<NUMBER> SEXUAL HEALTH AND PROTECTIVE BEHAVIOURS IN RESIDENTIAL CARE

Related Policies
WMV Child Safety Policy

Scope
These procedures apply to the following persons: individuals elected to Wesley Mission Victoria boards, committees and sub committees, permanent and casual employees, volunteer carers, mentors or other volunteers, contractors, sub contractors, agency staff providing care in WMV facilities or on behalf of WMV, persons working as "lead tenants", students completing practical work or other placements and any other person involved with Wesley Mission Victoria.

Definitions and Abbreviations
Protective Behaviours *refers to teaching behaviours which enable children to recognise situations in which their personal space and sense of safety may be compromised.* ***Sexual health*** *covers physical, emotional, mental and social wellbeing in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity.* ***Sexual abuse*** *involves the use of an individual's power or authority over the child to involve the child in sexual activity. Child sexual abuse involves a wide range of sexual activity including fondling genitals, masturbation, vaginal or anal penetration by a finger, penis or any other object, voyeurism and exhibitionism. It can also include exposure to or exploitation through pornography or prostitution. Failure to protect a child from sexual abuse may in part relate to parental impairment or lack of parental competence to protect the child from such abuse.* ***Sexual exploitation*** *is the involvement of children and young people under 18 in exploitative situations and relationships with an adult where the young person receives 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, or engaging in sexual activities with the person/ persons exploiting them or others* . ***Sexual orientation or sexual preference*** *refers to an individual's natural preference in sexual partners; including homosexuality, heterosexuality, or bisexuality.*

Problem sexual behaviours *or sexualised behaviours refers to sexual behaviour by children including excessive masturbation, sexual approaches to adults, play with overt sexual themes, forced sexual behaviour, sex play with other children and an obsessive interest in pornography. The term problem sexual behaviour generally refers to instances where all children involved in the behaviour are under the age of 10.*

Sexually abusive behaviours *refers to the use of a child's power, authority or status to engage another party in sexual activity which is unwanted or where, due to the nature of the situation the other party is not capable of giving consent (for example, animals or children who are younger or who have a cognitive impairment. Physical force or threats may sometimes be used. Sexual activity may include peeping, fondling, masturbation, oral sex, penetration of a vagina or anus using a penis, finger or object or exposure to pornography. This is not an exhaustive list.* *(Therapeutic Treatment Board)*

Introduction

Most children and young people receive education about sexuality, relationships, appropriate boundaries and self protection from parents, schools and others within the safe environment of their family.

The circumstances of children and young people in out of home care including fragmented relationships with parents, and multiple placements mean that there are fewer opportunities to learn about sexual health and relationships from trusted adults. Past sexual abuse leaves children/ young people vulnerable to further abuse (Family Planning Queensland) and unaware of sexual health and contraception information. Sex education provided in school may be missed due to poor attendance and placement changes resulting in the need to change schools.

Young people in residential care are particularly vulnerable to peer pressure to experiment sexually, vulnerable to assault by others in care and involvement in sexually exploitative relationships with adults.

Australian and American studies of children and young people in out of home care have identified;

- Children in care are less likely to access school sexuality education programs and are less likely to have the same sexuality knowledge of their peers (Family Planning Queensland).
- Both male and females who had been in care had higher sexual risk behaviors than their peers due to early life experiences. Female participants were more likely to have Trichomonas, a common sexually transmitted disease and the males were more likely to have Gonorrhea and Chlamydia.

(University of Washington)

- A quarter of girls in out-of-home care gave birth soon after leaving care - a rate 24 times higher than the rate of teen pregnancy in the general population. National Australian Study 2006.
- Young people in care are 2.5 times more likely than youth in the general population to get pregnant at least once before they turn 20. (National Campaign to Prevent Teen and Unplanned Pregnancy USA)

Role of residential care workers

Residential care workers play a significant role in assisting children and young people to make safe and positive choices about sex and relationships by;

- Modelling behaviour which affirms the worth of all children and young people in care and their value as individuals.
- Being familiar with the information provided to children and young people in sexual health and protective behaviour programs and supporting these messages in an ongoing manner, particularly with regard to appropriate contraception, transmission of HIV and other sexually transmitted diseases.
- Being prepared to answer questions in a clear and non-judgmental manner.
- Helping children and young people manage the changes associated with adolescence with information and support, promoting a positive body image and self worth.
- Helping children and young people who are victims of sexual abuse learn to separate affection from sexual contact and develop healthy relationships.
- Understanding the sexual health issues and needs of disabled children and young people in care.
- Responding sensitively to a young person who may disclose that they are gay or lesbian or that they are confused about their sexuality and ensuring they are not bullied or intimidated by others.

