



15 November 2013  
CCYPD/13/435

Justice Peter McClellan  
Chair  
Royal Commission into Institutional Responses to Child Sexual Abuse  
GPO Box 5283  
Sydney NSW 2001

Dear Justice McClellan

Thank you for the opportunity to contribute to the discussion arising from *Issues Paper 4 – Preventing Sexual Abuse of Children in Out of Home Care*. I have contributed comment on *Issues Paper 1 – Working with Children Checks* and *Issues Paper 3 – Child Safe Institutions*.

The *Commission for Children and Young People Act 2012* provides the legislative mandate for the Victorian Commission for Children and Young People (CCYP). The Act repeals and re-enacts with amendments some provisions previously contained in the *Child Safety and Wellbeing Act 2005* relevant to the functions of the previous Child Safety Commissioner. The CCYP is constituted by the Principal Commissioner and the Commissioner for Aboriginal Children and Young People. The Victorian Commission is the only jurisdiction in Australia to have a dedicated Commissioner for Aboriginal Children and Young People.

The objective of the Commission is to promote continuous improvement and innovation in policies and practices relating to the safety and wellbeing of vulnerable children and young persons, and children and young persons generally; and the provision of out of home care services for children. The functions of the CCYP include provision of advice to Ministers, Government Departments, health services and human services about policies, practices and the provision of services relating to the safety and wellbeing of vulnerable children and young persons. The Commission is also responsible for promoting the interests of vulnerable children and young persons in the Victorian community and more generally child-friendly and child-safe practices in the Victorian community.

The Commission is tasked with monitoring out of home care services, with three specific functions being:

- To promote the provision of out of home care services that encourage the active participation of those children in the making of decisions that affect them.
- To advise the Minister and the Secretary on the performance of out of home care services; and
- At the request of the Minister, to investigate and report on an out of home care service.

It is in this context, the Commission would like to highlight that the main issues relating to the prevention of sexual abuse of children in out of home care are perceived to be:

- An increasing proportion of the children in out of home care being in kinship care placements where the least resources are being targeted for assessment, training, support and monitoring of carers.
- Implementation of broader intervention strategies to address allegations of sexual abuse in out of home care, rather than a targeted focus on prevention strategies, in relation to both carers and empowerment of children and young people in care.
- Comprehensive implementation of the policy of zero tolerance of sexual abuse and sexual exploitation of children in residential care, including resource development, training and evaluation.
- For both prevention and intervention strategies there has been a lack of evaluation of their effectiveness, preventing the establishment of an evidence base for use in addressing the issue of sexual abuse in out of home care.
- A lack of focus on the "voice of the child", whereby children and young people are provided with a safe and supportive environment which will permit them to discuss their concerns and be heard by carers and independent community visitors who are trained and attentive to their behavioural cues.

In addition to the written submission, I would be pleased to answer any questions the Commission may have, or to provide any further information you may require.

If you would like to discuss any of these issues in more detail, please contact me on (03) 8601 5886 or by email to [Bernie.Geary@ccyp.vic.gov.au](mailto:Bernie.Geary@ccyp.vic.gov.au).

Yours sincerely



Bernie Geary OAM  
**Principal Commissioner**



Commission *for* Children  
and Young People

*improving young lives*

Submission to the

**Royal Commission into Institutional Responses to  
Child Sexual Abuse**

Issues Paper 4

**Preventing Sexual Abuse of Children in Out of Home Care**

22 November 2013



## Introduction

The Commission for Children and Young People (CCYP) has particular legislated responsibilities under the *Commission for Children and Young People Act 2012*, which provides in section 7, that the overarching objective of the Commission is to promote continuous improvement and innovation in policies and practices relating to the safety and wellbeing of 'vulnerable' children and young persons, and children and young persons generally; and the provision of out of home care services for children. 'Vulnerable' children and young persons are specifically defined in section 5 as those who are or were a child protection client, a youth justice client, a person attending a youth justice unit in accordance with an order of the Children's Court, a child who is receiving or has received services from a registered community service, a child whose primary family carer is receiving or has received services from a registered community service, a child who has died from abuse or neglect, or a person under the age of 21 years who is leaving, or who has left, the custody or guardianship of the Secretary to live independently.

It is in this context, that the Commission is making a submission in response to *Issues Paper 4 - Preventing Sexual Abuse of Children in Out of Home Care* and will attempt to address the issues raised in the eleven questions in terms of specific strategies, embedded within a broader discussion of the principles that should guide policy and procedural reform.

