



SPARK AND CANNON

TRANSCRIPT OF PROCEEDINGS

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THE HONOURABLE TIMOTHY FRANCIS CARMODY SC, Commissioner

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IN THE MATTER OF THE COMMISSIONS INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 1) 2012

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

..DATE 5/11/2012

Continued from 31/10/2012

..DAY 30

WARNING: The publication of information or details likely to lead to the identification of persons in some proceedings is a criminal offence. This is so particularly in relation to the identification of children who are involved in criminal proceedings or proceedings for their protection under the *Child Protection Act 1999*, and complaints in criminal sexual offences, but is not limited to those categories. You may wish to seek legal advice before giving others access to the details of any person named in these proceedings.

THE COMMISSION COMMENCED AT 10.02 AM

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COMMISSIONER: Good morning, everyone.

MS McMILLAN: Yes, good morning, Mr Commissioner. I appear as counsel assisting this morning with Mr Simpson. I think there's only otherwise one different appearance at the bar table.

MS STEWART: Good morning, my name is Stewart, initial L, counsel for the Aboriginal and Torres Strait Islander Legal Service.

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COMMISSIONER: Good morning, Ms Stewart. Mr Capper, I note your appearance for the - - -

MR CAPPER: Thank you.

COMMISSIONER: And of course Mr Hanger and Mr Selfridge for the crown.

MS McMILLAN: Yes, thank you. Mr Commissioner, this week we will focus on two issues; firstly the sexual health, and secondly the mental health of children and young people in the child protection system. Sexual health: the commission will hear evidence that compared to other children and young people, children in care have higher rates of earlier onset of sexual activity; sexually transmitted infections; younger age pregnancy and parenting; sexual abuse, including sexual exploitation; and problem sexual behaviours.

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To begin with I will call Ms Holly Brennan, who's the manager, research and program development, of Family Planning Queensland. Ms Brennan will give evidence about the dearth of sexuality and relationships education for children and young people in care. In particular Ms Brennan will speak to addressing the specific educational needs of these children and young people; for example, the distinct needs of children with disabilities and Aboriginal and Torres Strait Islander children.

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Ms Brennan will also discuss the confusion that exists in relation to different sexual health related procedures in the child safety practice manual; for example, the procedure required to gain consent for a young person in care to access contraception. It's also unclear from case to case who has the responsibility for meeting a child's sexual health needs. Questions will be raised in relation to providing for this responsibility in a child's care plan or a child's health passport, or indeed a cultural support plan.

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5/11/12

McMILLAN, MS

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Evidence also suggests foster and kinship carers and child safety officers alike are ill-equipped to meet the sexual health needs of children and young people in care and require greater training and access to evidence-based resources. It's particularly important that appropriate education is afforded to these young people because it's a key to protection and prevention of many of the above consequences I've just outlined.

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Secondly will call Prof Steven Smallbone, who's the director of the Griffith Youth Forensic Services. GYFS, as it may be called, provides specialised assessment and intervention services to children and young people who have been convicted of a sexual or sexually-motivated offence. Nearly two thirds of young people referred to GYFS have a child safety history which indicates missed opportunities by the department and others for early intervention.

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Prof Smallbone will also provide evidence that the department is ill-equipped to deal with youth sexual offending against other children as well as used sexual offenders in general. Prof Smallbone will cite case studies where the department has made placement decisions without considering the needs of the young offender or the safety of other children. Just pausing there, Mr Commissioner, you've already heard evidence about the inability of the child protection data system to incorporate information relating to placement issues. That was evidence in relation to a coronial inquest in Rockhampton.

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GYFS delivers its services in the community where the young person leaves, allowing for the young person to be observed in the context of their family and community and for capacity-building of local professionals. Service delivery in community is particularly important for Aboriginal and Torres Strait Islander young people. It increases cultural validity where it would be inappropriate to remove them from their community.

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Prof Smallbone will also discuss a new place-based prevention project being undertaken by GYFS into separate remote communities - which I should say he's asked that not be identified, given the nature of the therapeutic work they're undertaking - which focuses on the apparently endemic problem of youth sexual violence and abuse in these communities. Prof Smallbone will provide the commission with greater insight into sexual violence and abuse and a better understanding of how to prevent it.

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Moving then to the topic of mental health, there are three key stages of a child's brain development; before birth, during infancy, and beyond the third year. While brain cells are mostly unconnected to each other at birth, by three years they have formed dense connections. This is reflected in the following graphs which I propose to tender

5/11/12

McMILLAN, MS

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and my trusty junior will flick the right switch to show. The first one, as you will see there, is for those who it's a little difficult to read, Rates of Return to Human Capital Investment.

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Perhaps if I could hand one up for you, Mr Commissioner, to look at. In fact, I will tender that copy. Copies have been provided to the other counsel. The source of this is Heckman 2000 cited in the Royal Australian and New Zealand College of Psychiatrist's submission 2011. What this graph shows is that clearly the return on investment is at its highest shortly after birth and still quite significant up to preschool years, but drops away very considerably during schooling and job training times of a child's life.

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The second graph I propose to tender is entitled Brain Development, Opportunity and Investment. This is from Vandergaag 2004, which again was cited in that submission I've just mentioned. You will see there it's fairly startling that the brain malleability is greatest in utero; it drops away fairly significant by the end of the first year; and then it drops away very significantly after about the age of 10.

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You'll see that the greatest spending of course does not occur in relation to health, education, income support, social services, and crime until after the age of 10, and increases after that, you will see until late into a person's life. So the emphasis being of course that the opportunity for greatest input in terms of brain development issues, and particularly for children in care, is in those very early years.

COMMISSIONER: So the Heckman graph will be Exhibit 110 and be Vandergaag graph will be 111.

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ADMITTED AND MARKED: "EXHIBIT 110"

ADMITTED AND MARKED: "EXHIBIT 111"

MS McMILLAN: If it please you, Commissioner. These findings, as I said, reflected the importance of a child's development in the early years; for example, multiple out-of-home placements have been shown to produce attachment difficulties, but as one would see, in these early years, may well impede the brain development of young children. It prompts debates in relation to permanency planning and adoption, topics of which you have already heard some evidence.

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The key issues to be raised by the witnesses relevant to this topic will include: the impact of traumatic experiences on the brain and physical development of children; infant mental health programs for children; the critical emphasis of forming attachments to caregivers; and the cost benefits of early intervention and prevention.

5/11/12

McMILLAN, MS

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We'll be calling Dr Jan Connors, director of the child protection unit, Mater Children's Hospital; Dr Elizabeth Hoehn, consultant child psychiatrist and program director of Future Families; the infant mental health service of children's health Queensland hospital and health service. I will then call Dr Stephen Stathus, the clinical director of the child and family therapy unit at the Royal Children's Hospital, and then Dr Brett McDermott.

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Dr Stathus will say that amongst other matters, that 27 per cent of all Queensland children who were victims of substantiated harm and had contact with the Department of Child Safety subsequently offended and involved in youth justice system. One in six - that is 17 per cent of these - were in the care of the department prior to detention. All of these witnesses will emphasise the need for therapeutic early intervention and about systemic matters in terms of their interaction with the Department of Child Safety and their perspectives on prevention and intervention.

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I now call Ms Holly Brennan.

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BRENNAN, HOLLY LOUISE affirmed:

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COMMISSIONER: Good morning, Ms Brennan. Welcome?---Thank you.

MS McMILLAN: Thank you. Ms Brennan, have you prepared a statement in relation to this inquiry?---Yes, I have.

Could you have a look at this document?---Is that a copy of your statement with an attachment?---That's my statement, yes.

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Yes, and the contents are true and correct?---Yes, they are.

I tender that, Mr Commissioner. Ms Brennan, there's no reason that can't be published, is there?---No.

Yes, thank you.

COMMISSIONER: Ms Brennan's statement will be exhibit 112 - 113, sorry.

MS McMILLAN: 13, yes, thank you. Ms Brennan, do you have a copy of your statement with you?---Yes, I do, thanks.

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All right, thank you. Can I just ask you also, it's the case, isn't it, that Family Planning Queensland have already made a number of submissions to the inquiry?---Yes, we've made two submissions.

Yes, the first one is entitled "Children and young people with a disability, sexual abuse and sexuality and relationships education," and the second one is "Children and young people, problem sexual behaviours, access to sexual health services, access to sexuality and relationships education"?---Correct.

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Did you have a hand in the preparation of those submissions?
---Yes, I did.

COMMISSIONER: Sorry, Ms McMillan, I'm going to withdraw the exhibit number of the last exhibit and make that 112. I was right the first time.

ADMITTED AND MARKED: "EXHIBIT 112"

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MS McMILLAN: I shouldn't have cavilled with you.

Ms Brennan, in terms of your work history you have been since 2004 the manager of research and program developments with Family Planning Queensland?---Correct, I have.

You develop sexuality and relationships education programs, prevention of childhood sexual abuse programs and sexual

5/11/12

BRENNAN, H.L. XN

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behaviour programs?---Yes, I do. 1

You coordinate FPQ; I might call it by that acronym given it's a mouthful, state-wide projects relating to the child protection sector?---Yes.

You develop advanced training modules and brochures for foster and kinship carers?---Correct.

You develop training with the child protection workers, for example, the traffic lights framework?---Yes. 10

Indeed that's an attachment to your statement, isn't it? ---Correct.

All right, and I'll take you to that in a little more detail later. You have a bachelor of education. Correct? ---Correct.

And your certificate IV assessment in workplace training? ---Yes.

You are the author of early childhood sexual abuse prevention resources, an educational CD and a guide for parents to healthy sexual development?---Correct. 20

In your statement you indicate you've presented papers and workshops at conferences and forum in Queensland, nationally and internationally?---Correct.

You've developed and delivered nationally recognised training programs and non-accredited programs?---Correct.

You have amongst other things been awarded the medal of the Order of Australia this year, in fact?---Correct. 30

Yes, thank you, amongst others that are perhaps too numerous to name. FPQ is a non-profit organisation. Is that correct? ---Yes, we are.

You have provided sexual and reproductive health services to the wider population of Queensland since its first clinic in 1972. Correct?---Yes, for 40 years.

So some 40 years ago. FPQ offers clinical education and training services from metropolitan and regional locations throughout the state?---Correct. 40

In 2011 FPQ sponsored a CREATE Out of the Box Sexuality and Relationships forum, a brainstorming session about how to get sexual health information materials to children and young people in out of home care. Correct?---Correct.

All right, and you've developed, as I've already indicated, a number of resources for child safety?---Correct.

5/11/12

BRENNAN, H.L. XN

Can I just ask you, in terms of children who are in care, they include children who obviously have experienced sexual abuse?---Yes. 1

Have problem sexual behaviours themselves?---Yes.

And, of course, they may not be necessarily linked, may they not?---Yes, correct.

They have mental issues?---Some do, yes.

Yes, some do. Some have disabilities?---Yes. 10

There are clearly, as we've heard, an over-representation of Aboriginal and Torres Strait Islander children in care. There is also a group who identify as gay, lesbian, bisexual, transgender and intersex hermaphrodites. Correct?---Correct.

In fact, is it your experience that that category, if I can put it that way, is at times the reason why they've been relinquished?---Correct. That's what the research says.

These children also who are in care obviously come from diverse cultural and linguistically diverse backgrounds? ---Many of them do. 20

Yes, all right. So given you have all of those categories, if I can put it, of children in care, it's fair to say from your statement that you're very much of the view they need access to sexual health services?---Correct.

Comprehensive sexuality and relationships education? ---Correct.

And clear communication?---Yes. 30

You say in your statement and as I've just briefly mentioned in my opening, that compared to children and other young people children in care have higher rates of earlier onset of sexual activity, sexually transmitted infections, younger age pregnancy and parenting, sexual abuse, including sexual exploitation and also problem sexual behaviours?---Correct.

You also say in your statement that access to sexuality and relationships education for children and young people in care is extremely limited. Now, can I just ask you, in terms of the limitations, does that bear any relationship to regional issues in terms of how remote a community may be or not?---Yes, it can do, but it's interesting to look at it that you may find some regions who take it on as an issue, providing a better service, than you would necessarily in south-east Queensland. So, you know, I think you have to say that you have to look at each town and each pocket to really know what's going on, because 40

5/11/12

BRENNAN, H.L. XN

there are some wonderful champions out there who are doing good work in the regions. But, yes, access is extremely limited generally across the state.

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You also go on in your statement to say - paragraph 24, Mr Commissioner - "Comprehensive sexuality education programs have been shown to delay intercourse and increase the adoption of safer sexual practices in sexually active young people." What do you base that conclusion on?---On the evidence that's found both in Australia and also overseas looking at the effectiveness of comprehensive sexuality education.

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You also go on to say, "The curriculum needs to address the specific needs of children and young people in care." Can you just expand upon that?---Yes, well, there is a curriculum available in our schooling system that looks at sexuality and relationships education. First of all, that doesn't happen in every school, so that's a side issue, but then for children and young people in care who may not be in school consistently or who may have inconsistent placements or movement and also issues with their mental, emotional and relationship health, that those issues also need to be addressed specifically.

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So how would you see that practically as happening?---How does it happen now?

Well, how does it happen now and what's your view about how it might be improved?---It's so ad hoc now that I would find it very difficult to point out case studies where I'd say that it's been doing very well. How can it be improved? All of us should be involved in the sexuality and relationships education of children in care, so that's foster and kinship carers, residential placements, teachers, guidance officers and then also members of the department. So it's one of those things that you would be looking at a multi system approach to meet the needs of children and young people.

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All right. If I indicate to you Mr Brad Swan, who I think you know of from the Department of Communities and Child Safety, in relation to an information summons noted that the department provides grant funding to a number of organisations to provide community education and information on sexual abuse and preventative and protective measures. For example Bravehearts provides community education and awareness programs in school and Innisfail Community Support Council in far north Queensland delivers community awareness events and programs. I take it you're aware of those?

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---I am aware of the Bravehearts program and I'm not aware of the program in Innisfail so I'll look at more of that. The Bravehearts program is a sexual abuse prevention program. It's not a sexuality and relationships education program.

