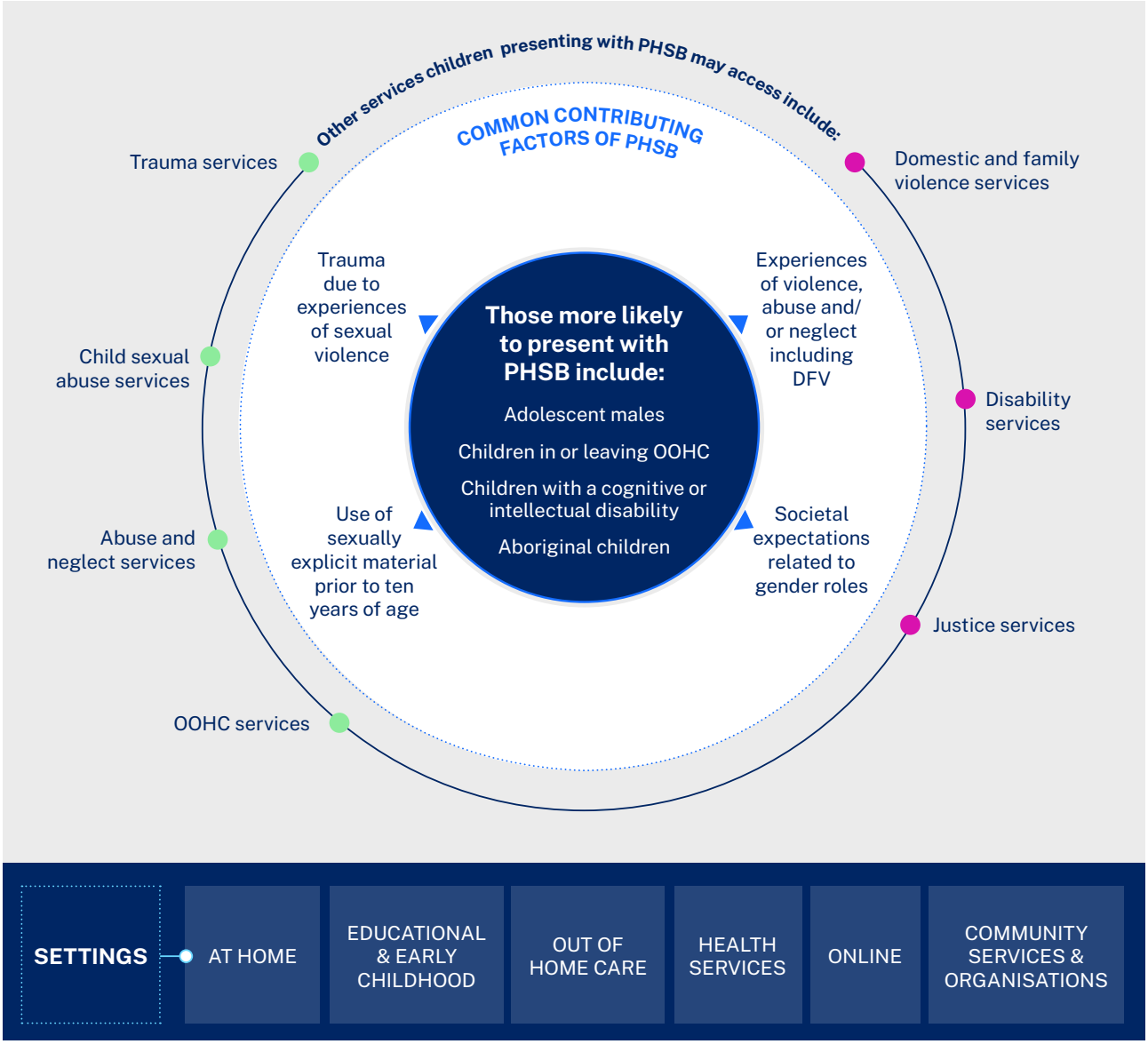


Figure 2 Who presents with PHSB and where in the service system

Childhood trauma

Children and young people who display PHSB are likely to have been exposed to a range of adverse experiences and circumstances including poverty, homelessness, living in OOHC, intellectual disability, social isolation and misuse of alcohol and other drugs (O'Brien, 2010).

While 'no single causal factor can best explain or predict sexual behaviour problems in children', sexual abuse (including sexual contact and exposure to sexually explicit material) is recognised as a frequent precursor to PHSB (Gil and Shaw, 2013:8). The available evidence suggests a significant proportion of children and young people who engage in PHSB, including those who sexually offend, have been victimised by child sexual abuse (Malvaso et al., 2020).

Research on the prevalence of child sexual abuse victimisation among children and young people who have sexually offended reports prevalence rates range from 28% to as high as 92% (Malvaso et al., 2020). The evidence shows that in addition to past experiences of abuse and neglect, this cohort are at increased risk of further abuse (El-Murr, 2017; Royal Commission, 2017, vol 10).

Links have also been found between PHSB and other negative life experiences including vicarious trauma from witnessing domestic and family violence (DFV), parental neglect, early exposure to sexual behaviour in the media, or societal expectations related to gender roles (Hackett et al., 2019a).

Although there is a strong body of evidence that children with PHSB are often exposed to adverse early life experiences, it is important to note that 'not all victims of childhood trauma go on to engage in problem sexual behaviour. Any identification of perceived pathways needs to be seen as contingent to individual circumstances' (O'Brien, 2008:15).

Gender and relationship

Recent testimonies of sexual assault by high-school students in Australia (6,729 as of 4th October 2021) recorded through the *Petition For Consent To Be Included In Australian Schools' Sex Education Earlier* started by Chanel Contos, indicate that sexual assault between peers is a significant issue and has been under reported. Chanel Contos has called it 'Rape Culture'.

In a White Ribbon Australia and Youth Action NSW survey that examined the perceptions and attitudes of young Australian adults (16-25 years old) toward domestic violence and dating violence, 'nearly three quarters (70.3%) of female respondents felt that dating violence was either common or very common compared to only half (50.1%) of the male respondents' (Cale and Breckenridge, 2015:18). Australian females aged 10-17 years had the highest police-recorded victimisation rate for sexual assault (41%) (Australian Bureau of Statistics, 2021). An American national longitudinal study of opposite-sex romantic relationships reported approximately one third of adolescents experience some type of victimisation from an intimate partner, with an estimated 12% experiencing physical violence (Halpern et al., 2001).

Most children and young people who engage in PHSB are male (Hackett et al., 2013a). NSW data shows 75% of children and young people reported for PHSB in the study period were male (Spangaro et al., 2021). The largest cohort were males aged 10 to 13 years (inclusive), followed by males aged 16 to 17. This correlates with international research findings that the overrepresentation of males with PHSB is largely concentrated in those aged between 10-17 years, and there is less of a gap between males and females in children aged under 10 years Cox et al., 2018).

There is a concern among researchers that the number of females who engage in PHSB may be underreported and underestimated, particularly females under 10 years of age (Shawler et al., 2020). The University of Wollongong's research showed the largest cohort of females reported for PHSB were aged 10 to 13 years inclusive, followed by those under 10 years of age (Spangaro et al., 2021). There is also evidence that female children and young people who engage in PHSB are more likely to have been previously victimised by child sexual abuse than males (Malvaso et al., 2020).

A significant proportion of PHSB occurs between family members, often involving the sexual abuse of a sibling or other close relative. Some research has estimated that half of all adolescent-perpetrated sexual offences involve the victimisation of a sibling (Shaw, 1999). This form of HSB often goes unreported with studies estimating that less than 20% of sibling sexual abuse victims disclose at the time (Carlson et al., 2006).

Children and young people with disability, mental health and co-occurring needs

Research estimates that about one-third of children and young people with PHSB have some form of learning disability or developmental delay (Hackett, 2014). In an Australian context, the New Street program data shows around half of their clients have a cognitive or intellectual disability, including autism (KPMG, 2014).

Hackett (2014) highlights that young people with learning disabilities are frequently unaware that their behaviour is inappropriate, and often don't understand its impact. Their behaviour as a cohort may also reflect the lack of appropriate sex education, and fewer opportunities for appropriate sexual development and experiences in line with their peers (Hackett, 2014).

In recent years, there has been increasing recognition of violence towards and abuse of people with disability, and of the need for mainstream violence policies and services to better include and address the specific needs of people with disability (Robinson et al., 2020).

An emerging body of literature addressing the specific treatment (as well as assessment) needs of children and young people with a disability who engage in PHSB points to the importance of specialist assessment frameworks that focus on identifying any issues with literacy, speech or communication difficulties, conceptual understanding and suggestibility with responses tailored according to individual needs (Hackett, 2014).

The Royal Commission highlighted there is a lack of training available for people working with children with intellectual disabilities, learning difficulties or emotional/behavioural disorders who display PHSB, and that service providers can be reluctant to take on children and young people with disability due to their apprehension of not having the appropriate skills and expertise to provide support (Royal Commission, 2017, vol 10).

Children and young people who have engaged in PHSB are children first, and often have other needs. Those with disability require specific interventions based on their needs and additional vulnerabilities. This may include diagnosis.

NSW Health New Street Data shows 58% of New Street clients in the 2020-21 financial year had a learning, intellectual, cognitive or psychosocial disability. Many of these clients were only diagnosed after they became New Street clients. University of Wollongong research found 8.3% of 5,105 children or young people displaying PHSB had documented disabilities, however in 22% of the 5,105 cases, no data was recorded on whether the child or young person had a disability (Spangaro et al., 2021).

Notably, of the children and young people in the University of Wollongong study, less than a third had received mental health assessments (Spangaro et al., 2021). However, many of the carers who participated in qualitative interviews reported seeking supports and services for a range of social, behavioural and learning difficulties. Given the findings from a research study of juveniles who sexually offend indicates that around 70% met the criteria for at least one mental disorder, (Boonmann et al., 2015), the low rate of mental health assessments among the University of Wollongong study group indicates significant service gaps. This may have 'obscured the extent to which children and young people who have displayed PHSB are affected by disability and mental health issues' (Spangaro et al., 2021).

The University of Wollongong created journey maps from this research to represent the interactions children and young people have with current NSW services. Figure 3 depicts the experience of a young person with an undiagnosed disability.

Identified practices to improve service accessibility for children and young people with disability who have engaged in problematic and/or harmful sexual behaviour are:

1. 'Strengths based, timely and proportionate responses. They include:
    - person-centred and relationship-based responses

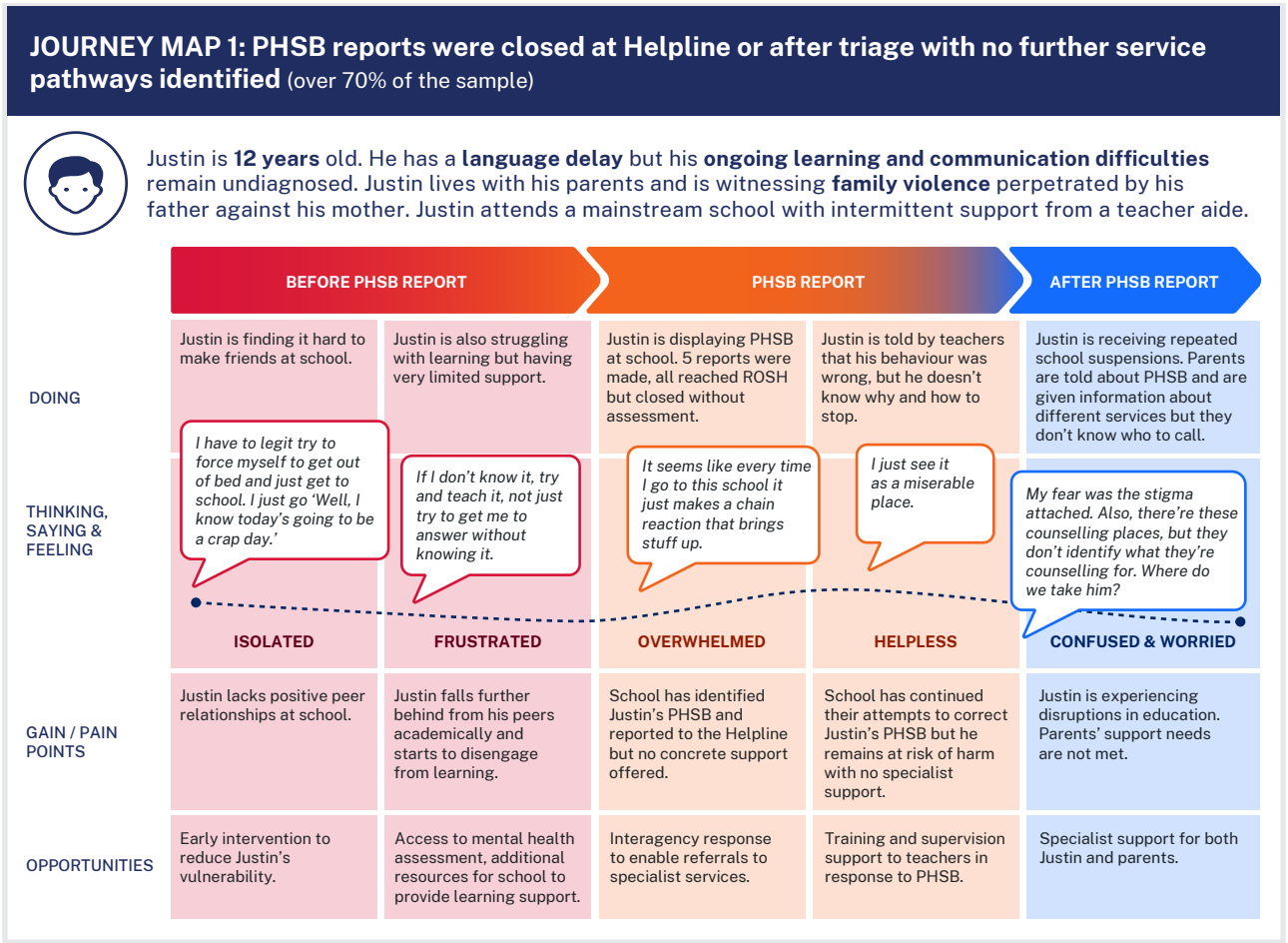


Figure 3 Journey Map - experience of a young person with an undiagnosed disability (Spangaro et al., 2021)

- developmentally and culturally appropriate programs, which include safety plans for children to prevent future harmful behaviours and who may be at risk
- holistic and trauma informed responses that recognise children and young people often have other traumatic events in their lives.

2. Multi-modal approaches to support children and their families, using different methods of support. Also developing parent/guardian support and skills.
3. Multiagency partnerships and collaborations.
4. Education and training to improve and develop workforce skills in trauma informed practices, working with children and young people with disability and their families' (Robinson et al., 2020).

The need for more trauma-informed knowledge and skills in services to support children with complex mental health needs was echoed by participants in the University of Wollongong study:

'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 (Spangaro et al., 2021).

To address these barriers and acknowledge the complexity of this work, NSW Government will need to further develop the service system to take a holistic approach, with a focus on early coordination of multi-disciplinary assessments and interventions for children with PHSB. This would complement and support the work of PHSB treatment services, early education services, schools and OOHC providers. This should include a review of access criteria and building capacity and capability in mental health services, child development and youth health services (including speech, occupational therapy and psychology) to participate in a collaborative care model.

Aboriginal and Torres Strait Islander children and young people

Other social groups are overrepresented in the population of children and young people who engage in PHSB, which is likely the result of significant social disadvantage (Cox et al., 2018). Aboriginal young people experience significant structural disadvantage which can lead to 'compromised educational outcomes, poor health indicators, adverse social-economic circumstances — the multiple contextual factors that cause obstacles for these children have also been obstacles for their parents' (O'Brien, 2008). Disadvantage has become trans-generational, with childhood trauma a major risk factor to adverse life outcomes including PHSB and child exploitation.

O'Brien (2010) reports Aboriginal children and young people are overrepresented in the population of children and young people that engage in PHSB. In the dataset examined by University of Wollongong, 17.5% of children and young people reported for PHSB were identified as Aboriginal, compared to 3.4% of the general population of NSW (Spangaro et al., 2021). NSW Health New Street Data shows that for the 2020-21 financial year, 33.5% of New Street clients identified as Aboriginal.