## Background

In Victoria, there are a broad range of out of home care placement types, including within the child's own extended family (kinship care), or friends and social networks (kith care), other home based family placements (foster care, adolescent community placements, shared family care and therapeutic foster care) and residential care with rostered, professional staff (generalist or therapeutic care models). There is a requirement that Child Protection seek a placement within the child's family network as the first option when a child or young person must be placed in out of home care. The Aboriginal Child Placement Principle legally specifies that Aboriginal children and young people must be placed subject to the advice of the relevant Aboriginal agency, in order of preference within their own or other extended family or relatives, the local Aboriginal community living close to the natural family, an Aboriginal family from another community, and as a last resort a non Aboriginal family living close to the child's natural family who will ensure maintenance of the child's culture and identity through contact with the child's community. A range of culturally diverse community groups who also come from a collectivist cultural background, such as Polynesian/Pacific islanders and African communities, have regularly expressed a desire for similar consultation and placement preference rules, emphasizing the need for cultural connection to be maintained.

For the general population, policy and procedures dictate that when placing children in out of home care, if there is no suitable placement option within the family, then home based care of some type is the next preferred option, especially for younger children, with residential care being seen as the least preferable option given the complexities for children in having multiple caregivers, residing with other traumatized children who may be undertaking risk taking behaviours, and the undesirability of institutional care.

As at 30 June 2012, in Victoria there were 6,147 children and young people living in out of home care. Of these children and young people, there were 2,832 (46%) residing in kinship care placements, and 1,437 (23%) were in foster care, a similar number of 1,400 (23%) were in permanent care and the very low 478 (8%) were in residential care. Therefore, equal numbers of children and young people were residing in kinship care when compared to those in foster care and permanent care combined. Of the total number of children and young people in Victoria living in out of home care, there were 1,028 (17%) identified as being of Aboriginal or Torres Strait Islander background, which represents 19% of the total number of

Aboriginal children and young people in Victoria aged under 18 years. In comparison, non Aboriginal children and young people in out of home care represent only 0.5% of the total non Aboriginal children and young people in Victoria aged under 18 years. The total Victorian Aboriginal population is also skewed towards a younger demographic, with 42% of the total Aboriginal population aged under 18 years compared to much lower 22% of the total non Aboriginal population.

In Victoria, child protection may contract Community Service Organizations (CSO's) to undertake full case management functions or some specialist functions only. This arrangement means that almost all provision of out of home care in Victoria is managed through agreements, known as case contracting, between the CSO and the Department of Human Services (DHS). Changing social structures mean that the pool of available foster carers is shrinking, as a greater proportion of women are in the paid workforce and experienced carers age out of the system (Cummins Inquiry Report, Chapter 10). This raises issues in relation to much greater reliance being placed upon recruitment of kinship carers and their need for adequate support, and higher dependence upon increasingly professionalized provision of home based and residential care for those children requiring therapeutic care responses. As the numbers of children in care continue to escalate and the pool of available foster carers dwindles (ABC Radio National, 17 November 2013), the care system is under increased pressure and the stated aim that children in care will be carefully matched when residing with others, becomes much more difficult to achieve in reality. Recent inquiry work by the Commission demonstrates that the risks of sexual abuse for young people in OOHC, and residential care especially, are not a matter of historical record, but behaviours that continue presently with impacts stretching into the future. Children in OOHC may already have experienced sexual abuse, resulting in them in being in care, where they are further at risk of abuse from their peers who have also experienced trauma and may act out through sexual aggression and abuse. Young women are disproportionately more vulnerable, being groomed by adult offenders who target them as being vulnerable.

The cumulative impact of this serial abuse can have severe impacts on the functioning and consequent behaviour of such young people, making the work of carers very challenging and often confronting. Highly skilled and supportive staff are needed to begin a process of addressing the young person's care needs effectively. These factors also contribute to the escalating pressures on the OOHC system, leading to an expectation that the attendant costs would also increase dramatically, threatening the sustainability of the system. For all of these reasons, it is critical that care providers and the regulators responsible for them place the greatest emphasis on prevention and early intervention with regard to threats to the health and wellbeing of children in OOHC. It is vital that the potential risks of sexual abuse outlined are comprehensively addressed for this highly vulnerable group of children, when we know the serious, short and long term impacts on all aspects of their lives that can result from it. To not act in relation to this risk of systemic abuse means the government is equally complicit in abuse of the most vulnerable children in OOHC.

## Questions

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

In considering core strategies to keep children in OOHC safe from sexual abuse, the major emphasis should be placed upon prevention and early intervention initiatives, with broader monitoring functions used to promote continuous improvement (please see response to Question 7).

The foundation to the human rights approach taken by the Commission can be found in the United Nations Convention on the Rights of the Child (UNCROC), to which Australia is a signatory. UNCROC states that 'governments should protect children from sexual abuse' and recognizes the vulnerability of

children 'who have been neglected or abused' and that they should receive 'special help' to restore their self respect (article 39). Children who reside in OOHC can be especially vulnerable to a risk of sexual abuse given that they have by definition a history of trauma, consequent behaviours which may place them at higher risk, and living arrangements which may involve frequent changes of carer, residence and school. Therefore, to keep children in OOHC safe from sexual abuse, it is necessary that core strategies build upon a rights framework and an "open" system of care that is transparent and accountable, and witnessed by external bodies.

