Royal Commission into Institutional Responses to Child Sexual Abuse

ISSUES PAPER 4:

PREVENTING THE SEXUAL ABUSE OF CHILDREN IN OUT-OF-HOME-CARE

Submission by Anglicare Victoria

November 2013

INTRODUCTION

Anglicare Victoria was formed through an act of Parliament - the Anglican Welfare Agency Act 1997 - which joined together three of Victoria's long established Anglican child and family welfare agencies: the Mission of St. James and St. John, St. John's Homes for Boys and Girls and the Mission to the Streets and Lanes.

Combined, these three former agencies had over 260 years experience in providing care and support services to Victorians.

Today, Anglicare Victoria is a leading social services organisation, with a total expenditure of over $60 million. The majority of this expenditure is on Department of Human Services (DHS) funded out-of-home care services and family services. During any given week, Anglicare Victoria works with around 1000 families within our family services, and supports close to 220 foster care placements and 164 residential care and unaccompanied minor placements. The agency also provides a great many other community programs, many of which are funded from the agency's own resources. These include counselling and targeted therapeutic services, crisis accommodation, financial counselling and emergency aid.

To accomplish this significant work to the high standard that the agency has set for itself, Anglicare Victoria employs a staff of 1000 professionals - including social workers, psychologists and other community and welfare professionals - and works with approximately 1200 volunteers. Staff are managed through a corporate governance structure incorporating a Board, Anglicare Victoria Council, CEO, executive staff group and a hierarchy of highly experienced and qualified regional managers, program managers and team leaders. All staff and volunteers across the organisation operate within a well-developed architecture of policies, procedures and accountability mechanisms, including internal and external auditing. These policies and procedures are structured in accordance with relevant legislation, as well as professional and funding guidelines.

As one of Victoria's largest providers of OOHC services, Anglicare Victoria has responsibility for the safety and wellbeing of many of our nation's most vulnerable children and young people. Our organisation has a strong, imbedded commitment to the prevention of sexual abuse in OOHC, underpinned by a firmly held belief that all children and young people have the right to experience safety, stability, security and wellbeing.

Child sexual abuse is unequivocally wrong. It constitutes a grave betrayal of trust, and a failure to fulfil the responsibilities we all have to nurture and protect children and young people, whether in family, community or organisational settings

Anglicare Victoria welcomes the opportunity to provide the following submission to Issues Paper Four to the Royal Commission on Institutional Sexual Abuse. We hope that the experiences, practices and views expressed herein can be of benefit to the Commission's examination of how the safety of children can be upheld in OOHC.

1. An essential element of OOHC is for a child to be safe and secure. Are there core strategies to keeping children in OOHC safe from sexual abuse and what is the evidence that supports them?

It is widely acknowledged across international and Australian research and policy that responsibility for the wellbeing, safety and security of children must be shared across individuals, families, communities, organisations and government (The Allen Consulting Group, 2008; Victorian Government 2012; Beyer, Higgins, Bromfield 2005). This is a preventative or 'systems' approach to child welfare and wellbeing, aimed at developing more resilient, connected and healthy communities through the increased availability of universal and targeted services and support. This approach seeks to strengthen the capacity of families and mitigate disadvantage, and create safer environments for children.

The 2012-2022 Victorian Government strategy 'Victoria's Vulnerable Children: Our Shared Responsibility' acknowledges the need to make this shift away from statutory interventions towards a more preventative, universal approach. The strategy aspires to keep 'vulnerable children safe from harm' and to provide children 'with every opportunity to succeed in life'. The strategy identifies three interconnected strategic goals:

- Prevent abuse and neglect
- Act earlier when children are vulnerable
- Improve outcomes for children in statutory care

Whilst greater long-term investment and focus on preventative interventions is rightly a priority for government, it is imperative that statutory child protection systems and community-based OOHC services are not weakened to enable such change. It is critical that tertiary care systems provide robust, evidence-based, well-regulated and appropriately-funded services to children, young people and families, and that any shift towards early intervention is conducted collaboratively and carefully across government, community, education and the broader health sectors. A focus on early intervention must not in any way diminish the quality of care and protection available to the children and young people in our communities who have already experienced neglect and abuse.

Anglicare Victoria's own research and organisational experience also tell us that the life chances for children/young people in OOHC are far lower than those within the general community (Wise et al, 2010). It also well established that children/young people who have experienced neglect and abuse in the past are more vulnerable to further abuse in the future. Workers within our agency's many community and OOHC programs are witness to this reality everyday. As an agency, we are committed to stemming this disadvantage by not only supporting safe, stable and secure OOHC placements for children/young people, but by providing holistic, client–centred interventions that support the overall wellbeing of the children/young people in our agency's care, together with their families.

The following key strategies are informed by the agency's own practice experiences and organisational knowledge, and draw upon the wider evidence-base regarding the ways in which organisations can best foster safe OOHC environments for children, reduce the potential for sexual abuse, and respond to incidents and allegations of abuse in manner that is sensitive, respectful, appropriate and timely.

1.1 Key messages from the research

From the substantial body of international and Australian research (Beyer, Higgins, Bromfield, 2005) emerge a number of key messages pertinent to this submission. These represent significant challenges to all community-based organisations providing OOHC.

- Perpetrators of sexual abuse often have no past criminal convictions (Wortley & Smallbone, 2006);
- Perpetrators of sexual abuse may have highly developed social skills, making grooming behaviours more difficult to detect (Wortley & Smallbone, 2006; Child Wise 2009). Those who know them often describe sexual predators as being particularly charming and caring. Potential perpetrators may also seek to develop emotional relationships with their victims (Wortley & Smallbone, 2000);
- The vast majority of known perpetrators of child sexual abuse are male, and the majority of victims female (Pritchard, 2004). Sexual abuse is far more likely to occur within families than outside of families, such as in organisations (Wortley & Smallbone, 2006);
- Abuse is more likely to be perpetrated by individuals that a child/young person has known for an extended period of time, and with whom they have a trusting relationship or strong attachment (Beyer, Higgins, Bromfield, 2005);
- Sexual abuse is also committed by children and young people, together with the demonstration of inappropriately sexualised behaviours. This is evidenced in Anglicare Victoria's own critical incident data;
- Where some perpetrators may involve themselves in organisations for the express purpose of abusing children[1], others may only engage in abusive behaviours should they be presented with sufficient opportunity (Wortley & Smallbone, 2006);
- Perpetrators may be more likely to target particularly vulnerable children, such as those who have experienced past abuse, trauma, neglect or adversity; experiences common to children/young people in statutory care (Conte, Wolfe & Smith 1989);
- Criminologists estimate that only half of those who experience child sexual abuse are likely to report it to a third party (Wortley & Smallbone, 2006);
- Grooming behaviours may extend beyond the child to involve members of the child's family and broader networks, which in turn minimises the potential for a perpetrator's actions being discovered. Grooming typically occurs slowly, over time, and can include seemingly innocent behaviours at first (such as hugging, tickling, gift-giving and creating opportunities for time alone with a child) that are difficult to assess and monitor (Irenyi, Bromfield, Beyer & Higgins, 2006; Child Wise, 2005).

[1] In one study involving 205 offenders in Melbourne, 39% of perpetrators studied had accessed children through participation in an organisation (Petraitis & O'Connor, 1999). Another Australian study of convicted child sex offenders found that 18.9% accessed their victims in organisational contexts, such as sports clubs and scouts (Smallbone & Wortley, 2001).

1.2 Screening, assessment and monitoring

The screening and assessment of all potential staff, carers and other volunteers seeking to work within community services agencies is a key and necessary practice – and one that is undertaken systematically across all Anglicare Victoria services and programs.

Consistent with DHS guidelines and Victorian legislation, all Anglicare Victoria staff, carers and volunteers must undergo a national police check, and obtain (and maintain) a valid Victorian Working With Children's Check (WWCC) before contact with any child or young person through an Anglicare Victoria program can proceed. Individuals seeking to become foster carers must also become registered with the Victorian Department of Human Services' (DHS) (consistent with the Department's guidelines), and can have their registration removed should quality of care concerns be raised against them and substantiated. The 'overseeing' role of the DHS is important, as it ensures an added layer of accountability and the ability for a centralised point of registration across the state should carers move across organisations.