NSW Government has a responsibility to implement culturally safe practice and service frameworks that reflect Aboriginal worldviews and provide 'positive and emotionally safe experiences for Aboriginal people in mainstream systems' (Henderson and Navarro, 2020). This will mean a focus on:

- increasing Aboriginal workforce
- ensuring services are culturally safe for both Aboriginal workers, children and young people and their families
- working in collaboration with Aboriginal communities.

Aboriginal and Torres Strait Islander children and young people and their carers may prefer to access workers who are Aboriginal or Torres Strait Islander, however in many cases this is not possible because the service has not employed Indigenous staff members (Funston et al., 2013). This issue was identified as a crucial service access barrier to NSW Health SAS in NSW by the Aboriginal Child Sexual Assault Taskforce in 2006, the Specialist Inquiry into Child Protection Services in NSW (Wood, 2008) and the NSW Ombudsman in his report Responding to Child Sexual Assault in Aboriginal Communities (2012).

This was also raised by participants in the recent Workforce Survey, and although there has been an enhancement of identified Aboriginal counselling roles as part of the NSW Government response to the Royal Commission, this will need to be expanded further to ensure meaningful representation and access to counselling and healing services, in the context of the over representation of Aboriginal children in the child protection, OOHC and criminal justice systems. There should be a strong focus and investment on supporting and developing the Aboriginal workforce alongside improving the cultural competence of the non-Aboriginal workforce, to ensure our services are a safe place for Aboriginal people to work.

Partnerships between NSW Health and community-controlled organisations, to support culturally safe

practice will be essential. The Royal Commission found that to meet the needs of children who had experienced childhood sexual abuse, the service system should include Aboriginal and Torres Strait Islander understandings of social and emotional wellbeing and healing approaches.

Culturally appropriate assessment and treatment practices might include the consideration of intergenerational as well as current trauma, a consideration of a broader definition of family when scoring protective factors, cultural values and beliefs around sex including taboos about talking about sex, and the importance of a cultural connection (Queensland Health 2013). NSW service providers should ensure that non-Aboriginal staff access cultural consultation when working with Aboriginal children and families. Cultural safety also means 'engaging children and young people in safe places in their communities' (Funston, 2013:3830) and in the context of PHSB, providing cultural and gender sensitive service provision, for example being respectful of 'men's and women's business'.

The Keeping Our Children Safe resource developed by SNAICC defines cultural safety for children as:

> *'... the child being provided with a safe, nurturing and positive environment where they are comfortable with being themselves, expressing their culture... their spiritual and belief systems, and they are supported by the carer... (who) respects their Aboriginality and therefore encourages their sense of self and identity.'*
>
> Commonwealth Government (Department of Prime Minister and Cabinet, 2021)

Interviews with young people and carers in treatment for PHSB 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 by participants.

Children and young people from culturally and linguistically diverse backgrounds

Assessment and treatment practices for children and young people from culturally and linguistically diverse backgrounds need to be based on an understanding of the migrant and refugee experience and the intergenerational impacts that may be experienced. Some people who have migrated may have come from countries and cultures in which gender roles and expectations differ from those that are widely accepted in Australia, or where sexual behaviours are a sensitive or taboo topic, and this can contribute to conflict in the family home as young people challenge their parents' expectations and views.

Many refugee women and children have been victims of sexual violence or observed sexual violence in their country of origin (especially where it is used as a weapon of war), or on their settlement journey (NSW Government, 2020a).

There are additional factors for people from culturally and linguistically diverse, migrant and refugee backgrounds which may pose barriers to seeking help for PHSB, or act as drivers of PHSB (similar to those which pose barriers to accessing support for sexual assault), including:

- 'lack of support networks
- socio-economic disadvantage (or relying on family for financial support)
- systemic barriers including language, communication, informed understanding, racism and discrimination, cultural stereotypes
- community pressure and lack of knowledge about rights for victims
- being more vulnerable to sexual exploitation and added abuse. Some women may be at increased risk of sexual violence from strangers because of 'cultural stereotyping' or participation either forcibly or willingly in prostitution
- not seeing sexual violence within marriage as a 'real' crime, not having the knowledge to recognise sexual violence, or stigma associated with speaking out against abuse
- feeling obliged to stay in the relationships where the sexual abuse is occurring due to religious beliefs, rituals, traditional attitudes and rules or worldviews
- fears about breaches of confidentiality and fear of institutional responses, particularly where they have experienced oppressive or corrupt government institutions, systematic torture and trauma, or displacement from their country of origin
- reluctance to report ...because of the threat of deportation
- cultural 'justifications' or cultural barriers...' (NSW Government, 2020a).

It is important that PHSB interventions consider systemic barriers to access, as well as each child and young person's holistic experience, and that they be

flexible enough to adapt to different ethnic and faith-based communities.

Co-design workshops with stakeholders highlighted some culturally and linguistically diverse communities

> *'Immigration-related stress has been identified as a risk factor for child sexual abuse in a number of ethnic groups. A lack of awareness of the possibility of sexual abuse occurring in a family relationship (including sibling abuse) may blind parents to risk and occurrence of intrafamilial abuse.'*
>
> (Esposito and Field, 2016:36)

had generally low awareness of PHSB and its potential to be treated through therapy. Stakeholders noted the importance of family preservation, and that this can influence whether or not PHSB is disclosed, and act as a barrier to support-seeking. They also noted the need for cultural humility as a principle of engaging effectively with culturally and linguistically diverse families.

Local partnerships need to be strengthened between child protection, health, education and ethnic community organisations and service providers to build cultural competence and culturally safe and appropriate responses. A Queensland Government paper on working with people from culturally and linguistically diverse backgrounds suggested this approach facilitates more effective supports and referral channels, and that bicultural support workers may provide a helpful bridge between families and departmental staff (Queensland Government, 2010).

Children and young people in OOHC

The Royal Commission reported 'the risks of harmful sexual behaviours by other children appear to be particularly high in residential care settings,' (Royal Commission, 2017, vol 12:13). This is supported by reports from both the Australian and UK contexts showing children and young people living in OOHC are more likely to engage in PHSB (Cox et al., 2018; Hackett, 2014). NSW Health New Street data shows that for the 2020-21 financial year, 34.5% of New Street clients were in OOHC.

The Royal Commission heard many reports of OOHC institutions failing to protect children from PHSB or take seriously the complaints of children or families. It reported that in contemporary OOHC settings, factors that need to be addressed to increase the safety of children from child sexual abuse include:

- 'adequate screening, authorisation and training of carers and staff
- ongoing supervision and training on how to keep children safe
- adequate monitoring and supporting of OOHC placements – including regularly visiting foster and kinship/relative care placements, creating opportunities to talk with children on their own, and directly observing carers and their interactions with children
- establishing residential care as a safe, supportive and therapeutic environment for children with complex needs, staffed by skilled and experienced workers
- taking sufficient care in placing and supporting children with harmful sexual behaviours, especially in residential care settings' (Royal Commission, 2017, vol 12).

The Royal Commission noted specific risks in the context of residential care, where a number of young people are housed together who have potentially displayed PHSB or who are at higher risk of PHSB due to a history of child sexual abuse.

These are amplified by workforce issues such as high turnover, casual labour, lack of skills and experience and gap in staff training and supervision (Royal Commission, 2017, vol 12).

It is essential home care staff are capable and confident in assessing and managing risks to prevent PHSB occurring and to create environments where children feel safe to disclose and to respond appropriately. The Royal Commission reported a need to:

- 'Ensure professional assessment of all children with PHSB
- Provide case management and support services
- Undertake careful placement matching, ensuring that carers have the information they need to support the child, while taking steps to protect other children in the placement' (Royal Commission, 2017, vol 12).

The Parenting Research Centre undertook an evidence review and found most children and young people displaying PHSB 'will first engage in less-severe forms of PHSB, which may escalate if not addressed'. In the context of OOHC, behaviour management responses may be implemented by OOHC staff, foster and kinship carers, schools, birth families and others involved in the child's life to prevent escalation, when appropriate training and support has been provided (Pourliakas et al., 2016). Where these responses are not effective

in resolving the behaviour, or the behaviour is more severe, they recommended pathways into specialised services be available (Pourliakas et al., 2016).

The Parenting Research Centre recommended accessible training and support be developed and delivered to foster and kinship carers, child protection staff and residential care staff so they are able to identify PHSB and understand how to appropriately respond. They further recommend residential care staff are provided with specific training, support and supervision to manage the complexities of PHSB within residential care settings and that foster and kinship carers might benefit from training and 'coaching' in relation to supporting children in their care to change their behaviours (Pourliakas et al., 2016).

Enabling consistent responses

Where there is a lack of clear guidelines or access to information, individuals are more likely to make subjective interpretations about sexual behaviours influenced by their own values and beliefs around sexuality. This can lead to inconsistent responses that might not be evidence or trauma informed (Clements et al., 2017).

The literature indicates educators, practitioners and other professionals across the system would benefit from guidance on a consistent approach to identifying PHSB and standardised assessment tools for more serious PHSB.

The National Society for the Prevention of Cruelty to Children (NSPCC) Framework argues local service systems need a shared understanding of the continuum of sexual behaviours, and local agencies should agree on thresholds for normal, inappropriate, abusive and violent sexual behaviours for children and young people. Such thresholds can also be adapted to the range of services available for PHSB in a particular area or jurisdiction (Hackett et al., 2019a).

A key tool in the identification and management of PHSB for workforces is the traffic light tool. Several versions of this tool have been developed and used around Australia and globally, and can help to inform and embed a common language and understanding of the PHSB spectrum. It shows the continuum of normal to harmful sexual behaviours using a colour code of green (normal), orange (outside normal) and red (problematic or harmful).

The Traffic Light model was one of the key identification and assessment models mentioned as useful or known to respondents in the Workforce Survey. An evaluation of use of the Brook Traffic Light Tool showed it supported shared terminology and better understanding of healthy sexual development and confidence among professionals. This impacted positively on risk assessments where all agencies had been trained consistently in the same tool and were able to work with a common language (King-Hill, 2021).

Developing a Traffic Light Tool for the NSW context would help to inform a shared language for agencies, the workforce, parents and carers.

CURRENT PRACTICE EXAMPLE

Supporting young people in OOHC engaging in PHSB or at risk of sexual exploitation

Practice Guide: Responding to young people living in OOHC who engage in HSB

In response to concerns raised by the Royal Commission, the Centre for Excellence in Therapeutic Care published a Practice Guide: Responding to young people living in out of home care who engage in harmful sexual behaviour (Mitchell et al., 2020). Supported by the Department of Communities and Justice and written by the Australian Childhood Foundation's Centre for Excellence in Therapeutic Care, the guide provides carers and professionals with information to understand PHSB, how to reduce the risk of behaviours developing, the risks when behaviours do present and how to develop safety plans to protect everyone.

Training: Responding to Child Sexual Exploitation

Responding to Child Sexual Exploitation is an online self-paced training for caseworkers, residential workers, house supervisors and managers, therapeutic specialists and organisational leaders working in out of home care and therapeutic care. It was developed collaboratively by the (Australian Childhood Foundation, 2021). Given the intersections between PHSB and sexual exploitation in the residential care setting, this may have potential to expand in terms of content and reach.

The training is complemented by the Safe Connections Resource Kit – a guide for working with young people regarding child sexual exploitation. The guide was designed for caseworkers, residential workers and therapeutic specialists to support young people in care at risk of, or experiencing, child sexual exploitation.

6 https://www.brook.org.uk/training/wider-professional-training/sexual-behaviours-traffic-light-tool/

Key argument 2

We can prevent harmful sexual behaviours from occurring

Changing the culture – we can't let embarrassment and stigma get in the way of our children's safety and wellbeing

A number of aspects of our culture contribute to PHSB remaining hidden. The topic of sex and sexual health and respectful relationships is still an uncomfortable one for many teachers, parents and carers to address openly. The experience of discussing sexual health education in school was described in one report as 'awkward, brief, infrequent and embarrassing.' (Connolly, 2021:23). The shame and embarrassment surrounding these conversations only serves to perpetuate the stigma of PHSB.

Despite these pervasive attitudes, many young people are calling out for effective, early and consistent education on topics such as negotiating intimacy in relationships and consent. Young people are very clearly stating they want relationships and sexuality education that is 'engaging and affirming, delivered more often, and covering a wide range of age-appropriate content provided by well-trained teachers or other professionals who are comfortable with the topic' (Fisher et al., 2019).

Over 44,042 young people signed the 'Petition for Consent to be included in Australian Schools' Sex Education Earlier', with more than 6700 providing public testimonies of sexual assault by other young people. A significant proportion of these testimonies are by young women in NSW protesting the lack of formal teaching about sexual development and respectful relationships. An effective response to PHSB means listening to the children, young people and their families impacted by PHSB. There is ongoing work to be done in elevating young people's voices to inform our actions on PHSB.

Addressing social norms that contribute to a culture of silence and reinforce gender inequity and gendered violence

What makes conversations about PHSB even more difficult is the fact that there are a lot of different ideas, informed by culture and context, about what constitutes a 'problematic' or 'harmful' sexual behaviour. To change the culture of taboo and embarrassment around sexual development and relationships, our response to addressing PHSB must include a whole of community approach. Social norms around gender and expressions of gender inequality are also known drivers of gender-based violence (Our Watch et al., 2015). We need to change societal culture by challenging gender norms that reinforce inequity and equip families, carers and the community with the knowledge and understanding they need to approach conversations with children and young people about respectful relationships and negotiating consent.

> *'We now have a generational gap where parents may have different perceptions of what is acceptable behaviour amongst males in their teens compared to females in their teens who are growing up following the "Me too" movement.'*
>
> Workforce Survey Respondent

> *'It's not just about educating parents. It's education across the board including formal and informal community and religious leaders'*
>
> Consultation participant

There is also a great deal of stigma associated with inappropriate and/or harmful sexual behaviours and the labels historically attached (juvenile sex offender for example). There may also be stigma attached to attending treatment programs or services (Fox et al., 2015), both for parents/carers and the children or young people.

> *'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 (Spangaro et al., 2021)

> *'People don't want to think of themselves as a bad parent'*
>
> Consultation participant

A recent NSW study found feelings of being judged, not being heard and being labelled or name-called by services themselves can hinder further help-seeking (Spangaro et al., 2021).

> *'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 (Spangaro et al., 2021)

This study also cited additional considerations that further complicated carergivers' decisions to seek support for a child with PHSB. For example, the occurrence of sibling HSB creates unique challenges for parents and families by destabilising family dynamics, intensifying parental distress, and, in some cases, requiring the separation of the siblings which can present practical challenges such as financial stress. The decision to report poses multiple dilemmas as responding to the victimisation of one child may appear to be done at the cost of the other child's welfare due to the risk of long-term consequences including criminal conviction or removal of one or more children from the family home (Spangaro et al., 2021).

To create a culture where children and young people feel safe to speak up and for young people and their carers to seek support, our response must work to promote and normalise gender equality in our communities, schools, homes and public life (Kearney et al., 2016). It must equip parents and carers, children and young people with knowledge and understanding about the spectrum of sexual development, power in relationships, online safety and pornography (Johnson et al., 2016). By providing specialist, non-judgemental support and care, and universal education, we can change how we understand PHSB and its drivers, and create a culture that can talk about, identify, and appropriately respond to PHSB.

We can only respond appropriately if we can talk about healthy sexual development and behaviours and recognise when behaviours are problematic and harmful.

