Royal Commission into Institutional Responses to Child Sexual Abuse

CASE STUDY 24:

PREVENTING AND RESPONDING TO ALLEGATIONS OF CHILD SEXUAL ABUSE OCCURING IN OUT-OF-HOME CARE

Submission by Anglicare Victoria

February 2015

Introduction

Anglicare Victoria is Victoria's largest Out of Home Care and family welfare provider. It 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.

Each night over 400 children would be placed under Anglicare Victoria's care. Over the course of a year, (2014-2015), the agency facilitated placement of 664 children and young people into foster care, and directly provided 109 children and young people with residential care placements.

Additionally, our kinship care programs assisted 193 children and young people to access kinship care placements. The agency also provides a comprehensive range of family services including intensive family support, parenting courses, emergency relief and a range of counselling and support programs in the areas of financial stress, alcohol and drug and mental health.

To accomplish this scope of service provision, Anglicare Victoria employs a staff of approximately 1400 professionals - including social workers, psychologists and other community and welfare professionals - and works with over 1300 volunteers.

With the responsibility of the safety and wellbeing of many of our nation's most vulnerable children and young people, our organisation has a strong, embedded 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.

Anglicare Victoria welcomes the opportunity to provide this submission for Issues Paper 24 to the Royal Commission into Institutional Responses to Child 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.

How to read this submission

Anglicare Victoria has addressed the terms of Case Study 24 within Part 1 of this submission. 1.1 addresses Question 1 (a-e) of Case Study 24, whilst Section 1.2 addresses Question 2 (a-e). Section 1.3 provides a combined response to Questions 3 and 4 of Case Study 24. This is because Anglicare Victoria's processes and systems for both reporting and responding to allegations of sexual abuse in care are heavily interrelated. Our response to Question 5 of Case Study 24 is contained within Section 1.4 of this submission, whilst our response to Question 6 is contained within Section 1.5.

In addition to these responses, Anglicare Victoria has provided – in Part 2 of this submission – our views and concerns regarding the risks that various placement modalities present for children and young people, and some recommendations for how such risks might be mitigated; thereby allowing for more effective prevention of sexual abuse (and other damaging experiences) in out-of-home care. We respectfully offer these to the Royal Commission for consideration.

Copies of Anglicare Victoria policies referenced in this submission are attached to the email by which it has been submitted to the Royal Commission.

Section 1. Current processes and systems for preventing and responding to sexual abuse

1.1 Recruiting, assessing and training staff in residential care

1.1.1 Screening of carers and staff as well as carers household members.

With regard to the use of screening and other personnel practices, Anglicare Victoria complies fully with relevant Victorian DHHS guidelines, as well as the legislation to which such guidelines accord, such as the Working with Children Act 2005.

In accordance with these guidelines, Anglicare Victoria requires that:

- All staff and volunteers undergo and maintain a current national police check, and Victorian Working with Children Check, before they are allowed to engage in agency work. This is outlined within Anglicare Victoria's *Criminal History Checks (Police Checks) Policy* and the *Working with Children Check Policy*.

- All staff and carers must also provide confirmation of any relevant experience, qualifications, and any other skills or competencies required for the role. At least two referees will be contacted as part of this screening process.

- All carers who provide out-of-home care to children and young people through Anglicare Victoria are registered with DHHS, as per their guidelines. Such registration can be removed in cases of misconduct, resulting in exclusion from being allowed to provide further out-of-home care for children within the state of Victoria. Exclusion is managed through DHHS processes, with this decision being made by an independent suitability panel.

For carer registration to be successful, the carer must pass a criminal history check and working with children check. Furthermore, before Anglicare Victoria places any child or young person with a carer the agency requests what is known as a 'disqualification check' of that carer, which is facilitated by DHHS as part of their carer registration facility, and involves another criminal history check and Working With Children Check being carried out. This ensures that both DHHS and Anglicare Victoria possess the most up-to-date criminal-records history about any carer who is being considered for a placement.

Along with screening processes being applied to each carer, they are also applied to any adults (including the carer's biological children and relatives) who may reside, even temporarily, within the carer's household. Such individuals are required by Anglicare Victoria to pass a Working with Children Check, as are any babysitters that the carer may use from time to time.

Furthermore, Anglicare Victoria has in place a *Babysitting Policy*, which requires that, in addition to passing a Working with Children Check, prospective babysitters who may look after clients placed with volunteer foster carers must be chosen on the basis of having a positive approach to behaviour management, and agree not to use corporal punishment of any kind on children and young people under their supervision. Decisions about the use of babysitters are negotiated with case managers.

The overall thrust of the above procedures is to ensure that Anglicare Victoria and DHHS can screen out any individuals with concerning criminal histories when making decisions about who will have contact with children and young people within their care settings. This is a very important component of preventing child abuse.

It is important to note though that 'Screening is not without its limitations. Such practices rely on previous offences [and]… Research has also indicated that, when charged, the majority of perpetrators detected do not have prior convictions for any form of child maltreatment, and thus would not have been detected by screening processes.'[1] Accordingly, whilst screening processes must be a part of any effective set of protections designed to prevent abuse in institutional contexts, it is important not to be overly reliant on these processes, and to thereby consider them sufficient alone in minimising the likelihood of abuse occurring.

1.1.2 Assessment of carers and staff.

Anglicare Victoria upholds the DHHS standards of care regarding assessment of the competence of volunteer foster carers and staff working in residential care facilities.

As noted in DHHS *Program Requirements for home-based care in* Victoria, foster carers, once screened, are required to complete a mandatory, competency-based carer assessment called *Step by Step Victoria.* This allows staff to assess carers according to key competencies including the provision of a safe environment free from abuse and demonstration of a personal readiness to become a carer. This assessment of suitability - which involves mandatory components being completed in full – is applied to all members of a carer's household. This assessment is designed to determine whether carers possess the required personal attributes, skills, attitudes and ability to practise cultural competence as carers. Carers must also provide evidence that they do not experience any medical problems which might impeded their ability to provide high-quality care.

Paid staff who work in residential care facilities are employed on the basis of holding relevant qualifications and experience, and demonstrating this adequately during job interviews, induction processes and probationary periods. We attempt to recruit a person with the personality qualities that we believe through our experience provide the best care and support for the children and young people under our care.

Over 80% of Anglicare Victoria's residential care staff hold a tertiary qualification in a relevant, welfare-related paradigm. Of the remainder, these are employed due to their experience and "fit" within particular residential care units (such as in the case of residential care staff who are of Polynesian cultural background, so are well positioned to build engagement and trust, and provide a culturally appropriate response to the clients of Polynesian background who reside in that unit).

1.1.3 Training of carers and staff in identifying signs of sexual abuse in children, encouraging disclosures and responding to those disclosures.

Anglicare Victoria case managers who work with volunteer foster carers seek to train and educate these carers regarding appropriate ways of responding to the often challenging behaviours that children and young people placed in their care might exhibit. This is very much a central purpose of out-of-home care case management, as "skilling up" and supporting carers equips them with important skills required to care for vulnerable children and young people; including recognising signs that they may have experienced or may be continuing to experience sexual abuse, and interacting with children and young people in ways that make them feel safer and more able to disclose such experiences. Such ongoing training and education of carers by case managers occurs in addition to their initial, pre-service training – the completion of the Shared Stories, Shared Lives modules; as required by DHHS standards.

