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

WITNESS STATEMENT OF SALLY ANTOINETTE ROBINSON

I, Sally Antoinette Robinson of Flinders University, Sturt Road, Bedford Park, in the State of South Australia, 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.

BACKGROUND AND QUALIFICATIONS

2 I am currently employed as a Professor of Disability and Community Inclusion at the College of Nursing and Health Sciences at Flinders University. I have been in this role since July 2019. I am a disability studies scholar, drawing on doctoral qualifications in sociology and Master's degrees in Policy and Applied Social Research and in Education (Adult Rehabilitation).

3 Prior to working at Flinders University, I worked for the Centre for Children and Young People, Southern Cross University, as an Associate Professor and leader of the disability research program (2012-2019). Here I developed and led a wide range of research with children, young people and families on issues significant to their safety and wellbeing.

4 Prior to academic positions, I have a long history of supporting people with disability in a range of systemic advocacy and service provision roles. My entire work life has been focused around supporting people with disability.

5 I have the following qualifications:

(a) Doctorate of Philosophy (Sociology) conferred by Griffith University in 2010, in completion of which I wrote a thesis titled '*Insult and Injury: a narrative approach to understanding the emotional and psychological abuse and neglect of people with intellectual disability living in accommodation services*';

(b) Master of Policy and Applied Social Research conferred by Macquarie University in 2001;

(c) Master of Arts (Education – Rehabilitation) conferred by Macquarie University in 1995; and

(d) Bachelor of Arts majoring in (*Social Anthropology and English*) conferred by Sydney University in 1990.

6 Attached to this statement and marked **SAR-1** is a copy of my curriculum vitae.

7 I am the author or co-author of the following academic works which are relevant to the work of the Commission:

(a) ‘Belonging and exclusion in the lives of young people with intellectual disability in small town communities’ in *Journal of Intellectual Disabilities* (Co-authored with KR Fisher, M Hill and A Graham, 2020);

(b) ‘Child safety in policy: who is being kept safe and from what?’ for the *Australian Research Counsel* (co-authored with MA Powell and others, 2020);

(c) ‘Children and safety in Australian policy: Implications for organisations and practitioners for the *Australian Research Counsel* (co-authored with MA Powell and others, 2020);

(d) ‘Feeling safe, avoiding harm: safety priorities of children and young people with disabilities and high support needs’ in *Journal of Intellectual Disabilities* (co-authored with Anne Graham, 2020);

(e) ‘Preventing abuse and promoting personal safety with young people with disability – final report’ prepared by the *Centre for Children & Young People, Southern Cross University* (co-authored with A Graham and others, 2017);

(f) ‘Preventing abuse of children and young people with disability under the national disability insurance scheme: a brave new world?’ in *Australian Social Work* (2014);

(g) ‘Promoting personal safety and preventing abuse for young people with disability: new research and young people’s advice for improving services and systems’ for the *Australian Society for Intellectual Disability* (co-authored with J Speeding and others, 2018).

(h) ‘Promoting the safety of children and young people with intellectual disability: perspectives and actions of families and professionals’ in *Children and Youth Services Review* (co-authored with A Graham, 2019);

(i) ‘Safety and harm in school: promoting the perspectives of students with intellectual disabilities’ in *Journal or Research in Special Educational Needs* (2018);

(j) ‘The right to safety: promoting the authority of disabled children to tackle rights resistance’ in *Routledge Handbook on Children’s Rights and Disability* (co-authored with Jan Idle, 2022); and

(k) Violence prevention and early intervention for mothers and children witn disability: building promising practice’ commissioned by Australia’s National Research Organisation for Women’s Safety (co-authored with K Valentine and others, 2020).

Attached to this statement and marked **SAR-2** is a bundle of these articles.

8 The following articles have also informed me of the matters to which I depose in this statement:

(e) **SAR-3**: ‘Children and safety in Australian policy: implications for organisations and practitioners’ in *The Australian Journal of Social Issues*, (M A P owell and others, 2020);

(f) **SAR-4**: ‘Children and young people with harmful sexual behaviours – executive summary’ in *Research in Practice* (S Hackett, 2014);

(g) **SAR-5**: ‘Children and young people with harmful sexual behaviours’ in *Research in Practice* (S Hackett, 2014);

(h) ‘Disability and Child Sexual Abuse: lessons from Survivors' Narratives for Effective Protection, Prevention and Treatment’ by M Higgins and J Swain (Book - *Jessica Kingsley Publishers*);

(a) **SAR-6**: ‘Maltreatment and disabilities: a population-based epidemiological study’ in *Child Abuse and Neglect* (P M Sullivan and J F Knutson, 2000);

(b) **SAR-7**: ‘Personal safety issues in the lives of children with learning disabilities’ in *Children Australia* (F Briggs and R Hawkins, 2005);

(c) **SAR-8**: ‘Practice and policy in the UK with children and young people who display harmful sexual behaviours: an analysis and critical review’ in *Journal of Sexual Aggression* (A Smith and others, 2014).

(d) **SAR-9**: 'Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies' in *The Lancet* (L Jones et al., 2012);

(e) **SAR-10**: 'Prevention of and responses to harmful sexual behaviour by children and young people' commissioned by the Scottish Government (Expert group on preventing sexual offending involving children and young people, 2020);

(f) **SAR-11**: 'Taking time – framework: a trauma-informed framework for supporting people with intellectual disability' by A L Jackson and S E Waters (*Berry Street*, 2015);

(g) **SAR-12**: 'Violence among children with disabilities in *Clinical Child and Family Psychology Review* (P Sullivan, 2009); and

(h) **SAR-13**: 'Workforce perspectives on harmful sexual behaviour – findings from the Local Authorities Research Consortium 7' commissioned by the National Children's Bureau, London (K Clements and others, 2019).

Current role and areas of research

9 My work at Flinders University is focused on key social policy concerns for people with disability, such as safety and abuse, wellbeing, participation and funding, and organisation of community services.