## Potential Abusers

A first step when considering core strategies to keep children in OOHC safe from sexual abuse is to think about who the potential sexual abusers might be, with the three main groups being carers, adults in their own or the carer's family or social network, or peers. Children in OOHC who may be there as a consequence of experiencing sexual abuse from their family members, would be expected to be protected from experiencing this further, although there may be rare occasions when incidents may occur during contact with an abusive family member, who may not have been known to be an abuser. Potential abusers may also include residential care staff or home based carers such as foster carers or their networks of extended family members or friends, either within the home or whilst visiting other places. The same scenarios would apply for those in kinship care, with the potential for a higher risk of abuse if issues such as family violence, physical abuse, emotional abuse, neglect or intergenerational sexual abuse have been present within the extended family. Children in OOHC are also at risk of sexual abuse from their peers, whether they are acquaintances, other children in care or the carer's own children in the case of home based care.

## Prevention Strategies – Carer Recruitment and Supervision, and Child Empowerment

When considering how to achieve the maximum protection of children in OOHC from sexual abuse, a two pronged approach is needed, whereby it is ensured as far as is possible that carers and others do not present a risk of abuse, are aware of what behavioural indicators to be alert to, and are able to create a safe environment which would permit the child to disclose current and/or previous sexual abuse. Secondly, the child needs to be empowered through being aware of their right to be safe and to feel safe, to be able to identify abuse as such and to have avenues where they can talk to a trusted adult about their experiences and be confident that they will be listened to and supported appropriately. The relatively recent development of therapeutic residential and foster care options, with their emphasis on staff training and engagement with the child, are critically important to the creation of care environments which have a greater potential to keep children safe.

There are a number of core strategies that form the basis for prevention of sexual abuse of children in OOHC which relate to carers, with stark differences between the current requirements imposed for residential carers, home based carers and kinship carers :

- Recruitment/Selection
- Assessment
- Training
- Support and Supervision
- Monitoring and Review (see Response to Question 7.)

## Residential Carers and Home Based Carers – CSO Role

In terms of home based and residential carers, core strategies to keep children in OOHC safe from sexual abuse should take a risk management approach and must be focussed on careful recruitment, selection, assessment, training and supervision of carers, which are the elements of a child safe organization. To assist agencies to undertake these activities, Child Wise developed the foundational resource, *Choose with Care: Building child safe organizations*, which has a handbook, workbook and audiovisual resource for use in conjunction with the training program which is aimed at supporting organizations and their staff to establish their agency as a child safe organization. Subsequently, the Commission (as the former OCSC) also developed *A Guide for Creating a Child-safe Organisation* which aimed to provide organizations with the basic elements for developing a child safe policy. There are also a range of similar resources now available to help agencies in undertaking these processes.

(See enclosed *Guide for Creating a Child-safe Organisation*)

## Residential Carers

In the *Program requirements for residential care services in Victoria*, version 1 July 2012, it is acknowledged that the skills and personal attributes of CSO staff have a significant impact on the lives of children residing in residential care. Furthermore, the support received by these CSO staff from their employing organization will have a direct impact upon their ability to fulfil their role. The philosophy, practices and organizational structure underpinning the CSO will affect the standard of care children receive. The relevant requirements for selection, training, supervision and support of residential care workers are specified in section 4. *Organisational and human resource requirements* of the *Program requirements for residential care services in Victoria*, version 1 July 2012 (*see attached*).

### *Therapeutic Residential Care*

The Therapeutic Residential Care (TRC) units provide intensive and time-limited care for children aimed at responding to the complex impacts of abuse and neglect. Residential care staff have the same variation in qualification levels (with some lacking any formal qualification) as generalist residential care staff, but they undergo enhanced training in reflective practice which is supported by Therapeutic Specialist who collaborates with the staff to identify the best matched young person to enter the unit and develop strategies to ensure this young person is successfully integrated.

The particular attributes sought in residential care staff are:

- Understanding of therapeutic processes and how to apply them
- Understanding of their own triggers and responses
- Being responsive rather than reactive
- Considering and discussing their own impact upon children and other staff
- Working with known risks

Residential care staff are committed to the therapeutic model of care and to using their skills to create positive, safe, healing relationships and experiences, with practice informed by a sound understanding of trauma, attachment difficulties and developmental needs.

See attached *Evaluation of the Therapeutic Residential Care Pilot Programs: Final Summary & Technical Report (Verso Consulting)*

## *Selection*

CSOs must have in place written procedures and policies that ensure all applicants for positions which involve direct contact with clients, or the management/supervision of services to clients, are thoroughly assessed prior to their commencement of employment. This requirement applies to paid employees, subcontracted workers, volunteers and student placement staff.

See Appendix 1 for further details of selection processes for residential care staff.

