Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

WITNESS STATEMENT OF JENNY WING

I, Jenny Wing of [redacted] in the State of Victoria, do solemnly and sincerely declare that:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2. I make this statement in my capacity as the Chair of the Victorian Harmful Sexual Behaviour Network and as the General Manager of Therapeutic Services for the Australian Childhood Foundation.

Background and qualifications

3. I am a strategic organisational leader with expertise in assessment and therapeutic approaches for children and families addressing the challenges of developmental trauma, sexual assault, harmful sexual behaviours and sibling sexual abuse. I have presented my work at national and international conferences, and regularly provide training and consultation to professionals across the sexual assault, child welfare, early childhood, and education sectors.

4. I have worked in various roles focusing on issues of child protection, out of home care, family violence, sexual assault and harmful sexual behaviours.

5. I am currently employed as General Manager, Therapeutic Services at Australian Childhood Foundation (**ACF**). I hold responsibility for development and implementation of therapeutic programs for children and young people who have experienced trauma across Victoria and Tasmania.

6. Since 2020, I have been the Chair of the Victorian Harmful Sexual Behaviour Network (formerly known as CEASE) and a board member of the peak body Sexual Assault Services Victoria.

7. I have the following qualifications:

   (a) Bachelor of Social Work from Monash University;

   (b) Associate Diploma in Professional Writing and Editing from RMIT University; and

(c) Graduate Diploma in Family Therapy from La Trobe University.

Harmful Sexual Behaviour Network

8. Sexually Abusive Behaviour Treatment Services (**SABTS**) have operated in Victoria since the early 2000s. SABTS address problem sexual behaviour and sexually abusive behaviour in children and young people, and help families and carers to understand and support the child or young person to change their behaviour.

9. The Victorian government funded a statewide therapeutic service system in 2007 to deliver treatment services to young people aged 10-15 years who had engaged in harmful sexual behaviours. There are 12 funded services located throughout Victoria, servicing the 17 regional Areas across the 4 Department of Families, Fairness and Housing (**DFFH**) Divisions. One of these services, the Male Adolescent Program for a Positive Sexuality (**MAPPS**), is specifically funded to work with young people subject to Youth Justice Orders related to sexual offending. All other 11 services may also engage this cohort of young people, in addition to clients being mandated to attend treatment through a Therapeutic Treatment Order (**TTO**) or as voluntary clients referred by both statutory agencies and the community.

10. Typically, one full episode of treatment occurs across a 12-18 month period. Treatment services are delivered by specialist sexual assault clinicians who are degree qualified (predominantly in Social Work, Psychology, Occupational Therapy or Criminology) with additional post-graduate studies in therapeutic modalities such as art therapy, sensorimotor therapy, Dyadic Developmental Psychotherapy, play therapy and music therapy.

11. The *Children, Young Persons and Families Act 2005* (**CYF Act**) sets out a pathway for young people who have engaged in harmful sexual behaviour to receive treatment. This can be facilitated through a TTO which requires the young person to attend an appropriate treatment program to address their behaviours (discussed further in paragraphs 35 and 49 below). In 2019 the CYF Act was amended to include provisions for young people up to the age of 18 years to engage in therapeutic treatment either under a TTO or through a voluntary pathway.

12. The CYF Act commenced operation in 2007. Around that time, the government-funded SABTS came together to form a network called CEASE. The purpose of CEASE was to provide one voice to government around the development of the state-wide service system (for the TTO regime under the CYF Act) and to establish standards and guidelines for consistent practice across the state.

13. It is important to recognise that Victoria had an existing state-wide service system for sexual assault at the commencement of the CYF Act. The Victorian government was able to 'attach' funding to these sexual assault agencies for the provision of harmful sexual behaviour treatment services, for their respective regions. Accordingly, agencies did not have to compete against each other for this funding but instead were able to support each other to expand their service offerings.