10 Most of the work in our research program has been co-produced with people with disability and builds from their experiences and priorities. This approach has generated a series of important thematic areas. Those areas include:

(a) relationships;

(b) violence and violence prevention;

(c) loneliness;

(d) belonging; and

(e) quality of support.

11 It has also translated into new approaches to research and evaluation for government and non-governmental organisations. This includes the inclusion of people with cognitive disabilities as co-researchers, accessible approaches

to data analysis, and an emphasis on knowledge translation which sees research findings prioritised for community audiences.

12 I am particularly interested in the environmental and systemic factors that lead to people with disability being subject to violence, abuse, neglect and exploitation. Much of my research is targeted towards what can protect against these experiences.

13 The opinions and conclusions that I express in the statement are based on my research and the literature I have reviewed in conducting multiple studies in the field over the last decade. I have also included examples from people who have contributed to the research and from people with disability I have been connected to as colleagues.

My involvement in past Royal Commissions

14 I provided a witness statement on the multidimensional nature of abuse in the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disabilities (**Disability Royal Commission**). Attached to this statement and marked **SAR-14** is a copy of this statement.

15 I was commissioned along with Anne Graham and Lel D'Aegher (SCU) and Matthew Bowden and Jess Cadwallader (People with Disability Australia) by the Royal Commission into Institutional Responses to Child Sexual Abuse (**National Royal Commission**) to undertake a research project involving children with disability into those children's views of safety. The report of this project, *'Feeling safe, being safe: what is important to children and young people with disability and high support needs about safety in institutions*?', provides detail on the experiences of children and young people who otherwise were not appearing in front of the Royal Commission. Attached to this statement and marked **SAR-15** is a copy of this report. It shares their experiences and ideas for improvement and draws implications for systems and structures.

SEXUAL ABUSE AND CHILDREN AND YOUNG PEOPLE WITH DISABILITIES

16 Children and young people with disability are at an increased risk of being subjected to child sexual abuse.

17 Research about the prevalence and rate of abuse for children and young people with disability is difficult to rely on because, as a society, we have not put effort into capturing data about it. This in itself says something about the status of children and young people with disability in society.

18 In Australia, we do not have reliable figures about sexual violence and abuse against children and young people with disability. We still largely rely on a study by Sullivan and Knutson (2000) called *Maltreatment and disabilities: a population-based epidemiological study* (Attachment SAR-6) which found that children and young people with disability are three times more likely to be sexually abused than other children. While this study is old, it drew on a large data set and is considered the most reliable establishing evidence.

19 Other studies have confirmed this figure, including Jones et al. (2012): *Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies* (Attachment SAR-9), which provides pooled estimates of prevalence and risk of violence for children and young people with disability.

20 Disabilities are diverse, and children and young people can live with physical, psycho-social or intellectual disabilities, and of course, they are not mutually exclusive. Some children may live with a number of disabilities.

21 For female children and young people with intellectual and behaviour related disabilities, we know that the rates of child sexual abuse are even higher again (Jones et al., 2012; Koh et al., 2021).

22 Children and young people with harmful sexual behaviours are often victims of sexual violence themselves, and so these ‘children and young people occupy dual identities as the perpetrator of abuse and the victim of harm’.

23 The literature notes many children present with complex and intersecting challenges in their lives, and many have also had adverse childhood experiences. While the issue of assessment is not explored in the literature, particularly for children with disability experiencing adversity, stakeholders across interviews in a project we conducted discussed assessment, and described how many young people present to services with a range of disability-related diagnoses, some of which appear to be inaccurate and unhelpful to the child (e.g. inappropriate medication or stigmatising labelling). It was the view of providers that these may have been provided earlier in

childhood, for example, to ensure the child can access learning support at school. Services providers noted the difficulty of 'undoing' diagnoses through processes of re-assessment and, most significantly, felt it had significant impacts on children. In addressing the need for proportionate and timely interventions, the research notes it is common for professionals to find that families and carers discourage the expression of sexuality by children and young people with disability, and some prevent young people's access to sex education. These attitudes have raised some concern about families being prepared to report or seek help when needed.

Increased risk factors for children and young people with disability

24 It is important to consider that child sexual abuse perpetrated against children and young people with disability occurs in a social context. These children and young people are often socially isolated and/or live service dominated lives. By 'service dominated lives', I mean that children and young people with disability intersect with and interact with health and medical services and other institutions at a much higher frequency than the wider population.

25 The intersectional factors that all children and young people face, which put them at higher risk of being a victim of child sexual abuse (such as gender, age, socio-economic disadvantage, Aboriginality), also apply to children and young people with disability.

26 This creates several compounding risk factors that lead to children and young people with disability being three times more likely to be the victim of child sexual abuse. For example, children and young people with disability are more likely to live in families experiencing economic stress, to have little choice about health and other kinds of care, to be exposed to changing staff in services, to have less choice about their schooling, and to experience social isolation due to stigma and discrimination. In this climate, children and young people are less likely to have trusting relationships with adults who are consistently in their lives outside of their immediate family sphere. If their family is under pressure, they may feel unable to raise their own problem.

27 The question then turns to why children and young people with disability are more susceptible to being the victim of child sexual abuse. Institutions that are responsible for supporting children and young people with disability not only

need to meet their immediate need for services, but also their need to feel, and be, safe. Without investment in relationships of trust, it is almost impossible for children and young people who have difficulty communicating to share when something is wrong – or when they share their distress through behaviour, for adults to understand their message. Children and young people with support needs need to be known, and to know, the people around them. This is not an unreasonable expectation.

Service dominated lives

28 Firstly, children and young people with disability live service dominated lives because they have support needs that expose them to several more institutional settings than other children and young people. For example, all children attend school, but children and young people with disability may need to interact with speech therapy, occupational therapy, physical therapy and swimming therapies. Some children and young people with disability live in respite, use accommodation services or have at home carers either part-time or full time. In those examples, there are residential additional institutional settings, namely: home-care, health, medical, and sport and leisure.

