BELIEVE INQUIRE RESPOND TO DISCLOSURES (BIRD)

Research Report, August 2023

Yamurrah
Connections with Care

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National Voice for our Children

Our ways of knowing, doing and being are centred in child safety, connection and protection. Safety of children is inherent in Aboriginal and Torres Strait Islander families, communities and Nations.

The BIRD project brings forward the wisdom of our Ancestors.

Birds and birdsongs tell stories of the land, warnings and good news stories, as well as messages from the Ancestors and loved ones who have gone to the Dreaming. The bird represents freedom, strength, safety and communication.

Aboriginal worldviews have held child safety and protection at the centre of our culture since time began. Reconnecting with our Ancestors' wisdom will help us chart a path to greater safety for our children.

Yamurrah and SNAICC - National Voice for our Children (2023)

Believe Inquire Respond to Disclosures (BIRD) Research Report
Gorokan, NSW, Australia, August 2023

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Trauma-informed safety protocol

The BIRD Research Report contains content that may cause distress and overwhelm.

This report covers themes of child sexual abuse, family and domestic violence, complex, collective systemic and vicarious trauma, as well as racism. Readers are encouraged to practice self-care while reading. Take your time, take breaks and observe the feelings that come up for you as you read. Discuss such feelings with a safe person, and if they are still coming up seek professional supervision and support where appropriate:1800 RESPECT (1800 737 732), 13 YARN (13 92 76), Beyond Blue (1300 224 636), Lifeline (13 11 14), Brother to Brother (1800 435 799), Kids Helpline (1800 55 1800), Blue Knot Helpline (1300 657 380), Suicide Call Back (1300 659 467) and Support Act. .(1800 959 500).

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The Yamurrah BIRD Research Team would like to thank those who shared knowledge and stories with our team as we gathered information about responding to disclosures of child sexual abuse, including research and training. We thank our team of experts who reviewed our findings. We also want to thank our partners - SNAICC – National Voice for our Children (SNAICC) for its leadership and collaboration, as well as The National Indigenous Australians Agency (NIAA) for its ongoing commitment to supporting children who may be disclosing child sexual abuse. We would like to acknowledge the guidance from members of our governance structure and stakeholders who participated in conversation to improve responses to child sexual abuse disclosures. We would like to thank Tovani Cox for her beautiful bird designs. We acknowledge and stand in solidarity with all victims and survivors of child sexual assault. This Report is dedicated to all victims and survivors of child sexual assault.

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A note about language

The terms Indigenous, Aboriginal, Aboriginal and Torres Strait Islander, First Nations and Blak are respectfully used interchangeably in this document.

The terms child sexual assault and child sexual abuse are used interchangeably in this document.

INTRODUCTION

The project team, Yamurrah and SNAICC identified a working title of Project BIRD in recognition that the training will address upskilling the health sector to Believe, Inquire and Respond to Disclosures of child sexual abuse.

The BIRD Research Report has been written by Yamurrah in partnership with SNAICC. Together, we are co-designing with First Nations experts a trauma-aware, healing-informed and culturally appropriate national training package and resources to improve culturally safe responses in primary healthcare for First Nations victim-survivors of child sexual abuse. This includes trauma-aware foundational modules on cultural safety and healing-informed practice, as well as trauma-specific specialised modules in responding to child sexual abuse disclosure.

The BIRD Research Report examines current approaches, literature, legislation and relevant training across Australia and has formulated key understandings and insights that will guide the development of the training package and resources. The BIRD Research Report highlights content that could be covered in training, as well as locations where the training may be established for user testing sites. The ideas presented in this research report will be further explored with governance partners and key stakeholders.

The BIRD Research Report examines responses to child sexual abuse, has developed a BIRD Practice Framework that provides key training objectives, and is informed by First Nations worldviews, including behaviours found typically in birds. The BIRD Practice Framework recommends desired professional development and practice that is required in responding to disclosures of child sexual abuse. Further subject areas are recommended as key training content.

Our decolonised approach centres Aboriginal and Torres Strait Islander worldviews and narratives.Before invasion, Aboriginal and Torres Strait Islander people operated under different legal systems, including lore and law. These culturally diverse and sophisticated systems managed conflict, child protection and human relations. These systems also carefully managed child safety and wellbeing, including kinship structures that protected, educated and collectively cared for children. These systems are still operational in many Aboriginal and Torres Strait Islander communities. We acknowledge that colonialism has fractured these systems in many Aboriginal and Torres Strait Islander communities (Atkinson, J. 2002, Terare, M. 2019, Lawrie, R. et. al 2018).

The animal and plant world are deeply integrated in Aboriginal and Torres Strait Islander belief and knowledge systems. Birds are central to Aboriginal and Torres Strait Islander culture, spirituality and connections to Country.

Creation and dreaming stories of birds are prolific across Aboriginal and Torres Strait Islander nations from the cockatoo, owl, kookaburra, lyrebird, willy wag tail, emu, crow, magpie, kingfisher, eagle, parrot, brolga, swan, galah and honey eater. The stories vary with messages and meaning. Some have stories that consider morals, responsibilities and values while others include ways to relate with the land and each other. Some stories reveal the importance of learning, sharing and caring for each other and the land. Birds are incredibly special and, for some tribes, birds represent a clan or personal totem. They often hold deep spiritual significance and their stories can be represented in the Milky Way and the land itself.

Birds communicate about weather patterns and changes and, for Aboriginal people, birds and birdsongs tell stories of the land, warnings and good news stories, as well as messages from the Ancestors and loved ones who have gone to the Dreaming.

Birds signal, communicate and call on each other when there is danger; bird calls can signal a distress call. Birds socialise in flocks and communicate with other bird species when there is a threat or predators. Birds work together as communities to protect and guard against predators and dangers. When birds fly in a flock, there is usually a lead bird in the flock who flies forward and can also fall back and allow another bird to lead when they tire. Pelicans are a fair example of this - there is lead pelican who flies ahead and searches for food sources and circles back to the flock to align with the formation.

Hearing birds sing and chatter in the bush can also signal that there is no imminent danger, which signals to other animals and humans that the environment is safe. This is important information for humans both neurobiologically and physiologically. The very sound of birds singing and chattering can help regulate the parasympathetic nervous system, assisting with emotional regulation, anxiety and connection generally. Going outside in nature and connecting with birds and nature can help reduce stress, tension and depression, as well as support physical, cultural and spiritual wellbeing. New research is showing that hearing birdsongs helps create a sense of calm and has been found to be beneficial in reducing depression, stress and anxiety. These benefits are free and accessible to everyone globally.

Similarly, the bird represents freedom, strength, safety and communication. Birds can offer an inclusive way for survivors across Australia to connect to pathways of healing by having safe experiences of disclosures.

SUMMARY

About the Project

SNAICC - National Voice for our Children in collaboration with Yamurrah have created the **Believe Inquire Response to Disclosures (BIRD) Project**.

The BIRD Project decolonises child safety approaches by centering First Nations worldviews and ways of knowing, being and doing to improve responses to First Nations children and adults who are victim-survivors of child sexual assault. In Australia, settler-colonial racism, white privilege and white-Western bias have driven interventions and responses to child sexual abuse in First Nations communities. This has exacerbated the trauma and marginalisation experienced by First Nations communities and has not improved child safety.

Responses to child sexual abuse must be led by First Nations people. The BIRD Project offers a national, trauma-informed and strengths-based training package and collection of resources which are aligned with the National Strategy to Prevent and Respond to Child Sexual Abuse 2021-2030 (Commonwealth of Australia, 2021).

Birds are central to Aboriginal and Torres Strait Islander cultures, spirituality and connection with Country. The BIRD Project draws inspiration and guidance from the wise, protective and collective behaviours of birds in the BIRD Practise Framework for responding to First Nations children and adults who may be victim-survivors of child sexual assault.

Our approach

- Aboriginal worldviews and First Nations sovereignty
- Human rights focused
- Trauma-informed
- Eco-jurisdictional analysis
- Sociopolitical context
- Anti-racism, decolonisation

First Nations Methodologies

- The BIRD Project draws from First Nations research methodologies including Yarning Circles and Yarning with Country. The project also involved a literature review exploring current approaches to responding to victim-survivors of child sexual assault and an analysis of relevant legislation and training across Australia. The key understandings, insights and recommendations from these research findings have informed the development of of the BIRD Project Report, training package and resources.
- A collective and collaborative approach was key to our methodology - not replicating dynamics of abuse.
- A legislative review across jurisdictions.

Key Understandings

- Responses to child sexual assault must always be determined by First Nations people and communities. Child sexual assault is a violation of human rights and dignity, and this must always be named and understood as a crime.
- First Nations victim-survivors of child sexual assault often experience feelings of shame and stigma related to the abuse or assault, and this is compounded by racist violence, generational harm and injustice from institutional and systemic racism, white privilege and a lack of culturally-safe responses. Racism and white privilege are forms of abuse that compromise the safety that is required to support First Nations victim-survivors of child sexual assault.
- Disclosure of child sexual assault is not usually contemporaneous and children and adults often make partial rather than full disclosures about child sexual assault to assess how the person they have disclosed to will respond. It is useful to understand disclosure as a process which can take place across the victim-survivor's lifetime.

Recommendations

- The BIRD Practise Framework centres First Nations' worldviews and practices in responding to child sexual assault disclosures.
- Develop a national accredited culturally responsive trauma-informed training package along with key resources which includes key modules.
- Working alongside Aboriginal communities and developing key partnerships.
- Mandatory training - embed BIRD Training in Work Safe legislation.

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INTRODUCTION

Project Background

Experienced team

SNAICC - National Voice for our Children in partnership with Yamurrah are co-designing with First Nations experts a trauma-aware, healing-informed and culturally appropriate national training package and resources for primary healthcare workers to improve the early disclosure experience of, and responses to, First Nations victim-survivors of child sexual abuse.

Training built on the best evidence

The training package and resources will include trauma-aware foundational modules on cultural safety and healing-informed practice, as well as trauma-specific specialised modules in responding to child sexual abuse. Resources to support training will include working with First Nations victim-survivors with diverse needs, for example, people from LGBTIQA+ communities and people with disability. Resources will also address preventing and responding to vicarious trauma experienced by health service staff.

This project is informed by the critical work of Yaitya Mingkamingka Purrutiapinthi (Aboriginal Trauma Healing) in South Australia, which supports culturally responsive and trauma-responsive practice with Aboriginal and Torres Strait Islander people through training of the entire Safer Families Services workforce by Aboriginal community-controlled organisations.

This training was developed through an Aboriginal-led co-design model that was also supported by a Trauma Responsive Framework (Government of South Australia, Department of Human Services, 2021) and an Aboriginal Cultural Practice Framework that embeds ethical, family-led, partnership driven self-determination and healing as best practice (Government of South Australia, Department of Human Services, 2022).

Strong cultural governance

Both SNAICC and Yamurrah have strong expertise, leadership and shared commitment in giving a voice to victim-survivors of child sexual abuse. SNAICC is the National Voice for Aboriginal and Torres Strait Islander children and families.

SNAICC's vision is to create an Australian society in which the rights of Aboriginal and Torres Strait Islander children, young people and families are protected, our communities are empowered to determine their own futures and our cultural identity is valued.

Yamurrah is a collective of First Nations experts working with victims and survivors of complex and collective trauma, as well as the clinicians and services who work with them.

Yamurrah's holistic values include: Connection, Integrity, Empowerment, Humility, Social Justice and Safety. Yamurrah provides wellbeing clinical services, training and consultancy with care and integrity.

Overwhelming need for action

The Royal Commission into Institutional Responses to Child Sexual Abuse found that the failure to protect children and to understand that child sexual abuse was a crime led to devastating impacts for many victims across a range of institutions, including schools, religious institutions, foster and kinship care, respite care, health and allied services, performing arts institutions, childcare centres and youth groups (Commonwealth of Australia, 2017). The report recommended that institutions need to have a culture of safety that empowers children, prevents child sexual abuse and encourages identification and disclosure (Commonwealth of Australia, 2017).

Numerous Australian Government consultations and strategies have also identified the critical need for holistic wraparound service provision and support for Aboriginal and Torres Strait Islander victims and survivors of child sexual abuse and their families including:

- National Strategy to Prevent and Respond to Child Sexual Abuse 2021-2030
- Closing the Gap Implementation Plan 2023 (Specifically Target 13 and Target 14, and Priority Reform Area Two)
- Indigenous Advancement Strategy
- National Mental Health and Suicide Prevention Plan 2021
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031
- National Aboriginal and Torres Strait Islander Health Plan 2013-2023
- National Plan to End Violence Against Women and Girls – First Action Plan 2022-2023
- Fourth Action Plan – National Plan to Reduce Violence against Women and their Children 2010-2022.

Building capability in the healthcare workforce

The training will be designed to be nationally applicable and target all staff working in health services, including health practitioners (GPs, health workers, practice nurses, nurse practitioners, allied health) and health service administration staff (reception staff, practice managers). Resources will also be designed for future adaptation to match the contexts of different support services.

The pivotal role of health workers was recognised in the first World Health Report on Violence and Health acknowledging health services' significant contribution that can and should be made to reduce the health consequences of violence through prevention, coordination of multidisciplinary and multi-sectoral efforts and availability of services for victims (Krug et al., 2002). Health services, both Aboriginal and Torres Strait Islander controlled, and mainstream primary health are one of the main entry points through which victim-survivors of child sexual assault may seek help, disclose abuse or access support services. A focus will also be on refurbishing the health context to be more trauma and healing friendly and culturally appropriate so that victim-survivors feel safe enough to disclose.

Improving responses to First Nations victim-survivors of child sexual abuse is central to increasing accountability for people who have perpetrated child sexual abuse, preventing ongoing harm and to building safety. This requires a national health response which enhances the capability of the Health workforce to provide safe, culturally-informed, anti-racist, trauma-aware and healing-informed responses and appropriate referral. This is a large-scale target audience as 15% of Australia's workforce are situated in the Healthcare and Social Assistance industry, which amounts to 1.7 million employees (ABS Census, 2021a). If this large industry is given access to tailor made training and resources developed by First Nations experts and the voices of victim-survivors there is more chance of victim-survivors of child sexual abuse being believed, heard and effectively supported.

It is important to keep a focus on the fact that Aboriginal and Torres Strait Islander people are significantly under-represented in the health workforce. Aboriginal and Torres Strait Islander people represented 1.8% of the health workforce, despite being 3.8% of the Australian population (3.1% of the working age population) (ABS, 2016; ABS, 2021). To address this under-representation, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 is in place to reach a target of 3.43% of Aboriginal and Torres Strait Islander people to be employed in the national health workforce by 2031 (Australian Government, Department of Health, 2022). Every effort must be made to support this plan. Greater recruitment and retention of an Aboriginal and Torres Strait Islander trauma-informed health workforce of staff and leaders will likely result in this workforce becoming more culturally safe over time.

Project Outline

This project has three phases (Figure 1). **Phase 1** was completed in February and March 2023 with the following in place: Project Plan, Governance and Project Management Strategy, Stakeholder Engagement Plan and Safe and Trauma-Informed co-design processes developed. The governance structure is a National Reference Group, all of whom are identified as First Nations experts in child sexual abuse and/or trauma-informed care.

The co-design process actively involved people likely to receive or be impacted by the training in identifying and refining course content and recommending modes of delivery. This included people with lived experience and key stakeholders who hold expertise that relates to content in the modules and a national scoping workshop to inform initial training and resource development. Following the scoping workshop, 10 module workshops were held to refine content and ensure specialised content areas are informed by relevant expertise and evidence. In the last stage of the project, focus groups were hosted to support the testing and finalisation of the training package.

Throughout Phase 1, the project team identified a working title of Project BIRD in recognition that training will address upskilling the health sector to **B**elieve, **I**nquire and **R**espond to **D**isclosures of child sexual abuse. Similarly, the bird represents freedom, strength and communication. Birds are central to Aboriginal and Torres Strait Islander culture, spirituality and connection to Country. Birds can offer an inclusive way for survivors across Australia to connect to pathways of healing by having safe experiences of disclosures.

Phase 1
Governance and planning
Feb-Mar 2023

- Project plan
- Governance and Management strategy
- Stakeholder engagement plan
- Safe, trauma-informed co-design process

Phase 2
Research and development
May-Aug 2023

- This research report
- BIRD Practice Framework to inform trauma-aware, healing-informed and culturally appropriate national training strategy

Phase 3
Development of training
Jun-Dec 2023

- Develop BIRD National Training package
- Co-design modules
- Testing the package

Phase 4
Pilot and evaluation
2024-2025

- Pilot BIRD practice framework and BIRD training program in primary healthcare services
- Evaluate

This report covers Phase 2 of this project, which aims to build the evidence underpinning this Trauma-Aware, Healing-Informed and Culturally Appropriate National Training Strategy. This report positions child sexual assault as a crime as opposed to being hidden under the generic veil of trauma theories, which contribute to silencing and rendering victim-survivors' experiences invisible. A human rights framework in the training package positions children as the 'bearer of rights' as they have the fundamental right to be protected and safe from sexual abuse (Commonwealth of Australia, 2017). Health workers will be positioned as the 'bearer of duties' to enable children and victim-survivors to be afforded these rights.

Phases 3 and 4 translate the work of Phases 1 and 2 into practice.

Project Purpose

The overall project purpose is to improve early disclosure experience of and responses to First Nations victim-survivors of child sexual abuse by the primary healthcare system.

The program aim is to improve the cultural safety and responsiveness of the primary healthcare system in order to drive improved support and referral outcomes for First Nations victim-survivors of child sexual abuse.

Resources to support training will include working with victim-survivors who face additional challenges as a result of prejudice and discrimination, such as people from LGBTIQA+ communities and people with disability. Resources will also address preventing and responding to vicarious trauma experienced by health service staff.

Project Scope

National training

SNAICC and Yamurrah are funded to co-design training that will be targeted towards all staff working in health services, including health practitioners (GPs, health workers, practice nurses, nurse practitioners, allied health) and health service administration staff (reception staff, practice managers) in government and non-governmental organisations (NGO) healthcare services. The training will be suitable for use by both Aboriginal and Torres Strait Islander and mainstream primary health workforces and front-line services.

Core training components will include:

- guides to the training package (for facilitators and learners)
- foundational modules (e.g. culturally-safe, trauma-aware and healing-informed practice)
- specialised modules (e.g. referral pathways, problematic and harmful sexual behaviours in children and adolescents, child sexual assault, adult survivors of sexual assault)
- resources and information to support a training package including working with diverse needs, preventing and responding to vicarious trauma and understanding rights and responses across state and territory jurisdictions. These will be tailored for various professionals.
- the project team will design a minimum of 10, maximum of 12, training modules.

The literature in this report, and input from stakeholders, will inform the co-design of:

- common themes to be addressed in the training package
- effective training practices for primary health sector workforces
- online or face-to-face delivery preferences
- accredited or non-accredited training preferences
- possible locations to pilot training and rationale for each.
- methods for flexibly adapting training, including advice on how to tailor to local context.

Further research is required to identify potential web-based platforms for hosting training and resources and was outside the scope of this report.

Our Approach

At the heart of our approach is honouring the depth and breadth of Aboriginal and Torres Strait Islander worldviews, the voices and spirit of Aboriginal and Torres Strait Islander people with lived experience of child sexual abuse and Aboriginal authors, researchers and specialists who have worked alongside victims and survivors of child sexual abuse.

The BIRD team is strongly committed to engaging in decolonising, anti-racist, culturally safe and responsive practice so that we keep making space for Aboriginal and Torres Strait Islander peoples' wisdoms, experiences, stories of resistance and worldviews to be voiced and centred.

We have considered decolonised frameworks as critical and necessary in responding to disclosures of child sexual abuse for Aboriginal victims and survivors. Sherwood and Edwards (2006) propose that in order to understand the context of Aboriginal peoples' health, necessary steps to decolonise health practises are essential.

Storytelling, including stories about birds, and other narratives have been woven throughout this report to keep us accountable to Aboriginal and Torres Strait Islander people with lived experience. This approach sets the scene for our future co-design approach with stakeholders with lived experience where we will adopt First Nations co-design principles of First Nations leadership; ulturally grounded approach; Respect; Benefit to community; Inclusive partnerships; and Transparency and evaluation (Anderson K. et al., 2022).

We understand that to make real headway in addressing child sexual abuse for Aboriginal communities we need to always consider it as a criminal act of violence that requires a steadfast and relentless human rights approach. Our focus is on developing the capacities of 'duty-bearers' (such as health workers and supportive parents, carers, family and community members) to meet their obligations to assist child and adult victim-survivors of child sexual abuse as 'rights-holders' to claim their rights (United Nations Sustainable Development Group, 2019).

This project has referred to disclosure of child sexual abuse within a human rights context where children and their supportive family members are considered bearers of rights. There are limitations of national definition of child sexual abuse. If we are not clear on our definitions of sexual abuse, how can we be clear on what a disclosure is? Given the importance of this question, a section in this paper has been dedicated to exploring, deconstructing and understanding disclosure as a process.

This report has been written and reviewed collectively by a team of like-minded, skilled and committed people. Our process is collaborative by acknowledging and embedding our many thoughts, voices and experiences alongside evidence-informed practice. We aim to steer well away from replicating any colonist or violence dynamics within our work by privileging only a few voices at the expense of others.

Aboriginal Worldviews: Our Ways of Knowing, Doing and Being

Our approach and training recommendations centre Aboriginal worldviews: Our ways of Knowing, Doing and Being and Aboriginal narratives. Aboriginal worldviews are culturally rich and diverse; there is not one Aboriginal worldview.

This research process honours Indigenous research methods, which are respectful, collaborative and relational (Wilson, 2001). Parter et al. (2021) argue:

> ***"Elevation and implementation of Indigenous knowledges relating to cultural ways of being, knowing and doing are principal factors required to close the health disparity between Aboriginal and non-Aboriginal people."***

Aboriginal ways of knowing, doing and being are centred in child safety, connection and protection. Safety of children is inherent in Aboriginal and Torres Strait Islander families, communities and Nations. Aboriginal worldviews have held child safety and protection at the centre of our culture since time began. Aboriginal people invested in the wellbeing of the children, with knowledge that it would be those children who would carry forward the knowledge and practice of culture. In these worldviews, Aboriginal children were visible, loved and deeply valued, and to harm a child in many Aboriginal communities was a grave offence that would attract severe discipline and penalties. Atkinson & Woods (2008) state that 'Indigenous peoples of Australia have always had laws, processes and procedures that address, govern and control violent behaviours both at the interpersonal and group levels'. Aboriginal and Torres Strait Islander communities have complex systems of lore and law which safeguarded and protected children from harm, including sexual harm (Lawrie & Cousins, 2018).