[1] p. 17, Irenyi, M., Broomfield, L., Beyer, L. & Higgins, D. (2006). Child maltreatment in organisations: Risk factors and strategies for prevention. In *The Australian Institute of Family Studies National Child Protection Clearinghouse, Child Abuse Prevention Issues*, 25.

With regard to the training of paid staff who perform caring roles within residential care facilities, Anglicare Victoria actively builds on knowledge and skills that our staff have acquired in the course of tertiary studies and experience in social services roles. Anglicare Victoria has developed extensive resources – including a residential care "Pillars of Practice" service manual – to this end.

Signs of sexual abuse can be difficult to identify in some children in out of home care. Whilst some may display sexualised behaviours or inappropriate approaches to staff or co residents, or display signs of depression or self-harm, other children or young people may not show any initial signs or behaviours.

It is therefore crucial that all of our interventions are based on the development of effective and engaging relationships by our staff with our children and young people.

Along with this approach it is also important that staff receive cyclical training and peer reflection on this difficult area of out of home care response.

So as to improve this standard of training and support, Anglicare Victoria has commissioned the Children's Protection Society to provide intensive, expert training to Anglicare Victoria's residential staff on how to manage young people displaying sexually abusive behaviours.

This training will focus on enhancing staff understanding of:

- Sexually abusive and maladaptive behaviours – including knowledge of potential triggers and effective and safe management and care of this cohort of young people.
- The effects of trauma on young people and those who work with them.
- High risk behaviours and sexual exploitation
- How to manage residential care staff working with young people – including a focus on key considerations and responsibilities (e.g. supervisions and professional development)
- Effective safety planning (individual, group, unit, community and staff)
- How to address vicarious trauma

Anglicare intends to provide this training every two years to its staff.

1.1.4 Assessment and ongoing training of carers in accordance with National Standards 12.

Anglicare Victoria has developed and implemented a range of policies to ensure that residential care staff and foster carers are adequately supported within their roles beyond the initial training they are given (see response to section c over the previous two pages). These policies, which accord to DHHS standards and residential care and home-based-care service requirements – themselves in accordance with Standard 12 (and others) of the National Standards for out-of-home care - include our *Staff Supervision Policy and Standards* and *Home Based Care Placement Supervision and Home Based Carer Support Policy*.

In a recent (late 2014) and comprehensive external audit of Anglicare Victoria's compliance with DHHS standards and service requirements - carried out for DHHS by the organisation Quality Innovation Performance – Anglicare Victoria was found to be 100% compliant.

The abovementioned Anglicare Victoria policies regarding supervision and support prescribe that employees and volunteers are provided with regular and readily accessible supervision.

Anglicare Victoria currently has arrangements in place to ensure that residential care staff receive frequent individual supervision and engage in reflective practice sessions in a peer group setting.

Anglicare places great importance on the vehicle of supervision to ensure staff and carer confidence, skill and capability is at the required level to work with our complex and vulnerable group of young people and children.

With regard to foster carers that are supported by the agency, they receive intensive and regular supervision throughout the course of placements from case managers. This helps to ensure that children and young people receive a high standard of care, and that case managers have the opportunity to continually assist carers to improve their capabilities and skills.
However delivering ongoing training and support, particularly for foster and kinship carers can be challenging. This is because carers can often be time poor in managing the competing interests and needs of households often consisting of several foster and biological children. Kinship carers can in particular fly below the radar. Provision of Kinship care training can be underdone and is an out of home care option that requires further focus to ensure the training needs of kinship carers are reflected in any support and training agenda.

This is why Anglicare Victoria in partnership with Children Protection Society is developing a mobile application to provide training, reading resources and online advice to kinship carers. Development of this mobile tool for kinship carers is in its infancy, but this innovation we believe will be an accessible and value adding way to engage and train kinship carers.

In addition to the aforementioned practices related to supervision, staff at Anglicare Victoria are provided with the opportunity to undertake internal and external training courses (please refer to the *2014 to 2015 Learning @ Anglicare Victoria Professional Development Program Information Pack* that accompanies this submission).

1.1.5 Other mechanisms for assessing the effectiveness of recruitment, assessment and training of carers and staff in residential care.

Staff and volunteer feedback is gathered via periodic surveys. This has proved to be a useful approach for ascertaining whether staff feel that the training they receive is adequate – which has largely proved to be the case.

1.2 Monitoring of children in out-of-home care

1.2.1 Who monitors children in out of home care, how is this monitoring carried out and with what frequency does it occur?

Children within residential care placements are monitored every day by staff who are on shift within the residential care units (which are staffed 24 hours per day). Staff frequently communicate important observations to other staff who take over at the end of their shift (this is done verbally and/or via log books). Moreover, all children and young people within residential care units have a Child Protection case manager or agency-contracted case manager who frequently meets with them. In addition to this, the Victorian Commission for Children and Young People is trialling a community visitors program for residential care units. Anglicare Victoria is participating in this trial in our Southern region.

At night, after young people have gone to bed, alarms are activated which are triggered by movement in common areas (such as hallways). This ensures that staff are alerted if clients attempt to go into each other's rooms.

Children and young people residing in home-based-care placements receive, at minimum, fortnightly visits from their home-based-care caseworker. It is a requirement that at least part of such contact occurs away from foster carers; thereby providing children and young people with the opportunity to discuss their placements without their carer hearing this

discussion. In addition to this, many children and young people in home-based-care have weekly access with their birth families which is facilitated by their home-based-care caseworkers. This provides these caseworks with further opportunities to engage in monitoring.

One of the issues in monitoring in Out of Home Care is ensuring that each child has an allocated child protection worker, or a contracted case manager.

There have been times in the past where up to 25% of children in out of home care have lacked an allocated case worker. One way through this and to ensure a smooth and responsive case work approach to the child is to contract out cases to the out of home care provider sector, thereby insuring that the out of home care provider is also providing responsive case work to the child. Too often children in out of home care experience 'case drift' or infrequent case intervention due to competing demands on the child protection workers.

Child Protection then can provide the case contract management monitoring and oversight of the child in the care system.

Depending on the model of Kinship Care, children and young people residing in kinship care placements do not receive monitoring that is as frequent and intensive as is the case for those residing in home-based care. If Kinship is provided by the Department, (of which 80% of kinship cases are), then visiting can be infrequent, and often only monthly. If Kinship is provided by the community sector, weekly visits are maintained until the placement required fortnightly visit routines to be implemented.

1.2.2 Practices which Anglicare Victoria has adopted in order to encourage disclosure by children of sexual abuse in out-of-home care.

Upon any child or young person commencing a placement provided or facilitated by Anglicare Victoria, they are provided with child/youth-friendly, plain language brochures which outline their rights – including their rights to safety and security, and their rights to make complaints (and the mechanisms for making complaints or other such disclosures). As several researchers have identified, 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.[2] This is because organisations' increased receptiveness to receiving complaints reduces potential abusers' opportunity to "get away with" their crimes.