Responding to contemporary issues facing our children and young people as they navigate the digital environment

There is evidence to suggest that exposure to pornography can negatively impact:

- 'children's mental health and wellbeing
- their knowledge, attitudes, beliefs and expectations about sex and gender
- their involvement in risky or harmful sexual practices or behaviours' (eSafety Commissioner, 2021a)

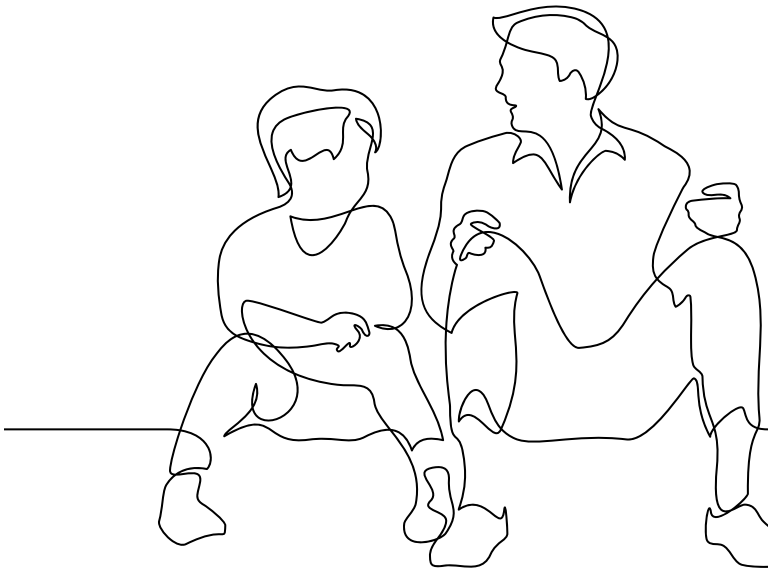
> *'I didn't really watch [pornography] when my sister was around, usually at that point my head was thinking let's try what I've seen. Then, so as well as the pornography and that sense of power, they just pretty much added together and then caused [my harmful sexual behaviour]'*
>
> Young person, male (McKibbin et al., 2017)

The accessibility of the internet and increased exposure of children and young people to pornography adds another dimension to gender stereotypes and gendered violence. There is strong evidence from international studies on children and young people, both correlational and longitudinal, that pornography exposure is associated with sexual violence, and that young people are using pornography to educate themselves about sex (Crabbe and Corlett, 2021).

Boys are generally exposed to these factors earlier than girls, with a recent South Australian study showing over half of boys had intentionally viewed pornography before the age of 16, compared to 14% of girls (Connolly, 2021).

Digital technology, including the internet, social media and apps are part of the shifting landscape in which children and young people are experiencing their sexual development.

The internet is a key source of sexual health information for young people, with 78.7% of students in the 2018 National Survey of Secondary Students and Sexual Health reporting they had accessed the internet to find answers to sexual health questions, although around half of these indicated they had only moderate levels of trust in online information (Fisher et al., 2019).



Children and young people are also taking and sharing images of themselves and making and sharing pornography, although may not define it in this way themselves or be aware of the implications of doing so from either a legal or social-wellbeing perspective. A 2019 study found that receiving sexually explicit text messages, photos and videos had been experienced by around half of students, and 32% reported sending a sexually explicit nude or near nude photo or video of themselves. Around one third had used social media sites for sexual reasons (Fisher et al., 2019).

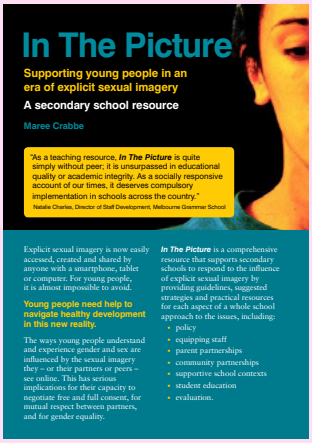
Technology also provides new tools (mobile phones, social media, recording devices) for domestic abuse, a known driver of PHSB.

A recent study showed children are involved in about a quarter of technology-facilitated domestic violence cases, either as victims of abuse themselves, or when used by perpetrators to facilitate abuse directed at their mothers (eSafety Commissioner, 2020a).

The eSafety Commissioner is leading concurrent development of an implementation roadmap for a mandatory age verification scheme that limits access to online pornography, and a Restricted Access System to limit the exposure of children and young people under 18 to pornography and other age-inappropriate online content (eSafety Commissioner, 2021a).

CURRENT PRACTICE EXAMPLE

Educating secondary school students about the impacts of sexually explicit imagery



Resource kit: It's Time We Talked, In the Picture

In The Picture is a comprehensive education resource designed to support Australian secondary schools to address the impacts of explicit sexual imagery. It provides strategies, checklists, guidelines and a range of practical tools to help schools create a whole-of-school approach to the issues that is tailored to their community and context. In The Picture is also used in a wide range of other settings, including in out of home care and in services working with young people with HSB. The resource seeks to support young people to build the critical media literacy and relating skills they need to navigate the influence of pornography and develop relationships that are safe, respectful and consenting.

In The Picture provides curriculum resources for teachers, tools to equip staff, resources to support parent and community engagement, and survey tools to evaluate changes in young people's knowledge. The resource was produced by Maree Crabbe of It's Time We Talked; a multi-faceted violence prevention initiative focused on addressing pornography's impacts on young people which Crabbe co-founded with David Corlett. In The Picture was developed in line with best-practice approaches to violence prevention and sexuality education.

CURRENT PRACTICE EXAMPLE

Supporting young people who have engaged in technology based PHSB and their families

Educational program: Inform Young People

The Lucy Faithfull Foundation provides a psycho-educational program in the UK and Ireland for young people in trouble with the police or their schools for technology based PHSB, such as sexting and possession of explicit images of children, or risky online behaviour including accessing adult pornography.

The Foundation provides a phone-based or face-to-face counselling service of 3-5 sessions, working to educate the young person and their carer or family members on problematic online sexual behaviour and legal versus illegal behaviours, and provides support and advice to prevent escalation or reoccurrence of PHSB. A phone helpline is available to the young person and their family after their sessions have ended. Inform Young People has not yet been formally evaluated, however anecdotal evidence suggests the program helps families talk about and reduce recurrence of the behaviours. (Hackett, 2014; Lucy Faithfull Foundation, 2020).

CURRENT PRACTICE EXAMPLE

Educating young people about technology based PHSB

Resource: eSafety's Best Practice Framework for Online Safety Education in schools

The issue of child sexual abuse has sometimes been addressed in broader violence prevention and online safety programs delivered in Australian schools. More recently there are examples of PHSB being addressed as part of a range of issues in education responses. An example is eSafety's Best Practice Framework for Online Safety Education (2020a), which provides a nationally consistent approach for educators to develop, assess or refine whole-school online safety education programs using evidence-based practices. This includes guidance on addressing age-specific risks of harm that young people may be vulnerable to and should be aware of, such as exposure to sexually explicit material, receiving or sharing unwanted contact or content and other sexual harms.

The Framework delivers on Recommendation 6.22 of the Royal Commission into Institutional Responses to Child Sexual Abuse. The Recommendation called for eSafety to oversee the development of a framework and resources that support schools in creating child-safe online environments.

Resource: eSafety website

The eSafety website also provides a range of downloadable resources for parents, educators and young people that address issues facing children and young people when they are using technology and navigating online safety issues. This includes classroom content that addresses unwanted contact, image-based abuse and respectful online relationships.

Taking Action: Primary and targeted prevention

'I think if I had sex education before everything had occurred, like obviously before I hit full on puberty, I think everything would have changed. I think, I'm not even sure if what had happened would have happened, because I would have known it was wrong, more so than what I did at the time. I would have known why it was wrong and why not to do it.' Young Person, male, 19, who sexually abused his sister (McKibbin et al., 2017)

The NSW Government is committed to empowering, equipping and supporting children and young people, their families, carers and communities in our prevention efforts and responses to PHSB. We recognise the serious and often lifelong impacts on victims of child sexual abuse, on children and young people who display PHSB, and the broader negative affect PHSB has on families, carers, the workforce and community.

NSW Government accepts the Royal Commission recommendation that prevention of PHSB is

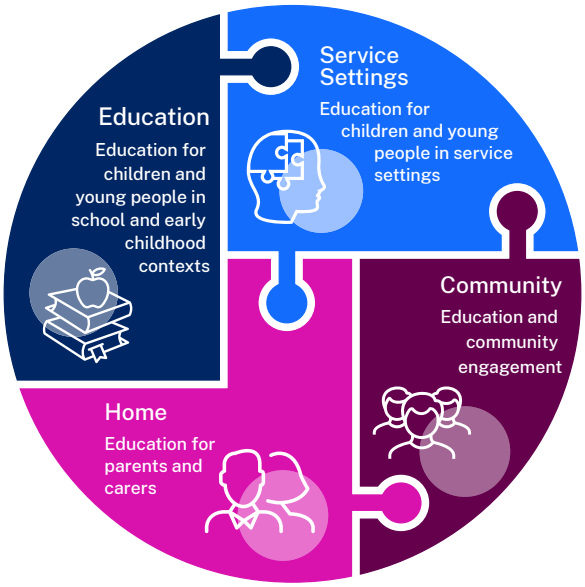


Figure 4 Four primary prevention settings identified in the literature

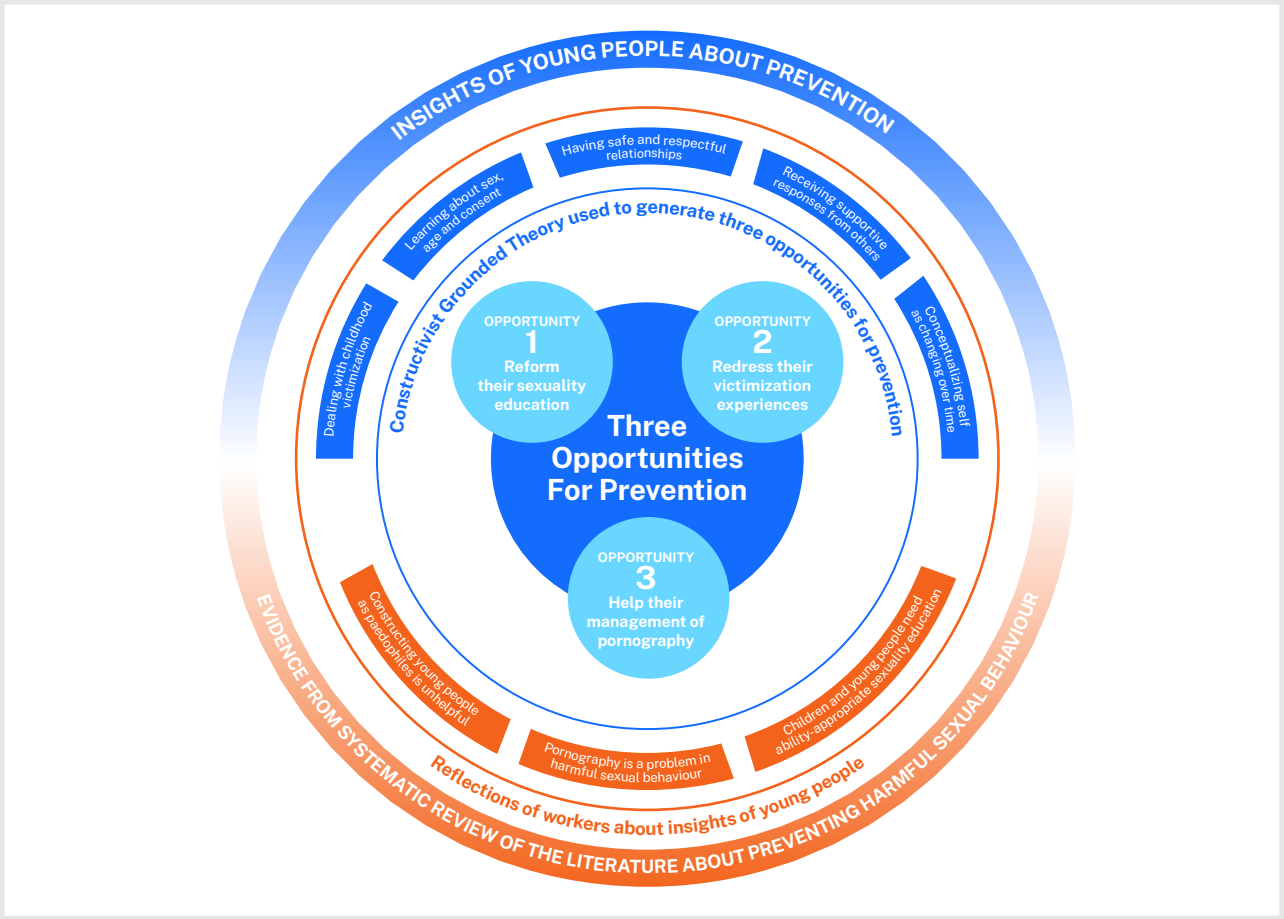


Figure 5 Three opportunities for prevention (McKibbin et al., 2017)

embedded in broader strategies to prevent child sexual abuse. Prevention of PHSB is possible when we take a whole of government, whole of community approach to address the attitudes, behaviours, practices and power dynamics that contribute to gendered and sexual violence.

A key aspect of the public health approach is the recognition that responding to a problem involves more than treating individuals who are already experiencing the problem – it must consider how the problem can be prevented from occurring. Research highlights three key opportunities (Figure 5) to prevent PHSB: reform sexuality education; redress victimisation experiences and; help management of pornography (McKibbin et al., 2017).

We need whole of population approaches to address the underlying cultural causes of PHSB and targeted approaches to meet the needs of priority populations and those at higher risk of developing PHSB.

The universal prevention approach supports activities for all children and young people, their parents and carers and the broader community – such as education on sex and healthy relationships and more targeted child sexual abuse awareness and prevention education. Opportunities for this begin in the early years and continue through to primary and secondary schooling ages.

Targeted prevention initiatives are also necessary for children and young people who are a priority for additional education and supports or whose specific needs, circumstances, context and/or lived experience must be considered.

The literature identifies four settings that primary prevention needs to be engaged with and delivered from: education settings, service settings, home (parental and carer education) and community (engagement and capacity building).

Education: Early childhood services and schools

The World Health Organisation (WHO) classified school-based programs to prevent violence within dating relationships as being effective in preventing violence (Australian Government, 2016:15).

There has been increased recognition of the need to include respectful relationships and gender equality education in school-based sex education. Programs generally involve techniques borrowed from psychoeducational theories, including cognitive-behavioural, behavioural and social learning approaches, however, there has been variation in components and topics that are covered (McKibbin et al., 2016).

PHSB cannot be prevented in isolation from broader efforts to address other forms of violence. The literature on addressing gender-based violence through schools indicates a whole school approach is most effective. The whole school approach addresses gender equality not only within the curriculum but built into the whole ethos of the school as well – focussing on 'changing the structures, norms and practices within our education system.' (Kearney et al., 2016).

Our Watch, an independent not-for-profit organisation of which all state and territory governments are members, is an initiative under the *National Plan to Reduce Violence against Women and their Children 2010-2022* (the National Plan). Our Watch undertook a review of national and international evidence on violence prevention in schools, which found that the education system can be a catalyst for generational and culture change, however 'short-term and ad hoc inputs in classrooms and schools tend to be unproductive in bringing about change' (Our Watch, 2021a). They developed a set of core elements of effective respectful relationships education in schools (Figure 6).

'With over 9,500 schools, 4 million students and 290,000 teachers across Australia, our education system provides near universal reach to children in their formative years and to adolescents creating their first intimate relationships...'

(Our Watch, 2021a).

Figure 6 Our Watch Core Elements of Respectful Relationships (Our Watch, 2021a)

The Victorian Government partnered with Our Watch to pilot a Respectful Relationships: Education in Schools (RREiS) program in Victoria. The evaluation has shown the RREiS program improves awareness, attitudes, behaviour and language of both staff and students around gender equality. The RREiS evaluation also noted improvements in classroom behaviour, and in students' understanding of violence (Kearney et al., 2016). The RREiS program is being implemented across schools and early childhood services across Victoria, with an investment of $82 million[7]. Implementation is supported by intensive training provided to over 1,950 government, Catholic and independent schools, a professional development program for early childhood educators, and a regional workforce to support schools and early childhood education settings to implement the program and strengthen family violence referral and response networks.