14. In my view, competition for funding has potential to create a hostile environment between agencies and does not always lead to best practice. I am aware that Queensland has been facing difficulties in bringing its services together as a network, and I believe that this has a lot to do with the competitive nature of their initial funding round; unlike Victoria, Queensland did not have an existing state-wide service system that the government could leverage. Consequently, a number of organisations who have never delivered harmful sexual behaviour treatment services have subsequently entered the market whilst one organisation with more than 25 years of experience in treating this cohort of young people was de-funded resulting in extensive knowledge and expertise leaving the sector.

Present

15. In 2020, CEASE renamed to Harmful Sexual Behaviour Network (**Network**).

16. The Network sees around 1,600 children and young people each year. All 12 SABTS funded services are members of the Network, representing a workforce of approximately 100 therapists.

17. The Network represents the sector of treatment services. The Harmful Sexual Behaviours service sector was previously known as the SABTS sector, and the funding activity continues to be known as SABTS within the DFFH.

18. ACF delivers SABTS in the East Metro region of Melbourne and the Goulburn region of North East Victoria.

19. SABTS funded agencies are separate organisations independent from each other who come together to share practice and knowledge, participate in research, deliver training, and inform government policy through the Network. As independent agencies they are located in a range of organisations:

    (a) 11 of the 12 SABTS are located within agencies that also provide sexual assault support services (**SASS**);

    (b) seven services are located within hospitals;

    (c) one service, MAPPS, is located at the Parkville Youth Justice Centre;

    (d) four services are community based; and

    (e) in regions where Multi-Disciplinary Centres (**MDCs**) have been established, the SABTS team is either wholly or partly co-located in the MDC to promote closer collaboration between Police, Child Protection and SABTS.

Standards of Practice

20. The CEASE Standards of Practice for Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Programs (**Standards of Practice**) is a set of common standards to guide workers in agencies providing treatment for children and young people with problem sexual behaviours and sexually abusive behaviours to ensure quality service delivery.

21. The Standards of Practice were developed by the Network in consultation with the Department of Health and Human Services and Victoria Police in 2007.

22. The Standards of Practice cover a wide range of topics, including:

    (a) treatment models, including ecosystemic interventions, individual work, family work and group work. The Standards of Practice recognises that treatment models need to be flexible enough to accommodate the developmental needs of all children and young people, and their families, including children with learning and language difficulties and varying levels of intellectual ability;

(b) key issues to consider in risk assessments, emphasising that adolescent harmful sexual behaviour and adult offending are not the same. The Standards of Practice also provides guidance on use of recommended risk assessment measures and suggested assessment formats;

(c) considerations for the development of safety plans, including process and points of review;

(d) safe placement guidelines for children and young people, which includes consideration of statutory requirements, safety factors, responsibility of treatment providers and principles of separation and reunification; and

(e) continuous professional development, including five days of training per year (discussed further below in paragraphs 52 to 56).

23. The Standards of Practice are based on an ecological model, in recognition of the fact that harmful sexual behaviours do not occur in isolation of their environment. As such, engagement of the broader family and care system for the young person is a critical aspect of the Standards of Practice.

24. This important systemic engagement includes:

(a) working with other professionals also involved with the young person (for example, health and education providers, other counselling and support services, child safety, police) and meeting regularly as a care team to develop cohesive and complementary goals for intervention across all providers and planning service delivery so it is realistic and achievable for the young person and their family to commit to;

(b) developing the knowledge and skills of the broader professional groups to ensure that young people are understood and responded to in similar ways and by all professionals using a similar approach;

(c) family systems work, particularly engaging with the parents/carers in the work so that changes that need to occur in the living environment can be supported and sustained, and safety plans can be put in place to ensure the safety of all children in the home. This also includes working with siblings (who may or may not have been harmed) to

ensure they are safe and are able to express when they are not feeling safe, and to undertake restorative practices between siblings where appropriate; and

(d) broader system advocacy work to promote policy and legislative change where needed.