This process is completed as part of a comprehensive induction processes which is facilitated by Anglicare Victoria staff - case managers in home-based-care program contexts, and residential care workers, unit coordinators and team leaders in residential care settings. Furthermore, within residential care settings, these induction processes are reinforced through provision of a Client Code of Behaviour booklet, which explicitly outlines to young people:

- 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 them.
- That drugs, drug paraphernalia and weapons are not allowed in the house.

[2] Bichard, M. (2004). The Bichard inquiry report: An independent inquiry arising from the Soham murders. London: House of Commons The Stationery Office London; Utting, W. (1991). Children in public care: A review of residential child care. London: Her Majesty's Stationery Office; Wardhaugh, J., & Wilding, P. (1993). Towards an explanation of the corruption of care. Critical Social Policy, 37(1), 4–31.

- That it is unacceptable to be under the influence of alcohol and other drugs whilst in the unit.

Anglicare Victoria is very much a child-focused organisation. Children and young people's wellbeing and safety are at the core of the agency's mission, purpose and values, and this is well reflected within our policy architecture and program focus.

Given the nature of the type of work the agency does, most "frontline" staff are required to have training in social work, psychology, community services or some other welfare-oriented knowledge base.

Furthermore, staff receive a great deal of on-the-job training and supervision aimed at improving their knowledge about children's development, as well as those experiences which threaten it. As a result of this, Anglicare Victoria staff members typically have an advanced understanding of the dynamics and indicators of child abuse, as well as the importance of "hearing the voices" of children and young people – of artfully engaging them in discussion, rather than just "talking about" them and affording them little opportunity to speak. All of this strongly contributes to the child-focused culture within the agency.

1.2.3 What is the mechanism by which other authorities – for example law enforcement, health and schools – exchange information with Anglicare Victoria about risks of sexual abuse of the child in care?

Within our out-of-home care (and other) services, Anglicare Victoria receives and discloses information about children at risk in accordance with the DHHS and other services standards and requirements to which the agency is subject. This is also done in accordance with relevant legislation (such as the Victorian Children, Youth and Families Act 2005, the Crimes Act 1958 (with regard to the 2014 "Failure to disclose a sexual offence committed against a child" amendment) and the Information Privacy Act 2000) and in context of the agency's mission, and the purpose of these services – which centre on ensuring children's best interests.

Under relevant provisions of these legislation, Anglicare Victoria staff frequently consult with authorities and bodies such as DHHS Child Protection, police, healthcare services and schools with regard to the needs of children and young people in care.

Where staff believe that children/young people are at acute and immediate risk of sexual abuse, assault or exploitation (for instance, during an access session with a birth father), Child Protection are immediately contacted and – where there is a reasonable index of suspicion that criminal behaviour has taken place – the police are contacted too. Urgent actions are then taken to ensure the safety of the child/young person.

1.2.4 Anglicare Victoria's registration as a community service

In accordance with the Victorian Children, Youth and Families Act 2005, Anglicare Victoria must maintain registration as a community service in order to continue to provide community-based child and family services, and out-of-home care services. In order to meet requirements for this registration, Anglicare Victoria has to undergo periodic external audits against DHHS standards and program requirements. More information about this process is available at the following webpage:

http://www.DHHS.vic.gov.au/for-service-providers/children,-youth-and-families/Community-service-organisations/registration-requirements-for-community-services

In our most recent audit (late 2014) - carried out for DHHS by the organisation Quality Innovation Performance – Anglicare Victoria was found to be 100% compliant.

1.2.5 What mechanisms are there for children in out-of-home care to talk to someone outside the immediate out-of-home care placement?

In addition to the mechanisms described in Section 2.2.1 of this submission, the vast majority of children and young people in out-of-home attend school where they have access to supportive adults such as teachers and school psychologists. Also, many such children are engaged with other professionals – such as trauma counsellors and private psychologists – outside of their school and placement contexts.

1.3 Practices, procedures and systems for reporting and responding to allegations of sexual abuse in out-of-home care

1.3.1 Requirements and practices for reporting allegations of child sexual abuse both within and outside of Anglicare Victoria.

All out-of-home care services provided by Anglicare Victoria are funded by DHHS. Any allegations that are made relating to sexual abuse/assault of children or young people in care fall within the parameters and requirements of the DHHS *Guidelines for Responding to Quality of Care Concerns in Out of Home Care*, and the *Critical client incident management instruction* and *Responding to allegations of physical or sexual assault* instruction.

Accordingly, Anglicare Victoria has incorporated the directions of all of the above within the agency's *Out of Home Care Quality of Care Practice Instructions* document and *Client Critical Incident Reporting Policy*.

Within a review of research on child maltreatment in organisations, the Australian Institute of Family Studies[3] published the following principles with regard to how organisations can demonstrate capacity to encourage disclosures of abuse alleged to have occurred in organisational contexts, and to respond appropriately to these allegations:

- *Act on all disclosures*: All disclosures should be acted upon, regardless of how long ago the maltreatment occurred, who is disclosing and who is the alleged perpetrator.

- *Encourage early disclosure*: Research shows that maltreatment is often not disclosed until some years after the first incident, during which time the perpetrator has victimised many more children. Organisational policies ought to encourage children to disclose as soon as possible.

- *Clarify unacceptable behaviour*: All children and adults connected to an organisation need to be aware of what is deemed acceptable behaviour from both parties and that every person is equally accountable for their behaviour. Each person must also be aware of the consequences of unacceptable behaviour.

- *Empower children and adults to disclose*: children and adults should be confident that all people involved with the organisation will be heard if they disclose maltreatment, no matter who the perpetrator is, and that all disclosures will be treated equally.

[3] Irenyi, M., Broomfield, L., Beyer, L. & Higgins, D. (2006). Child maltreatment in organisations: Risk factors and strategies for prevention. In *The Australian Institute of Family Studies National Child Protection Clearinghouse, Child Abuse Prevention Issues*, 25.

- *Be transparent*: responses to disclosures must be open and transparent and involve the police, the statutory child protection services or other relevant authority. Managers or church leaders should not be given the power to determine the guilt or innocence of a person alleged to have perpetrated child maltreatment.

- *Respond appropriately to criminal behaviour*: Organisations must recognise the criminal status of abuse. Most child maltreatment and all sexual abuse is criminal behaviour and must be referred to external authorities (police and statutory child protection departments)

Anglicare Victoria fully supports the above principles, with their focus on being approachable, seeking justice and ensuring the protection of victims and other community members. These principles are reflected in the agency's policies and practices that are related to this issue.

All allegations that a child or young person has been sexually abused or assaulted constitute "critical incidents – usually of the most serious category (category one) – depending on the nature of the incident (a young person in residential care "flashing" another young person, for example, may qualify as a category two incident due to its lower severity. Categorisation of critical incident as category one or two is guided by DHHS's *Critical client incident management summary guide and categorisation table: 2011 (Updated December 2012*)).

In accordance with Anglicare Victoria's *Client Critical Incident Reporting Policy* and the DHHS standards, program requirements and instructions to which it accords, such allegations are immediately reported to: both middle and senior managers within the relevant Anglicare Victoria program, and; in the case of category one incidents - Anglicare Victoria executive management, including the Director Quality, Director Client Services, relevant Regional Director, and CEO. Additionally, a formal report is made to the "critical incident reporter" at DHHS, which is usually the program service advisor, as well as the relevant child protection unit manager and any child protection caseworkers and team leaders involved with the child or young person (where they are on a child protection order). Reports for category one incidents are submitted to DHHS within one working day, and reports for category two incidents are submitted within two working days (there are no other incident category levels).

