Summary of panel discussion at the CCC forum on children with harmful sexual behaviour

Professor Helen Milroy (HM), Dale Tolliday (DT), Dr Robyn Miller (RM), Mary McKinnon (MM)

Question 1: How does collaboration work in our competitive world?

HM: No-one collaborates well and perhaps we should think about it differently. One option is to have core experts/specialists within an area or system who collaborate with experts/specialists in other systems or areas.

RM: Collaboration is one of the MacKillop values. It is all about relationships and we tend to underestimate the effort and skill it takes to build and maintain relationships. MacKillop has had success through embedding or co-locating child protection staff in other systems.

DT: Collaboration requires both an attitudinal and behavioural shift. One way to estimate the level of collaboration is to look at what services have been wrapped around a young person. Two resources in NSW have recently been developed through multi-agency contributions – NSW FACS *See, understand and respond to child sexual abuse* and a kit that is currently being rolled out in public schools. NSW Health is also developing practice guidelines that will become publicly available.

Question 2: What does collaboration look like in upper levels of management and between agencies of different sizes and resources?

RM: The whole is greater than the sum of its parts and there is a need to share resources. The funding environment sets up competition but what is needed is partnership in tendering, sharing research and practice. The idea of working as a matrix rather than a hierarchy is more conducive to collaboration because people can be encouraged to form teams and develop integrated holistic approaches to their practice.

HM: We need to stop being so precious so we can share collective resources. Specialists tend to think only they can do this work and in fact the focus should be on the child and family's needs, not on who meets the needs. In the UK there is a model where a child/family has one prime service or therapist and services are wrapped around that one worker.

There needs to be clarity about and respect for each other's roles.

RM: A good story about collaboration: Federation University Australia and La Trobe University have collaborated to support care leavers to attend university. With one project worker, some support and a bit of financial help, over the last two years the number of enrolled care leavers has risen from 40 to more than 260. This didn't cost a lot of money but has high impact.

MM: Collaboration is rocket science. It is easy to say and hard to achieve. It's hard to quantify but collaboration often makes a big difference.

Question 3: It all feels overwhelming. What would be the one thing each of the panelists would look for in an agency working well with this issue?

RM: Awareness – that harmful sexual behaviour is talked about, that there are systems in place, training, supervision, strategies, that incident reports name it correctly. There isn't one single thing as it's a complex problem that requires a whole lot of concurrent strategies and planning. It comes back to collaboration and

to leadership. The Jonathan Lord case demonstrated the dangers of policies on the shelf and a very different culture on the ground (Case Studies 2 and 47, Royal Commission into Institutional Responses to Child Sexual Abuse).

HM: Everyone does feel overwhelmed and the danger is of going back to denial and avoidance. Push feelings of overwhelm to one side and embrace what has been revealed and discussed in the last few years. Go forward, not in trepidation, but knowing that we can do a whole lot better. We need a very positive shift in attitude and leadership.

DT: Clearly focused leadership that supports middle managers with awareness and education.

Question 4: Research suggests that kids in care are concerned about many things – bullying, theft of their belongings, lack of privacy, being misled into criminal activities – as well as sexual abuse. Is it important to deal with all these risks or just focus on the sexual abuse?

DT: It is a mistake to look at just the sexual abuse. It's very clear from the sexual harm literature that, if you do, you may impact on a repeat of sexual harm but you do nothing to address the vulnerability of the young person and evidence shows an enormous flow into other anti-social behaviour and diminished outcomes. Harmful sexual behaviours need to be understood in the context of all the drivers. You can't put the same level of response into every factor – the approach needs to be quite refined. Specialist input can help determine achievable targets and the priorities among the range of adversities the young person is facing.

RM: You have to think about the whole child. An example of a young woman with a terrible history of abuse, shocking substance abuse and recruiting other kids into sexual exploitation. She has turned her life around in the last two years- and notwithstanding all the therapeutic interventions and partnerships, the thing that she felt had made the most difference was getting a part-time job. She felt normal. Kids need to feel normal.

DT: Just imagine if that young woman had been regarded as such a risk to her peers that she needed 1:1 supervision – not allowed out of people's sight and certainly not employed. There is a calculated risk in facilitating steps to independence. If the service had been completely risk averse, she could have been completely shut down.

HM: A holistic approach is definitely needed but there needs to be a specific focus on sexual abuse. It has been such a taboo in society and the most common response has been denial, minimisation and avoidance. Young people will talk about violence, about having their stuff stolen but they may not talk about sexual abuse. Sexual abuse is not the only thing but if we miss this, we miss one of the most damaging and traumatic experiences someone can have.

Question 5: Can technology be used to increase the reach of expertise and knowledge? Do panelists have any examples?

HM: Too much expertise sits in offices down dark corridors that kids can't get to.

Telepsychiatry could be used more but a further issue for rural and remote workers is that they don't have the buffering or clinical support they require. There is a need for a more sustained model of supervision, advice and consultation. One option is to have real time assessments conducted by less experienced

frontline workers that are fed immediately back to expert clinical services that can provide real time consultation and expertise.

RM: Building capability more important than doing video conferencing directly with kids or communities. It would be fantastic to see more focus on supervision of workers rather than direct counselling of clients. You can't do it all by video or phone – sometimes you need a person on the ground.

MacKillop is trialling an app which enables workers to write up information about a young person 2-3 times a day. This produces a graph at the end of a week about how much sleep they've had, whether they've gone to school, contact with family etc – it provides a more holistic picture than incident reports. MacKillop is willing share the app when fully developed.

DT: Work is being done in NSW Health on standards and ways of using telehealth. Mixed results. Direct service for children needs face-to-face work: if a young person has a relationship with a local worker telehealth can work well. But outreach into communities is better done in person – it is expensive but there is a cost saving overall with better engagement and stable outcomes. Telehealth is also tricky when it's used for group supervision - it's hard to manage nuances and team dynamics via technology.

Question 6: Has there been any study/research on working with culturally and linguistically different communities and cultural stereotyping of girls' and boys' behaviour?

DT: New Street Services get assistance with cultural expertise, particularly with communities that staff are not familiar with. They tend to use telephone interpreters rather than local folk when working with small communities as this more closely protects privacy.

RM: It's very important to be attuned to culture or you can do more harm than good. Cultural consultants can be very useful.

HM: The Royal Commission consulted with many migrant groups. Some had yet to grapple with the issue. Some viewed girls as more at risk than boys and so boys were slightly less protected. This is of course a myth across all communities.

There is a need to differentiate between cultural and religious groups. Some religious groups hold beliefs that conflict with child safe practices, for example the group that refuses to allow children to attend sex education classes at school.

Wrap up

MM: Many thanks to panelists for their presentations and their participation in the discussion, and thanks to all participants.

The Children in Care Collective aims to lift the capacity of senior leaders across the sector on various topics and to contribute to discussions so that different groups can collaborate on solutions in a united way based on discussions and evidence. I hope the forum today has made a contribution to that.