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Right. Ms Gilchrist has also provided a statement which, Mr Commissioner, I intend to tender tomorrow along with Mr Swan's statement.

She's a manager of positive behaviours, high and complex needs in the department. She says that when children with disabilities are sexually abused, the perpetrators or often the people responsible for the most intimate aspects of their daily care. Would you agree with that?---Yes, absolutely.

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Negative societal attitudes, she says, towards sexuality for people with disabilities means that young people with disabilities may not be provided with adequate sex education, thus heightened interest in sexual activity combined with a lack of understanding and knowledge may result in young people with a disability being more vulnerable to becoming involved in sexually exploitative relationships. Would you agree with that also?---Yes.

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She says that a decision to cease funding in the 2012-13 financial year for the women's reproductive health program will impact upon young women with a disability. The funding enabled your organisation to provide sexual and reproductive health education tailored for women with a disability across nine locations in Queensland. Now, firstly, was that correct that your organisation provided that health education?---That's correct.

And will the ceasing of funding have an impact on that delivery?---Yes, it will.

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Will it be able to continue?---We received some other funding through what's called the NSO Commonwealth grants to work with children and young people in schools so some of that money will continue, but we've also lost the professional development component on that so, yes, we will continue in some capacity to meet the needs of children and young people with a disability but it has been affected.

You say "training". Who did you train within those programs?---So with those programs, the NSO one in particular, that was with teachers and advisory visiting teachers, with assistant teachers in classrooms and also with guidance officers. We were able to provide that training free of charge to people who supported children in schools to stay in schools.

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So I imagine, given you talk in your statement later about the role of teachers, they have been mandatory reporters

5/11/12

BRENNAN, H.L. XN

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for quite a number of years, haven't they, of - - -?
---They've had a policy to be reporters. They have only recently become mandatory reporters the same way as GPs and nurses.

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All right; and I take it you would regard their training as being an important aspect of both prevention and intervention, wouldn't it?---It would be essential.

Because they're often, if a child is attending school, a good objective benchmark, if I can put it that way, as to what might be normal behaviour in children of that age as opposed to behaviour that might give rise to concern?
---Yes, and they're also one of the few workforces that are trained in understanding childhood development and so they're - you know, they're fairly aware when something isn't going quite right. Teachers are often the people who spend the most time every day with children and young people other than their foster and kinship carers or other carers.

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All right. So I take it then you would have quite a level of concern about the fact that the cut in funding would mean that you're not able to continue education and skilling with, for instance, teachers and other workers?
---Yes, we have a level of concern but, you know, we're hoping that the training we've done will help people to continue.

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All right, thank you. Now, Mr Swan also talks about in terms of - you say that children in care have poor access to sexual health services. Mr Swan's statement indicates that intake information received may identify general or specific sexual health issues or needs. Now, I take it though that, of course, may be problematic particularly if a young person may identify, say, as being bisexual or transgender, the issues of balancing that against privacy, I imagine?---Yes, so there are real issues with regards to sexual health and access to sexual health services and then also for young people around their sexual identity. So there's quite a lot of research into gay, lesbian, bisexual and transgender young people talking about it being put in their case files about their sexual identity, but saying that their heterosexual counterparts don't get it put in their case files that they're heterosexual. So it's a fine line though because you do want to support these young people who may have additional support needs.

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I take it too because their orientation may not be fixed also at that age?---Yes, certainly.

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Is that your understanding?---Yes. I mean, obviously some young people seem to know that they're gay from very, very young and others go through a time of learning about who they're sexually attracted to and how they identify.

So there are a number of factors that are involved in whether that information should be included and perhaps how it's included?---Yes, and how we support foster carers and kinship carers to be able to work with those young people in the journey that they're going on with their sexuality.

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What general age are we talking about with these young people with issues of orientation? Are we talking mid-teens or later teens?---Well, I mean, we've worked with people far younger than that. I mean, I think it's generally that young people might access services or be leaving home, you know, from the 10 and upwards age range, but more obviously when they enter, you know, issues of homelessness or their case - you know, the breakdowns of their placements, that's usually in mid-teens.

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So is it your understanding that there's some link between, for instance, this group with orientation issues, if I can put it that way, and then a link to placements breaking down and homelessness?---That's what the research says, yes.

I take it, would they then be particularly vulnerable, this group of young people, if they're homeless?---Yes.

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Well, you're obviously vulnerable if you're homeless anyway but particularly if you have got issues around this and it may have led to the breakdown of a placement, I take it? ---That's right; you know, you've got issues of self-worth and mental health and where do you belong and are you an accepted member of society.

All right, thank you. Now, Mr Swan also says that children and young people in risk of entering the child protection system have accessed - the only access they have is sexual abuse counselling services. I take it you're talking that there should be a much broader range of services available? ---Correct.

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Because you're not just addressing issues of whether they have been sexually abused or at risk of it. It's a much broader cross-section of information and education you say should be available to them?---Yes, all young people deserve access to sexuality and relationships education and then there will be other needs for those who may have experienced trauma or abuse.

In terms of the Child Safety Practice Manual you say in your statement that the policy within it regarding access to sexual health for young people in care is ambiguous; for example, the decision-making guidelines for assisting young people in care to access contraception methods and termination of pregnancy. Can you just expand upon that? ---Yes, the decision-making guidelines in there are slightly confusing both for carers, the CSO's and also for clinicians. When it talks about access to contraception,

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5/11/12

BRENNAN, H.L. XN

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it actually asks - it says that you have to go through the Department of Child Safety or the guardian before you can access contraception, but then there is a point that is later made that the medical practitioner may be able to use Gillick competency to be able to work out if that young person can access contraception, whereas you have to really read through it and look at that to find out that that's the case and so for a lot of workers or a lot of carers they don't believe that they can support young people in care just the same way we would support other young people to access contraception with informed consent.

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COMMISSIONER: Ms Brennan, can you just explain for the record what Gillick competency is?---Yes, it's the medical practitioner's ability to work out whether or not the young person is informed and understands the procedures and side effects of the choice that they are making.

And it comes from a case in England?---Yes, it does.

And what that case says is that children have a graduating level of competence. It varies from child to child?---Yes.

But at some point in time they become responsible - well, at some point in time before they reach majority they become self-autonomous enough to make decisions that affect their own lives and to the point where their decision can replace the decision of their parents?

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---Correct.

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MS McMILLAN: Thank you.

And do you with your work with, firstly foster carers, believe that that is well understood, the issue about Gillick competency and - I'm not asking if they understand the legal concept of it, but in terms of their understanding of being able to support a young person to gain access to, say, contraception?---Sure. I mean, I'm sure there's carers out there who do understand Gillick competency, but I haven't had conversations with many of them about that. I do talk to them about issues of informed consent. And no, I don't think from my experience that I've talked with many foster or kinship carers who understand a young person's right to make some decisions about their health.

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COMMISSIONER: And Gillick competency extends beyond medical intervention?---Yes, so - - -

- - - it's just decided in the context of medical decisions?

---Yes. And as a non-legal person who works in sexual health, I suppose that's specifically my knowledge of the area.

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Yes.

MS McMILLAN: Thank you.

Again, Mr Swan's statement says that:

While in out-of-home care, responsibility for a child's sexual health is dependent on the child's legal status, level of statutory intervention, and their case plan.

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Is it your view, reading your statement, that there is a degree of confusion about who actually has the responsibility to provide sexual health education to children in care?---Yes.

And so for instance is it the case then that if there is a level of confusion that perhaps this has fallen through the cracks; that is, they're just not getting the education because there's not clarity about who has responsibility for it?---Yes. It's one of those things that often gets missed.

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All right. And in terms of foster and kinship carers you say report difficulties communicating with children and young people in their care about, for example, puberty and safe sex. Now, I take it is part of their reticence also that they may not be aware, for instance, of the experiences that the child has had, what trauma the child

5/11/12

BRENNAN, H.L. XN

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may have experienced, for instance, prior to that place?
---Yes. I mean, there's a number of reasons but foster and kinship carers report to being unsure about their role in communicating with the young people in their care. For some of them it's just nervousness about their role and whether or not it's appropriate; for some, they're nervous that talking about healthy sexuality or healthy development could re-traumatise a child, and so they may avoid it; and then, you know, there's just issues about culturally often many parents and carers, whether or not you're a foster or kinship care, need support in knowing how to communicate clearly.

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So you're saying just generally communicating, for instance, with adolescents is beset with difficulties, whether they're in care not?---It's certainly one of those things parents are appreciative of support.

Yes, thank you. That's bright a very tactful way of answering that. There is a Department of Communities foster and kinship carer handbook which highlights the role of foster and kinship carers in communicating about sexuality with children and young people in their care. You address that in your statement. Has it been communicated to you that carers have found this to be helpful?---I think the most helpful thing about that being in the handbook is that it actually sets out that the department does say that it's part of a foster and kinship carer's role to communicate about sexuality. It is incredibly powerful that it's there and it really sends a clear message. Whether or not many foster and kinship carers have actually read those pages, or whether or not that has been enough to give them the confidence to feel okay in performing that role is a different matter.

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And you say in your statement also there are other issues, particularly that the foster carers and kinship carers may not feel able to identify what constitutes normal sexual development?---Correct.

And they don't know, as we've already canvassed, who's responsible for meeting those needs. Mr Swan's statement also says:

Prior to becoming an approved foster carer applicants must undertake pre-service training, which includes information for carers about sexual abuse with a focus on the role carers play in children about self-protection.

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Are you aware of that training?---Yes.

Again, what's your view about that?---I think that it's wonderful that there's training on the issue of sexual abuse. It's fairly brief training and it looks at strategies, but they can certainly, you know, give

stronger, more practice-based skills.

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All right. Again, some earlier answers, would an issue, though, that you raise is that you're again targeting it about protective aspects is self-protection rather than general sex health education matters?---Correct. A lot of the research that's emerging now talks about sexuality and relationships, education actually having a protective factor. So it can help with the prevention of sexual abuse and give children more understanding about mutual relationships and their body belonging to them. So only concentrating on the issue of sexual abuse doesn't include the skills to develop healthy relationships.

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I take it, too, if it's at least raised with them, they may also feel more comfortable about raising issues of concern they have if they're given a broad - - -?---Yes, if they're given - - -

- - - sex health education?---If you're given a broad framework about sexuality that just doesn't look at the issue of sexual abuse or problem sexual behaviours, the way we look at sexuality often in society is to make it quite problematic rather than looking at it as being a developmental thing that happens from birth to death, and that it's about knowing about your body and growing up healthy and making decisions about relationships. So immediately sexuality is problematised and it's certainly problematised within the department.

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With its evidence up north that there is criticism that child safety officers aren't necessarily trained in child development stages. Now, I take it from your answer you think that that would be an important thing for them to have knowledge of and have some training about?---Correct, it would be important.

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And not just in terms of the area you're talking about, but generally - - -?---No, no - - -

- - - what connotes normal, healthy behaviour in children of particular chronological ages?---Yes.

Mr Swan also talks of their advanced carer training modules, the positive and protective series that have been developed for foster and kinship carers both your organisation. Can you just tell us a little about how they take into account the specific needs of children in care? ---Okay. So the advanced training modules that were developed, three of them look at personal safety skills, one is for children, one is for adolescents and one is for the young people the disability. There is also a program written on puberty issues and then another one looking at children with autistic spectrum disorder. And then the last advanced training module looks at sexual behaviours and understanding what's normal or of concern.

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5/11/12

BRENNAN, H.L. XN

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Now, do you have some understanding how readily available has this module been throughout Queensland?---Look, the department really should be praised for how readily available they are. They are on the web site. Anyone can access them and download the facilitator guides and the PowerPoints and workbooks that foster and kinship carers can use. To the best of my knowledge, though, only one of those advanced training modules has been run.

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Only one?---To the best of my knowledge. So I would really love to find out whether or not they're being run more often, and by whom, and what support those people might need in being able to run those.

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All right. Now, can you just elaborate - your attachment to your statement has some information about the traffic lights model. Can you tell us in what context is that model provided, and to whom?---Well, the department in 2010 actually funded Family Planning Queensland to write three brochures for foster and kinship carers, and one of those brochures tries to make the traffic lights model more accessible for foster and kinship carers. The uptake and use of the brochure is another thing that was very difficult to quantify. Most staff in the department would know of the traffic lights model just because it's one of those things that people on the ground actually access and use because it's practical.

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Okay. So I take it just in general terms green light is healthy behaviour?---Correct.

Amber, I take it, is that cautionary?---Yes, of concern.

Of concern. And red, I take it, is it reached probably a notification level within the department?---There are certain issues of harm.

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All right, thank you. Can I just ask you, you also say in your statement that policies for reporting sexual activity between young people differ between departments in Queensland. Could you expand upon that?---So different departments in Queensland have different thresholds for reporting sexual activity of young people. In particular, the department that I work with a lot, which is the Education Department, they ask for anyone under the age of 16 to be reported if they are involved in sexual activity.

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I take it that that is then devoid of context, isn't it, because, for instance, I take it you would think there may be a great deal of difference between two 16-year-olds engaging in sexual intercourse as opposed to a 16-year-old and perhaps a 40-year-old or 29-year-old partner. Correct?---Yes. Making it a requirement to report all young people under 16 or young people under 18 who are having anal sex makes it not look at the actual issue that we're talking about here, which is risk of harm.

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And obviously issues of coercion and exploitation as well? ---Yes, which, I mean, the thing is, if it becomes that you have to start reporting everything and not use your understanding and your practice, then it becomes more difficult for people to report when issues are really genuinely of concern.

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In terms of your statement you also say, "Professionals have a clear frustration with what they see as a lack of response to reports of suspected harm." Could you just elaborate on that?

---So I work with, you know, professionals in many sectors and when I'm doing training, particularly the training on the traffic lights where we talk about people's role as a reporters and in seeking assistance, I spend a lot of time trying to convince workers that it's still important to report even if they don't see that anything is done to assist those children. You know, there's a lot of people who have been working in schools or in other services who do report when they believe that children are at risk of harm who don't feel that the department does anything about that.