## *Assessment*

CSOs should seek to employ residential care workers who have relevant interpersonal skills and attributes, and the capacity to support the varying needs of clients. CSOs are encouraged to employ, wherever possible, staff who have a combination of relevant qualifications and the personal attributes, with the preferred qualification in Victoria being the Certificate IV in Child, Youth and Family Intervention (Residential and Out of Home Care). However, it should be noted that qualifications are considered to be desirable, but not essential for those providing care in residential units (Centre for Excellence in Child and Family Welfare, 2006). The CSO must maintain staff records detailing their academic qualifications and relevant work experience, with non-identifying information in relation to these areas being made available to DHS upon request. The CSO must also maintain records detailing the rate of staff turnover and use of labour hire agency staff for direct care positions, also for provision to DHS upon request.

## *Training*

Upon the commencement of employment, new residential care workers are to be introduced to children using a gradual process, which is managed by other residential care staff or CSO staff with whom the child has a relationship. An induction training program is to be provided by the CSO for new residential care workers. The CSO must also have policies and procedures in place to identify the developmental needs of direct care staff and supervisory staff, and provide the opportunities and resources required for their ongoing professional development.

## *Support and Supervision*

The CSO is to have written policies and procedures regarding staff supervision, which require that:

- Every residential care worker has an identified supervisor with whom they have regular contact and easy access
- Direct care staff are provided with regular supervision and support
- Staff providing supervision and support to direct care staff must have the appropriate skills and qualifications to undertake this role
- Staff providing supervision and support to direct care staff must also receive ongoing supervision and support in their role from appropriately qualified and skilled senior staff.

There must also be policies and procedures to manage critical or stressful incidents and their associated impact upon staff and children. Relevant policies should outline procedures in relation to debriefing, de-fusing and on-call support. The CSO must have a written code of conduct for all staff and management, and ensure all employees are familiar with its requirements.

## *Recommendations*

1. That a standard minimum qualification, such as the Certificate IV in Child, Youth and Family Intervention (Residential and Out of Home Care), be required to be completed before a prospective carer can be employed as a residential care worker. In the case of staff who are already employed, they should be encouraged and supported to attain this qualification by a specified date.

2. That specifications are provided regarding the expected minimum frequency of provision of supervision to direct care staff (such as the once per month for foster carers), and the basic qualifications or training required to be undertaken to perform a supervisory role.

## Home Based Carers

When recruiting carers to provide care in their homes, as foster carers or other home based carers, it is vital that suitable and appropriate people are selected, supervised and supported. The requirements for CSOs who provide home-based care services are specified in the *Program requirements for home-based care in Victoria*, July 2012, with the relevant section 3. *Carer and care environment requirements* attached as an appendix.

### *Therapeutic Foster Care*

Therapeutic Foster Care (TFC) has also been implemented in the form of The Circle Program which currently has 97 places available in Victoria with eligible children mainly being those coming into care for the first time and eligibility criteria for those currently in care being aged under 12 years at the time of program entry, in care for up to 2 years and having experienced up to two placement breakdowns. Foster carers are trained initially as generalist foster carers and then receive enhanced training designed by therapeutic specialist providers with a focus on child development, attachment, trauma and managing challenging behaviour. It is believed that with this underpinning knowledge, carers can focus on the needs of the child, rather than focussing upon their presenting behaviour.

*See attached Report of the Circle Program: An evaluation of a therapeutic approach to foster care*

### *Recruitment*

Good recruitment practices reduce the opportunities for harm to occur by deterring the 'wrong' people from applying and selecting skilled and motivated individuals. CSOs are required to evaluate the effectiveness of their recruitment campaigns to inform future campaigns and contribute to statewide data collections on recruitment and accreditation of carers for sector analysis and development.

*See Appendix 2 for details of a CSO Recruitment Strategy*

### *Assessment*

The CSO must ensure that any prospective foster carers and their family members are thoroughly screened and assessed to ensure their suitability to care for children in foster care. The screening and assessment processes for foster carers are to be fully completed prior to any child being placed with the carer. CSOs in Victoria undertaking assessment processes for potential foster carers are guided by the mandatory, competency-based carer assessment tool, *Step by Step Victoria*. The assessment of potential foster carers of Aboriginal children requires the use of the *Step by Step Aboriginal assessment tool*, or the *Step by Step Victoria* assessment tool by Aboriginal community controlled organizations. CSO staff using either of these tools must have fully completed the relevant familiarization training before undertaking assessments.

*See Appendix 2 for details of the Assessment of Potential Foster Carers*

### *Foster Care Panels*

Any CSO providing foster care must participate in a formal foster care panel, which is conducted on either a regional or CSO basis, and formally approves or rejects carer applicants. The panel is to consist of CSO management representatives, DHS representatives and other relevant people. The CSO worker who has undertaken the carer assessment attends the panel to discuss the accreditation of the potential carer. The applicant is considered to have been approved only after the foster care panel chairperson signs a final

report. The CSO informs DHS of the approval of the foster carer by formally registering the carer on the Carer Register within 14 days of the approval. The final report is kept as a record of the panel meeting. Successful applicant carers must sign a copy of a code of conduct for approved foster carers. The CSO will ensure unsuccessful applicants are provided with a rationale for the decision.