In accordance with the DHHS *Responding to allegations of physical or sexual assault* instruction, all allegations of criminal sexual abuse/assault are immediately reported to police (Section 2.4 of this submission explains this process in further detail. It also explains processes for informing others external to the agency (such as legal guardians of children in care, and sexual assault counsellors) of such critical incidents).

These processes ensure that all allegations of sexual abuse/assault are responded to with a swift, effective and accountable investigation that prioritises the safety of children and young people, and involves the police where criminal behaviour has been alleged.

1.3.2 What data is collected of these reports?

In accordance with Anglicare Victoria's *Client Critical Incident Reporting Policy*, when an incident of alleged sexual abuse/assault occurs involving a child or young person in care, there is a requirement for the staff who witness or become aware of this incident to submit an incident report to RiskMan – the agency's intranet-based incident reporting system. Riskman incident reports – which are used to generate the incident reports that are sent to DHHS – contain important information about critical incidents, including:

- The incident type and category.
- Who was involved (names of clients, staff and others – to the full extent known).
- Where and when the incident occurred.
- The details of the incident (what happened), including immediate action taken by staff to keep clients and other safe.
- Follow up action intended to ensure the ongoing security, safety and wellbeing of clients, staff and others, including plans to prevent reoccurrence of the incident.
- Whether the police were contacted (and if so, the name of the officer/s who received the report).
- Whether the client received medical assessment/treatment, including whether they were admitted to hospital.

Anglicare Victoria collates data on critical incidents and conducts analyses of this data so as to inform service development and ongoing service improvement. This reporting occurs at local and senior management, and Board levels.

1.3.3 With which agencies or authorities does Anglicare Victoria exchange information about these reports?

Anglicare Victoria exchanges information about these reports with DHHS Child Protection and the police, as previously described in this submission. This information may also be provided to parties to legal proceedings within the Children's Court and other Courts/Tribunals.

Recently Anglicare sent our detailed internal reports on our Category 1 and 2 incidents to the Secretary of the Department to illustrate the depth of analysis we undertake on a monthly basis on all of the reports and incidents that occurred in the agency.

Anglicare also has a Board subcommittee that analyses all incidents and reports. We have external experts co-opted to that Committee including Victoria's Deputy Public Advocate and former Departmental Executives.

1.3.4 Anglicare Victoria's view concerning the merits of a consistent national approach.

There is merit to having a consistent national approach. The advantages include that data can be cross checked, policies discussed across jurisdictions to enable the greatest learning and improvement and innovations can be more readily considered. However this won't be a total game changer, as these are State based systems where the focus on the delivery and operation of the out of home care sector is very much at a state operational level.

The Commonwealth Government can play a useful role by using legislation, policy and federal funding to ensure that best practice is continually refined (through empirical research) and consistently employed within state-funded out-of-home care services. However, it is helpful for States to be able to interpret conventions and guidelines concerning best practice into state-based structural and cultural contexts.

Comparison of other state run human services unified by a consistent national approach may be useful to ascertain the merits of a national approach.

1.4 Practices, procedures and systems for supporting children who have been sexual abused in out-of-home care

1.4.1 What does Anglicare Victoria do to support children who have been sexually abused in out-of-home care including providing counselling, support services, specialist services, financial assistance or recompense while in care and after exiting care?

All of Anglicare Victoria's current out-of-home care services are funded by DHHS. Therefore, in accordance with DHHS program requirements, allegations of sexual abuse of children and young people within their out-of-home care environments are considered to be serious critical incidents which trigger "quality of care" investigations. These investigations are planned and carried out by quality of care planning groups comprising both agency and DHHS staff.

Anglicare Victoria's management of and response to such allegations of sexual assault/abuse in care accord to the DHHS *Guidelines for responding to quality of care concerns in out-of-home care* – as set out within our own *Out of Home Care Quality of Care Practice Instructions* document.

The DHHS *Guidelines for responding to quality of care concerns in out-of-home care*, in turn, mandate that our staff must respond to allegations of sexual assault in accordance with the following DHHS instructions:

- *Critical client incident management instruction*
- *Responding to allegations of physical or sexual assault*

Staff receive extensive on-the-job training from their line managers to ensure that their responsibilities as set out in these two DHHS instructions are understood and observed. In a recent (late 2014) and comprehensive external audit of Anglicare Victoria's compliance with DHHS standards and service requirements - carried out for DHHS by the organisation Quality Innovation Performance – Anglicare Victoria was found to be 100% compliant.

The DHHS *Responding to allegations of physical or sexual assault* instruction makes many prescriptions around actions and processes that need to be carried out following an allegation of sexual assault/abuse in care. It is important to note that Anglicare Victoria works with each child's allocated case manager and Child Protection staff in order to ensure that these actions and processes are observed.

Within section 4.2 of the instruction, it states that following an allegation of assault, staff:

- listen to and support the client
- reassure the client that they did the right thing by talking about the assault
- ensure the client's, and others', immediate safety, health and wellbeing needs are met, such as obtaining medical attention and referral to other specialist/victim support services
- ensure the client's specific support needs are addressed including access to communication aides and resources, if required
- tell the client what [they] plan to do next [this will include, amongst other actions, reporting of the critical incident to DHHS in accordance with the DHHS *Critical client incident management instruction*, as well as reporting the incident to the police, in accordance with section 1.6 of the DHHS *Responding to allegations of physical or sexual assault* instruction (or confirming –with absolute confidence - that another professional, such as a Child Protection case manager, will inform the police)]

- with the client's consent engage family, significant others, an independent key support person and/or advocate to support the client and advocate on behalf of the client and ensure their rights are respected [note: later sections of the DHHS *Responding to allegations of physical or sexual assault* instruction set out that when clients have legal guardians (whether or not they are on Custody to Secretary Orders), these guardians must be informed of the incident (see sections 4.3.3 and 4.3.5 of the instruction). An additional section sets out that when a client is on a Guardianship to Secretary Order, their allocated case worker must be informed of the allegation (see section 4.3.4). Furthermore, another section of the instruction (4.3.6) prescribes that when Child Protection clients do not wish for their next-of-kin or guardian to be contacted, the decision about whether to do this is made by a divisional Child Protection manager, taking into account factors such as the client's age and capacity].[4]

This instruction also prescribes (within its section 4.2.1) that clients are to be supported through subsequent justice processes, such as police investigation, prosecution and crimes compensation processes as appropriate, through such actions as:

- ensuring the client has access to appropriate communication aides and tools to facilitate disclosures and the provision of evidence
- ensuring the client has access to a key support person of their choosing [section 4.1 of this instruction sets out that, during police interviews with the child or young person under the age of 18, they must have a parent, guardian or an independent person (other than a DHHS or funded agency employee) present]
- alerting police to the need for an independent third person or independent person [as required in such circumstances as when the client has an intellectual disability] and the client's particular communication support needs, and the need for timely interviews to facilitate the recall of information
- facilitating arrangements with police for interviews and examination of evidence
- facilitating arrangements with specialist support services.