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I just want to ask you about some issues in relation to Aboriginal and Torres Strait Islander children. Now, we've heard evidence about babies being born with foetal alcohol spectrum disorder and the very problematic issues that that child is often born with, including intellectual impairment and others, and I take it you're aware broadly of the issues relating to that, and then the roll-on effect, if you like, is these children have such complex and high needs they often can't be cared for within their communities. Is that your understanding as well?---Yes.

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So in terms then of looking obviously at some of the primary issues here, if one understands that at least some

5/11/12

BRENNAN, H.L. XN

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of these pregnancies are unwanted, it seems many of them are unplanned, quite a number of them are underage, what do you propose and what have you seen that is effective in dealing with these sorts of issues?---Look, obviously it's an incredibly complex issue and the things that you can do to help lower unwanted pregnancies range all the way from looking at housing issues and access to education and building up community support. So I don't want to be simplistic about the solution of issues regarding teenage pregnancy or unwanted pregnancy. There is a role, though, that can be played by access to sexuality and relationships education and access to sexual health services.

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Were you funded, I mean, your organisation, to deliver the Cape project as part of the project your officers trained Aboriginal and Torres Strait Islander sexual health workers? That's now been de-funded, if I can put it that way. Is that correct?---That's a project that is no longer running that worked with health workers, indigenous health workers, to build up their capacity and confidence in being able to work in community regarding sexual health issues.

Was this funded by business?---Yes, it was.

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All right, okay.

COMMISSIONER: Did it achieve its goals?---The evaluations from that particular project look very good.

MS McMILLAN: Because is it correct that these workers prior to that time screened for sexually transmitted diseases and that sort of health issue but didn't do broader educative services?---There are sexual health workers, indigenous sexual health workers, whose primary role is to do more of the screening, and that's another project and work that we've been doing, and also trying to just, you know, build up the confidence of people to talk about basic sexuality issues.

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COMMISSIONER: Sorry, what does the screening involve? ---For sexually transmitted infections.

So, what, they identify them and report them?---Yes.

MS McMILLAN: So the perspective of the project as it was run was to provide a broader spectrum of education, was it, to young - particularly young women?---Young women and young men. I mean, we're one of those services that try and work with everyone.

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Yes. In terms of that, I mean, obviously the remoteness makes the roll-out, if you like, of education difficult, so obviously skilling up, if I can put it that way, indigenous sexual health workers. What else would you suggest are ways of actually implementing the broad range of sexual health issues that you've spoken of in your statement?

5/11/12

BRENNAN, H.L. XN

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---Sure. I mean, there are actually a lot of projects that Family Planning Queensland have been involved in and also that other services are involved in that look at the sexual health needs of Aboriginal and Torres Strait Islander communities. Some of those projects develop resources that can be used in communities, you know, make DVDs. There's even a lovely tablecloth that's making its way around communities that looks at the sexual health needs of community, and there's books that look at prevention of sexual abuse in community as well. So there are a lot of - not a lot. There are many separate projects that look at sexual health issues, but they're often, you know, one-off projects that happen through the Department of Health.

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I was going to ask about funding for these projects with indigenous communities. You say health. There was - obviously business funded the Cape project?---Correct.

Where else has been sources of funding?---Sometimes we approach other philanthropic organisations to do that work. They're pretty much - and also fee for service, you know, so if there are services in communities that want to pay us to come in and do that work, that's also something else that happens.

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Do you find that there's any difficulty in terms of cultural issues in delivering that service, particularly in the indigenous communities?---I think that we all have to be aware that each community is very different and that there is not one answer, and that being culturally sensitive is incredibly important and working with community is very important and going in and thinking that you can just do some kind of quick intervention that doesn't involve key people isn't a very good idea.

So your key people, are they elders, or is it the recognised entity? Who do you liaise with?---Well, in each project it will be different. I've just finished a project that we did at an Aboriginal and Torres Strait Islander school and we worked with the parents and carers, we worked with the council for that school, we worked with the recognised elders at that school, and then we also worked with all of the staff at that school, so that everybody was involved before we went and worked with the young people.

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All right, so I take it that's the other aspect. Because there's clearly a school in each of these communities, that the Education Department through the teachers and staff must play an important part in rolling out sexual education. Correct?---Yes, an essential part.

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Yes, again, presuming children are going to school?---Yes.

In terms then of that, what about further - I take it you've just co-published a book with the Murray school about the prevention of abuse?---Correct.

5/11/12

BRENNAN, H.L. XN

Who is that written for?---Actually, the children and the young people at that school wrote the stories and the children and the young people at that school did the illustrations, but the support material and lesson plans are written for anyone who wants to try and do a prevention program and adapt it for their community.

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All right?---Yes, we've done a program and then written how you would change this or who you would involve to make it relevant for where you are.

Just more broadly other cultural groups within Queensland - has your organisation been involved in trying to deliver sexual education within those communities?---Yes. So I think it's 14 years we've been funded to do the female genital mutilation program in Queensland and with that we've been working with different culturally and linguistically diverse populations looking at women's health and men's health issues and sexual health issues, you know, with the hope of tackling the issue of female genital mutilation.

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In terms of your recollections, one of them is to include sexual health checks and information on sexual development milestones in child health passports and health plans. I take it you would see that as important, would you, because at the very least it raises consciousness on the part of child safety officers. Correct?---Correct.

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And also medical practitioners?---Correct.

The child consults with the GP is your understanding of the health passport?---And also you would hope that it's one of those things that - if they change placements or they move about, it's one of those things that they can take with them so that there's some kind of record of, you know, the sexual health needs that they have.

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I guess the benefit also is that general practitioners are often used to having to address some of the trickier aspects, if I can put it this way, of sexual health education. Correct?---Yes. Well, you'd hope they're good at talking about periods.

Yes. Mr Swan in his statement says that the sexual health outcomes from a child in care form a component of the child health passport and case-planning processes for a child. Is that your experience?---I haven't seen the most recent child health passport. I tried to get access to that and was unable to. The last version that I saw of it, it wasn't as explicit and clear as it could be, but I must say that maybe it's absolutely perfect now and has all the information in it that's required.

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All right, thank you. Ms Gilchrist says in her statement, "The department does not currently hold a human relations policy. The development of a human relations policy would be beneficial when supporting young people with a disability exiting care and transition into adult service." What do you understand by that statement?---So I presume that she is talking about the whole of the Department of Communities and human relationships policy. I know that there have been people advocating for a human relationships police for over 20 years in Queensland.

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What do you understand by "human relationships policy"?---A human relationships policy is one that includes, you know, accessing sexuality and relationships education but it also brings into it, you know, other issues of sexual and relationship health.

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So the idea, is it, for those agitating it is that it's at a policy level to prescribe these issues?---Yes, so then, you know, if there is a policy that a department has - I mean, obviously the department is the one that leads the way for any of the NGOs or other services that are working with people. If there is a policy that says and states how important the human relationships issues are, whether

5/11/12

BRENNAN, H.L. XN

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they're for children in care or people with a disability or other marginalised or disenfranchised people, then it states from the very beginning that this is something that the department has a role in making sure it happens, and you will find then that NGOs and other services who are funded through the department will then need to take that on as a basis for their work also. 1

So underpinning their work?---Yes.

Just excuse me. Yes, thank you. I have got nothing further with this witness, Mr Commissioner. 10

COMMISSIONER: Mr Hanger?

MR HANGER: Thank you.

The issue of educating children about sexuality is always a fairly controversial area. I take it the attitude of your association is that this kind of education begins in the home?

---Yes. I mean, parents are usually the primary sexuality educators of their children and in a recent survey that we did in 2011 98 per cent of parents and carers believed that they wanted sexuality education provided before their children became sexually active. 20

Were they doing it in that survey or were they just saying it? It's a great idea but - - -?---Actually it was interesting a lot of them said that if sexuality education was provided in schools, it would help them a lot more as well because they would have a way of broaching the subject and doing it together.

Right, but the approach is that the primary educator in that field is the family or should be the family?---Yes, that would be lovely. 30

Secondly, of course, children in some schools get education on sexuality but it's a matter for the headmaster, is it?-- -So sexuality and relationships education exists in the curriculum, most solidly within the health and PE curriculum, so it can be taught in every Queensland school and that will also happen with the national curriculum as well, but what you'll find is it's a very ad hoc approach and that it's very hard to say how many schools in Queensland actually have sexuality education. Some estimates say, you know, only between 5 and 15 per cent of schools in Queensland actually have a comprehensive approach. 40

So is it actually the choice of the school as to whether it implements that curriculum. It's voluntary, or should they be doing it?---The curriculum says that it's part of their health and PE curriculum. It's also provided in a subject

5/11/12

BRENNAN, H.L. XN
BRENNAN, H.L. XXN

called "SOS" and you also see elements of it in science. So it's in the curriculum but some schools may not provide that service. I need to say though that a lot of the schools that we come in contact with do a brilliant job.

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Now, for the children that are in care and in foster homes obviously the desire is that the foster parents do the same education that the parents should be doing?---Yes, well, you know, if we're saying that foster and kinship carers are actually, you know, working as a substitute parent, then that would be logically part of their role.

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But experience indicates that it's what, more awkward for them and they're not doing it as well as parents are doing it?---I wouldn't say it's more awkward. I mean, in some senses it may - - -

That's my word?---Yes; no, I mean, for some people it may actually be - could be perceived as being easier because there's a bit of a one-step removed, you know. You're not talking to your biological child about safe sex.

Sure?---You can see if more as a role and a professional role that you have as a foster or kinship carer so, you know, as long as you've got the training and support.

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So is there any evidence that the foster carers are not doing it as well as the parents are or are they just as good and just as bad?---I've actually never read anything that says whether or not they're just as good or just as bad. From talking with lots of carers, some of them do a fantastic job and some, you know, put their head in the sand.

And you would make the same comment about parents? ---Absolutely.

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And, of course, the child safety officers have, as you've told us, some significant education in this field?---They have access to education in this field. Whether or not they've all received that would - - -

It depends on how conscientious they are and so on?---Yes, and, I mean, obviously they've got an extremely hard job and they're doing a lot.

But the material is available, as I understand it?---Yes, I mean, as I was saying before, really the department, you know, has done a great job in trying to make sure that people see sexuality as part of their role. It doesn't seem to come through in practice though.

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In your statement you mention rolling out the program that had been devised. I think it was in paragraph 41. This is the seven advanced training modules?---They are for foster and kinship carers.

5/11/12

BRENNAN, H.L. XXN

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Yes, and you mention that you're only aware that it's been offered once and I think my instructions are that's correct, but it is in fact widely available on the web?
---Yes.

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And you may or may not be aware that the department has made a great effort to at least promote the program with the appropriate web facilities such as emails and so on?
---Yes. No, I'm very aware that they've made a great effort. I'm one of those people who asks them how they're going and what they're doing and if they've sent those emails.

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Yes, and it is sent to all the foster and kinship services across the state as well?---Yes, I think the last time that that was sent out was probably in December last year. 1

Thank you. You say - and I'm not sure if you're going to be able to answer this - but in paragraph 15 you say that children and young people in care are consistently represented throughout the literature as "at risk" with regards to sexual health and they have higher rates of early sexual activity and so on?---Correct.

Why?---Why? Why, because there are numerous reasons. Some of them is that they have had a life that's been socially disrupted and so that they - you know, their access to services or support or to feeling stable about relationships may have changed to them a little bit. And also, you know, for a lot of young people maybe being in a sexual relationship or having somebody who loves them and who cares about them could be something that they're actually striving for. 10

Yes, because they've not had enough love in their life and they see this as being possibly care, affection?---Yes, I mean, I think, you know, all of us can think that sometimes people get confused about sex and love. 20

All right. In paragraph 26 you say, "There are many sexuality and relationship education programs for mainstream children and young people that are able to be adapted for children with the care experience"?---Correct.

Why do you need to adapt?---I think - you know, obviously it would be really wonderful if we had sexuality and relationships education programs in all schools in all centres. That's going to be one step of answering part of the process, but even within those mainstream schools and even if young people with a care experience are actually going to school, there can be elements of that that may not really speak to the experience of that young person, so a lot of young people in care would really like to hear about the issues of other young people in care and the things that they've looked at and struggled with, so that the sexuality and relationships education of them is a bit more realistic. 30

In paragraph 29 you mention inconsistent interpretations in the child safety practice manual. I think you dealt with this before, but what are you referring to there?---That was about access to contraception or termination by young people and, you know, whether or not young people are assisted to make those decisions. 40

So you think that should be clarified?---Yes, I believe so.

At paragraph 67 you talk about common solutions?---Okay.

Can you simplify there, what are your suggestions to Mr Carmody?--My suggestions are that sexuality and relationships education are looked at as a basic part of what needs to be provided by the Department of Child Safety. Obviously it needs to be looking at policies and procedures and manuals and training packages, but they need to really meet the need of foster and kinship carers; of service providers, including CSOs; and then also the needs of children and young people. I think that we've got a great - well, we have a good scaffolding at the moment that says that this is an issue and it says it is an issue that should be addressed, but at the moment we're not looking at the really practical strategies that can be used to build the confidence of those people, the capacity of foster carers, the capacity of workers to be able to communicate with children and young people. So, you know I can - this program is - - -

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But if I gave you your magic wand you'd say the same thing for all parents, wouldn't you?---Sorry, I would say what is the same?

You'd make all those comments in relation to the ordinary - - -?---With parents and carers I think that - if we are looking at mainstream parents and carers the slight difference is that they already feel like they have the right to give the children that they have in that their birth family or the family of origin the education that those children can receive. They don't feel that there is any ambiguity about what their role is or isn't. So sure, I mean, I'm an educator, I'm a teacher, and I think that, you know, access to information to build skills and to change behaviour will help everybody, but I think we can't ignore the fact that if we're supporting people and support children and young people in care, there are some obvious differences.

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Thank you.

COMMISSIONER: Thank you. Ms Stewart.