*See Appendix 2 for details of the Operation of a Foster Care Panel*

In summary, the home based carers have put themselves forward for this role and a planned approach can be taken to assess their suitability, with the assessment processes being quite lengthy and detailed, and subject to the checks and balances offered by approval through a foster care panel. The situation can be very different with kinship and kith carers who may find themselves suddenly in the role of carer, as a result of family circumstances, which may dictate the timing and nature of assessment processes.

### *Training*

CSOs are obligated to ensure that foster carers and their families are fully trained to ensure their suitability to provide children with appropriate care. Mandatory, pre-service training using the *Shared Stories, Shared Lives* package must be used by the CSO and completed by the carer before a child is placed with them. This package or the *Our Carers for Our Kids* package is mandatory for use by Aboriginal community controlled organizations training potential foster carers for Aboriginal children. Potential carers and their partners, including new partners, and any other adult in the household who will have a parenting role, are required to attend and participate in this training. The CSO staff delivering this training must have first fully completed the relevant familiarization training. Carers and other household members, as determined by the CSO, will be required to attend subsequent training on a range of issues relevant to children in their care. The training will be scheduled to accommodate the commitments of carer as far as possible. CSOs are required to ensure that training provided to carers includes infection control procedures, procedures to be followed in medical and non-medical emergencies and accidents, thus CSOs are expected to encourage carers to hold an approved CPR and first aid certificate.

### *Additional Training*

There is also an expectation that CSOs will ensure that **both fostercarers and kinship carers** have timely access to support, information and training which will allow them to be competent to meet the specific needs of children in their care. For example, carers may require training to ensure effective management of a medical condition, a disability, sexual assault, challenging behaviours, a therapeutic approach to care or any other special needs. In the circumstances where an Aboriginal child is placed with a non-Aboriginal carer, the CSO is required to ensure that at the earliest possible opportunity, the carer receives information and training on culturally appropriate caring. This training aims to ensure that the child's cultural values, beliefs and practices are respected and upheld. CSOs are similarly required to ensure that carers receive training on culturally sensitive training to ensure that a child from a CALD background's cultural values, beliefs and practices are respected and upheld.

### *Support and Supervision*

The *Charter for people in care relationships* provides a foundation for CSO practice and is provided to carers. The CSO must have written supervision policies which specify that each carer has an appropriately skilled CSO worker, or case manager of the case is contracted, to act as a supervisor or key contact. The CSO will determine the level of supervision and support required by the carer at the commencement of the placement, based upon the child's level of need and the carer's needs. It will be ensured that the minimum level of supervision whilst a child is placed with a carer is once per month. The CSO's policy and procedures must be readily accessible and familiar to staff and carers.

In deciding the level of supervision required for an individual placement, CSO policies and procedures need to take into consideration the factors of:

- The assessed level of need of the child, that may vary over time
- The level of supervision and support required for new carers
- The level of supervision and support required at the beginning and end of a placement
- Arrangements for after-hours support
- Supervision and debriefing after a critical incident
- Access to a key CSO contact, including when the designated worker is unavailable, to obtain advice and support as needed

CSOs are to ensure that issues identified during supervision are recorded and acted upon appropriately to ensure “the ongoing safety and healthy development” of children in placement. CSOs must ensure carers receive carer reimbursement and financial assistance for which they are eligible, including all relevant documentation. CSOs are also to provide mechanisms for carers to link with other carers to receive and provide support, including the establishment of support groups. Carers are also to be informed by CSOs about Victorian peak bodies that can provide them with independent advice, information, support and advocacy. The CSO and carers will also sign an agreement which outlines their individual roles and responsibilities.

## **Kinship and Kith Carer Strategies**

Kinship care has always been provided within extended family networks when parents have been unable to provide primary care for their children. Communities who operate on a collectivist model, such as Aboriginal communities, Pacific Islander communities and many African groups have traditionally relied upon kinship care to keep children cared for within the community and will often find foster care and residential care quite unfamiliar and challenging concepts. In recognition of the importance to children’s development of maintaining connection with their family and community, when out an out of home care placement is required, kinship care options must be investigated and exhausted before any other placement option is considered.

### **Assessment**

Kinship and kith carers are recruited on the basis of having a family or social linkage to the child, and a planned placement may be possible, but often the child is placed with them during a crisis, when the primary caregivers are unable or unwilling to care for the child.

#### ***Preliminary Assessment***

Consequently, there may only be the opportunity for the child protection practitioner to complete a Preliminary Assessment (Kinship Care Assessment Form A) in such emergency situations, which focuses primarily on safety through criminal record checking and a brief assessment of the suitability of the carer.