Whilst it is clear that criminal history checks and WWCCs are an important and necessary means of statutory and community service agencies screening potential staff, carers and volunteers, the effectiveness of such mechanisms is limited to information that is 'on record' (i.e. past criminal offences) and to that which is available within state jurisdictions (i.e. state-based professional disciplinary findings). Given that most sexual perpetrators are unlikely to have past criminal convictions, these checks do not in anyway replace the need for other forms of ongoing screening, assessment and monitoring within organisations, or diminish an agency's responsibility to institute practices at multiple program levels to prevent the likelihood of sexual abuse being perpetrated against the children/young people in their care. In fact, an overreliance on such screening practices may have the potential to *increase* the risk of sexual abuse against children should their use reduce other forms of prevention instituted by organisations as part of their duty of care.

The responsibility for screening, assessment and monitoring lies at all levels of an organisation, and is a continual process (Beyer, Higgins & Bromfield, 2005). Screening and assessment practices must be informed by robust organisational policies, frameworks and procedures, and all staff and volunteers (frontline and management) must be trained and supported to integrate them routinely and knowledgably into their practice (Wortley & Smallbone, 2006). Such policies, frameworks and procedures extend to:

- Systematic employee screening - including three reference checks, police checks, WWCCs, three-month probation periods, shadowing of new staff;
- Regular (fortnightly) staff supervision;
- Ongoing employee training (see response to **Question 6**);
- Opportunities for regular client (child/young person/carer) feedback;
- Systematic carer/volunteer screening – including police checks, WWCCs and inter-agency assessments;
- Obligatory carer training (see response to **Question 6**);
- Police checks and WWCCs for all adults that a child may regularly encounter in a carer's home;
- Critical incident reporting – including training, clear lines of reporting and delegation of responsibilities, appropriate infrastructure and adherence to DHS guidelines.

With respect to carers specifically, screening and assessment must commence from the point of initial contact with the OOHC system. Carer assessments must consider issues such as an individual's motivation, expectations, personality/temperament, flexibility, compassion, resilience, and should be undertaken *over time and in multiple contexts*. This should include assessments in the potential carer's home together with office/community settings, and should extend to how a potential carer participates, comprehends and behaves in group settings, such as carer training and information sessions. A potential carer's openness or resistance to the organisation's guidelines and practices must also be considered.

The value of worker professional judgement and 'intuition' have also been identified by staff in our OOHC programs. This is supported by Child Wise's (2009) sexual abuse prevention training 'Choose with Care', which acknowledges that a worker's 'gut instincts' may act as valuable 'red flags' or 'warning signs'. Whilst such 'red flags' should by no means be interpreted or utilised as *evidence* of potential abuse, they may highlight the need for closer assessment or monitoring in a particular area. Providing space for workers to discuss and examine such responses through regular supervision is important, as is the practice of joint visits and collaborative assessments involving more than one practitioner.

1.3 Reducing the opportunity for sexual abuse and maltreatment

Like all community service organisations that provide statutory care to children/young people, Anglicare Victoria has the potential to be targeted by individuals who either have the intention to abuse children, or possess the potential to abuse children should they be given sufficient opportunity. The vulnerability of OOHC programs is made greater by the following factors:

- Contact with children/young people in OOHC typically occurs in private locations such as family homes, residential care settings and cars. Such locations aim to recreate normalised rather than institutional settings, and do not easily enable monitoring by third parties or 'natural surveillance' to occur (Irenyi, Bromfield, Beyer & Higgins, 2006);
- Children/young people in OOHC may be particularly vulnerable to sexual abuse due to their past experiences of adversity (Conte, Wolfe & Smith 1989);
- Within OOHC programs (particularly residential care) there is a risk of psychosocially unwell young people (who may have been abused themselves, have poor impulse control or inappropriately sexualised behaviours) perpetrating abuse against other children/young people with whom they are placed (Forde, 1999).

In recognition of these risks, Anglicare Victoria has adopted a series of agency-wide supervision, education and accountability procedures that operate to maximise the safety of children/young people by minimising the situations in which abuse can occur. These are outlined accordingly.

1.3.1 Regular contact with children/young people and carers

Researchers contend that frequent contact between case managers, carers and children/young people (including active monitoring) can minimise the potential for sexual abuse and its severity within organisations (Leclerc, Smallbone & Wortley 2013; Reynald 2010). A recent study by Leclerc, Smallbone and Wortley (2013) involving 208 interviews with known offenders in a prison setting, identified that the presence of 'a guardian' or 'extended guardianship' in a child's life (such as a parent, carer or case manager) had reduced the severity of sexual abuse perpetrated. The researchers contend that guardianship may also have significant deterrent and protective effects as well. Such extended guardianship can be fostered within organisations in a number of ways, namely through regular engagement with children/young people and carers, by empowering all carers and staff to be responsive to any care concerns they may have, and by developing a child-focused culture across all organisational levels, from governance through to direct service delivery.

The importance of frequent client contact is widely supported across all Anglicare Victoria's OOHC programs, and is conducted in accordance with the DHS Minimum Standards and Outcome Objectives for Home Based Care Services in Victoria, as well as the CSO Registration Standards Performance Criteria. Regular contact can enable closer monitoring and observation of carer behaviour and attitudes (i.e. identification of potential grooming behaviours by carers), and can provide opportunities to informally educate carers on how to recognise inappropriate grooming behaviours in others.

Regular face-to-face contact with children/young people *without carers present* is also important (Child Wise, 2009; Wortley & Smallbone, 2006). Such engagement may enable case managers to gauge how a child/young person is responding to their placement, and can provide opportunities for strengthened therapeutic rapport and trust that may in turn increase the likelihood of a child/young person reporting sexual abuse (or other concerning behaviours) to their case manager should it occur. Such contact may also provide opportunities for case managers to identify worrying changes in a child/young person's behaviour or wellbeing. Given the sensitivity of such interventions, the provision of suitable training is imperative (i.e. training on 'grooming' or how to work with vulnerable children), as is the employment of suitably qualified and experienced staff.

1.3.2 Situational prevention strategies

Organisational environments and infrastructure (and the policies and procedures that shape them) can play a large part in the prevention of sexual abuse in OOHC. This is a situational or environmental approach to prevention - the value of which is established in the literature (Cornish & Clarke 2003; Beyer, Higgins & Bromfield, 2005).

Practices such as routine case manager engagement, together with clear communication of such practices to carers, can enable organisations to have a 'greater presence' within OOHC settings that may be otherwise difficult to monitor. Such practices heighten the potential of a perpetrator 'being caught', which may in turn deter potential perpetrators who seek to infiltrate organisations for the purpose of abusing children (Irenyi, Bromfield, Beyer & Higgins, 2006). As offenders will typically 'select targets that require the least effort', organisations that make offending behaviours more difficult to carry out through their

policies and practices are better placed to provide safe care environments for children (Wortley & Smallbone, 2006, p. 23).

Examples of situational prevention are evidenced in many ways across Anglicare Victoria's OOHC programs, and are informed by the DHS services standards for OOHC. Practices may include:

- Requiring staff members to keep doors open when entering a child/young person's bedroom;
- Children/young people must have their own bedrooms;
- Requiring all children/young people who have perpetrated past sexual abuse (or demonstrate inappropriately sexualised behaviours) to be monitored, separated from their peers if needed, and to have access to specialist therapeutic support and/or treatment. Such responses are intended to minimise the potential for further offending, support safe OOHC residential environments and promote the development of more appropriate sexual behaviours and boundaries in offenders;
- Requiring all incidents or allegations of sexually inappropriate/abusive behaviours perpetrated by either children/young people or staff to be immediately reported to DHS, escalated and managed via the appropriate channels. In most instances this should involve the immediate removal of a child/young person or staff member from the residential environment.

