Response to Consultation Paper: *Institutional responses to child sexual abuse in Out-of-Home Care.*

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Northern New South Wales Local Health District (NNSW LHD) is the primary health service provider in the northern region of New South Wales (NSW). NNSW LHD provides a dedicated pathway for provision of health services for children and young people entering statutory out-of- home care (OOHC). This pathway was established as a '*Keep Them Safe'* initiative resulting from the Wood Special Commission of Inquiry into Child Protection Services (2008). Coordinating a comprehensive health assessment and follow up for children on entry to OOHC requires contact with children and young people, carers and caseworkers for children in OOHC as well as health providers, both public and private, within and outside our geographical location. The service has been in operation since 2010 and to date close to 600 children have been supported by the service.

This consultation paper reflects many of the issues that we encounter. We are grateful for the opportunity to provide the following response to the Royal Commission into Institutional Responses to Child Sexual Abuse in Out-of-Home Care.

Child sexual abuse by carers and staff (page 5)

Government agencies, regulators, oversight bodies and service providers can improve, and provide adequate screening checks, assessments and re-assessments of children's placements, carers and other household members by requiring agencies to: demonstrate they regularly assess risk to individual children in their care; make statements in induction, orientation and training programs that acknowledge that some carers and staff working with children may be deliberately seeking to work with children in order to gain access to children, identifying exactly what steps need to be taken if staff become aware of inappropriate behaviour and reportable conduct; demonstrate that they audit their carer and staff knowledge of the types of behaviours that would be of concern, agency policy and procedure in responding; and, transparency in the investigation of complaints/concerns process. In relation to children, carers should be required to undertake 'responding to disclosure', and 'reparative parenting' training.

Terminology 'sexually harmful behaviours' (page 6) and child-to-child sexual abuse in OOHC

NNSW LHD agrees that this terminology is non-stigmatising to the child, while it also acknowledges that these behaviours result in harm. Other terminology such as 'problematic' sexual behaviours does not capture the harm done to the child impacted by the behaviour. NNSW LHD also concurs with the actions the Royal Commission is considering on page 7, specifically the treatment responses for children across Australia who display sexually harmful behaviours. There is no dedicated service within the NNSW LHD geographical boundary that provides treatment for children with sexually harmful behaviours. Within this group, a cohort of significant concern to NNSW LHD is sexually harmful behaviours occurring between siblings. Unfortunately this population of children is growing without a corresponding increase in specialist treatment services for this group.

NNSW LHD would welcome funding for a New Street Service to be located without our boundary that would offer both a clinical service to children and young people and a consultative role to clinicians and carers. It is of significant concern to NNSW LHD staff that children with these behaviours have few accredited and experienced practitioners to attend for assistance. While foster care agencies indicate a willingness to financially support access to private counselling services, these services are also limited due to the lack of counsellors with adequate capacity and training.

An important improvement would be having a definitive list of 'accredited' courses. The system in NSW (to assist with locating an accredited counsellor with this speciality) is subjective and appropriately qualified and experienced counsellors are scarce. Several of the public health services that might have this target group as inclusion criteria to their service, do not have capacity to see these children. Therefore, it is often up to the private sector to provide a service response, and few private practitioners advertise as having the skills to provide this intervention.

Information sharing provisions (page 8)

The NNSW LHD experiences unrelenting difficulties with cross border child protection information exchange as we share a border with the state of Queensland (QLD). NNSW LHD supports the Royal Commission's suggestion of nationally consistent arrangements modelled on *Chapter 16A* of *the Children and Young Persons (Care and Protection) Act, 1998.*

Such changes would only result in better information sharing regarding children in OOHC if resourced appropriately. The Central Contact Points for exchange of child protection health information in NSW Health Local Health Districts already have operating procedures which could be used as guidance to formulate policies and procedures to operationalise such large scale reform across Australia.

NNSW LHD agrees that opportunities to improve information sharing through legislation, policy, practice and cultural change would make a significant contribution to better protect children from sexual abuse in OOHC contexts. Please find attached a newspaper article demonstrating this point.