25. The principles that form the basis of the Standards of Practice are consistent with those recommended by the Royal Commission into Institutional Responses to Child Sexual Abuse (**National Royal Commission**), even though the Standards of Practice predate the National Royal Commission. This is due to the collective knowledge and expertise of the member agencies, and the fact that the Standards of Practice were developed using knowledge and best practice principles current at the time, including incorporating evidence from USA, UK and New Zealand.

26. The Standards of Practice were last reviewed in 2016. They are currently in the process of review. The next version of the Standards of Practice will align with the recommendations of the National Royal Commission, whilst providing detail relating to best practice processes in risk and safety assessment and evidence-informed therapeutic interventions and multi-agency collaborative practice.

Strengths of the Network

Capacity

27. Most services sit within a broader agency that provides a range of specialist sexual assault services. As a result, services are well-equipped to understand the nature of the work and have resources they can draw from their broader agency.

28. Another advantage is that the person who has displayed harmful sexual behaviour, and the victim, can both be seen by the same agency. Its advantages include:

(a) families where sibling sexual abuse has occurred are able to be supported through engagement with one specialist service with a consistent vision and approach, rather than having to attend multiple agencies which might have conflicting philosophies. Coordination of

services occurs more smoothly. Information sharing processes need to be very clear to ensure confidentiality for all parties, however can also mean families, particularly parents, don't need to tell their story multiple times; and

(b) for practitioners, having a mixed caseload of SASS and SABTS, working with both the child/person who has experienced sexual harm and the young person who has used sexual harm, means they have a more sophisticated understanding of the dynamics of sexual violence. For example, understanding a victim's experience is important when sitting with a young person who has used harmful sexual behaviour to assist with not colluding in their justifications and cognitive distortions relating to the behaviours they are using. Likewise, understanding the behaviours, language and subtle messages a young person using harmful sexual behaviour might engage in is helpful when working with victims to assist their processing of the impacts of these behaviours, language and messages.

Agility

29. A key strength of the Network is that each agency is independent, allowing services to be delivered in a place-based way. While agencies must abide with the Standards of Practice, they are otherwise free to adapt their service delivery to address local drivers and context.

30. For example, some of our regional services operate in an area with a high population of Aboriginal and Torres Strait Islanders. That service has adapted its service delivery to promote increased accessibility and cultural safety, such as outreaching into community, building strong relationships with local Aboriginal services and community elders and focussing more time on relationship building and engagement.

31. In my view, there is a risk that nuanced cultural sensitivity may be lost in a centralised system. For example, I have observed challenges in the establishment of New Street Services in NSW (which is run by NSW Health) into regions where the central leadership group have needed to learn about the local population and its needs. Over time, this particular challenge can be mitigated by recruiting local clinicians who have or can develop a solid

understanding of their demographic. However, it is a challenge to ensure that centralised policies and practice processes are flexible enough to allow for regional differences and need in terms of how the service is delivered.

Sharing of knowledge

32. The agencies have a mutual commitment to collaboration, formally meeting monthly at the Network and also meeting between these meetings to action working groups, deliver training together or consult around case practice. At these meetings, agencies share their issues, trends and learnings, and collaborate on potential solutions. This collaboration is critical in specialised fields such as harmful sexual behaviour, as no single agency can possibly know everything about the subject matter and the sector is strengthened through collaboration and information sharing.

Relationship with funder

33. We are funded by Family Safety Victoria. A representative from Family Safety Victoria is a member of the Network and attends our meetings. They act as a conduit between the service system and government, bringing information to the Network and taking information internally into the department.

34. The benefits of having the funder represented at the Network include:

    (a) the funder develops a deeper understanding of the complexity of the treatment process, which assists the funder when reviewing funding modelling and resourcing the service system;

    (b) ongoing and up to date knowledge of demand issues which assists both the service system and the funder to identify issues related to demand management and need for increased funding across the service system or in specific regions; and

    (c) the funder can advocate on behalf of the service system internally across government (e.g. with Police and Health) and present the issues in a truly informed way.