Additionally, the DHHS *Responding to allegations of physical or sexual assault* instruction prescribes (within this same section) that:

> In the case of sexual assault, with the client's consent, staff should consider contacting the Centre Against Sexual Assault, to support the client during this process and ensure the client does not feel pressured to act in a particular way.
>
> It is acknowledged that some discussion may be required to establish safety and a basic understanding of what has occurred. If the client needs to talk about what happened, listen and support the client and reassure the client that they did the right thing by talking about the assault.

Moreover, with regard to clients from Aboriginal and Torres Strait Islander backgrounds, the instruction sets out that (within section 4.4.1):

> Staff should facilitate an integrated, holistic approach with other staff or service providers, which may include accessing both mainstream and local Aboriginal and Torres Strait Islander support services. The client may not want to access the Aboriginal services located in the local area where they reside. Where this is the case, staff should support the client to access services outside of their local area. Appropriate services may include the Aboriginal and Torres Strait Islander Corporation Family Violence Prevention and Legal Service or the Victorian Aboriginal Health Service.

The instruction also sets out, with regard to clients from culturally and linguistically diverse communities, the need to involve interpreting services where required, as well as the need to contact the Centre Against Sexual Assault in order to arrange culturally-specific services for victims (see sections 4.4.2 and 4.4.3 of the instruction).

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[4] Department of Human Services. (2014) *Responding to allegations of physical or sexual assault Technical update 2014.* Retrieved 29th January, 2015 from http://www.dhs.vic.gov.au/__data/assets/word_doc/0005/870035/responding-to-allegations-of-physical-or-sexual-assault-tech-update-2014.doc.

The DHHS *Responding to allegations of physical or sexual assault* instruction prescribes (within its section 4.5) that agreed actions for meeting the client's immediate and ongoing needs must be recorded on the client's care plan/support plan. Such actions must include:

- steps being taken to assure the client's safety and wellbeing in the future

  [in the case of home-based-care, this will include, amongst other actions, working with volunteer foster carers to ensure that they are knowledgeable about what kind of post-assault/abuse behaviours they might observe in the child/young person, how best to respond to these, and how best to otherwise interact with the child/young person so as to best attempt to help them heal and experience resilience. In residential care contexts, where carers are paid and qualified staff, line managers will have similar discussions with staff to ensure consistency of response aimed at achieving safety and promoting resilience]

- treatment or counselling the client may have access to [in order] to address their safety and wellbeing

  [as discussed on the previous page, the Centre Against Sexual Assault is a preferred service for providing counselling to clients who have experience sexual assault/abuse. However, children and young people may be referred to alternative counselling services if these are identified as more readily available and a "good fit" for the child/young person's needs. Such services include those provided by Take Two (Berry Street), the Children's Protection Society, the Australian Childhood Foundation, the Australian Childhood Trauma Group and similar organisations. Where no such services are readily available, or it is the child/young person's preference to do so, Anglicare Victoria supports children and young people to engage with private counsellors, psychologists or psychiatrists. Wherever necessary, the agency would broker any costs associated with children and young people accessing these private services]

- modifications in the way services are provided (for example, same gender care or placement)

- how best to support the client through any action the client takes to seek justice or redress including making a report to police

- any ongoing risk management strategy required where this is deemed appropriate.

Where the alleged perpetrator is a staff member or volunteer (other than a carer), after the agency informs the police (or otherwise ensures they are informed) of the allegations, the staff member/volunteer will either by directed to other duties that do not involve direct care of the client who is the alleged victim as well as any other clients, or stood down entirely (depending on the nature of the allegations and other relevant factors) pending further investigation. The decision to remove the child or young person from the placement (most likely a residential care placement in such contexts) is ultimately made by Child Protection, in consultation with Anglicare Victoria management, depending on the circumstances of the placement, nature of the allegations, and other relevant factors.

Where the alleged perpetrator is a volunteer carer, the decision to stand the carer down and remove the child from the placement is also ultimately made by Child Protection, in consultation with Anglicare Victoria management, taking into account the circumstances of the placement, nature of the allegations, and other relevant factors. In the great majority of instances, the carer is stood down and the child is removed from the placement, pending further investigation. However, in a minority of instances, where there is compelling evidence that the allegations are vexatious or the behaviours that are the subject of the complaint do not actually constitute inappropriate/illegal sexual behaviours (such as when a child might accidentally see a foster carer partially undressed as they get changed), the child may not be removed from the placement. Alternatively, they might be removed for a short time whilst the vexatious/non-concerning nature of allegations is confidently established, then returned to the placement.

When the alleged perpetrator is another out-of-home care client, then every attempt is made to prevent further contact between the alleged victim and perpetrator. Significant consideration is given to relocating one or both children/young people. Decisions in this regard are always made on a case-by-case basis, and are ultimately made by Child Protection in consultation with Anglicare Victoria management. As is prescribed within section 7.2 of the DHHS *Responding to allegations of physical or sexual assault* instruction:

> In principle, the alleged perpetrator should be moved from the immediate work area, such as a house or unit, while an investigation is undertaken.
>
> However, circumstances will differ and it may be more appropriate to move the alleged victim. In deciding who must be moved, consideration must be given to the length of time the alleged victim has been residing in the facility, and whether or not he or she wants to remain in or move from the facility. Action taken must be based on consideration of the best interest of the alleged victim. In the instance in which it is decided the victim should be moved, it should be clearly articulated to them that they are not being moved because they have done something wrong. Decisions to relocate or not relocate people should be documented clearly for future reference.
>
> If the alleged perpetrator is to remain in the same setting, it is essential to plan for the safety of other clients and staff. For clients receiving child protection services this will require DHHS Director approval.

It is important to note that if Child Protection staff decide to remove a child from a residential care or foster care placement to another placement setting that is not provided/facilitated by Anglicare Victoria, we are then unable to carry out the post-incident support actions outlined earlier in this response. The responsibility for ensuring that these actions are carried out then rests with Child Protection, allocated case workers, and staff from the agency that are providing/facilitating the new placement.

1.5 Anglicare Victoria's efforts to support outcomes 2.2, 6.1, 6.2 and 6.4 of the *National Framework for Protecting Australia's Children 2009-2020*

Outcome 2.2

The employment of every Anglicare Victoria employee and volunteer is conditional upon a successful and current *Working With Children Check* (as well as a National Police Check) - as per Victorian DHHS service standards and requirements – so as to assure accordance with the Victorian Working With Children Check Act 2005 and Working With Children Regulations 2006. In a recent (late 2014) and comprehensive external audit of Anglicare Victoria's compliance with DHHS standards and service requirements - carried out for DHHS by the organisation Quality Innovation Performance – Anglicare Victoria was found to be 100% compliant.

Within our out-of-home care (and other) services, Anglicare Victoria receives and discloses information about children at risk in accordance with the DHHS and other services standards and requirements to which the agency is subject. This is also done in accordance with relevant legislation (such as the Victorian Children, Youth and Families Act 2005, the Crimes Act 1958 (with regard to the 2014 "Failure to disclose a sexual offence committed against a child" amendment) and the Information Privacy Act 2000) and in context of the agency's mission, and the purpose of these services – which centre on ensuring children's best interests.

