Preventing Sexual Abuse of Children in Out of Home Care

Anglicare Australia is a network of over 40 agencies across Australia and within our region. We are a national voice for those who use our services; working as part of a network we put the most disadvantaged at the heart of our society.

In supporting children and young people in out of home care the Anglicare Australia network has 14 members placed in 46 sites around the country with over 460 people working to protect and support 2,350 children and young people. Combined the network expends roughly $63.5 million on out of home care services.

This response is provided as a complement to those submissions provided to the Royal Commission by Anglicare Australia network members. It is not an exhaustive response but is grounded firmly in the Anglicare experience. Any contradiction found between those submissions and this response is the responsibility of Anglicare Australia. In responding to the Commission’s questions, we have combined those questions of a similar nature to provide a comprehensive response and minimise duplication.

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

Whilst the National Standards for Out-of-Home Care seek to drive quality outcomes for children and young people in out of home care settings, the fact remains that child protection and the care of those young people who have been removed from their families remains a jurisdictional remit. And across the jurisdictions, the Commission might be well aware, there is variation in coverage, complexity and integration of child protection systems. Despite the range of variation there are common factors that Anglicare network members agree are essential elements to keeping children safe in OOHC settings.

Primarily, a strategy for the ongoing protection of young people in OOHC setting from abuse is – pragmatically – an integrated service system; the capacity of one entity or agency system to ‘speak’ – whether virtually or in real time – to another.

In most jurisdictions there are a number of key players involved in the child protection ‘system’. At any one time a young person might be engaged with the bureaucracy, community partners or an independent body regulating the process at the same time as becoming accustomed to a new homelife. Each of these players – and the associated frameworks and operations that support them – hold at their core the best interest of the children and young people they protect. The hinging point, however, is whether the expression of that interest is realised in practice.

Even from the point before removal, as the young person moves through the protection system, he or she is best supported by a seamless transition between each of those agents. We know from other sector experiences, such as disability, that navigating complex pathways can impact greatly on the efficacy of the support that is received. And a child’s movement through the protection system is very rarely linear, that is starting at one end and proceeding through to the other without interruption. More often than not their experience in the system is dynamic, transitioning between biological families, any number of foster care placements, possible residential settings and round again. Through targeting potential hazard points and developing strategies to increase connections between entities and systems the complexity of moving through the system with its numerous contact points is mitigated, allowing the young person’s focus to be
on settling into the new home setting. Navigating the complexity of the child protection system should not be the responsibility of the young person.

Interestingly, not all mechanisms ensuring child safety are subject to or the result of imposed conditionality by overseers but rather go beyond what is required to ensure best practice. Some of the strategies for enhancing the protection of children from sexual abuse listed by network members include organisational hygiene factors. Similar to the requirements of differentiated systems to be able to communicate, so too is it necessary for internal protocols to be cohesive with child protection principles. For example, quality recruitment practices, workload benchmarks, training, supervision and other internal protocols have all been cited as factors contributing to child safety. Quality Assurance in these areas ensures the right people are working with the young people and have capacity within those roles to build trusting relationships with them as well as those who care for them.

Building duty of care into broad organisational practices – as well as service practices – including role delineation and reporting lines creates transparency and accountability but at the same time enhances and protects the ability of staff to establish meaningful connections with the young person. It facilitates the consideration of the young person in the multifaceted context of their lives and allows support workers to operate dynamically with regard to their ongoing support and protection.

Of note here is often the expense of raising the standards of internal operations to reflect the best practices of working with and preventing further abuse of traumatised children and young people is in excess of that provided in terms of any funded arrangements with departments. Anglicare network members absorb additional costs as a necessary means of protecting young people which indicates, in some measure, the additional value that comes from agencies which are mission driven.

Child protection agencies – both statutory and community based – are encouraged to critically reflect on internal practices in order to ameliorate ineffective policies and processes and promote effective strategies for organisational development. National guidelines exist though the extent to which any jurisdiction adheres to them is a matter for that jurisdiction. Jurisdictional and national level standards should include within them guidance and tools around how agencies might reflect on these internal process but at the same time ought to be harmonised and consistent across jurisdictions.