Pathways to treatment

TTO

35. If child protection assesses that a child, who has displayed problem or abusive sexual behaviours, is in need of therapeutic treatment but unlikely to access it voluntarily, they can apply to the Family Division of the Children's Court for a TTO. A TTO requires the child's participation in treatment and also applies to the child's family. If the family is blocking the child from accessing treatment, child protection can apply for a Therapeutic Treatment (Placement) Order to place them out of the family home for the purposes of being able to receive treatment. A finding of guilt is not required for the child to be made subject to a TTO.

36. Any child displaying harmful sexual behaviour can be referred to child protection for assessment for a TTO. Children do not need to be existing child protection clients subject to a protection order. However it is important to note that children can be placed on a TTO in addition to being subject to a protection order as the TTO is focused solely on treatment for harmful sexual behaviour and does not have provisions around care or protection issues, thus a separate protection order may also be required to ensure the safety and care needs of the child.

37. Children not connected to any statutory system can be placed on a TTO. Children on youth justice orders, including those in youth detention, cannot be placed on a TTO, rather their youth justice orders should include a condition to engage in treatment for their harmful sexual behaviours which should compel them to engage in treatment processes.

38. If criminal charges have been laid against a young person, the Court can adjourn the matters pending completion of treatment under the TTO. At the end of the TTO, charges may be dismissed if the Court is satisfied that the young person has completed the treatment.

39. When a young person has been found guilty of a criminal offence and receives a Youth Justice supervised sentence, the Court will generally include a condition to attend MAPPS.

40. It may seem surprising that since the commencement of the TTO regime in 2007, only a few hundred TTOs have been made. However, it is important to

recognise the significant collaboration that occurred between child protection, police, Childrens Courts and SABTS during the establishment of the TTO process to raise awareness within these systems of the purpose and process of TTOs and the broader therapeutic treatment service system that was being established.

41. I think this process of information sharing and education about young people who use harmful sexual behaviours and the need for a developmental lens on treating the behaviour generated confidence within the broader service system. Statutory agencies such as child protection and police understood that diversion into treatment to address the behaviours so young people would desist in the use of the behaviours would result in better outcomes for those young people and for victims and families more generally.

42. Instead of high numbers of treatment referrals mandated through a TTO, child protection and police were actively facilitating young people's engagement in treatment. What I mean by that is, police and child protection were strongly encouraging parents to take their child who had engaged in the harmful sexual behaviours to a funded treatment service where the behaviours could be addressed, rather than going through a more formal process.

43. Also, the CYF Act is very clear that a TTO can only be made where a young person is refusing to engage in treatment, and given the majority of families spoken to by child protection or police about their child's harmful sexual behaviours were wanting help for their child and were willing to bring them to treatment services it was not appropriate to apply for a TTO.

44. The important thing to understand about the introduction of the CYF Act was that it facilitated statewide resourcing of an extensive treatment service system that was able to take referrals for voluntary clients as well as mandated clients, thus enabling young people who needed treatment to have access to a specialist service with or without the need for a TTO.

Voluntary referrals

45. Voluntary referrals are the predominant pathway to treatment.

46. Families can contact treatment services directly to discuss concerns about their child. Health professionals, schools, doctors, community services, child protection or the police can refer families to treatment services.

47. Youth justice services can also refer to SABTS providers for treatment through the 'voluntary' pathway. Whilst many young people on Youth Justice Orders attend MAPPS for treatment, a large number of young people also attend other SABTS services. Reasons for this are that young people may already be engaging in treatment at the time their criminal matters go to court, so it makes sense for them to continue to engage in the treatment service they are already attending once they are placed on a Youth Justice Order rather than starting again with MAPPS. Also, whilst MAPPS does offer outreach into regional areas such as Mildura and Gippsland, this is limited by resourcing within MAPPS, whereas regionally based SABTS agencies can offer a local treatment option.