NNSW LHD acknowledges the comment (on page 76) that "We also note that there is no comprehensive, systematic data about the use and effectiveness of Chapter 16A." Data to answer part of this question (use of 16A) could easily be answered by correlating administrative data from large prescribed bodies, such as NSW Police Force, NSW Health and NSW Family and Community Services (FACS) to count the frequency of use of 16A. Further, effectiveness of 16A could be in part evaluated by randomly allocated case reviews in FACS to determine if 16A information informed: decision to provide statutory response; decision to provide a face-to-face statutory response; of those face-to-face responses, what was the level of risk allocated to the child; referrals to other agencies; or a decision on placement (e.g. remain with carers, removal, restoration). It would be faulty to assume that just because "…inadequate awareness, practice, and confidence in sharing information under Chapter 16A have been reported." (page 76), that the benefits to the legislation did not outweigh the negative views expressed. The statement speaks to the lack of resourcing of implementation and governance of the system (exemplified by the fact that no agency has kept data on use and effectiveness), rather than the virtues of 16A to promoting children's wellbeing in a way that is far superior to the system operating pre 2009 in NSW.

Interagency case meetings held within our health district including the Out of Home Care and Child Safety Meeting designed to support vulnerable children rely on Chapter 16A provisions to share information.

The range of prescribed bodies in NSW 16A is appropriate, and should be mirrored in national legislation. The range of exceptions to information sharing obligations could be better defined in the legislation. The challenges jurisdictions may face in implementing these arrangements are based on cost impost. The costs of policy change, training staff, monitoring, evaluation and resources to assist with decision making (for example, access to legal advice when determining whether to provide information requested under Chapter 16A) will be substantial. Chapter 16A legislation is interpretive by nature and there is not sufficient support available to assist agencies to make decisions on the appropriateness of information exchange where there is a question about whether the information requested is legally able to be exchanged. Clearly, if there was national legislation, central contact points would need to be guaranteed in each agency and this would be costly and therefore could be a challenge in implementation.

The experience of clinicians supporting children in OOHC in our health district is that many carers receive little or no background information in relation to children coming in to their care. Carers report a frustration in not having this information. Health clinicians routinely make recommendations following assessment of a child's emotional and behavioural wellbeing that includes better sharing of information of a child's trauma history with carers. The rationale for this information sharing is to assist carers with better understanding the child's behavior. A greater understanding of a child's life experience is likely to enhance the carer's ability to provide reparative care.

NNSW LHD is also in support of information sharing relating to child sexual abuse with carers for all other reasons stated in the consultation paper including making informed decisions to accept placements, supporting placement stability, providing appropriate care for children who have been sexually abused and to support children with sexually harmful behaviours.

We have experience of carers telling us that they would not have agreed to the placement of a child with sexual harmful behaviours in their care due to risks to other children in their household.

NNSW LHD supports a nationally consistent approach to the collection of data, including agreement on key terms and definitions across jurisdictions, in relation to child sexual abuse in OOHC. Data should be provided by the OOHC agency with fixed response fields and disaggregated as proposed in the consultation paper.

Specialised training programs for children, carers and staff within OOHC and a national strategy (pages 9, 90 & 98-99)

NNSW LHD welcomes the suggestion of specialised training to attempt to prevent child sexual abuse in OOHC. In relation to agency training, this training needs to be provided at the interagency level. Service systems across government and non-government agencies continue to operate in isolation at times, and it is important that the content of such training is: standardised, delivered to the entire group providing care to children in OOHC (without leaving some organisations off the training list), and delivered at the same time allowing all agencies to participate.

NNSW LHD would support a national education strategy that included an awareness campaign that children in OOHC as being especially vulnerable to sexual victimisation.

Our health district would support an education program for the prevention of sexual abuse and promotion of sexual health targeted to children in OOHC, carers and practitioners with elements as identified in the consultation paper. Indeed our health district is currently partnering with the University of New South Wales (UNSW) in the development of a sexual health promotion program to be delivered to all health districts across NSW. This will include mechanisms for implementing, reviewing, evaluating and improving the program.

Mode of delivery and content of any sexual health program should be culturally sensitive to the audience as identified in the consultation paper.

NNSW LHD recognises that prevention of sexual abuse for children with a disability would benefit from resources individually tailored to meet the needs of that child.

It is possible that children in OOHC could access the same resource material or technology developed for all high school children for same sex attracted and gender questioning young people if these materials were developed giving consideration to the OOHC audience.

The level of health-literacy of young people in OOHC requires targeted work. Consideration should be given to developing a standardised education package that guides carers and caseworkers on what to do at each age to develop the child/young person's health literacy. For example a guideline with checklist on what to do with children aged 0-5 years, such as teach them to clean their teeth, to let carers know if they are feeling sick, or are in pain, teaching preschool children how to attend to basic medical self-care (for example washing a small cut, applying (with help) a bandaid); 5-10 years of age; and 10-17 years of age. Some of these things may be described as activities of daily living however it is the experience of NNSW LHD staff that children and young people in OOHC are not being provided with the skills to develop a functional level of health literacy prior to leaving care.