In addition to the Our Watch 'core elements', Letourneau et al. (2017) provides four key program design considerations for primary prevention activities for PHSB in schools:

1. **Program timing:** The onset of HSB peaks around 14 years of age, so school-based prevention and interventions should target children and young people younger than 14.
2. **Program content:** School-based interventions should explicitly address PHSB, particularly with older children (perhaps aged 10 and over). General abuse prevention content may be more appropriate for younger children. Other literature recommends age-appropriate foundational topics such as sexuality, gender, power, aggression, media influences, online safety and foundational learning, as well as critical media literacy are more appropriate for younger age groups (Crabbe and Flood, 2021).
3. **Participant gender:** School-based interventions should be delivered in mixed-gender classrooms. Although male children and young people are more likely to engage in PHSB, there are female children and young people who engage in these behaviours too. Furthermore, although the available evidence suggests school-based interventions have more impact on male children and young people, this impact is higher when interventions take place in mixed-gender settings.
4. **Parental involvement:** Parental involvement in therapeutic responses for children and young people who engage in PHSB and interventions for other behavioural problems experienced by children and young people is important, so it is likely parental involvement and engagement would be effective in school-based intervention contexts.

The NSW Department of Education also supports a whole school approach, with every part of the school community involved, from the principal, to staff, students and parents. They promote 'development of a school environment and culture that models safe and respectful practices and is consistent in dealing with incidents of bullying and violence is as important a teaching tool as the formal curriculum' (NSW Department of Education, 2021b). The 2021 Statement of Intent made by Government, Independent and Catholic Schools identifies their commitment to a whole of community approach to PHSB, involving parents and carers, students, schoolteachers and leaders, and collaborating with Aboriginal and other cultural representative groups, government agencies and departments and police.

CURRENT PRACTICE EXAMPLE

Educating young people about respectful relationships

Educational program: Sex & Ethics

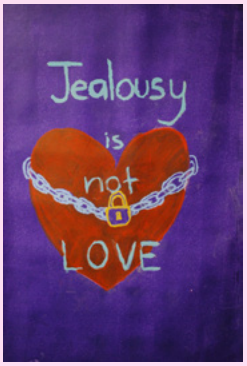
Sex & Ethics is a resource for educators, practitioners, and the workforce on sexuality and sexual assault prevention education, teaching young people aged 16-25 years ethical intimacy skills. It was developed by researcher Moira Carmody (University of Western Sydney) and research collaborator Karen Willis from Full Stop Australia, formerly known as Rape and Domestic Violence Services Australia (RDVSA). It aims to reduce coercion or unwanted sex, sexual violence and abusive relationships (Sex and Ethics, 2021). Research by Moira Carmody indicates the program teaches skills to actively shape participants' expectations about sexual intimacy and changing traditional gender stereotypes (Carmody and Ovenden, 2013).

The six-week program provides an ethical framework to inform young people's decisions around sex, relationships and consent.

7 https://www.premier.vic.gov.au/non-gov-schools-urged-take-respectful-relationships

CURRENT PRACTICE EXAMPLE

Educating young people about respectful relationships



Educational program: NAPCAN's Love Bites and Love Bites Junior

Love Bites is NAPCAN's respectful relationships education program for young people (11-17 years) that has been run in over 100 communities across Australia (Australian Government, 2016:9). Interactive and creative workshops and community campaigns are used to address knowledge, attitudes and behaviours of young people around relationship violence, sex and relationships. Evaluation of the program in one Sydney school showed it had a 'significant and positive impact on students' attitudes towards gender relations, and skills in having respectful relationships' (Flood and Kendrick, 2012:3).

A Love Bites Junior program is run for 11-14 year olds, with age appropriate topics such as jealousy, power and control in relationships, bullying, sexualised images, gender stereotypes and when to seek help (NAPCAN, 2021).

In partnership with Indigenous organisations, the Love Bites program has been adapted for Aboriginal communities, incorporating local language and stories, and delivered by facilitators with cultural knowledge. This aspect of the program has not yet been evaluated (Australian Government, 2016:9). The program has also been localised for certain areas and cohorts such as culturally and linguistically diverse and LGBTIQ+ groups in partnership with specialist community organisations.

Over 10,000 students in NSW participate in Love Bites programs annually (NAPCAN, 2021), with NSW Health providing trainers for the program.

Community engagement and community development

> *'Community engagement has a strong rationale and accumulating evidence of efficacy, and the potential to be a key strategy for improving outcomes for Australian children and their families'*
>
> (Moore et al., 2016)

There is growing recognition that community engagement is a necessary strategy for ensuring services are more responsive. Community engagement and community development is about seeking to understand community values, concerns and aspirations and incorporating them into the planning and implementation of initiatives and services. It requires an ongoing partnership approach.

Putting consumers at the centre of the services is a key priority for NSW Government, and for NSW Health this means designing our health system in partnership with patients and their families and carers, as well as the wider community (NSW Health, 2021). Given the evidence that effective PHSB responses must be holistic, flexible and culturally safe, seeking input from young people and the communities of care surrounding them is essential to the design of engaging and effective services. NSW Department of Education have developed a range of resources to promote 'student voice' and the active participation of students in the decision making in their school and learning (NSW Department of Education, 2021c).

CURRENT PRACTICE EXAMPLE

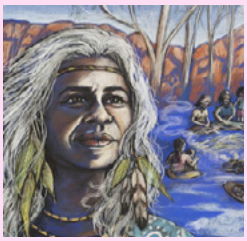
Engaging Aboriginal communities to prevent family violence and sexual assault

Community workshop: Strong Aboriginal Men

'Aboriginal men connecting and standing strong against domestic family violence and child sexual assault. These are a series of workshops delivered by Aboriginal men to Aboriginal men, talking in a safe way about the trauma associated with domestic family violence and child sexual assault. It is an opportunity to learn, change and grow for all our mob.'

Community workshop: Strong Aboriginal Women

'Aboriginal women connecting and talking about keeping themselves and children safe from domestic and family violence and child abuse. Helping women to say NO to violence.'



Artwork: Leanne Tobin

Engaging Aboriginal communities at every stage of service development – from defining the problem through to design, implementation and evaluation – will be crucial to the uptake and effectiveness of PHSB responses, and to ensuring the wellbeing of Aboriginal children, young people, families and communities (Australian Government, 2013).

A community engagement and development approach can also form part of our prevention and early intervention strategies. Engaging particular communities to raise their awareness of PHSB will increase the likelihood of early identification and facilitate early intervention. New Street Services, an existing PHSB program in NSW, delivers awareness-raising engagement activities in metropolitan, rural and Aboriginal communities (KPMG, 2014).

Community engagement strategies have also been effectively used as prevention interventions for other forms of violence, such as domestic and family violence. For example, the evaluation of the Strong Aboriginal Men and Strong Aboriginal Women community engagement programs (run by the Education Centre Against Violence), reported positive qualitative outcomes for Aboriginal communities (Carmody et al., 2014).

CURRENT PRACTICE EXAMPLE

Engaging CALD communities to prevent family violence and sexual assault

Initiative: Break the Silence: Culturally and Linguistically Diverse Communities Leading the Way to Respectful Relationships

InTouch developed and tested a first of its kind community-development approach to respectful relationships training in culturally and linguistically diverse communities. The approach is designed to be self-sustaining, steered by an ethno-specific Task Force Committee (TFC) set up in each community, with members including youth, elder and faith leaders, partnered with a local community organisation.
The Australian Government Department of Social Services (DSS) funded this initiative through Community Action Grants as part of the National Plan to Reduce Violence Against Women and their Children 2010-2022.

Training is provided to the TFC and community organisation, who then develop action plans in collaboration with their wider community and deliver awareness raising activities. This approach is designed to create community ownership of the program and outcomes, resulting in local champions who lead by example and continue to spread knowledge, information, and activities to promote respectful relationships and break the silence on family violence throughout their communities.

Break the Silence was tested over 30 months in 4 communities in metropolitan Melbourne, and evaluation findings showed the program activities had progressed discussions about gender equality, respectful relationships, and domestic violence in those communities. An increased awareness of respectful relationships was reported by 95% of people who participated in an activity run by their local TFC and community organisation (InTouch, 2014).

Parental, carer and residential care worker education on PHSB

We know how important parenting behaviours are in children and young people's development, behaviour, educational outcomes, mental and physical health

CURRENT PRACTICE EXAMPLE

Supporting young people in out of home care at risk of PHSB and sexual exploitation

Educational program: Power to Kids

The Power to Kids program implemented in MacKillop Family Services Residential Care homes provides one evaluated model of early intervention. The program focusses on training out of home care carers in a common understanding of PHSB, identifying PHSB, safety planning and risk management. The program also links carers and care teams with local specialist treatment services to discuss cases of concern, strengthen referral pathways and decrease response times in treating instances of HSB. It has a focus on strengthening carer's relationships with young people to counter grooming, and on equipping carers to engage children and young people in safety planning. This is reinforced through strengthening relationships with local PHSB, domestic and family violence (DFV) and child sexual exploitation (CSAE) professionals and police. Evaluation of the program found that children and young people were at decreased risk of HSB, as well as CSE and DFV (known drivers of HSB), that carers felt better equipped to discuss these issues with Young People, that children and young people were more knowledgeable about sexual health and their attitudes to sexual health and safety improved (McKibbin et al., 2020).

and socialisation. Evidence shows that parenting education can help modify parenting behaviours and is an effective way to create better outcomes for kids (Fox et al., 2015).

If parents and carers are educated and provided with the right tools, prevention initiatives can take place in the home through communication between children and young people and parents/carers (McKibbin et al., 2016). The goal of prevention interventions focussed on parents and carers is to provide non-stigmatising, non-judgmental, accessible and reliable (evidence-based) advice to all children and young people and their parents/carers to prevent PHSB from occurring.

For all of these primary prevention approaches to work, the workforce must be appropriately trained and resourced, especially the educators tasked with delivering psychoeducational interventions on sex and relationships as part of school curricula or specialist programs.

CURRENT PRACTICE EXAMPLE

Engaging young people at risk of PHSB through the arts

Initiative: Phunktional

Phunktional is an Australian not-for-profit arts company delivering long-term Community Arts and Cultural Development projects, tours educational theatre, and productions. Phunktional supports the creation of art as a lens for greater connectedness, community engagement and inter-cultural understanding.

One of Phunktional's dance projects, Beyond the Walls, was created in consultation with Aboriginal and Torres Strait Islanders artists and community, Muru Mittigar, NSW Police, Juvenile Justice Centres and Amnesty International. Beyond the Walls tells the stories of young people in custody shared with professional dancers over weeks of workshops inside Youth Justice Centres. It aims to positively empower culturally diverse, at-risk young people in custody in Sydney through performance.

#POINTS is another Phunktional production which uses rap, singing and break-dancing to engage high school aged young people about healthy and safe online relationships, the implications of their behaviour and new technologies. It was produced after the e-Safety Commissioner conducted a nationwide survey which found 94% of parents rated online safety as 'one of the primary parenting challenges of our time', and one in five children have experienced cyber-bullying while one in ten adults have experienced image-based abuse.

Key argument 3

Providing early responses will reduce negative impacts on children and families

Early identification of PHSB is key for the prevention of further harm, both for children and young people who engage in PHSB and other children who may be impacted. Early identification can reduce the likelihood of problematic sexual behaviour escalating to abusive levels (Hackett et al., 2019a).

Early identification and intervention of PHSB in children (under 10 years of age) and young people (10-17 years of age) has also been shown to reduce the likelihood of general offending as adults (Chaffin et al., 2008; Dopp et al., 2015).

The impacts on children and young people who have been harmed by PHSB from another child or young person are well documented

Child sexual abuse can negatively affect mental and physical health, relationships and sexuality, drug and alcohol use, connection to culture, education, employment and financial habits (Royal Commission, 2017, vol 3). It can result in Post-Traumatic Stress Disorder, and sexually reactive and harmful sexual behaviour (McKibbin et al., 2017). Young people who have experienced child sexual abuse have suicide rates 10 to 13 times the national Australian rates, and a large proportion experience suicidal ideation (Plunkett et al., 2021). Self-harming behaviour is also common (McKibbin et al., 2017).

There may be additional impacts for victims of sibling abuse, including 'family breakdown (for which the victim may be blamed) due to divided loyalties and disbelief; being forced to connect with the person (their sibling) who sexually abused them; feeling pressured to retract their disclosure' (Queensland Government, 2019).

It is not only the victim of sexual abuse who is impacted: their friends and family, and future generations can also be impacted in similar ways and areas of their life (Royal Commission, 2017, Vol 3).

There are also negative impacts on the life of the child or young person with the harmful sexual behaviours

These impacts range from their education, contact with the criminal justice system, facing stigma and isolation from their community, impacts on family and relationships, breakdown of OOHC placements. Feelings of shame or distress can be experienced in adulthood by some people who have displayed PHSB as a child or young person on mental health. Without access to appropriate treatment, behaviours may also escalate, causing additional harms.

Another key impact when PHSB is not recognised, reported or responded to, is the adverse environment or conditions frequently surrounding the child displaying PHSB are not being addressed. Children and young people who display PHSB are sometimes victims of child sexual abuse themselves and have often experienced other traumatic events or neglect.

Family members and carers are often under immense stress

Parents and carers are often 'early responders' to PHSB. The University of Wollongong's research showed 6% of reports about children and young people with PHSB were made by family (Spangaro et al., 2021). Carers were frequently at 'crisis point' following disclosure of PHSB as they dealt with the immediate emotional impacts, fearing for their child's safety and privacy, and concerned that they might be blamed for the behaviour (Spangaro et al., 2021). Parents and carers may experience isolation from their families or community.

> *'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 (Spangaro et al., 2021)

Tiered, collaborative responses support universal and generalist services identify PHSB and provide early help

A study of frontline workers' responses to PHSB identified four content areas workers need to be knowledgeable in to support identification and early response:

- the continuum from normal to harmful sexual behaviours, as well as an understanding of how PHSB manifests for specific groups, for example, children and young people with disability, Aboriginal children or children in OOHC
- a shared framework to inform responses that can be consistently applied when PHSB is witnessed, or disclosures are made
- the behavioural thresholds that trigger a tiered response and;
- an understanding of how PHSB impacts on victims, risks of escalation and recurrence of the behaviours, and the different contextual risk factors for PHSB.

(McKibbin and Humphreys, In press).

Shared tools to support screening and assessment practices

A collaborative, consistent interagency response, will contribute to the Premier's Priority to ensure that citizens of NSW only need to 'tell us once' by 2023.

High-quality assessment is an essential part of effective responses to PHSB. It ensures that the response (1) identifies and targets the range of issues in the child or young person's environment to support holistic responses and (2) ensures that the response is proportionate to the severity of the PHSB.

As the Royal Commission identified, the assessment process is the point at which linkages between generalist practitioners and specialist practitioners begins, and where generalist interventions are identified as of benefit to the child or young person, these should be supported by specialist practitioners (Royal Commission, 2017, vol 10:191).

Non-specialists likely to be involved in assessment and early support should be provided with resources and materials that guide their decision making, such as a Traffic Light tool (for example, True Relationships & Reproductive Health's Traffic Light Tool[8]). Approaches

8 https://www.true.org.au/Education/traffic-lights

Table 1 Three Tiered Screening and Assessment Model

Assessment action	Who	Resources required
Tier 1: Screening and early help assessment supports clarity of the level of concern about the behaviours and understanding of the context of the behaviours and child's needs. This determines if a report should be made to the Child Protection Helpline and/or if the child's needs should be met by generalist or specialist services	Teacher, health worker, other child-facing/frontline roles	Materials to guide decision making, such as: • the Traffic Light Tool • Mandatory reporter guide • Agency specific policy and procedures
Tier 2: Full psycho-social needs assessment	Counsellors, psychologists, social workers, youth workers, Aboriginal child and family workers. Some knowledge of PHSB required	A full psycho-social assessment should build on the above-mentioned screening processes. There is currently a gap in tools to support these "Tier 2" assessments where PHSB is a presenting issue.
Tier 3: Undertake specialist PHSB risk and needs assessment if behaviours have caused harm to another	Counsellors, psychologists, social workers, youth workers, Aboriginal child and family workers with extensive knowledge and skills in this area	Specialist assessments should build on earlier screening and generalist assessments. At any stage of the process where there are concerns about the safety of a child, the counsellor should apply the Mandatory Reporter Guide. Evidence-based assessment tools or questionnaires that can be used following appropriate training include: • Clinical judgement approaches • Actuarial tools • Structured Professional Judgement • Evidence based checklists

(Garrett et al., 2016)

may include 'psycho-education, behavioural strategies and parenting support' (May et al., 2020).