- Helping young people develop positive relationship skills, act responsibly and treat sexual partners and others with consideration.

Assessment

- On a child or young person's entry to residential care the case manager, in consultation with the care team must review information contained in previous care and placement plans/Assessment and Progress Record/Individual Education Plan (to determine sex education provided at school) and child protection history (including any history of sexual abuse or problem sexual behaviour) to assess how best to provide sexual health education and (as appropriate) information regarding contraception.

- The care team must assess the most appropriate person or agency to provide the sexual health education in the context of the child/ young person's age, stage of development, history of abuse and need for ongoing sexual health advice, support and counselling.

  Sexual health and protective behaviours programs for children and young people who have suffered sexual or other forms of abuse can revive painful memories.

  It is important that facilitators are appropriately briefed regarding the possibility children/ young people may be victims of sexual abuse or display problem sexual behaviour or sexually abusive behaviour as appropriate and consult with any assigned mental health clinician. Personal information regarding the child or young person should not be shared with facilitators.

- The key residential care worker must consult with the person or agency providing the sexual health education regarding the information to be covered and appropriate actions by residential care staff to support and reinforce the information provided to the child/ young person, particularly with regard to contraception and protection from HIV, Hepatitis C and other sexually transmitted diseases.

- The key residential care worker and other residential care workers must encourage and support the child/ young person to take part in sexual health education, provide confirmation of the care team that the education has been provided and document this on CRISSP.

Culture and Ethnicity

Some cultures and religions have differing views regarding appropriate sexual behaviour, relationships and use of contraception. It is important that advice is sought from culturally

appropriate agencies regarding issues of sexual health and relationships for children/ young people from different backgrounds and this information is considered in care planning decisions.

Protective behaviours

Protective Behaviours refers to teaching behaviours which enable children/ young people to recognise situations in which their personal space and sense of safety may be compromised. Research suggests that perpetrators of sexual abuse are less likely to choose victims who demonstrate knowledge of self protection skills. (Family Planning Queensland)

The benefits of receiving positive, consistent information about self protection include:

- the development of a safety network of trusted adults to talk to
- increased communication skills to talk about bodies
- an understanding of healthy, respectful relationships
- learning to identify and express personal boundaries
- knowledge to identify abusive situations
- children/ young people are less likely to experience future sexual abuse

- The Residential Care Program Manager/ team leader must ensure an age appropriate Protective Behaviours program and material is provided to all children and young people entering residential care or included in sexual health education as appropriate.

  It is important that facilitators are appropriately briefed regarding the possibility children/ young people may be victims of sexual abuse or display problem sexual behaviour or sexually abusive behaviour as appropriate.

- Residential care workers must familiarise themselves with the content of the Protective Behaviours program and support and reinforce the information provided in their day to day care of children and young people.

- The key residential care worker must document the child/ young person's completion of the Protective Behaviour program on CRISSP

Situations where a child/ young person's behaviour or relationships concern carers

- Residential care workers who become concerned that a child/ young person's sexual behaviour or relationships with others place them or others at risk must raise the concerns with the team leader and case manager.

Access to condoms and contraceptives for a young person under the age of sixteen

The age of consent in Victoria is 16. In instances where the care team identify a young person under the age of 16 is likely to begin to have sex or to continue to have sex, whether or not he/she is provided

with condoms or other means of contraception and where their physical and mental health would be likely to suffer if these are not provided;

- The case manager must consult with the child's General practitioner (G.P), sexual health educator or mental health clinician as appropriate regarding their views of the appropriateness of enabling the young person's access to condoms or other contraceptive measures.

- The case manager must obtain the consent of the DHS Case planner regarding provision of condoms or other contraceptive methods to a child under the age of 16.

- The case manager in consultation with the Child Protection Case Planner must consider consultation with the child/ young person's parents unless this is assessed to be not in the child's best interests.

- The residential team leader or key residential care worker must document the details and rationale for the decision to make condoms or contraception accessible on CRISSP and young person's unit file.