Traditional Aboriginal parenting practices illustrate richer relational environments for children, which have multiple attachments and connections with many significant and primary caregivers. In Aboriginal child-rearing practices there are complex and reciprocal obligations between a greater number of adults, who each take responsibilities in ensuring not only that children are safe, but they are secure and loved. This can enhance neurological benefits, as well as protective factors against risk of harm, and support in anticipating child needs and development. Collective child rearing has not always been valued by Western approaches and Western applications of attachment theory, yet, increasingly, the research supports collective approaches as a superior way of child rearing (Lawrie & Cousins, 2018).

In the Western model of two parents or a single parent, children are dependent on these adults. If one or both of these people become unavailable for whatever reason, or cause harm, the child or children are at greater risk – risk that can quickly escalate. Aboriginal collective parenting structures protect against this, providing a far greater number of supports and carers to 'pick up any slack', as well as educate, nurture and keep children safe (Lawrie & Cousins, 2018).

These kinship systems of care and safety are largely still part of Aboriginal and Torres Strait Islander families and community ways of knowing, doing and being. It is acknowledged, though, that colonialism has deeply impacted these systems for children (Lawrie & Cousins, 2018; Lawrie, 2003).

Aboriginal ways of knowing, doing and being, particularly concerning Elders, Mother Earth and children, protect and support the wellbeing of those who have experienced systemic and interpersonal trauma, including child sexual abuse. Connection to Mother Earth, the wisdoms of Elders to the teaching of children, is all about survival, wellbeing, love and lore. These coexist in harmony through lores which are entwined within epistemology (our ways of knowing), axiology (our ways of doing) and ontology (our ways of being). The wellbeing and future of First Nations peoples lies with our love and lore to protect, nurture and support our Elders and children (Terare, M. 2020, p. 127).

In Aboriginal worldviews, Country (or the land) holds the stories of survival, and is consistently in relationship with us (Atkinson, 2002). When people are harmed - they are harmed on Country - this is against the law of the land - "the harm happens on Country" (as spoken by Aunty Oomera Edwards). Crimes that occur against children are crimes against Country, because Aboriginal people are of, and related to, Country.

With interpersonal complex trauma, the harm happens in the context of a relationship - as does the healing happen in connections and relationship (Herman, 2015). As the harm happens on Country - the healing happens on Country as well (Oomera Edwards, 2022). Stories of healing that connect the ecology and ecosystems we live in are helpful both neurologically, psychologically and culturally.

There is growing evidence that optimising neurodevelopment for children can be enhanced by enrichment activities through repetition, stimulation and pattern, and further, that cultural enrichment activities, ceremonies and rituals may optimise child neurodevelopment (Perry & Levine, 2000). This can be carefully considered in the design of healing informed practices to support healing and recovery from complex trauma (Atkinson, 2013).

> ***"Some children are like the brolga in this story. They have great energy and enthusiasm for life. They are inspirational children, always encouraging others to embrace what life has to offer" (Milroy, 2019) from Brolga and Little Star***

Significance of songbirds

One very special story concerns the Regent Honeyeater, one of Australia's most precious songbirds. Due to widespread clearing of land and colonial farming practices, it is estimated that only 350 Regent Honeyeaters are left in small pockets in Victoria and Queensland. A research report led by the Australian National University found that 'song culture' is being lost due to the rapidly declining population. Due to the small numbers, across vast distances, the honeyeaters greatest challenge for their survival is finding ways to learn their mating songs from their Elders (Crates, 2011).

Typically, most other songbirds learn their songs in the first year of life, however Regent Honeyeaters leave their nests straight away, relying on finding older birds to teach them. Younger songbirds are finding it increasingly hard to find an older teacher in the wild to learn the mating songs from. These songs have been passed down for thousands of years and the loss of teaching and sharing them has meant male songbirds are learning the songs of other birds or their own songs are lacking in richness and complexity. This often leads to the experience of songbirds being rejected or avoided by the female birds they are trying to attract (Crates, R. 2011).

If the song is lost or not learned properly from another Regent Honeyeater it is likely that the bird will not attract a mate. This is significantly impacting reproductive rates for a songbird on the brink of extinction.

The quest of the Regent Honeyeater and the resistance to losing their song is strong. The protection of the Regent Honeyeater is underway and work is being done to make sure young birds are matched with their elders to learn song, as well as looking to technology to spread song culture across the vast distances. This story of resilience and strength in the face of profound loss has been a guiding story for Project BIRD.

Understanding Disclosure

To understand disclosure, it is essential to understand first why children don't disclose.

Perpetrators often anticipate the type and quality of social responses victims/survivors may receive and will utilise these predictions in their calculated efforts to extend abuse through families, systems and services (Coates & Wade, 2007). For example, perpetrators of child sexual assault often involve the targeted child's family and care givers in a range of deliberate predatory child entrapment behaviours also referred to as 'grooming' (Wolf, Pruitt, & Leet, 2021). By gaining the trust of parents and adult care givers, perpetrators can more easily gain unsupervised access to the child. Perpetrators also use predatory child entrapment behaviours in the attempt to control the kinds of responses a child may receive from adults following a child's disclosure - so that a child's direct or indirect disclosures are less likely to be believed (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017). The perpetrators close relational proximity to the child's parents, family and care givers often increases the child's hesitancy to tell someone about the sexualised violence (Morrison, Bruce & Wilson, 2018; Shackel, 2009). Children anticipate how adults and other children may respond to their disclosures. For example, if a child believes the perpetrator is has a close relationship with their family members a child may make the assessment that they will not be believed, that they may be blamed for the assaults/abuse. Children also anticipate the responses of the perpetrator(s). Children may not disclose experiences of child sexual assault because a perpetrator has directly or indirectly threatened to harm them, their family members and pets.

Disclosure of child sexual assault is vital for victims and survivors to get support and resources, as well as for the abuse to stop, but research shows that most victims and survivors put off disclosing the abuse. Some research suggest that delays to disclosure relate to the age of victims or survivors, intra-familial abuse, severity, 'fear of not being believed or a fear of being blamed for the abuse'. (deRoos, M.S. et al 2023).

Research suggests that only a small number of children (8.3%) disclose child sexual assault in formal (e.g., forensic) settings close to the occurrence of such abuse (Priebe & Svedin, 2008). The Royal Commission into Institutional Responses to Child Sexual Abuse estimated that **on average it took 23.9 years for victim-survivors to tell someone about the abuse**. Men often took longer to disclose than women (the average for male survivors was 25.6 years and for female survivors 20.6 years (Commonwealth of Australia, 2017, p. 22-23)).

Disclosure of child sexual abuse is rarely a one-off event. It is a process. Victims will disclose in different ways to different people at different times of their lives. Disclosures may be verbal or non-verbal, accidental or intentional, partial or complete (Commonwealth of Australia, 2017, p.23).

One review found that **fewer than 1 in 4 children immediately discloses their sexual abuse** (Paine & Hansen, 2002). Several researchers have noted three to four times as many instances of sexual abuse than are actually disclosed to family members or authorities (Goodman-Brown et al., 2003; Mills et al., 2016; Romano et al., 2019).

Being able to sexually abuse a child and get away with it (and conceal the crime) requires planning and tactics on the part of the perpetrator. This is now commonly called 'the grooming process' (Christianson & Blake, 1990).

These tactics include building trust, bribes, threats, making the child feel complicit in the acts, using their position of power over the child, and isolating the child from supports and community. Children are effectively silenced from speaking out about the abuse by these tactics which are often pitched to the child's age, developmental level and vulnerabilities.

Perpetrators often use tactics on the child's supports and network to ensure that if a child does disclose in some way, they are not believed or the abuse is not acted on. This process is made easier if they can undermine the child's relationship with healthy loving family members and adults. The child is enmeshed in this abyss of confusion, uncertainty and may even doubt the adverse event took place. This crime may impact on the victim-survivors' ability to believe they have been hurt (Mcalinden, 2006).

The powerful and long-term impacts of child sexual assault on an individual are often layered with feelings of shame, self-blame, responsibility and denial which also increase barriers for children and adults disclosing. The long-term effects may manifest as mental health issues, isolation, poor health and difficulties with trust. These effects are well documented (Cashmore & Shackle, 2013).

Many victim-survivors of child sexual abuse do not make the link between the childhood abuse and their current life challenges, and this also impedes disclosure.

These are universal experiences that many victims and survivors experience. Aboriginal and Torres Strait Islander victims and survivors face additional barriers and challenges, such as racism, lack of access to culturally safe services and generational trauma. These experiences can compound and further isolate Aboriginal and Torres Strait Islander victims and survivors of child sexual abuse, making disclosure even more difficult and complex.

The Nature of Disclosure

Despite the many barriers to disclosure, children find ways, often other than verbally, to indicate that something is wrong and to resist the perpetrator's actions and tactics. This may include avoiding contact with the perpetrator, expressing emotions in behavioural ways such as anger outbursts, self-harm, reckless behaviour, isolating, dissociating or becoming hyper alert and partial disclosure to test the water.

Disclosure of child sexual abuse is a lifelong process that can take years, if not a lifetime, to many different people. This knowledge is essential in responding to children and adults sexually victimised as children. Disclosure is often not made by children, and delay in disclosure is more common than immediate disclosure at the time when the abuse is occurring, meaning that most disclosures to child sexual abuse are not contemporaneous (Pratt & Tolliday, 2018).

Summit referred to this trend as behavioural sequelae of delayed disclosure, which over the years has influenced forensic interviewing practices (cited in London et al., 2007). The overall trend was toward delaying disclosure and those who attempted to disclose as children frequently did so through behavioural or indirect verbal means. However, males reported difficulty disclosing because of internalised homophobia and a fear of being portrayed as victims. There is a harmful social conflation between predatory abuse targeting boys and consensual homosexual activity between adults that inhibits disclosure for heterosexual and queer men alike. Women's difficulties with disclosure centred on feeling conflicted about responsibility and they more strongly anticipated being blamed or not believed.

Responsiveness to Disclosure

There is strong evidence that how a disclosure of childhood sexual abuse is responded to can have a huge impact on the trajectory of a person's life. The Royal Commission into Institutional Responses to Child Sexual Abuse investigated the **poor and traumatising responses of many institutions to victim-survivors who disclosed** and sought redress, justice or an apology for what had happened to them. Poor and inadequate responses may in fact be re-traumatising for victims and survivors generally, and racism, discrimination and lack of culturally safe trauma-informed responses are additional layers for Aboriginal victims and survivors.

Many children delay disclosure as they were not asked about the abuse, and further not being sure who or how they can tell (McGee et al., 2002; McElvaney, 2015; Schaeffer et al., 2011). Disclosures may also be impacted by many factors including developmental stages (age, disability, language) as well as the tactics victim-survivors have been subjected to. At the heart of all disclosures is the hope to be believed, validated, acknowledged and for the abuse to stop.

Research suggests that identifying factors that inhibit and facilitate disclosure would strengthen preventive strategies and improve treatment, support and understanding for all victims (Kellogg et al. 2020). Shame, fear of being disbelieved and self-blame are key barriers to disclosure across all cultures, countries and religions (Collin-Vézina et al., 2015).

Language is a profound issue that impacts on a child, young person or adult's capacity to tell their stories. It is in the interest of best practice in health services that we understand the complexities surrounding power of discourse and thus effectively respond as duty bearers to better support the child, young person and adult.

Access to culturally safe and trauma specific services that respond to sexual abuse, coupled with fear of accessing services that have caused harm (health systems, child protection systems, police and justice systems), present additional barriers to disclosures for Aboriginal victims and survivors (Herring et al.,

2013). Deep listening and culturally safe responses are critical.

At the heart of all responses to child sexual abuse is listening deeply to the victim-survivor, to believe them and respond in a way that values their experiences and rights to healing and justice.

Dadirri - the art of deep listening

Professor Judy Atkinson, a Jiman and Bundjalung woman, is a global trauma specialist who has revolutionised our understanding and approach towards trauma by embracing an Indigenous standpoint. Her groundbreaking work in her book ***Trauma Trails: Recreating Songlines – the Transgenerational Effects of Trauma in Indigenous Australia*** puts a spotlight on deep listening and the concept of 'Dadirri' and further states that 'listening invites responsibility to get the story – the information – right' and that 'Dadirri', or deep listening, is 'listening and learning at its most profound level – more than just listening by the ear, but listening from the heart' (Atkinson 2002, pp 17-20).

This deep listening is what every child, every victim and survivor requires. The learning of 'Dadirri' as both a concept and a response to disclosures should be embedded into the training modules.

'Dadirri' is a concept of the Ngan'gikurunggkurr people of the Daly River in the Northern Territory. Miriam-Rose Ungunmerr-Baumann, a distinguished Elder and knowledge holder of the Nauiyu community, first brought 'Dadirri' to the national attention in 1988 at a conference address in Tasmania (Ungunmerr-Baumann, 1988). 'Dadirri' as a research methodology was articulated by J. Atkinson (2002) where she established the strengths of 'Dadirri' in research. 'Dadirri' is the art of being present, being still, connecting with yourself and the environment in such a profound way that it creates space for deep relationships. 'Dadirri' encourages cyclical, deep listening and reflection. Through 'Dadirri', relationships are built on trust and respect, which provides opportunities to create the co-directional sharing of knowledge and privileges Indigenous voices. 'Dadirri' listens and knows, witnesses, feels, empathises in the pain of the Indigenous experience of trauma (C. Atkinson, 2008; J. Atkinson, 2002, in Ungunmerr-Baumann, Miriam-Rose, et al 2022).

Intersectionality

Intersectionality is a core concept when addressing child sexual abuse and rates of disclosure because there are broader influences and determinants that impact survivors' ability to report and disclose abuse. Intersectional discrimination refers to a situation in which people are discriminated against on different grounds which, taken together, result in a level of prejudice that is higher than if these different grounds were taken separately.

> ***Both intersectional discrimination and additive discrimination can be seen as different kinds of multiple discrimination (DeBeco, 2020).***

Since sexual violence is interconnected to other social justice struggles, prevention strategies must be grounded in an understanding of the larger structures of systemic oppressions that shape our society. The California Coalition Against Sexual Assault suggest that oppressive systems give greater social power to some people over others based on race, gender, sexuality, disability and other aspects of identity.

Working towards a future without sexual violence means that advocates, survivors and communities need to respond to a complex and layered reality that centres the needs of those survivors most marginalised, silenced and unseen and those who may experience additive discrimination or compounding discrimination and disadvantage.

An international example of intersectionality comes from the United Nations policy guidance on using an intersectional framework to account for the complex and wide-ranging factors framing how child sexual abuse is theorised and understood across disciplinary boundaries. It challenges deeply embedded racist assumptions and dominant discourses of child sexual assault that continue to be seen in the literature and, therefore, practices in the field.

Heteronormativity and patriarchy: Context of violence agaisnt boys and men

Sharma (2022) identified that disclosure experiences of men were strongly influenced by patriarchal and heteronormative norms and practices and that this is an additional barrier that male survivors face when making a disclosure of child sexual abuse.

Romano and De Luca (2001) identified that 1 in 6 men has experienced sexual abuse during childhood and/or adolescence, which, as with all sexual abuse rates, is likely and underestimates the true extent of the problem.

The social systems and structures that affect men are a leading barrier to delayed disclosures. Masculine norms and stereotypes, along with heteronormativity and homophobia, have contributed to an environment that often negates the experiences of men. Gagnier and Collin-Vezina (2016) identified in their study on male child sexual abuse survivors that 'the majority of the men waited until adulthood to disclose their abuse, with negative stereotypes contributing to their delayed disclosure'.

> ***Easton, Saltzman and Wills (2013) suggest that given homosexuality is often denigrated in the male socialisation process and most boys are abused by another male, they do not disclose for fear that their sexual abuse experience will be taken as evidence of their homosexuality. Spataro, Moss and Wells (2001) note that the "masculine stereotype does not sanction the expression of feelings of dependency, fear, vulnerability or helplessness (Esposito, 2014, p. 23).***

Disability

> ***Aboriginal and Torres Strait Islander people with disabilities are amongst some of the most disadvantaged of all Australians. This is often because they face multiple barriers to their meaningful participation within their own communities and the wider community (The FIrst Nations Disability Network Australia, 2019)***

Children with disability are at least 3 times more likely than children without disability to experience child sexual abuse and other forms of abuse (Sullivan & Knutson, 2000). Perpetrators may target children who have communication difficulties, an increased dependency on adults for daily living and isolation from peers and other supports.

Additionally, disclosure by children and adults living with disability may be impeded by a Western world model of marginalising and discriminating against people with disability in terms of access to the same human rights and human dignity as people without disability. This stands in contrast to Aboriginal understandings of disability, which emphasise each person's role in community and kinship networks rather than individual difference (Gilroy, 2009).

Racism and colonialism: Context of violence agaisnt First Nations people and People of Colour

While culture and racism do affect how victims and survivors make sense of child sexual abuse, their opportunities for recognition as victims, and the support they receive, overlooking the commonalities between different forms of child sexual abuse can result in racialising forms of abuse that are more common in minority communities than in other communities and so reduce the effectiveness of interventions (Gill & Harrison, 2019). Furthermore, a tendency to stereotype individuals based on their culture, ethnicity or gender also helps to explicate why some professionals may be less likely to recognise victims from ethnic minority communities as victims and to elucidate why, for example, **'black boys ... are rarely believed to be victims of sexual violence' (Curry, 2023)**.

Research tells us that children and adult survivors from minority communities face many additional barriers to seeking help and accessing support for sexual violence and abuse. These barriers are shaped by perceptions that statutory services such as the police, social care or children's mental health services will lack understanding of the communities concerned and may apply inappropriate and racist approaches (Allnock et al., 2009; Bradby et al., 2007; Gill & Harrison, 2019).

This is supported by reports such as the Royal Commission, which highlight Australia's horrendous history and continuing impact leading to failures in practice as well as greater difficulties for individuals to disclose. Furthermore, cultural stereotypes and racism can lead to failures on the part of institutions and professionals to identify and respond appropriately to child sexual abuse, making it even more difficult for First Nations people to disclose and speak up about child sexual abuse.

Aboriginal children and survivors have reported additional barriers to disclosure and the responses they have received when they have disclosed. Failure to address both the trauma and racism have been a significant factor in the experiences and responses of services. Mistrust of systems including police, health and justice systems; responses in family and community; fears of retribution, cultural and geographical isolation; lack of access to supportive services; and threats and compliance have an added dimension for Aboriginal victims and survivors of child sexual abuse (Herring et al., 2013).

Another challenge in both health and legal settings is the lack of culturally suitable options for the use of language interpreters. Effective communications between health professionals and the people they serve in health settings is essential for thorough healthcare and responses, and particularly important in some states, such as the Northern Territory, where for 60% of the Aboriginal population, English is not their first language (Kerrigan, 2021). Culturally safe approaches, such as using interpreters, may be explored in training, and trauma-specific training should also be made essential for interpreters who are supporting health professionals where disclosures of sexual abuse occur. Choices should be offered to victims and survivors on whether they would like to use interpreter services and options.

Despite the barriers, there is an under-resourced network of Aboriginal care, protection and responding to disclosures of child sexual abuse. These are Mothers, Aunties, Grandmothers, cousins, sisters, trans inclusive family, Uncles, Fathers and Grandfathers who are protective and safe people to disclose to. *Breaking Silent Codes: Across Australian and the Pacific Against Sexual Abuse and Family Violence for First Nations Women* (Gordon, 2019) is an important network of self-determining and culturally safe spaces to disclose. However, these examples are not adequately resourced to provide the counselling services and responses required for people who are disclosing.

Aboriginal people in institutional settings

It is critical to ensure that people in custodial settings receive adequate healthcare and responses, including responses to child sexual abuse.

Aboriginal people are significantly over-represented in criminal justice systems, particularly in custodial settings. Aboriginal women are the most rapidly rising prison population in the country. Many women in custody have reported having been victims of child sexual abuse before entering the criminal justice system. Approximately 73 per cent – or three out of four – Aboriginal women in custody reported that they were victims of child sexual abuse and 98% of those women had never disclosed the abuse until they were asked during Lawrie's research. (Lawrie, R. 2002).

> ***Persistent weaknesses and systemic failures that continue to place children at risk of sexual abuse. Sexual abuse by carers, their family members, visitors, caseworkers and other children in care continues to occur in Out of Home Care (OOHC) and sexual exploitation is a growing concern, especially for children in residential care (Commonwealth of Australia, 2017, vol. 12).***

Systemic failings that increase risk for children in OOHC include: frequent placement changes, poor information sharing, inadequacies in service providers' responses to children's prior abuse and trauma, and significant gaps in the training and support provided to staff and carers, especially kinship carers (Commonwealth of Australia, 2017, Volume 12). Poor practice by individuals, including failing to listen and respond to children, exacerbates these weaknesses and increases the risks of sexual abuse (Commonwealth of Australia, 2017, vol. 12).

Nationally, the rate of Aboriginal and Torres Strait Islander children in OOHC is almost ten times that of non-Indigenous children. Just 5 per cent of Australian children aged 0-14 years are Aboriginal or Torres Strait Islander, despite accounting for 36 per cent of all children in OOHC. OOHC presents risks to children, whose vulnerability is exacerbated by isolation from their families, communities and peers, as well as the instability of the settings in which they live (Commonwealth of Australia, 2017, Volume 12).

Certain individual circumstances can heighten a child's vulnerability to sexual abuse. In the context of OOHC, factors that contribute to greater vulnerability may include previous experience of abuse or neglect, loss of connection to family and culture and lack of understanding of what constitutes abuse.

Children in OOHC experience difficulties in being heard, feeling safe enough to disclose sexual abuse and the security of having their concerns taken seriously. Two key barriers to disclosure for victims of child sexual abuse in OOHC are not understanding what constitutes abuse and not having someone they can

trust (Commonwealth of Australia, 2017, vol. 12).

Children in OOHC are sometimes sexually abused by other children. The Royal Commission heard from experts, practitioners and survivors who told them about OOHC institutions that failed to protect children from the harmful sexual behaviours of other children, also of institutions that did not respond effectively to the complaints by children or their families of sexual abuse by another child, including not providing appropriate support and intervention to either the child who had been sexually abused or the child who exhibited harmful sexual behaviours (Commonwealth of Australia, 2017, Volume 12).