MS STEWART: Ms Brennan, throughout the inquiry we've heard from a range of sources in the community about the importance of Aboriginal and Torres Strait Islander people moving into more meaningful casework roles. I note in paragraph 21 of your statement you talk about a collaborative partnership with the Create foundation and the Out of the Box project?
---Correct.

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Can you talk to us about any key learnings that we can take from that partnership, particularly in regard to the capacity to respond to children in care's sexuality needs?--Yes, I mean, it was a really interesting project where we spent a bit of time with children and young people with a care experience and just asked them about whether or not,

5/11/12

BRENNAN, H.L. XXN

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you know, anyone had talked to them during their time in care and what they thought would benefit. And, you know, they're saying the same things that we're all saying, they wanted somebody to talk to them, they wanted someone to recognise that they were a child or young person who was developing who needed to know about relationships. You know, some of these were young people who were already young parents; some of these were young people who identified as gay or lesbian or bisexual, and they talked individually about their individual needs, but also their confusion about who was meant to have done that with them.

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What about in relation to the actual model of partnership between you and Create, how did that work and how effective did you find that?---Create are a very easy organisation to work with. We know that our expertise at family planning is sexual and reproductive health so we need to work alongside those people who have other expertise, so Create's expertise is engaging and working with young people with a care experience. So it was essential that if we're going to be looking at those issues, that would work with a service that has that experience of that knowledge of engaging young people.

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Could I take from that then that you could see a duplication of that partnership and transferring it to the Aboriginal and Torres Strait Islander sector?---Yes.

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If I can just take you to paragraph 9 of the statement, you've spoken to this a little bit, in relation to these training modules that you've developed, I particularly want to talk about number 4, the self-protection, specifically for the Aboriginal and Torres Strait Islander children and young people. Can you just provide a brief overview about the content in that training, how the information was provided and who the target areas were?---So the one that you're talking about is the self-protection Aboriginal and Torres Strait Islander children in care?

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Yes?---That hasn't been published this time. That one, what it did was look at the issues of sexual abuse and then look at practical strategies for communicating with children who may have had a sexual abuse history or who really - because children and young people in care are at risk of experiencing sexual abuse, how to prevent that. So it's a very practical hands-on workshop for foster and kinship carers who may be supporting a young person who identifies as Aboriginal and Torres Strait Islander.

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How was that information to be provided, though?---Yes, the way that the advanced training modules work is that it's a two to three-hour training session that is provided by a training service, so not by Family Planning Queensland, Usually by a Foster Care Agency.

What they would so is they would provide that training face to face with carers and so, you know, it's PowerPoints, it's a work book and it's also, you know, practical activities, looking at the resources that are available so that when people go home, they hopefully feel a little bit more confident about just engaging the young people in their family. 1

If I can just follow on from that point, in your opinion if an Aboriginal and Torres Strait Islander foster and kinship care agency sought to strengthen their capacity to respond to the young people's sexual health needs, the Traffic Lights module that you've developed - would that be an appropriate framework to commence?---Yes. 10

And is it transferable to a particular Aboriginal and Torres Strait Islander agency?---Yes, the Traffic Lights framework - what it does is it looks at the context for each child and it uses the research and practice that's available to try and work out what is a sexual behaviour that's normal, what is a sexual - sorry, and they go normal, normative, a sexual behaviour that is of concern and then sexual behaviours that may indicate harm of harm happening to somebody else and so those within the Australia context can be seen as being fairly stable and then you would look at the issues for each individual child. So, yes, even though there may be some communities where there may be more young people engaging in sexual behaviours, that doesn't - just because it's more common doesn't mean that it's healthy. 20

In addition to the Traffic Light - - -

COMMISSIONER: Can I just interrupt there, Ms Stewart?

Section 7 of the Child Protection Act sets out the chief executive's functions and one of them in 7(1)(e) is providing or helping to provide services that encourage children in their development into responsible adulthood. Have you got any ideas what services the chief executive might provide to discharge that function?---Well, I think that a framework like the Traffic Lights framework that includes the knowledge of sexual development needs to go alongside any kind of developmental model that the department would employ. It's quite interesting that I - you know, I've been working in this field for a long time and I will still speak with carers or workers who have no idea what normal sexual development is and they may actually be reporting a behaviour as being one that is of concern or that indicates harm when it actually very much fits into a healthy, normal sexual behaviour that is age appropriate for that young person once you look at the context and the story. 30 40

One of the general principles for the administration of the act which is in 5B, paragraph (k) which is presumably

5/11/12

BRENNAN, H.L. XXN

intended to reflect the law's view of the best interests of the child includes a direction that the child should have stable living arrangements that provide in (ii) for the child's developmental, educational, emotional, health, intellectual and physical needs. If you don't know what the developmental, including the sexual needs of a child are, how would you meet that principle?---Correct. 1

Yes, sorry, Ms Stewart.

MS STEWART: I have just got a couple more points. In addition to the Traffic Light module I also note that you have identified some other publications there that you have listed in paragraphs 9 and 10 that you've developed for the child protection sector?---Yes. 10

If we were looking at some kind of delegated responsibility to the Aboriginal and Torres Strait sector, as a way of building capacity to appropriately respond, would you see it beneficial to incorporate those publications into any future training model?---So the ones in paragraph 9 - would we incorporate those or do you mean the training? I mean, that any - - - 20

Probably both?---Yes, this is training that we've developed over the years in working with different key groups, some of whom have, you know, been Aboriginal and Torres Strait Islander. So just because it doesn't say there that they are doesn't mean they haven't been involved, but, you know, it depends with some of that training we were only funded to be able to run that as a one off or we were, you know, only able to do that in a very small way because it was a pilot project that we did with the department.

If I can just get you to reflect on the partnership that you had with CREATE, is there anything you want to add in regard to strategies to build and transfer that knowledge if you're looking at further resourcing the Aboriginal and Torres Strait Islander sector?---Look, I think the thing that I would like to say is that we can work to building the capacity of every sector that's working within Child Safety. I think it's quite - it appears quite unusual to me that the issue of sexuality and sexual health and relationships is seen as some, you know, very specific complex issue that isn't tackled within the system and that you need specialists or some other service to come in and do this work. Really, you know, most foster and kinship carers, most CSOs, most people who work already within this complex field - once they're given some training and some skill development and developed the confidence to work in this area are able to do this within their daily work. It's not something that you would always want to see, you know, referred out to another service or another specialist. The kids in care that I've worked with - you know, they're sick of if this happens to them, you go and see this person and then there's this person you have to 30 40

5/11/12

BRENNAN, H.L. XXN

see and then, "Now someone needs to talk to you about puberty. Now go and see that specialist." Really, you know, this should just be seen as part of the core work of people who work within the child protection system so it's not something that's outsourced.

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I have nothing further.

COMMISSIONER: Thanks, Ms Stewart. Mr Capper?

MR CAPPER: I have nothing, thank you.

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COMMISSIONER: All right. Any re-examination?

MS McMILLAN: From your evidence that you have given today, what's your view of how early sex education should occur in a child's life?---I must preface this with I'm a sexuality educator and that I believe and the research reinforces that sexuality education actually starts from birth and that's informally, you know, when you change a child's nappy and when you're talking to them about their body and how their body belongs to them and about being a boy or a girl. More formal sexuality education usually begins in kindergarten or pre-school and then, you know, prep to 12.

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COMMISSIONER: Presumably it's age appropriate and graduated?---Yes; yes, absolutely. I think that's the thing that people get really scared about, you know, when they think about sexuality or sexuality and relationships education. They're presuming that you're going to be talking about intercourse with a four-year-old when really if a four-year-old has the basic knowledge about their body and their body belonging to them and feelings and self-esteem and knowing about family relationships, it's going to be far easier to talk to them when they're 15 about issues of safe sex.

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I suppose one of the characteristics of a maturing child is gradually becoming not only sexually aware but also protective of themselves?---Yes, you would be hoping that, you know, as they develop and go through the milestones of sexual development that they also are building the protective factors along the way. I mean, obviously adults are responsible for the safety of children and adults are responsible for preventing sexual abuse, but you can help children to be more aware and to develop strategies so that they're able to disclose or talk or get help or know that when something is wrong.

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And to know that somebody is inappropriately taking advantage of their sexual person?---Yes.

MS McMILLAN: You were just being asked some questions, if you like, about outsourcing education for children. Is one of the downsides again, if you like, is that it makes it

5/11/12

BRENNAN, H.L. REXN

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problematic or seen as a difficulty rather than as part of the normal sort of information that, say, as a foster carer you would provide to a child?---Yes. **1**

Part of health, for instance?---It's part of health.

Yes?---So it's part of personal, social, emotional health and it just happens to be called "sexuality" but, you know, sexuality is more than just sex.

Yes, and one aspect that I touched on with you earlier - it's fair to say, isn't it, that issues of women with an intellectual impairment and issues of contraception and indeed even issues of menstruation are fairly much legally and socially complex issues, aren't they?---They are. **10**

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If you then move down the rung, if you like, to young women under 18 who may well be at risk in relation to contraception issues and unwanted - and unable to obviously care for a child, what's your understanding about what's available for them?---So services available for young people - - - 1

Yes, young - - -?--- - - - who still live with their child, or are you asking about contraception - - -

No, who are in foster care or residential care?---It can be interesting looking at young people in care, their access to contraception. Some young people - you know, people will look at them accessing contraception as a way of preventing pregnancy fairly early, but without giving them the information about preventing assault. So really it can be that people go, "Well, it's time to put them on the pill so that there's not a pregnancy," rather than going, "This person is in a dangerous non-mutual situation," and preventing that. 10

Because their impairment may be concomitant with why they may have been relinquished, for instance, mightn't it? ---Yes. 20

Can I also just ask you, young people who have the category of behaviours that we've discussed earlier, say, broadly ranging about sexual orientation and including even gender identity disorders, what age have you seen cases going down to where their sexual orientation has been an issue - for the child, I mean, in terms of - - -?---Yes, for the child.

Yes?---I mean, I - you know, I've worked with young people in lower primary.

All right. So I take it that therefore perhaps underpins, if you like, that necessity for formal education to start fairly young, in terms of pre-school?---Yes, and, you know, broaden people's expectations of gender or the stereotypes of what it is to be a male or female. 30

I suppose again that's strengthened by the fact that there's now prep and of course now grade 7 is going to be part of high school in future years. So again, I suppose as sexual education you say it's important that they're equipped generally regarding understandings of appropriate behaviour, relationships, all of those sorts of issues?--- Yes, and for teachers I know that - you know, I can speak anecdotally as somebody who provides assistance with regards to sexual behaviours, that when prep was introduced into Queensland that I got far more phone calls and referrals, you know, from the early childhood teachers about trying to work out what were the normal sexual behaviours of the children in their classrooms, just because they hadn't had children that young and they were just concerned about whether or not what was happening was 40

5/11/12

BRENNAN, H.L. REXN

okay.

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I have nothing further, Mr Commissioner. Might this witness be excused.

COMMISSIONER: Yes. Ms Brennan, thanks very much for your time and the evidence that you've given. It's much appreciated. We'll have a break for 15 minutes.

MS McMILLAN: Thank you.

COMMISSIONER: You're excused from the obligations of your summons?---Thank you.

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WITNESS WITHDREW

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 11.25 PM

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5/11/12

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THE COMMISSION RESUMED AT 11.51 AM

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COMMISSIONER: Yes, Ms McMillan?

MS McMILLAN: Mr Commissioner, I now call Professor Stephen Smallbone.

SMALLBONE, STEPHEN affirmed:

COMMISSIONER: Good morning, professor. Long time no see? ---Yes.

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We seem to keep our meetings restricted to inquiries of one sort or another?---Yes, indeed.

Yes, Ms McMillan.

MS McMILLAN: Thank you. Professor, you are the director of Griffith Youth Forensic Service, and perhaps I'll call it GYFS, if I might. You're a psychologist and you are a professor in the school of criminology and criminal justice at Griffith University and an Australian Research Council future fellow?---Yes.

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You have prepared a statement in relation to this inquiry, have you not?---I have.

All right. Would you look at this document? That is your statement, is it not, with annexures?---Yes, it is.

It's true and correct?---Yes.

Professor, there's no reason that couldn't be published, is there?---No.

All right, thank you. I tender that, Mr Commissioner.

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COMMISSIONER: Prof Smallbone's statement will be exhibit 113.

ADMITTED AND MARKED: "EXHIBIT 113"

MS McMILLAN: Thank you. Professor, you've been the director of GYFS from 2001. Correct?---Yes, I have.

You've also been the director of the Griffith longitudinal adult child sex offender study which was originally funded in 1999?---Yes.

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Is that still extant?---We're still conducting analyses on the data that we have, yes. We're not collecting further data.

All right. Professor, it will take too long to perhaps canvass all of your CV, but you obviously hold a doctor of

5/11/12
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SMALLBONE, S. XN

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philosophy and your research expertise covers correctional theory and services?---Yes. 1

Criminology, detection and prevention of crime?---Yes.

Development psychology and ageing?---Yes, tangentially, perhaps.

Yes, well, adult attachment theory, applications of that? ---Yes.

Law enforcement generally but particularly about sex offenders and assessment of sex offenders?---Yes. 10

Medical and health sciences, adolescent health?---Yes.

Psychology, generally children and adolescents, and intervention programs. Have I covered the major - - -? ---Yes, indeed, I think.

- - - areas of your interests and expertise? Now, professor, if I could just start, please, to gain some understanding of the risks to children in relation to sexual abuse. I think you mentioned that in the early 1980s the material was directed in terms of sexual education to children about them being at risk from strangers, if you like; that is, strangers to the household. In terms of your experience and your research what is your view is the greater risk to children from within their household, and I mean by that not just their biological parents but perhaps a step-parent or the partner of say the mother or the father? What would you say are primarily the risks, in your view?---Well, I think the evidence indicates that the greatest proportion of child sexual abuse occurs in domestic settings, usually in family settings. There is a substantial proportion that appears to occur in organisational settings as well, and those kinds of organisations in my mind have some important parallels with domestic settings; that is, it's not any kind of organisation that presents a risk of abuse to children, they're the kinds of organisations where there are adults in roles that are quite similar to a parental role. 20

So by that I imagine you would include schools?---Schools, recreational settings, pastoral care settings, yes, and the like, organisations where adults are placed in charge of children's welfare. 40

So authority figures?---Yes, well, more than that. Authority and also caretaking.