- Where access to condoms or contraceptives has been authorised, the sexual health education provider, General Practitioner (G.P), case manager or key residential care worker must discuss this decision with the young person in the context of their ongoing sexual health and responsibility to ensure their own safety and the safety of others.

Safety

Sex education and protective behavior programs need to occur in a safe stable environment which nurtures the development of a healthy sexual identity

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All children and young people in residential care have a right to expect carers will act protect them from abuse, harassment (including sexual harassment or harassment due to sexual preference), intimidation and bullying.

- The residential care worker introducing a new child/ young person to the unit expectations must explain the purpose of the unit is to keep children/ young people safe. If they feel unsafe at any time, they must tell the staff member on duty, another staff member or an adult they trust.

  Workers should assist children/ young people to identify trusted adults to whom they could disclose if felling unsafe.

- Residential care workers must provide effective levels of supervision of children and young people. They must act to prevent or stop instances of bullying, intimidation or harassment (including sexual harassment or harassment due to sexual preference, derogatory language gestures or innuendo) between children/ young people quickly, calmly and firmly.

  Carers must implement measures to comfort and support those who have been targeted. Details must be recorded in the unit communications book and child's unit file to ensure other staff are aware and act consistently.

- Residential care workers must inform the team leader or case manager where a child/ young person repeatedly bullies, or intimidates other children or young people. This information must be discussed with the care team and appropriate strategies to address the behaviour must be incorporated into the behaviour management plan.

- If there is concern regarding potential for further bullying or intimidation of a child/ young person who has informed the carer they feel unsafe, clear messages must be provided to that this will not be permitted. Carers must monitor that this does not occur, implement appropriate consequences (in accordance with the child/ young person's behaviour management plan) if there is evidence of further bullying and inform the care team for review.

- Residential care workers must not use language or humour which incorporates derogatory or other negative comments, put downs, threats or remarks regarding a child's gender, culture, religion, disability, sexuality, sexual orientation or appearance.

- Residential care workers must not use obscene or suggestive language, gestures, jokes or innuendos of a sexual nature with or around children.

Problem sexual behaviour and sexually abusive behaviour

- Where carers become aware of sexualised or sexually abusive behaviours by children or young people in residential care they must respond in accordance with the procedures contained in the WCYFS Children with sexualised behaviour in out of home care procedures.

Sexual exploitation

Sexual exploitation is the involvement of children and young people under 18 in exploitative situations and relationships with an adult where the young person receives 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, or engaging in sexual activities with the person/ persons exploiting them or others.

- Where residential care workers are concerned a child/ young person may be involved in an exploitative relationship or at risk of involvement they must respond in accordance with

the procedures contained in the WCYFS Caring for children/ young people at risk of sexual exploitation procedure

Privacy

All children and young people in residential care have a right to private space and time. It is important for the child/ young person to understand that privacy does not mean that he/she can take part in sexual relationships or sexual activity where it is not allowed.

- Residential care workers must ensure children/ young people have private space and time in accordance with their age, stage of development, the identified risks and the care plan.

  For example children should:

  - be able to dress and bathe and go to the toilet in private
  - be able to spend time in private if they choose.
  - be able to store their personal belongings safely in a private place.

  Protecting a child/ young person's privacy must be balanced against their age and stage of development, the responsibility to protect the child from harm and to act in their best interests.
- Residential care workers must always conduct personal discussions with a child in private but preferably in sight of others where possible.

Children/ young people who are gay or lesbian

Children and young people who are gay, lesbian or confused regarding their sexuality can find residential care a particularly difficult environment. US research suggests young people may not perceive it as safe to identify as gay or lesbian in a group care setting (Mallon, Aldedort, & Ferrera, 2002, p.419).

Where young people perceive carers and other young people in residential care display negative attitudes to homosexuality or where carers fail to protect or support a child who is bullied by others due to their sexual orientation this may compound trauma experienced as a result of abuse and impact significantly on a young person's feelings about themself. It may also deter them from seeking help or advice regarding their sexuality, safe sexual practices or seeking medical attention for treatment of sexually related symptoms if they are sexually active.

Children and young people with disabilities

Young people with an intellectual disability have the same range of sexual thoughts, attitudes, feelings, desires and fantasies as young people without disabilities. Yet, they often have fewer opportunities to engage in age-appropriate sexual activity than others of the same age. Sex Education – Young People with Disabilities. Better Health Victoria

It is important that all young people are educated about sex and given the chance to explore, and express their sexuality in positive and healthy ways. Sex education also provides the opportunity to learn protective behaviours.