29 Interactions with service institutions do not stop at adulthood. For example, as children and young people with disability grow older, they transition out of school to supported employment services or day support services. So, there is a whole range of institutional settings that children and young people with disability are exposed to that other children do not come into contact with at all, or at least to the same depth.

30 Because some families rely so heavily on these services, those families can feel like they are unable to complain about services being provided, even if they have concerns about them, because they are so necessary to sustain not only the child who is using the service but that child’s broader family’s life. In these situations, the agency and needs of the child can be rendered invisible because the needs of the family and the needs of the child do not properly align.

31 Physical therapies are particularly common for children and young people with physical disabilities who have high support needs.

The broken touch radar

32 Children with high physical support needs are touched all the time. Some of the research for the National Royal Commission talked about people having a ‘broken touch radar’ in that they find it very difficult to discern whether certain kinds of touch are appropriate. They also do not have the agency to complain about touch that feels inappropriate to them. Further, some children do not have ways to articulate that they are uncomfortable with the touch. For example, children with verbal communication disabilities may be unable to raise an objection to inappropriate touch, whether to the perpetrator or to a trusted adult.

33 Services and systems are structured in such a way that children who are least able to raise concerns independently may be touched by multiple people each day - without giving any of them an opportunity to object to being touched or choosing who touches them.

34 By way of example, a speech therapist who took part in the research conducted by the National Royal Commission talked about how as part of her therapy, she put her hand inside one of her client’s mouths to help them adjust their tongue. This is an example of how the concept of bodily integrity for the person receiving the treatment may be broken down or eroded. It is difficult to know what touch is right and what touch is wrong when you are being touched all the time. This does not mean that children and young people do not experience trauma from abuse. It means that it makes it much more difficult to identify and share abusive experiences when others expect people to be touching you.

35 In a UK study, young people with disability who participated in research with Higgins and Swain (2009) (*Disability and Child Sexual Abuse: Lessons from survivors’ narratives for effective protection, prevention and treatment, Jessica Kingsley Publishers*) talked about lacking a sense that their bodies belonged to them, of privacy, and of not having to be touched if they didn’t want to be. In another UK study by Hollomotz (2011, Learning Difficulties and Sexual Vulnerability: A social approach. Jessica Kingsley Publishers), children and young people with disability reported feeling ‘immunised’ from regarding their bodies as their own domain due to being handled multiple times each day, and the effects of this on their sense of bodily integrity.

Expectations of compliance

36 Children are generally expected to be compliant. If they are not compliant with what people are telling them to do, then more often than not they are referred for behaviour management, which just adds another exposure to institutional settings and another label with which they are stigmatised.

37 This is even more so with children and young people with disability. They are so heavily surveilled and so controlled by institutions that their behaviour is even more likely to be labelled as non-compliant, resistant or some other disability label if they do not act in the ways adults expect them to. For children with intellectual or behavioural disabilities, or who communicate without spoken language, resistance to touch and a readiness to resist can be misinterpreted as disobedience or a presentation of the disability.

An ecological perspective on child sexual abuse and children and young people with disability

38 I think it is appropriate to take an ecological approach to how we think about preventing child sexual abuse from being perpetrated against children and young people with disability. An ecological perspective views children as active agents who shape, and are shaped by, their environments.

39 An ecological perspective starts by examining a child at the centre of their wider socio-ecological context, which is comprised of various interacting domains or spheres of influence and understanding the way they understand themselves in the context of those spheres of influence, which includes the health services they are accessing.

40 The second level considers the child’s relationship with immediate family and looks at how and when things do not work within the family unit without the interactions with services.

41 The third level examines the services themselves. From an ecological perspective, this level can become really important in the lives of the family, which in turn can have huge influences on the child or young person at the centre.

42 The fourth level examines the effect of wider cultural and social factors, such as poverty, homelessness, discrimination etc. The attitude of people at this

level establishes societal expectations towards acceptable conduct towards children and young people with disability.

43 When the community compartmentalises children and young people with disability, who have to rely on formal support instead of or in addition to natural networks and safeguards, and implicitly says that it is okay for these children to be at three times more of a risk of becoming the victim of child sexual abuse, that puts a message out there that it is okay for all this to happen, which in turn allows it to happen.

44 By way of example, in research for the National Royal Commission, our team worked with a parent who was pressed to have their ten-year-old son take a taxi to school. This child had very significant intellectual and physical disabilities, was not able to move independently and could not communicate verbally. They explained that they would not allow their other son to take a taxi by himself, but was asked by service providers to have their disabled son travel unaccompanied. This is a perfect example of how we normalise what is okay for a child to do because it fits in with the system. Taking a child-centred approach quite quickly casts a different light on what works best for the child and their family.

45 In research we did about safety and harm at school, children and young people and their families discussed a wide range of harms that they had personally experienced in and around school, ranging from cruel teasing to sexual assault. While there is considerable cross-over between the groups, some distinct differences also emerged in the emphases of each group. Students and ex-students talked predominantly about the ongoing (sometimes daily) interpersonal abuses they face or faced, and how these impacted their confidence, happiness and wellbeing. Families raised more ‘critical incident’ types of injury and assault, and talked about distress and discord that these harms caused to both their children and the wider family, and about the difficulties they had in trying to resolve both the causes and the effects of the harm in the education system. Key stakeholders – educators and administrators in schools, child protection workers, therapists and disability support workers – spoke more structurally about the impact of low expectations, discrimination and lack of access to needed support. Many of them saw the abuses experienced by students with cognitive disability arising in response to these core causative features.

Current policy issues

46 Even though we know that children and young people with disability are overrepresented as victims of child sexual abuse and violence, the broader policy measures that we have in place to counter violence and abuse against children rarely appropriately consider disabled children.

47 You can see this in high-level government policies like the National Framework for Protecting Australia's Children. The Framework includes children and young people with disability as one of four priority groups, but has little detail about how to recognise the agency and authority of young people and their basic right to bodily autonomy, or the over-representation of children and young people with disability in child-protection. As is provided for Aboriginal and Torres Strait Islander children and young people, a framework is needed to ensure a focused and coherent approach and move beyond statements of principles for children and young people with disability. '*Is Children and safety in Australian policy: implication for organisations and practitioners*' (Powell et al., (2020)) analyses Australian Policy.