Accordingly, when our trained staff and volunteers form a reasonable suspicion that a child or young person might be at risk of abuse, information is both disclosed to, and received from, Child Protection. This also occurs - to the full extent legally allowable – with other Government bodies and the service staff of other organisations who may usefully contribute to risk assessment of that child or children, and the planning and carrying out of actions aimed to foster protection, wellbeing and resilience for that child or children.

It is worth noting, in regard to this, that our staff report continuing difficulties in pursuing such information from some service staff within many organisations. Many professionals within Victorian social services, educational, healthcare and other relevant sectors that work with children and families remain unaware of the extensive leeway that the Children, Youth and Families Act 2005 provides them with regard to the allowable disclosure of private information for the purpose of protecting children at risk.

With regard to the issue of Anglicare Victoria receiving information about children-at-risk from interstate organisations and Government departments, we do not have legal power to pursue this information directly. DHHS Child Protection in Victoria has in place legally allowable protocols with its interstate counterparts to support the exchange of such information. Accordingly, once DHHS ascertain such information, they pass it onto Anglicare Victoria service staff wherever this is in the best interest of individual children and young people, and legally allowable. In turn, any information that Anglicare Victoria provides to DHHS – as described above – may be passed on by Child Protection to their interstate counterparts.

When Anglicare Victoria out-of-home care staff provide and receive information – in documented form - from Child Protection and other DHHS-funded children, youth and family services, this occurs via a common assessment framework called the *Best Interests Framework*, which in turn incorporates the *Looking After Children* framework. However, these frameworks are typically not in use within other service sectors with which our staff liaise concerning children's needs (such as mental health and other healthcare services, educational institutions, and so on).

Outcome 6.1

Consistent with DHHS service standards and program requirements, Anglicare Victoria's out-of-home care services have procedures in place to ensure that clients are provided with age-appropriate information from parents, carers, health professionals, teachers and/or Anglicare Victoria staff regarding sex, sexuality, relationships, sexual consent, and other important information (such as cyber-safety). This requirement is explicitly prescribed within Anglicare Victoria's *Sex Education Policy*, and, as indicated by a great deal of research findings, is a useful approach to lessen the likelihood of children and young people being subjected to sexual abuse, sexual assault or sexual exploitation.

An additional initiative concerning cyber-safety which Anglicare Victoria provides is operated by our Gippsland Community Legal Service (GCLS), which provides a *Sexting Program*.

The Sexting program is delivered in real court room settings in the Gippsland region with a target audience of secondary students (Year 7 and upwards). GCLS facilitates two versions of the program – one involving mock court scenarios and one involving court room dramas. The sessions run a mock plea in a court room for a young male charged with several sexting and child pornography offences.

Upon conclusion of the scenario, there is a facilitated discussion about the long-term consequences of a criminal conviction – including having one's name placed on the sex offenders register. In the case of the mock court sessions, a police prosecutor, Magistrate and several lawyers are present and directly engage with the students on the repercussions of committing sexting offences, and also the impact this may have on the victim.

Surveys are conducted with both students and teachers after completion and feedback to date has been positive, including that:

- Students feel more confident and assertive when making important decisions about friendships and interacting with their peers, and take the time to consider the consequences of their actions.
- Students know where to go for help with their legal issues.
- Students have an increased awareness of the legal penalties and personal implications of being convicted of an offence for sexting.

With regard to the issue of intervening early with young people exhibiting sexually abusive behaviours, as stated in Section 2.4 of this submission, Anglicare Victoria's management of and response to such allegations of sexual assault/abuse in care accord to the DHHS *Guidelines for responding to quality of care concerns in out-of-home care* – as set out within our own *Out of Home Care Quality of Care Practice Instructions* document.

The DHHS *Guidelines for responding to quality of care concerns in out-of-home care*, in turn, mandate that our staff must respond to allegations of sexual assault in accordance with the following DHHS instructions:

- *Critical client incident management instruction*
- *Responding to allegations of physical or sexual assault*

Within Section 5 of the *Responding to allegations of physical or sexual assault* instruction, prescriptions are set out regarding how to respond to allegations that sexual abuse/assault has been perpetrated by a child or young person who is a client. As these prescriptions state:

> Agreed actions for [meeting] the client's immediate and ongoing needs must be recorded on the client's care plan /support plan. This must include:
> - steps being taken to assure the client's safety and wellbeing in the future
> - treatment or counselling the client may access to support their wellbeing [which, in this context, would encompass intervention aimed at diverting the young person from any future sexual offending]
> - modifications in the way services are provided
> - how best to support the client through any action to prevent recurrence
> - any ongoing risk management strategy required where this is deemed appropriate.

Staff receive extensive on-the-job training from their line managers to ensure that their responsibilities in this respect are understood and observed. In a recent (late 2014) and comprehensive external audit of Anglicare Victoria's compliance with DHHS standards and service requirements - carried out for DHHS by the organisation Quality Innovation Performance – Anglicare Victoria was found to be 100% compliant. We are confident that Anglicare Victoria effectively intervenes early with children and young people who exhibit or report sexually abusive/assaulting behaviours whilst in care – in accordance with the aforementioned requirements set out in the *Responding to allegations of physical or sexual assault* instruction subsequent to any such critical incidents occurring whilst the child/young person is undergoing an out-of-home care placement provided/facilitated by us.

Outcome 6.2

So as to improve the standard of training and support provided to our residential care staff, Anglicare Victoria has commissioned the Children's Protection Society to provide intensive, expert training to Anglicare Victoria residential staff on how to manage young people displaying sexually abusive behaviours.

This training will focus on enhancing staff understanding of:

- Sexually abusive and maladaptive behaviours – including knowledge of potential triggers and effective and safe management and care of this cohort of young people.
- The effects of trauma on young people and those who work with them.
- High risk behaviours and sexual exploitation
- How to manage residential care staff working with young people – including a focus on key considerations and responsibilities (e.g. supervisions and professional development)
- Effective safety planning (individual, group, unit, community and staff)
- How to address vicarious trauma

Outcome 6.4

Anglicare Victoria was formed through an act of Victorian 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.

We feel it is important to acknowledge that throughout this long period, there were clients who received adequate or even excellent care. This care was provided by dedicated and nurturing men and women, and it is important to honour the valuable work that these people performed, sometimes in very challenging contexts such as economic depression and world war.

Despite these "good stories", there were vulnerable children, young people and adults who, tragically and terribly, experienced abuse perpetrated by those charged with their care, or by others within those care settings. Children and young people placed within institutionalised out-of-home care were particularly vulnerable to this abuse.

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 plight 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 Victorian Government from Premier Bracks in 2006, and an apology on behalf of the Australian Government from Prime Minister Rudd in 2009, 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 those victims of abuse who approach the agency seeking redress.

Usually when Anglicare Victoria receives an allegation that a former client was abused whilst in the care of one of the agency's three predecessor agencies, this is made by the former client's legal representatives. In such instances, where former clients are seeking financial compensation, Anglicare Victoria, along with the Anglican Diocese of Melbourne, engages in a process which is designed to help victims of abuse experience redress. Anglicare Victoria has previously described this process on the public record through our submission to The Victorian Parliamentary Inquiry into the Handling of Child Abuse by Religious and Other Organisations (see http://www.parliament.vic.gov.au/fcdc/article/1789).