Sexual health services for young people

- **The Action Centre – Family Planning Victoria** provides sexual and reproductive health services for people under 25. Level 1, 94 Elizabeth Street, Melbourne. (Near Flinders St Station).
- **Young People's Health Service – Centre for Adolescent Health**. Co- located in the CBD with Frontyard Youth Services 19 King St, Melbourne
- **Youth Clinic – EACH Social and Community Health.** 36 Warrandyte Rd, Ringwood.
- **South Eastern Centre Against Sexual Assault**. 11 Chester St, East Bentleigh
- **Victorian Aboriginal Health Service**. 186 Nicholson St, Fitzroy
- **Gay and Lesbian Health Victoria.** For referral and information. Tel 9479870

Variations to Procedure

Service Specific Variations

Related Documents

Related Forms, Guidelines, other documents
Children with problem sexual behaviours and their families. Best Interests case practice model. Specialist practice resource. DHS. 2012 Adolescents with sexually abusive behaviours and their families. Best interest case practice model. Specialist practice resource. DHS. 2012
Related Local Procedures

WCYFS Children with sexualised behaviours in out of home care

WCYFS Caring for children at risk of sexual exploitation procedures.

WMV Child Safety Procedures

WCYFS Appropriate physical contact with children guidelines.

WCYFS Responding to Allegations of Physical and Sexual Assault.

External Context

Relevant Standards
Program requirements for residential care services in Victoria 2014 (DHS)
Relevant Legislations / Regulations
Children, Youth and Families Act 2005

Revision Record

Version	*Date*	*Document Writer*	*Revision Description*

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Attachment 1

Recognising signs of abuse and neglect

Behavioural or physical signs which assist in recognising child abuse are known as indicators. A single indicator can be as important as the presence of several indicators. A child's behaviour is likely to be affected if he/she is under stress. There can be many causes of stress, including child abuse, and it is important to find out specifically what is causing the stress.

Physical Abuse

Signs which indicate possible physical abuse include:

- Bruises, burns, sprains, dislocations, bites, cuts
- Fractured bones, especially in an infant where a fracture is unlikely to occur accidentally
- Poisoning
- Internal injuries

Possible behavioural indicators include:

- Showing wariness or distrust of adults
- Wearing long sleeved clothes on hot days (to hide bruising or other injury)
- Demonstrating fear of parents and of going home
- Becoming fearful when other children cry or shout
- Being excessively friendly to strangers
- Being very passive and compliant

Sexual Abuse

Sexual abuse is not usually identified through physical indicators. Often the first sign is when a child tells someone they trust that they have been sexually abused. However the presence of sexually transmitted diseases, pregnancy, or vaginal or anal bleeding or discharge may indicate sexual abuse.

One or more of these behavioural indicators may be present:

- Child telling someone that sexual abuse has occurred
- Acting out sexual behaviour with dolls, toys, siblings or other children
- Drawing or writing that directly or indirectly describes abuse
- Changes in behaviour when personal needs are attended to e.g. bathing, nappy changing, toileting.

- Complaining of headaches or stomach pains
- Experiencing problems with schoolwork
- Abnormal wetting or soiling problems
- Loss of appetite
- Displaying sexual behaviour or knowledge which is unusual for the child's age
- Behaviours such as frequent rocking, sucking and biting
- Experiencing difficulties in sleeping or night terrors
- Having difficulties in relating to adults and peers
- Obsessive and compulsive washing
- Behaviours which are out of character
- Self harming behaviours
- Sudden unexplained fears, or the fear of being alone with a particular person
- Bed wetting or soiling
- Implication that they must keep secrets

Emotional Abuse

There are few physical indicators, although emotional abuse may cause delays in emotional, mental, or even physical development.