There are a number of standardised assessment tools to support PHSB assessment, however these have limitations in that they don't necessarily take a socio-ecological approach:

> *'Some assessment tools do not take enough account of variables such as age, gender, disability and cultural context, often leading to a choice of therapeutic intervention that is ineffective for a child. There is a need for well developed and contextually appropriate assessment tools that are supported by informed clinical judgement'*
>
> (Royal Commission, 2017, vol 10:15)

Development of a common structured assessment tool to assess and respond to PHSB within a socio-ecological framework would support universal and generalist services in NSW to apply consistent assessments (May et al., 2020).

Key principles to build into a common structured assessment tool and model include:

- paying close attention to child protection concerns
- using evidence-based assessment models
- involves a holistic appraisal of strengths, risks and needs, not just focus on the PHSB
- needs to support effective inter-professional communication (Hackett et al., 2019a).

The literature supports a three-tiered assessment model.

Royal Commission Recommendations about assessment

'Recommendation 10.2: The Australian Government and state and territory governments should ensure timely expert assessment is available for individual children with problematic and harmful sexual behaviours, so they receive appropriate responses, including therapeutic interventions, which match their particular circumstances.

Recommendation 10.4: State and territory governments should ensure that there are clear referral pathways for children with harmful sexual behaviours to access expert assessment and therapeutic intervention, regardless of whether the child is engaging voluntarily, on the advice of an institution or through their involvement with the child protection or criminal justice systems.'

(Royal Commission, 2017, Recommendations).

Building resilience and safety through a coordinated Team Around the Child and Family approach

> *'Multi-agency collaboration should be at the heart of a public health approach to children with harmful sexual behaviours. Child protection, police, health, therapeutic treatment services, juvenile justice and institutions where a child has exhibited harmful sexual behaviours will all have expertise and particular insight that can inform interventions for the child. Information sharing is key to achieving the best possible outcomes'*
>
> (Royal Commission, 2017, vol 10:13)

As stated in the NSW Government submission to the Royal Commission consultation paper in relation to criminal justice, 'a number of institutions have significant roles to play in responding to the issue of children with harmful sexual behaviours', and suggested that 'clarity of practice across institutions about what steps are appropriate and necessary is important' (Royal Commission, 2017, vol 10:139).

Addressing the complex drivers of PHSB requires a whole of community approach. There is growing consensus that no single service or service system has the capacity or expertise to respond to the multi-faceted nature, causes and effects of children and young people who display or engage in PHSB (Hackett et al., 2019a).

Quadara et al. (2020:80) reported that key to improving responses to PHSB is enhanced 'interagency collaboration, particularly in relation to human service agencies, child protection, OOHC workers, education and mental health services: shared principles and a shared understanding of therapeutic goals across these services and departments.'

The Workforce Survey identified clear interagency communication facilitates rapid response times. In some areas local relationships support collaborative, multi-disciplinary and inter-agency case planning. There is an opportunity to embed the mechanisms needed for multi-disciplinary planning at a system level. Stakeholders observed this works well at the tertiary child protection level through the Joint Child Protection Response Program (JCPRP) and supported implementation of a 'lead professional' or 'key contact' and 'team around the child' approach for cases that do

not meet the ROSH threshold.

A Team Around the Child (TAC)[9] model brings together a range of practitioners to support a child and their family, through the assessment and intervention process, coordinated by a lead practitioner who is appointed to: act as a single point of contact for the child or young person's family; coordinate early help and; develop a care plan, specifying needs, timeframes, intended outcomes and how the plan will be monitored and reviewed (May et al., 2020). It is important that the child/young person and family are considered a part of the TAC, alongside the team of interagency professionals.

This approach is effective in facilitating case coordination and support in a range of inter-agency settings and with children who have specific needs. The TAC model has been used in the UK within the child in need and child protection context, including by a number of councils where the TAC was tailored to specifically address PHSB.

> *'Our "love of silos" is a problem – very rarely a child or young person is going to have every other aspect of their life be perfect – therefore we need wraparound services to meet their and their family's goals'*
>
> Consultation participant

As noted in the Royal Commission 'no state or territory has a comprehensive and coordinated policy approach for preventing, identifying or respond to children with harmful sexual behaviours' (2017, vol 10:9). The comments in the Workforce Survey support this:

> *'We work with teenagers and often reports do not screen as ROSH [at risk of significant harm]. It is difficult to get students and parents to go to support agencies. If agencies worked within our school as part of our team there would be greater chance that students/families would seek support. Tele health does not work for the kids we work with [because] they refuse to sit down in front of a screen and work. It takes us many weeks, if not months to form relationships with our students to a point where they feel safe, valued and respected and start to engage with us.'*
>
> Workforce Survey Respondent

With the right training, resources and mechanisms for collaboration in place, early support from non-specialists for low-level problematic behaviours can be provided by a range of community and government providers, schools, police and health care workers, coordinated by the lead practitioner, according to the care plan.

The JCPRP provides an example of a collaborative service delivery model in place in the NSW child protection system. It provides a coordinated safety, criminal justice and health response to children and young people alleged to have experienced sexual abuse, serious physical abuse and serious neglect. The JCPRP is a tri-agency program delivered by the NSW Department of Communities and Justice, the NSW Police Force and NSW Health, which coordinates agency specific expertise around the child or young person's needs. The JCPRP ensures the victim's safety

9 A care model used globally, first developed in the UK by Peter Limbrick to meet support needs of children with disabilities. It has since been adapted in Australia in a number of states to coordinate interventions for children and families with complex needs (Early Childhood Intervention Australia, 2016).

is assessed, and their needs are addressed. There is an opportunity to leverage off this in NSW for children with PHSB by building in formal pathways to specialist assessment, case coordination and therapeutic support for the child or young person and their parents or carers through policy, practice and potentially legislation change.

Resourcing and building capability of generalist services to provide early support and programs

> *'We were told that many children do not require specialist, intensive therapy to address their harmful sexual behaviours. For some children, particularly those exhibiting problematic sexual behaviours where no other child was harmed, counselling from a generalist practitioner, with skills and knowledge in responding to harmful sexual behaviours, may be an adequate intervention.'*
>
> (Royal Commission, 2017, vol 10:191)

Research has shown early intervention programs which build social and emotional capability and resilience in children and young people and their families, and focus on key protective factors are effective at shifting the impact of disadvantage on life outcomes (Fox et al., 2015). We also know that parental or caregiver involvement is an important part of effective treatment programs (NSW Department of Family and Community Services, 2016).

The Australian Research Alliance for Children and Youth (ARACY) Better Systems, Better Chances report identified three optimal points for investment in prevention and early intervention for child and youth wellbeing: in antenatal to age five through universal services; in parenting using both universal, systems approaches and targeted intervention; and in universal and targeted mental health programs to prevent poor outcomes in adulthood arising from multiple risk factors and the cumulative effects of these (Australian Research Alliance for Children and Youth, 2015; Fox et al.,2015).

> *'There is evidence that prevention and early intervention services targeted at parents experiencing mental illness, substance abuse and/or family violence, transmits significant benefit to their children.... Prevention efforts to support parents in their own social, emotional and mental wellbeing have significant effects for protection of children from harm.'*
>
> (Fox et al., 2015)

Core requirements for effective early intervention at a system level include:

- A common approach to measuring outcomes and taking a data-driven approach to implementation, learning and design, to enable continuous quality improvement
- Creating consistent principles, processes and practices across the prevention, identification, early intervention and tertiary treatment phases and actors
- Governance models that allow tailoring for local contexts and decision-making to allow system barriers to be addressed at the local level
- Building the capabilities of organisations and practitioners, as well as of the system as a whole (Fox et al., 2015).

The Royal Commission heard from participants that in some cases it was more appropriate and practical for therapeutic treatment to be conducted by generalist practitioners, under the guidance of specialist clinicians, rather than to be delivered by the specialist clinicians themselves. The Royal Commission noted that generalist practitioners' skills in delivering therapeutic treatment could be enhanced through such guidance, in the form of supervision sessions, regular phone or face to face contact, or through training and development opportunities (Royal Commission, 2017, vol 10:192).

Key argument 4

Specialist treatment services can prevent harmful sexual behaviours from re-occurring or escalating and help victims recover and heal

While some children and young people's needs can be addressed through generalist responses, including case management and/or parental monitoring plans; other children and young people may require additional psychoeducation; and some may require specialist assessment and response (Hackett et al., 2019a).

'Specialist assessment can identify and plan interventions that are tailored to the child's particular needs, background, and situation so that the harmful sexual behaviours are more likely to cease and less likely to escalate' (Royal Commission, 2017, vol 10:80).

The NSW Ombudsman reported on the then Joint Investigation Response Team (JIRT) in 2017 and 2018 (The JIRT Partnership—20 years on), in which responses to children with HSB were canvassed. The NSW Ombudsman noted the gaps in the provision of service for children in contact with the criminal justice system and recommended agencies develop an integrated service response framework for children with HSB, which included a

'In Australia, studies of children with harmful sexual behaviours who have attended therapeutic treatment show low rates of the behaviours recurring post-intervention'

(Royal Commission, 2017, vol 10:79)

cohesive legislative and policy framework considering the use of treatment orders.

The Royal Commission made similar recommendations for a comprehensive government response to children with HSB, including 'timely expert assessment' for children with HSB, clear referral pathways into and adequate resourcing of therapeutic interventions.

Additional resourcing is required to build capacity in specialist counselling and support services to meet demand in NSW

While NSW has a number of existing specialist counselling and support services for PHSB, we need greater investment to meet the demand, and fill the gaps in service delivery for specific groups.

- NSW New Street Services were expanded across the state through the NSW Government response to the Royal Commission. New Street provides evidence informed 'tertiary' services, including specialist assessment and counselling to young people aged 10-17 years with HSB (and their families). New Street has been evaluated on three occasions (Vinson, 2000; KPMG, 2014; Laing et al., 2014), with the results demonstrating children who completed treatment were less likely to be reported to police for violent behaviours compared to matched controls (Laing et al., 2014). New Street Services are a valued source of expertise in this area and require additional resourcing to meet the demand by agency partners for case consultation and advice.
- The NSW Child Sex Offender Counsellors Accreditation Scheme (CSOCAS) provides voluntary accreditation for counsellors working with children with PHSB. CSOCAS promotes the wellbeing of children and young people through a public register of counsellors with the necessary knowledge and skills to work with young people who sexually offend against children. CSOCAS is undergoing a refresh to ensure it promotes the principles for therapeutic treatment recommended by the Royal Commission. The Scheme relies on the expertise of NSW Government clinicians to support the accreditation process. There are less than 50 accredited counsellors across NSW, the majority of which are NSW Health employees.
- Only a few Health and Non-Government services in NSW provide counselling to children under 10 years old with PHSB. NSW Health is developing a program to improve coordination of NSW Health and inter-agency responses for this group of children, and there is an opportunity to strengthen the capacity of services to undertake the direct support, counselling and psychoeducation for this age group.
- Stakeholders reported Sexual Assault Services (SAS) and Violence Abuse and Neglect services (VAN) services work well as referral pathways for children who have been sexually assaulted. Stakeholders called for better resourcing to help meet demand and specific community needs. Stakeholders noted more comprehensive state-wide clinical and cultural support for the services and an expanded workforce was likely to increase the quality and availability of support for victims and their families.
- The Victims Support Scheme helps people who are victims of a violent crime that happened in NSW, including child sexual assault or child abuse. The counselling is intended to help the victim of crime to recover from the psychological and emotional impacts of the crime. Counselling is also available for a parent or guardian of a child who has been sexually assaulted. Victims Services provides a list of counsellors who are suitably qualified and have been 'approved' to provide counselling as part of the Scheme. Counsellors are available across the State, however not in all areas. Victims need to apply for and meet the criteria to be accepted into the Scheme.

There are gaps in availability of holistic, trauma-informed specialist treatment services at the time young people and their families need to access them. This was a clear finding of the NSW Workforce Survey, with over half of the respondents reporting that it was

> The system is drastically under resourced and the fact children and young people who receive support are less likely to reoffend means the system in reality is letting our children and young people down… where is the flexible, responsive support to enable recovery and therapeutic interventions to mitigate the likelihood of sexually harmful behaviours continuing.
>
> Workforce Survey Respondent

not at all easy to access specialist services for PHSB. Responses showed service gaps are greater:

1. in rural and remote areas
2. for Aboriginal and Torres Strait Islander families – a lack of Aboriginal and Torres Strait Islander specialists and specialists with expertise in disability were mentioned in comments by respondents
3. for families from diverse cultural and linguistic backgrounds
4. for children with additional needs such as learning or developmental difficulties.

The greater difficulty of accessing specialist services in regional and rural areas was emphasised by respondents who recommended specific strategies be implemented to attract counsellors in these areas.

Investing in recruitment pathways that support the workforce to take up positions in specialist services and programs in these gap areas was seen as a priority. Strategies to better support the workforce in undertaking this complex work were also highlighted by survey respondents, to improve retention of the workforce.

> *'I would like to request that long-term vacant child related health positions in rural settings be prioritised to be filled. The big issue in some of our centres is that positions are left vacant for extended time frames.'*
>
> Workforce Survey Respondent

Positive outcomes are achieved through evidence informed assessment and treatment services

A strong evidence base to inform all policy design is the most critical component of an investment approach. The Royal Commission recommended a principles-based approach be used to guide therapeutic interventions and identified nine best practice principles to inform treatment of PHSB, relevant to children of all ages (Table 2).

The literature further identifies some overarching goals of treatment (Table 3).

In the last decade and a half, treatment approaches have generally transitioned away from drawing solely on individual behavioural modification models to more holistic, ecological frameworks that encompass the complex lived environments in which PHSB occur (Quadara et al., 2020). Specialist assessment protocols need to be holistic and flexible enough to detect issues like intellectual disability, child abuse, trauma, and other behavioural problems and consider the child or young person's context, including culturally safe definitions of family, when assessing protective factors.

Table 2 Best Practice Principles for Treatment of PHSB

Specialist interventions	All types of therapeutic intervention
1. A contextual and systemic approach should be used	6. Developmentally and cognitively appropriate interventions should be used
2. Family and carers should be involved	7. The care should be trauma-informed
3. Safety should be established	8. Therapeutic services and interventions should be culturally safe
4. There should be a focus on accountability and responsibility for the HSB	9. Therapeutic interventions should be accessible to all children with HSB
5. There should be a focus on behaviour change	

Table 3 Goals of interventions with children and young people with PHSB

Intervention Goals
Help young people understand and accept responsibility for their behaviour and develop strategies and coping skills to avoid future PHSB.
Promoting the physical, sexual, social and emotional wellbeing of children and young people who have sexually harmed/ abused.
For carers to acknowledge what their child has done, believe in and support change, and to take on responsibility for changing the context of the family.
To help children and young people with emotional regulation strategies, the development of empathy.
To help children and young people to develop healthy and respectful relationships.

(Hackett et al., 2019a; Quadara et al., 2020)

Therapeutic treatment needs to be delivered as an integrated whole of government program which includes availability of trauma-informed safety planning and supports that meet each child's specific needs. This includes integration of cultural healing frameworks to guide practice when responding to PHSB in Aboriginal and Torres Strait Islander, and culturally and linguistically diverse communities.

A public health model supports an alternative justice approach with diversionary programs and restitution or restorative justice as part of a broader therapeutic response.