Homophobia, transphobia, biphobia and intersexphobia: Context of violence agaisnt LGBTQIA+ people

Aboriginal men and women report experiencing gendered racism and stereotyping, and Aboriginal LGBTQA+ and intersex people report experiencing transphobic and homophobic abuse from both within and outside of their own communities (Aboriginal Health Council of South Australia, 2019). It is important to note that existing research and data on child sexual abuse is documented almost exclusively in terms of binary sex (male and female) and gender (boys and girls), which erases intersex and transgender children who may not fall within these categories.

Given that child sexual abuse is a gendered and racial issue, as discussed further below, and that it is impacted by unequal power relations, it follows that the likelihood of higher rates of child sexual abuse against Aboriginal LGBTQA+ and intersex children and the erasure of their experiences may be related.

There is little to no research which examines the experiences of Aboriginal LGBTQA+ and intersex people and disclosures of child sexual abuse. Gray et al. (2020) have discussed the lack of appropriate services to make referrals for LGBTQA+ and intersex people who are more likely to experience family violence. However, further examination into the experiences of children and victim-survivors who are Aboriginal and LGBTQA+ and/or intersex is needed. Given the compounding discrimination and trauma experienced by Aboriginal and LGBTQA+ and intersex people in all other areas, including incarceration and family violence, there is an urgent need for further research and responses in this space (Day et al., 2023).

Intersectionality was designed to interrogate compounding systemic oppression. Crenshaw has stated that it is not intended to describe or theorise identities and it could be said that the notion of intersectionality is under-theorised, suggesting that it has thus far focused on how marginalised people are (adversely) affected by their identities, rather than how those in power can use intersectional identities to their advantage.

Key insights:

- disclosure is a lifelong process
- disclosure is not often contemporaneous
- shame, fear and not being believed are significant factors associated with disclosure
- Aboriginal and Torres Strait Islander victims and survivors experience additional factors that impact on disclosure such as racism, lack of culturally safe trauma-informed service responses, discrimination, generation trauma, and cultural and geographical isolation
- additive and compounding discrimination affects the experience of victims and survivors when they access services
- Aboriginal and Torres Strait Islander communities are not resourced adequately to support culturally safe responses to trauma
- culturally safe responses and deep listening is critical
- universal precautions are important - we should act on the premise that child sexual abuse may have happened
- responses to child sexual abuse should be at a minimum aligned to culturally safe trauma-informed responses that are aligned with child safety standards, legislative requirements and human rights principles
- health practitioners should act as bearer of children's rights.

Key takeaways

The complex nature of sexual assault requires strategic approaches, especially regarding initial contact. Access and equity for victims and survivors of sexual assault require service providers to have extensive understanding and knowledge of disclosure and follow-up. Consideration needs to be given regarding policy and practice frameworks that support access and equity for children and adult survivors of child sexual abuse offences.

Human services professionals, like all health professionals, are 'duty bearers'. It is within their roles and responsibility to proactively respond to children and young people in the interest of the rights of the child and their non-offending family members who are defined as bearers of rights. Health professionals can work collaboratively with families to raise consciousness and alleviate isolation (Terare, M. 2019) when children are displaying behaviours that could be perceived as 'acting out' and consider a culturally responsive, trauma-informed approach.

We cannot look at what has been done without acknowledging the impact of colonialism on Aboriginal and Torres Strait Islander systems, which impacts on Aboriginal and Torres Strait Islander child safety systems. According to McGlade (2012), colonisation involves forms of systemic power and control of Aboriginal people and the impact of collective trauma still affects Aboriginal people today. Furthermore, trauma and oppression have compounded over generations (McGlade, H. 2012, pp37) and sexual abuse

and rape have been synonymous with acts of harm such as war, colonialism, institutionalisation, forced removals and incarceration.

In many communities, Aboriginal systems of child safety and protection were – and continue to be – highly sophisticated and focused on the wellbeing of children and, as previously stated, all were responsible for the care of children. There were legal sanctions that dealt with harm to children. McGlade (2012) suggests that Aboriginal cultures do not sanction sexual violence and goes on to describe the safety, care and diligence of many Aboriginal family traditions across various individual Aboriginal countries, as well as that the stereotype that Aboriginal culture permits sexual abuse diminishes the grave harm inflicted on Aboriginal people through colonisation (McGlade, H. 2012, pp 55-67).

The care of Aboriginal children is embedded in stories, songs, lore and law across Countries. It shows how deeply children are valued in Aboriginal communities – carrying into the future, the stories and songs of culture. Children in these systems feel connected, loved and safe and they have a strong sense of purpose and responsibility, which is vastly different from the colonial child safety systems that invaded Aboriginal and Torres Strait Islander lands. The Western legislation at the time of colonisation did not have child protection safeguards. In fact, in England, it was legislated that it was permitted to harm your child (sexually). This legislation was carried over to Australia and child safety legislation was not introduced until the late 1890s (Lawrie & Cousins, 2018; Herring cited in Lawrie, 2018; Randall, 2003). This means that Aboriginal and Torres Strait Islander lands were invaded by a colony that had very little focus on child safety, connections and attachments.

Tribal authority to deal with offenders of child sexual abuse was not valued or sustained in Western legislation, which subsequently had limited understanding and strategies for dealing with child sexual abuse until after federation. According to Tatz (2017), this was a deculturation of people who had one of the best practices in the world in terms of child-rearing, aged care, incest prohibition, kinship reciprocity and art recording. Tatz also states that the structure that held communities changed and that relatively ordered societies became disordered. Values dissipated and disappeared ... incest prohibitions fell away and child molestation appeared ... conflict resolution, always under unwritten rules ... to regulate harm, became murderous assaults. Reciprocity went out the window and a selfish pattern emerged. Generations of children were sexually abused in missions and in white institutions (as cited in Milroy, H. et al 2016).

The existing body of research and literature suggests that child sexual abuse was undoubtedly introduced to Aboriginal communities through colonisation. In Australia, colonial occupation is ongoing, as is systemic harm against Aboriginal people, including child sexual abuse (McGlade, 2012).

> ***"The impacts of colonisation, the erosion of tribal authority was when the problems started. Colonisation impacts the systems that are established to deal with the issue of child sexual abuse. Abuse was taught by the colonisers."***
> ***We're all dealing with the impacts of colonisation, intergenerational and trans-generational trauma. Child sexual abuse is a manifestation of that"***
> ***(as cited in Milroy, H. et al 2016)***

The history of institutionalised child sex abuse for First Nations people dates back to the invasion and colonisation of Australia and Aboriginal people's trauma experiences included rape, stolen land, violence, oppression, and genocide (Black, Bamblett, Frederico, 2019). The Frontier Wars used rape as a tool of war

(Lilbesman and McGlade 2019), as well as forced removals, child trafficking and institutional sexual abuse and child slavery. In Australia, both historical and contemporary child welfare legislation is the domain of the colonies. Victoria was the first colony to legislate and authorise the removal of Aboriginal children from their families. Other states and territories soon followed.

The way Europeans viewed landscape as a separate entity, a non-human space in which they had both the right and the duty to enter, subdue and make ... fruitful, bringing culture and civilisation into Nature (Strang, 2010 125), was diametrically opposed to how First Nations engaged with and perceived country. Imposing rigid borders was one of many tactics used to colonise Australia and further disrupt the cohesion that existed prior to colonisation.

However, these borders more than disrupted the fluidity and exchange. Instead of 'crossings and connections' (Lloyd et al 2010), Western legal frameworks were imposed. These frameworks were bound and defined and, consequently, not only dictated ways of doing but also set up each individual colony with differing responses, frameworks and even definitions of what child sexual abuse is. In some ways this fragmentation, splitting, taking of power and confusion reflects the dynamics of child sexual abuse.

Currently, each state and territory has its own legislation, child protection responses and data about child sexual abuse. What is shocking is that in no state is there any plan or clear direction of addressing and responding to disclosures of child sexual abuse. Furthermore, because of the fracturing described above, no nationally agreed legislation defines what constitutes child sexual abuse. There is, however, some policy direction.

Our research found no specific detail in any government report across states and territories or federally on how to manage disclosure, how to create safe spaces for disclosure or how to respond.

This is despite government inquiries concerning child sexual assault, including those specific to Aboriginal victims and survivors, having been established throughout Australia. These inquiries have led to a wealth of information, knowledge and data and significantly increased awareness of the nature and extent of the problem, yet few solutions (McGlade, H. 2012).

Whilst there have been some changes in legislation, practice and workforce development over the last 40 years, it reasonable to question whether or not this has been adequate. What we do know is that there has been a failure to accept and fully implement significant Royal Commissions and Reviews including Bringing Them Home (1997), Aboriginal Child Sexual Assault Taskforce (2006) and Gordon Inquiry (2007).

A cultural framework, Looking Where the Light Is: Creating and Restoring Safety, coincided with the National Apology to Victims and Survivors of Institutional Child Sexual Abuse, delivered on 22 October 2018. The Framework was released on this day to draw attention to the high number of recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse that relate to Aboriginal narratives - approximately 14 per cent of all respondents were Aboriginal people. The framework was designed to create and restore safety and healing for Aboriginal and Torres Strait Islander children, families and communities. It takes a holistic view of sexual abuse in terms of its causes and impacts on children, families, perpetrators and communities, and proposes an integrated response to the complex challenges of those causes and impacts.

The concept of creating and restoring safety and healing connects the present with the past and future. It

draws upon the enduring strength and resilience of Aboriginal and Torres Strait Islander cultures to drive safety and healing for children, families and communities along with relevant literature on child sexual abuse, trauma and healing.

The Looking Where the Light is Cultural Framework addresses:

- the context of child sexual abuse and gaps in current approaches to addressing it.
- values-ed approaches.
- key elements and strategies for creating and restoring safety and healing.

At the heart of the healing framework is "safety", which includes physical, emotional, social, cultural and spiritual safety. All dimensions must be safely restored for children who have been harmed sexually.

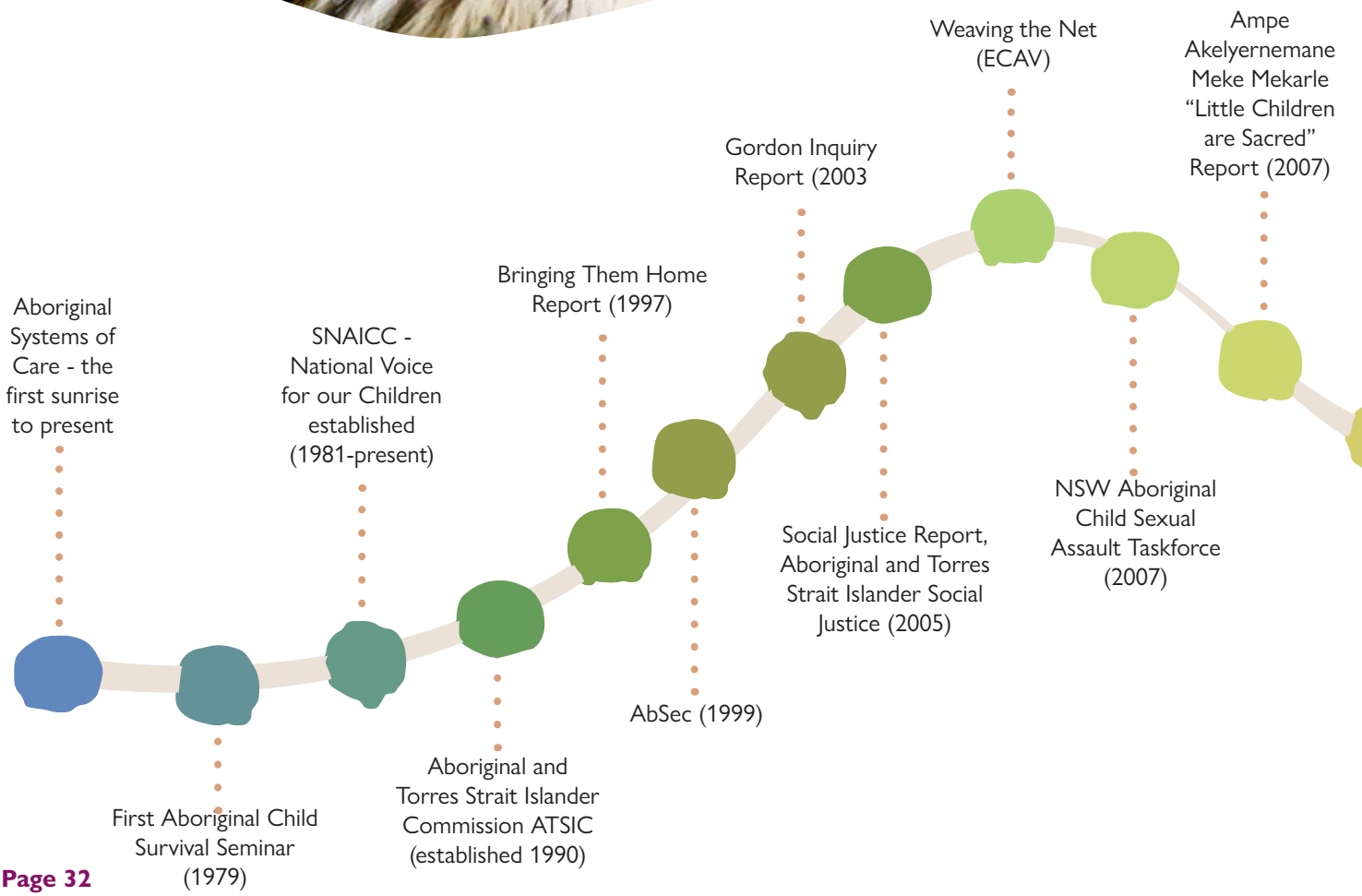
Self-determination and Aboriginal community control is very important for Aboriginal victims and survivors. Lawrie (2002) suggests that alternate points of disclosure are critical in restoring healing and control to survivors of child sexual abuse, and proposed alternate community controlled justice and healing spaces to provide support and healing for victims and survivors as well considers ways to deal with offenders (Lawrie, R & Matthews, W. 2002).

Listening to what works for survivors of abuse is critical, as evidenced by research that explored cultural healing through connection, such as connection to Country, Elder involvement and connection to community, community control and self-determination, cultural activities and practices, and 'sharing our story and Survival and the long journey' (Black, C. et al 2019).

Having culturally safe spaces to disclose abuse and begin healing is vital. The concept of 'Dadirri', as an Indigenous healing practice, highlights the process of 'listening and learning from stories of others' and the value of increasing a sense of community and connection, in particular, healing from trauma and colonisation. 'It was this feeling of belonging and community which allows stories to be shared without fear of judgement' and that 'your story eventually changes, and the pain of trauma is released and replaced with love and acceptance as the healing process begins' (Morris,G. et al 2022).

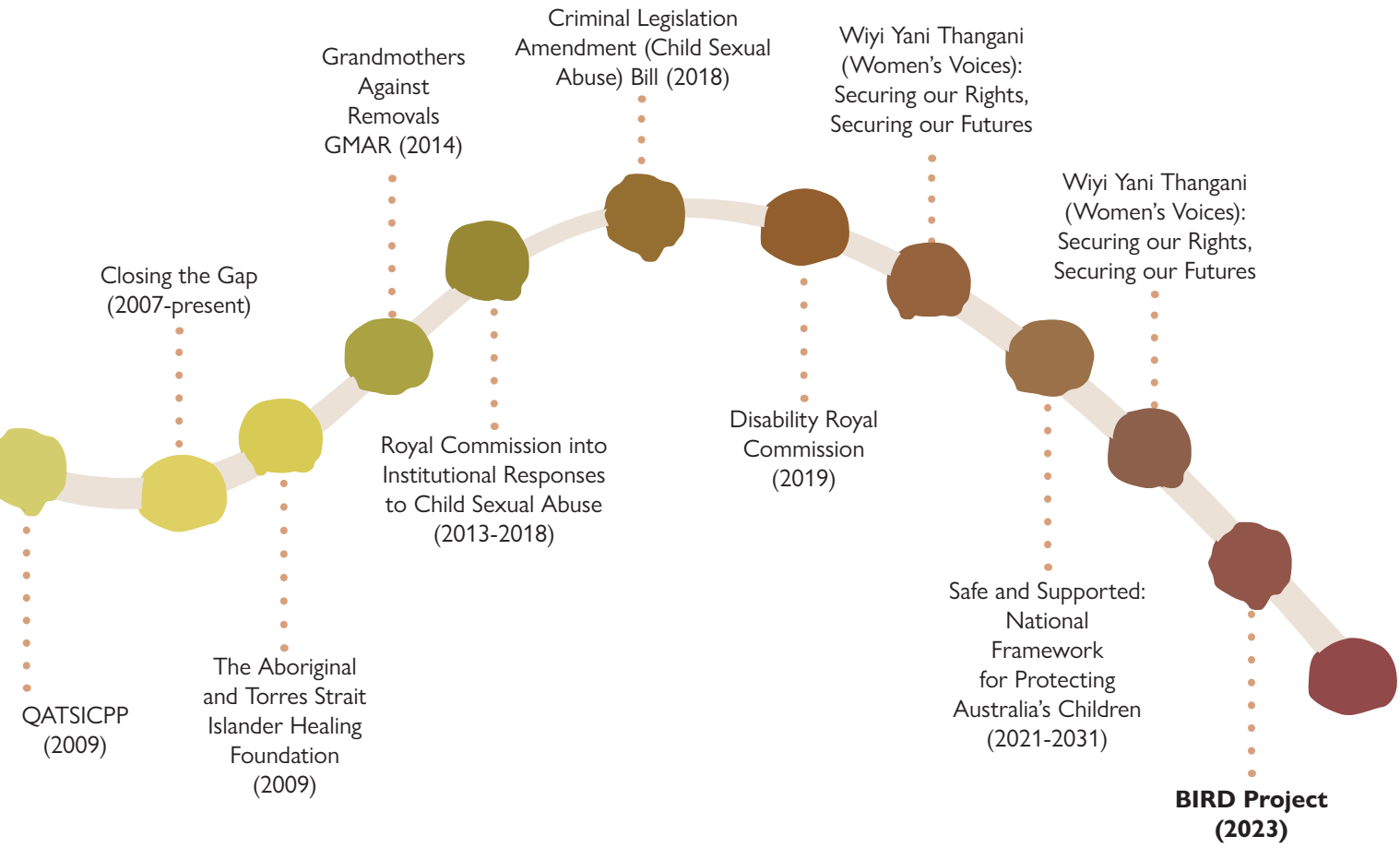
The below diagram depicts a timeline of major responses to child sexual abuse over the past 40 plus years. It is acknowledged that victim-survivors, families and communities as well as local, state and national efforts have been made to respond to child sexual assault that are not included in the below diagram.

Timeline of Responses to Child Sexual Assault



First Nations children and young people, families and communities have always resisted and responded to child sexual assault including institutional violence and mass sexualised violence perpetrated by British settler-colonial invasion from 1788 to the present.

For every act of violence and abuse, victim-survivors including children, always resist and respond.



What's Got in the Way?

Not supporting community to have self-determined spaces, the 'expert' has got in the way

The lack of dedicated and sustainable support for Aboriginal communities to have self-determined spaces to address child sexual abuse is a major reason that we fail to keep children safe.

The expert has got in the way. Typically, this is a white middle-class expert with no connection to Aboriginal people and no knowledge of Aboriginal ways of doing, being or knowing, or that they even exist. The dynamic of 'power over' is widely evidenced as having a significant impact on social, emotional and health outcomes both domestically and internationally. At the centre of a culturally safe and responsive health system would be the absence of the 'expert' role and, instead, an embedding of Aboriginal ways of doing, knowing and being that uphold cultural responses (Coalition of Peaks 2020; Dudgeon et al. 2010; IAHA 2019).

The dominance of Western approaches has left little space to acknowledge the supportive 'work' that many Aboriginal Elders, leaders and community members do in responding to disclosures and supporting family and community to deal with the impacts of sexual abuse. Cripps and McGlade (2008) suggest that professional helpers have not been the first point of disclosure of sexual assault and, instead, 'informal helping systems' including Aunts, sisters, mothers and Grandmothers have held safe spaces (Cripps, K. & McGlade, H. 2008). This informal 'work' has been happening for a long time and will continue to happen, yet, often remains invisible to the wider helping system, including the health workforce. Acknowledging, inquiring about and supporting this 'work' needs to be the starting point of any training or workforce development strategy for progress to be made around this issue. Establishing genuine partnerships and local support is a great starting point.

Decolonising health approaches requires non-Indigenous health workers to take an active approach to addressing power dynamics, racism and ongoing forms of colonisation (Dudgeon et al. 2010). Past strategies have bypassed this key element and effectively created responses that fail to position Aboriginal children and their families in the context of their culture, family and community. The only "expert" is the victim or survivor. They are the "expert" on their trauma experiences as well as on their healing and recovery.

Keeping child sexual assault hidden and replicating the dynamic of secrecy

Child sexual abuse was once identified and spoken about as an issue on its own, however, with the introduction of "trauma informed practice" we ceased naming the crimes and acts of violence that create the trauma in the first place. Naming child sexual abuse as "trauma" keeps it hidden away, as helping professionals and systems do not identify the real issues when victim-survivors and their families reach out to them.

This may replicate the dynamic of secrecy for many victims, which benefits perpetrators to continue to commit this crime and creates a system that is ill equipped to deal with the very issues that are causing the

trauma in the first place. Health professionals may inadvertently re-traumatise child sexual abuse victims and survivors when they are not clear on the active dynamics of child sexual abuse. This understanding is critical to ensuring a general trauma-informed approach but often lacks trauma-informed training, which may focus on trauma responses and neurobiology only.

Child sexual abuse victim-survivors do need a trauma-informed response, but they also need a sexual violence-informed response where workers clearly understand the crime of sexual violence, the perpetrators' actions and patterns of behaviour and how victim-survivors continue to resist these behaviours during the abuse and long after the abuse has stopped. This knowledge and approach will place workers in a better position to believe, inquire and respond to victim-survivors of child sexual abuse. Without this approach we will continue to fail to offer a helping system that can genuinely receive and respond to disclosures of child sexual abuse.

Not keeping the child at the centre

Often when disclosures of child sexual abuse are made either by children or adult survivors, the first place many people go to is trying to make sense of whether or not the perpetrator could have done this and what their intentions were. This can be especially difficult when the person receiving the disclosure knows and is connected with the perpetrator and, in most situations, this is the case for family or community members receiving a disclosure. This is unhelpful as it distracts from attending to the victim and the supports they need. The focus, by default, is typically 'could this have really happened?'. It is the job of the legal system to deal with this question not the job of helping professionals or systems. Their job is to switch this default focus to a more productive focus, such as 'what a brave person for speaking up' and 'how can I help them?'. This is why the first step of the BIRD Practice Framework is to believe.