Similarly, within Anglicare Victoria's foster care programs, the homes of all carers are assessed, with particular attention to privacy and safety issues, such as the number of bedrooms in the home and the placement of bathrooms. Strict protocols also guide:

- *The placement of children in care* – i.e. the placement of children from different families with the one carer is largely avoided, and at a minimum, the sharing of bedrooms across families not permitted. The placement of children/young people with known sexualised behaviours (or past offending) also requires particular care - in such instances it is imperative that placements are not combined across families, that younger children are not placed with older children/young people, that carers are appropriately trained, and that case managers provide regular support and monitoring;
- *The behaviour of carers* - i.e. all children/young people must be afforded reasonable privacy, particularly when bathing (if age appropriate); carers must demonstrate respect for a child/young person's (age-appropriate) bodily autonomy by not engaging in inappropriate touch or other intimate behaviours, such as lying in the same bed as a child, bathing/dressing in the same room.

1.3.3 Supervision of staff

It is critical that organisations 'take responsibility for supervising the behaviour of employees and volunteers' and develop sensible protocols to govern interactions between staff members and children (Wortley & Smallbone, 2006, p. 26). As such, all staff working with children/young people in OOHC should be subject to regular fortnightly supervision conducted by experienced program managers or team leaders, and supervision should require staff to account for their practice, and encourage discussion of any signs of abuse or worrying behaviours that staff members themselves may encounter (Beyer, Higgins & Bromfield, 2006).

Program managers and team leaders should also undertake direct contact with children/young people and carers – both independent of, and in collaboration with case managers. This should be in-person or over the phone; regularly and irregularly. These practices have the potential to strengthen the rapport between management and clients, and in turn may increase the likelihood of a child/young person feeling sufficiently comfortable or safe to report an incident of sexual abuse or 'grooming' should it be perpetrated by a staff member or a carer. Such contact may also provide greater opportunities for managers to observe case manager engagement with clients, including any potentially inappropriate or concerning behaviours.

1.4 Strengthening resilience in children, empowerment and respecting their voices

Developing an organisational culture that respects the voices and capacity of children/young people, and seeks to strengthen their resilience, self-efficacy and psychological and emotional wellbeing is a further key prevention strategy (Smallbone, Marshall, & Wortley, 2008; Irenyi, Broomfield, Beyer & Higgins, 2006).

It is important that organisations are child-focused, and do not unintentionally dehumanise children/young people by viewing them primarily as 'clients'. Organisations should strive to develop the sense of agency within children/young people, particularly those in OOHC who, as a result of past experiences of adversity and trauma may leave them more vulnerable to grooming and abuse (Conte, Wolfe & Smith, 1989). Strengthening the confidence and assertiveness of children/young people in OOHC, together with their understanding of what constitutes acceptable behaviour (Bilchick, 1989) are important protective measures against potential abuse (Beyer, Higgins, Bromfield, 2005).

Given such findings, we contend that when *delivered holistically* age-appropriate sex education is a potential protective factor against sexual abuse. Sex education may help children/young people to better understand what constitutes appropriate and inappropriate physical contact (i.e. grooming); may uphold their right to reject unwanted and inappropriate physical advances[2], and may strengthen their capacity to disclose sexually abusive behaviours to others (Irenyi, Bromfield, Beyer & Higgins, 2006). As several researchers have identified, strengthening the ability for those connected with an organisation to feel empowered to make complaints and allegations is an important preventative factor with regard to child abuse (Bichard, 2004; Utting, 1991; Wardhaugh & Wilding, 1993).

By focusing on capacities and strengths, organisations can help strengthen the resilience of children/young people. This can be achieved through targeted support services (such as mental health treatment, counselling, peer support and help at school), and engagement in activities that contribute to their broader self-esteem, wellbeing and confidence (such as involvement in sport, music, clubs etc).

[2] Research conducted with child sex offenders by Smallbone & Wortley (2001) found that a child/young person's reaction to an abusive act may affect a perpetrator's subsequent behaviour; with assertively saying 'no' and 'demanding to be left alone' identified by offenders as potentially effective deterrent strategies. Children however cannot, and must not bear the burden of preventing their own sexual abuse.

Children/young people who feel more confident, in control, stable and supported, may in turn be more able to act upon, recognise and/or report situations that make them feel uncomfortable or unsafe. Towards this end, it is again imperative that case managers provide regular support to the children/young people in their care; model respectful adult-child relationships with appropriate boundaries, and strive to meaningfully involve clients as much as possible in the decisions that affect their own lives.

The value of a *resilience* focus that aims to strengthen the overall wellbeing of children/young people in care, whilst also encouraging protective behaviours, cannot be over-emphasised (Smallbone, Marshall, & Wortley, 2008). Given that Anglicare Victoria's own data shows that nearly half of all critical incidents pertaining to inappropriate or abusive sexual behaviours are experienced by children/young people *outside of OOHC settings*, the need for a child/young person-centred approach to prevention *that looks beyond the direct OOHC environment* is imperative. The value of a child-focussed resilience approach is similarly supported by criminologist Stephen Smallbone in his 2012 submission to the Queensland Child Protection Commission of Enquiry.

In addition to this, it is important that all children/young people in OOHC are informed of their rights to safety and security. At Anglicare Victoria this is achieved through a comprehensive induction process for all new staff, and through the direct dissemination of information to children/young people. For example, the 'Client Code of Behaviour' booklet provided to all children/young people in residential care setting outlines the following:

- Their right to live in a safe environment where their rights are respected;
- That they have the right to make complaints that will be treated seriously and investigated fairly;
- That no other young people in the unit are allowed in their room without their permission;
- That others in the house have the right not to feel or be threatened by another resident's behaviour.

Finally, it is commonly accepted that a predisposing factor in the abuse of children in organisational settings (particularly within religious settings) has been the power imbalance between worker (or priest) and child. This imbalance has many sources including: the perceived knowledge and leadership of the worker; a culture of reticence to discuss sexuality; a culture of secrecy among those in authority and a failure to acknowledge the rights of children. Anglicare Victoria works carefully to minimise these factors to enable children/young people in the agency's care to feel strong, be knowledgeable and assertive, and have their voices heard. We believe that these are central components of a child-focused organisational culture.

1.5 When children/young people are perpetrators of sexual abuse

As previously stated, children/young people have the potential to be both victims and perpetrators of sexual abuse. In residential care settings, inappropriate sexualised behaviours, sexual risk taking and sexual acts between consenting children/young people are also seen. Critical incidents reported within care settings also often relate to sexually abusive acts perpetrated against children/young people in the broader community, outside care settings themselves.

When sexual abuse or sexually inappropriate behaviours are perpetrated within OOHC settings by children/young people, organisations and protective services face considerable challenges. In terms of duty of care, there is a dual responsibility to 'victim' and 'perpetrator', and a need to consider the wellbeing, safety and support needs of both parties. Given the young age of some of the children perpetrating such abuse, and that incidents may relate to inappropriate sexualised behaviours in children that require specialist therapeutic interventions, the importance of supporting young perpetrators together with their victims is paramount.

Particular consideration should be given to the following:

- All children/young people who have been abused within OOHC must have access to specialist therapeutic support;
- All staff within residential care settings should receive training on 'Methods of working with children and young people demonstrating sexually abusive behaviours'. Some form of targeted training and support should also be available to carers;
- All children/young people demonstrating sexually abusive or age-inappropriate sexual behaviours should have access to targeted, therapeutic interventions, supported by their broader care teams (i.e. foster carers, case managers and/or residential care staff). The potential value of early intervention is identified by Wortley & Smallbone (2006), with therapeutic rehabilitation in justice settings associated with reduced rates of recidivism in young perpetrators;
- When a child/young person is moved from a placement following an act of sexual abuse, consideration must be given to where that child/young person is consequently placed, and the associated impact upon other children/young people. At a minimum, it is imperative that the new placement (staff/carers) be informed of the child/young person's past offending behaviours, that staff/carers are supported to provide suitable care (via training, supervision, resources, organisational policies and procedures), and that pro-active strategies are employed within the placement to reduce the potential for future abuse, and to support a safe OOHC environment for all children/young people. Such environmental prevention strategies (Cornish & Clarke 2003) may include close environmental monitoring, additional staffing, alarm systems, locks on doors, immediate responses to any concerning behaviours (including the police) and provision of education to all children/young people within the care setting (both in groups and one-on-one) about house rules, how to voice safety concerns and what constitutes appropriate and respectful behaviour towards others.
- In term of contingency placements, it is integral that long-term planning be undertaken to move children into more suitable forms of OOHC. Contingency placements are not only extremely resource intensive, but generally have a short-term focus. As such, they may ameliorate immediate risk by focussing on environmental prevention (i.e. separating the child/young person from other children/young people in care) but do not provide an imbedded, therapeutic response to enable rehabilitation, and a pathway back into normalised care over the long term. Given that these children/young people will eventually leave statutory care (and will no longer be subject to supervision and monitoring), the implications are considerable for both care leavers and the safety of the wider community. To

minimise the risk of recidivism into adulthood (and entry into the adult criminal justice system), statutory services must do more to help young perpetrators *earlier.*