[Please see Appendix 3 for further details of Preliminary Assessment Requirements](#)

#### ***Comprehensive Assessment***

The expectation is that the Comprehensive Assessment will be conducted for all kinship care placements likely to extend beyond three weeks. The child protection practitioner is to complete this within six weeks of commencement of the placement, but it appears that this process is often delayed as the child protection practitioner is simply unable to make it a priority when the child is deemed to be safe. Completion of the comprehensive assessment focuses on the carer’s capacity to meet the ongoing needs of the child and to engage in long term planning for the child. Clearly, it is beneficial for this assessment to be completed as soon as possible to identify any potential difficulties and avoid the situation of the child becoming attached to the carer, only for the placement to be deemed as unsuitable for the longer term.

The information for this more detailed assessment is recorded in the Kinship Care Assessment Form B (Comprehensive Assessment), with the assessment expected to involve more than one visit and include the key members of the carer family and household, including all adults and older children. It may also be useful in some cases for the child protection practitioner to undertake a reference check. The potential carers are asked to nominate two personal referees who can be contacted by phone, with any issues raised or identified followed up with the carer.

[See Appendix 3 for further details of Comprehensive Assessment Requirements](#)

However, the Commission has received feedback from many kinship carers at group meetings, that follow up assessment and support were not forthcoming after the emergency placement of a child in their care (OCSC submission to Cummins Inquiry, 2011, please see attached). This was seemingly due to demands upon the time and resources of child protection staff, which prevented implementation of policy and practice guidelines relating to requirements for completion of the Comprehensive Assessment. Kinship carers were left with the impression that because they were related to the child, they did not receive priority attention for scrutiny or support “as they would hang in there”.

Kinship care placements may have many benefits, including the ability for pre-existing relationships to assist in easing a child into a placement away from their primary caregivers, with carers who may share a family history, culture and/or identity. However, these benefits should not serve to indicate that a less comprehensive assessment of the capacity to provide ongoing care is required, than for a foster care placement, but rather a much more detailed and nuanced assessment is essential for taking into consideration the family dynamics. Kinship care may present very complex challenges such as tensions and hostilities within family relationships, which pose ongoing or new risks of abuse to the child and/or their carer, especially during activities such as supervised access.

### *Training*

At present, kinship carers do not automatically participate in training to equip them to provide for children’s care needs in the same ways that a foster carer does. The rationale often cited for this is that kinship carers may have experience raising their own children and see such training as redundant, yet the same could be said for many foster carers. However, the foundational training provided to foster carers equips them with basic information and skills for handling physical care needs of children, which they can build upon with more specialist training. Kinship carers may actually require extra skills and training to manage complex family dynamics which foster carers do not have to contend with. It would be useful to have an evidence base as to what training kinship carers believe they would find beneficial. Although there is an expectation that CSOs will offer **additional training** to foster carers and kinship carers on specialist areas of interest, such as sexual abuse, it would not seem that this occurs in practice.

### *Support and Supervision*

Unlike other home based care placements, caseworkers are not allocated to provide support and supervision in kinship care placements. Case management responsibility usually remains with the child protection practitioner (except in some cases when the case has been contracted to a CSO), whose role it is to ensure such placements are adequately monitored and supported, aside from their usual investigative role. The Commission has come to question the appropriateness of ‘stretched’ child protection practitioners being expected to be able to adequately provide an ongoing support role for the child and their kinship carer throughout the duration of the placement, and develop good working relationships with other care team members, in the midst of undertaking forensic investigations and given the issues of staff turnover.

It would seem that kinship carers would particularly benefit from having the support that dedicated caseworkers from a CSO are more able to provide, as demonstrated through home based care arrangements. Kinship carers do not seem adverse to accepting offers of support, as their usage of various services such as the Mirabel Foundation would suggest. Furthermore, kinship carers would

certainly seem likely to benefit from the additional functions CSOs are also able to provide such as mechanisms for carers to link with other carers to receive and provide support, including the establishment of support groups. Carers can also be informed by CSOs about Victorian peak bodies that can provide them with independent advice, information, support and advocacy. The CSO and carers sign an agreement which outlines their individual roles and responsibilities. It would seem essential that resources are provided to the rapidly growing kinship care sector to remove the current inequity, in recognition of the importance of investment in enduring placements.

### *Recommendations*

3. That following the completion of the preliminary assessment by the child protection practitioner at the time of placement, responsibility be transferred to an appropriate CSO for completion of the comprehensive assessment of kinship and kith care placements.
4. That a training needs analysis be undertaken through direct engagement with kinship and kith carers, and a training program developed and implemented to meet the needs identified.
5. That the role of providing ongoing support and supervision to kinship and kith carers be transferred to CSO's to provide the full range of support, monitoring and advocacy functions, consistent with the way this operates for foster carers and other home based carers.