How racism gets in the way of responses

Child sexual assault in Aboriginal communities cannot be understood in isolation from the ongoing impacts of colonial invasion, genocide, assimilation, institutionalised racism, and severe socio-economic deprivation. Service responses to child and adult survivors of child sexual assault are often experienced as "racist, culturally unsafe, financially and/or geographically inaccessible" (Funston, 2013).

In terms of trauma and disclosure of violence and sexual assault, there is a significant lack of specialised support, which 'ignores the historical, personal and cultural factors that uniquely create vulnerabilities and risk' for Aboriginal people (Walker, N. et al 2021).

Complex interpersonal trauma, specifically child sexual abuse, occurs within the context of a relationship, as well as within the context of generational trauma and racism.

The failure to understand the historical, socio-political context of sexual violence has fuelled racist attitudes and policies and replicated ongoing impacts of colonialism and racism at the level of human services, arguably contributing to the isolation of communities, protection of abusers, and under-use of mainstream services by Aboriginal people (NSW Ombudsman, 2012).

Child sexual abuse is perpetrated in the context of relationships and in the context of racism. Structural racism reduces access and consumer experiences for Aboriginal people and overwhelmingly affects

Aboriginal people's mental and physical health (Dudgeon et.al 2023).

Recent studies indicate approximately 52 per cent to 70 per cent of Aboriginal people experience racism on a regular basis (Paradies & Cunningham, 2009; Priest, Paradies, Stewart, & Luke, 2011) and 22 per cent of Aboriginal people report racism by health providers, and even higher rates at work and from other service providers (Paradies & Cunningham, 2009, as cited in Herring et. al 2018).

Victims-survivors from racially minority communities have been found to face particular barriers to help-seeking and accessing support for sexual violence and abuse, shaped especially by perceptions that statutory services such as the police, social care or children's mental health services will lack understanding of the communities concerned, and may apply inappropriate and racist approaches (Allnock et al. 2009; Bradby et al. 2007; Gill and Harrison 2019).

For instance, the report from the Independent Inquiry to Child Sexual Abuse (Hurcombe, R. et al, 2023) on child sexual assault in relation to children from Black and minority communities, concludes that cultural stereotypes and racism by lead to failures in practice as well as greater difficulties for individuals to disclose.

A study which examined interventions and beliefs to child sexual abuse disclosures found that blame allocation was a factor in attitudinal intolerance to racism for victims and survivors disclosing child sexual abuse (de Roos, M.S. et al 2023).

Aboriginal and Torres Strait Islander workforces are also deeply affected by psychosocial impacts of racism. These are critical factors when considering a culturally safe and responsive approach to responding to Aboriginal and Torres Strait Islander victims and survivors of child sexual abuse.

Parter et al (2021) suggest privileging Indigenous knowledges and culture in policy design, sharing power and resources, critical reflection and discussion about addressing racism.

Common beliefs about Aboriginal people - are they supporting the supporting parent?

Cultural stereotypes and racism can lead to failures on the part of institutions and professionals to identify and respond appropriately to child sexual abuse. They can also make it more difficult for individuals in ethnic minority communities to disclose and speak up about child sexual abuse (Hurcombe,R. et al 2023).

Racism is about non-Aboriginal and Torres Strait Islander people, professionals and helping systems holding common beliefs about Aboriginal people that are wrong and disrespectful. 97% of Aboriginal and Torres Strait Islander people experienced racism in the past year (VicHealth, 2012). 2 out of 3 Aboriginal people experienced more than eight incidences of racism in a year (VicHealth, 2012). On one hand, these beliefs lead to Aboriginal people dying from undiagnosed health issues and, on the other, they result in roadblocks that stop Aboriginal victims of child sexual abuse and their supportive parents, carers and family members from accessing supports.

Many non-Aboriginal workers hold deeply entrenched racist beliefs that disrespect Aboriginal peoples' parenting practices and ways of being. These beliefs directly lead to harmful racist responses causing shame and blame for many Aboriginal people and stops them from continuing to reach out and seek support.

This is the reason why many Aboriginal academics call for an urgent need for a dedicated and ongoing commitment to Aboriginal cultural responsiveness/safety training and workforce development strategies for non-Aboriginal workers. This is the only way that these racist beliefs can be challenged and addressed so that Aboriginal people aren't continually placed in positions where they have to suffer poor and unprofessional practice (Herring, et al 2018).

Little research has addressed the specific problem of child sexual abuse from a multidisciplinary perspective (Gill 2021). One reason for this lacuna is that the recent foregrounding in media and policy discourses of child sexual abuse in racially minority communities has taken place through the lens of cultural essentialism, occluding the causes of child sexual abuse by focusing on minority elements, such as the role of traditional cultural practices. As "black and racially minoritised children are located at the intersection of multiple, overlapping structural inequalities" (Gill 2013), their specific experiences of victimisation are still largely overlooked in the criminological literature, even though solid progress has been made during the last decade in understanding child sexual abuse in British-Asian communities. For instance, Gill and Harrison (2019) have highlighted the role of cultural factors in concealing child sexual abuse, including how notions of 'honour' often act as barriers to disclosure. Although honour and its inverse, shame, have been explored in many scholarly discussions of gendered violence in Asian communities (Cowburn et al. 2015; Gilbert et al. 2004; Gill and Brah 2014), more work could enable culturally competent responses to child sexual abuse cases, in particular through recognition of the unique barriers and difficulties that racially minority victims face.

However, how these barriers operate in specific contexts remains opaque (Alaggia et al. 2019) and so inhibits efforts to help and encourage children to disclose swiftly, thus preventing further abuse (Alaggia and Wang 2020).

Anecdotally, workers not wanting to be seen as racist respond differently to disclosures and warning signs from minority groups. They may miss vital information and cues, in the bid for not wanting to perpetuate myths about Aboriginal and Torres Strait Islander communities being trauma saturated.

While culture and racism do affect both how victims and survivors make sense of child sexual abuse, their opportunities for recognition as victims, and the support they receive, overlooking the commonalities between different forms of child sexual abuse can result in racialising forms of abuse that are more common in minority communities than in other communities and so reduce the effectiveness of interventions (Gill and Harrison 2019). Furthermore, a tendency to stereotype individuals based on their culture/ethnicity/gender also helps to explicate why some professionals may be less likely to recognise victims from ethnic minority communities as victims and to elucidate why, for example, Black boys are rarely believed to be victims of sexual violence.

Victim blaming is not exclusive to the victim and survivor of child sexual abuse. Mother blaming is well documented in much of the research. Gill and Begums use of intersectionality highlights some case studies showing mother's responses to their child's disclosure can be informed by their own experiences of disclosure that possibly was shut down and or not believed.

In an interview between Aunty Pam Greer and Sigrid Herring (2016), there is emphasis placed on history and knowledge of addressing sexual assault in Aboriginal communities (specific to NSW), and responses which require Aboriginal leadership (Tolliday, D. et al 2016).

An exert from Aunty Pam reads as "Of course there were blocks and barriers. We had prominent Aboriginal women saying we had no right to be talking about the issues of child and adult sexual assault and domestic violence, but victims and survivors were able to overrule these and block their objections on the spot and this became a part of their healing.

We heard women talking about their own experiences of abuse. We heard them say they were the second and third generation of women to have been abused by the same man. Their stories of their experiences evoked so much interest in Aboriginal women, support and resources. A decade later, in 2003, these identical yarns were echoed in the voices of women from 29 communities who came forward at roundtables that preceded the 2006 Aboriginal Child Sexual Assault Taskforce." (Tolliday, D. et al 2016).

Today, we are still raising the flag – and we are still saying the same thing – victims and survivors must be heard and believed, and responses must be self-determined and centre Aboriginal ways of knowing, doing and being – designed, delivered and controlled.

Here's Where We Are Now: Current Context

Child sexual abuse is a human rights issue

The United Nations' Convention on the Rights of the Child (1989), in which the 194 ratifying countries including Australia (November 2009), explicitly states that they will take all appropriate 'legislative, administrative, social and educational measures, either nationally, bilaterally or multilaterally, in order to protect children from sexual abuse' (Stoltenborgh et. al 2011).

Sexual abuse and exploitation are a breach of human rights. Policy on Integrating a Human Rights-Based Approach to United Nations Efforts to Prevent and Respond to Sexual Exploitation and Abuse, issued by the United Nations (UN) in December 2021, sets out a 'consistent application of a human rights-based approach to sexual exploitation and abuse, irrespective of the affiliation of the perpetrator'. The policy also defines sexual abuse as a crime under international and national law.

Six UN-appointed human rights experts stated on 18 November 2022, in preparation for the first commemoration of the World Day for the Prevention of and Healing from Child Sexual Exploitation, Abuse and Violence, that 'countries must step up efforts to combat the global emergency of child exploitation and abuse.'

Child sexual abuse is a crime that involves any act that exposes a child or young person to or involves a child or young person to sexual activities that they don't understand, do not or cannot consent to, are not accepted by the community and are unlawful (Commonwealth of Australia, 2017). This is defined as:

"...any sexual act inflicted on a child by any adult or other person, including contact and non-contact acts, for the purpose of sexual gratification, where true consent by the child is not present. True consent will not be present where the child either lacks capacity to give consent, or has capacity but does not give full, free, and voluntary consent. Operationally, acts of sexual abuse include forced intercourse; attempted forced intercourse; other acts of contact sexual abuse (e.g., touching, fondling); and non-contact sexual acts (e.g., voyeurism, exhibitionism)." (Scott et al, 2023, 6).

The impacts of child sexual abuse have broad effects on psychological, health and social wellbeing from childhood across the lifespan. Survivors report experiencing psychological distress, learning difficulties, relationship and employment difficulties and health issues more broadly (Felliti et al 2009). Research has demonstrated that child sexual abuse can have significant impacts, including health outcomes, across the lifespan, as shown in studies which looked at adverse childhood experiences and essentially that responding with a safe trauma-informed multi-disciplinary response can interrupt and support recovery for survivors (Edwards, E.J. et all 2004). Survivors also demonstrate creative, prudent acts of resistance and live incredible lives, despite the harm that has been done to them (Wade, et al 1997).

Birds display acts of resistance too. A study found that metal spikes used to deter birds from landing on buildings have since been used by birds to design their nests. Crows and magpies, known for their cognitive abilities, have incorporated the metal spikes on the buildings as part of their nest structure, ultimately protecting the nests from other predators - the birds are now utilising the very thing that was designed to restrict them (Hiemstra, A.F. et al 2021).

The impacts of child sexual abuse can often be experienced as cumulative harm, resulting from multiple episodes of sexual abuse and other types of child abuse over prolonged periods. The Royal Commission into Institutional Responses to Child Sexual Abuse listened to and documented the personal stories of over 8,000 victim-survivors and read over 1,000 written accounts. These stories were of personal trauma and tragedy and betrayal. They identified adverse life experiences before, during and after the abuse and spoke of 'a childhood lost, innocence stolen, and a life journey irreparably and adversely changed' (Commonwealth of Australia, 2017, p15).

48%

Meet the criteria for a mental disorder

4.6x

More likely to have attempted suicide in prior 12 months

3.9x

More likely to have self-harmed in prior 12 months

The first national study on child maltreatment in Australia shows that the associated impact is broad and long lasting. Mental health disorders and health risk behaviours related to experiences of maltreatment crystallise early and can present across life. Adults who experienced child maltreatment are 2.8 times more likely to have a mental health disorder than adults who have not experienced child maltreatment. Almost half (48%) of Australians who experienced maltreatment in childhood met criteria for a mental disorder, compared with 21.6% of those who did not experience child maltreatment. Data also shows that young

people aged 16-24 years are 2.9 times more likely to have a mental health disorder compared with those who did not experience maltreatment. Australians who experienced maltreatment in childhood are 4.6 times more likely to have attempted suicide in the prior 12 months and 3.9 times more likely to have self-harmed in the prior 12 months (Scott et al, 2023). The findings from recent research are compelling and substantiate further the concerning statistics relating to child sexual abuse in Australia especially against Aboriginal children. The research found that: around one in six (15.1%). Around one in 10 (9.4%) Australian men has sexually offended against children (including technologically facilitated and offline abuse), with approximately half (4.9%) of this group reporting sexual feelings towards children. (UNSW, 2023) On an international level, A report by the Independent Inquiry into Child Sexual Abuse (IICSA) also found that the majority of known perpetrators are young, white men (Conversation, 2023).

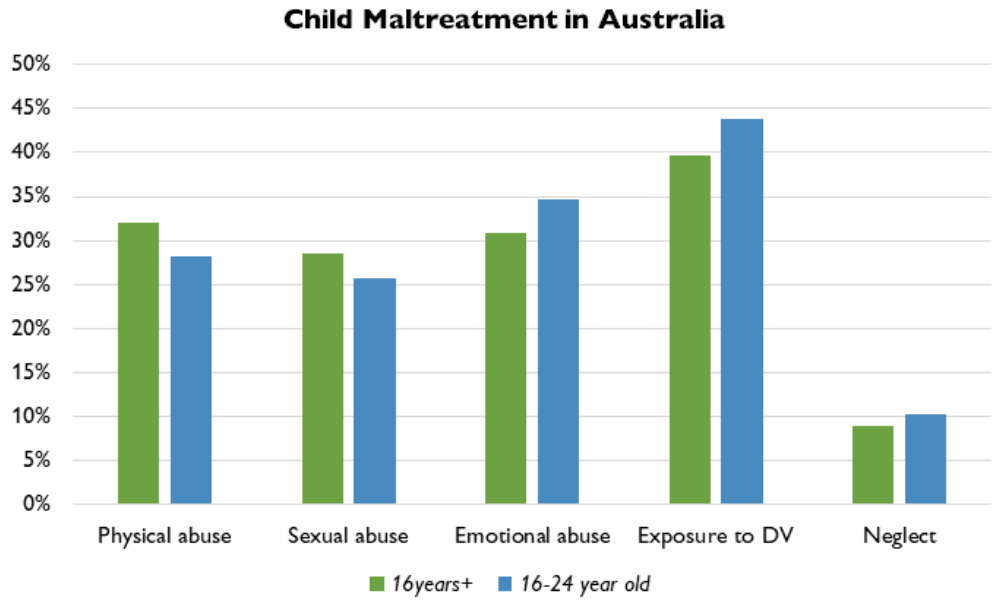
Global recognition and prevalence

There is global recognition that child sexual abuse alongside other forms of child maltreatment is common and causes substantial adverse health, educational and behavioural consequences. Yet estimates of prevalence are often inadequate and underestimated. Studies vary widely in terms of design, sample and methods, which make it hard to get a clear picture of this crime (Mathews et al, 2020). Nonetheless, worldwide, it is estimated that between 8 per cent – 31 per cent of girls and 3–17 per cent of adolescent boys are affected by child sexual abuse (Barth et al, 2013). Other international studies reveal that nearly 3 in 4 children aged 2-4 years regularly suffer physical punishment and/or psychological violence at the hands of parents and caregivers, and 1 in 5 women and 1 in 13 men report having been sexually abused as a child (World Health Organisation, 2022).

The global prevalence of child sexual abuse was estimated to be 11.8% or 118 per 1000 children with a significant difference in the prevalence of self-reported child sexual abuse between girls and boys. Self-reported child sexual abuse was more common among female (180/1000) than among male participants (76/1000). Lowest rates for both girls (113/1000) and boys (41/1000) were found in Asia, and highest rates were found for girls in Australia (215/1000) and for boys in Africa (193/1000). The findings confirm significant rates of child sexual abuse and Australia as having the highest reported rate for child sexual abuse of girls internationally at 21.5 per cent (Stoltengorgh et al 2011).

Australian context

The first nationally representative data on the prevalence of child maltreatment in Australia shows child maltreatment is endemic in Australia. Across the population, high prevalence was identified of physical abuse (32 per cent), sexual abuse (28.5 per cent), emotional abuse (30.9 per cent), and exposure to domestic violence (39.6 per cent). Neglect was less prevalent (8.9 per cent). In young people aged 16-24 years, the prevalence of child maltreatment was: physical abuse (28.2 per cent), sexual abuse (25.7 per cent), emotional abuse (34.6 per cent), neglect (10.3 per cent) and exposure to domestic violence (43.8 per cent) (Scott et al, 2023).



In Australia, 1 in 13 people (7.7 per cent or 1.4 million) aged 18 years and over have experienced child sexual abuse. Approximately 2.5 million adults experienced physical and/or sexual abuse before the age of 15 years (ABS 2017; AIHW, 2018). Both adolescent girls and boys can be the victims of child sexual abuse. However, women were twice more likely than men to have experienced child sexual abuse, this included 1 in 9 women (10.7 per cent or 1 million) and 1 in 22 men (4.6 per cent or 411,800) (ABS 2017).

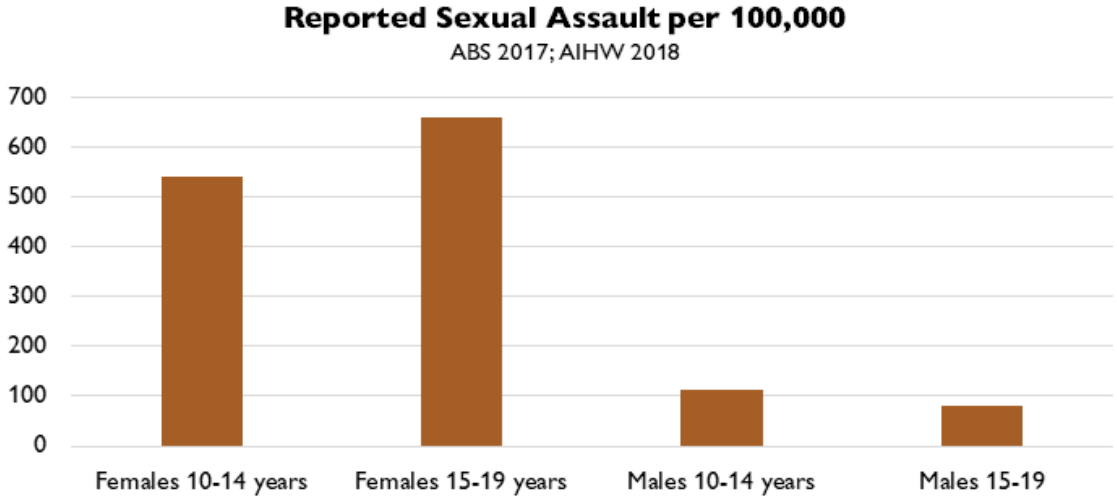
There is also variation in age of reporting between adolescent girls and boys. Young women aged 15-19 had the highest rates of reported sexual assault (661.9 victims per 100,000 women). Girls aged 10-14 had the second highest rates of reported sexual assault (542.8 per 100,000 girls), whilst boys aged 10-14 had the highest rates of reported sexual assault for males (112.3 victims per 100,000 boys). Young men aged 15-19 had the second highest rate of reported sexual assault for males (82.2 victims per 100,000 males) (ABS 2017; AIHW 2018).

This is not a crime of the past, as data highlights child sexual abuse reports are increasing. Between 2014 and 2019, the number of sexual assaults against children and young people (aged zero to 17 years old) recorded by police increased by 21 per cent (from 13,353 to 16,140) (ABS 2021). For NSW, data highlights that reporting of child sexual abuse is on the increase where child victims reporting current sexual assaults are up by 12.4 per cent and historic child sexual assault reports are up by 27 per cent (NSW Bureau of Crime Statistics and Research, 2021).

Gender considerations

This is a gendered problem which disproportionately affects girls. Compared with boys, girls are significantly more likely to experience sexual abuse, emotional abuse and neglect (Scott et al, 2023). Studies show that women reported child sexual abuse more often than men, which may be due to either higher occurrence of child sexual abuse among girls than among boys, or that boys may not be disclosing their experiences, or due to both factors (Dhaliwal et al 1996; Finkelhor et.al 1986; O'Leary et al 2008; Romano & De Luca, 2001). Aboriginal women are disproportionately affected by sexual assault, with a 3.4

to 8.3 times higher likelihood of becoming victims than men. Furthermore, 87% of these incidents involve perpetrators known to the victims, which has an impact on police reporting, with 'almost 9 in 10 instances of sexual assault never being reported' (Cripps, K, 2021).



Factors which may impact male disclosure of child sexual abuse can include 'feelings of weakness and of failure because of society's traditional view of men as aggressors rather than as victims' (Dhaliwal et al, 1996; Romano et al 2001), adolescent boys might be afraid of being considered the instigator of child sexual abuse rather than the victim (Dhaliwal et al, 1996) or they may not view their 'sexual experiences with older women as sexual abuse because of sex stereotypes' (Coxell et al 1999). Research suggests most male victims of child sexual abuse disclose their experiences later than female victims (O'Leary & Barber, 2008).

The Royal Commission into Institutional Responses to Child Sexual Abuse data analysis of 6,875 survivors' private sessions revealed some important themes about the nature of this crime:

- more than half of survivors reported being aged between 10 and 14 years when they were first sexually abused
- female survivors generally reported being younger when they were first sexually abused than male survivors
- the average duration of child sexual abuse experienced in institutions was 2.2 years
- 36.3 per cent of survivors said they were abused by multiple perpetrators (Commonwealth of Australia, 2017).

Children are more likely to be victims of child sexual abuse by someone they know, are related to or are dependent on for care, rather than a stranger. In a study of people who experienced sexual abuse before they were 15 years old, 79 per cent were abused by a relative, friend, acquaintance or neighbour (AIHW 2019). Only 11 per cent of people who experienced sexual abuse before they were 15 were abused by a stranger (ABS 2018). Whilst both men and women were significantly more likely to have experienced child sexual abuse by a known adult perpetrator there is some variation; 9 in 10 of these women (91 per cent or 907,300) reported experiencing child sexual abuse by someone known to them and 8 in 10 of these

men (83 per cent or 343,700) reported experiencing child sexual abuse by someone known to them (ABS 2017; AIHW, 2018).

Research shows that men are more likely than women to commit child sexual abuse (Proeveet al 2016). Of the victims and survivors who told the Royal Commission about sexual abuse by an adult, almost all (93.9 per cent) said they were abused by a man (Commonwealth of Australia, 2017).