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

Based on anecdotal evidence from Anglicare network members there are indeed distinct differences in the strategies required to protect children from abuse in different care settings. Among network members one of key mechanisms for preventing or detecting early signs of abuse is the level of and quality of contact the young person has with adults separate to those providing care. The impact of direct observation by trained workers of the young person’s physical appearance, emotional state or change in mannerisms due to abuse cannot be underestimated. Nor can be the opportunity for relationships to develop between the young person and adults, independent of carers, which might provide a safe space for the young person to disclose experiences of abuse.

If the different types of care were represented on a scale of contact, residential care settings would sit at the high-contact end with the greatest opportunity for access while kinship care would sit at the other with the least opportunity for contact with the young person. Foster and family group homes would sit somewhere in-between. As adult contact with the young person diminishes the risk of abuse going undetected increases.

In all cases, it is vital to respond quickly to signs and disclosures of abuse. When the young person has fewer connections with formal agencies the opportunities to disclose abuse or have the signs of abuse recognised, if it is occurring, are considerably curtailed. In turn this lack of engagement with the young person limits how responsive care workers can be.
In many jurisdictions there are concerns over the rigour of the processes for identifying and supervising kinship care placements. Whilst the child is moving into a family setting there is very little engagement with the child thereafter and as Anglicare Sydney illustrates, if the protective boundaries are not established and well-enforced within that family unit the young person may be at risk of further harm. Across jurisdictions there is agreement that kinship care placement processes ought to mirror foster care placements more closely.

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

Monitoring of practices is one aspect of the child protection continuum but is an effective contributor to the prevention of abuse. The efficacy comes, however, from a combination of the above named strategies but where they operate in harmony and do not cause duplication of effort, rather than any stand-alone approach. As referred to in question one: where systems, such as those involved in monitoring and regulation, can share information to limit invasive questioning of the young person, can reconcile irregularities in reporting and generally share surveillance information to support decision making is a great strength of a child protection strategy. The risk of focussing on only one or two monitoring approaches is that systems can become ‘lazy’; and in the worst of scenarios, they become their own benchmarks. Continuous improvement of systems and processes seeks to not only meet the standards set for a particular aim or purpose but also to exceed them and in the case of child protection, it would be expected that this should be the case. It is not satisfactory to only meet expectations but to be continually seeking ways to rise above them and set new standards of care and protection.

At the risk of being repetitive, the processes and systems supporting the work of child protection are integral to positive outcomes. Such is the recognition of this importance by Anglicare network member Child and Adolescent Specialist Programs and Accommodation1 (hereafter CASPA) that it has employed a Quality Assurance Manager to ensure that their systems do not get ‘lazy’.

Anglicare agencies have noted the effectiveness of random/irregular visits for maintaining standards however it has also been noted by some agencies that “administrative reviews” whereby only case files and agency staff are examined – such as in home-based settings – can limit the efficacy of some monitoring processes for identifying risk. As an approach to monitoring adherence to policy and establishing comparative benchmarks administrative reviews are an effective mechanism but as a stand-alone approach to preventing abuse, severely limited.

As Anglicare Southern Queensland points out the voices of the children and young people are filtered by the adults who care for and supervise them in the home-based care setting with little opportunity for the young person to share their own intelligence. Those workers who undertake regular contact with the carers are limited in their contact with the young person, only being able to talk with them in the presence of the carer. The ability to engage, build relationships with and learn to trust other adults is crucial for creating not only a sense of stability and attachment for that young person but also the potential for them to disclose abuse should the need arise. Through keeping the young person separate from the monitoring process, their voice is effectively muted and their opportunity to establish trusting networks is suppressed. Mitigating this risk, in those jurisdictions where it exists, is the access to children and young people in the foster care setting of the community visitor, for example in Queensland. Though this seems to be the exception rather than the rule and as Anglicare Victoria points out, there are considerations around the practicalities and intrusiveness of a community visitor approach. Monitoring models ought to include the ability to hear the voices of young people but that these models should be developed sensitively.

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1 North Coast Children’s Home Inc. trading as CASPA
What are the strengths and weaknesses of having OOHC providers regulated by the child protection department, or regulated by a body separate from the child protection department?

and

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

There seems to be consensus among Anglicare network agencies for a separation of powers within child protection regulation; the additional administrative costs to support such a structure not-withstanding. Whether a matter of resourcing/funding, case investigation, follow-up support or monitoring, it is apparent that the differentiation between regulator and care manager – and the subsequent separation of those roles and associated powers – must be made clear.