### **Children and Young People Prevention Strategies**

A second group of strategies which contribute to the prevention of sexual abuse through empowerment of children in OOHC includes the Charter for Children in OOHC, which has accompanying resources for children and guides for professionals. In addition, there are a range of initiatives which seek to hear the voice of the child, which plays an important role in keeping children safe through being able to express their concerns to someone who will listen. The Community Integration Program operates in residential care units and the Independent Visitor Program in Youth Justice is proposed to be expanded to cover the Secure Welfare Service (SWS) and the broader residential care sector. Recent work by the Commission has led to a proposal for development of a Zero Tolerance of Child Sexual Exploitation Policy, with a focus on protecting young people in OOHC.

#### *Charter for Children in OOHC*

In attempt to undertake the two pronged approach with carers and children and young people, the Commission (as the former OCSC) developed the Victorian Charter for Children in Out of Home Care (based on the United Nations Convention on the Rights of the Child, UNCROC), as a guide for consumers and service providers, regarding what children and young people should expect from those who are caring for and supporting them whilst they are residing in out of home care. The first right described is "to be safe and feel safe", with "safe" being defined to include the absence of abuse and was deliberately listed as the paramount charter right. There have been a number of resources developed to embed the charter into practice, including resources to help children understand their rights in care, assist staff to effectively engage with children about their rights and to assist agencies to embed the charter into their policies and procedures.

Resources for children and young people specifically include:

- A DVD for those aged under 12 years
- A DVD for those aged over 12 years
- A story book for those aged under 12 years
- An activity book for those aged over 12 years
- An Entering Care Kit developed by the CREATE Foundation, and

- An Easy Read version of the Charter for those children and young people with a disability.

A range of resources have also been developed by VACCA (Victorian Aboriginal Child Care Agency) to promote the Charter to those Aboriginal Children and Young People who are new to out of home care, specifically including:

- A boys poster and a girls poster
- Night time storybook
- Rights booklet
- Game
- Postcards, and
- An overnight bag.

A set of *Getting It Right* resources were also developed for agencies and practitioners, including:

- The governance level booklet for boards and executive management teams of agencies to assist with thinking how to embed the charter into their policies and practices, which includes a section on evaluation and monitoring for practitioners.
- The practice level booklet is for practitioners in agencies and department staff to assist them to reflect on the charter and how they can embed it into their practice.
- Activity card packs can be used by practitioners to engage children and young people in discussion of the charter.

These resources are available through Berry Street Victoria. There does not appear to have been an evaluation of the effectiveness of these resources.

### ***Recommendations***

6. That an evaluation be conducted to assess the effectiveness of the resources developed for children are in terms of explaining the Charter rights and enabling them to use it.
7. That an evaluation also be conducted as to the effectiveness of the *Getting It Right* resources for practitioners, to ensure continuous improvement.

### ***Community Integration Program (CIP)***

In 2010, the Commission (as the former Office of the Child Safety Commissioner), commenced a three year pilot program designed to link young people in residential care with their local community. The Community Integration Program (CIP) is built upon a partnership between the Commission and Whitelion, with Community Integration Leaders (CILs) based in agencies in three regions. The CIP aims to connect the young person with a volunteer able to support their involvement in chosen activities in their local community. To date, about 80 young people have participated in this program and anecdotal evidence suggests that most have had a positive experience with their volunteer and have tried a range of activities (Commission for Children and Young People Annual Report, 2013, please see attached). The formal evaluation currently underway is expected to be completed in 2014. The Commission's role in this program has provided an insight into issues which can make it more challenging for young people to connect meaningfully with their local community, such as placement stability, a crisis response environment and finding sufficient suitable volunteers. The supportive relationship with the volunteer helps the young person to build their confidence, broader social connections and networks, increasing their resilience and ability to be, and keep safe.

### *Independent Visitor Programs*

In April 2012, the Commission (as the former Office of the Child Safety Commissioner) established the Independent Visitor Program, initially at the Parkville Youth Justice Centre, but which has recently been extended to the Malmsbury Youth Justice Centre, with plans for development of a culturally appropriate component of the program to specifically assist Aboriginal young people in custody. The program aims to provide young people in custody with access to Independent Visitors whom the Commission recruits, and provides with ongoing training and support. The young people can express any concerns they have about their care environment to the Independent Visitors. Unsurprisingly, most issues the young people wish to discuss relate to their day-to-day living such as food, activities, relationships, recreation, air conditioning and access to learning. The Commission works through these issues with the management and staff, and believes that through provision of supported access to issue resolution, the program has contributed to the safety and wellbeing of these vulnerable young people in custody (Commission for Children and Young People Annual Report, 2013).