Despite adult men being the main offenders of this crime, we also know that young people can also sexually harm. Research shows that 30-40 per cent of sexual harm of children is by children and young people (Latzman et al, 2011; El-Murr, 2017). According to Australian recorded crime data from 2017-2018, children and young people aged 10 to 19 years were alleged offenders in 14% of sexual offences in Australia (ABS 2018). Approximately half (50 per cent) of adolescents who perpetrated sexual offences involved sibling abuse (Latzman et al, 2011).

Child sexual abuse in Aboriginal communities

As evidenced by the statistics and research mentioned earlier in the report, sexual abuse of children occurs all over the world and is more common in minority communities (Gill and Begum 2022). While this is not novel data, child sexual abuse has been described as a 'silent pandemic' (Gill and Begum 2022). The failures of both the legal system and health system to prevent, respond and further protect children have been well documented.

Significant government inquiries into child sexual abuse in Aboriginal communities have been undertaken across different states, such as the Gordon Inquiry in Western Australia (2002), the Aboriginal Child Sexual Assault Taskforce (ACSAT) in NSW (2006) and the Little Children are Sacred Report in the Northern Territory (2007). All highlight that child sexual abuse is widespread, underreported and can have devastating impacts on our First Nations communities (Gordon, S, 2002; Ella-Duncan et al, 2006; Ampe Akelyernemane Meke Mekarle, 2007).

The ACSAT identified barriers to reporting child sexual assault, including complex extended family and community networks, geographic isolation, mistrust of the service system and poor responses from existing service providers (Ella-Duncan et al, 2006). The recent Royal Commission into Institutional Responses to Child Sexual Abuse reported that 14.3% of the 6,875 survivors' private sessions involved Aboriginal and Torres Strait Islander people (Commonwealth of Australia, 2017). This statistic is particularly noteworthy, considering that our population constitutes only 3.8%, as per the 2021 Census of Population and Housing by the Australian Bureau of Statistics (ABS, 2021).

Both the Gordon Inquiry and ACSAT highlighted a link between family violence and child sexual abuse and acknowledged that the prevalence is significantly higher in Aboriginal communities than non-Aboriginal communities (Gordon, S 2002; Ella-Duncan et al 2006). This is reflected in subsequent research which highlights the cumulative nature, co-occurrence and re-victimisation of abuse demonstrating that victims of child abuse and neglect, domestic and family violence, and sexual assault rarely experience one type of violence or abuse in isolation of others; and a single abusive incident is often the exception rather than the norm (Scott et al 2023; Laing, et al 2018).

The Gordon Inquiry considered the high prevalence together with co-existing issues of family violence

and child sexual abuse within the context of Australia's history of colonisation which has resulted in 'marginalisation, dispossession, loss of land and traditional culture, and the forced removal of children which has led to ongoing trauma within Aboriginal communities. These underlying factors are coupled with extreme social disadvantage including poverty, racism, passive welfare, drug, alcohol and substance abuse. Persistent assaults on Aboriginal culture, kinship systems and law have created a situation where Aboriginal communities are extremely vulnerable to family violence and child abuse' (Gordon 2002, pg 50-51).

Aboriginal and Torres Strait Islander victim-survivors have many reasons to resist making disclosures about child sexual assault. These reasons are based on skilful strategies to resist and respond to racism, whiteness and colonial violence in the current Australian context. This may include:

- Fear based responses due to lived experiences of colonial violence, institutional and systemic racism.
- Police violence, racial profiling, mass incarceration and deaths/murders in custody
- Racist child removal practices (ongoing Stolen Generations)
- Lack of Culturally Safe Aboriginal-specific victim-survivor support services
- Services and authorities lacking Aboriginal staff and the implementation of Aboriginal Worldviews and local cultural protocols.
- Services and authorities operating through a dominant white lens, lack of cultural awareness or cultural safety
- Cultural and language barriers to accessing relevant authorities
- Lack of reporting mechanisms in remote locations

During the ACSAT consultations, participants revealed that they believed 'child sexual assault is one of the key, underlying factors in the high levels of violence, substance abuse, criminally offending behaviour and mental health issues that many Aboriginal communities are grappling with today' (Ella-Duncan et al, 2006).

Online child sexual exploitation and abuse

Children are among the most vulnerable members of our society. Research highlights that 'online child sexual abuse and exploitation involve the use of information and communication technology to sexually abuse and/or exploit children' (Interagency Working Group, 2016, p. 23 and 28).

Online child exploitation is a form of child sexual abuse which can involve but is not limited to:

- online grooming
- live streaming
- online coercion and blackmail
- possession, production and sharing of prohibited images.

Technology has significantly changed the way offenders exploit children and this will continue to evolve rapidly, as advancements occur so quickly that offenders can stay 'one step ahead' of investigators and

the law. Technology has also enabled offenders to engage in exponentially more 'non-contact' child sexual abuse and exploitation offences with the internet providing an anonymous platform to groom victims and connect offenders.

The estimated number of internet users increased from 16 million in 1995 to 580 million in 2002 and was expected to exceed 2 billion by 2010. Currently, there are no 'internet police' (Aiken, M. et al, 2011, p. 3). Industrial and technological advancements have had an impact on the availability of child pornography, photography, printing and online distribution (Taylor & Quayle, 2003; Ropelato, 2006; Bourke & Hernandez, 2009). It was identified in a recent transparency report completed by Australia's e-Safety commissioner (Basic Online Safety Expectations, 2022) that some technology companies are not doing enough to tackle child sexual exploitation on their platforms. The report highlighted 'inadequate and inconsistent use of technology to detect child abuse material and grooming and slow response time when this material is flagged by users' (e-Safety media release, 2022). 'WhatsApp report they ban 300,000 accounts for child sexual exploitation and abuse material each month – that's 3.6 million accounts every year' (e-Safety commissioner BOSE transparency report, 2022).

Over the last thirty years, society has become increasingly reliant on technology and the internet; it is now ingrained in most people's lives (personal, educational and professional) and is used daily. In today's world, where connections can occur both in real life and online, offenders have an unlimited platform from which to abuse and exploit children.

Indicators are that child sexual abuse and exploitation online will continue to grow and evolve (Moran, 2010). Children are placed at significant risk, either by entering an offender's online domain accidently or becoming a high-risk victim in terms of self-generated pornography (Aiken, et al 2011). Due to this, parents and other professionals may not be equipped well enough to inform and protect children in the ever-evolving problem of sex offending online.

> ***All abuse perpetrated has lifelong impacts on survivors however historically abuse has been defined as an incident or event that ceases once the abuse stops, generally occurring when the perpetrator stops or a disclosure is made by a child.***

In Australia, the eSafety Commissioner has a mechanism supported by an Online Safety Act where an image or video can be reported and removed from the internet. Online child sexual abuse and exploitation may have no end point for some children whose image or video has been distributed online and the experience of this can never be eradicated. What does this mean for survivors of online child exploitation and disclosure? Not only will disclosure be a lifelong process, but there is also a deeper level of powerlessness, given the victim has no choice about who knows about this offence as there is physical proof/evidence in existence. When thinking about child sexual abuse and disclosure, the ongoing legacy, re-traumatisation and impacts of online child exploitation and abuse need to be considered.

As a result of legal reform, young people under the age of 18 who voluntarily share nude photos of themselves may face charges and be added to the child sex offender registry. This is a perverse and unintended consequence of legislative changes that have not been able to keep up with the speed at which technology is developing and the social norms of young people.

Young people with concerning sexual behaviour

Adolescence is a period of rapid growth and development. There are three main stages of adolescent development, early (10 -13), middle (14-17) and late (17-21), however this varies enormously from one young person to another and it should be noted that age does not define maturity. Often adolescence is a point of time where the struggle for autonomy commences, emergence of sexual identity begins, and experimentation and risk-taking behaviours occur (NSW kids and families, 2014).

Most sexual behaviour in children and young people is age appropriate and a typical part of their development. However, some behaviours are not within the typical range of behaviours expected for the child or young person's level of development. In 2017-2018, the Australian Bureau of Statistics recorded crime data suggested that children and young people aged 10-19 years were the alleged offenders in 14 per cent of sexual offences committed in Australia. Ferrante et al (2017) have identified that in Australia 1 in 5 sexual assaults reported to the police between 2010 and 2014 were recorded as an instance where both the child or young person has engaged in and has been affected by, sexual assault was under the age of 18. Approximately 30 per cent to 40 per cent of incidents involving sexual harm to children are perpetrated by other children and young individuals (Latzman, Viljoen, Scalora & Ullman, 2011).

Between 2018 and 2019, in NSW alone, the NSW Child Protection Helpline received reports concerning over 5,000 children exhibiting problematic and harmful sexual behaviours (Spangaro, J. et al, 2021). Limited research and literature have been completed from a First Nations perspective about Aboriginal young people with problematic and sexually harmful behaviours, however, due to the over-representation of Aboriginal children and young people in statutory out-of-home care and the criminal justice system alongside ongoing oppression, structural racism and intergenerational trauma due to colonisation, it is statistically more likely for Aboriginal children and young people to experience or engage in problematic or harmful sexual behaviour due to their vulnerability.

While there is no single cause of problematic and sexually harmful behaviour among young people, it is statistically more likely for Aboriginal children and young people to experience or engage in problematic or harmful sexual behaviour, common contributing factors include:

1. societal context of inequitable gender norms and expectations
2. trauma due to experiences of sexual violence
3. experiences of violence, abuse and or neglect
4. domestic and family violence
5. male privilege and entitlement
6. exposure to pornography.

Problematic and harmful sexual behaviours have been recognised as a public health concern. Consequently, NSW is in the process of developing a public health approach that emphasises prevention and structures the wider system to deliver appropriate and proportionate responses to young people and families. A pivotal commitment in this endeavour is the creation of a shared framework, known as Children First,

which is dedicated to preventing and responding to problematic and harmful sexual behaviours exhibited by children and young people in NSW.

In response to the Royal Commission, the Children First framework was developed with four domains (Children First, 2022-2031):

1. reaching everyone with education and information
2. targeting prevention where its most needed
3. getting early support to children, young people, parents, caregivers and families
4. providing access to holistic specialist services.

Sexual behaviours sit along a continuum, it is important that professionals have a clear understanding of what is developmentally normal to abnormal, distinguishing between problematic and abusive. Hackett (2010) has proposed a model that identifies five areas: normal, inappropriate, problematic, abusive and violent. Sexually harmful behaviour by young people needs to be viewed in a developmental context alongside this continuum (Hackett, S, 2010).

Data on children under 10 years of age is limited. Cavanagh-Johnson (2013) cites that sexualised behaviours are reported in 40%-85% of children before the age of 13. The public response to a 2014 7.30 Report is also significant. Additionally, research indicates that approximately half of adolescents who commit sexual offences involve a sibling victim (Latzman, Viljoen, Scalora & Ullman, 2011; Johnson & Friend, 2013).

> ***"Australian studies find that 30-60% of childhood sexual abuse is carried out by children and young people", and***
> ***"Most young people target younger children or peers, and know their victim"***
> ***However, accurate statistics are difficult to obtain" (El-Murr, 2017).***

There is a lack of consensus on what defines harmful behaviour, particularly regarding the concealed aspect of sexual abuse involving young people who have sexually harmed. This issue is shrouded in denial, shame, secrecy and silence. Victims within this context often endure and disclose instances of sexual abuse amidst the backdrop of systemic racism. Addressing sexual abuse in marginalised communities becomes notably intricate, given that victims and survivors have deep distrust towards institutions, such as the police and social services. Additionally, there exists a fear of betraying their families.

This, coupled with the complexity of multiple family and kinship relationships and responsibilities, is very challenging for families to navigate. Additionally, health systems are often not well-equipped to respond in ways that are helpful to restore safety for the family.

Perpetrator tactics of child sexual abuse

Child sexual abuse is fundamentally about the abuse of power by the perpetrator over the victim. The offender, who is typically older, more powerful and in a position of authority or trust, exploits the vulnerability and dependence of the child. This power dynamic can be used to manipulate, coerce and groom the child into compliance, and to maintain secrecy and control over the abuse. Often perpetrators groom their victims by building trust and establishing emotional connections. They may shower the child with attention, gifts and affection to gain their trust and create a sense of dependency.

Grooming can also involve manipulating the child's family or caregivers to gain access to the child and create opportunities for abuse. This can cause victims to feel confused and conflicted due to the mixed messages they receive from the offender. They may feel a sense of betrayal and violation when they realise that the offender's actions were not genuine and were intended to manipulate them. This can lead to long-term emotional and psychological distress, as well as difficulties in trusting others and forming healthy relationships (Katz et al, 2016; Leclerc et al, 2010; Smallbone et al, 2001).

Children and adolescents with problematic and harmful sexual behaviours may use manipulation and coercion to intimidate or force a child into compliance. This can involve threats, blackmail or other forms of psychological manipulation to silence the child and prevent them from disclosing the abuse. Victims may feel fear, helplessness and powerlessness, they may develop feelings of guilt or shame for not being able to stop the abuse, even though they were not at fault. This can lead to low self-esteem, self-blame and a sense of worthlessness, which can persist into adulthood and impact their overall wellbeing (Katz et al, 2016; Leclerc et al, 2010; Smallbone et al, 2001).

Targeting vulnerable children is often tactic child sexual perpetrators use, such as those who are marginalised, isolated or have a history of trauma. They may exploit the child's vulnerabilities, such as their need for love, attention or validation, to gain access to them and abuse them. Child sexual abuse offenders may hold positions of authority, trust or influence over the child, such as family members, caregivers, teachers, coaches or religious leaders. They may abuse their power and authority to exploit the child and maintain secrecy, often using tactics such as manipulation, coercion or threats (Katz et al, 2016; Leclerc et al, 2010; Smallbone et al, 2001).

Key dynamics of child sexual abuse

Tolliday, Spangaro and Laing propose the key dynamics of child sexual abuse as a critical framework in linking perpetrators use of tactics to continue the abuse, with the impacts this has on the victim and their family. These dynamics of secrecy, responsibility and protection/loyalty reflect dominant societal discourses that perpetuate violence against women and children (Tolliday et al 2018).

These include the following dynamics:

Secrecy

Where the offender uses deception and secrecy to conceal their actions and maintain control over the child, this creates a web of silence and entrapment around the child. They do this by employing tactics of tricks, lies or threats to prevent the child from disclosing the abuse or seeking help.

Responsibility

Perpetrators often shift the responsibility away from themselves and blame the child directly - 'I know you wanted this' - or blame their mother by planting the idea with the child that their mother knows about it. This encourages blame and shame and entrenches the secrecy further.

Protection / Loyality

As a consequence of enforcing secrecy and shifting responsibility onto children, this burdens them with the responsibility for taking care of others and putting their loyalty to their family before their own safety and wellbeing. Often children believe it's their fault to put up with the abuse to protect their siblings.

Resistance

The perpetrators' use of secrecy, shifting the blame and exploiting a child's loyalty to their family can be viewed as their efforts to overcome and dismantle a child's resistance. Children resist sexualised violence and abuse in skilful and highly creative ways and that children also use strategies with the intention of protecting other children and family members from the perpetrator's use of violence and abuse Given the power imbalance between perpetrators and victims (adult–child) most forms of resistance are subtle and indirect but nonetheless brave acts that require close attention to help shift shame and self-blame and rebuild dignity and respect (White, 2007; Wade, 1997).

These dynamics are critical in ensuring health services are not replicating these dynamics when a victim-survivor disclose child sexual abuse.

Legislation Review Across Jurisdictions

There is no current national legislation which defines and responds to child sexual abuse. Each state and territory has its own legislation.

Legislation which relates to child sexual abuse have been mapped across jurisdictions. Each jurisdiction provides a range of offences relating to sexual behaviour committed against children and responding to disclosures to sexual abuse (see Appendix A).

There have been a number of advancements and amendments to legislation which relate to providing evidence, specifically the way children provide evidence, as well as what constitutes a crime and the procedures for reporting child sexual abuse.

Health and other professionals are sometimes uncertain of the processes they need to take when a disclosure of child sexual abuse occurs. There are fears they will be considered to be 'coaching' the witness should they inquire about the abuse that may have occurred. Knowledge about the criminal process, legislation and relevant policies is critical to ensure optimal responses to disclosures of child sexual abuse.

Limitations in Mandatory Reporting

The groups of people mandated to report vary, with Queensland specifying a limited number of occupations, Victoria and Western Australia outlining a more extensive list and the Australian Capital Territory, New South Wales, South Australia and Tasmania having a very comprehensive list, extending to every adult in the Northern Territory. Mandated reporters are typically individuals frequently interacting with children in their professional capacity, such as teachers, early childhood education and care practitioners, doctors, nurses and police.

Mandatory reporting legislation does not define child sexual abuse. This is defined by the various offences found in each jurisdiction's criminal code or act. Sexual offences against children are worded in terms of the age of the victim. Offences under the age of 10 (ACT and NSW), under the age of 12 (ACT and Vic), under the age of 13 (WA), under the age of 16 (Queensland, Northern Territory, ACT and NSW), under the age of 17 (Tasmania) and under the age of 18 in Tasmania pertaining to child exploitation material offences. A list of relevant state-based legislation is provided at Appendix A.

In terms of mandatory reporting, most jurisdictions define a child as a young person under the age of 18. In NSW, mandatory reporting applies to those under 16 years and in Victoria it applies to those under 17 years. In the ACT, NSW, Victoria and Queensland, in addition to mandatory reporting under relevant child protection legislation, failing to disclose sexual offences against children is a criminal offence.

In all jurisdictions, the legislation protects the mandatory reporter's identity from disclosure. In addition, the legislation provides that as long as the report is made in good faith, the reporter cannot be liable in any civil, criminal or administrative proceedings.

The Context of Sexual Assault Proceeding in Criminal Court

……and the health worker response.

Child and adult survivors of child sexual abuse who are complainants in sexual assault proceedings can experience high levels of stress, re-traumatisation and additional challenges, including giving evidence, cross-examination, low levels of convictions, stereotyping and perceptions about children who have been sexually abused, courtroom and legislative processes, remembering the abuse and having the abuse discussed publicly (Richards K, 2009; Herman J, 2015; Want C, 2000).

McGlade (2012) refers to 'double discrimination' that Aboriginal female victims-survivors may experience when they are witnesses in sexual assault proceedings, on the basis on both gender and race, referring to research which found that not only were Aboriginal women subject to false accusations, stereotypes and discrimination during cross examination, but experienced heightened distress and ultimately impacted on their capacity to continue giving evidence (McGlade 2012pp 139-144).

Despite some good law reforms, Goodman-Delahunty (2011) suggest that sexual assault trials are still the most difficult to prosecute. Court outcomes are not always conducive to recovery and healing and adversarial court proceedings often mirror child sexual abuse dynamics and can re-traumatise victims and survivors and argues for alternative sentencing proceedings (Herman, J. 2005).

Once the disclosure occurs for a child, it goes from being a very 'private' matter to a very 'public' matter which is a big transition for the child and supporting family (Want, C. 2000). Working alongside the child and supporting family is critical is restoring control, safety, empowerment and ensuring the child's voice is heard and responded to. These are universal experiences for all children who are witnesses in sexual assault proceedings - and there are additional challenges for Aboriginal witnesses in sexual assault proceedings. This includes (and is not limited to):

- historical trauma and the family's experiences of judicial systems
- court and legal language, processes and systems generally
- Aboriginal witnesses may need interpreters as may be bi or multi-lingual
- institutional racism in justice systems
- additive discrimination
- fear of retaliation in the community
- distrust and fears of justice systems
- being isolated culturally.

Gaining comprehensive knowledge of how the legal process operates is important knowledge for health workers to develop. This knowledge can assist with establishing supports for victims and survivors of child sexual abuse and their supporting family members or key caregivers, as well as information about court support and preparation, where appropriate. Understanding legal requirements and limitations can help

health practitioners deliver trauma-informed care, in a way that is not hindered by their worries about legal processes, nor compromising the witness and their evidence.

The development of training pertaining to various legislation and regulations should be relevant to each jurisdiction. For example, when training is held in South Australia – training, information and resources should be provided relevant to the location of training.

The Education Centre Against Violence (NSW Health) have developed and deliver a two-day training package and resources called "Nothing But The Truth: Court Preparation for adult and child witnesses in sexual assault proceedings". It is not a competency-based course and was developed in response to requests from sexual assault services for guidelines on preparing and supporting witnesses who are proceeding through the criminal justice system. It covers NSW legislation only and has Aboriginal specific content that was developed by Yamurrah.

The vast majority of disclosures, even when all efforts to support criminal proceedings are in place, do not result in that matter proceeding to court. In the small proportion of cases that do, few result in a conviction, and when there is a conviction, the sentence may not be the sentence that victims and survivors had hoped for. Research that was based on an analysis of police and court administrative data in NSW, over a 14-year period (2003-2016) found that only one in five (21.6%) of child sexual offences reported proceeded beyond the investigation phase and just over half (55,5%) of the matters finalised in court resulted in a conviction, which an overall estimate of 12% of offences reported to the police resulted in a conviction (Cashmore, J et.al, 2000).

A study which examined the attrition of child sexual abuse cases for Indigenous and non-Indigenous children across two Australian jurisdictions found that, in both jurisdictions Indigenous children were less likely than non-Indigenous children, where the child had disclosed to police in a forensic interview, to have the case proceeded by public prosecutors (Bailey, C. et al, 2017).

The findings present a compelling reminder for health practitioners that criminal proceedings can, for certain victims and survivors, offer a space for empowerment, enabling them to have their voice and truth heard in court. However, for others, from reporting to the court process, this may be a confusing and disheartening experience. It is important to acknowledge that not all victims and survivors will have their matters heard in court and some may not receive a conviction. Therefore, caution is advised against making promises about the court process.

Reforms in the way evidence is provided, such as closed circuit television, pre-recorded evidence, no further cross examinations, support person, child intermediaries and champions, Aboriginal witness assistance officers and thorough court preparation have significantly improved experiences for child witnesses in child sexual assault proceedings (Richards, K, 2009).

Walking and working alongside victims and survivors is a critically important step for health practitioners, and working in ways that empower, validate and believe victims and survivors is crucial. Ensuring the victim and survivor is equipped with accurate information, forensic procedures being followed as well as referrals for appropriate supports such a sexual assault counselling and court preparations is critical.

Justice is not always synonymous with healing nor healing with justice for victims. Empowering victims and survivors in their healing journeys is a key principle for health practitioners – determining their own story of and making meaning of what healing and justice means for them.