Pragmatic though it may be, resourcing of the different components of child protection is a clear factor in the prevention of initial or ongoing abuse. In some jurisdictions resource-intensive investigations cause under-resourcing in ongoing support and case management under a Departmental oversight model. In others, it is the sheer number of cases that result in less than the optimum of care. But where there is a separation of responsibilities such as in New South Wales whereby the investigation and court processes are undertaken by the Department up to substantiation with cases then referred to community partners ensures that the subsequent care and management of the young person’s interests are not negated by overbearing departmental case loads. Again, the integration of systems and information sharing at the handover point are integral to seamless transitions for the young person.

Beyond resourcing constraints however, which is a problem not only in this sector but across the social services, a lack of separation of powers has other implications for transparency, accountability, adaptability and responsiveness. Along the continuum of care and protection there are a number of components, each of which fall under one or other of these common standards of practice. Should the broad scope of these responsibilities rest in any one entity, conflicts of interest; complaints and appeals processes; transparency and accountability; and workforce requirements issues must be considered.

Conflicts of interest arise in scenarios where roles with associated executive/statutory powers are not clearly differentiated. For example, in jurisdictions where the department funds as well as provides children’s services and then also has an oversight role, could constitute a conflict of interest in two ways. In the first, in this landscape of competitive tendering of devolved services, a department awarding tendered services to itself could be seen as a conflict or at the very least an unfair advantage. Secondly, a department which regulates and provides oversight of its own services also constitutes a conflict of interest. In both of these scenarios, operations are closed and in no way accountable to third parties. Although government departments are subject to various financial management and legal regulations which support their accountability, these mechanisms alone do not prevent abuse and it is still not an appropriate circumstance for one agency to have outright determination over all executive powers.

Similarly, for those whom the care and protection sector has not served well should be rightly able to make complaints and appeal against decisions. A complaints and appeals process that sits under the same Minister or executive head as the regulatory and/or service provision components is compromised. People have the right to a fair and impartial hearing of their grievances and a process that reports to the same authority as named in the complaint cannot ensure that impartiality.

Ideally, no child should ever experience abuse. However, it is a reality for our society that we cannot shy away from. The responsibility then is ours to protect children where abuse has occurred from further abuse through the accurate cataloguing of events and adherence to policy. Where positive outcomes for children hinge as they do on the ability of agencies to hold perpetrators to account, transparency of systems and processes are vital. Separating out some of the powers or functions of child protection allows for transparent interactions between agencies. In this way, each of the separate bodies can hold the others formally accountable resulting in strengthened and meaningful commentary or recommendations regarding systems and processes.
The social services sector is a bordering on a workforce crisis with a number of sectors crying out with workforce shortages. The aged and disability sectors alone are predicted to swell considerably in the next few years and are already facing the dilemmas of non-competitiveness with the private sector. For the care and protection sector these issues are no less felt. In the highly specialised field of child protection the question must be asked: should people employed in this sector be generalists or specialists?

Investigating, practicing and monitoring child protection each call for a distinct set of core skills that predispose a worker to work effectively in their particular area. Recognising that many skills are transferrable and equip people to work effectively across fields, child protection is a highly sensitive area with a high rate of burnout, thus indicating that people need to be adequately trained and prepared for the work they are to undertake. Government departments are large enough that they could potentially separate the workforce into the necessary divisions and employ people within the speciality areas. However, large organisations like government departments do not usually have the agility or adaptability to respond swiftly or innovatively to crisis situations like smaller organisations have the capacity to do.

Separating powers, as in the case of community housing for example, where tenancy management and case management for the most part are undertaken by separate bodies, so the same principles might be applied in care and protection sector. By allowing separate entities to focus on a particular stream of the child protection process such as investigating and substantiating by the department, caring and managing by community partners and regulating and monitoring by an independent body each of the entities is able to perform its function to a high level of efficacy (not to mention improved workloads) rather than attempting to do all of them moderately well.