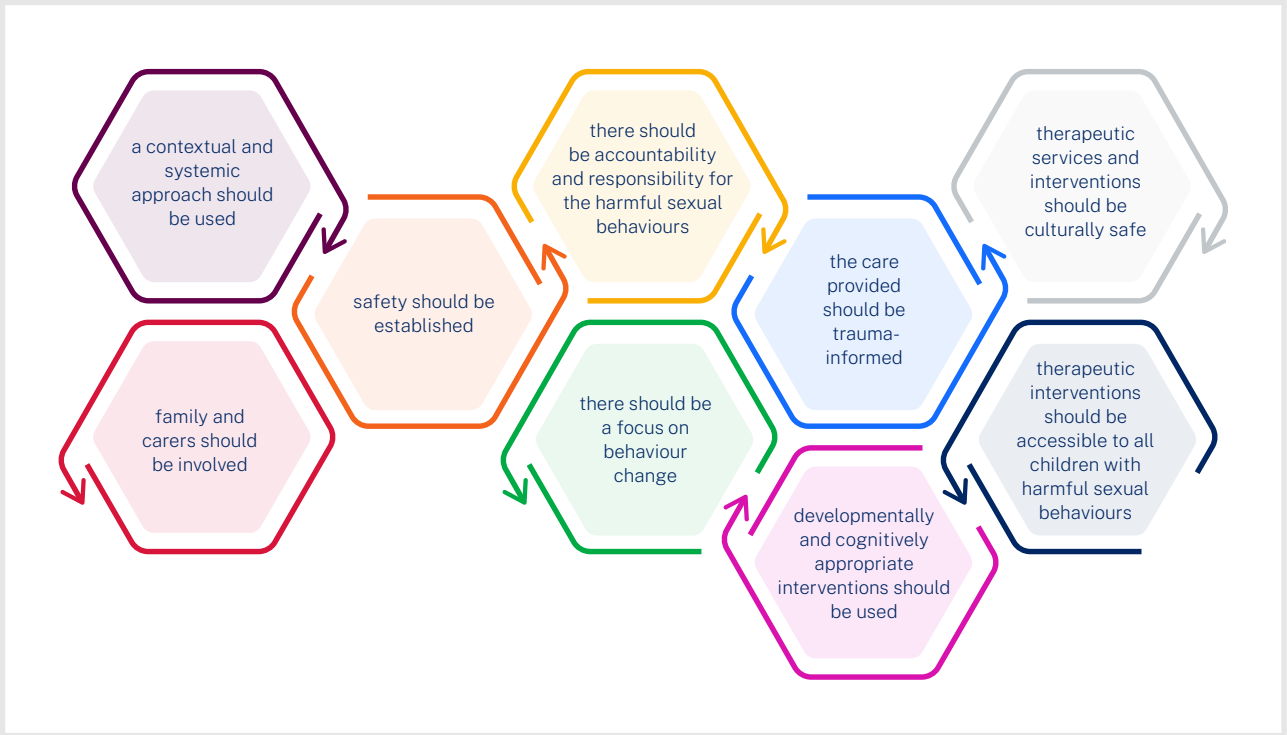


Figure 7 Key Components of specialist responses

Table 4 Key components of effective responses by age group

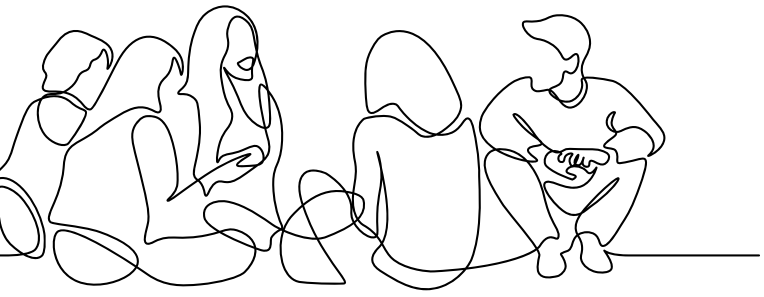
Children under 10	Young people 10-17
1. Using Cognitive Behavioural Therapy as a framework for interventions (Cox et al., 2018)	1. Designing interventions with ecological, holistic approaches (similar to Multi Systemic Therapy) that address the intrapersonal (cognitive, mental health and other psychological issues), familial and community-based challenges – this requires a coordinated interagency approach across different organisations and sectors (education, health, police, community services, justice)
2. Tailoring interventions for children and young people and their families that include the provision of, or strong links with, trauma- or culturally-informed services wherever necessary; (Cox et al., 2018) and	2. Tailoring interventions for children and young people and their families that include the provision of, or strong links to, trauma- or culturally-informed services wherever necessary; and
3. While not explicitly stated in the literature, it is plausible that parental involvement could improve the effectiveness of programs as it does with children of the same age who may experience other complex behavioural issues and young people (aged 10-17) who engage in PHSB (Cox et al., 2018).	3. Using high levels of parental/caregiver involvement, with other provisions in place to assist children and young people living in OOHC (Shlonsky et al., 2017).

(Hackett et al., 2019a; Quadara et al., 2020)

Treatment approaches also need to be sensitive to the age and developmental needs of the child or young person, hence there are some differences in recommended approaches for different age groups (Table 4).

Research conducted by the University of Wollongong on parents' and carers' experiences of PHSB services can also help to inform more effective current and future services in NSW. Themes emerging from this research show:

- parents and carers value being included in PHSB treatment services
- social stigma and judgemental language encountered in services is a barrier to accessing support
- fears about consequences (e.g., children being removed from their family) is one of the key reasons for not accessing support
- some carers have concerns over their privacy or the levels of information they are asked to provide
- there is seen to be a lack of specialisation for children. This correlates with the findings of the Workforce Survey, which showed access to specialist services was a common challenge (Spangaro et al., 2021).



'Parents/carers want to feel confident and empowered when they are seeking support and are responded to in a dignifying and non-judgmental manner.'

(Thompson and Want, 2020)

TREATMENT CASE STUDY

New Street Services

New Street Services provides a therapeutic intervention for children and young people aged 10-17 who have engaged in HSB and their families and/or carers to help the children and young people desist from the harmful behaviour. New Street has been in operation since 1998.

New Street Services have a defined, evidence-informed model of operation, working with each young person to assist them to understand, acknowledge, take responsibility for and cease the HSB. The model involves working with the whole family unit and engaging with other agencies and community services to sustain and support interventions. Central to the model is the principle of safety, both for any children that have been sexually harmed and for the young person engaged in the harmful behaviour who may themselves be a victim of abuse and neglect. New Street Services also provide a range of training and consultation services to other organisations, for example OOHC agencies.

The New Street service model evolves as new evidence becomes available, providing valuable learnings on the effectiveness of specialist services in improving outcomes for children and young people with PHSB.

A 2014 evaluation of participant outcomes found that out of the 170 young people who were receiving the service from 1 January 2010 to 30 June 2013, only three (less than 2%) subsequently reoffended. This suggests that 98.24% of participants who completed the program achieved a positive outcome compared to only 1.76% who experienced a negative one (KPMG, 2014).

The evaluation also suggested outcomes were much poorer for young people who did not access a service or who dropped out of New Street after entering the intensive support phase or extended assessment phase of the program. For these young people, the likelihood of achieving a positive outcome was reduced to 79-80% (KPMG, 2014).

Figure 8 depicts the experience of a young person with an autism diagnosis, who receives treatment from New Street.

JOURNEY MAP 4: Receives New Street Services (only ISLHD & WSLHD data available)

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.

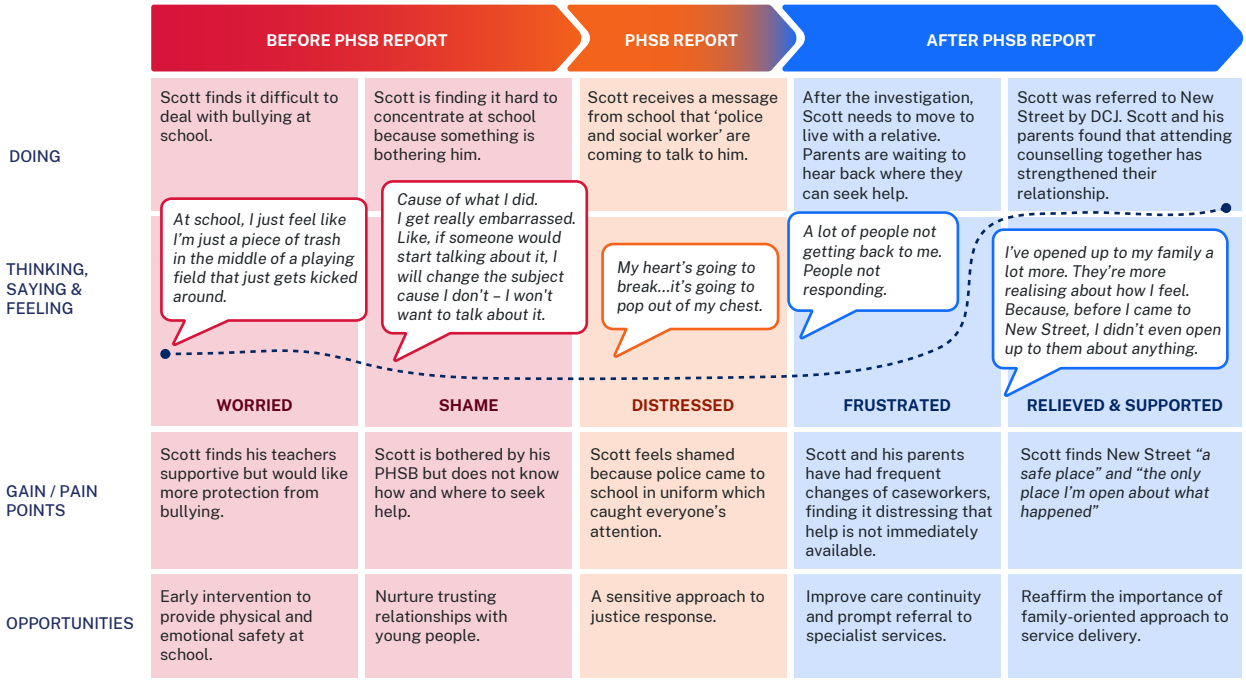


Figure 8 Journey Map - young person with an autism diagnosis in treatment for PHSB (Spangaro et al., 2021)

TREATMENT CASE STUDY
Office of the Children's Guardian

The Office of the Children's Guardian administers a scheme that supports young people and their parents/carers and professionals to find an accredited counsellor to work with them on their HSB against children.

Who benefits from the scheme?

- Children and young people - the counsellors in the scheme have the best interests of children and young people at heart.
- Courts - the courts know the counsellor is a recognised expert in the field.
- Clients - clients work with counsellors who have specialist skills and experience.
- Counsellors - counsellors are formally recognised for working in this highly specialised field.

How the scheme works

The NSW Child Sex Offender Counsellors Accreditation Scheme promotes the wellbeing of children and young people by establishing a public register of counsellors with the necessary knowledge and skill to work with young people who sexually offend against children.

The scheme has been reviewed and is being refreshed to ensure that accredited practitioners meet the recommended principles for treatment of children and young people, as outlined by the Royal Commission.

Key argument 5

Pathways into treatment can prevent re-harming

Current barriers in the criminal justice system and proposed way forward

Both the Royal Commission and NSW Ombudsman review of the Joint Investigation Response Team (now the Joint Child Protection Response Program) highlighted the gaps in service provision for children and young people with HSB who come in contact with the criminal justice system and recommended an integrated service response framework including legislative and policy considerations.

There is a strong evidence base supporting the role prevention and early intervention play in responding to youth offending. In their report on youth offending, the Queensland Government Statistician's Office (2021) highlight the effectiveness of intervening early, diverting away from criminal justice responses, applying a strengths-based approach and employing an integrated multi-agency response in achieving positive outcomes for children with offending behaviour.

The Royal Commission's Final Report noted the difficulties and problems associated with criminal justice intervention. This included the operation of doli incapax; the difficulties with procuring adequate evidence for prosecution; and the exclusion from diversionary options for children charged with sexual offending.

The Royal Commission recommended clear referral pathways to

'Children with harmful sexual behaviours should be able to participate in therapeutic intervention either voluntarily or, where required for their own wellbeing and the safety of others, compulsorily via the child protection or criminal justice systems. Victoria is currently the only Australian jurisdiction with all of these pathways to therapeutic intervention in place. The Victorian model also promotes the collaboration between formal systems – the child protection, criminal justice and therapeutic service systems – that is necessary for children with harmful sexual behaviours to access therapeutic intervention through these pathways'

(Royal Commission, 2017, vol 10:190)

assessment and therapeutic intervention, including through child protection and criminal justice systems., and raised two key issues for jurisdictions to address:

1. That children in contact with the criminal justice system, but who do not have a conviction may not be eligible for therapeutic treatment
2. That while only a small proportion of children with HSB require a criminal justice response, ensuring therapeutic treatment is available both during detention and after their release is critical (Royal Commission, 2017, vol 10).

The Royal Commission stated that drawing on the Principles of Youth Justice in Australia in relation to diversion of young people who have committed sexual offences might be useful, particularly to guide pilots of legislative and organisational change towards diversion. The identified principles include:

- 'Diverting children from the criminal justice system can be important to inhibit young people's offending trajectories and to rehabilitate them.
- Allowing young people to restore relationships and develop or maintain community connections may help them to become accountable for their offending behaviour.
- Enabling young people to continue education, training and employment is also likely to help prevent future offending' (Royal Commission, 2017, Appendices:426).

Both the Royal Commission and the NSW Ombudsman pointed to the Therapeutic Treatment Order (TTO) framework in Victoria as a model approach to provide appropriate care and protection orders for children in need of treatment and a clear pathway from criminal justice into treatment.

NSW Government, in response to the Royal Commission, stated that "Children with harmful sexual behaviours should have access to assessment and therapeutic intervention. Therapeutic interventions can help children to stop their problematic and harmful sexual behaviours and promote the safety and wellbeing of all children. Appropriate criminal justice responses are also required to provide justice for victims and survivors of sexual assault, and serve the interests of the community".

In the response, NSW Government committed to give careful consideration to options to implement clear referral pathways, including consideration of referral pathways through the child protection and criminal justice system, where participation in therapeutic treatment is required.

NSW agencies have undertaken significant work to improve responses to children with HSB. For example: the Department of Education has improved information exchange across the Department when incidents are reported; the Department of Communities and Justice has trained caseworkers to respond to children with HSB; and NSW Health has introduced state-wide access to New Street Services. Following the NSW Ombudsman's Report on JIRT, improvements to the operation of the JCPRP are ongoing.

Despite these improvements, the current pathways into therapeutic intervention for children who display HSB in NSW are complicated. These involve multiple agencies and points at which a referral into treatment or support may be overlooked or prohibited. The main determinants of the pathway depend on the availability and expertise of therapeutic services and whether: the child is under or over the age of 10; criminal investigations are underway; and whether there are criminal proceedings against the child for the HSB.

Children and young people in contact with the child protection and criminal justice systems in NSW

To inform the Case for Change and development of the NSW Framework, NSW Government commissioned the University of Wollongong to undertake research to better understand the experience of and pathways through the system by children and young people with PHSB. This research found that approximately three quarters of the children and young people in NSW (January 2018 to December 2019) reported to the child protection Helpline for PHSB were assessed as at ROSH Spangaro et al. (2021) noted this demonstrates that experience of victimisation is common among children and young people who display PHSB, although cautioned that 'it should only be understood as correlation rather than causation'.