Key Insights

- no national legislation for child sexual assault
- no national regulations relevant to child sexual abuse
- mandatory reporting obligations vary between jurisdictions
- there are inconsistencies in the age of mandatory reporting across states and territories
- there has been some advances and amendments in legislation which are designed to support child sexual abuse victims and survivors
- under some relevant child protection legislation it is also a criminal offence not to disclose sexual offences committed against children (NSW, ACT, Vic & Qld)
- court outcomes not always conducive to healing and recovery for victims and survivors
- court processes can replicate dynamics of child sexual abuse and be retriggering
- health practitioners can benefit from professional development about judicial processes and relevant legislations
- additional barriers for Aboriginal victims and survivors in the criminal justice system
- justice and healing should be determined by victims and survivors.

Work Health and Safety

In Australia, Work Health and Safety (WHS) for health workers is governed by the Work Health and Safety Act 2011 (Cwth) at the federal level, as well as corresponding state and territory legislation.

Under the WHS Act employers have a legal duty to ensure the health, safety, and welfare of all people in the workplace; this includes workers, patients or clients. While WHS legislation in Australia does not specifically address child sexual abuse victims, it does require employers to have a duty of care to provide a safe work environment for all workers, as well as other persons who may be affected by their work activities. This includes taking reasonable steps to prevent and respond to incidents or reports of harassment, discrimination and violence in the workplace, which can include child sexual abuse.

WHS legislation in Australia covers psychosocial health, which refers to the mental, emotional, and social wellbeing of workers and patients. In recent years, there has been increasing recognition of the importance of psychosocial health in the workplace and its impact on overall health and safety. Child sexual abuse can have psychological and emotional impacts on victims, and it is important to understand how WHS legislation may apply in the context of child sexual abuse.

This legislation acknowledges the need to address psychosocial hazards and risks, and employers have a legal obligation to manage these hazards to protect the mental health and wellbeing of their workers, patients and clients. This legislation may impose a duty of care on employers and organisations to ensure their psychological health and safety, including protection from child sexual abuse. This may involve

providing a safe and supportive work environment, addressing any identified risks of child sexual abuse, and taking appropriate action to prevent and respond to child sexual abuse incidents/reports.

To respond effectively to child sexual abuse victims, employers should be mandated to implement policies, procedures and practices that create a safe and supportive work environment and provide training and resources to workers on how to identify, prevent and respond to incidents/reports of child sexual abuse. This may involve developing clear reporting mechanisms, response protocols, documentation processes and providing access to confidential support services.

In some jurisdictions, WHS legislation may have specific provisions that require employers and organisations to address the risk of child sexual abuse disclosures in certain settings, such as hospitals, community health facilities, schools, childcare facilities, youth organisations or other environments where children are present. The National Child Safe Standards play a key role in assisting workplaces to promote the safety, wellbeing and rights of children, and to create a culture of child protection that prioritises the best interests of children in all activities and services. These standards include promoting a child-centred approach, preventing child abuse, encouraging reporting and response, and ensuring monitoring and compliance processes are in place (Australian Human Rights Commission, 2018; Powell 2020).

In summary, the WHS legislation provides a standard for ensuring adequate responses are provided to children disclosing sexual abuse and further that workers are supported through this process to reduce the impacts of vicarious trauma or compassion fatigue. Aboriginal and Torres Strait Islander staff may have additional layers of responsibility as they are often navigating workplace load and cultural load. Mandatory training ensures that (health) workers are adequately equipped to respond in a culturally safe trauma-informed way to disclosures and prevent the potential of re-traumatising Aboriginal children who have disclosed sexual abuse. Overall themes that may be considered for training:

- First Nations worldviews
- nature of disclosure
- child Sexual abuse - context, dynamics, impacts
- intersectionality, racist and trauma legacies
- neurobiology – optimising neuronal pathways and Aboriginal ways of knowing, doing and being
- online harm and exploitation
- children and young people with harmful and problematic sexualised behaviours
- human rights, legislations, policy and best practice standards
- compounding discrimination, disadvantage and compounding trauma
- What is trauma-aware, healing-informed and culturally appropriate practice
- practices and values that promote safety, healing and reconnection
- worker wellbeing, vicarious trauma and vicarious healing
- centre and elevate Aboriginal ways of knowing, being and doing and healing frameworks.

What Training is across Australia that relates to disclosure of child sexual abuse?

Mandatory Reporting

There are various training programs that respond to mandatory reporting and responding to disclosures according to the various state and territory legislation. This shows a strong commitment to putting measures in place to respond to children who may have disclosed child sexual abuse.

This training does not generally cover trauma specific content nor the nature of child sexual abuse, dynamics and impacts, and as such is not a holistic response to child sexual abuse.

Currently, the NSW Health Education Centre Against Violence and NAPCAN offer training that is informed by Aboriginal Worldviews and is specifically focused on responding to disclosures of child sexual assault.

Examples include:

- Mandatory health child protection training localised in local health districts in NSW (Child Wellbeing and Child Protection Facilitators Training @ ECAV). Non child contact roles 4 hr training. Child contact roles 8 hour training.
- Safe communities for children program (NAPCAN, Protective behaviours)

Trauma-specific training

Nationally accredited training programs cover all states and jurisdictions – for example NSW Education Centre Against Violence – Aboriginal Qualification Pathway is a nationally accredited training course.

Child sexual abuse specific training

The NSW Health Education Centre Against Violence (ECAV) has been delivering a specialist Aboriginal competency-based national qualification pathway for Aboriginal workers in the areas of family violence, sexual assault and child protection. It consists of three tiers: 10619NAT Certificate IV in Aboriginal Family Wellbeing & Violence Prevention Work; 10634NAT Advanced Diploma of Aboriginal Specialist Trauma Counselling; and Graduate Certificate in Human & Community Services (Interpersonal Trauma). An evaluation was conducted on the two latter qualifications which were found to be well regarded by students and stakeholders, were delivering on their objectives to fulfil skill and qualification gaps, and was making a significant contribution to building the capacity of the NSW Health Aboriginal Family Health workforce. This Aboriginal Qualification Pathway as a whole was viewed as unique in terms of training an Aboriginal family violence, sexual assault and child protection workforce, and also providing a model for Aboriginal education and training more broadly. Several strengths were identified of the two courses, including the close involvement of the Aboriginal community, culturally appropriate and trauma-informed content and teaching methods, and flexibility and support for participants. The study also found that these

courses provided benefits to both workplaces and participants, with benefits extending to participants' personal lives (e.g., greater self-confidence) (Ministry of Health 2022).

For this report, a search was conducted on the current nationally Accredited Units of Competency available across Australia in the area of child sexual assault/abuse. There are units of compentency that cover responding to child sexual abuse but these units do not cover cultural safety or cultural responsiveness.

There are three units of competency related to child sexual assault of Aboriginal people nested within qualifications designed for Aboriginal workers, these include:

- NAT11080004- Provide support to communities affected by sexual assault of children and young people in 11080NAT – in the Certificate IV in Aboriginal Family Wellbeing and Violence Prevention Work.
- NAT11154002- Provide specialist counselling to children and young people affected by child sexual assault and NAT11154005- Provide specialist counselling to adult survivors of child sexual assault in 11154NAT – in the Advanced Diploma of Aboriginal Specialist Trauma Counselling.

There is also a child sexual assault unit designed for medical and forensic doctors, NAT10882002- Provide a medical and forensic response for child sexual abuse in 10882NAT Graduate Diploma of Medical and Forensic Management of Violence, Abuse and Neglect. As well as a specific unit on young people with problematic sexualised behaviour, NAT10826007- Deliver counselling to children and young people engaged in problematic sexualised behaviour in 10826NAT - Graduate Certificate in Integrated Violence, Abuse and Neglect Interventions.

In partnership with Sydney University, ECAV offer a Graduate Certificate in Human Services which includes a week long unit on Sexual assault in the Australian Context. This covers responding to disclosures and relevant legislation.

ECAV also offer a two-day training package and resources called Nothing but the Truth: Court Preparation for adult and child witnesses in sexual assault proceedings. It is not a competency-based course but was developed in response to requests from sexual assault services for guidelines on preparing and supporting witnesses who are proceeding through the criminal justice system. It covers NSW legislation only and has Aboriginal specific content that was developed by Yamurrah.

This search also identified that a number of units of competency on trauma-informed care and cultural competence are available, however, they did not specifically focus on responding to child sexual abuse disclosures.

The **Blue Knot Foundation** offers various trauma specific and trauma-informed short courses and aim to be a responsive community to those who are impacted by trauma and, specifically, child sexual abuse.

These cover working with complex trauma, vicarious trauma and responding to complex trauma.

Trauma healing

South Australia

The Yaitya Mingkamingka Purrutiapinthi (Aboriginal Trauma Healing) is a two-day training program for Intensive Family Service practitioners that supports culturally responsive and trauma-responsive practice with Aboriginal and Torres Strait Islander people in the South Australian Aboriginal Community context. The South Australian Department of Human Services funded Aboriginal community-controlled organisations to provide this workshop to 300 Intensive Family Service practitioners from July 2021 to December 2022. Feedback from training participants has been very positive. The training stimulates self-reflection and increased awareness to address cultural bias and racism, through a non-shame-based style of teaching. Even though this training does not have a specific focus on responding to child sexual abuse, it explores both the principles of trauma-informed and culturally responsive practice and how these approaches can be applied together in practice. We have identified from our eco-jurisdictional mapping across Country that this is one of the very few training programs that combines both approaches. Instead, we have noticed the trend to silo out cultural responsiveness from trauma-informed approaches.

(We acknowledge Dana Shen who spent time discussing with our team the training and cultural framework).

Trauma-informed

AbSec offer a number of competency-based programs including a two day trauma -informed and responding to trauma course. The course aims to equip workers with basic skills, knowledge, understanding, approaches and strategies to work effectively with survivors of past and current/ongoing trauma. In particular, this course explores the way that complex trauma, caused by early childhood abuse and neglect, impacts survivors and outlines a number of principles and approaches for working in a trauma-informed way with children and families. Additionally, there is a focus on understanding and responding to Aboriginal intergenerational trauma using both mainstream and traditional Aboriginal healing methods to optimise worker practice.

Course content draws on and aligns with current, sector best-practice. A range of activities provide learners in diverse roles with opportunities to develop practical skills to enhance their work with trauma survivors. A blend of mainstream, clinical, non-clinical, (recovery), Aboriginal and lived-experience expertise has been utilised to develop the course materials.

An accredited version of this course (CHCMHS007) is available.

An innovative training program in Canada, EQUIP Health Care, provides a free Equity-Oriented Health Care training which incorporates the three key dimensions of:

1. trauma- and violence-informed care;
2. cultural safety/anti-racism; and
3. harm reduction/substance use health.

Many of the issues taken up in the training modules resonate for Australia's First Nations people and their

experience of the healthcare systems. Ideas and strategies to address cultural safety and trauma aware responses to violence, abuse and neglect are a feature of the modules.

In 2019 NSW Health Education Against Violence partnered with a regional NSW Health District to develop a Trauma-Informed Training Package to improve health worker's responses to victim/survivors of interpersonal violence through responses that reflect trustworthiness, empowerment, safety, choice and cultural, historical and gender issues.

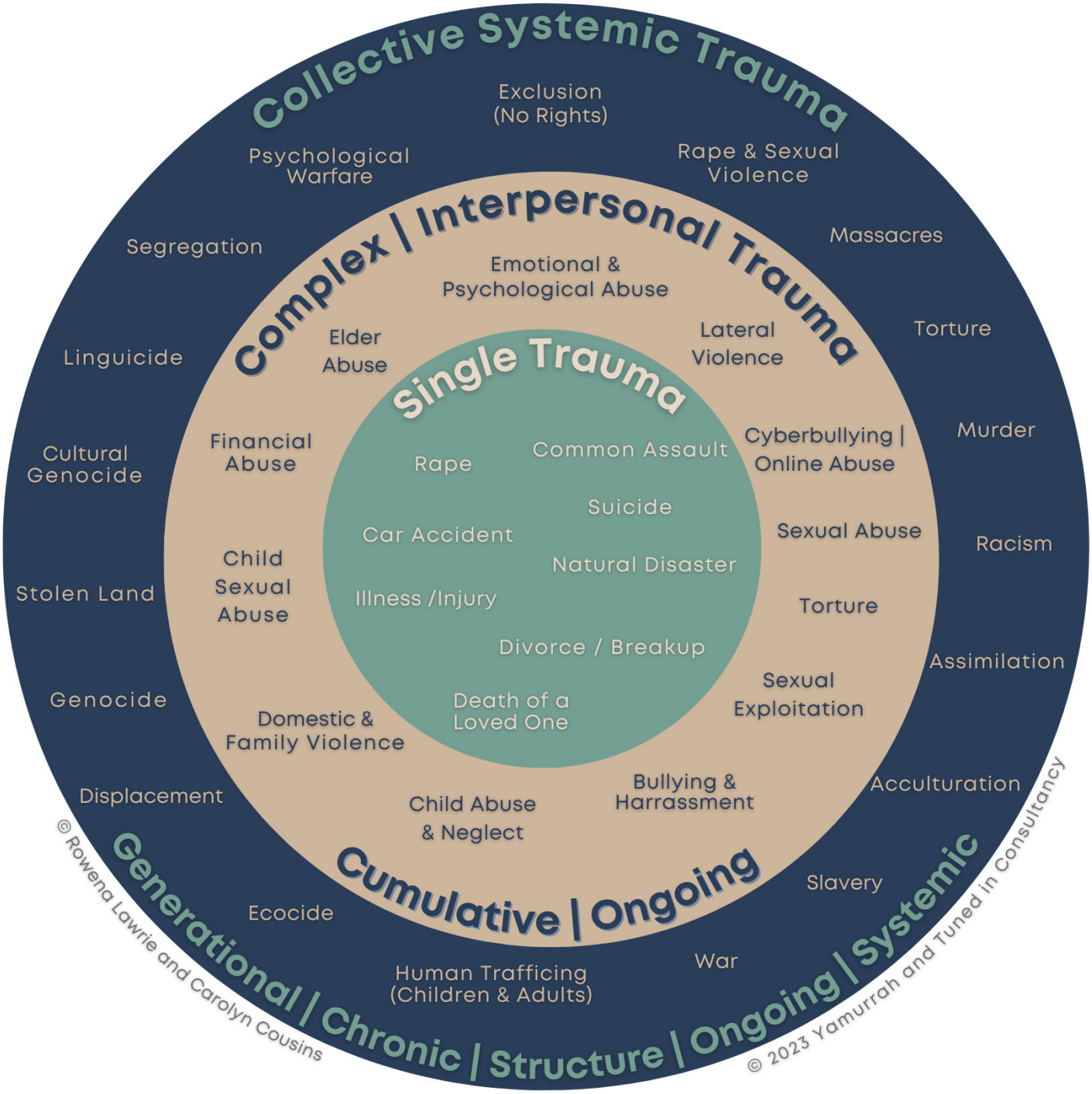
Culturally informed trauma integrated healing approach

We Al-li provides several training packages and some are recognised as continuing professional development through the Psychotherapy and Counselling federation of Australia. We Al-li offer Culturally Informed Trauma Integrated Healing Approach (CITIHA) training for individuals, families, communities and organisations. It presents on informed Indigenous and non-Indigenous practices from which new theories are presently evolving. We Al-li education and training packages move beyond the mental health services delivery model and into a socio-cultural model of health which skills and empowers workers for personal and community developmental approaches for individual and group wellbeing.

Culturally safe and responsive trauma-informed

Yamurrah provide a number of short training packages including Culturally Responsive Trauma-Informed Care, Critical Practice with Aboriginal people, families and communities, and The Journey of Integrated Practice with Aboriginal families.

All courses cover culturally safe and responsive, trauma-informed care and address responding to disclosure of child sexual abuse. The attached First Nations Trauma Model is used to explore the dynamics, impacts and recommended trauma-informed responses, including responding to disclosures of child sexual assault and how to work alongside victims-survivors and supportive family members. The courses feature review sessions to consolidate learning links to practice.



Source: Rowena Lawrie & Caroline Cousins

Online training platforms

Since COVID-19, we have seen several changes in how training is delivered. Training experiences have embraced online learning, which can be interactive and still allow participants to process trauma related content in a meaningful way. Stakeholder feedback will be sought during co-design processes to gather further input on training platforms used by the health sector and their appropriateness for this training package.

Trauma-informed

There are a number of online mandatory reporting, cultural awareness and trauma-informed programs being offered by above providers (such as Blue Knot and Yamurrah).

A recent e-learning course from the **Public Service Commission (NSW)** covers trauma-informed content, a key recommendation from the Bringing them Home Report (1997), and discusses survivor stories of child sexual abuse. Titled, **Everyone's Business**, it provides a bespoke e-learning training package, including mandatory information about the impacts of past forcible removal policies and practices on First Nations communities, to build a trauma-informed, and culturally capable, public sector workforce. Yamurrah worked in partnership with the PSC on this training package which is being rolled out currently to the NSW public service sector.

The NSW Framework for responding to sexually harmful behaviours (NSW Health) is supporting the NSW Government to develop a framework for the prevention and response to children and young people with problematic and harmful sexual behaviours. This work is in response to recommendations made by the Royal Commission into Institutional Responses to Child Sexual Abuse and NSW Ombudsman in their report of the then Joint Investigation Response Team Program.

There are also national education-based campaigns and international training for example the New Zealand campaign around pornography - https://www.theguardian.com/world/2020/jun/15/new-zealand-government-deploys-nude-porn-actors-in-web-safety-ad).

Protective behaviour programs

Protective behaviour programs currently place the responsibility on children to ensure their own safety, rather than addressing the responsibility of adults who perpetrate sexual abuse or violence. Recommendations should focus on preventive measures through psychoeducation in schools, targeting essential subjects such as healthy relationships, sexuality, ethics, gender, pornography, gender-based violence, feminism and toxic masculinity for young people. To ensure a cohesive and uniform approach, consistent messages and language should be integrated nationally from K-12 throughout the core syllabus and this implementation should be made mandatory.

The information provided should coincide with the developmental and social stages at which children naturally learn about these topics, rather than waiting for adults to feel comfortable discussing them. A thorough review of current prevention-based programs, such as Love Bites, the Sex and Ethics framework developed by Moira Carmody and 50 Shades of Pornography (Relationships Australia), is necessary. Recommendations should be made to select one of these programs for consistent use within schools. It's crucial to update and revise these programs to ensure they are inclusive of all genders and sexualities.

Esposito found that:

> ***"There is no one signal or sign of child sexual abuse. Instead, to facilitate a disclosure, it is critical that practitioners be on the lookout for indirect, non-verbal hints or out of context signs and statements that may suggest abuse has or is taking place. Strategies to help children disclose include building trust and rapport with the child, taking an interest in them and, letting them know that they will be believed. Asking children direct or indirect questions about the abuse, using open ended exploratory questions, active listening and creating multiple interview opportunities conducted in safe child friendly spaces, may all help children feel comfortable and able to tell their story in their own manner and time. Letting children have some control over the disclosure process is also important. This involves informing children about what is likely to happen to them and their family, who will be involved and the timeframe for actions".***

Central to all work is the need to take time to explore what life is really like for the child and remember that children are the experts of their context and experience and they have important insights to share about the perpetrator's behaviours and what they need to increase their safety. Disclosure is rarely a spontaneous event and is more likely to occur slowly over time. It is therefore important to remain open to a future disclosure when working with children, because some children may disclose sexual abuse and then retract their allegation (especially if they are pressured to do so). It is important to gently probe and be aware of external pressures and thoroughly document an early or first disclosure. Don't assume a recantation means that abuse has not or is not occurring. The research suggests that workers need improved training and educational preparation to deal with the cases involving child sexual abuse.

Generalist knowledge and practice wisdom combined with specialist knowledge and skill will help boost worker's confidence and capacity to talk to children about sexual abuse. It will also prevent them from minimising or denying the risk of sexual abuse. Noting assumptions and interpretations about the case with others will assist in reducing professional and personal bias about child sexual abuse. Organisational improvements mentioned in the literature include more regular on the ground training and supervision of workers.

Value of Trauma-Informed Care and Training Across Health Settings

Trauma-informed care is considered a priority and an important model of care across health settings and effective in improving patient engagement, treatment, health outcomes and referrals, and staff wellbeing. There is recognition that healthcare systems remain an important setting for identifying children and families who have been exposed to trauma (Menschner et al, 2016). Organisational wide approaches to incorporating trauma-informed care are being implemented by Australian health and the broader social services sector (NSW Health (PARVAN), 2023; State of Victoria, Australia, Department of Families, Fairness and Housing, 2022; Government of South Australia, Department of Human Services, 2021).

Studies highlight the merit of adopting trauma-informed care as a universal health precaution, where staff are encouraged to work from the presumption that all patients/people they care for, may have experienced trauma. Implementing trauma-informed care techniques of building trust, safety and healing, regardless of people's trauma history, encourages staff to deliver a more holistic healthcare service (Palmieri et al, 2021). A strong organisational commitment can facilitate a shift in the identification of trauma and create pathways for victim-survivors to holistic wellbeing as well as the prevention of long-term negative health outcomes and an overall reduction in healthcare costs. This can also benefit health staff who have personal histories of trauma and can mitigate against vicarious trauma (Oral et al, 2020).

Trauma-informed leadership is recommended to support the integration of trauma-informed principles into policies, procedures, practices and training across healthcare settings (Oral et al, 2020). The need for a multilevel, organisational framework to understand and respond to the impact of trauma on both survivors and healthcare providers, is becoming more apparent (Menschner et al, 2016; Oral et al, 2020). Strong leadership initiates collaborations beyond healthcare settings into education, legal and child protection systems and have greater potential to enhance wellbeing, decrease re-victimisation, improve health, social and educational outcomes and promote change at a societal level (Oral et al, 2020).

Trauma-informed care must involve both organisational and clinical practices that recognise the complex impact trauma has on both patients and providers. Delivering trauma-informed training in the absence of broader organisational changes will be less effective. Widespread changes to organisational policy and culture need to be implemented for a healthcare setting to become truly trauma-informed (Menschner et al, 2016). A good example of this in the Australian context is the Yaitya Mingkamingka Purrutiapinthi program which was developed following significant organisational reform by the Department of Human Services in South Australia through their Trauma Responsive Framework (Government of South Australia, Department of Human Services, 2021) and Aboriginal Cultural Practice Framework (Government of South Australia, Human Services, 2022).

Core components of trauma-informed systems include staff understanding the impact of trauma on children and families in their care, engaging in trauma identification, and delivering effective responses and treatment. Strong communication and collaboration between services are also key components (Kerns et al, 2016; Oral et al, 2020). Trauma-informed care principles across a healthcare setting includes: realising that trauma affects all aspects of a person's life, including families and communities; recognising the signs of trauma; responding on a personal and organisational level in a way to promote healing; and providing an environment that resists re-traumatisation (Palmieri et al, 2021; SAMHSA, 2015).