It is the concern of Anglicare Victoria, that when the processes and strategies outlined above are not systemically applied or enabled, there is a greater risk of children/young people who have perpetrated abuse (or other inappropriate or threatening sexual behaviours) being 'churned' through the OOHC system; that is, moving from placement to placement without any clear rehabilitative pathway, in turn undermining the safety and wellbeing of other children/young people in care and increasing the likelihood of future offending into adulthood.

Further discussion of the current residential care system with respect to the safety of children/young people safety is discussed in more detail in **2.2 Residential Care**.

1.6 Resourcing and Case Loads

The issues of resourcing, case loads and OOHC funding models must also be an immediate priority for Government. Whilst community service organisations providing OOHC may aim to institute regular contact with carers and children/young people as best practice, large case loads can inhibit this practice on the ground. Within Anglicare Victoria's own OOHC programs, the smaller case loads of 6 cases per case manager associated with therapeutic foster care (together with greater funding) have been found to enable more frequent case manager contact than the standard form of foster care, where caseloads are at a minimum of 10 cases per worker. A further complication across standard foster care is the balance of case manager caseloads; with significant organisational and worker time required for the case management of short-term and emergency placements, with inappropriate levels of associated DHS funding. This can in turn make it more difficult for case managers to provide regular monitoring and support across the remainder of their case loads.

The role community services organisations rightly play in the prevention of child sexual abuse does not in any way supersede or diminish that of Child Protection. 2012 DHS data shows that in Victoria, up to 1400 cases had no allocated DHS case worker. This can place undue pressure on the community services sector to 'fill the gap', and results in fewer children/young people receiving appropriate monitoring and support. Such responsibility is regularly assumed by community services organisations without access to additional resources to do so, or the means of recording this work against DHS key service targets. As identified previously, *responsibility for the safety of children/young people in care is the responsibility of everyone.* If community service organisations are expected to provide the levels of case management and care required to maintain the safest possible placement environments for all children/young people, the current funding models guiding OOHC services and case management responsibilities must be reviewed.

1.7 Taking Responsibility

Organisational mishandling of disclosures of sexual abuse can be attributed to a number of factors; these may include an initial minimisation and denial of the abuse upon disclosure, lack of respect for the child's rights and experiences (i.e. doubting or attributing blame to the child), irresponsible and inadequate management of critical incidents; lack of action to ensure that the child/young person is removed from the unsafe environment, and a failure to encourage the reporting of alleged assaults to police (Irenyi, Broomfield, Beyer & Higgins, 2006).

The responsibility to safeguard the wellbeing of children lies at all levels of government and community services organisations. Abdicating responsibility for the prevention of abuse to one part of an organisation represents an abject failure in the duty of care towards children. Organisations that encourage and empower all staff to be responsible for the safety of children/young people (through culture, systems, policies and resources), are more likely to foster OOHC environments in which the potential for abuse is minimised.

Responsibility also lies in the manner in which case managers, senior management and wider organisations respond to, and *act upon* disclosures of sexual abuse made by the children/young people in their care. As argued by Smallbone (2012):

> 'the most important factor (in the prevention of child sexual abuse) is to create the conditions whereby children feel safe to report, and where the responses by others are sensitive, supportive and effective in ending the abuse (p. 2)*'.*

1.8 Final Message

Whilst it is imperative that the OOHC service system apply rigorous processes and practices to ensure the safety of the children in their care, the creation of 'cultures of suspicion' and over-regulation should be avoided. The vast majority of carers and staff engaged in agencies such as Anglicare Victoria are highly committed individuals, whose compassion, goodwill and expertise make a significant difference to the wellbeing, safety and future life chances of so many children and young people touched by adversity.

Whilst there is of course no acceptable level of child abuse, and organisations must do all they can to prevent the possibility of sexual abuse occurring in their care, research on known offenders indicates that the majority of sexual abuse is perpetrated within families rather than within the wider community or organisations, and that the vast majority of carers and staff working with children are not abusers.

We contend that too great a shift towards 'suspicion' has the potential to erode the invaluable caring relationships fostered between children/young people, carers and staff. Whilst regulation is critical (and has led to significant improvement in the quality of care provided by organisations), over-regulation has the potential to make the act of 'caring' unduly intrusive and institutionalised, which can both deter valuable carers, and undermine the best interests of children. In this regard, it is imperative that OOHC programs maintain a balanced approach of sensible risk management coupled with holistic support to children/young people and their carers.

2. Is there evidence for having different strategies to keep children in OOHC safe from sexual abuse depending upon whether a child is in relative or kinship care, foster care or one of the forms of residential care?

As indicated in our detailed response to **Question One**, the strategies that organisations can employ to help keep children in OOHC safe from sexual abuse are largely consistent across all types of statutory care. Given that the majority of OOHC is delivered in private homes and spaces (foster and kinship care) it is imperative that organisations reduce the potential for sexual (and other forms of) abuse by implementing rigorous screening, assessment, training, supervision and case management policies and practices – pertaining to staff, carers, other volunteers and children/young people in care.

The funding of organisations, and the national shortage of foster carers, are significant considerations and potential barriers to optimal OOHC placements. OOHC teams with large caseloads and stretched resources are less able to thoroughly and routinely undertake the protective measures required to support safe caring environments, whilst a shortage of foster carers can pressure organisations to place children/young people in OOHC settings that do not comply with an organisation's own best practice guidelines; for example placing children from different families with the one foster carer.

2.1 Kinship Care

Given the importance of the strategies outlined above, we contend that the current kinship care system in Victoria faces particular challenges. A review of this system should be an immediate priority for Government, legislators and community services programs, particularly as more children/young people are now placed in kinship care settings than in other types of OOHC, and this number is only set to grow in the future.

In the current Victorian kinship care system, children/young people are often quickly placed in kinship placements due to immediate care concerns, thus reducing the potential for rigorous carer screening and assessment. Kinship carers also do not typically receive the level of ongoing supervision and carer support (via regular case management) as foster carers. Currently, the majority of kinship carers are case managed by DHS, whose large caseloads can impede frequent contact and monitoring. This is further undermined by the frequent turnover of DHS frontline staff.

As kinship care placements do not easily allow for rigorous initial assessment, it is imperative that placements are reviewed over time with due rigour. To Anglicare Victoria's knowledge this does not occur consistently across the current kinship care system. Inappropriate placements can have many undue consequences; in particular (i) over-burdened carers who lack the resources, capacity, experience or will to provide suitable care to vulnerable children in the long-term, and (ii) the increased potential for already vulnerable children/young people to experience further harm, neglect or abuse. Given these factors, ensuring that the kinship care system is sufficiently resourced to enable regular case management contact, carer support and placement review is imperative.

A final key consideration specific to kinship care extends to what we know about the prevalence of sexual abuse against children; namely that it is more likely to occur within

families and by trusted individuals with whom a child/young person has a long-standing relationship. Given the very nature of kinship care placements (where children/young people are typically placed with family members or friends with whom they have an established and trusting relationship) and the reduced level of carer screening, assessment, training, monitoring and support in place across the current kinship care system, the risk of sexual abuse in kinship care placements has the potential to be significantly higher than in other OOHC settings.