48 It is common that we focus policy on harm after a child has already experienced the abuse rather than taking a preventative approach. This also drives the general culture and practice about risk management by focusing on the personal vulnerability of a child or young person with disability rather than their situational vulnerability. We need to consider the situations into which we are putting children and young people that makes them vulnerable. The baseline should not be that all children and young people with disability are inherently vulnerable. They are not.

49 Instead, policy needs to be approached from the view that the child is made vulnerable because of the environments in which they are placed. If the environment is safe, any vulnerabilities the child may have are not compounding the risk of their exposure to child sexual abuse. For example, children with high communication or behaviour support needs who have participated in our research who are well supported by people they know and trust have shown they have multiple ways to share what is important to them – through mutual understanding built up over time and shared experience.

50 Children and young people with disability are made more vulnerable by having to engage heavily with systems with which children without disabilities are not

required to interact. While there is always the risk that a predator will enter a system, there is a general lack of readiness in disability systems to respond to child sexual abuse, despite the National Royal Commission making very clear its prevalence.

51 There is also a reluctance to think about violence and abuse as affecting children and young people with disability and a reluctance to include these children in things that we know protect children from child sexual abuse. These are basic things, too, like building a voice and agency and opportunities to develop that voice and agency in a safe space or encouraging children and young people with disability to develop strong relationships and networks and learn how to be safe. This includes peer relationships, informal opportunities to build social and interpersonal skills, and access to information in the media.

52 We need to make sure that children and young people are provided all the same opportunities to develop identity and self-expression, including sexual self-expression, and to learn what behaviour is appropriate and inappropriate.

53 Right now, children and young people with disability are often left out of these opportunities, both because service settings like schools are not providing them adequately and because of the flow-on effect of this in discrimination and social isolation that goes unchallenged. Basic social connections are more difficult to establish for children and young people with disability when there are no inclusive options. Basic activities like Saturday sports, social gatherings, house parties and dating all help a child participate in community life, develop relationships and learn social expectations and boundaries. These are all much harder to access for children and young people with disability because they are not routinely expected and welcomed into those activities.

54 People in key positions in institutions need to approach providing children and young people with these same opportunities as something that is just done rather than something that just should be done. Setting standards where inclusive practice is expected that children and young people with disability take their place in the fabric of community life needs to be a minimum expectation. Too often it is viewed as a favour, or an extra task to include children and young people with disability, and something which can be withdrawn when resources are scarce or a particular advocate for the young person's participation leaves. Training and support to encourage inclusive

practice is needed, alongside reminders of the rights of children and young people with disability as citizens – delivered with warmth and with the authority of young people themselves. Self-advocates have great authority in this space, with many excellent examples of attitude change through education (see WWDA Youth and CYDA Youth for examples).

A sense of safety

55 An important part of making institutions child-safe is by providing children who interact with those institutions agency, by which I mean the capacity to act on their feelings, thoughts and experiences in a way that has an impact. A lot of research into children and young people directly supports this, including our research with children and young people with disability in schools, disability services and violence prevention services (Robinson & Graham, 2020; Robinson & McGovern, 2015).

56 My current work is predominantly focused on two aspects of institutional abuse:

(a) The abuse that occurs in institutional settings; and

(b) Ineffective responses by institutions to abuse that might occur outside of the institutional settings.

57 A team of researchers at Flinders, Uni SA and UNSW have a project at the moment working with children and young people of domestic and family violence and how services can better support those children and young people after experiencing family violence. A consistent theme across all the projects on which we have worked is that there is a real lack of authority for children and young people with disability about their own lives. Particularly in times of crisis, children and young people are rarely consulted about their views and priorities, and they have little opportunity to exercise their voice about how services and systems act on their behalf.

58 A strong focus of our work over several years has been in working with children and young people to listen to their ideas and insights into what helps them feel safe and be safe, and what helps them recover when their sense of safety has been broken.

59 From one of these projects, our research team developed a model for feeling and being safe derived from young peoples' priorities. The children and young

people involved in the project talked about the way they understood safety and the things that they identified as priorities for being safe - comprising physical safety, emotional safety, having their access needs met and feeling capable. (Robinson, S., Graham, A., Fisher, K.R., Meltzer, A., Blaxland, M. & Johnson, K. (2017) Preventing abuse and promoting personal safety in young people with disability: Final Report. Lismore, Southern Cross University.)

60 Physical safety was a baseline need, and young people felt safe when they had a safe place to be, were out of danger, had someone to stick with, and they were not mistreated. Problems here were the most likely to be responded to by adults when young people experienced abuse, assaults or concerns about their safety.

61 Emotional safety was the most consistent focus, by younger people in particular. Feeling emotionally safe was rated as most important, and comprised of trusting relationships, feeling comfortable, known and understood, respected, and protected. Lack of emotional safety caused significant pain, and was poorly responded to by both service providers and informal supporters in their lives. Young people acknowledged that this kind of help-seeking might be through challenging behaviour, and its meaning is not always well recognised.

62 Access needs was a broad safety area and related to the environment being physically accessible, available, approachable, welcoming and appropriate. Having access needs met established, constrained, or made fragile a sense of safety for people with disability. It impaired or emboldened their confidence and affected how secure they felt in engaging outside of known relationships.