48. An advantage of the voluntary referral system is that the child can participate in treatment as soon as possible, instead of waiting for a TTO or prosecution outcome. Further, as explained above, if a child had already started to engage with one of the treatment services and is later found guilty of a criminal offence, the Court will usually allow the child to continue treatment with their current service, rather than starting afresh at MAPPS.

49. Upon receiving a referral, each service will undertake its own safety risk assessment of the child. If the safety risk is considered too high, then the service would work with child protection to find an alternative treatment solution. For example, the child may be assigned to a different service within the Network that has the facilities, resources or specialists to deliver treatment in a safer way.

Demographics

50. There is no single causal factor that explains or predicts sexual behaviour problems in children. Having said that, research shows that around 94% of young people with harmful sexual behaviours have experienced family violence.[1]

51. There is emerging research coming out of the University of the Sunshine Coast which has found higher prevalence of harmful sexual behaviour in remote communities, compared to metropolitan communities, and is now investigating

---

[1] Quinton, V (2009). Towards an understanding of children and young people who exhibit sexually abusive behaviour. The introduction of therapeutic treatment orders in Victoria. Unpublished Masters thesis.

the reasons for this uneven distribution. The findings of this research will be very important, because understanding how contextual factors contribute to the occurrence of harmful sexual behaviours is critical from both prevention and intervention perspectives.

Workforce training and recruitment

52. Professional development and training for therapeutic staff is a critical component of the Standards of Practice. Victoria's peak body for sexual assault, Sexual Assault Services Victoria, is funded by Family Safety Victoria to provide five training days for the SABTS workforce each year. Generally, three training days will be facilitated by experienced practitioners within the Network, at no additional cost. For the remaining training days, Australian and international experts are engaged to conduct webinars on specialised or emerging topics.

53. Our staff also attend the Australian and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA) conferences and roundtables, which are opportunities for knowledge and practice development, and to engage with treatment agencies from other jurisdictions on policy and practice.

54. It is important to recognise that harmful sexual behaviour is a specialised field within a broader specialised field of sexual assault. For that reason, it is often difficult to find and recruit people who already have the skills and experiences to do the work. Unless we take someone from another service, there tends to be something extra we have to do to build a new recruit's capacity.

55. We aim to recruit people who have experience in either working with victims of sexual assault or in providing generalist counselling to children. The value of having an integrated network of services is that we can draw on one another to train new staff. For example, a service which has a lot of less experienced staff can seek to set up mentoring arrangements with experienced staff from another service. While we are not funded to do this for each other, we do this anyway because it helps to achieve best outcomes for children and young people.

56. Ideally, clinicians hold a caseload of 10, depending on the complexity of issues in each case. There is an expectation that clinicians would work with the broader family system, particularly the parents/carers, and would be actively

supporting the young person's school as well as being engaged in the care team. The caseload needs to reflect the additional systems work required beyond provision of counselling to the young person. The majority of SABTS agencies allocate a combined caseload of HSB clients and SASS victims (usually children, but in smaller services could also include adults) for professional development reasons mentioned earlier in paragraph 28(b), and also to offer a varied caseload to reduce burnout.

Role of private practitioners

57. There are many private practitioners who work with children and young people displaying harmful sexual behaviour. Due to the high demand for treatment that exists, there is a role for private practitioners to play in delivering harmful sexual behaviour treatment. However, it is critical that private practitioners comply with Standards of Practice relating to treatment, which includes taking an ecological approach that involves working with parents/carers and the service system around the young person. If a private practitioner cannot commit to active engagement in the care team, supporting schools and parents, and sharing information then the young person's treatment needs cannot be adequately supported by that practitioner. Practitioners also require very specialist skills in risk and safety assessment and management, and need specific supervision around this work.

58. However, harmful sexual behaviour treatment in private practice has its limitations. For example:

    (a) I have seen the important systemic work fall to the wayside, even for the best intentioned practitioners, because they do not get paid for all of the additional work. Examples of the important systemic work are set out in paragraph 24; and

    (b) if the parent does not want to engage in counselling themselves or does not want to facilitate changes required in the home environment, the practitioner is left in a compromised position. This is because the parent pays the practitioner for the services.