Kinship care is an important part of the current statutory OOHC system. Placing a child/young person in the care of people they know and trust without thorough screening is often a necessary response to an immediate care concern, and can represent the least distressing and secure placement option for a vulnerable child. Given the diminishing number of foster carers in our community, and the costs of residential care (in terms of resources and the impacts on children), the growing reliance on kinship care cannot be understated. As such, the current system of kinship care in Victoria, including its regulation, funding and modes of delivery, must be an immediate priority for Government.

2.2 Residential Care

The current system of residential care also requires attention. It is important to recognise that children/young people can be both perpetrators and victims of abuse, and that residential care environments, by virtue of the number of clients within them, may provide greater opportunities for client-to-client abuse to occur.

The primary source of Anglicare Victoria's concern relates to the current pressure to fill residential care 'beds' (in the context of placement shortages and reduced placement options), and the impact this can have on the wellbeing, best interests and safety of children/young people. Residential care services are too often forced to support pragmatic placements that do not take appropriate account for a given child/young person's stage of development, gender, level of vulnerability, capacity to be independent and complexity of need. Given that children/young people placed in residential care are typically those with the most complex needs and behaviours, the consequences of poor placements are significant. We highlight the following key issues.

In the current system, children/young people can be placed with others who are both considerably older than them (and thus at a different development stage with different needs for support), and of the opposite sex. Given that children/young people in residential care typically have particularly complex issues, the risks associated with large age-discrepancies and mixed gender placements are heightened – particularly when children/young people are known to have perpetrated sexual abuse in the past, and continue to demonstrate sexually inappropriate behaviours. When residential care placements are heavily influenced by pragmatic issues, the safety and wellbeing of children/young people can be worryingly undermined. This may leave children/young people more vulnerable to sexual (and other forms of) abuse, and may minimise the potential for those children/young people who have perpetrated (or have the potential to perpetrate) sexual abuse to receive adequate support and opportunities for rehabilitation.

In addition to this, poor placements can (i) put further pressure on community service organisations (and their staff) who provide safe care environments for children/young people, and (ii) can result in significant resources being spent at the 'service end point' of care (i.e. via surveillance systems, alarms, cameras, locks on doors, additional staff and resource-heavy contingency placements that provide children/young people with 24-hour, staff supervised, one-on-one care) which could be alternatively utilised to strengthen the number and range of residential care options available across the system (i.e. earlier intervention).

Whilst we strongly believe that Anglicare Victoria's OOHC programs are rigorous in their practice, the effectiveness of this work is undoubtedly limited by the current system. Due to the large demand for placements, OOHC service providers are not in a position to effectively self-regulate their practices, despite their own best efforts and their genuine commitment to ensuring that all children/young people have access to placements that are most appropriate for their needs. The lack of 'quality principles' to guide DHS referrals into standard residential care (despite the existence of National OOHC Standards) is a further complicating factor.

Due to a rising complexity in the needs of children requiring statutory care, and the challenge of developing/implementing more intensive and specialist models of foster care (i.e. professional foster care), a number of specific residential care units have been established for children under 12 years of age. This model however, has been undermined in practice by the increased longevity of residential care placements and the resultant lack of available beds. In fact, the current system in Victoria now demands that all available beds be filled almost immediately, with OOHC service providers required to maintain a 95% occupancy rate to retain required funding. In our experience, a target-driven model such as this can significantly impact the suitability of placements, and can result in poor household combinations that serve no one. We are concerned that an unbalanced focus on beds and targets, has the potential to undermine quality of care, and can lead to unacceptable situations where children as young as 8 years old are regularly placed with adolescents twice their age.

Whilst Anglicare Victoria does not currently have access to formal statistics on age diversification in residential care units, it is quite common for children/young people across a very broad age-range to be placed together in the one unit. Whilst this is a normal occurrence within families, in residential care settings such wide-age bands are problematic. Along with different stages of physical, sexual and emotional development (expressed across pre-puberty, puberty, and post-puberty) come the challenges associated with bringing together multiple children/young people with complex issues and/or behaviours and support needs. In terms of risk factors for sexual abuse, inadequate consideration of these factors when determining placements is worrying.

In addition to this, we are also now witnessing a greater number of younger children (i.e. 7 to 10 year olds) entering residential care due to a lack of available foster care placements. This points to broader system issues. The pressure for DHS to find appropriate accommodation for these children increases the likelihood of large age variation within units, and the potential for less appropriate placements. We argue that as long as DHS

Placement and Support operates separately from the Child Protection system, 'available beds' will continue to be prioritised to the detriment of the wellbeing and safety of children/young people.

In consideration of these concerns, we offer the following key strategies to support safer residential care environments for children/young people, and to reduce the likelihood of sexual abuse in residential care settings:

- A maximum two or three year age range amongst children/young people in residential care units;
- Greater support for developing and expanding alternatives to residential care for children under 12 years of age, such as more therapeutic foster care and introducing professionalised care;
- Whilst good progress has been made in the development of therapeutic care units, expanding these programs must be an immediate priority. Units that can provide specific therapeutic or rehabilitative support for children/young people with problematic sexual behaviours should also be explored;
- Funding is needed to enable residential care units to be staffed by two qualified and trained staff members at when needed. The current non-therapeutic or intensive system is funded for only one EFT which limits opportunities for support and monitoring;
- Options for single sex units should be resourced and made available in response to child/young person need;
- System-wide protocols for referral and intake must be developed and implemented to ensure rigorous assessment of all new referrals before placements are determined; including assessment of the child/young person's needs, placement history, past and current behaviours and placement 'fit';
- A more reasonable timeframe for the acceptance of referrals is required to enable organisations to review whether they have suitable placement options for the child/young person. This should be a timeframe of up to four days, rather than 'immediately' as is the current expectation and practice.

3. What are the strengths and weaknesses of models that check OOHC practices by an audit approach, a regular supervisory visit, or an irregular visit by someone like a community visitor?

External mechanisms such as audits, regular supervisory visits and irregular community visitors designed to 'check' OOHC practices may all have a role in strengthened OOHC practices.

Currently in Victoria external audits are undertaken at least every eighteen months as part of a three-yearly registration basis to assess organisational adherence to DHS practice and quality standards. Adherence to these standards is a requirement of all DHS-funded program delivery. Amongst other things, standards inform organisations of their duty of care responsibilities, and provide service parameters, targets and processes for the management of quality of care concerns. Audits offer Governments a standardised means of checking the quality of OOHC service delivery consistently across organisations, and allow for an examination of the prevalence of critical incidents, with the potential to further investigate the practices within organisations if necessary.

Whilst important, audits are limited however by the broad and retrospective nature of their focus. Whilst audits may require organisations to develop strengthened practices, they are not 'immediate' mechanisms, nor do they allow for a deep examination of an organisation's practices or the direct participation of service-users.

Methods such as regular or irregular supervisory visits have the potential to provide a more direct and 'applied' level of intervention and monitoring. The value of introducing additional third parties (i.e. community visitors) into the lives and homes of children and carers is less clear however. Without appropriate training or a clear mandate or purpose, a community visitors program could result in children/young people having to bear yet another layer of 'third party intrusion' in their lives for little benefit to their safety. Given the number of professionals generally involved in the lives of these children/young people, this is an important consideration. Moreover, we question whether a child/young person would be likely to disclose such sensitive information to a third party with whom he/she has little connection, trust or rapport. Consideration must be given to whether the resources needed to implement a community visitors program would be better served strengthening existing aspects of the OOHC system, such as kinship care or residential care.

If a community-visitors program were to be implemented, it is critical that the program be evidence-based, work collaboratively with statutory bodies and OOHC providers (with defined processes for information sharing and the escalation of concerns) and that all community visits be conducted sensitively by trained professionals, rather than by volunteers. In addition to this, it is imperative that the same screening, monitoring and supervision practices required of OOHC case managers and staff within community and child protection services (as detailed in our response to **Question One**) be systematically and rigorously applied to those employed by a community visitors program. In the absence of such, we fear that children/young people in OOHC have the potential *to be at further risk of abuse*. The costs associated with implementing rigorous screening, assessment and

supervision practices in a community visitors program would be considerable. Issues of client/young person consent and confidentiality would also need to be considered.