63 Feeling capable was more readily expressed by people with disability than supporters about the knowledge and capacity of people with disability (particularly young people) to implement their safety strategies. It was important to them that:

(a) they could use their strategies wherever possible;

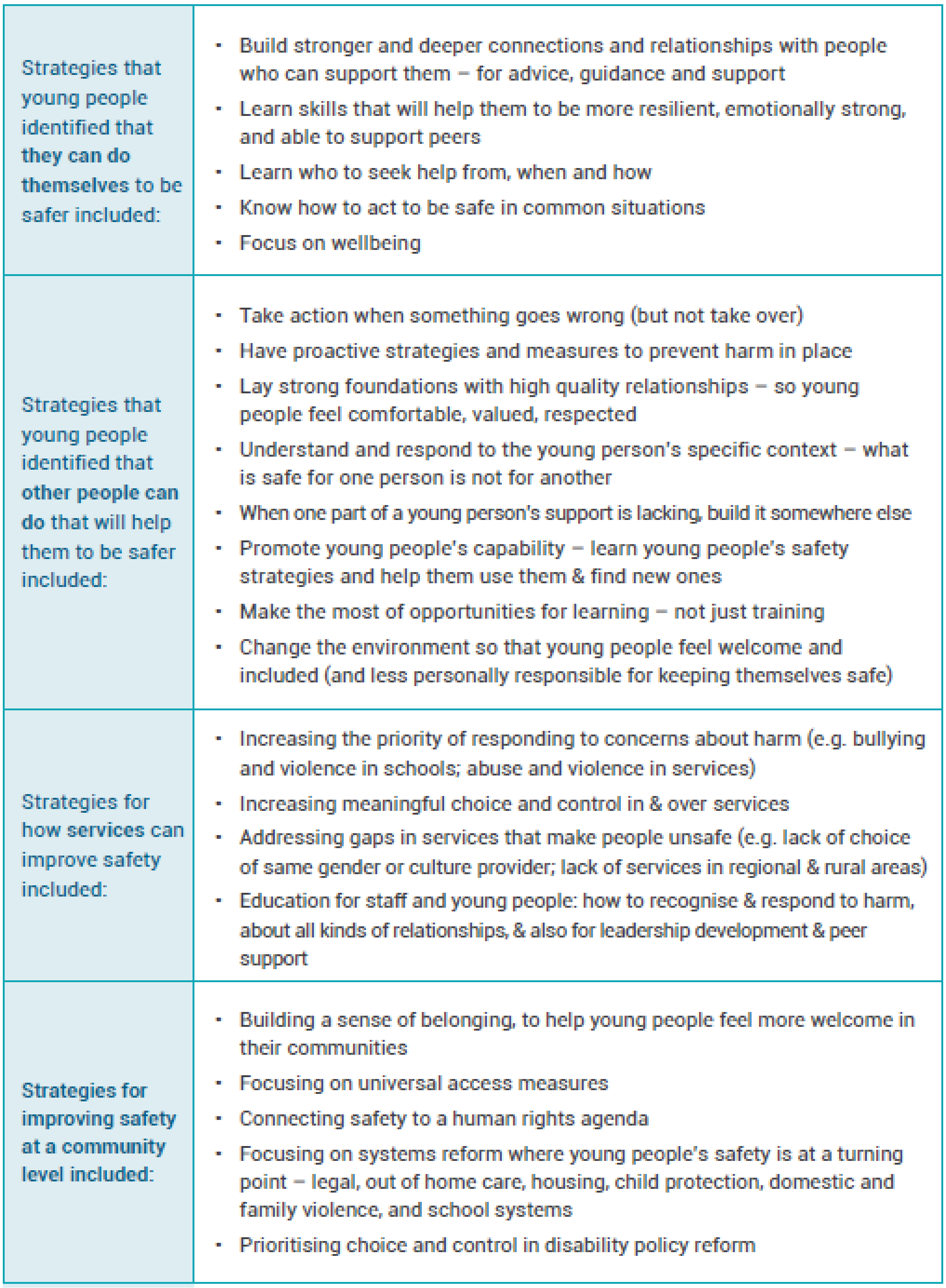
(b) When help was needed, it was offered in a complementary way; and

(c) Success of this influenced how much they felt listened to and involved in problem-solving

64 These children and young people had acute insights into what helped them feel and be safe. They came up with an amazing list of strategies, and they talked about things they could do themselves.

65 They were also aware that there were limits to their self-efficacy, and nominated areas where they required assistance, areas where others needed to take action, and issues where systemic change was needed. They were looking for alliance from both service providers and informal supporters, and their ideas for systemic and structural change were about increasing their capacity to have real choice and control.

66 A summary of the strategies developed by children and young people is below.



Strategies that young people identified that **they can do themselves** to be safer included:	• Build stronger and deeper connections and relationships with people who can support them – for advice, guidance and support • Learn skills that will help them to be more resilient, emotionally strong, and able to support peers • Learn who to seek help from, when and how • Know how to act to be safe in common situations • Focus on wellbeing
Strategies that young people identified that **other people can do that will help** them to be safer included:	• Take action when something goes wrong (but not take over) • Have proactive strategies and measures to prevent harm in place • Lay strong foundations with high quality relationships – so young people feel comfortable, valued, respected • Understand and respond to the young person's specific context – what is safe for one person is not for another • When one part of a young person's support is lacking, build it somewhere else • Promote young people's capability – learn young people's safety strategies and help them use them & find new ones • Make the most of opportunities for learning – not just training • Change the environment so that young people feel welcome and included (and less personally responsible for keeping themselves safe)
Strategies for **how services can** improve safety included:	• Increasing the priority of responding to concerns about harm (e.g. bullying and violence in schools; abuse and violence in services) • Increasing meaningful choice and control in & over services • Addressing gaps in services that make people unsafe (e.g. lack of choice of same gender or culture provider; lack of services in regional & rural areas) • Education for staff and young people: how to recognise & respond to harm, about all kinds of relationships, & also for leadership development & peer support
Strategies for improving safety at a community level included:	• Building a sense of belonging, to help young people feel more welcome in their communities • Focusing on universal access measures • Connecting safety to a human rights agenda • Focusing on systems reform where young people's safety is at a turning point – legal, out of home care, housing, child protection, domestic and family violence, and school systems • Prioritising choice and control in disability policy reform

Robinson et al., (2019, p. 8)

67 An example provided by one participant was that when they walked into a café, staff would shuffle and move furniture to accommodate them. They said that they just wanted to walk in and feel accepted; that the café had already anticipated and planned for them to be there, rather than making changes once they arrived.