Evaluation of treatment programs

59. In June 2020, Australia's National Research Organisation for Women's Safety (**ANROWS**) published its research report titled "Good practice in responding to

young people with harmful sexual behaviours". Attached to this statement marked **JW-1** is a copy of this research report.

60. ANROWS evaluated three treatment programs for young people engaging in harmful sexual behaviour. These were the Griffith Youth Forensic Service in Queensland, New Street Adolescent Service in NSW and Sexually Abusive Behaviours Treatment Service in Victoria.

61. The key findings of this report were:

(a) there are variations and gaps in services for young people engaging in harmful sexual behaviours within all jurisdictions, and information about service availability is not readily accessible;

(b) specialist services operate in a complex environment that may make service provision challenging;

(c) good practice in intervention is underpinned by conceptual, therapeutic and enabling principles, which are expanded upon in the report as follows:

(i) conceptual principles describe how practitioners should approach young people and their behaviours. For example, practitioners must recognise the developmental trajectories and capacities of young people, and that young people's behaviour is largely a product of what they have experienced at home and in their significant attachment relationships;

(ii) therapeutic principles describe how interventions should be designed and delivered. For example, this includes working systemically, being trauma-informed and tailoring therapeutic responses to the young person taking into account cultural safety, gender, developmental stages and capacities; and

(iii) enabling principles describe other factors that support therapeutic interventions. This includes engaging family/carers, conducting comprehensive assessment and case planning and engaging broader system agencies ; and

(d) factors in the broader service system may help or hinder good practice, such as:

(i) the highly specialised and demanding nature of harmful sexual behaviour work, resulting in issues in recruitment and retention, service demand and funding;

(ii) the location of services (especially in regional and rural areas) and stigma around harmful sexual behaviour, which are some of the barriers to service accessibility and engagement; and

(iii) clashes in organisational priorities and pressures between specialist services and criminal justice, child protection and education systems.

62. ANROWS then made the following recommendations:

(a) establish a public repository of information about services available for young people with harmful sexual behaviours in each state and territory;

(b) practitioners should apply the principles of good practice developed by the project to therapeutic work with young people with harmful sexual behaviours;

(c) funders should dedicate resources to collaborative research into tailoring therapeutic work to vulnerable young people; and

(d) service systems design should support holistic interventions.

Inter-agency relationships

63. Keeping children safe requires effective inter-agency partnerships and responses. Codes of Practice and Memorandums of Understanding (**MOUs**) exist at various levels to inform and guide these partnerships and provide clarity around respective roles and interface at a Victorian inter-departmental level. MOUs exist between police, child protection and SABTS services who are co-located in MDCs. Localised MOUs and agreements exist between Police, child protection and SABTS agencies to guide how they work together at the local level.

64. Since the commencement of the CYF Act, I have observed a shift in police attitudes toward children with harmful sexual behaviours. A part of the shift in discourse is from success equalling a criminal conviction to success equalling the safety of the young person and supporting changes to their behaviour.

65. In my view, this shift has been enabled primarily through education. In the period leading up to the commencement of the CYF Act, child protection led a state-wide roadshow for police, educating them on the intent behind the legislation and the anticipated outcomes. As treatment providers, we were part of that education process in helping police understand how the behaviours occur from a developmental lens, and the work that we do around helping young people take responsibility and be held accountable for those behaviours, in a treatment sense.

66. That said, it is a constant relationship that needs to be maintained. Being co-located in multi-disciplinary centres provides greater opportunities to maintain these relationships and has enabled us to understand each other's work in a much more integrated way. Regardless of whether we are co-located or not, there still needs to be a combined effort to meet and engage regularly for the relationship to work effectively.