And also caretaking?---Caretaking.

All right. So they're seen as a benign figure, if you like?---Yes. An entrusted figure, yes.

5/11/12 SMALLBONE, S. XN

Entrusted. You were also mentioning prior to us commencing that there is evidence based literature which suggests that the presence of a biological father in the life of an infant girl child in some ways ameliorates future risks of sexual abuse occurring to that child. Can you just expand upon that a little more?---Yes. It does seem to be the case. The involvement of a father, particularly a biological father, in the caretaking of an infant appears to inoculate that relationship, in the sense that it's less likely ultimately that that father will ever see that child in sexual terms. So within homes, for example, perhaps 20 per cent of abuse in homes - and this is really an informed guess. The actual figures are notoriously difficult to be precise about, but as an educated guess, around 20 per cent of abuse in homes may involve a biological father and even in those cases it may well be that there has been some kind of absence or disruption to the attachment relationship between the father and the child. The remainder of the abuse within home settings, the remaining 80 per cent or so, tends to occur at the hands of a stepfather or an uncle or a visitor to the home or a boyfriend of a single mum, for example.

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Is there also literature, continuing on the spectrum, that girls who have a constant - even if it's not a biological father, perhaps a stepfather, into puberty later?---Yes. It's a little bit controversial but, yes, there's some evidence suggesting that as a trend. It seems to have an effect on boys as well, by the way. So both boys and girls who have stable family relationships tend to - the onset of their puberty tends to occur later. They tend to have fewer sexual partners over the course of their lives and they will have fewer offspring over the course of their lives as well, but particularly for girls it seems to be the case.

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What is your understanding of the rationale for that? Is that because there's been stability in their very formative years?

---I think so. I think a stable relationship over a child's life provides a very significant model for how relationships work. So when children are looking to establish relationships for their own they are likely to adopt some kind of model that they've observed somewhere for them to conform to. So, you know, the opposite case is if a child has been brought up with an unstable family environment, perhaps where there's lots of violence, it's often the case where those children will themselves become involved in relationships, intimate relationships, sexual relationships, where there is also violence and instability.

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So obviously the stability of placement, and talking about children, for instance, who are in the child protection system, you would see as extremely important?---Yes.

Particularly in these very - let's say zero to five years. That's obviously very important, one would think, from what you've indicated in terms of for future development of the child, but particularly leading into adolescence it would seem stability is also very important?---Yes.

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You've heard, I think, the entirety of Ms Brennan's evidence this morning?---I did.

Is there anything in her evidence that you would like to comment on from your perspective?---I over the years have found myself cautious, I guess, about the idea of engaging children directly in conversations about sex, but I understand that Ms Brennan's approach is more of a general approach than a specific one, in the sense that my understanding is that she's not advocating having conversations with five and six-year-olds about sexual abuse specifically, or kind of, you know, alerting them to dangers from people about sexual abuse. So I have some concerns about that latter approach. I mean, it seems to me that sexual abuse - our concern to protect children against sexual abuse is a concern to allow children to grow up without having adult sexuality concepts imposed on them, and sexual abuse imposes those, I think, in probably the worst kind of way, but I think there are risks anyway in involving children in sexual concepts early. I say leave them alone, you know.

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All right. So you perhaps fall on the other side of that idea of some early education commencing about general sexual health and educative prospects?---It seems to me the key is to inculcate in children a sense of respect for one another and a sense of - you know, some ability to be able to engage ultimately in intimate relationships themselves. That seems to me to require an understanding of relationships and intimacy, not necessarily sex per se.

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So is this perhaps a fair way of putting it: you believe educated aspects should be particularly with younger children more in the setting of appropriate relationships and appropriate social interactions and intimate relationships in the sense of within the family and perhaps siblings, et cetera?---Yes, but I do accept that it can be important for parents and others to have a relaxed way of speaking with their children about sexual matters as they arise, but I think that's different from imposing that as a kind of a program, if you like, for the child.

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I imagine that stemming from what you have just said the role, for instance, for a foster carer is particularly problematic about how to effectively deal with those sorts of issues with a child in their care, adopting the right pitch, I mean, in terms of when and where?---I think Ms Brennan made the point though - and I would tend to agree with it - that sometimes the step removed, so to speak, might make it a little bit easier. Curiously - and I don't mean to go on a tangent here, but in some Aboriginal societies, including here in Australia the role of education of children is actually given to an uncle and not a biological father, you know, a relative of the mother, for example. So there are anthropological circumstances, if you like, in which societies have made decisions about having people a little bit removed from the relationship to take the responsibility for that kind of education.

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I suppose the distinction there is it's culturally appropriate. That's the normative sort of behaviour, isn't it? Can I then ask you, please, just rounding that off, is it the case that - what's the prevalence of someone who is a stranger to a child being the perpetrator of sexual abuse?

---My estimation would be around 5 to perhaps 10 per cent. Stranger offences are more likely to be reported as well. We know there's a very big problem with under-reporting of sexual abuse, as there is with many other kinds of crime actually, mostly personal crimes, but there is a serious under-reporting of sexual abuse. So of the cases that come to light around 5 to 10 per cent involves strangers as offenders, but I would say that it's the known offender circumstances that are even more under-reported than that. I hope I'm making myself clear.

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Yes?---I'm saying 5 to 10 per cent would be then probably a more accurate kind of estimate or overestimate perhaps

5/11/12

SMALLBONE, S. XN

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Because there's no doubt very different reasons for not reporting, for instance, a known offender?---Absolutely. Most children who experience sexual abuse are involved in a very, very complex relationship. It's often not just about - the relationship isn't always just defined by sexual abuse. There's often other kinds of aspects to that relationship as well, including very strong emotional ties to the abuser and a sense of loyalty and so on.

All right, thank you. Now, can I just turn specifically to your work with GYFS? This service is being contracted by the Queensland government, currently the Department of Justice and Attorney-General, the Youth Justice branch, since 2001 to provide statewide specialised assessment and intervention services for young, that is, 10 to 17-year-old, sexual offenders and their families. Correct?---Yes.

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And the referrals are received exclusively from the courts? ---Yes.

All right. Anyone who wants to read further about this, this is contained, the body of this information, in the submission that you have provided to the commission. Correct?---Yes.

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All right, thank you. Now, in that submission which I understand you were instrumental in the preparation of - correct?---Yes.

GYFS has received referrals concerning 395 young people proceeded against under the Youth Justice Act. Correct? ---Yes.

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The referrals are from children who have been charged and sentenced with a sexual offence or a sexually motivated offence. Now, just so it's perhaps clear, a sexually motivated offence, for instance, might be a break and enter with intent to commit a sexual offence?---Yes, it's in fact unusual though. Almost all of those 395 cases will involve a charge, a sexual offence charge, but occasionally we will see people who haven't been charged for a sex offence.

The referrals are prioritised with offenders living in more remote and regional areas more likely to be accepted, I understand, because there are fewer services otherwise available in those areas. Is that correct?---Yes.

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Budget limits the number of staff and impacts on the number of clients that GYFS is able to service. Correct?---Yes.

Of those 395 referrals, how many has GYFS accepted?---I don't have those figures with me, I'm afraid.

5/11/12

SMALLBONE, S. XN

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Could you supply them in time?---I could, yes.

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Yes, thank you, if you would. Now, GYFS, just to contextualise it, is part of a large group of researchers and practitioners based at the university working together to understand and prevent sexual violence and abuse. Is that correct?---Yes.

I will ask you to expand a little more on this but, as I understand it, the GYFS services are guided primarily by a social-ecological framework whereby problem behaviour is understood in the context of the youth offender's family, peer, organisational and neighbourhood systems. It's also mindful of the developmental and situational context of offending. Correct?---Yes.

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All right. So could you perhaps elaborate on that and perhaps give an example of the way in which it operates? ---I think in a word the approach is to take account of the context in which the problem behaviour has occurred or is likely to reoccur into the future. So our view is that the problem - that the individual youth offender brings certain characteristics of themselves to this point, but the behaviour is enacted in the context of a very specific set of situational circumstances and in the wider context of that young person's relationships with their family and indeed the victim's relationships with their family as well. So the family, peer, organisational, including school and neighbourhood systems provide a context in which to understand the behaviour. So a social-ecological theory tells us that human behaviour is influenced by the social ecology in which we are all embedded.

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All right. So if you have, say, a young offender who's convicted of a sexual offence, you would look at, for instance, whether they live in a large metropolitan district, for instance, what their socioeconomic circumstances would be, their family of origin, how or if they knew the victim prior to - are those the sorts of - I'm trying to think of concrete examples of what you look at?---Yes, sure. I mean, in fact we would start in the reverse direction to that. We begin with the circumstance of the offence. Well, social-ecology theory - one of the principles of social-ecology theory is that the more proximal the system, the more powerful the effect. So what a young person's peers think, what their peers' attitudes are, will have a lot more influence over their behaviour than what's going on in their neighbourhood more broadly, for example. So the influence of those neighbourhood factors, in effect, filters through the other systems as they become more and more proximal to the young person themselves. So, yes, we take account of neighbourhood and community factors but we in a sense start at the immediate point and work our way out to their - - -

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So the immediate facts and circumstances of the actual

5/11/12

SMALLBONE, S. XN

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offence and then work out from there?---Yes.

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And guided by the degree of proximity to the offender and the victim?---Yes, we're much more interested to know what the influence of the peer associations of the young person are or the family, indeed, than the community. In some specific circumstances the community factors become highly relevant for us.

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5/11/12

SMALLBONE, S. XN

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All right?---But generally speaking the interventions that we provide are contained within those systems that are most closest to the young person, so generally we're working with the young person and their family; and through the family to try and intervene in the kinds of peer associations if they're problematic.

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Yes?---But occasionally we're dealing with circumstances where there's a whole neighbourhood or community that's become problematic.

Right. So I take it that the peer relationships perhaps take on even a greater importance as that young person goes through adolescence, because they're a very significant factor in most adolescent's life, aren't they, their peer relationships?---Yes. When you mentioned before that we see young people from 10 to 17, by and large we're seeing people around 14, 15, and 16; very rarely do we see a 10-year-old, for example; occasionally 12 or 13-year-olds.

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Is that to do also that 14, 15, 16-year-olds have well and truly entered puberty and issues associated with that as a starter?---I think it's because police and the courts are likely to see the offences of older people more seriously and that there are likely to be - there is likely to be discretion, particularly by police, more likely to have diversionary positions or processes - - -

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Processes for a 10-year-old as opposed to a 15-year-old? ---Yes.

Right, okay. Now, your interventions aim, according to the submission, "To address individual situation, ecological risk, and protective factors. The primary goal is to prevent further offending, particularly further sexual or violent offending." That's really what you've just outlined, isn't it, that you're looking at those factors so obviously you look at addressing those in terms of prevention of future offences?---Yes.

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In terms of service delivery in regional and remote areas, it's a truism that obviously there are fewer services available in remote communities?---Yes, I think so.

And I note again from the submission that more than 80 per cent of your accepted referrals have originated from outside Brisbane?---Yes.

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And about 40 per cent of accepted referrals have involved indigenous youth and their families, again according to your submission?---yes.

You say that, "Specialist clinical services for youth sexual offenders in Australia and elsewhere are typically centralised, requiring the clients to travel to major urban centres to be assessed and participate in treatment"?

5/11/12

SMALLBONE, S. XN

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---Yes.

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Requiring them to travel - according again to your conversation with members of the commission in your interview you say, "It's obviously inappropriate to remove an Aboriginal youth from his or her community and their offenders' behaviour needs to be considered in the context of the community and it's more financially viable for staff to travel to the offender's community." I suppose, too, that given the situational approach that you take, it would also be far less relevant to take the youth away from the community, wouldn't it?---Yes.

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And you also go on to say that, "An issue or social problem may be particular to a certain community. There is a need to consider those contextual issues in order to understand behaviour and develop solutions." As I understand it the practise model you've adopted is the practitioners who you work with travel to where the young person lives, including to regional and remote locations?---Yes.

At the moment I think you're working in two remote indigenous communities. Is that correct?---No, we have - I'm not sure how many there are presently, but we certainly had involvement in numerous Aboriginal communities. I think you may be referring to some prevention work that we're wanting to do beyond the treatment work.

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Yes, sorry?---Those two places, one of those is a remote Aboriginal community, but the other is a suburb, actually, of a regional city.

Right. And I take it you'd prefer not to identify them, obviously because it may impede the work that you're doing there?---Yes.

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Now, in terms of again the practise model you adopt, you obviously observe directly factors you say that may contribute to the sexual abuse offending and the victimisation, as well as other problem behaviour. And it allows the intervention to be delivered in the same context, if you like, or environment in which the risk occurred?---Yes. Can I perhaps add a little context around that?

Yes, please?---We also provide services to the two youth detention centres in Queensland and occasionally we have clients who are on remand or serving a sentence in those centres but we'll follow them into the community as well. The point that I wanted to make is that Queensland - well, Australia generally, but Queensland in particular, I think, has made a significant effort over the years to reduce the number of young people in detention. So most of our clients - by far the majority of our clients - are serving community orders. Sometimes for us that means that we from time to time see very high-risk young people in community

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5/11/12

SMALLBONE, S. XN

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settings, which presents an additional set of challenges to the work that we do. 1

Just can you elaborate on that a little more?---Yes. Personally I think it's a good thing that we try and keep young people out of detention where possible. But there certainly have been circumstances for us where we've been working with young people who we think are frankly dangerous and require a very high level of supervision and monitoring in community settings. So as I say, that presents special challenges. One of the challenges, for example, is it's been very hard for us - there've only been a few cases where this has become particularly relevant for us, and I certainly don't want to paint the whole of our client group in the context of the worst offenders - there's a handful of young people - but for those we've sometimes not been able to find secure residential circumstances for them that would help to contain the risk that they might pose to other people. 10

Do you know a Dr Stephen Stathis?---Yes.