68 At a broad level, there are protective measures that come from feeling welcome, and the lists of strategies developed by children and young people through this project demonstrate that children and young people with disability are thinking about prevention of and protection against abuse and harm at really broad levels.

69 However, what came out of my research into these strategies is that it is very difficult for children and young people to get a sense of how effective their strategies are because they have limited opportunities to test them in a safe way. This itself comes from the constrained lives that children and young people with disability experience, such as going to school, working and living in segregated settings. The effect of this is that children and young people with disability not be confident to try new strategies, and it is hard to engage with new people.

70 For example, some of the children and young people with disability in the safety study had very heightened anxiety about answering their front door. Two others spoke about crossing the street to avoid people they didn't know. Another spoke about not going to a particular part of town because people dress 'gangsta' there, and he would be at risk. One young woman talked about dressing in ways that would not draw anyone's attention.

71 All of these strategies responded to lived experience of insults and intimidation. They were logical and helped the young people get through their days. However, they also increased their isolation and consequently their risk of exposure to predatory child sexual abuse, among other forms of abuse. This effect of isolation is a strong example of how a lack of proactive safety building is increasing the risk of harm to children and young people with disability.

72 The risk management approach taken to preventing child sexual abuse for children and young people with disability is often to manage around them, rather than to involve them to the utmost of their capacity. This leaves children and young people with disability lacking knowledge that is crucial for protection against violence and abuse, but also for personal development, growth and pleasure. Education for children and young people and all the people around them is vital – so that key messages are clear, consistent and supported from an early age.

PROTECTIVE MEASURES

Educating institutional communities

73 It is important to acknowledge that the sphere of influence within which all children operate is small. As an example, take a child at a school who is being groomed by a teacher. That child's capacity to recognise what is happening and act on it is low.

74 However, if you educate the teachers and parents of students to work with teachers at that school about recognising and responding to indicators of child sexual abuse, that creates a layer of protection for the children by ensuring that the adults can effectively act against that behaviour. This is especially true when there is a dominant culture that neither recognises the agency and rights of children nor protects children.

75 Educating institutional communities like schools also acts as a general deterrent because perpetrators know that people have a higher awareness of indicators of child sexual abuse and know what to look out for. Accordingly, there is a greater chance of a perpetrator being detected.

76 For children and young people with disability, their sphere of influence is even smaller. So the need to have educated communities and networks around them is even more important.

77 The important work of preventing child sexual abuse cannot be left to an approach of upskilling children in how to recognise and complain about abuse. It is too hard and cannot be expected of them. Children should not be the ones given the responsibility to keep themselves safe. We need to educate the broader population because it is completely unrealistic to rely on children, especially children and young people with disability, who may have limited communication skills and limited power to tell anyone what is happening to them. Education is particularly important for people who have responsibility for the care and support of children, but is also needed in the wider community, to raise awareness of the importance of personal safety, the need to act on concerns, and how community members can take action on concerns. There are additional and persistent barriers for children with disability that can prevent bystanders and concerned community members from taking action, such as

myths around the burden of disability on families, that people with disability don't feel or understand pain, and so forth.

Redefining children's autonomy

78 We need a system that gets in front of the perpetration of child sexual abuse and focuses on building opportunities for children and young people, both with and without disabilities, to lead a good and protected life. This is not just about abuse prevention. The system needs to focus on building up skills to be safe and protected and providing them with every opportunity to flourish and grow.

79 There has been a signal failure between promoting personal safety and wellbeing and children and young people with disability. For people with disability generally, including children, policy and practice attention has been heavily weighted towards responding to abuse already experienced. We need to connect responding to harm with building a good life and having appropriate systems in place to empower children and young people with disability to be and feel safe.

80 An illustrative example is the NDIS's participant safety policy, which is only now under development, eight years after the NDIS was created.

81 Connecting safety to services is fundamental when it comes to proactive safety building measures and ensuring children remain safe in the event that more formal safeguards, such as policies or police/working with children checks, fail. In these situations, the children are then equipped with the personal skills and knowledge to know what to do and how to do it, such as reporting an instance of child sexual abuse to a trusted adult.

82 I think that schools are really important for children to obtain knowledge and skills in safety, autonomy and respect because it is where children are in their formative years. Ensuring that all students have education and understanding about personal safety, harm prevention, and help-seeking skills is vital – in the context of positively framed education about rights, safety and relationships. Teachers should not only focus on the academic performance of students but take a proactive role in developing safe personal relationships with children to ensure that they are meeting the benchmarks about what knowledge is needed to ensure fundamental understandings of safety, belonging, autonomy and respect.

Building trusted adult relationships

83 Throughout my research and that of many others in sensitive areas, including abuse, children have emphasised their need to have an adult whom they know and trust and who has demonstrated that they are trustworthy. This does not align with current policy practice, which responds to disclosures of child sexual abuse at times by requiring the disclosing child to engage with a number of different people who have otherwise never had contact with the child.

84 Part of making sure that children are able to develop trustworthy relationships with adults is to upskill adults to know how to build and maintain mutually respectful and trustworthy relationships. Respectful relationships between adults and children require that children are cared about, valued and respected, including having clarity about what happens when things go wrong for them. For example, that might mean letting the child know that if something is said to the adult that requires reporting, it cannot be kept a secret because the child is not safe. Adults need to do the work to establish themselves as a trustworthy person.

85 If we listen to what children and young people value, we would know that they do not want to be passed on to a new person or persons in the process of responding to a report of child sexual abuse. If a child has made the difficult decision to confide in an adult, then the child’s interests are served by that adult remaining available to them as long as they need them. Adults need to be upskilled so that they have the skills to stay with, and support, a child who has selected them as a trusted adult until that child is ready to move to the next step in the process without them. This means investing more heavily in educating adults who work with children about how to support them with disclosures.

Sex education resources

86 It has been my experience that sex education resources and sex education settings are not created and made available in ways that are accessible to children and young people with disability. There is also a belief that the resources will not be relevant to them or needed by them.