NNSW LHD agrees with the national education strategy outlined on pages 98-99.

Develop a nationally consistent therapeutic framework for OOHC service delivery (page 9)

NNSW LHD agrees that a nationally consistent therapeutic framework for OOHC service delivery is required, particularly in relation to the mental health care that children and young people in OOHC do or do not receive. Government services appear to be best placed to deliver evidence based care with a transparent clinical governance structure that ensures clinicians delivering mental health care are appropriately trained and registered, are using best-practice, contemporary therapies and that the counselling and support is delivered in an occupational health and safety approved environment. These things are not always guaranteed in the private practitioner model of service provision, and the cost of counselling in the private sector often prohibit OOHC carers attending long-term appointments for children with complex post traumatic stress disorder, or for other therapies such as speech and occupational therapy.

Placement stability (including post-OOHC care) (pages 10 & 116-117)

Kinship/relative carers face different challenges than those in general foster care as identified by the Commission. NNSW LHD would support the development of a 'kin-specific' approach to a culturally safe and appropriate kinship/relative carer assessment and recruitment that is differentiated from foster care approaches.

Kinship carers frequently report to our health workers the difficulties they face providing for the children in their care. Increasing casework support sensitive to the needs of relative carers is likely to benefit carers and enhance the

experience of the children in kinship care. Grandparent carers frequently report a sense of grief about loss of retirement plans, capacity to save for retirement and concern for the additional domestic workload of elderly carers.

When a child is missing from placement there are currently no strategies in place within our organization to assist with finding the child. We would support a cross-sectorial response.

Leaving home is a significant adjustment period for any young person, however young people leaving OOHC face additional challenges that can severely impact their quality of life, and potential career options. This is particularly the case with young people who have been living with ageing grandparents. As described in the consultation paper (page 116) there is currently inadequate preparation to leave care. Further, the timelines set for young children leaving care to set themselves up as adults, appear to be severely out of step with what society expects of young people who are not in out of home care and are leaving home. That is, young people leaving home at 18 years of age who are not in OOHC are given significantly more support and physical resources from their immediate and extended family, than young people leaving OOHC. At the same time, young people not in OOHC also have better job prospects, possibly better health and more mobility to 'go where the work is' than young people leaving OOHC. Young people leaving OOHC who are deemed of 'independent' age, may still try to reside in the area in which they were in care to keep contact with younger siblings etc., when in families where children are not in care, the young person simply moves away knowing that the parents will care for their younger siblings. Shifting the age that young people have support ceased by the statutory agency to the age of 25 would meaningfully assist young people, if they require it, to adjust to their adult life and physically set themselves up in accommodation, employment, further education etc.

NNSW LHD therefore agrees that OOHC organisations and governments should remain responsible for helping those children who have been in care to access necessary counselling and support as they transition out of care and into adulthood. NNSW LHD also agrees that social media applications could be better utilised to help care leavers e.g. Sortli.

Reportable conduct schemes (page 58)

Reportable conduct schemes are most valuable when sufficiently resourced. Commencing at the investigation phase, physical resources such as recording equipment, access to transcription services, investigator training and mentoring are all necessary to support the success of reportable conduct schemes. Such schemes should be established in all states and territories. The reportable conduct scheme operating in NSW contains all of the features required, however agency resources to complete investigations are sometimes lacking. This is of particular concern when allegations of abuse against employees teams cannot complete the investigations due to demand versus personnel to complete same e.g. in the statutory child protection agency, or in the education department.

Schemes should be reciprocal in that a person should not be able to get a blue card in QLD if they have reportable conduct findings against them in NSW and fail the working with children check in NSW.

Applying the child safe elements to the OOHC sector (page 88)

NNSW LHD is in support of the suggested strategy of all carers (and other adults residing in the home) fulfilling the requirement of both criminal record check and working with children check. We acknowledge the resource implications of this approach, in addition to the significant strain on the availability of suitable placements for children in care.

Access to care leaver records (page 119)

The work undertaken on record keeping is welcomed, and all strategies in the consultation paper on this initiative are supported by NNSW LHD. In particular, the face-to-face access to a free counsellor when the care leaver reviews information they receive from their OOHC service provider.