Yes. In his statement - Mr Commissioner, paragraphs 12 and 13 - he states that, "Childhood abuse and neglect is associated with increased criminal behaviour during adolescence." I imagine you wouldn't argue with that? ---No, I wouldn't. 20

"27 per cent of all Queensland children who have been victims of substantiated harm and had contact with the child protection system subsequently offended and became involved in the youth justice system." Would that accord with your experience?---More or less, yes.

He says, "Approximately one in six - 17 per cent - of the children in detention centres had been in the care of the department prior to their detention." Again, would that accord with your experience?---Yes. I think the evidence suggests that sexual offences by young people tend to emerge - sometimes a little often - in the context of a developmental pathway, if you like, that involves increasing levels of seriousness of offending. So young people - adults too - tend not to be - you know, the first offence is usually not a very serious one, so serious offences often are a culmination, really, of a process of increasingly more serious and more frequent offending. And sexual offending is one of those kinds of offences that seems to be a kind of an outcome of that process. 30 40

Right. And I should say he's putting this in a general, not particularly sexual offences. He says, "Young people in the youth justice system rank among the most socially disadvantaged in the community." I imagine you wouldn't disagree with that either?---No. There are always exceptions, of course, but no, as a general rule that seems to be true.

5/11/12

SMALLBONE, S. XN

"And are at an increased risk of mental health and substance misuse problems"?---Yes. 1

"In Queensland a high proportion of these young people identify themselves as being Aboriginal and Torres Strait Islander. Approximately 50 per cent of mental health, alcohol, tobacco, and other drugs service clients identify as being indigenous." I imagine you wouldn't argue with that?---It sounds very high, but I would have expected something in that order, yes.

And indeed as I understand he would say that those young offenders you talk about as posing risks to others, including the community, and needing a very high level of care, he favours a model where they can receive, within that residential placement, therapeutic services. What would you say about that?---Well, I think that would be a very good facility to have available. I'm also a little bit reserved with it because I'm aware of the history of institutionalisation that I think is - it's a good one to remember, that in the past we've not managed these kinds of institutions very well and there can be as many problems as there are solutions in them. So I think a move further to a residential or institutional regime clearly, in my mind, needs to bring with it the lessons of that history. 10 20

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I think, to be fair, he wasn't talking about large-scale institutions, he was just saying a number, perhaps four, or of that number, and delivering it to them and so that's in situ?---Yes. 1

Because he said - as I understand, he will say one of the important aspects is they need to have that social interaction and need to be able to manage within that sort of framework?---Yes, absolutely. I don't think, though, that it needs large-scale institutions for them to become abusive, because it's all about having people in charge of other people in an environment that doesn't have very clear, sometimes, transparency or accountability by others. So I think really these solutions, in my mind, need to be thought through in detail. You know, there can be very good residential homes and there can be very terrible ones, so the idea of having a residential home by itself doesn't seem to me to be at all useful. Having a high quality one that's really thought through well makes a whole lot of sense to me. 10

All right. Now, just going back to your particular practice model, you identify and recruit local collaborative partners. I take it that would be essential to the success of your work, wouldn't it?---Indeed it is, yes. 20

Obviously you identify who those partners are by a case by case basis, wouldn't you, what community you were talking about, who was available and who was influential with the young person, wouldn't you?---Yes. We try to do this for all clients, not just those from regional or remote places.

Yes?---But it can become particularly important in regional and remote places. 30

So, for instance, you would look at perhaps child safety officers, depending, I suppose, on the degree of input they have with the young person?---Certainly if our young client is also serving a child safety order, which is quite often, then we will definitely be trying to recruit a child safety officer into that team.

All right, because you'd want that absorbed in their case plan, wouldn't you, what you were trying to do with the young offender?---Yes. I mean, we're aiming for a very reciprocal arrangement. 40

Yes?---We want to benefit from this and also have others benefit by it.

I take it, if appropriate, if they were in foster care, the foster carers, obviously?---Yes.

Mental health practitioners, teachers, youth workers, family members?---Yes.

5/11/12

SMALLBONE, S. XN

All right. And in some indigenous communities I imagine elders would be an important component too. Now, one of the - the collaborative aspect also has a secondary aim, doesn't it, of building capacity within the local community. Is that correct?---Yes.

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I take it that you see that as an important aspect in preventing sexual abuse or responding quickly and effectively to it if it does occur?---Yes. We're aiming for our involvement to produce an effect that lasts beyond our involvement, if you take my point. We think that we have something useful to contribute, but ultimately we'll have a limited period of time with any case and in any particular place and we want our involvement to have some benefits to people after we've left so that they are more able to deal with similar problems should they arise in the future.

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Now, just in terms of some of the remote indigenous communities what are endemic risk factors that you've identified in a number of these remote locations?---Well, I can take one place as an example. The place that I have in mind is a place where I think that the usual kinds of social controls have almost completely broken down. So parents' ability to monitor the whereabouts of their children, for example, to take basic care of their children, is compromised. There is public violence, so children are exposed to violence from a very young age very routinely. In fact, it becomes a spectacle, so people actually go to watch it. We've become aware of an alarming level of family violence involving weapons. By the time children reach the age of say 10 almost all of the children will be involved sexually one way or the other either through abuse or through peer relationships and so on. Some of that itself involves violence. Would you like some more detail?

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Yes, please?---Well, if we take the ecological framework we begin with the individual. So there are individuals who lack self-regulation capacity, so they don't manage their emotions very well. If they're angry they will hit somebody, you know, if they want something they will take it. This all obviously comes through parenting and so on. There are some intellectual disability problems there, some of which but not all would be associated with foetal alcohol problems. There's a poor educational attainment, poor prospects for the future, very poor connections with the outside world, so to speak, so, you know, it's all very kind of concentrated on within the community. So young people aren't really growing up with much of a capacity to be able to engage with the world more broadly, and then at a peer level young people spend a lot of time together without the supervision of adults. The age ranges in those peer groups is very wide, so very young children are being exposed to adolescent behaviour, including sexual behaviour, from a very young age, as I say, a lot of

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SMALLBONE, S. XN

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violence and so on. At the school level there are certainly many efforts to improve school engagement and the school experience and yet we're aware of evidence that sexual abuse is occurring in the school quite routinely, including in the classroom. So these are places where sometimes the teachers have very little prior experience so they may doing a period of remote service early in their career. They're kind of - you know, weren't there the day of the training when they were told about what to do when kids start penetrating one another in the classroom. You know, it's a dreadful situation. Some children don't go to school, we hear, because of their concerns about being sexually harassed.

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I see?---We know of cases where a teacher issued sticks to children when they went to the toilet so that they could protect themselves from other children who were going into the toilet to abuse them. Then there is a layer of family problems as well there, yes. I mean, it's - - -

So, professor - and I'll ask you in a moment, because I gather this is not endemic to certainly all of the indigenous communities that you've had contact with, by any means?---No. I don't think so, no.

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But how do you address issues where you've got - normative rules have largely broken down, you've got the factors that you've outlined? How does your team address those? How do you work within that sort of community?---Well, it became clear that within an otherwise very distressing set of circumstances in that community there were nevertheless considerable variations from family to family and from individual to individual, and it seemed very clear that some families were, despite the general problems, remarkably resilient to some of those problems. They seemed to be the families that had the strongest connections both to their own traditional Aboriginal culture and also to the earlier mission environment. That itself presented them with a certain kind of moral framework that they were able to internalise. So some families do reasonably well despite these general problems. At a universal level, though, even when families are suffering the worst problems, because of the remarkable extended family networks that many Aboriginal families preserve. There are almost always opportunities for a responsible adult to be found to take a particular role to help to influence the positive behaviour in that young person. So in our case we were able to find through - and it took us a long time to develop the relationships with the families concerned, but we were able to find by and large family members who were prepared to take a particular role. It might even be a small thing. So a grandmother might be able to seek a park, for example, from her verandah, "I'll take the role of making sure that this young man comes home after a sports game," or something like that. It's just a very small kind of almost trivial example, I suppose, but our experience that even in those circumstances the thing that most motivates people is concern for children. It's something that hasn't been lost despite the many other things that perhaps have been lost in some of these places. So people are willing to with assistance - and they often are open for assistance.

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What sort of assistance would you provide through your model practically, a practical sense?---Time in conversation, yes. It's really about building relationships over a period of time and building kind of a trust, I suppose. See, one of the things that we think in a sense we don't have that's important not to have for us is statutory authority so we're not bringing with us the capacity to remove a child or to arrest somebody in a home. We have obviously working relationships with people who do have that authority, but I think because we don't, we have a different starting point of a relationship with those families. The other thing that we have we've noticed is that in some Aboriginal communities in particular the idea of education is very highly valued and because we come from a university, it seems to give us a certain kind of status for them that we might not have were we to come from some other kind of institution. So those two things - I think they seem to work in our favour.

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In terms of just staying for a moment with remote indigenous communities from the ones you have had contact with, what do you say are some common factors that you have observed in terms of risk factors and what are perhaps distinctive characteristics that you have noted?---Well, I'm not sure. I mean, I think in some communities there seem to be - some communities seem to be somewhat less broken in the sense that there has been a preservation of authority within the community so certain people have roles that are respected by other people in the community. I think men in particular in some communities have lost or - happily and others have preserved a sense of importance of a role. I think that's very important. Alcohol I think is an enormous difference. The alcohol prohibition seems to have made a major difference in some places to reducing levels of general violence.

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What about sexual offences? Has it had any impact, in your view, about that issue?---I really don't know whether that has or has not occurred. Part of the problem for us is that much of this problem is hidden, including from us, so it's very hard to say what's really going on, particularly behind closed doors, so to speak.

Yes?---I mean, we know, for example, that in some communities there are known - this is information that is known by people in the community, including people in authority of quite young girls being in sexual relationships with older men and that seems to be kind of accepted or at least not intruded upon.

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In terms of collaborative partners, how much influence do you find the recognised entities have in terms of your dealings in these communities?---Could you just - - -

Do you find that you consult often with the recognised entity or do you yourselves go and find, if you like,

5/11/12

SMALLBONE, S. XN

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elders or people within the community that you feel will best assist you?---The latter by and large. 1

The latter. How representative do you think the recognised entities are in the communities you have dealt with?---I think that probably varies, and I should say too that some of these questions may be better responded to by my clinical colleagues who have much more on-the-ground experience than I. I have visited a number of these communities. I don't do much of a hands-on clinical work that this project does. I very much rely on my clinical colleagues to do this. 10

Okay. How often would you - for instance, if you're working with a young offender, how often would your team visit that community and for how long when they go?---It varies very widely. In one particular community that we've spent the most time that involves visits probably once a month or every two months over a period of three or four years, but that probably isn't typical and it was a situation that presented itself to us as an opportunity, I guess, to trial some procedures and processes that we would like to be able to transfer elsewhere in a much more efficient kind of way. I don't think it would necessarily require that length of time to be successful with this in other places. It was just a particular opportunity for us that we saw and we wanted to concentrate our attention on this particular place for a period of time. 20

So how do you actually go into capacity with local partners, as you call them, in communities? How is it practically done?---Well, the members of these teams - what we aim to do is to develop plans that are aimed at preventing any further abuse or sexual violence and so on by that young person and also perhaps to protect other potential victims, including by other potential perpetrators, but each of the people in the team - we seek to commit to certain kinds of roles or a level of involvement in this. We have provided training as well and in fact the training program that we have had has been really designed to develop the ability within potential collaborative partners in various places of the state. 30

I was going to ask what does that training involve?---There are various levels. The first level is an introductory level which is really trying to present information about who these young offenders are; how we understand the behaviour to occur. We try to talk about theory with them so explanations of why the behaviour occurs. We describe out intervention model. We talk about the different roles of collaborative partners. For example, some of the training might involve Youth Justice workers. Some might involve Child Safety workers. Some may be mixed groups so it really does vary, but essentially it's about trying to impart knowledge and develop skills. Just as an example, what we have found is that many professionals see sex 40

5/11/12

SMALLBONE, S. XN

offences as a bit of a special case that they don't - they see as something that requires a specialist. They can't deal with this sexual abuse. So a lot of our effort has gone into trying to debunk that myth; trying to tell people, "Look, you have generic skills of various kinds. They can be put to good use in your work with this young person."

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So do you, for instance, impart what you have just said some minutes before that often it's the culmination of less serious offences so to contextualise it presumably? I mean, is that the sort of training within your training? ---That would certainly be part of that training, yes.

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Yes, okay. So you have got the introductory level. You have then got - is that the next level giving specific training to specific groups or workers? Is there another level or levels above that?---Yes, a more advanced level would be spending time actually collaborating with workers on individual cases and having them take sometimes a very significant part of the intervention role in our absence and staying in touch with them by email or by telephone and so on.

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Right?---So that era of working in remote places in particular is that we want to find local people whose skills we can build - is knowledge and skills we can build so that they can, in effect, work with this young person in our absence. And so the visits from our team, you know - - -

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Are meaningful?---Those who bring the specialist skills.

Yes. So in other words you ask them to do specific types of work ahead of your visit up there - is this how it works - and then presumably it means your time on the ground can be spent usefully?---Yes.

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Right, okay. And in terms of having it dovetail, if you like, with a child's case plan if they're in the child protection system, do you find that in general child safety officers are welcoming of the sort of plan that you perhaps envisage for this young person in terms of prevention for reoffending?---Yes, generally. Sometimes very much so, because it's sometimes seen as a real gap or - again, going back to the point that I was making that many professionals, including child safety workers, see sex offences as quite kind of mysterious and problematic and troubling and, "The kind of thing that I can't really deal with myself, I need a specialist to do this."

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And I take it that would apply equally to a lot of non-indigenous and in fact it urban communities, wouldn't it? ---Certainly, yes.