Anglicare Australia is not stipulating a particular model for the regulation of the child protection system but rather is highlighting that the regulatory model adopted ought to have at its foundation a separation of executive powers to allow for the transparent and accountable conduct of child protection by agencies. However, it is clear that in any model, the processes for working together and sharing information between entities must be explicit to ensure continuity, fluidity and responsiveness to the risk or declarations of abuse.

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

Comprehensive training programs exist around a variety of issues for care workers and, to a lesser extent, home-based carers. Recruitment either as an employee or as a carer by Anglicare network members requires a degree of prior knowledge or qualification in the case of staff and intensive preparation in the case of carers.

Unfortunately, working with such vulnerable young people, there are a number of separate issues that all staff and carers ought to be familiar with of which sexual abuse is one. The depth to which any of these issues is covered is largely dependent on the mandated training requirements for accreditation, the therapeutic framework adopted by the agency, the case histories of the young people that are currently being supported and the availability of the most up-to-date evidence on working with and supporting children in out of home care settings.

There are a number of cohorts that have been identified as having the potential to benefit from further training. The logistics and practicalities of delivering training to these groups has not been considered here except to say that the cohorts noted could have a direct bearing on the prevention or early detection of abuse:

- Teachers and other professionals with access to children, such as police and youth leaders and the like.
- Children and young people who have experienced abuse – about the behaviours they may exhibit and how to manage them and understand why they may be occurring. It is vital that this training/education be conducted in a person-centred and supported environment and no way infer
fault on the part of the young person. This training might also be extended to carers to recognising the factors behind sexualised behaviour in addition to training around their own behaviours that might be misinterpreted by or confusing to young people.

- Children and young people who have experienced abuse – about the appropriate and inappropriate behaviours of adults toward them. (Though this training could be broadened to include all children and young people).
- Carers – in the specific education of recognising sexualised behaviour in young people.
- Biological children in the homes where traumatised young people will be residing. This training is around what to expect and how they can manage their own feelings of anxiety as well as establishing protective behaviours.

As mentioned above, there are a number of issues people operating in this field ought to be aware of. Anglicare members are often innovating in this space in order to maintain coverage of those issues. Agencies such as Anglicare NSW.W, NSW.S and the ACT assist carers by taking a harm minimisation approach to staff and carer induction training by building in an expectation of allegations to be made and preparing them ahead of time for such an occurrence. Another area where an Anglicare network member is innovating in the training space is around support for staff whose own memories and reflections of their own trauma are triggered whilst working with the young people. On the NSW North Coast CASPA has implemented Vicarious Trauma Training whereby staff learn to recognise when their own emotions and memories of abuse are triggered and how to work through those instances in a supported environment whilst continuing to provide full support to the young person.

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

Again, there are a number of issues involved here that go beyond the adequacy of the training itself. Primarily, we refer to the support to implement the learning in the home, residential or work setting, however, other issues exist around responsiveness of training to emerging trends and access to training rather than the quality of the training itself.

Firstly, the appearance of sexualised behaviour in children can be confronting. The theoretical tools provided to carers through training ought to be augmented by support in the home by qualified agency support staff. This ongoing support allows for smooth transitions for both the carer and the young person in identifying and addressing inappropriate sexualised behaviour. At the same time as supporting carers agency staff can be educating and supporting the young person in behaviour that is positive and age appropriate. Supporting this process is the follow-up and implementation of training undertaken by carers in the home. It is maintained by Anglicare agencies that in any event carer training is optimised when it is augmented by home visits and in-home applications.

An issue that sits alongside the content of training has been the currency and responsiveness of training, and more particularly guidelines, to emerging trends. For example, Anglicare Sydney has included in its *Carer Handbook* for foster carers an item on the appropriate use of the internet and social media by children. Modules such as this were developed internally due to the lack of coverage in the NSW Office of the Children’s Guardian guidelines. Whilst seemingly pedestrian it is a contemporary issue and one which helps to maintain the ‘ordinariness’ of life at ‘home’ in addition to educating about a potential avenue for further abuse.

The other particular issue that was raised in terms of quality training for carers but also for agencies more generally is access to specialist training. For metropolitan agencies, there are options for training that match the ethos of the organisation, its processes and time frames. For agencies based in locations outside the largest metropolitan centres this flexibility and choice is not as well established. Lack of access to specialist training is not constrained to regional and remote areas, Anglicare SA based in Adelaide has also reported difficulties. Anglicare Central Queensland adds the corollary that access to therapeutic and counselling services is equally limited but the biggest gap in services in that area is access to therapeutic services for
young people who perpetrate sexual abuse. This also raises the questions of how well equipped carers can be to support these young people when the service structures are not adequately in place.