Part 2. Sexual abuse in out-of-home care – context, key issues and recommendations

Victoria has around 7500 children in out of home care. An estimated 3500 children or young people will move in and out of the system each year. Victoria's out of home care system is growing at an annual rate of 5% per annum. This growth is different, depending on whether the child is indigenous or non-indigenous. For the non-indigenous, the growth is not attributed to a higher number of children coming into out of home care year after year, it is due to children staying in out of home care longer.

For the indigenous population the growth rate is attributed to more children coming into out of home care each year.

Preventing or minimising the occurrence of sexual abuse, assault or intimidation in out of home care has a number of dilemmas.

Firstly, with demand growing at 5%, the ability to mix and match placements as children come into out of home is not 'rated' with the importance it should in our view. As our CEO recently stated in an ABC interview on incidents in out of home care, 'demand placement trumps quality matching every day of the week in this system'.

Thus it is not unusual to have children as young as 9 or 10 in a residential unit with a 15 or 16 year old. Further, gender ratios are not taken into account, as is the process of assessing whether the new placement is in the interests of existing residents. Assessments for residential units tend to only focus on the incoming referral with little focus on the implications on the existing household.

A further dilemma is that children and young people coming into care are often at an age where they are exploring their own sexualities. This can be precarious in residential units where children's developmental milestones will be wide and varied.

Finally there is a demonstrable lack of diversity in the placement options in out of home care. Professionalised foster care, family group homes, and intensive in home professional support are all options that the child entering out of home care could benefit from. Obstacles exist in taxation or employment law that is the domain of the Commonwealth and with their assistance could open up these options as possibilities for out of home care clients.

Further, as the sector has moved away from reception type facilities that were evident in the 60's and 70's, and often for good reason, there are now few residential assessment models operating in the out of home care sector, particularly for a child entering out of home care for the first time. It is Anglicare Victoria's view that too often, due to demand pressure, children go straight through to residential care, often finding themselves mixing with young people who have been in the care system for many years. These can place children at risk of avoidable incidents sometimes of a sexual nature. We believe that jurisdictions need to recognise that models are required to provide an assessment on the needs of the child and on the right placement that they would thrive in.

Anglicare Victoria as Victoria's largest provider of out of home care has been long concerned with these factors in out of home care. To this point we have introduced our own quality mechanisms to minimise the incidents of sexual abuse within out of home care, some of which have been mentioned already in this submission and some of which we present here in this section. The following reflect observations and recommendations at an operational level in addition to the Case 24 terms of reference. Anglicare Victoria has developed approaches to new referral procedures that require better gender balance in units, (with the preference of single sex), guidelines on age differentiation within units to ensure we are developmentally appropriate and senior approval mechanisms when considering the admittance of a child with sexualised behaviours into multi bed units.

The following is a commentary on specific out of home care models and issues of sexual abuse and or exploitation.

Foster care

In our experience, the risk of children and young people experiencing sexual abuse whilst in modern-day foster care placements is low. This is primarily for three reasons. Firstly, the moral character of those people and families who volunteer to care for vulnerable children and young people in their homes is overwhelmingly very high. Secondly, good processes are in place which ensure that any would-be sexual offenders who might infiltrate the foster care system have a drastically reduced opportunity to perpetrate sexual abuse. Such processes include volunteer foster carers and their family members undergoing rigorous screening and assessment, and placements being consistently monitored (these processes were detailed in Part 2 of this submission). Thirdly, unlike with residential care placements, children and young people in foster care are not usually placed with other OOHC clients unless these are their siblings. However there are occasions when allegations of abuse have occurred in the system.

As Anglicare Victoria has advocated many times, foster care placements remain the placement option of choice for children and young people who cannot live at home, and do not have other responsible family members with the capacity to nurture and care for them. As Commissioners of the Royal Commission are no doubt aware, however, the foster care system within Victoria and Australia more broadly is in decline. There are fewer and fewer volunteer foster carers available each year. The reasons for this are complex and multi-factorial, and beyond the scope of discussion here. However, the decline of the foster care system is concerning, as this has resulted in an increase in residential care placements and inadequately scrutinised kinship placements. As will be detailed in subsequent sections of this submission, residential care placements tend to present fewer protective factors and more risk factors for children and young people, whilst kinship care placements currently receive minimal assessment and monitoring (compared to foster care placements), which increases the risk of them being unsafe and decrease the likelihood of this being detected.

Residential care

Anglicare Victoria is vigilant when it comes to preventing sexual abuse occurring within our residential care settings. However, despite our careful and professional approach in this respect, residential care settings – as currently funded and designed by the Victorian Government - are generally less protective placement environments for children and young people than is the case with foster care. This is because of a number of factors, detailed in the following points. Any one of these factors presents risks. However, it is these factors operating in confluence that increases the vulnerability of children and young people experiencing in-care sexual abuse, and other damaging experiences:

1. The great majority of residential care units contain multiple children and young people (usually four within Victorian residential care facilities) who have each been removed from their parents' care due to substantiated neglect and/or abuse. As has been established within a great deal of empirical research,[5] even though the majority of children and young people who experience sexual abuse, physical abuse and/or neglect within their birth families do not go onto perpetrate sexual abuse themselves, having had such experiences puts them at much higher risk of becoming juvenile perpetrators of child sexual abuse.[6] Furthermore, there is evidence that the experience of sexual abuse predicts children and young people subsequently engaging in hypersexual and sexually exhibitionist behaviours;[7] thereby making them vulnerable to further abuse.

   In bringing multiple children and young people who have suffered abuse and neglect into the one living environment, the residential care system functions to bring would-be juvenile sexual offenders into repeated and intimate contact with other vulnerable children and young people, including those who engage in sexualised behaviours that further inflate their risk of experiencing sexual abuse.

2. Despite the risk outlined in the previous point, it is usually the case that little or no attempts are made by DHHS Child Protection's Placement Coordination Units (PCUs) to assess the needs of, and risks posed by, individual children and young people and ensure that appropriate placement-matching takes place when arranging residential care placements. This is attributable, to a great extent, by the need for Child Protection to find placements for children who cannot live at home, in the context of an under-resourced and over-burdened out-of-home care system that contains diminishing foster care options.

   Accordingly, residential care service providers such as Anglicare Victoria are often pressured into accepting placements that do not take appropriate account of a given child or young person's stage of development, gender, mental health, behavioural tendencies and overall potential to be a perpetrator and/or victim of harm in context of the mix of other children and young people in the prospective residential care unit.

   Consistent with this, it is important to note that mixed gender units are virtually the norm within the system, and that it is not uncommon for children and young people across a very broad age-range to be placed together in the one setting. Whilst this is a normal occurrence within families, in residential care settings such wide-age variation within living environments, and mixing of genders, is highly problematic, and can unnecessarily inflate the risk of sexual abuse occurring between residents.

[5] For a review, see Vizard, E. (2013). Practitioner Review: The victims and juvenile perpetrators of child sexual abuse – assessment and intervention. In *The Journal of Child Psychology and Psychiatry*, 54(5): 503-215.
[6] Overwhelmingly, this is relevant to males, as the vast majority of juvenile sexual offenders are male (see Vizard (2013)).
[7] See Vizard (2013)).