That wouldn't be particular to indigenous and remote communities, I would imagine?---No.

All right. Do you find that there are particular obstacles faced by the GYFS clinicians in building collaborative partners, particularly in promote areas?---Well, the travel itself that they do is an obvious strain for them. We took this decision to do this at the beginning. The original idea that was proposed to us by the then Department of Families, Department of Communities, was that some proportion of the original funding would be administered to relocate temporarily individual offenders and their families down to a motel at Mount Gravatt near our university and we would see them in a clinic. That just didn't make sense to us for a whole range of reasons so we took the decision then - we propose to them, "Why don't we go there?" It was a bit of a fateful decision, it really requires, I think, on behalf of my colleagues, a remarkable level of commitment on their part. So one of the real obstacles is having a small group who is trying to cover the whole of the state. They're on a plane or sometimes in a bus and a car and boat and so on very often.

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Are there some cases where it's viewed by the GYFS team that it is appropriate to remove the young person from,

5/11/12

SMALLBONE, S. XN

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say, an indigenous community?---Well, we don't take those decisions ourselves - - -

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No, but a recommendation?---Yes, absolutely.

Yes?---Yes.

And would that be because, what, the set of factors are such that that it's viewed that it's not likely to assist them rehabilitate, if you like, or - - -?---Generally I think it would be fair to say see this as a last resort.

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Yes?---And only in the circumstances where we cannot see how it would be possible to contain that risk in that natural setting.

How did you get young offenders to engage with your team? ---With sometimes extraordinary tenacity and patience.

How do they - - -?---It varies, too, but some young people - some people readily engage, some find it considerably difficult. In fact, we did some research on this ourselves. We looked at the kinds of predictors of engagement and we discovered that Aboriginality actually was a significant predictor of engagement difficulties and high levels of antisocial attitude and behaviour, so the more kind of generally antisocial the young person was, the more difficult it was to engage; and if they were Aboriginal they were more difficult to engage as well. And having found that information out, we then tried to modify some of our practices in response to that. And we were able to show, in fact, improved levels of engagement, except that we had two cohorts, the second cohort was treated, if you like, under the modified regime and we found that both indigenous and non-indigenous clients were both more likely to be engaged, except that we hadn't closed the gap, so there was still a gap between Aboriginal and non-Aboriginal kids.

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In terms of engagement?---Yes.

Right. And what did you do to modify the program that made it more effective?---Part of it was trying to better on what we were already doing in the sense that I think our view is that the clinicians themselves take the responsibility for the engagement rather than relying on the young person to take that responsibility, so all appointments, for example, are made in a way that tries to maximise the convenience of the young person. We try to identify what the obstacles might be and tried to remove as many obstacles as possible to their participation. So it's going to where they live or going to somewhere that's very convenient for them to be at a time that's convenient to them, trying to solve problems like transport and so on.

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In terms of recidivism, have you got any information on whether the program is effective in terms of preventing young people from either repeat sexual offences or offences generally?---We currently have funding from the Federal government through the Australian Research Council to do this. In fact, Friday last week we received data from the Queensland Police Service on the basis of police records checks for all of GYFS' clients as well as a group of sex offenders in Queensland of the same age and matched who we've not seen, and in fact a group of serious non-sex offenders as well, so in fact this week I'll have a preliminary look at that data. The reason, by the way, that we've left it until now is because reoffending rates - official reoffending rates are quite low, actually, for this cohort. You need a large number of clients over a significant period of time to be able to test the effects of interventions.

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So when you say risk, you mean just generally offenders of this age, not just sexual offences, but - - -?---No, particularly sexual offences.

But particularly, so you need a long period of time and quite a number of them?---Young people who commit sex offences are eight to 10 times more likely to be rearrested for a non-sex offence as they are to be rearrested for a sex offence. It's not generally speaking an offender cohort that specialises in sexual offences. These sex offences generally happen as part of a general pattern of offending behaviour. So we could have examined non-sexual offence recidivism earlier but we had to wait is time to do properly an evaluation of this kind.

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Right. And I take it that the fact that you haven't looked at that data yet, would you be able to provide it in time to the commission in terms of those rates?---Certainly.

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In terms of looking at that?---Yes.

Would you do that?---Yes.

Yes, thank you. In terms of communities - and again just returning to indigenous remote communities - have you in your view built sustaining relationships with them in terms of once perhaps you work with that young offender and those around them in terms of building up expertise?---Yes. Some more than others, yes.

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What, that last some years?---Yes.

So how does that work? Do you contact them by email, or how do you know that you've in effect got a continuing relationship with them?---In one community - again, the one I guess that are most familiar with and that was spent the most time in - we in fact spent social time with some of these families, and it's not just the families of young

5/11/12

SMALLBONE, S. XN

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offenders, but there are other families as well. So we -
well, we were invited, for example, to go fishing with
them. My female colleagues are sometimes invited to
involve themselves in activities with women to do with
gathering of certain kinds of materials, the baskets and so
on. They're just, you know, small, but I think important
gestures of acceptance of relationship. In fact, we've
spent a lot of time talking about this within our group,
that we've all been trained in a sense of professional
ethics that imposes really very clear boundaries between
professional and personal relationships.

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Yes?---But we've found that in some of these communities that while we certainly keep a very strict eye on ethical principles in a general sense, we have found it necessary to behave in unusual ways from our own experience in the sense of being more personally involved with people than we otherwise had been trained to do and we found that that was really a key. In some communities, for example, it's important to be vouched for and in the particular - the community that I'll keep coming back, just by way of illustration there was a moment - it probably was six or eight months into the period of our visits where for the first time the family or an uncle greeted our group on the main street and came over and had a conversation with them and that was somewhat of a signal to the town really that we're being vouched for and almost immediately we found an effect from that in terms of our ability to be able to have people talk with us.

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So are most of your team psychologists as well?---Yes.

All right. So you obviously have your ethical constraints in terms of being registered as psychologists, but from what you say you need to modify them to some extent to be able to effectively interact with people particularly in these indigenous communities?---Yes. I mean, I'm not by any means saying that we're breaching any ethical rule. We're absolutely not, but it's a sense of professional ethics to do with in the example that I used this interesting blurring, I think, between a professional role and a personal role in relationships.

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Yes, all right. Just generally about some recidivism issues, generally what percentage of sexual youth offenders continue to commit sexual offences in adulthood?---I was involved in a research project using data from New South Wales in fact. There was about 400 young people who were being seen by New South Wales Juvenile Justice and being assessed for sex offences. I think only about 5 or 8 per cent of those came to the attention of police again for sex offence matters as adults. We followed them on average to about the mid-twenties so you would really need to follow them for another couple of decades to really know this, but at least by that stage of early adulthood it was a very low rate of transition into adult sex offender. What alarmed us a bit though in those figures was that 25 per cent of that cohort came to the attention of police again for a sex offence matter before they were adults. So what we think we've learned from that is that there's a real peak of risk during adolescence that probably reduces once these young people enter adulthood, but that's a generalisation. All of these recidivism trends are generalisations and there's a lot of interesting variation within those that's very important to know about. So we're aware that we will be seeing in our client group some number of young people that without, we think, careful intervention are very likely to go on to a lifetime history

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of sex offending. The problem for us is that we don't really know very well who those people are ahead of time. These things are much easier to see backwards than they are ahead of time.

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All right?---So the answer to your question is that there seem to be low sexual recidivism rates into adulthood by young sex offenders.

What about non-sexual offences into adulthood?---As a general rule, much more likely to go on to commit other kinds of non-sex offences, including sometimes violent offences.

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Why is that the case in your view?---Because I think that sex offending is in some senses motivated by the same kinds of factors that all other kinds of offences are motivated by. It's being prepared to exploit other people; being prepared to break a rule; not being concerned about the welfare of others. I mean, these are the kind of things that seem to me to define criminal conduct.

Now, you indicate in the submission that few therapeutic victim services are available on a statewide basis and there is a need for accessible and high quality victim services. I take it that one of the reasons why it's important is it reduces their vulnerability, does it, to access proper services?---Yes. I mean, I don't have a professional background in victim services, but my observation is that most victim services are concentrated on ameliorating the harm of abuse which I think is a perfectly reasonable thing to aim for, but I haven't seen much evidence that victim services aim to prevent revictimisation and I think that's a real - I think it's an important issue. Children who are sexually abused are at significantly increased risk of further sexual victimisation; not just while they're still in childhood but in fact as they become adults as well, sometimes in completely unrelated circumstances, so there's obviously - from a prevention point of view there seems to me a real need to prevent further victimisation experiences among known victims now as well as to help to repair whatever damage there might have been from that experience.

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Is there data about whether in fact some of those victims themselves become perpetrators of criminal offences?---Yes, there is. There seems to be increasing evidence in fact that sexual abuse for boys does seem to be a risk factor for becoming a sex offender. Most boys that are sexually abused won't go on to become sex offenders but that experience does increase the risk of people doing so; not for girls apparently but for boys.

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All right. Now, just in terms of Child Safety policies and practice, again in the submission you opine that available and quality of child safety services is highly variable.

5/11/12

SMALLBONE, S. XN

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There's a need for greater uniformity and access and practice standards. There's missed opportunities for early intervention. You also say that there's no consistent guidance, support and intervention for youth sexual offenders. By the time your service sees a client they are problem saturated. So I take it by that there has been - you mean by that there's been many systemic interventions, if you like, with this young person prior to you becoming involved?---Yes.

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I imagine that must resonate with your success at times of being able to engage this young person. Correct?---Yes, we're investigating this more systematically as well as part of the same project that we're looking at recidivism. We're also looking in some detail at the developmental experiences of our clients, particularly with a view to identify what in fact might have been the missed opportunities for that group.

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All right; and so you're doing that as ongoing work?---Yes.

I suppose, as with most types of harm, the earlier, the better in terms of interventions. That's a truism, isn't it?---Yes.

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You also say in the submission Child Safety Services tend to focus on harm to children from parents and other adults and children with sexual-behaviour problems fall through the statutory net. So is what you're saying there that it focuses on adult-child interrelationships, if you like, and harm from that rather than looking that children may have problematic sexual behaviour towards other children, for instance? Correct?---Yes, that seems to be our experience, that the focus for child safety officers is typically on the risks that adults may pose to children and there is this group of children who don't seem to be in the spotlight so much who may be presenting risks to peers, for example.

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All right; and that is because they don't fall within the statutory net, if you like, of child protection?---I think so.

You say that multiple out-of-home placements often compound serious personal and social attachment difficulties and associated behavioural problems. Do you find that that's an issue that resonates with the work you have done with these young offenders?---Yes. Again it's really hard to speak in terms of generalisations. I mean, we've seen some really dreadful examples of young people who have come to our attention with a very, very significant child-protection history, but then we have also seen many clients that have not had that kind of history and some of our clients in fact come from perfectly well-functioning families as well. So I don't want to leave the impression that this is all connected to, you know, early

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5/11/12

SMALLBONE, S. XN

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developmental problems, although much of it is. 1

I would imagine you would have a view about high staff turnover and also lack of training with child safety officers. I imagine that would have some impact of their ability to engage with, for instance, the cohort you're treating?---Yes, I think definitely that's the case.

Particularly if they have otherwise had instability in placements, wouldn't it?---Yes.

Because it would be yet another person they have to engage with along the way?---Mm'hm. 10

You say that one of the benefits you have is you're not a statutory-intervention agency?---Well, benefits for our particular purpose.

For the purpose that you're engaging in?---Yes.

One of the aspects you would be aware that child safety officers need to address is obviously in some ways a therapeutic role to assist the child, hopefully, through a case plan and intervention. What strategies do you think might assist those who have that statutory-intervention role and being able to therapeutically engage?---I wonder whether it needs to be a separate group of people that have that role. I mean, I am sceptical that - from an outsider's view into child protection services it seems to me that it's an organisation that is always at risk of being overwhelmed with problems that have to be solved today and they're often, you know, important things that have to happen as a reaction to certain circumstances and I think in that kind of environment it's really hard to plant that kind of seek of prevention and therapeutic services and get it to blossom. I really wonder whether it needs to be a group more like ours in a sense; you know, somebody who's aside from them but works very closely that isn't drawn into the reactive, you know, sometimes more kind of punitive thinking about problems, about individuals, but can have their own space to maintain that focus on prevention and therapeutic services. I don't see - I'm no specialist in child protection services. It's not really within my expertise, but, as I say, from an outside it seems to me that an independent or somehow separate set of services needs to take care of that aspect, otherwise it will continually be at risk of being overwhelmed by the need to react and deal with these day-to-day problems. 20

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All right. Now, you have proposed in the submission a comprehensive sexual abuse prevention framework that aims to integrate public health, child maltreatment prevention and crime prevention concepts and methods. The model recognises that separate strategies are needed to prevent sexual abuse before it would otherwise occur and for responding effectively after the fact. Now, I imagine that

5/11/12

SMALLBONE, S. XN

would be a simple endeavour?---Yes.

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What concretely do you propose in terms of how to go about doing that?---Well, I mean, there are many, many things that we could - I could get to here. Look, I think that one of the things - the most important is to maintain a focus on prevention as the primary goal and I think that is often lost in practice and in policy. It's very often lost. It links to my earlier point that because of the overwhelming demand for services that are reacting to known problems, it becomes the business of the organisation. The whole system is built around this kind of reaction. We need to, you know, kind of deal with notifications and allegations and we need to make arrests and we need to do this and that and so on. All those things are important but sometimes it seems to me that very few of those activities ever really take a breath and realise that there's a prevention agenda that might be followed.

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Is that a convenient time?

COMMISSIONER: It is.

MS McMILLAN: Thank you.

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COMMISSIONER: We will adjourn now until 2 o'clock.

THE COMMISSION ADJOURNED AT 1.05 PM UNTIL 2 PM

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THE COMMISSION RESUMED AT 2.06 PM

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COMMISSIONER: Yes, Ms McMillan?

MS McMILLAN: Yes, thank you, Mr Commissioner.