As discussed in our response to **Question One**, we believe that regular and irregular visits are valuable, and may reduce the incidence of abuse by adding a further layer of monitoring and deterrence. These are practices that all organisations and statutory services have the capacity to fulfil themselves, via a formalised system of irregular and regular checks or 'joint visits' conducted by managers and team leaders. Such practices are already informally conducted across a number Anglicare Victoria programs, demonstrating that within organisations a level of third party scrutiny can be achieved without the need for a separate body. Mandating regular or irregular visits via the OOHC Service and Quality standards may imbed such practices more systematically and consistently across the care system.

4. What are the strengths and weaknesses of having OOHC providers regulated by the child protection department, or regulated by a body separate from the child protection department?

Anglicare Victoria supports the regulation of OOHC service providers by an independent body, separate from Child Protection. In Victoria, this could be undertaken via an expansion of the role, responsibilities and mandate of the current independent *Commission for Children and Young People*. Independence has the potential to strengthen regulation, enable improved transparency and reduce conflicts of interest (i.e. when auditing, program tendering and direct service provision are the responsibility of the same Government department). An independent body could also regulate the child protection department, which currently holds responsibility for the case management and supervision of many kinship care and home-based care placements, and also some residential care placements,

The process underlying the development of such a body must be consultative and should draw upon the strengths and knowledge across the system. To avoid fragmentation, consideration must be given to how the responsibilities currently held by protective services would be transferred to, and then shared with an independent body (including processes guiding information provision), and what mandate it would have. As identified by Cummins (2012), an independent regulator could have an important role in the following:

- Ensuring accuracy in categorising and investigating incidents to identify lessons and make recommendations for reducing risk to future clients and staff;
- Systematically reviewing incidents and investigating where appropriate, focusing on the root cause of the incident rather than the immediate event.

We contend that the following roles (identified by Cummins, 2012) could remain the responsibility of protective services:

- Undertaking compliance checks to assess the ongoing implementation of incident reporting policy. A compliance check would involve a review of documentation, data analysis from information systems and discussions with staff to determine the extent of compliance with the policy;
- Ensuring community service organisations are aware of, and comply with the incident reporting instructions;

- Where the department holds case management or statutory responsibility for clients, ensuring that appropriate actions are taken in response to critical incidents;
- Ensuring that community service organisations are informed of relevant authorities;
- Reviews of all incident data in consultation with the regions, to inform policy development, practice and policy implementation;
- Overseeing the quality of reporting, compliance, and the identification of systemic issues arising from reports and referral.

5. What are the core components of the training needs of those working with children who might be sexually abused including carers, caseworkers and staff of regulatory bodies? What priority should be given to training in relation to sexual abuse compared to other training needs?

As previously outlined, the training needs of staff providing care to vulnerable children are wide ranging, and the priority for training should be informed by the nature and purpose of the program, the worker's/carer's role and the particular needs of the child/young person or client group. Training in the following key areas may be of particular value, however minimum community services qualifications must be a requirement of all staff working directly with children/young people in care settings. Much of the training identified below is currently available to all Anglicare Victoria staff via the agency's professional development program.

Case managers/Residential Care staff:

- How to recognise grooming behaviours and how they may affect children's behaviour (i.e. training available through Child Wise, 2005);
- Methods of working with children and young people demonstrating sexually abusive behaviours – particularly valuable for staff in residential care settings;
- Understanding and responding to children/young people who have experienced complex trauma;
- Managing challenging behaviours – for case managers and residential staff;
- Training for managers regarding employment screening practices and supervision methods to reduce the potential for abusers to infiltrate organisations (Child Wise, 2005);
- General supervision training for new supervisors
- Working with Indigenous and CALD children and families;
- Working with children with disabilities;
- Suicide prevention training (i.e. ASIST);
- Casework preparation and court skills (i.e. 'In Court' training);
- Use of the LAC tool ('Looking after Children' assessment tool for OOHC).

Carers:

In Victoria, all new foster carers are required to participate in 8 two-hour training modules through the 'Shared Stories, Shared Lives' training program. Minimum training should be a requirement of all carers, including those in kinship care. Standard carer training in Victoria covers motivations for becoming a carer, bonding and attachment, grief and loss, managing challenging behaviours, working as a team, maintaining cultural connections

Further to this, the provision of more extensive training should be made available to carers when needed:

- How to recognise and respond to grooming behaviours;
- How to provide care for children/young people who display problematic sexual or other challenging behaviours, have attachment issues or mental health problems (including suicide and self harm), have a disability or who have experienced complex trauma.

Staff in regulatory bodies:

Given the contact that staff in regulatory bodies would be expected to have contact with children/young people in response to allegations of abuse, a baseline level of training is required. This should include training in:

- Grooming behaviours – how to recognise them, how they manifest in children's behaviours (Child Wise, 2005);
- How to support children/young adults who have experienced complex trauma, including sexual abuse (similar to the 'Take Care' training provided to all residential care staff in units funded for therapeutic residential care);
- How to respond to suicidal behaviours and self-harm (baseline program such as 'Safetalk');
- Casework preparation and court skills.

6. Is there adequate and effective training and information available to carers who are caring for children who have sexually abused other children?

In Victoria, carers receive broad training to assist them to better support children with a range of challenging needs and behaviours. To Anglicare Victoria's knowledge however, no specific training is available to carers who are caring for children/young people who have perpetrated sexual abuse.

Given the prevalence of sexual abuse (or sexually inappropriate behaviours) amongst children/young people in care, carers must receive ongoing support from case managers and have access to targeted training if needed. Training should aim to strengthen carers' capacity to provide ongoing care to children/young people who have perpetrated abuse, including how to implement boundaries, how to recognise and respond to sexualised behaviours and how to maintain safety. It is important that carers be informed of their reporting responsibilities in the event of sexual abuse taking place (and to whom they can seek support in such instances), and receive assistance to navigate the wider statutory and criminal justice systems should a child/young person in their care face an abuse allegation or become subject to community-based order. Consideration could also be given to how the training available to case managers and residential staff on 'Methods of working with children and young people demonstrating sexually abusive behaviours' (available through Anglicare Victoria and other agencies) might be tailored for use with carers faced with similar challenges.

Carers should also receive support to address their own needs for safety and wellbeing, together with the safety of any other children/young people that a perpetrating child/young

person may have contact with during their OOHC placement. OOHC services must ensure that carers are appropriately informed of their caring responsibilities, in this case the types of behaviours to avoid whilst caring for a child/young person who demonstrates inappropriate sexualised behaviours, and the importance of clear boundaries.

7. How should the rate of sexual abuse of children in OOHC be determined, noting that the National Standards for Out-of-Home Care require reporting of substantiated claims of all types of abuse? Would a form of exit interview assist in capturing information? What should be introduced to ascertain whether information on child sexual abuse in OOHC is resulting in changed OOHC practices?

The frequency of both substantiated and unsubstantiated sexual abuse allegations in OOHC should be separately determined and reported. Given that many victims do not disclose their experiences of sexual abuse until later in life, and others may find it too distressing to pursue an allegation following an initial disclosure (particularly given the challenges of the justice system), access to unsubstantiated figures may provide an alternate view on what the underlying frequency of abuse may be. This however is made complicated by the different mechanisms guiding the reporting of quality care concerns – for example in Victoria, the DHS database does not allow for the recording of all quality of care concerns, but only those for which there has been a DHS investigation or formal care review. Anglicare Victoria acknowledges the recommendations expressed by the Cummins' (2012) report on the 'Protecting Victoria's Vulnerable Children Enquiry', in particular the need for DHS to

> 'record and report on the number of quality of care concerns raised, the number of investigations of abuse in care, the number of formal care reviews including outcomes of investigations and reviews and their timeline (p.490)'.

Anglicare Victoria also supports Cummins' (2012) view that data should be presented according to region, allegation/quality concern type and OOHC placement type.

Given the responsibility of organisations to report all sexually abusive or inappropriate behaviours as critical incidents, there is potential for the 'unsubstantiated rate' to be disproportionately inflated. For example, should a child mention to a case manager that he/she saw his/her carer in the shower, then the case manager would be obliged to report the incident, even if it was immediately found to be a one-off accident that occurred due to a carer forgetting to lock the bathroom door. Such considerations should be acknowledged in the reporting of any rate.