In addition to these aforementioned risk factors which are characteristic of residential care environments, it is also important to note that children and young people in care face the risk of experiencing sexual abuse or assault outside of their care environments during the period of their placements (for instance, when they are out with friends, or have absconded from their placements).

In Anglicare Victoria's experience, a minority of reported 'critical incidents' of a sexual nature concerning children/young people in care occur outside of their care settings (most are reported as having allegedly occurred within residential care units). However, whilst fewer in number, these incidents tend to be more serious or harmful to victims, such as those outlined in the points below. Overwhelmingly, incidents of this nature involve alleged perpetrators that are not co-residents within the clients' care environments.

- More serious acts of indecent assault (involving forced skin-to-skin contact, rather than unwanted touching over clothes)
- Rape (attempted and completed)
- Adults grooming children and young people under the age of 16 for the purpose of initiating an abusive sexual relationship
- Young people engaging in prostitution – typically for the purpose of acquiring money and/or illicit substances
- Young people below the age of consent entering into sexual relationships with other young people or adults who are more than two years older than them.

Sexual abuse or exploitation perpetrated against children and young people residing in care typically concerns female clients, and tends to be perpetrated by male adults or peers who opportunistically assault or exploit them. Most (but not all) of the more serious critical incidents of a sexual nature – such as rape – appear more likely to occur in such circumstances.

Kinship care

Kinship care placements involve children and young people being provided with an out-of-home living arrangement by extended family members - such as grandparents, or aunts and uncles - or, less commonly (though increasingly), non-relatives - such as family friends, sports coaches, and so on. Such placements may be voluntarily agreed to by birth parents or ordered by the Children's Court, and are an alternative to agency-facilitated foster care or residential care placements.

Within Victoria, and Australia more broadly, such arrangements now comprise at least half of all out-of-home placements. In Victoria, the majority of kinship care placements are arranged and supported by Child Protection workers, whilst a minority are supported by DHHS-funded kinship programs which are provided by agencies such as Anglicare Victoria.

In many cases, kinship care arrangements are ideal placement options for vulnerable children and young people who cannot live at home. When kinship carers have the capacity to consistently provide nurturing care to children and young people which is on par with the quality of care that would be provided within a sound foster care environment, these arrangements present an added protective factor in that an established, positive relationship already exists between the carer/s and the child/young person.

However, Anglicare Victoria is concerned that screening, assessment and monitoring of these kinship placements, and ongoing support provided to kinship carers, is quite minimal compared to what is the case with foster care and residential care placements.

Within Anglicare Victoria's kinship program, DHHS funding of the program - which is in line with DHHS program requirements – only financially allows for our staff to visit children and young people in kinship care placements once per month, however we visit on a weekly and fortnightly basis as a norm. Most Kinship case management are managed by Child Protection and given the demands on their time such contact often occurs even less frequently when kinship placements are supported by Child Protection workers only. Moreover, our staff are not involved in the initial arrangement of these placements. Rather, these kinship care arrangements are organised by Child Protection workers who often assess the suitability of potential carers only by conducting a police check of them; with little consideration being given to the "fit" between a kinship carer's capacities and family situation with the specific needs and presentation of the child/young person being placed. Improvements can be made with systems on these fronts.

Monitoring and quality improvements are needed to be further developed for the kinship area, but also do require such improvements to reflect the unique and sometimes more complex circumstances that surround kinship care in particular. Such carers should also be provided with much more intensive ongoing support and training; at least on par with that provided to foster carers (see Part 1 of this submission).

The importance of assessing "fit"

The views and concerns raised in this submission so far are all underpinned by a central theme - the importance of assessing the "fit" between each child/young person who is to be placed in OOHC with the characteristics of any prospective placement environment.

Conducting such assessment involves considering the child's/young person's age and developmental stage, gender, culture, personality, mental health presentation, abuse/neglect history, known behavioural tendencies and any other relevant factors in light of the personalities and profiles of other people who will be present in the placement environment. Such other people might include co-residents – in the case of residential care placements - or the family members of a foster carer or kinship carer. It also involves consideration being given to the skills and capacities of the carers themselves, whether these are paid residential carers or volunteer foster carers or kinship carers.

At present, the OOHC system within Victoria, is not structured, funded and run in such a way that adequate assessments of "fit" consistently guide decisions about where a child or young person is placed, and how they and their carers will be supported in this placement. Largely, this is due to inadequacies within the residential care and kinship care systems, rather than in the foster care system.

The result of this is can be that children and young people are placed at increased risk of being sexually abused whilst in care, as well as experiencing other damaging events.

What would make a difference?

In light of the views and concerns raised in this submission so far, Anglicare Victoria contends that the following actions and initiatives could ameliorate some of the aforementioned risks, and thereby lessen the likelihood of children and young people being sexually abused in care.

1. **Substantial investment is made to increase the number of foster carers available to care for children and young people who cannot live at home. This will help diminish the need for residential care.**

   Foster care placements are not only better placed to provide highly traumatised and vulnerable children and young people with more naturalised and less-institutional home-like environments, but can offer greater opportunities for consistent, positive, normative and potentially restorative attachment relationships.

2. **Investment is made to develop a professionalised 'in-home care' service-option for children and young people as an alternative to residential care when foster care placements are not available.**

   Rather than paying volunteer foster carers so as to render them 'professionalised', as has been suggested by some within the sector, it would be preferable to pay appropriately-qualified professionals (such as nurses, social workers, youth workers, etc.) to live within a home-based care environment with cared-for children and young people, instead of simply "doing shifts" in such environments - as is currently the case with residential care. This would enable such professionals to develop more stable and caring/mentoring relationships with children and young people; thereby imparting on them more of the relationship-mediated protective influence which tends to be more characteristic of foster care, and not residential care.

3. **That, in making decisions about potential placements into residential care, Child Protection (and equivalent statutory bodies across Australia) should be guided by the following principles:**

   a. **Children under twelve should not be placed into residential care.**

   b. **No child or young person within a unit should be more than two years older or younger than any other child or young person in the same unit.**

   c. **Units should only contain children and young people of the same gender.**

4. **For kinship placements:**

   a. **That more effort is put into kinship care placement monitoring, including ensuring kinship carers and children/young people placed in kinship care receive at least fortnightly in-person visits from Child Protection workers or contracted social services staff.**

   b. **Require kinship carers to be offered training and support options on par with those offered to foster carers.**

5. **That dedicated, short–term 'assessment homes' are established to provide interim support and accommodation to children and young people for whom an appropriate out-of-home care placement is yet to become available.**

   These homes would need to be constantly staffed with sufficient numbers of highly qualified professionals, and have in place appropriate resources and specific protocols to best cope with the mix of clients they would receive, and any associated risk. Concerted efforts must be made to avoid the creation of an institutional environment. This must be a short-term placement setting only.

6. **That the residential care service model enables the employment of one full-time nurse, trained in mental health screening and sexual health interventions, per 16-20 beds.**

   Bringing health into as a mainstay of out of home care provision would be a welcome discipline that residents should be exposed to. The role of this nurse would be to consult with children and young people and residential care program staff, extending to the provision of sexual health education/interventions and screening of mental health issues. The nurse will also act as a bridge; enabling clients better access to the broader healthcare system, particularly for youth mental health and alcohol and other drug services.