With potentially limited options for specialist training in these locations, some thought ought to be given to how to address the implications. This may include regulator or departmental support to training organisations to provide support to regional settings or potentially include a remoteness loading on training budgets to funded agencies in regional and remote locations to counteract the tyranny of distance.

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

Anglicare Australia is not in a position to provide advice on how to empirically measure and record the incidence and prevalence of sexual abuse, or any form of abuse, in Australia. We do however have some observations on the matter.

In all cases the best interest of the child is paramount and reported, suspected or disclosed abuse needs to be responded to quickly. Responding immediately to allegations of abuse does not dismiss the technical – and perhaps intellectual – difficulties arising from the use of unsubstantiated or substantiated abuse as a measure for the rate of abuse. The tension here is compounded by the difficulty in actually substantiating abuse.

As indicated by Anglicare network members, rates of substantiation can be challenged by delayed disclosure, non-disclosure and recants of disclosures. In effect, there is potential that by focusing solely on a substantiated rate of abuse then a large proportion of those experiencing abuse are not captured and therefore the rate becomes less reliable. How can you recognise that the OOHC practices are effective if a large part of the cohort is not being captured?

Agencies such as Anglicare Victoria suggest that the use of unsubstantiated reports might be useful as an indicator as to the effectiveness for OOHC practices however this also comes with its own challenges. One of these is the risk of an over inflated rate of reports due to strict mandatory reporting requirements and the hyper-vigilant reporting of incidents. We refer to the example given by Anglicare Victoria where a young person may mention to a care worker that they happened to see their carer in the shower but which was a one-off incident and irregular lapse in remembering to lock the door. Whilst the worker is obliged – correctly – to report the incident, such considerations are necessary when utilising unsubstantiated reports of abuse as a method of measuring rates of abuse.

Issues of record keeping also have an impact on the way abuse may be measured and recorded. Whilst administrative reviews have been cited in this paper as an ineffective sole means of identifying and preventing abuse, they are not without their value. The detail recorded in administrative files can be a valuable asset for the measuring and recording of rates of abuse. Of course this would require consistent reporting mechanisms – which might be overcome by a standardised series of questions as suggested by Anglicare Sydney – but would also rely on the continuity, portability, and detail of case notes as well as the potential to share that information across agencies to contribute to a case history that could be mapped against certain benchmarks.

National trend data is required to determine the improvement – or not – nationally of responses to and the prevention of child abuse. Trend data supports the analysis of the impacts of structural change within the child protection system and acts as both early warning system and adjudicator by highlighting when trends rise and fall. This data however should also be available at state and local government levels requiring that the methods used to record the rates of abuse must be consistent across all jurisdictions.
What is the usefulness and validity of different ways to address allegations of sexual abuse brought against carers? In particular, which approaches enhance participation by the child particularly approaches best suited to seeking possible disclosures of abuse (including disclosures that might be inferred from behavioural changes) from children? Are the current processes fair? What appeal processes should be available for carers?

and

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

Processes across the board dictating the response to allegations of abuse are generally considered to be fair. Though with any generalisation there are caveats to be made.

- In all cases it has been noted that the investigation arising out of allegations must be conducted in a timely manner. Families undergoing investigation, though considered fair, are still stressed and fatigued by the process. For the investigation to be unduly drawn out can increase the likelihood of carer burnout.
- Case workers participating in or contributing to the investigation ought to be familiar with the nuances of the case, in which case they will be better placed to make determinations, informed as they are by the case history.
- Similarly, the same workers should be present for an investigation from commencement to completion. Lengthy investigations often experience a change-over of workers as people move on. This can be to the detriment of the investigation as the familiarity of the case history and the case nuances exits with them often leaving those with little experience of the case to finalise the investigation and make determinations (in those jurisdictions where agencies conduct investigations into allegations; the same also holds for departmental staff).
- The voices of children should be encouraged however not to the detriment of the health and/or emotional wellbeing. Further trauma arises in the repeated retelling of traumatic experiences, as such mechanisms need to be put in place to allow for a proxy or other mechanisms to share intelligence of the events themselves. Organisations such as Parkville Child and Youth Care have established multi-disciplinary child advocacy centres whereby the young person is intensively supported and their need to retell their story is limited. One family, before the child and advocacy centre existed, had to retell their story 48 times, contributing itself to a form of abuse.