Support for schools

67. My sense is that schools are not aware of the extent to which students engage in problematic behaviours.

68. In my view, the greatest challenge is that educators do not really know what they are looking for, often until it has already happened. While we receive referrals from schools, there are also schools that we have never heard from. I find it surprising that the behaviour is not occurring at those schools we have not heard from, when it is happening everywhere else.

69. Further, my experience is that schools are doing their best to try and keep everyone safe. However, schools often make the mistake of taking punitive action against the young person who has caused harm, such as keeping them inside a classroom during recess and lunch. Schools need to recognise that the young person engaging in harmful sexual behaviours also needs support, and that taking action that is stigmatising will not help them change their behaviour. Educators need to understand that the student is not a 'mini sex-offender', rather someone who has experienced trauma of some form themselves who needs support.

70. This of course must be balanced against the need to keep other students safe. The more support we can give schools, to figure out what is a very difficult

pathway, the better. Therefore, I am an advocate for targeted training programs for educators around harmful sexual behaviours.

71. In Victoria, treatment agencies provide various forms of support to schools on an ad hoc basis, including training educators around harmful sexual behaviours and delivering respectful relationships curriculum for students. However, as we are not funded to provide this support, it is limited to the time that we have available to do it.

Support for out of home care

72. I am aware that most Victorian treatment agencies provide ad hoc support for out of home care staff who deal with children exhibiting harmful sexual behaviours.

73. However, the only agency that receives funding to provide specific training, consultation and debriefing into out of home programs is ACF. ACF is funded to provide this support for rostered care workers across the North DFFH Division of Victoria (from Melbourne through to Mildura).

74. As part of this program, ACF consults with rostered care workers on ways to communicate with children and young people about sexual behaviour. Knowing what to say (and what not to say), for example, when you walk into a room and see two young people engaging in sexual behaviour, is important but something that care staff often find challenging.

75. I believe there should be funding to enable specialist services to support out of home care staff to understand harmful sexual behaviours – what it is and how to respond appropriately. This support should be prioritised for staff in rostered care as many young people who use harmful sexual behaviours are placed into rostered care settings due to their behaviours being too unsafe for them to reside in a family setting with other, often younger, children and parents/carers who are untrained and unable to provide sufficient supervision 24 hours a day.

New Zealand residential care model

76. New Zealand has a residential care program for young people with harmful sexual behaviours. The program is funded by the NZ Ministry for Children and provides 3 'group homes' consisting of five young people with harmful sexual

behaviours placed in the same house as they participate in treatment through the local SABTS service.

77. In Victoria, there is a general reluctance to place young people with harmful sexual behaviours in a home with other young people. There are a range of risks involved with such placements, for example, learning behaviours from one another and the vulnerability of other young people in the home. The general approach in Victoria is to create an independent living arrangement for each child who has exhibited harmful sexual behaviours. In my view, this is an expensive way to run an out of home care system and also isolates young people from opportunities to learn appropriate social behaviours through supervised peer interactions.

78. However, New Zealand has managed these risks by employing qualified youth workers as carers and providing them with comprehensive and continuous training around harmful sexual behaviours. Carers understand the issues contributing to the development of harmful sexual behaviours, they understand how to identify and respond to these behaviours, and how to have clear and open conversations with individual young people and the group of young people together about their behaviours.

79. Carers have transparent conversations with young people around their behaviour in a therapeutic way, as opposed to a treatment way. For example, a carer would explain to residents that there is to be no wrestling in the house because the reason that they are here is because it is hard for them to manage their sexual arousal and that play wrestling might cause them to become aroused. By addressing the elephant in the room through clear communication, what they have found is that young people's shame around their behaviour reduces, they are more able to talk about their experiences and ask for help to change their behaviours, and they are not continuing to offend. Young people have said that they feel well supported, and do not feel secrecy or shame because they know why each other is there. They all have different needs but they are all aware of what their safety plan is and what others' safety plans are.

80. While the New Zealand model might be slightly more expensive than a regular rostered care model, it is significantly less expensive than having independent arrangements for each child with harmful sexual behaviours.