Of the children and young people reported for PHSB to the Child Protection Helpline in the period of study, 11% had been in contact with the criminal justice system prior to that report, and 2.2% had 10 or more contacts (Spangaro et al., 2021). The criminal justice group were more likely to have a prior Helpline report unrelated to PHSB and higher rates of emergency department presentations and of being admitted into hospital for care. Despite this, over 45% of Child Protection Helpline reports in the criminal justice group were were not able to be allocated for a full child protection assessment. Spangaro suggests that 'not being allocated and subsequently not having access to services may be a risk factor for contacts

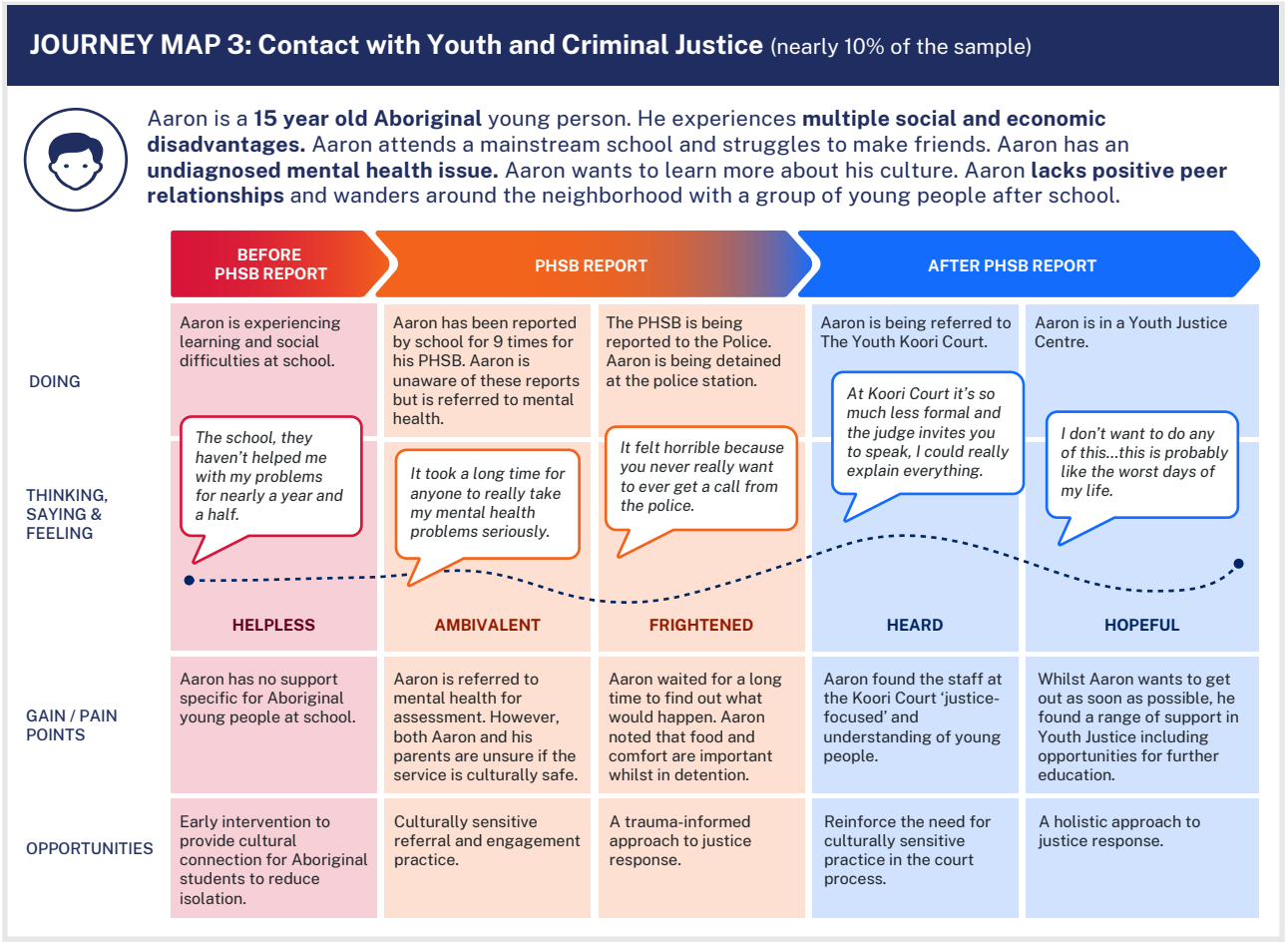


Figure 9 Journey Map - young person in contact with Youth and Criminal Justice (Spangaro et al., 2021)

with youth and criminal justice' (Spangaro et al., 2021).

Spangaro et al. (2021) also reported children and young people who had contact with the criminal justice system were predominantly male and '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.' There is a clear need to address the over representation of Aboriginal children in this group and to ensure specific and multiple treatment needs of children and young people who are in contact with the criminal justice system are addressed. To achieve this, NSW will need to shore up the identified gaps in treatment pathways.

From their research the University of Wollongong created journey maps that are representative of the interactions children and young people have with current services. Figure 9 depicts the experience of a young Aboriginal person in contact with the criminal justice system.

In response to the recommendations by the Royal Commission and the NSW Ombudsman, NSW Government also undertook a comprehensive review of policy and legislation models in related jurisdictions; and to identify gaps and opportunities in NSW to provide pathways to treatment for children over 10 years old with HSB, especially those who are in contact with the criminal justice system because that is where the key systemic barriers lie to receiving appropriate treatment.

The NSW Ombudman's review of the Joint Investigation Response Team[10] identified the majority of children with HSB are not subject to criminal charges and are eligible for therapeutic services. These children may be referred into treatment by a Community Services Centre (CSC), Local Health District Services (LHDS) or a school or family, and may participate in therapeutic treatment without a formal order.

A smaller proportion of children with HSB will come into contact with the criminal justice system and will be unable to access therapeutic services until their criminal proceedings are finalised. In the 2018-19 period, there were 314 children who were persons of

10 https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0017/133073/Annexure-2-The-JIRT-Partnership-20-years-on.pdf

interest under police investigation for HSB, and 149 children who had matters finalised in the Children's Court (noting there may be some overlap between the two). For these children, pathways into treatment are not currently available. Up to a quarter of all children who are prosecuted for sexual offending may not receive a therapeutic response.

There are many points in the system when a child may be exiting the criminal justice system without a clear statutory or recognised pathway into therapeutic treatment. The review concluded elements of the Victorian system may be usefully applied to the development of a treatment order regime in NSW.

Primarily, it may provide treatment pathways for children with HSB and divert them from the criminal justice system when appropriate. It was however identified that the following key issues must be considered if the Victorian model is adapted to the NSW context:

1. Nature of the HSB and the experience and views of victims: child sexual abuse is a serious crime, often having lifelong traumatic impacts on victims and their families. The majority of victims may have a pre-existing relationship with the child with HSB, and are often siblings—complicating issues around reporting, prosecution and the safety of the victim.
2. Interaction with legal principles: such as the presumption of innocence, especially when diverting a child prior to any admissions or findings by the court, and the interaction of any scheme with doli incapax.
3. There is a requirement for a proportional response. Victoria has instituted a concurrent voluntary regime, which it reports has greater use than TTOs.

All stakeholders consulted through the review were supportive of policy and legislation change to better support access to treatment for young people with HSB and agreed that development of clear thresholds to guide decisions on cases are needed in NSW.

The risks of not addressing the service pathways gaps are significant, as highlighted through consultation with NSW service users:

> *'I did have people [helping me] before I meet the [New Street] team, but they weren't doing enough to help me – if not for this team I don't think I would still be here'*
>
> (NSW Government, 2021b)

Community-based programs for adolescents who sexually harm have also been found to provide an effective low-cost alternative to residential or custodial treatment, which also means young people are more likely to be able to access the key protective factors of connection to family and community (Australian Institute of Criminology, 2018:8).

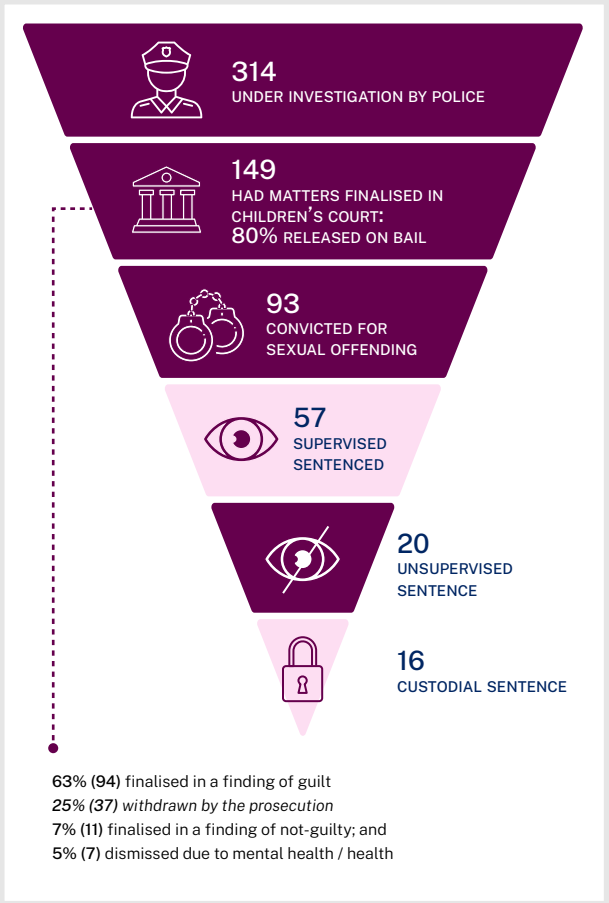


Figure 10 Number of children charged with HSB offences in the criminal justice system, NSW (2018-2019)

Key argument 6

We need to build a skilled and confident workforce

Impacts on the workforce supporting victims of sexual assault and children with PHSB

Working with children and young people who have experienced violence or abuse and/or who have caused harm to others or committed an offence can be rewarding, but it is also challenging.

A significant proportion of the children and young people with PHSB in NSW have experienced challenging, traumatic and distressing experiences in their lives. These are not considered 'normal' experiences, and when you hear about or experience these repeatedly it can impact your personal life, health and functioning. This is vicarious trauma.

It is widely understood that people working in counselling and trauma therapy are at risk of experiencing vicarious trauma if they do not have appropriate support, supervision and personal strategies in place. The literature on PHSB consistently shows that direct engagement with children and young people displaying PHSB has an adverse impact on the emotional and psychosocial wellbeing of professionals (Russell and Harvey, 2016; Clements et al., 2017; Lonne et al., 2019; McInnes and Ey, 2020).

There is also growing recognition that vicarious trauma can occur for anyone who is exposed to trauma or traumatic material for extended periods (Morrison, 2007). Research suggests that first responders (such as educators) are at increased risk of experiencing vicarious trauma, requiring supervision and support through peer networks (McInnes and Ey, 2020). Many professionals find themselves trying to balance and meet the needs of children who have been harmed, are at risk of harm and those of the child or young person with PHSB. This can be stressful if there are no clear policies and guidelines in place and the right supports and resources are not provided.

There is relatively little literature on training professionals to work with children and young people with PHSB (Hackett et al., 2019a). However, there is some evidence about how organisations can create the supportive environment and resources to prepare the workforce and to prevent and manage vicarious trauma. The literature identifies the follow actions:

- supervision, case consultation and peer to peer training and knowledge sharing opportunities

- organisational recognition of the impact this type of work can have (the organisation does not 'normalise' vicarious trauma)
- evidence-based training and professional development, which is evaluated to assess its impact
- de-briefing and reflection processes
- creating diversified caseloads, ensuring practitioners work with a variety of clients, rather than with only those with high levels of trauma, or with a diversity of tasks to reduce exposure to trauma
- creating an organisational culture that values staff care and safety
- recognising that everyone who works with children and young people with PHSB needs support
- providing specific training for those caring for higher risk groups, such as children and young people in OOHC (Morrison, 2007; Hackett et al., 2019a).

Specialist workers have reported engaging in varying degrees of formal supervision and peer supervision, with those who did explaining they found it central to managing their work and maintaining professional levels of detachment (Russell and Harvey, 2016). Some researchers suggest promoting staff resilience is essential to building an effective, stable and skilled workforce (Lonne et al., 2019).

Building capability in the workforce to prevent and safely respond to PHSB

A high proportion of respondents (48%) to a NSW Government commissioned sector-wide workforce survey provided comments on their lack of access to specialist advice about responding effectively to PHSB concerns for children and young people.

Respondents were also asked to provide open-ended commentary on what helped or hindered access to appropriate services for children and young people affected by PHSB. Answers to this question were clustered around lack of specialist resources and services particularly in regional/rural areas, lack of funding and issues with communication and timeliness of response.

An effective public health approach to PHSB requires that the workforce be equipped with the knowledge, skills and confidence to respond appropriately to PHSB when it is encountered, and to collaborate to ensure the child or young person and their family receives appropriate and timely support. Increasing workforce capability and capacity will require:

- investing in workforce expansion to address unmet need
- building capacity of service providers to deliver new support models involving interagency and community collaboration
- building the skills and capabilities of workers in delivering services that are trauma-informed and violence-informed, strengths-based, child and family-focused, culturally competent and culturally safe.

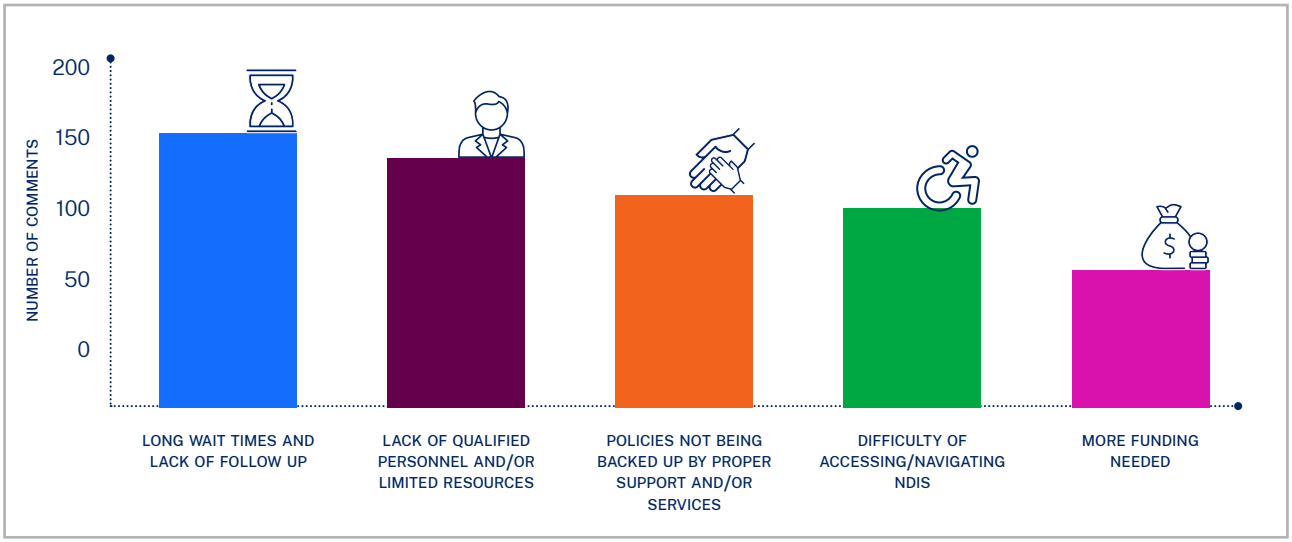


Figure 11 Comments on barriers to responding appropriately to PHSB

There also needs be increased capacity and capability to respond appropriately to the specific needs and circumstances of Aboriginal children and young people, families or carers and communities, children and young people with disability and their families or carers, as well as those from culturally and linguistically diverse backgrounds.

Only 36% of respondents had any training in working with children displaying PHSB in the last 2 years. NGO respondents were more likely to have received training than other groups (48%)

70% of respondents reported that it was not easy to access good quality training and professional development regarding how to respond to PHSB behaviours.

NSW Workforce Survey 2021

Training, education, access to resources and the integration of multi-disciplinary and interagency approaches are regularly called for in practice frameworks (South Australia Department of Education, 2019; Hackett et al., 2019a) and guidelines around how to respond to PHSB (Hall, 2006). This recommendation is well-supported in the research literature (Martin, 2014; Masson et al., 2014; Nixon et al., 2019; McInnes and Ey, 2020).

Workforce Survey results indicated low rates of recent training and a perception that it is difficult to access good quality training.

Workforce Survey findings suggested that when training was accessed, this significantly increased confidence and understanding of dealing with PHSB. However, training had less of an impact on a person's confidence in managing PHSB in a classroom environment and delivering therapeutic interventions.