87 While there are generalised resources available to children that guide them through what to do in the event that they are sexually abused, they are not

developed for children and young people with disability and do not help them. For example, few resources break down abstract concepts into easier to understand language, or have easy-read versions of handouts. For students with cognitive disabilities who need more concrete concepts and easier language, these kinds of resources make a great difference.

88 Moreover, any resources that are designed specifically for children and young people with disability require adults to provide the resources to them, which severely limits accessibility and utility.

89 There is an unfair presumption that children and young people with disability will not benefit from learning about how to be safe, what is appropriate touch and what bad touch is, or general sex education. People do not think that resources about sex, sexuality and sexual safety are appropriate for children and young people with disability. There is a real pervasive myth about people with disability generally—and about children and young people with disability—that education about relationships, sex and sexual identity will lead to 'undesirable sexualised behaviour', which may be behaviour like masturbation, a strong desire for relationships, or watching porn, that would be considered completely ordinary teenage behaviour in a person without a disability. This is part of a broad denial of the sexuality of people with disability, which increases children and young people's risk of sexual abuse and assault.

90 I do not believe that this comes from any malign intent; it comes from a desire to protect children and young people with disability. But the foundation upon which we base this desire is improper. We underestimate what children and young people with disability want and their capacity to come up with strategies and their own priorities for change (as discussed earlier).

91 This is because of our belief and perception about what is expected and anticipated for the life of a child or young person with disability: that they will not be able to understand and process sex, will never have it, and accordingly we do not need to educate them about sex. This assumes that education about sexuality and relationships is only about sexual activity, for a start, and that sexuality is not part of children and young people's developing identity.

92 Not only does it unfairly assume the scope of their lives and severely limit it, but it makes children and young people with disability far more vulnerable to be induced into behaving in sexual ways, either as the initiator or recipient of a

sexual act. Without (age-appropriate) knowledge about what constitutes private sexual acts, it is difficult for children and young people with cognitive disability in particular to both identify whether something is wrong and tell someone about it.

93 Failing to educate children and young people with disability about sex education or safety speaks to a broad social assumption that it is okay to let bad things happen to children and young people with disability. There is a long history of abusive and neglectful treatment of people with disability – institutionalisation, poor standards of care and low expectations in education. Any improvement is seen as progress. Yet standards for children and young people with disability remain far below those for the wider population of children and young people. Education is an important place to start to redress this.

94 There was an excellent program in the mid-1990s) demonstrating why it is important to educate everybody around the young person at the same time as educating that young person. Briggs and Hawkins evaluated the program and conducted further research with children with learning disabilities in 2005, concerned about the high rates of disclosures. In their research, they found that providing education to the children and also to teachers and parents in parallel was important and valuable for children with disability who came from family backgrounds where they received little if any information about safety or sex education; where they experienced high rates of family violence and neglect; and where family life was complex. (Briggs, F. & Hawkins, R., (2005) Personal safety issues in the lives of children with learning disabilities. *Children Australia*, 30, 2, 19-27)

95 There have been some other programs set up to provide education modules for attitudinal changes and skills development for children in schools – for example, the ‘SoSafe! System’ and SCOPE’s ‘Speak up and be Safe program’.

96 A child-centric approach is really important when it comes to educating children about sex and safety. An issue with this is that children and young people with disability are often labelled. The way they are treated is then influenced by the label, rather than focusing on the inherent qualities and characteristics of the child themselves. Children and young people with disability are then triaged

into different streams of education which do not necessarily provide the same level of education as a mainstream curriculum.

97 A holistic approach to pedagogy is important. This means recognising that each child is entitled to the same level of education about sex, sexuality and keeping safe, but the methods by which that education is provided may differ between different children and young people. It means that a child or young person with disability has that taken into account to enhance their education, not limit it because of unfair labels. It is about changing the method of education, not the outcome.

98 It is really important that when we educate children and young people with disability, we do not compartmentalise them, because it means they miss out on developing really important safety skills and sex education.

Trauma-informed resources and specialist support

99 With cohorts of children who might move into exhibiting harmful sexual behaviour, the importance of early intervention in a trauma-informed way cannot be understated. The issue is that we lack trauma-informed resources. The standout Taking Time guide to trauma-informed practice is an excellent exemplar, but much more is needed. (Jackson, A. L., & Waters, S. E. (2015). *Taking Time – Framework: A trauma-informed framework for supporting people with intellectual disability.* Melbourne, Australia: Berry Street). Despite the high rates of adult to child sexual abuse and peer to peer abuse, and the evidence of the benefits of trauma-informed practice in child sexual abuse generally, we really do not see it being appropriately brought into disability services.

100 When children, including children and young people with disability, engage in what is classified as harmful sexual behaviour, they may have no intention to harm the other person. There are several guides for recognising problematic or harmful sexual behaviours for those people working with children. Problematic or harmful sexual behaviours are defined on a continuum taking into account the young person’s age and development, and can be understood through the Traffic Lights Model. When looking at harmful sexual behaviours, it is important to consider whether the behaviours are developmentally expected; socially acceptable; consensual, mutual, reciprocal; and include shared

decision making. While normative or abusive behaviours can be recognised, the complexity of identifying younger children's problematic behaviours should not be underestimated.

101 Features of cognitive impairment that can increase risk for children and young people with intellectual disability are around issues with communication ability and understanding, psycho-social skills, planning and consequences, emotion regulation and friendships, understanding of, and influence by peers. A report commissioned by the Scottish government outlines service provision for children with harmful sexual behaviours through public health, prevention and risk, individual intervention and trauma-informed workforce, changing community culture and attitudes around gender, and psychological support for the individual and their families.

102 Service providers in research conducted by our team emphasised the importance of looking beyond static descriptions of 'vulnerability' or 'risk factors', which are focused on deficits in children, and focus on the integration of the young person's strengths and needs, which responds to the capabilities principle, family and carer support, and collaborative work across services to reinforce behaviour change. Both service providers and policy makers heavily stressed the need for interagency and holistic responses to address gaps and shortfalls which left children lacking effective support.