Possible behavioural indicators include:

- Displaying low self esteem
- Tending to be withdrawn, passive, tearful
- Displaying aggressive or demanding behaviour
- Being highly anxious
- Showing delayed speech
- Acting like a much younger child, e.g. soiling, wetting pants
- Displaying difficulties in relating to adults and peers

Neglect

Physical indicators include:

- Frequent hunger
- Malnutrition
- Poor hygiene
- Inappropriate clothing, e.g. Summer clothes in winter
- Left unsupervised for long periods
- Medical needs not attended to
- Abandoned by parents

Possible behavioural indicators include:

- Stealing food
- Staying at school outside school hours
- Often being tired, falling asleep in class
- Abusing alcohol or drugs

- Displaying aggressive behaviour
- Not getting on well with peers

Attachment 2

Appropriate physical contact with children

Cultural considerations

Different cultures have varying attitudes to appropriate physical contact. Some also have strong views regarding physical contact between genders which has important implications for the care of children from these backgrounds. There are a range of culturally specific agencies which will provide guidance regarding appropriate care for children.

A significant number of children receiving services from WMV come from communities which have experienced significant violence and trauma in their countries of origin. The needs of these children are complex and significant and it is essential that program managers and stakeholders access relevant cultural information regarding appropriate physical contact and implement this approach consistently. Approaches utilised must comply with the provisions of this policy.

Children with disabilities

Children with disabilities have a range of needs and it is likely stakeholders may be required to engage in a greater degree of physical contact than with other children. This may involve providing assistance with dressing and undressing, bathing or showering, toileting and other personal care needs. Children with disabilities may also engage in a range of sexualised behaviours toward stakeholders and others due to their disability.

Supervisors or program managers must provide comprehensive pre briefing information and direction to volunteer carers or others providing care to children regarding communication strategies where required, the management of sexualised behaviours including the need for additional staff to monitor or assist, recording or reporting arrangements and appropriate practice for bathing, toileting or personal care requirements. The behaviour of stakeholders must comply with the information, direction or management plans provided by supervisors at all times.

The vulnerability of children with disabilities means they have an increased reliance on adults to protect them from harm. Stakeholders must remain continually alert to verbal and non verbal cues from children and the behaviour of other stakeholders.

Appropriate physical contact

Physical contact between stakeholders and children must only occur when it is essential to the work role of the individual and appropriate to the activity and the needs of the child. Physical contact should take place in view of others wherever possible, undertaken only with the permission of the child and be appropriate to the child's age, developmental stage, disability, gender and cultural background. In all instances contact must be limited to completion of a specific task and for the minimum time necessary.

Physical contact between adults and children has the capacity to be misconstrued. Stakeholders must consider what is an appropriate response to a child or situation before acting.

The following considerations are a guide only. Their relevance to particular stakeholders will vary depending on the age, behaviour, disability and needs of children and the specific work environment.

- Touching a child between the neck and knees is generally inappropriate unless required to provide particular assistance. Contact with the bony areas of the body including the child's hand, arm, shoulder, upper back, elbow or head is preferable.

- Stakeholders must always ask a child's permission to touch and signs from the child that contact is unwelcome (such as stiffening or pulling away) must be respected.

- Where ever possible stakeholders should avoid physical contact with a child out of view of others.

- Physical gestures to provide comfort or congratulations should be non intrusive and accompanied with comforting or positive words. A sideways hug around the shoulder from a stakeholder to a child is more acceptable than around the waist. Care should be exercised to ensure these situations do not occur in private.

- The use verbal directions or gestures are preferable for activities rather than physically moving the child to a particular location. Where touch is necessary always ask the child's permission and conform to the guidelines listed above.

- Stakeholder involvement with toileting, bathing or personal needs must reflect the child's individual management plan and where possible and appropriate, should be undertaken in view of another stakeholder.

- In some situations it may be necessary for stakeholders to discourage a child from unnecessary or inappropriate displays of affection including holding hands, hugs and cuddles. This should be done gently and in a manner which does not embarrass or offend the child.

- Stakeholders must not engage in any physical activity with a child which could be construed as sexually stimulating.

- Stakeholders must not initiate or respond to inappropriate or unnecessary physical contact with children, e.g.: tickling, massages.

- Stakeholders must not use physical punishment of children under any circumstances.

- Stakeholders must not use physical restraint of a child unless this is in accordance with an endorsed

behaviour or crisis management plan. Methods of restraint should avoid contact with the areas of the groin or breasts.

Reference:

Safe People, Safe Programs, Safe Places. Team members guide. Child Safe

Protective Practices for staff in their interactions with children and young people. Guidelines for staff working or volunteering in education and care settings. Department of Education and Children's Services. South Australia. 2011

A guide to protecting children and young people with disability and preventing abuse. Department of Education and Child Development. South Australia