In response to the value of an exit interview, Anglicare Victoria acknowledges the valuable role they may play, but *only when conducted sensitively by an established care-team, as part of a holistic, child-focused and comprehensive post-care planning and support process.* In the context of such care-planning (essential for all children/young people leaving OOHC), questions about the child/young person's experiences of care, including those pertaining to safety and potential abuse, may be appropriate and useful. In fact, by asking direct questions about abuse (rather than using euphemisms or softened language) case managers could potentially encourage and support children/young people to talk about difficult experiences that they may not otherwise have the strength, confidence or intention to raise

independently. This is especially important given that only half of the children/young people who experience sexual abuse are estimated to report it to a third party (Wortley & Smallbone, 2006), and that making disclosures is extremely stressful.

Lastly, with regard to what could be introduced to help ascertain whether information on child sexual abuse in OOHC is resulting in changed OOHC practices, we propose that an evaluation framework should be developed, requiring the cooperation of all stakeholders across the sector. This must include goals for change that reflect the available data, development of strategies to enable such change (i.e. revised procedures) and reliable methods of measuring outcomes. This process would require strong leadership, and would be best undertaken by an independent regulatory body with a clear mandate, governed by (or working in concert with) the *Office of the Child Safety Commissioner*. It is integral however, that the processes governing the sharing and availability of data between DHS and any independent body be transparent and rigorous. The absence of systematic data sharing could significantly weaken the efficacy of any such independent body, and could lead to unnecessary duplication between DHS and an independent regulator.

8. What is the usefulness and validity of different ways to address allegations of sexual abuse brought against carers? In particular, which approaches enhance participation by the child particularly approaches best suited to seeking possible disclosures of abuse (including disclosures that might be inferred from behavioural changes) from children? Are the current processes fair? What appeal processes should be available for carers?

Anglicare Victoria has considerable experience handling allegations of sexual abuse made by (and about) children/young people in our OOHC settings. In accordance with DHS guidelines, Anglicare Victoria takes every allegation received very seriously. The agency ensures that all allegations are met with a swift and transparent response, facilitated by the agency's executive management. Our response seeks to encourage disclosure, protect the safety of children and young people, and always immediately involve child protection and, in the event that criminal behaviour is alleged, the police.

As a community-based OOHC service provider, our remit is to ensure and maintain safe environments for the children/young people in our care. By virtue of this, a large proportion of our work is by necessity directly related to carers; including the initial recruitment, assessment and training of carers, through to the provision of ongoing placement monitoring and carer support. As described in response to **Questions One** however, it is imperative *that the needs, wellbeing and safety of the children/young people in our care remain the agency's primary focus.* As such organisations like ours must, in all cases, prioritise the support provided to children/young people who have disclosed abuse or made allegations above that offered to any staff member, carer or volunteer subject to an allegation. Our duty of care to children/young people extends to the following practices – some of which have been identified repeatedly through this submission:

- Frequent engagement with children/young people in care, and the development of trust and rapport. In their research, Lawson & Chaffin (1992) found that rates of

sexual abuse disclosure by children increased in conjunction with the level of support provided to them by their care-givers [3];

- Development of a child-focused organisational culture that aims to strengthen client resilience, self-esteem, protective behaviours and ability to affect decisions in their own lives;
- Interest in, and respect for a child/young person's own knowledge, resources and strengths;
- *Immediate responsiveness* to any disclosures of sexual abuse, including mandatory reporting to DHS and the police. It is imperative that workers clearly explain to the child/young person what the next steps are to minimise the potential for added distress, that they are responsive to the child/young person's voice and needs, and that they are available to provide consistent and ongoing support and advocacy;
- Organisations must never minimise or deny a child/young person's experiences, but listen with respect and compassion. They must never blame a child/young person for being abused;
- Using open-ended questions, rather than those that are leading, suggestive or require yes/no answers (Smallbone, Marshall & Wortley, 2008);
- Not assuming that professionals always 'know' what is best for a child/young person, but asking children/young people themselves what they feel they need. This means supporting and strengthening the ability of all children/young people to pursue allegations of sexual abuse through the justice system, but not pressuring them to do so. Such pressure could in fact be further traumatising for a child/young person;
- Continuing to assist the child/young person throughout the investigative process; from the point of initial disclosure and response (i.e. mandatory reporting to DHS/police) through to any consequent OOHC placement changes and the criminal justice system;
- Assisting or advocating for the child/young person to access specialist therapeutic support (such as a specialist sexual assault service) and working collaboratively with a child/young person's care team to strengthen his/her ability to receive holistic, ongoing support.

In the course of responding to abuse allegations, Anglicare Victoria has found however that *in a small minority* of cases some children/young people, as well as parents who have had children removed from their care due to protective concerns, have made false allegations of sexual abuse in order to try to alter placement arrangements with which they are unhappy. It is very important to reiterate at this point that Anglicare Victoria treats all allegations of child sexual abuse within care settings as legitimate and serious, and never minimises or denies any allegation of abuse.

[3] Lawson & Chaffin (1992) also found that 'disclosure was strongly associated with the attitude taken by the child's caretaker toward the possibility of abuse. Children whose caretakers accepted the possibility that their child might have been sexually abused disclosed at a rate almost 3.5 times as great as those whose caretakers denied any possibility of abuse (63% vs. 17%) (pg. 532)'.

When made, false allegations can have the unfortunate effect of 'burning' carers. Foster carers are, after all, volunteers who make great sacrifices to provide care to vulnerable children and young people who are unfortunately unable to live with their own families. In the event that false allegations are made, the resulting investigative process in which carers must then become engaged can be fatiguing, demoralising and even traumatising. Many times, this results in the carer going 'on hold', and ceasing to provide placements in their homes for children/young people. Whilst there are many factors, including economic and other structural factors, that have contributed to the decline in the number of foster carers in Victoria, the impact of investigations on carers who have been subject to false allegations of abuse is significant. In the case of allegations that are proven false, this impact can also extend to other children/young people living with the carer (including potentially, the carer's own children); disrupting their placement and causing further stress and instability.

Anglicare Victoria offers the following recommendations regarding how the investigative process could be improved to minimise the chance of carers who have been wrongly abused becoming disillusioned and leaving the foster care program:

- That child protection ensures that investigative responses to allegations of abuse in care are as swift as possible, and not unnecessarily 'dragged out' due to workload pressures;
- That the child protection worker/s who conduct investigations are comprehensively informed of the nuances of the placement they are investigating, including the profile and history of the child/young person and carer/s involved (particularly any history of false allegations having been made by children, young people or their biological parents in previous placements);
- That the same child protection worker/s can see the investigation through to completion. Unfortunately, when the investigative process is unnecessarily slow, this may mean that several shifts of child protection workers come and go, and that successive workers involved are not fully informed of the nuances of the placement;
- That a senior placement and support worker or manager chair each investigation, and that they be impartial – that is, not hitherto involved with the placement, or those facilitating it in any way. This may enable the carer involved in the investigation to continue to receive some level of information or support from the OOHC organisation with which they have an established relationship (and, in our experience, to whom they are most likely to turn to for support), whilst minimising the impact of bias on the investigation through establishment of the impartial chair. This support however, should be provided by a program manager or team leader only, as the direct case manager must be available to support the child/young person who has made the allegation of abuse *as a first priority*. This is particularly important in instances where the child/young person has made a disclosure directly to their case manager, where the need for ongoing trust is critical;
- That a review be conducted by an independent regulatory body into the management of allegations of abuse in care, so as to produce refined models of best practice;
- That all carers are afforded the right to appeal, facilitated by a separate committee within child protection or by an independent regulatory body.

9. What measures could be used to assess whether the safety of children from sexual abuse in OOHC is enhanced by independent oversight of the handling of allegations of sexual abuse?