Observations on the out of home care system in Tasmania

81. Through my involvement in ACF's services in Tasmania, I have found that the Tasmanian out of home care system is generally stretched and under-resourced. Carers and child protection are trying to do their best with the resources they have.

82. ACF has contracts with Department of Communities to deliver Special Care Care Packages, to deliver therapeutic support into home based care placements, and to undertake assessments of Special Care Packages in Tasmania. The assessments of Special Care Packages involves:

    (a) conducting an assessment of the young person and their needs;

    (b) reviewing the policies of the care organisation;

    (c) meeting with the team of carers and the management group to talk through their processes and procedures; and

    (d) providing recommendations to improve the quality of care.

83. In general, the majority of organisations providing Special Care Package placements in Tasmania provide the material needs for children, such as providing food, shelter and enrolment at school.

84. However, we have found that not all organisations provide for the therapeutic care needs of children. These include ensuring that staff are well-trained to respond to children who have experienced trauma, and that children feel supported in attending school and feel safe and cared for in the home environment, and are supported to heal from the harm they have experienced.

85. Having organisational frameworks in place to support carers in understanding each young person as an individual and their respective needs is critical to establishing a culture of care necessary to meet all care needs of children. This includes the particular needs of young people who have used harmful sexual behaviour to express their trauma and attempt to have their needs for nurture and care met.

ACF in Tasmania

86. In Tasmania, ACF has offices in Hobart, Launceston and Burnie. We are funded by the Tasmanian Government to provide specialist family violence

counselling for children across the North, North West and South. We are also funded to deliver the out of home care programs mentioned above.

Therapeutic Out of Home Care Program

87. Since October 2009, ACF has operated a trauma service for children in the care system in Tasmania, primarily delivering therapeutic support to carers and counselling for children. In 2015 the contract was re-tendered and since that time ACF has specifically provided:

    (a) individual counselling for children living in care who have experienced trauma;

    (b) education and support for carers; and

    (c) ad hoc consultation to Child Safety Service, on matters such as placement of children.

88. ACF is funded to employ five full-time staff across the state, with a combined case load of 70 children or carers at any given time. However, the demand for our services outstrip the supply, and the waiting list is around six months.

89. We have a six-month counselling model for our work with children. For our work with carers, we have an initial three-month block with an option for an additional block of up to three months where further support is required. We could work with children and carers for longer periods, but it is a compromise we have had to make due to resourcing constraints.

Family Violence Counselling Program

90. ACF delivers a specialist family violence counselling service for children and young people impacted by family violence. The waiting list for this service is around six months.

91. A key focus on our counselling work is helping to repair relationships that have been ruptured as a result of family violence. This means that our work may involve working with parents who have used violence, as well as working with children whose parents may still be in relationships characterised by violence.

92. We have a six-month counselling model. Again, we would work with children for longer periods, but it is a compromise we have had to make due to resourcing constraints.

Addressing harmful sexual behaviours

93. Through all of the programs ACF delivers across all regions of Tasmania, we come across children and young people who display early warning signs of harmful sexual behaviours.

94. While we are not funded to address these behaviours specifically, we have some capacity to prevent the occurrence of harmful sexual behaviour by:

    (a) working with the child around processing the trauma they have experienced;

    (b) working with the parent or carer, specifically around things they can do to support the child such as safety planning and supervision; and

    (c) training out of home care providers and their carers to identify and respond to harmful sexual behaviours emerging in the children they care for.

95. We refer children exhibiting harmful sexual behaviour to SASS, who is funded to deliver the Harmful Sexual Behaviours Program in Tasmania. However, due to SASS being Hobart-based, it has often been difficult to get treatment for children in the North and North West of Tasmania.

96. I am aware that Laurel House does some work with children with harmful sexual behaviours, although I am unsure to what extent.

I make this solemn declaration under the *Oaths Act 2001* (Tas).

Declared at Melbourne
on 8TH June 2022

[redacted]

Before me

[redacted]