103 We need to remember that children and young people with disability are often excluded or poorly served when it comes to sex education, and this may play into their behaviour. This is where specialist support needs to be deployed as opposed to ostracising the instigator of harmful sexual behaviour or labelling them as something predatory.

104 Unfortunately, there is a national lack of resourcing of specialist psychologists and psychotherapists to support children who need specialised therapy. Children with cognitive disabilities need to be quickly referred to proper treatment.

105 It is important that we understand the behaviour because the harmful sexual behaviour may be the manifestation of a trauma experienced by the instigator that itself needs to be treated with trauma-informed therapy.

106 Trauma-informed practice involves meeting the child where they are at mentally and developing an understanding of the environment within which the

child operates. It is about people making a safe space for a child and the service provider developing a trusted relationship with them. It involves giving the child autonomy over what happens, collaborating with the child regarding how they want to approach their trauma, and empowering the child to move forward. Trauma-informed therapy requires that practitioners listen and respond rather than dictate what happens.

107 For children who have experienced trauma, it is really important to develop safe relationships with a trusted adult.

108 Trauma-informed practice appreciates that trauma manifests in different ways. For example, a trauma-informed approach to peer to peer child sexual abuse acknowledges that the instigation of that abuse can be a manifestation of the trauma experienced by a child. It is often not malign intent from a child, its trauma experience showing itself to a peer.

109 When child sexual abuse is identified, it is important to have adequate referral systems in place so that children are referred to people that can help them.

110 I am currently involved in research funded by Australia's National Research Organisation for Women's Safety (ANROWS) about the experiences of domestic and family violence of children and young people with disability and their families. One of the most devastating things I witnessed during this project was the lack of access to trauma services for children and young people with disability, including children who were using behaviour that was harming other family members, despite knowing that often the children were exhibiting behaviours that mirrored the trauma they experienced.

111 We first received funding from ANROWS for our research in this area for another project about early intervention in domestic violence where the mothers or children in the family had a disability (Robinson, S., Valentine, K., Newton, B.J., Parmenter, N. (2020) *Violence prevention and early intervention for mothers and children with disability: building promising practice. Final report.* Australia's National Research Organisation for Women's Safety (ANROWS), Sydney). In these situations, children were treated as passive members of their family. Their views and priorities about the DFV they had experienced were generally not sought, and often providers did not even meet the children, focusing on providing assistance at the 'whole family' level.

112 When these children had their unaddressed support needs identified as part of whole family support, they were generally referred to the NDIS for disability related funding and support. In part, this was a function of working with available resources. However, there appeared to be little consideration of whether the child had experienced any trauma arising from the family violence which had occurred in their home. No effort was made to establish whether trauma had any influence on the child's disabilities and whether their behaviours were an ongoing disability or a manifestation of trauma. This matters because a diagnosis of trauma-related harm as a disability at an early age will follow children into school and change their trajectory.

113 In a different project, practitioners working with teenagers with cognitive disability who were engaging in harmful sexual behaviours told us that often a first step in the trauma-informed treatment process is undoing all the incorrect diagnoses with which the young people had been diagnosed over time. If this was not done, often those teenagers would be moved through the health and community services systems while being treated for disabilities that they do not have (including with psychotropic medications), whilst leaving their potential trauma unaddressed.

OUT OF HOME CARE

114 There is an overrepresentation of children and young people with disability in out of home care. Attached to this statement and marked **SAR-16** is a copy of the Monash University's Rapid Evidence Review.

115 It is important to discard any assumption that adults, including parents, will be advocates for children's safety. There is a substantial amount of research to suggest that adults are not always the best advocate for children. This can be because adults often do not appreciate the autonomy of the child and/or fail to recognise their priorities and individual needs.

116 It is really important to recognise with respect to children and young people with disability who are transitioning from out of home care to independent or assisted living that they have a need and a right to maintain close personal relationships with people.

117 For example, I worked with a young man with disability who was in foster care. Upon turning 18, he was sent to live in a town quite far away from his foster

home, which meant that he lost contact with his foster parents because it was difficult for him to travel independently. He then became socially isolated and lost the protections that came with being around trusted people. This is just one example of how the needs of individuals are not taken into account in providing services

118 These strong social connections play an important protective role for children and young people with disability, and if we implement policies that deny them the right to maintain those relationships, we are unnecessarily exposing them to harm and potential abuse.

PUBLIC GUARDIANSHIP

119 There is a general lack of effective oversight to keep children and young people with disability safe when they are in the care of the public guardian. While not specific to Tasmania, the public trustee or public guardian is a strong example of a lack of oversight and synergy within the system.

120 Public guardians are responsible for decision-making and administration of finances of some children with disability, which is important when it comes to accessing services. There is a high level of staff turn-over for public guardians which means the child or young person is frequently re-assigned a new public guardian. Further, many public guardians will never meet with children they are guarding or are slow to disburse finances. I hear so many stories about how poorly coordinated care for children in out of home care is and how those children are severely disadvantaged.

121 In our research in the ANROWS Domestic and Family Violence Project, one person related their circumstances. A mother who was unable to adequately tend—through no fault of her own—to her son’s trauma-informed behaviour, relinquished his care, and he was moved by Child Protection into a group home.

122 At the group home, she had one hour a month to visit her child. He became so stressed following his mother’s visits that Child Protection and the service provider jointly decided that the visitation time would be limited to 30 minutes. She said this has been even more distressing for them both.

123 I cannot see how this was acting in the best interest of the child. The response failed to attend to all the sources of the child’s distress, and the therapeutic

needs of the child were clearly not paramount. I consider that both the mother's and the son's lives were worse as a result of the action taken.

124 The issue can continue into adulthood because people adults with disability are less likely to take up their own life administration at 18 years old.

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

Declared at [redacted]
on 26 April 2022

…… [redacted] ……
Sally Antoinette Robinson

Before me:

[redacted]
Commissioner for Declarations

This Declaration was witnessed by audio-visual means in accordance with the 'Notice Under Section 17' dated 4 September 2021, as authorised by the *COVID-19 Disease (Miscellaneous Provisions) Act 2020.*