The purpose, responsibilities, auspice and role of any independent regulatory body must be clearly defined in collaboration with child protection the broader sector. Goals for change must be identified, together with processes to govern practice and methods of measuring outcomes. Broad baseline data should be collected (i.e. number of initial allegations vs number that proceed to go to court), and utilised as a basis for comparison to determine the benefits independent oversight bring. Where possible, any assessment framework must engage children/young people with direct experiences of the system (including adults reporting historical incidents of abuse), together with community service organisations and Government with regard to the handling of specific allegations.

10. What are the strengths and weaknesses of different oversight mechanisms in keeping children safe from sexual abuse in OOHC?

In **Question One** we discuss in detail the potential value and limitations of oversight mechanisms such as (i) regular supervision of case managers, (ii) frequent contact between case managers, carers and children/young people and (iii) contact between management, carers and children/young people, both in collaboration with case managers and independently. Further in **Question Three** we explore the strengths and weaknesses of organisational audits, regular supervisory visits and irregular visits by community visitors.

11. What implications exist for record keeping and access to records, from delayed reporting of child sexual abuse?

Given the long organisational history of Anglicare Victoria's founding three agencies, and the role of these agencies in the care of children, there are considerable implications for record keeping, and access to records from delayed reporting of child sexual abuse.

As stated in the introduction to this submission, Anglicare Victoria was formed through an act of Parliament - the Anglican Welfare Agency Act 1997, which joined together three of Victoria's long-established Anglican child and family welfare agencies - the Mission of St. James and St. John, St. John's Homes for Boys and Girls and the Mission to the Streets and Lanes. The Mission of St. James and St. John began providing services in the late 19th century, whilst St. John's Homes for Boys and Girls and the Mission to the Streets and Lanes began their work in the early 20th century. From this period, right up until 1997 when these three agencies were amalgamated to become Anglicare Victoria, approaches to providing care for vulnerable children, young people and adults underwent a dramatic evolution.

In 2004, the Senate Community Affairs References Committee released its now famous report into the experiences of such children and young people throughout the previous century. This report was titled 'Forgotten Australians: a report on Australians who experienced institutional or out-of-home care as Children'. The committee's report led to much greater awareness of the experiences of these vulnerable children and young people, and the damaging effects of their experiences of abuse. This ultimately culminated in

several formal apologies being made to the Forgotten Australians, including an apology on behalf of the Australian Government from Prime Minister Rudd in 2009, an apology on behalf of the Victorian Government from Premier Bracks in 2006, and an apology from the Anglican Diocese of Melbourne in 2004.

Anglicare Victoria recognises that some Forgotten Australians who were placed into care by, or with the Mission of St. James and St. John, St. John's Homes for Boys and Girls and the Mission to the Streets and Lanes experienced such abuse. The agency considers all such incidences of abuse to be unequivocally wrong, and takes very seriously its ethical obligations to work effectively with any past victims of abuse who approach the agency seeking redress.

11.1 Working with heritage clients from Anglicare Victoria's three predecessor agencies

Anglicare Victoria has great responsibility to provide assistance and support to former clients who were raised in institutional care facilitated by the organisation's three predecessor agencies. This assistance and support is multi-faceted. For example, some of these former clients have developed their own traditions with regard to holding reunions and other get-togethers, and, in recent years, Anglicare Victoria has begun to offer support with regard to facilitating these functions. The agency is also developing a repository of photographs of children and young people from their time in the care of the Mission of St. James and St. John, St. John's Homes for Boys and Girls and the Mission to the Streets and Lanes. Former clients of these agencies will be able to access photographs of themselves through this service.

11.2 Providing access to records

Anglicare Victoria is responsible for keeping and facilitating access to case records of the three predecessor agencies that were amalgamated to become Anglicare Victoria. These records may pertain to time spent in institutionalised care, and all former clients are able and supported to access them. Protocols for accessing records are outlined in the agency's 'Access by Former Clients to Anglicare Victoria Out-of-Home Care Client Records' policy. Given the long history of service provision across the three founding agencies, there are considerable infrastructural, managerial and resource-based demands associated with the storage, access and handling of records over such a wide space of time. Given that records may be later utilised as part of criminal proceedings, or may inform a client's civil claim for financial compensation against an organisation, ensuring systematic access to client records is imperative.

The issues which prompt people to seek access to their records generally have powerful personal significance to them and members of their family. For some former clients, they may be experiencing a crisis in life or a developmental phase in which it becomes apparent to them (or those close to them) that they are still grappling with issues from their childhood. This may be related to experiences of abuse whilst in care, and as such, requests to access records may precede, coincide with, or follow an allegation being made to Anglicare Victoria regarding such abuse.

Given the importance of these requests, all are handled directly by Anglicare Victoria's Heritage Client Liaison Officer, who works within the office of the Director of Quality. In

accordance with the recommendations of the aforementioned Senate Community Affairs References Committee's 2004 report, responses to requests for records are approached in such a way as not to hinder access by care leavers to information about their childhoods. To the fullest extent allowed under the provisions of the Information Privacy Act Victoria (2000), the Commonwealth National Privacy Principles, and the Health Records Act Victoria (2001), as well as in respect to the agency's duty of care, Anglicare Victoria makes as much information available as it can to former clients.

Furthermore, wherever possible and acceptable, the agency endeavours to take former clients through the content of their files during a face-to-face interview. During the course of these interviews, a copy of each former client's file is provided to them, minus information that is legally required to be restricted by the abovementioned legislation.

11.3 Offering respect and support to any person who makes a complaint.

The following practices underpin our organisation's responsibility to be respectful, and provide an immediate response to those seeking access to past records, or seeking to make a claim of past abuse whilst in the organisation's care:

- Being as open, transparent and accountable as possible while respecting the rights of complainants to privacy and to make their own informed choices about whether to engage with Anglicare Victoria;
- Supporting complainants in making a report to police where allegations of abuse involve behaviour that may constitute a criminal offence, and inviting any person who has been abused, no matter when, to come forward and make the matter known, so that his or her ongoing needs can be addressed.

When any person makes an allegation of abuse to a religious or other organisation, the challenge for organisations is considerable. On the one hand, responsible workers will seek to promote the wellbeing and healing of the complainant, and on the other, given allegations frequently coincide with the pursuit of financial compensation, not-for-profit organisations will inevitably be mindful of limiting, to some extent, the extent of their financial liability.

Such tension has the potential to negatively influence how organisations respond to allegations of abuse in care settings made by their former clients, patients and community members (or any other term for people previously connected with an organisation). We believe that our processes for responding to such allegations, whilst by no means perfect, promote justice and the pursuit of healing.

Given child abuse is a largely hidden phenomenon, evidence to substantiate its incidence in individual cases can be scant, or even non-existent - particularly with regard to incidents which are alleged to have occurred years, or decades ago. Anglicare Victoria recognises that it is difficult for former clients to substantiate their allegations of abuse with corroborative evidence, much as it is difficult for Anglicare Victoria to obtain evidence that abuse did not occur. This in turn creates difficulties in responding to such allegations. Anglicare Victoria has previously made an apology to Forgotten Australians and the agency is very committed to hearing from former clients who have experienced harm and injustices whilst in care, so that we can help individuals as best we can, and learn from them.

From this perspective, Anglicare Victoria approaches claims for financial compensation in a spirit of fairness and genuine pursuit of redress. The agency actively instructs our consultants who engage in mediations not to take an adversarial approach in dealing with such claims. Rather, we prefer to see these matters resolved so as to avoid forcing former clients into situations where they must prove Anglicare Victoria's liability, or where the agency attempts to disprove their allegations.

We believe that we have developed a fair and protective system. Our former clients are afforded the opportunity to access their records, have their experiences and allegations respectfully and seriously heard and validated, are offered a formal apology by the agency, have access to support services if needed (including legal representation) and the right to financial compensation if appropriate. This practice of atonement and redress reflects the values of the agency more broadly.

Finally, in providing this response over the years, we contend the following:

- That independent oversight in managing such allegations is extremely important.
- That systems for managing such allegations need to be guided by principles informed by the considerable responsibilities agencies have towards both current and past clients;
- All Governments should look to introduce a designated redress scheme for care leavers, such as those enacted in Tasmania, Queensland and Western Australia. The scheme should provide opportunity for Forgotten Australians to voice allegations available.

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