The benefits of trauma-informed training have been documented. A US study shows preliminary evidence of the viability of training strategies to teach the use of trauma screening tools and conduct trauma-informed case-planning for child welfare professionals. It found that training contributed to workers being more trauma informed, aware of symptoms, and able to link children and youth with effective services designed to meet their specific needs (Kerns et al, 2016). The training delivered as part of this study, incorporated a number of adult learning strategies to enhance transfer of knowledge such as scaffolding knowledge from exposure to foundational concepts followed by more in-depth skills, use of case vignettes to ensure applicability, use of videos, small and large group discussions, and case presentations (Kerns et al, 2016).

Trauma-informed training can provide staff with support and knowledge to recognise, assess and refer

traumatised children and their families from a range of health settings (such as inpatient, outpatient or rehabilitation) to much needed services within and outside the healthcare system. Such training is designed to result in more effective patient-centred communication and responses (Oral et al, 2020). A coaching or a train-the-trainer component is considered a critical strategy to support dissemination of knowledge (Beidas et al, 2013; Dorsey et al, 2012).

Whilst the research indicates that trauma-informed training and implementation of a multisystemic and organisational response has an important place, in general this approach tends to lack a specific focus on identifying and responding to disclosures of child sexual abuse. One exception to this, is the adoption of Child Safe Standards as recommended by the Royal Commission into Institutional Responses to Child Sexual Abuse. This is a leading example of a systems-wide focus on child sexual abuse that is underpinned by a trauma-informed approach in the Australian context (Commonwealth of Australia, 2017).

However, there are targeted child sexual abuse training strategies that are separate from trauma-informed training. The need for this training is recommended as part of an ongoing program rather than a one-time event which focuses on skill building around believing the victim-survivor and acknowledging their pain, burden and reality of what they have been carrying; reassuring them that this is not their fault; then asking how they can help, as well as following protocols around safety, reporting and attending to immediate injuries (Palmieri et al, 2021). Other training programs include content regarding child sexual abuse prevalence, risk factors, grooming behaviours, warning signs, prevalence of youth problematic sexual behaviour, organisation's code of conduct and commitment to child protection and responding and reporting to child sexual abuse, including mandatory and legislative requirements.

It is critical that decolonised approaches centre Aboriginal knowledge systems and focus on enhancing the capabilities of workforces, building on interagency partnerships and collective learning around eliminating colonisation, racism and Whiteness (Cullen,P et. al 2020)

In an effort to support victim-survivors to regain control and choice over their lives, the training designed under this project will send a strong message to organisational leaders, managers and staff that we cannot shy away from naming the realities of child sexual abuse.

What About Cultural Safety?

Trauma-informed training programs rarely embed a focus on skill building in culturally safe practices despite the strong call by First Nations academics in this country for programs to focus on Aboriginal worldviews and experiences.

The concept of cultural safety originated within nursing education. The term cultural safety first was first proposed by Dr. Irihapeti Ramsden and Māori nurses in the 1990s and in 1992 the Nursing Council of New Zealand made cultural safety a requirement for nursing and midwifery education (Ramsden, I 2002).

Terare (2020) argues that Aboriginal Worldviews—ways of knowing, ways of doing and ways of being—are critical to the wellbeing of First Nations children and adults, this includes acknowledging First Nations people as experts in their own lives, applying Indigenous methodologies of knowledge building such as yarning and Dadirri involves listening to storytelling that creates new knowledge and understanding can

build deep reflection, silence and stillness and empathy amongst non-Indigenous people (Terare et al, 2020, 949-950). Terare also highlights the importance of addressing the health inequalities experienced by Australian First Nations Peoples through deep understanding and capacity to respond to the impact of their trauma, the diversity of their experience and realising the centrality of connections to their Worldviews (Terare et al, 2020).

Culturally safe practice and training should start with a strong awareness, sincere reflection and commitment to take a stand against the ongoing trauma legacies Aboriginal people have experienced since invasion as well as the ongoing experiences of racism that Aboriginal people are forced to continually endure (Herring et al, 2013; Menzies 2019). The Yaitya Mingkamingka Purrutiapinthi program focusses on how to implement both trauma-informed and culturally responsive practice with Aboriginal people and is a worthy framework to consider when developing specialised training.

Competency-Based Training

There is continued demand on higher educational institutions to introduce competency-based education to deliver graduates with relevant competencies and skills, also referred to as outcome-based learning (Sistermans 2020; Vasquez et al 2021). The importance of competency-based education in the health industry has been highlighted within the context of building accountable, responsible and competent workforces that emphasises learning milestones, measurable activities and progression of smaller cumulative steps to assist workers to undertake varied job tasks (Pandit et al 2019; Jones 2005; Vasquez et al 2021). Research shows that competencies developed based on best practices identified at the field level, have higher chances of preparing workers (Abrams 2004). Evidence of applying a competency-based framework has had a positive influence on changes to training and education opportunities for some Australian workforces (Priddis et al 2015).

Competency-based education is described as a step-by-step process where learning occurs over time, which is student centred, self-directed, applying a skill building and experiential approach. The process works backwards by first asking 'what should the learner be able to do at the end of the training?' A detailed benchmark is then developed to specify the skills, knowledge and evidence the learner needs to confirm their competencies (Sistermans 2020). Instead of focusing solely on student knowledge there is more emphasis on what students are able to do, this job-related outcome approach can support employers to know their staff have the skills and knowledge needed to do their job (Kelly & Columbus 2016).

Kelly and Columbus's (2016) conducted a meta-analysis of research on competency-based education and identified that most studies focused on questions of program design such as processes around identifying competencies, developing assessments and structuring courses; rather than program outcomes such as learning, completion/graduation, retention or job placement rates.

However there are smaller qualitative studies that show positive impacts of competency-based training such as significant improvement in students' scores (Pandit et al 2019), higher completion rates (Parsons et al. 2016), and increased self-awareness of skills and stronger alignment with students' professional, personal and social goals of students (Navarre Cleary, M 2020).

A holistic culturally safe and responsive trauma-informed training program

As outlined in this report, the Australian health sector urgently needs to improve responses to Aboriginal and Torres Strait Islander victim-survivors of child sexual abuse. Funding is needed to develop First Nations-led, holistic, culturally safe and responsive and trauma informed training and resources. Improved responses will create greater safety for First Nations peoples to make disclosures and will support responders to walk respectfully along-side victim-survivors while always upholding their dignity and safety.

Identifying factors that inhibit and facilitate disclosures will strengthen preventive strategies and improve support and understanding for all victims (Kellogg et al. 2020), understanding what they are and how to deconstruct them is vital.

For disclosure of child sexual abuse there needs to be safety, and there are many factors which are essential for creating a safe environment which is conducive for a disclosure to occur.

BIRD Practice Framework provides a culturally safe model for responding to disclosures of child sexual abuse and centres First Nations ways of knowing, doing and being. The BIRD Practice Framework also outlines key areas for workforce professional development to improve response to disclosures of child sexual abuse.

The BIRD Practice Framework encourages the worker to develop necessary skills that support not only the actual disclosure but also create an environment and skills conducive for a disclosure to occur and ensure the relevant safe and supportive post care.

Creating a safe 'nest' or environment, having knowledge of trauma-informed care for victim survivors of child sexual abuse, and having a network of skilled trauma-informed practitioners to consult with and reach consensus-based decision-making, are all precursors to implementing the BIRD Practice Framework.

Believe Inquire Response to Disclosures

Songs of Survival, Resistence to Violence, Abuse an Racism, Connection to Culture, Identity and Truth

Learning to fly

Professional development and learning to work alongside First Nations children, young people, families and communities - elevating their expertise and voices. Utilising cultural humility and life-long learning to work strategically within systems to resist racism and to support the social justice demands defined by First Nations people.

Territorial and protective

Fighting for justice and taking a stand against the perpetration of child sexual assault while supporting children, young people and families.

Flock and migration

Bringing together community and professional supports who are there for victim-survivors before, during and after they have disclosed. Disclosing child sexual assault take place across the life of a victim-survivor, and it is important that survivors have a "flock" of support through their life-journey.

Safety, nesting and nurturance

Just as birds feather their nest to make it safe, comfortable and nurturing for their young, responders can also prioritise safety and choice to support victim-survivors. Feathering the nest also makes space for celebrating Black love, Black cultures and Black joy.

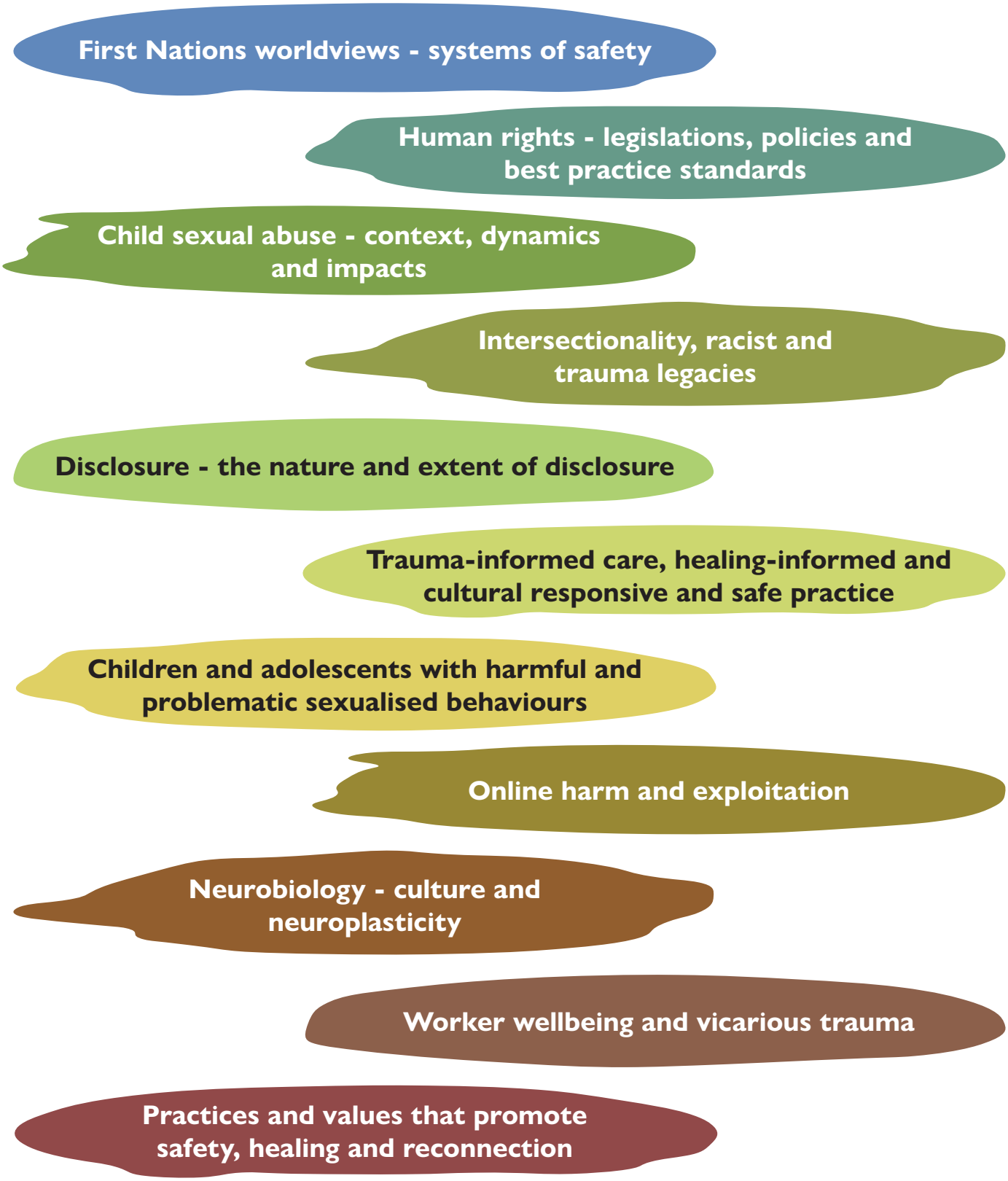
Birds have powerful instincts and memories

Professional judgment informed by lived and living expertise of children and adult victim-survivors of child sexual assault. Empathy, deep listening, cultural care, cultural humility and working collectively with others are core practices.

Birds signal threat and safety through bird song

Responding to child sexual assault relies on ongoing collective and collaborative communication. Everyone has a collective responsibility to respond to child sexual assault and to uphold the safety and dignity of children. The BIRD Project Practice Framework is a holistic way of responding to and preventing violence and abuse against children and supporting adult survivors.

Themes that can be considered for modules have been informed by evidence and can include:



It is recommended that the BIRD Practice Framework is central to the training package that is developed to respond to disclosures of child sexual abuse.

CONCLUSION

The evidence is clear that our systems neither create safety for children or adults to disclose sexual abuse nor respond adequately to disclosures of sexual abuse. There are serious gaps in the provision of culturally safe responses that align currently to responding to disclosures of child sexual abuse.

What is clear from the research and mapping is there is not a shared view of what constitutes harmful behaviour. Indeed, in Australia, we have differing definitions across our jurisdictions. There is no current national legislation which defines and responds to child sexual abuse. Each state and territory has its own legislation, and there have been several advancements and amendments to legislation relating to providing evidence, specifically how children provide evidence, as well as what constitutes a crime and the procedures for reporting child sexual abuse. There is, however, a national definition which can inform policy direction.

Very few child sexual assault matters will progress to criminal proceedings and the likelihood of conviction is low. This does not mean that victims and survivors should be disbelieved nor nor stop receiving support from health practitioners through their healing journey. Victims and survivors, and their supporting family and/or network, should be believed and supported by health practitioners despite criminal proceedings and outcomes.

As previously outlined, interventions in Australia, ranging from racist policies of genocide and assimilation to protectionist policies of stolen generations and, more recently, responses from the health system, such as the Intervention in the Northern Territory, have been deeply harmful and distressing for Aboriginal and Torres Strait Islander peoples. While there are differences in intention of these interventions, what they all have in common is a consistent failure to prevent and further protect. On many levels, even well-intentioned health interventions have been re-traumatising and the level of abuse with devastating consequences has continued to increase. One of the reasons for these failures as documented by the Royal Commission into Institutional Child Sexual Abuse of children is our failure to facilitate and respond to disclosures of child sexual abuse.

Given the lack of significant change in statistics, reporting and barriers, the seriousness of this issue and the lack of progress resulting from various interventions, as well as the fact that these issues exist in other minority communities around the world, as documented by government-funded reports such as our own Royal Commission and similar reports in other developed countries, require critical focus.

There is not a large body of research on sexual abuse of children in minority communities, let alone research specifically about how to facilitate and respond to disclosures of sexual abuse. Given the seriousness of these crimes and breaches of human rights, the dearth of research is shocking. Perhaps this lack of research is also a reflection of the hidden nature of sexual abuse; it is shrouded in denial, shame, secrecy and silence. Encouraging more research in this area could play a part in breaking silence and speaking out. It is also important to consider structural barriers of racism and white privilege that impede this research being done.

Disclosures of child sexual abuse are not usually contemporaneous and very rarely are disclosures a spontaneous event; they are more likely to occur slowly and over time. Disclosure is a lifelong process. Central to restoring safety and control to victims and survivors is feeling believed, heard and understood.

The barriers to disclosure for all sexual assault victims and survivors include shame, fear of being disbelieved and self-blame occur across all cultures, countries and religions (Collin-Vézina et al. 2017).

For example, notions such as victim blaming transcend culture (Kenny et al, 2022). Yet, despite these commonalities Gill and Begum also make the key point that child sexual abuse is not a one-dimensional, homogenous cultural problem, but instead 'must be understood within an intersectional framework, often featuring multiple overlapping structural inequalities' (Gill et.al, 2022).

Poor responses to child sexual abuse, such as not believing the victim, can have a significant impact on the trajectory of victims' and survivors' lives. The research confirms that poor and inadequate responses can re-traumatise victims and survivors, and racism, discrimination and a lack of culturally safe trauma-informed responses are additionally layers of trauma for Aboriginal victims and survivors.

We are seeing emerging evidence for the need to respond to child sexual abuse disclosures that have occurred by other children with harmful and sexualised behaviours, as well as online harm and exploitation. It requires deeper understanding of how to respond to these types of disclosures and support families who may be grappling with the complexity of supporting more than one family member (such as a child who has disclosed sexual abuse by another child in the same family, community or neighbourhood).

It is encouraging to report that in very recent years there have been some very valuable contributions to the field. Gill and Begum (2022) analyse and research different communities across the globe, including a chapter on Aboriginal experiences of institutionalised child sexual assault. There was also a Canadian literature review (Ettinger 2022) analysing Indigenous cultural considerations during disclosures of child abuse. It means change is possible and responses can actually improve and not further re-traumatise victims and survivors of child sexual abuse (Ettinger, T. (2022), Gill, A. K., & Begum, H. (2023).

The importance of experiencing culture, connection and belonging is fundamental in Aboriginal ways of knowing, doing and being – and all human relationships – and happens to be just as important when it comes to healing processes and restoring and optimising neurological pathways (Atkinson, J., 2013). However, focusing on culture ignores the commonalities of the impacts of sexual abuse, as if in some way, because of culture, First Nations people are immune to these impacts. While each individual experiences abuse differently and faces different obstacles than their white peers, adhering to a human rights framework requires us to acknowledge the impacts of sexual abuse, such as victim blaming/shaming, which transcends culture.

There have also been some remarkable insights from our own country (Funsten (2013), Dudgeon (2023) Atkinson (2002), Terare (2019) Milroy, H et al (2018)) that draw attention to the need to understand the need for trauma-informed, healing, cultural safety and elevating and centring First Nations voices in responding to child sexual abuse. Culture and reconnecting with First Nations ways of knowing, doing and being may enhance the healing journey of victims and survivors and should be at the core of providing culturally safe and trauma-informed responses to disclosures of child sexual abuse.

The concept of 'Dadirri' as a healing practice from trauma and colonialism was demonstrated in research which showed the process of listening and learning from the stories of others and for healing to occur through a sense of community and connection and that your story eventually changes, and the pain of trauma is released and replaced with love and acceptance as the healing process begins.

Responses to disclosures for Aboriginal victims and survivors should include best practice that incorporates culturally safe responses that recognise that sexual abuse committed against Aboriginal and

Torres Strait Islander children occur in the context not only of abuse of power and control but also in the context of colonial oppression, racism, discrimination, cultural dislocation and generational trauma. The responses need to be trauma-specific and culturally responsive to address the compounded trauma and multiple layers of trauma.

> ***A human rights focus is absolutely essential in all responses, which should be consistent with the rights of a child and child safe standards.***

In conclusion, the BIRD Training Package and BIRD Practice Framework offer a holistic and culturally safe approach to responding to disclosures of child sexual abuse. It is a strong and evidenced-based core to develop training to support health practitioners. It requires a national effort to ensure this is nationally accredited and embedded in relevant legislation.

The approach centres First Nations worldviews, human rights and healing responses to improve early disclosure experience of, and responses to, First Nations victim-survivors of child sexual abuse by the primary healthcare system.

The approach will be workshopped at a national forum in Sydney in June 2023 with key stakeholders to consider our approach and key recommendations.

The approach honours the voices of children and young people and has been informed by research, literature, findings from key Reports, Reviews and Royal Commissions as well as the collective insights from experts who have worked in the sector for many generations.