Workforce Survey respondents were asked about their interest in training topics. Of the ten provided topics, four emerged as the most needed, with some differences as to which was most preferred by agency and sector. These were:

- how to talk to children about their behaviours
- how to talk to parents/carers
- early intervention approaches
- understanding and identifying PHSB

Findings from another NSW study of workforce needs regarding PHSB reported similar findings. Workers lacked knowledge and confidence in identifying

whether a behaviour was harmful or problematic and because of their uncertainty preferred to leave it to specialists to respond, which increased the delay in intervention. They also identified that different worker functions required different knowledge and resources, and that training suitable to their role and responsibilities was required (Thompson and Want 2020).

As an integral pillar of its actions towards ensuring all children and young people with PHSB receive support that meets their needs, the NSW Government is committed to ensuring the broad workforce is confident, competent and consistent in its awareness and understanding of PHSB and has capacity to provide a respectful, culturally safe and trauma-informed response using evidence-informed practice approaches.

NSW Department of Education provides annual mandatory Child Protection training for all staff and published the 2022 Child Protection Update focusing on PHSB to support staff to recognise indicators of PHSB and respond appropriately

Key argument 7

Committing vital resources now will deliver benefits and cost savings in the future

The costs of inaction and ineffective services are significant. PHSB adversely affects the social, emotional, and cognitive development of child and adolescent victims.

According to some estimates, the annual budgetary cost of unresolved childhood trauma and abuse in adults in Australia could be as high as $24 billion (Kezelman et al., 2015) (Figure 12).

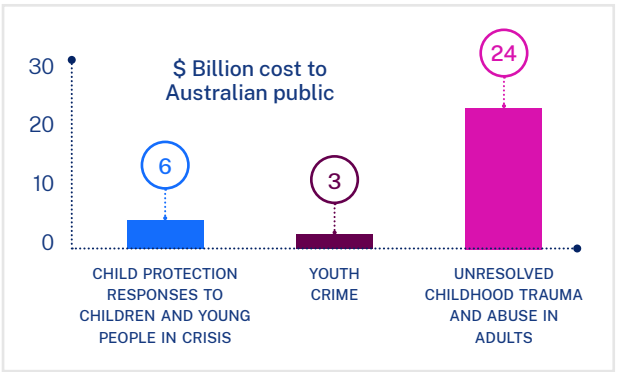


Figure 12 Annual cost to Australian Public (Teager et al., 2019; Kezelman et al., 2015)

The landmark *Forecasting Future Outcomes – Stronger Communities Investment Unit 2018 Insights Report* identified that 7% of children, young people and young mothers in NSW are expected to experience the poorest outcomes later in life and make up about 50% of the estimated future cost for NSW services (Table 5).

Forecasting Future Outcomes included consideration of the service pathways and outcomes of vulnerable adolescents aged between 10 and 14. The 'vulnerable young adolescents' cohort was defined as having been assessed as at risk of significant harm in the five years prior, and/or having experienced justice system interactions and/or having experienced parental risk factors associated with interactions with the criminal justice system, mental illness, alcohol and drug dependence or domestic violence. The study also considered pathways for vulnerable young people aged 16 to 18 who had experienced interactions with the justice system and/or had been assessed as being at risk of significant harm (Taylor Fry, 2019).

The total cost to government of the 10 to 14 cohort at age 40 was estimated at $25.1 billion (average

$344,000 per person) which was $13.6 billion more than a comparison group (equivalent to an average difference of $187,000 per person). For the cohort aged 16 to 18, costs to government were estimated at $11.5 billion (average $382,000 per person), which is $7.1 billion more than the comparison group, equivalent to an average difference of $235,000 per person.

Poorer social and economic outcomes underlie the high forecast service costs for vulnerable groups. For example, the study found that vulnerable young adolescents aged 10 to 14 are:

- 2.1 times more likely to interact with the justice system in the future, and 3.8 times more likely to enter custody than those in a comparison group
- Females are 5.4 times more likely to have children who eventually enter OOHC, and are 2.4 times more likely to become young mothers
- 3.4 times more likely to use social housing services in the future
- 2.5 times more likely to have alcohol and other drugs related hospital admissions in the future, and 2.3 times more likely to use mental health services (NSW hospital or ambulatory)

In addition, only 48% of vulnerable young adolescents were projected to complete their Higher School Certificate, compared to 63% of the comparison group. Overall future welfare costs for vulnerable adolescents were estimated 1.8 times higher than those of the comparison group.

There is significant overlap in the characteristics and pathways of vulnerable children and young people assessed as at risk of significant harm considered in the Forecasting Future Outcomes study and the characteristics and pathways of young people with PHSB identified in other research and evaluations.

Children and young people who engage in PHSB can also experience a range of poor social, educational and health outcomes if not provided with therapeutic intervention (Letourneau et al., 2014; Hackett et al., 2019b). Over half of children and young people reported to the NSW Child Protection Helpline in the study period had presented in a hospital emergency department at least once, and 42.1% were earlier listed with the Helpline for other child protection concerns (Spangaro et al., 2021). The approximate cost per emergency department presentation in 2018-19 in NSW was $700[14].

Many children and young people with PHSB come into contact with child protection and/or justice systems (KPMG, 2014). An analysis of the NSW Department of Communities and Justice ChildStory data identified 5,105 children and young people who displayed PHSB from 7,440 Helpline reports made within a 2-year study period (January 2018 to December 2019).

14 National Hospital Cost Data Collection Report, Public Sector, Round 23 (Financial year 2018-19) Infographic: https://www.ihpa.gov.au/publications/national-hospital-cost-data-collection-report-public-sector-round-23-financial-year

Table 5 Comparison of total estimated future cost of each vulnerable group to its comparison group

Group	Cost	Comparison	Difference
Children and young people affected by mental illness	$55B	$32B	$23B
Vulnerable young children age 0-5	$40B	$24B	$16B
Vulnerable young adolescents	$25B	$12B	$14B
Vulnerable young people transitioning to adulthood	$11.5B	$4.4B	$7.1B
1000 individuals with highest estimated service costs	$2.3B	$0.4B	$1.9B

Note: Each of these vulnerable groups has defined risk factors. These include: parental risk factors, perinatal risk factors, interactions with the justice system, assessment at Risk of Significant Harm+, use of mental health services, mothers aged 21 years or younger and their children.

(Taylor Fry, 2019)

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). Nearly 75% of children and young people reported were male, aged between 10 and 13 (Spangaro et al., 2021).

Almost 11% of the 5,105 children and young people identified in ChildStory, also had contact with the criminal justice system prior to their PHSB report (Spangaro et al., 2021). These children may enter OOHC or youth justice facilities to ensure their safety and the safety of other children and young people.

The social, health and economic costs of entering either OOHC or youth justice detention are significant. The Independent Review of Out of Home Care in New South Wales found the average costs for a child in OOHC each year were between $27,000 to $41,000 (Tune, 2018). On average, the costs of holding a young person in juvenile detention are over $500,000 per year (Productivity Commission, 2016). There is evidence that therapeutic interventions with children and young people are more cost-effective than punitive responses (Dopp et al., 2020). Failing to appropriately respond to PHSB increases the likelihood of a child or young person experiencing negative life outcomes.

We know what works

> *'Getting it right in the early years reduces downstream expenditure on remedial education, school failure, poor health, mental illness, welfare recipiency, substance misuse and criminal justice. Expenditure on evidence-based prevention initiatives can reduce incidence and prevalence at a population-level. It is most cost effective to invest in early intervention that resolves issues as they emerge and are malleable, rather than responding to crisis, toxic stress and trauma, which is both more challenging and more expensive to resolve.'*
>
> (Fox et al., 2015)

Investing in a public health approach to prevent and respond to children and young people with PHSB provides NSW Government with a compelling opportunity to avoid high service costs, deliver greater return on investment and – most importantly – contribute to achieving improved life outcomes for children, young people and their families. Evidenced-based interventions have proven highly successful in reducing PHSB in children and young people (KPMG, 2014).

The Evaluation of New Street Adolescent Services, identified potential cost-benefits associated with improved education pathways for young adults and reduced future costs associated with health care, child protection and crime. The expected net benefit over a ten-year period for a young person completing the New Street program was significantly greater than for a person who dropped out or had no service access at all (KPMG, 2014).

The specific benefits associated with improved participant pathways and reduced service costs over time include:

- the **expected earnings** that are conferred from higher levels of education, as a result of a greater proportion of young people being able to complete high school and enter further study (university or vocational)
- **avoided health costs**, which reflect the range of health and mental health issues experienced by a young person, especially as a result of previous trauma, if not counselled
- **avoided costs of crime**, this is because a young person, if their range of personal issues is not effectively addressed, may sexually reoffend and commit other crimes. There is literature indicating the types of crime that are linked with sexual offending/reoffending. Crimes with the most marked elevation among child sexual assault cases compared with the general population were sexual offences, violent offences, drug offences and theft. The costs of crime include police costs in responding to an incident, lifetime victim costs and medical costs, and lost productivity for the offender
- **avoided child protection costs** A significant number of participants are in care arrangements, including foster care, kinship care, residential care and high-cost residential care. It is understood that a proportion of these participants have been removed from their family or caring arrangements as a result of displaying sexually harmful behaviour. Therefore, if sexually harmful behaviour can be addressed, the costs associated with caring arrangements can also be avoided (KPMG, 2014).

Next steps towards healthier, safer lives for children and young people

We commit to putting the child at the heart of all decisions as we support them and their families towards safety and wellbeing, including their cultural safety. This means understanding trauma and its impacts, and placing empathy and respect at the centre of all aspects of practice and service system response.

Informed by the understanding that children and young people's behaviours are related to social and environmental factors outside of their control, we are committed to delivering strengths-based, tailored and proportionate approaches to address individual needs and enable equitable outcomes and access for all children and young people.

We will work to develop mechanisms for collaboration across government agencies, non-government organisations and communities, starting with the development of a framework. Building on existing and emerging evidence, with input from young people and relevant stakeholders, we will design tools, resources and programs, and will continue to learn from the implementation of these to inform future policy and practice. Monitoring and evaluation will be an essential part of quality improvement and will tell us whether our approaches are working and how we may need to adapt them over time.

Invest, innovate and evaluate

Primary and targeted prevention

Public recognition and attention on the issue of PHSB is growing, and young people themselves are calling for earlier and more effective education on relationships and sex. We must invest in prevention activities to improve understanding of PHSB and promote safe, healthy relationships and sexual behaviours. Investing in preparing the workforce, particularly educators and OOHC workers, is also key.

Universal and targeted community prevention campaigns and programs can draw on learnings from existing prevention programs, such as the Power to Kids program[11] in OOHC, the Respectful Relationships in Schools program, the Strong Aboriginal Men and Strong Aboriginal Women programs run by the

11 https://www.mackillopinstitute.org.au/programs/power-to-kids/

Education Centre Against Violence, and awareness raising programs run by New Street Services.

Schools will be supported to take a whole-of-school, whole-of-community approach to respectful relationships and sexuality education. NSW will build on the existing work in this area, under the Statement of Commitment and will look to the evidence base in doing so. Victoria's Respectful Relationships: Education in Schools[12] program has provided evidence of what works in school prevention programs and the scale of investment needed and will continue to do so as it is implemented. Adaption of programs for NSW and design of new programs will involve the voices of young people, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, people with disability and their families and carers, young people and workers and carers in the OOHC system to ensure they are effective.

Targeted prevention programs will focus on the needs of the children, young people and families who are at higher risk, displaying one or multiple risk factors for PHSB. Approaches will be culturally safe and grounded in a socio-ecological view. What we know about the positive impacts on children of providing education and supports to parents provides a strong rationale for continued investment in and growth of universal health, parenting and education programs.

Monitoring and evaluation of these and newly designed programs will inform innovations to create programs that are maximally effective and direct investment to where it is most needed. There is an opportunity for NSW to lead the development of an evidence base around effective approaches to preventing PHSB through community engagement and parent education and engagement.

Identification and Assessment

Creating tools for screening and assessment and investing in training the workforce in their use will ensure consistency of PHSB assessments across NSW, limiting harms to children and young people. Developing a NSW specific Traffic Light tool[13] will help to embed consistent understanding and language around the continuum of sexual behaviours.

Investing in developing a NSW wide response model will clarify the roles and responsibilities of the workforce and streamline referrals, ensuring children and young people and their families and carers have the support they need to prevent further harm. The response model will contain mechanisms to coordinate collaboration, such as the Team Around the Child model[14], which is coordinated by a lead practitioner.

Building an online hub of information and resources for young people, families and professionals will support a shared understanding of PHSB and promote pathways into support.

Early Intervention

Early support can be provided by non-specialists if we invest now in community education, workforce training and toolkit development. Existing tools can be reviewed to assess whether improvements can be made to cultural safety and responsiveness.

Early intervention should be holistic, focusing on children and young people who have displayed PHSB, but also on supporting parents, and providing training for OOHC workers and carers.

Leveraging necessary supports across the service system for children and young people and their family/carers will require a governance model that works to create the mechanisms for collaboration, while remaining flexible enough to allow tailoring for local contexts. With the right governance model and investment in place, we can begin building the capability of organisations and the workforce, as well as the system itself.

Investment in monitoring and evaluation of early intervention strategies should be undertaken to inform program innovations and guide resource allocation.

Tertiary Response

Existing high-quality specialist services can be grown and further developed to meet the need and address service gaps, growing service to regional areas, reducing wait times and creating more opportunities, training and pathways to accreditation and employment of Aboriginal and Torres Strait Islander workers, and those with expertise with priority cohorts. Creating a network of support for professionals will reduce vicarious trauma and losing staff to burnout.

A range of pathways into treatment will be developed that address current service gaps and promote diversion away from the criminal justice system, where appropriate.

12 https://www.education.vic.gov.au/about/programs/Pages/respectfulrelationships.aspx

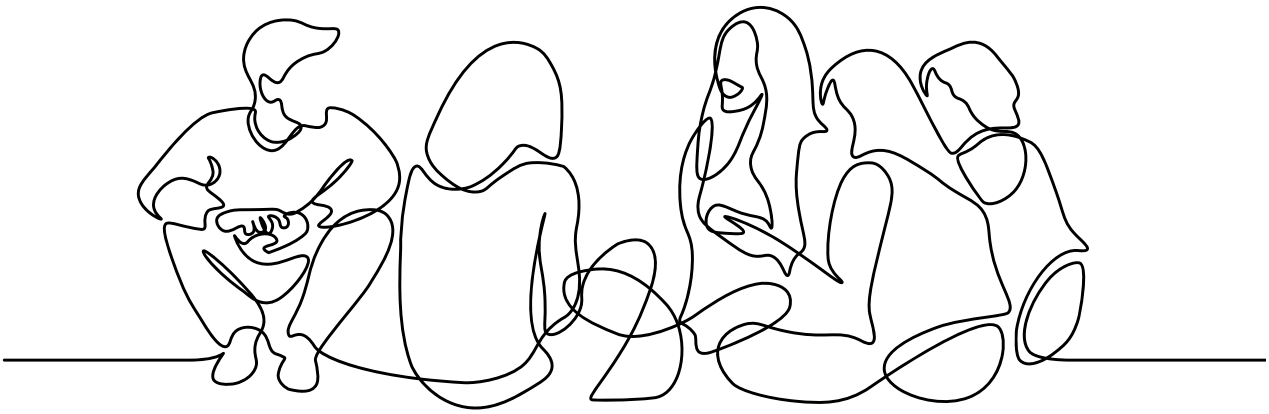
13 An example is the True Relationships & Reproductive Health's Traffic Lights® https://www.true.org.au/traffic-lights

14 https://www.tacinterconnections.com/index.php/tacmodel

Evaluation of New Street Services has shown the economic logic in investing in specialist treatment, and commissioning future economic and outcomes evaluations of services will continue to provide the evidence needed to guide the design of effective treatment programs and assess social return on investment.

Our commitment

We are committed to working together to make the changes young people, parents and carers and the workforce are calling for. It will take all of us together to transform our culture, systems and services to create safe environments free of stigma and shame that empower children and young people to share their experiences and seek support, and to meet the needs of victims and survivors of sexual abuse.



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