Professor, just before lunch I was asking you about some preventative aspects that you thought could be useful in terms of the child protection arena, if I could put it that way. In the submission from GYFS you say that prevention centred approach is aimed to provide non-causative, non-stigmatising neighbourhood based, family focused, child centred interventions. Knowing various systems that exist, have you got any suggestions as to how that might actually be practically implemented?---I think to some extent some of these already are. Sometimes I think it's a matter of joining up resources and so on. I think that the key thing, though, is to maintain, or establish and maintain, a clear focus on prevention as the primary goal.

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You then go on to say evidence points to family and parenthood education, family support and home visiting programs as the most promising approaches to preventing child maltreatment, including sexual abuse. Now, in terms of parenthood education do you mean things like the PPP parenting program, that type of issue, or do you think more targeted - - -?---Yes, that's an example. That's an example. I mean, these are the kinds of strategies that have a substantial evidence base for preventing child maltreatment in a general sense. I think since the 1980s the focus on sexual abuse has taken sexual abuse almost away from the wider child maltreatment agenda and ideas have developed around prevention of sexual abuse that I think are organised on the basis that sexual abuse is somehow a unique, completely different form of child maltreatment so there needs to be unique solutions and so on. My argument with respect to those points is that sexual abuse can still be seen as part of child maltreatment, so that things that work to reduce child maltreatment will also likely work to reduce sexual abuse as well. There still do, though, I think, need to be services of interventions designed specifically around sexual abuse, because there are some unique components as well. So in a sense I'm trying to have my cake and eating it too. I think sexual abuse needs to be thought of as a form of child maltreatment and on its own terms.

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You also look at home visiting programs. Do you mean by that, for instance, what did exist, the clinic nurse that might, for instance, visit a family? If you try to have your cake and eat it too is it perhaps appropriate that they may visit, if they see signs that might be suggestive of indicia of sexual abuse that they then put them in touch with more specific services or in fact make a referral? ---Well, yes, but most of those nurse home visit programs

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5/11/12

SMALLBONE, S. XN

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are focused on the perinatal period.

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Yes?---So the visits begin before a baby is born and continue for a time after the baby is born.

Yes?---At that point it would be unlikely, I would think, that - you know, there might be some general circumstances that could be noticed in the household that might lead to a referral to other kind of services of that kind.

But you're not aware of any other home visiting programs, are you, that exist?---No.

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Outside child safety, I should say, in terms of their ambit. All right, is there anything else you wanted to add in terms of issues you wanted to highlight in relation to the sexual abuse matters that you identify both in the submission, your statement and any other solution based views you have?---Well, I think a point that I tried to raise in the statement, one of the points there was that I thought that a lot could be done by applying what I call situational crime prevention concepts and methods to this particular problem. I don't think that that's been done anywhere. I know there's interest in this in the UK and there has been some interest here, particularly in the New South Wales through the New South Wales Children's Commission, but I think that there's considerable scope to think about the kinds of environments that are conducive to maltreatment across the board and sexual abuse in particular. So as an example, the New South Wales Children's Commission, as I pointed out in my statement, had organised its Working with Children check procedures around these kinds of concepts. So it wasn't just about trying to identify who the risky people were, it was about understanding or appreciating that certain kinds of organisational environments, particularly - I mean, these principles apply to domestic settings as well, but it's much harder to intervene in a domestic setting than it is in an organisational setting where there are people in authority that have control over the way that the organisation is designed and runs.

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And are accountable?---And are accountable, yes, and have considerable capacity to make changes.

All right, thank you. I have nothing further, Mr Commissioner.

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COMMISSIONER: Thanks. Mr Hanger?

MR HANGER: I have nothing, commissioner.

COMMISSIONER: Ms Stewart?

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MS STEWART: Good afternoon. Lisa Stewart from the Aboriginal and Torres Strait Islander Legal Service. Professor, throughout the inquiry there has been a strong emphasis on universal and early intervention strategies. In the context of that emphasis attachment 2 of your statement, your articles on situational prevention principles and sexual offences against children, we're particularly interested in the prevention aspect. If I could just highlight the evidence you gave earlier about the number of risk factors that relate to the environment, would you also accept - and you make note of this in one of the chapters, the Aboriginal and Torres Strait Islander task force on violence position, that accommodation pressures, including cramped sleeping arrangements and excessive consumption of alcohol are also significant factors?---Yes.

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Would that be another pressure?---Emphatically, yes.

If we're to accept the situational prevention model as a strategy to reduce abuse against children would you see the development of universal education and awareness aimed at creating protective environments and reducing opportunity to abuse children as a key step forward in Aboriginal communities?---Yes, but I think the situational model offers more than this, though. The situational model is about thinking creatively and in an informed way about very specific kinds of environments or settings. So it doesn't really rely on changing individuals by itself. The situational model in a way - in a sense isn't interested in the variations in the potential of people to abuse children. It's about creating environments where everybody who encounters that environment becomes safer because of the environment.

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Yes. If I understand the concept correctly, there's like three levels?---Of?

Situational prevention strategies?---Well, there are different ways to think about it. I mean, there are certainly different sorts of settings. In one of our chapters we talked about, you know, domestic settings, organisational settings and public settings.

That's specifically the concept that I was interested in? ---It is? Yes. So, I mean, we know that most child abuse generally and most sexual abuse in particular happens in domestic settings, but that's the hardest setting to impose, if you like, situational prevention strategies. The easiest places are in organisations and in public places, but in public places it's a little bit like a needle in a haystack problem where, you know, there are so few incidents of sexual abuse that occur in a public environment that it would be hard to know where to focus

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5/11/12

SMALLBONE, S. XN

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your resources. So our argument is that organisations are in fact the most appropriate target for situational prevention of sexual abuse in particular for a range of reasons. One of them is we know through, for example, the Ford inquiry, Commissioner Ford pointed out a whole host of environmental or situational features that she thought, you know, kind of allowed or encouraged certain kinds of child maltreatment to occur. Sorry, I've just lost my train of thought.

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Yes. No, I've read that part of your statement?---Yes.

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But if I can just follow on to one comment that you've just made about it's more difficult in a domestic setting. If I could just refer you to - I think it was page 26 of one of your articles, and you might remember this quote, that you identified parents may potentially play a proactive role in 85 per cent of cases that would occur. In light of that evidence, I take it you place significant emphasis on maximising protective capacities in a domestic situation. Would you accept that as the most effective strategy to educate and inform parents and caregivers in the Aboriginal community would best meet that challenge?---Yes, I think that's part of what I think would be a good mix of things to do, yes.

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Just had - gave some evidence earlier before about collaborative partnerships. You did caveat that by saying that some of your clinical partners might be best placed to speak to this, but to your knowledge do collaborative partners in Aboriginal communities, do they involve the Aboriginal and Torres Strait Islander family support services?---They certainly can, yes. I wouldn't be able to say to what extent that occurs, but it does.

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Just touching on something else in your evidence earlier that you identified that Aboriginality as a predictor to engagement. Having a specific Aboriginal and Torres Strait Islander family support service as a provider on the ground, do you accept that would overcome that hurdle?

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---Yes. I mean, I think there could be a range of alternatives, but that would certainly be one. I mean, in our experience we spend some time trying to identify who within particular communities is most likely to be able to contribute to the positive outcomes for the particular clinical cases that we're dealing with. What we find is that there are some people, for example, as Elders in Aboriginal communities that hold certain kinds of authority, but the authority doesn't necessarily extend to all aspects of problems or decision. So there may be somebody who can contribute to a particular problem or solving a particular problem, whereas somebody else may have limited ability to be able to do that, even though they may carry a kind of a more general authority as a respected Elder in the community. So it seems to me it's really about a case by case, you know, more nuanced appreciation, I think, of the specific context that you're dealing with. I think that's key. I think that raises an important issue in policy. I think it's really hard - I imagine as an outsider that it would be hard to construct policies that are equally useful in all of the different kinds of settings that they're designed to be dealing with. So at some level there has to be that kind of flexibility at the practice level apart from policy that allows certain kind of discretion to occur that provides for the kind of tailoring of certain kinds of options from one place to the next, from one individual to the next. I don't think it's just pie in the sky; I think it can be done with good training and good professionalism.

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If I can just also go on to the other point that you made, that organisational strategies are easier to incorporate. If, say, in the future Aboriginal - future child protection system gave greater authority to Aboriginal and Torres Strait Islander sector and organisations; from the situational prevention perspective, what would be your opinion on what further techniques could be further developed to create the safe organisational structure?

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---Again it's really hard to talk in generalisations. The thing about situational prevention is it requires the most specific target possible and the most specific strategies to target those specific problems. So it's really hard to

5/11/12

SMALLBONE, S. XN

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make any general statements about how it might work. For example, in the community that I was referring to earlier it seems to us that one of the starting points would be to really work at creating a safe environment at the school. Not to say that there isn't work elsewhere that might need to be done and that situational prevention might not reach into other kinds of places, but just from the logical point of view, this is a place where children spend a lot of time. There are a range of adults in that community that have potential to be very effective guardians, and it's a physical and social environment that it's possible to exert considerable amount of control over. So I think the application of the situational principles has to be done in a very specific way. For example, what you might think to do to prevent sexual violence in and around bars is going to be completely different to what you might do to prevent the abuse of children in an organisational or a school setting. The principles are the same but what actually would be done would be almost completely different because you're dealing with a different kind of problem. So sexual abuse isn't just a single phenomenon, it's many, many, many different types of thing that we call sexual abuse. But from a situational prevention point of view we need to kind of target very, very specific aspects of these problems in specific places.

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So just to clarify, it's a matter on a case by case basis depending on, I suppose, the organisation, the type of services that they're delivering and - - -?---Yes, and in a context, I think, of Aboriginal communities particularly, one of the things that we've experienced is that conversations with local community members about situational prevention, our sense is that it's quickly understood and quickly embraced. One of the reasons why we think it's quickly embraced is because it doesn't come with the message that this is all about the problem people that you have here; it's not about problem people, it's about problem circumstances. And it's a way of communicating around the problem that really seems to avoid the historic experience of many of these people that, "Here we go again, we're just going to deal with another set of problems we people have," and so we're not talking to them at that level. It's not what it's about. So our experience is that at least in some communities the idea of situational prevention is something that's seen immediately as something quite positive and doable because it's small things that produce small, immediate effects and don't rely on, you know, interventions that nobody knows what (indistinct)

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I've just got one last question. You've highlighted that there are particular challenges creating protective factors within children, particularly balancing specifying details of abuse alongside building confidence and assertiveness with children. Can you just elaborate on that because I view that in light of the evidence that you gave earlier

5/11/12

SMALLBONE, S. XN

when you were asked to comment on Ms Brennan's evidence and I'd like your opinion on the particular challenges of how much information you give to a child, how do you take it? Because there must be that live where you can go too far too young and that ends up being detrimental to the child? ---Yes, I think potentially that's true. I'm not sure that I could do it without repeating something I think that I said earlier in the day, that it seems to be the whole point of wanting to prevent children from being sexually abused is about leaving them to not have to experience adult sexual concepts. So I think it can be problematic to introduce those concepts to children too early in their life. So, yes, I guess from my point of view I'm much more in favour of a more generic model in that sense. Where I was talking about situational prevention, it is highly specific but there is room for very generic kind of approaches as well. I think this is one example of that, that it's really about trying to create the right circumstances for children to grow up with a sense of confidence and so on. One of the things we know from the sex offender literature is that the children who are most vulnerable to active sex offenders are children who lack confidence, who are emotionally needy, so these are the kind of things that are qualities of children that make them more vulnerable than other children to the attentions of a sex offender of some kind. So if we can reduce the level of emotional vulnerability in children, we can, you know, increase their level of confidence and engage them in programs that are designed to teach them about respectful relationships and so on, that seems to me to make a whole lot more sense.

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I have nothing further, Mr Commissioner.

COMMISSIONER: Mr Capper.

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MR CAPPER: We have no questions, thank you.

COMMISSIONER: Ms McMillan?

MS McMILLAN: I have nothing in the examination. Might this witness be excused?

COMMISSIONER: Professor, thanks very much for your time and your statement. It is very much appreciated?---Thank you for the opportunity.

You're formally released from your attendance obligations.

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WITNESS WITHDREW

MS McMILLAN: We've run a little bit short, I'm afraid, today. We've got Mr Thompson coming tomorrow, but the other witnesses had been prearranged, so we'll have Dr Stathis and Dr Connors on Wednesday; and Thursday we will have Dr Hoehn and Dr McDermott, but we're just waiting for

5/11/12

SMALLBONE, S. XN

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that last statement, so the parties will have it as soon as we get it. 1

COMMISSIONER: All right, okay. Mr Hanger, before we adjourn, there's something that I've been thinking about and it only relates to term 3(e). But I'm wondering who your client is for the purposes of that term of reference, and if it's any different to the other terms. Would you mind thinking about that? I've got a view about it but obviously you announce your appearance for whoever you're appearing for. 10

MR HANGER: What do you see as the problem if I continue - - -

COMMISSIONER: Well, I just don't want to run into any conflicts. I can foresee a situation where depending on who you're acting for there may be a conflict of interest with some of the entities that make up the body politic. I'm thinking current as opposed to former, that's all.

MR HANGER: Yes.

COMMISSIONER: So can I leave that with you? 20

MR HANGER: Yes, thank you, your Honour.

COMMISSIONER: Thanks. I just to give you that heads-up.

MR HANGER: Thank you very much.

COMMISSIONER: We were going to resume at nine o'clock tomorrow morning, but is there any need?

MS McMILLAN: No. Could we do 10 o'clock also because Mr Thompson is coming down from the Sunshine Coast, so I think it's - - - 30

COMMISSIONER: We'll give him - - -

MS McMILLAN: I think it's - and he's been good enough to come in at short notice, given we looked like we were moving more speedily for once than we expected to.

COMMISSIONER: Yes. We'll resume again at 10 in the morning.

MS McMILLAN: Yes. I must say that's the indication I've given him thus far. 40

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 2.27 PM
UNTIL TUESDAY, 6 NOVEMBER 2012