Appendix A - Legislation

Australian Capital Territory

Relevant Act to Child Protection	Children and Young Persons (Care and Protection) Act 1988 (NSW) Section 356 of the Children and Young People Act 2008 (ACT)
Who is mandated to report?	A person who is: a doctor; a dentist; a nurse; an enrolled nurse; a midwife; a psychologist; a teacher at a school; a person authorised to inspect education programs, materials or other records used for home education of a child or young person under the Education Act 2004; a police officer; a person employed to counsel children or young people at a school; a person caring for a child at a child care centre; a person coordinating or monitoring home-based care for a family day care scheme proprietor; a public servant who, in the course of employment as a public servant, works with, or provides services personally to children and young people or families; the public advocate; an official visitor; a minister of religion, religious leader or member of the clergy of a church or religious denomination; a person who, in the course of the person's employment, has contact with or provides services to children, young people and their families and is prescribed by regulation. Children and Young Persons (Care and Protection) Regulation 2012
Human rights, including children's rights	Children and Young Persons (Care and Protection) Act 1988 (NSW) Section 356 of the Children and Young People Act 2008 (ACT)
Police powers and responsibilities	Acts about police powers and responsibilities do not specify provisions for child protection. However, reports regarding child abuse and neglect can be made to the police.
Youth justice	Children and Young People Act 2008 (ACT)
Registration and reporting of child sexual abuse offenders	Crimes (Child Sex Offenders Act) 2005 (ACT) Crimes (Child Sex Offenders) Regulation 2005 Ombudsman Act 1989 (ACT) outlines the responsibilities of the Ombudsman to monitor compliance with the Crimes (Child Sex Offenders) Act 2005 (ACT)
Working with Children Check	Working with Vulnerable People (Background Checking) Act 2011 (ACT) Working with Vulnerable People (Background Checking) Regulation 2012

Family services and child care services	Children and Young People 2008 (ACT)
	Children and Young people (ACT Childcare Services) Standards 2009 (No 1)
	Children and Young People (ACT Out of Home Care) Standards 2016 (No 1)
	Children and Young People (Care and Protection Organisation) Standards 2018 (No 1)
Family and domestic violence	Family Violence Act 2016 (ACT)
	Family Violence Regulation 2017
Child employment and related services	Children and Young People Act 2008 (ACT)
	Children and Young People (Employment) Standards 2011 (No 1)
	Children and Young People Regulation 2009
Commissioner	Human Rights Act 2005 (ACT)
Criminal legislation	Crimes Act 1900 (ACT)
	Part 3 – Sexual offences
	Part 3A Intimate image abuse (s72D) Distribution of intimate image of young person under the age of 16)
	Part 5 Sexual Servitude (s82) less than 18 years
	66AA Failure to report child sexual offence
	*Criminal Law reporting duty

Part 3 Sexual Offences - Crimes Act 1900 ACT (Jurisdiction: ACT)

Relevant Legislation	Section	Offence	Age of Victim
Crimes Act 1900	55(1)	Sexual intercourse with young person	Under 10
Crimes Act 1900	55(2)	Sexual intercourse with young person	Under 16
Crimes Act 1900	56	Persistent sexual abuse of child or young person under special care	Child – under 16 Young person - at least 16 but not yet an adult
Crimes Act 1900	56(2)	Engages in a relationship with a child, or a young person under the special care of the adult, that involves more than 1 sexual act. * Relationship under 56(2)(a) means a "relationship" includes repeated contact, interaction, engagement or association, of a sexual nature or otherwise	Child – under 16 Young person - at least 16 but not yet an adult
Crimes Act 1900	61(1)	Acts of indecency with young people	Under 10
Crimes Act 1900	61(2)	Acts of indecency with young people	Under 16
Crimes Act 1900	62(1)	Incest	Under 10
Crimes Act 1900	62(2)	Incest	Under 16
Crimes Act 1900	64	Using child for production of child exploitation material etc	Under 12 Over 12
Crimes Act 1900	64A	64A Trading in child exploitation material	Under 12 Over 12
Crimes Act 1900	65	Possessing child exploitation material	Under 12 Over 12

Relevant Legislation	Section	Offence	Age of Victim
Crimes Act 1900	66	Grooming and depraving young people	Child under 10 Young person between 10 and under 16
Crimes Act 1900	66AA	Failure to report child sexual offence	Under 12
Crimes Act 1900	66AB	Making false report about child sexual offence	
Crimes Act 1900	66A	Failure by person in authority to protect child or young person from sexual offence	Child under 12 Young person under 16

New South Wales

Relevant Act to Child Protection	Children and Young Persons (care and Protection) Act 1988 (NSW) Children and Young Persons (Care and Protection) Regulation 2012 Sections 23 and 27 of the Children and Young Persons (Care and Protection) Act 1998 (NSW)
Who is mandated to report?	A person who, in the course of his or her professional work, or other paid employment, delivers healthcare, welfare, education, children's services, residential services or law enforcement, wholly or partly, to children. A person who holds a management position in an organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of healthcare, welfare, education, children's services, residential services or law enforcement, wholly or partly, to children. A person in religious ministry, or a person providing religion-based activities to children. A registered psychologist providing a professional service as a psychologist. Note: Children's services means either or both of the following (subject to the regulations): (a) an education and care service within the meaning of the Children (Education and Care Services) National Law (NSW); (b) a State regulated education and care service within the meaning of the Children (Education and Care Services) Supplementary Provisions Act 2011
Human rights, including children's rights	Anti-Discrimination Act 1977 (NSW) Children (Criminal Proceedings) Act 1987 (NSW)
Police powers and responsibilities	Law Enforcement (Powers and Responsibilities) Act 2002 (NSW) relates to child protection in relation to the following sexual offences against children: (i) s47 (1) Police may apply for search warrants if they believe on reasonable grounds that there is a "searchable offence" at the premises including child abuse material offences listed under the Crimes Act 1900 (NSW) (ii) s47(2) Police may apply for search warrants if they believe on reasonable grounds that that a "Child prostitution offence" has recently been committed at the premises or will be committed at the premises within 72 hours at the premises. Child prostitution offences listed under the Crimes Act 1900 (NSW)
Youth justice	Young Offenders Act 1997 (NSW) Young Offenders Regulation 2016

Registration and reporting of child sexual abuse offenders	Child Protection (Offenders Registration) Act 2000 (NSW) Child Protection (Offenders Prohibition Orders) Act 2004 (NSW) Child Protection (Offenders Prohibition Orders) Regulation 2018
Working with Children Check	Child Protection (Working with Children) Act 2012 (NSW) Child Protection (Working with Children) Regulation 2013
Family services and child care services	Children and Young Persons (care and Protection) Act 1988 (NSW) Children and Young Persons (Care and Protection) Regulation 2012
Family and domestic violence	Crimes (Domestic and Personal Violence) Act 2007 (NSW) Crimes (Domestic and Personal Violence) Regulation 2009
Child employment and related services	Industrial Relations (Child Employment) Act 2006 (NSW) Children and Young Person (Care and Protection) (Child Employment) Regulation 2015
Guardians and Advocates	Advocate for Children and Young People Act 2014 (NSW) Children's Guardian Act 2019 (NSW) Ombudsman Act 1974 (NSW)
Criminal legislation	Crimes Act 1900 (NSW) S 43B – failure to reduce or remove the risk of a child falling victim to child abuse Part 3, Division 10 – sexual offences against children Part 3, Division 15 – child prostitution and child abuse materials (Division 15A) S 93AC – child forced marriage S316A – concealing a child abuse offence *Criminal Law reporting duty

Part 3 Sexual Offences Against Children (Jurisdiction: NSW)

Relevant Legislation	Section	Offence	Age of Victim
Crimes Act 1900	66DA	Sexual Touching-child under 10 * Aggravated indecent assault (s 61M(2)) – old offence	Under 10
Crimes Act 1900	66DB	Sexual Touching- Child between 10 and 16 (s 66DB)	10-16
Crimes Act 1900	66DC	Aggravated Act of Indecency (s 61O(1)) Sexual Act- Child between 10 and 16 years * Aggravated Act of Indecency (s 61O(1) -old offence	10-16
Crimes Act 1900	66DE	Aggravated sexual act- Child between 10 and 16 years (s 66DE) *Aggravated Act of Indecency (s 61O(1) – old offence	10-16
Crimes Act 1900	s 6DF	Sexual act for production of child abuse material- child under 16 * Aggravated Act of Indecency (s 61O(2A) – old offence	Under 16
Crimes Act 1900	73A	Sexual touching- young person between 16 and 18 under special care.	16-18
Crimes Act 1900	66EB	Procuring or grooming a child under 16 for unlawful sexual activity	Under 16
Crimes Act 1900	66EC	Grooming a person for unlawful sexual activity with a child under the person's authority (s 66EC)	Under 18
Crimes Act 1900	43B	Failure to reduce/remove risk of child abuse (s 43B)	Under 18
Crimes Act 1900	316A	Concealing Child Abuse * Conduct previously prohibited by Conceal Serious Indictable offence, section 316	Under 18
Crimes Act 1900	316A(4)	Accepting a Benefit for Concealing Child Abuse *Conduct previously prohibited by Conceal Serious Indictable offence, section 316	Under 18

Northern Territory

Relevant Act to Child Protection	Care and Protection of Children Act 2007 (NT) Care and Protection of Children (Placement Arrangement Arrangement) Regulations 2010 Sections 15, 16 and 26 of the Care and Protection of Children Act 2007 (NT) Section 26(2) of the Care and Protection of Children Act 2007 (NT)
Who is mandated to report?	A health practitioner or someone who performs work of a kind that is prescribed by regulation.
Human rights, including children's rights	Anti-Discrimination Act 1992 (NT)
Police powers and responsibilities	Care and Protection of Children Act 2007 (NT) Part 2.1, Division 3, s28 when a police officer receives a report Part 2.1 Division 4, s33 and s 36 – police powers to inquire or investigate concerns about a child's wellbeing
Youth justice	Youth Justice Act 2005 (NT) Youth Justice Regulations 2006 Criminal Code Act 1983 (NT) Part IIAA, Division 3, Subdivision 1: Lack of capacity of children
Registration and reporting of child sexual abuse offenders	Care and Protection of Children Act 2007 (NT) Child Protection (Offender Reporting and Registration) Regulations 2005
Working with Children Check	Care and Protection of Children Act 2007 (NT) Care and Protection of Children (Screening) Regulations 2010
Family services and child care services	Care and Protection of Children Act 2007 (NT) Care and Protection of Children (Placement Arrangement) Regulations 2010
Family and domestic violence	Domestic and Family Violence Act 2007 (NT) Domestic and Family Violence Regulations 2008 Personal Violence Restraining Orders Act 2016 (NT)
Child employment and related services	Care and Protection of Children Act 2007 (NT) pertaining to child employment

Commissioner	Children's Commissioner Act 2013 (NT)
	Information Act 2002 (NT)
	Care and Protection of Children Act 2007 (NT)
	Care and Protection of Children (Mediation Conferences) Regulations 2010 (NT)
Criminal legislation	Criminal Code Act 1983 (NT)
	Part V, Division2, Subdivision 1: child abuse material and indecent articles
	S127 – sexual intercourse of gross indecency involving a child under 16 years
	S128 – Sexual intercourse or gross indecency involving a child over 16 years under special care
	S131 – Attempts to procure a child under 16 years
	S131A – Sexual relationship with a child
	S132 – Indecent dealing with a child under 16 years
	S 148F – Recruiting a child to engage in criminal activity
	S149 - Duty of person in charge of child or others
	s 201 – Abduction, enticement or detention of a child under 16 years for immoral purpose
	s202D – Deceptive recruitment of a child for sexual services

Queensland

Relevant Act to Child Protection	Child Protection Act 1999 (QLD) Part 1AA, section 13F of the Child Protection Act 1999 (Qld).
Who is mandated to report?	An authorised officer, a public service employee employed in the department, a person employed in a departmental care service or licensed care service Part 1AA, section 13E of the Child Protection Act 1999 (Qld). Doctors; registered nurses; teachers; a police officer who, under a direction given by the commissioner of the police service under the Police Service Administration Act 1990, is responsible for reporting under this section; a person engaged to perform a child advocate function under the Public Guardian Act 2014; early childhood education and care professionals. Sections 364, 365, 365A, 366, 366A of the Education (General Provisions) Act 2006 (Qld) School Staff Child Protection Regulation 2011
Human rights, including children's rights	Human Rights Act 2019 (QLD)
Police powers and responsibilities	Police Powers and Responsibilities Act 2000 (QLD)
Youth justice	Youth Justice Act 1992 (QLD) Youth Justice Regulation 2016
Registration and reporting of child sexual abuse offenders	Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004 (QLD) Child Protection (Offender Reporting and Offender Prohibition Order) Regulation 2015
Working with Children Check	Working with Children (Risk Management and Screening) Act 2000 (QLD) Working with Children (Risk management and Screening) Regulation 2020

Family services and child care services	Child Protection Act 1999 (QLD) S 122 – The Chief Executive must take reasonable steps to ensure children placed in care are cared for in a way that meets the 'statement of standards' listed in this section. Part 6 – obligations and rights under child protection orders and care arrangements Child Protection Regulation 2011 Disability Services Act 2006 (QLD) Public Health Act 2005 (QLD) Public Health Regulation 2018
Family and domestic violence	Domestic and family Violence Protection Act 2012 (QLD) Domestic and Family Violence Protection Regulation 2012
Child employment and related services	Child Employment Act 2006 (QLD) Child Employment Regulation 2016
Guardians and Advocates	Public Guardian Act 2014 (QLD) Guardianship and Administration Act 2000 (QLD) Family and Child Commission Act 2014 (QLD) Family Responsibilities Commission Act 2008 (QLD) Director of Child Protection Litigation Act 2016 (QLD) Ombudsman Act 2001 (QLD)
Criminal legislation	Criminal Code Act 1899 (QLD): Part 4, Chapter 22 includes provisions around child sexual offences including child exploitation and failure to protect from child sexual offences. S 286 – Duty of persons who has care of child S 229BC it is a criminal offence when any adult in Queensland, including students who are 18 years or older, fails to report to the Queensland Police Service (Police) a reasonable belief that a child sexual offence is being, or has been, committed against a child by another adult.

South Australia

Relevant Act to Child Protection	Children and Young People (Safety) Act 2017 (SA) Children and Young People (Safety)Regulations 2017 Sections 17, 18, 30 and 31 of the Children and Young People (Safety) Act 2017 (SA)
Who is mandated to report?	Medical practitioners; pharmacists; registered or enrolled nurses; dentists; psychologists; police officers; community corrections officers under the Correctional Services Act 1982; social workers; ministers of religion; employees of, or volunteers in, an organisation formed for religious or spiritual purposes; teachers employed as such in a school (within the meaning of the Education and Early Childhood Services (Registration and Standards) Act 2011) or a preschool or kindergarten; employees of, or volunteers in, an organisation that provides health, welfare, education, sporting or recreational, child care or residential services wholly or partly for children and young people, being a person who – (i) provides such services directly to children and young people; or (ii) holds a management position in the organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of those services to children and young people.
Human rights, including children's rights	Equal Opportunity Act 1984 (SA) Disability Inclusion Act 2018 (SA)
Police powers and responsibilities	SA police powers and responsibilities do not specify provisions for child protection. The Children and Young People (Safety) Act 2017 (SA) deals with: Chapter 5, part 1 – reporting of suspicion that child or young people at risk. Police officers have mandatory reporting obligations under this act (ss30(3)(b), 31).
Youth justice	Young Offenders Act 1993 (SA) Young Offenders regulations 2008 Youth Justice Administration Act 2016 (SA) Youth Justice Administration Regulations 2016
Registration and reporting of child sexual abuse offenders	Child Sex Offenders Registration Act 2006 (SA) Child Sex Offenders Registration Regulations 2007

Working with Children Check	Child Safety (Prohibited Persons) Act 2016 (SA)
	Child Safety (Prohibited Persons) Regulations 2019
	Children and Young People (Safety) Act 2017 SA
	Children and Young People (Safety) Regulations
Family services and child care services	Family and Community Services Act 1972 (SA)
	Family and Community Services Regulations 2009
	Children and Young People (Safety) Act 2017 (SA)
	Children and Young People (Safety) Regulations 2017
	Education and Children's Services Act 2019 (SA)
	Education and Children's Services regulations 2020
Family and domestic violence	Intervention Orders (Prevention of Abuse) Act 2009 (SA)
Child employment and related services	Education and Children's Services Act 2019 (SA) – s74
Guardians and Advocates	Children and Young People (Oversight and Advocacy Bodies) Act 2016 (SA)
	Children and Young People (Oversight and Advocacy Bodies) Regulations 2017
	Child Protection Review (Powers and Immunities) Act 2002 (SA)
	Health and Community Services Complaints Act 2004 (SA) s28A – child protection complaints are to be dealt with under the Ombudsman Act 1972 (SA)
Criminal legislation	Criminal Law Consolidation Act 1935 (SA):
	S 50 – unlawful sexual relationship with a child
	Part 3, Division 11A – child exploitation material and related offences
	S68 – Use of children in commercial sexual services
	Part 5, Division 5A – Dishonest communication with children

Tasmania

Relevant Act to Child Protection	Children, Young Persons and their Families Act 1997 (Tas) Sections 3, 4 and 14 of the Children, Young Persons and Their Families Act 1997 (Tas.)
Who is mandated to report?	Medical practitioners; registered or enrolled nurses; persons registered under the Health Practitioner Regulation National Law (Tasmania) in the midwifery, dental (dentists, dental therapist, dental hygienist or oral health therapist) or psychology professions; police officers; probation officers; principals and teachers in any educational institution including kindergartens; persons who provide child care or a child care service for fee or reward; persons concerned in the management of an approved education and care service, within the meaning of the Education and Care Services National Law (Tasmania) or a child care service licensed under the Child Care Act 2001; a member of the clergy of any church or religious denomination; a member of the Parliament of this State; any other person who is employed or engaged as an employee for, of, or in, or who is a volunteer in, a government agency that provides health, welfare, education, child care or residential services wholly or partly for children, and an organisation that receives any funding from the Crown for the provision of such services; and any other person of a class determined by the Minister by notice in the Gazette to be prescribed persons.
Human rights, including children's rights	Anti-Discrimination Act 1998 (Tas)
Police powers and responsibilities	Police Offences Act 1935 (Tas). S 7A specifies offences relate to loitering around children
Youth justice	Youth Justice Act 1997 (Tas) Youth Justice Regulations 2019
Registration and reporting of child sexual abuse offenders	Community Protection (offender Reporting) Act 2005 (Tas) Community Protection (Offender reporting) regulations 2016
Working with Children Check	Registration to work with vulnerable People Act 2013 (Tas) Registration to work with vulnerable People Regulations 2014
Family services and child care services	Children, Young Persons and their Families Act 1997 (Tas) Child Care Act 2001 (Tas)

Family and domestic violence	Family Violence Act 2004 (Tas) Domestic Violence Orders (National Recognition) Act 2016 (Tas) Community Protection (Offender Reporting) Regulations 2016
Child employment and related services	Children, Young Persons and the Families Act 1997 (TAS)
Commissioner	Commissioner for the Children and Young People Act 2016 (Tas)
Criminal legislation	Criminal Code Act 1924 (Tas): S105A – failing to report the abuse of a child Chapter XIV – sexual crimes against children and offences related to child exploitation material Chapter XX – Rape, abduction, stalking and bullying Ss 336 and 337B – child sexual abuse S 337C – Involving person under 18 in production of child exploitation material

Victoria

Relevant Act to Child Protection	Children, Youth and Families Act 2005 (Vic) Sections 182(1), 184 and 162(1)(c)–(d) of the Children, Youth and Families Act 2005 (Vic.)
Who is mandated to report?	Registered medical practitioners, nurses, midwives, a person registered as a teacher or an early childhood teacher under the Education and Training Reform Act 2006 or teachers granted permission to teach under that Act; principals of government or non-government schools within the meaning of the Education and Training Reform Act 2006; police officers, a person in religious ministry, out-of-home care workers (excluding voluntary foster and kinship carers), early childhood workers, youth justice workers and registered psychologists Children, Youth and Families Regulations 2017
Human rights, including children's rights	Charter of Human Rights and Responsibilities Act 2006 (Vic) Charter if Human Rights and Responsibilities (Public Authorities) Regulations 2013 Charter of Human Rights and Responsibilities (General) regulations 2017 Equal Opportunity Act 2010 (Vic)
Police powers and responsibilities	Victoria Police Act 2013 does not specify provisions related to child protection against sexual abuse. Reports of child abuse can be made to the Police Sexual Offences and Child Abuse Investigation Teams. Police have mandatory reporting obligations under sections 182(1) and 184 of the Children, youth and Families Act 2005 (Vic).
Youth justice	Children, Youth and Families Act 2005 (Vic)
Registration and reporting of child sexual abuse offenders	Sex Offenders Registration Act 2004 (Vic) Sex Offenders Registration Regulations 2014
Working with Children Check	Worker Screening Act 2020 (Vic) Worker Screening Regulations 2021
Family services and child care services	Children, Youth and Families Act 2005 (Vic)
Family and domestic violence	Family Violence Protection Act 2008 (Vic)
Child employment and related services	Child Employment Act 2003 (Vic) Child Employment Regulations 2014

Commissioner	Commissioner for Children and Young People Act 2012 (Vic)
Criminal legislation	Crimes Act 1958 (Vic): Part 1 Division 1 (8B) – Sexual offences against children Part 1 Division 1 (8D) – child abuse material Part 1 Division 1 (9) – Child stealing Part 1, Division 11A- Recruiting a child to engage in criminal activity S 327 - Failure to disclose sexual offence committed against child under the age of 16 years.

Western Australia

Relevant Act to Child Protection	Children and Community Services Act 2004 (WA) Sections 124A and 124B of the Children and Community Services Act 2004 (WA)
Who is mandated to report?	Who is mandated to report? Doctors; nurses and midwives; teachers and boarding supervisors; and police officers. Sections 5 and 160 of the Family Court Act 1997 (WA) The Principal Registrar, a registrar or a deputy registrar; family counsellors; family consultants; family dispute resolution practitioners, arbitrators or legal practitioners independently representing the child's interest. Children and Community Services Regulations 2006
Human rights, including children's rights	Equal Opportunity Act 1984 (WA) Equal Opportunity regulations 1986
Police powers and responsibilities	Police have a mandatory duty to report sexual abuse of children under s 1224B(q1) of the Children and Community Services Act 2004 (WA)
Youth justice	Young Offenders Act 1994 (WA) Young Offenders Regulations 1995
Registration and reporting of child sexual abuse offenders	Community Protection (Offender Reporting) Regulations 2004
Working with Children Check	Working with Children (Criminal Record Checking) Act 2004 (WA) Working with Children (Criminal Record Checking) Regulations 2005
Family services and child care services	Children and Community Services Act 2004 (WA) Childcare Services Act 2007 (WA)
Family and domestic violence	Restraining Orders Act 1997 (WA) Family Court Act 1997 (WA) Domestic Violence Orders (National recognition) 2017 (WA)
Child employment and related services	Children and Community Services Act 2004 (WA)
Commissioner	Commissioner for Children and Young People Act 2006 (WA)

Criminal legislation

Criminal Code Act Compilation Act 1913 (WA) includes provisions around sexual offences against children:

Part IV, Chapter XXII – sexual offences with children outside of WA and offences related to exposing children to offensive material or indecent matter

Chapter XXV – child exploitation material

Chapter XXXI – sexual offences against children

S55K – child sex offenders

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DEFINITIONS AND KEY TERMS

Active discrimination	Additive (or multiple) discrimination is when a person suffers discrimination on the same occasion but on two grounds, for example a gay woman is harassed because she is a woman and gay. This type of discrimination is additive because each of the grounds can be identified independently.
Adverse childhood experiences	'Adverse Childhood Experiences' (ACEs) is a term used to describe very stressful events or circumstances that children may experience during their childhood, and which can have serious impacts on later life development of chronic diseases, mental health issues and problematic social functioning.
Child sexual abuse	Child sexual abuse is any interaction between a child and an adult (or another child) in which the child is used for the sexual gratification of the perpetrator or an observer. Sexual abuse can include both touching and non-touching behaviours. Non-touching behaviours can include voyeurism (trying to look at a child's naked body), exhibitionism or exposing the child to pornography. Children of all ages, races, ethnicities and economic backgrounds may experience sexual abuse.
Duty-bearers	Duty-bearers are entities or individuals having a particular obligation or responsibility to respect, promote and realise human rights and to abstain from human rights violations.
Harmful and problematic sexual behaviours	Sexual behaviours expressed by children and young people under the age of 18 years that are developmentally inappropriate, may be harmful to self or others, or may be abusive to another child, young person or adult.
Healthcare provider	An individual (e.g., doctor, nurse, psychologist) or organisation (e.g., hospital, clinic) trained and knowledgeable in providing preventive, curative, or rehabilitative healthcare services, as well as healthcare information, in a systematic way.
Intersectionality	A theoretical framework for understanding how aspects of one's social identities (e.g., gender, sexuality, religion, culture, social class) interact to create unique modes of discrimination and disadvantage.
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and queer/questioning. This and other terms (such as LGBT) are used to refer to anyone who is non-heterosexual, non-cisgender and/or non-gender binary. The + denotes the many different self-identifiers adopted by individuals within these populations.
Victim-survivor	This term is used to reflect the process of victimisation and work survivors do to rebuild their lives after abuse has occurred.

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