There are some distinctions in the way that support for carers is provided across jurisdictions. It almost goes without saying, the primary focus in the investigations of alleged abuse are the interests of the young person and each claim that is made is treated as legitimate. Having so stated, it remains that there are times when allegations are determined to be false. These cases cannot be identified from the outset and all cases undergo an investigation process. Until such time as the investigation becomes a criminal matter or the investigation returns a confirmation of the allegations, agencies offer support to carers who are subject to claims of abuse. Whilst the degree to which agencies can engage with the carer differs across jurisdictions, what remains the same is the carer’s right to fair treatment throughout the investigation and the right to appeal judgements and to have that appeal adjudicated by a separate entity.

As an aside, there is one particular technical loophole existing in the NSW system that Anglicare Australia wished specifically to raise. It relates to those cases where an allegation of abuse is made by a young person about a staff member. While the staff member is still employed by the agency an investigation is undertaken and if substantiated referred as a criminal matter and the incident is flagged on the working with children check. However, and this is where the loophole exists, should the staff member resign before the investigation is completed, that agency is no longer able to conduct the investigation and must refer the matter to the police. In some jurisdictions where the police may not have the capacity to follow-up the report the staff member is not investigated and if indeed the allegation were true – no report of the event will be flagged on the working with children check. There is potential then for a serial offender to become employed, commit an offence and leave again without any formal means of preventing it in the future.
What implications exist for record keeping and access to records, from delayed reporting of sexual abuse?

Sadly, child abuse is not only a modern blight. With each new generation of young people we have failed to protect comes new learning for better ways to protect the next generation. One of the areas that has improved from history’s teachings is in the area of record keeping. Accurate records are key in investigations of historical abuse and tragically, those for whom it has taken many years to build their courage and find their voice to share their trauma, evidence of their experiences is very difficult to find.

Current record keeping practices are far improved however there are still areas – mentioned previously in this response – that could better facilitate positive outcomes for people accessing their information post-care. Other issues that have not been raised include the following.

Current records are not life-affirming. For the most part they contain information gathered through investigations and other formal processes such as transitioning from care arrangements. Even care plans for those transitioning out of care may not contain positive messages about the young person’s childhood and formative years which might contribute to their sense of identity in later life. Often those returning to review their case files are doing so in a bid to find or reclaim their identity and in the end, what they find is not as helpful as they hoped it might be. Whilst maintaining accurate records of trauma events there is scope to also maintain a history, importantly, on which includes life affirming material.

For many young people, moving through a number of placements can mean a disjointed history. Often personal belongings can be lost through the swift removal from a family home or through the wilful destruction of property by other young people. Digitisation of personal effects that can be held in a cloud format and that is portable and can follow the young person as a record of their personal history would contribute greatly to a positive sense of identity in later years.

As a corollary to the type of information contained in personal files, the way the information is presented to the person requires consideration. The experience of revisiting past traumas can itself be a traumatic experience and as such, people need to be supported to face that material. Anglicare agencies note special rooms and processes where past care leavers can sit and reflect and be supported through the experience of confronting their past.

Concluding comments

Commissions and inquiries into the abuse of children have been in a large part responsible for many of the advancements made in the protection of children. Anglicare Australia views this current Royal Commission as a necessary and important step in that process and we will continue to work with the Commission to better support children and young people in care.

Whilst clearly, there are different systems in play within each of the jurisdictions there exists a high degree of consensus as to the gaps or improvements that can be made to further protect children across jurisdictions. The protection of Australia’s most vulnerable citizens is – as the national framework suggests – everybody’s business. It is imperative that the system supporting these young people is as robust and integrated as possible to ensure that their journey through it does not traumatised them further. In that regard,

Anglicare Australia calls for a nationally cohesive system with legislation, regulations and processes mirrored across state and territory boundaries.

There is no competitive advantage to be had here, only the risk of further trauma for these extremely vulnerable young people. Failure to come together to protect them shames us all.