The success of this program has led to the formal proposal that the same model be applied for children placed in Secure Welfare Service (SWS) facilities. Child protection clients who need a secure, highly structured setting during a significant crisis which has resulted in them being at substantial and immediate risk of harm, are placed in SWS on a temporary basis not exceeding 21 days. The similarity in features of a SWS to a closed custodial setting, indicate this proposed program will offer an important avenue for the voice of children to be heard and lead to improvements in their care and consequent safety and security. On a broader scale, it is also proposed that the Independent Visitor program be expanded to residential care services to provide another tool for ensuring the voice of children is heard in decision making about their care provision. It is believed that implementation of this program would provide an essential way for young people in residential care to explore their concerns with a trusted other, thus improving their safety.

### *Zero Tolerance of Child Sexual Exploitation and Abuse*

Work undertaken recently by the Commission on a number of inquiries has found evidence of systemic sexual abuse of children in out of home. Primarily young women and some young men were identified as being subjected to sexual exploitation and sexual assaults by adult sexual offenders and/or other clients. This comprehensive work has resulted in the Commission gaining a range of insights into the risk factors for this criminal behaviour occurring and potential strategies to prevent it. The Commission has subsequently made a number of quality improvement recommendations across a range of areas, designed to address the lack of protection afforded to this highly vulnerable group of young people, with a particular focus on those placed in residential care. The Commission is currently awaiting DHS' response to these recommendations.

### *Sexual Health Guidelines*

Some years ago, the issue of specific development of Sexual Health Guidelines for use with young people in OOHC was raised in conjunction with the implementation of the Looking After Children (LAC) model of practice. This project was led by Berry Street Victoria in conjunction with DHS. However, it would appear that this important resource has not been progressed for some time. This is concerning given that the available evidence would indicate that young people in OOHC would seem more likely to contract STI's, have higher rates of teenage and unplanned pregnancy, problematic sexual relationships given histories involving sexual and other forms of abuse and less oversight by a "parent" figure who might be expected to play some role, in conjunction with the education provider, in ensuring that they are fully informed regarding sexual and reproductive health issues.

### *Recommendations*

8. That Sexual Health guidelines for young people in OOHC be developed, in addition to specialist training and education resources for carers.

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

Currently in Victoria, there are different strategies for keeping children in OOHC safe from sexual abuse depending upon whether the child is in relative or kinship care, foster care or residential care. However, regardless of the type of care placement, the principles for keeping children safe remain the same, with some variations as to how they may be applied in practice. These principles relate to careful recruitment of the carer, which requires adaptation when considering the care setting: the kinship carer will be required to have or develop the capacity to negotiate family dynamics, the home based carer such as a foster carer will need to keep the child safe in the context of providing care in their home and the people who are in their networks, and the residential care worker needs to be able to work with other professionals and traumatized children, to keep children in their care safe from sexual abuse.

Secondly, assessment of carers from each of these care types needs to operate from the general principle of comprehensively ensuring that the carer will be able to meet the health and wellbeing needs of a traumatized child. In the context of a kinship carer, this may potentially be a placement within their extended family as a base for the child's lifetime. In the case of a foster carer, the potential time span may be until the child turns 18 years of age and leaves care, but is also likely to include direct or indirect interactions with the child's family of origin. The residential care worker must be assessed against being able to meet the obligations of their professional role.

At present in Victoria, it would appear that the assessment process undertaken by child protection practitioners of kinship carers is less rigorous than that undertaken for foster carers, who nominate themselves as carers, and are subjected to an exhaustive assessment process by the relevant CSO, which includes mandatory training.

It could be argued that kinship carers may need more in-depth assessment and similar preliminary training given they had not actively sought this role in the same way. However, the Commission is not aware of any comparative research that would provide an evidence base for customizing the assessment process and preliminary training to meet the differing needs of kinship carers and foster carers respectively.

When it comes to training, the contrast is even greater, with the service system perceiving kinship carers as probably not being keen to participate in formal training, as they "already know how to care for children", and very few training opportunities would seem to be offered for them. Foster carers would usually receive opportunities to participate in various training opportunities with the support of their CSO. Residential care workers have even greater training opportunities through their CSO and broader education providers. Provision of support is similarly inequitable, kinship carers have limited avenues for seeking support, or for their provision of care to be monitored, as they are allocated to child protection practitioners rather than having a caseworker from a CSO, and the recently established kinship care agency network are generally restricted to provision of support groups given resourcing constraints. Foster carers receive support from their assigned CSO support worker, often with complementary support from a child protection practitioner or contracted case manager. Residential care workers receive support and monitoring of their practice via their line management structure and the CSO more broadly.

Foster carers and residential care workers are also subject to registration, which means that their contact details are kept on the DHS Carer Register, and if they are ever disqualified, their registration as a carer is removed and their Working with Children Check card is cancelled. However, kinship carers (and lead tenant carers) are not subject to the same registration processes, and perhaps lesser scrutiny of their care, which raises concerns about an increased risk that those potentially looking at placing a child with this individual might remain unaware of previous care issues. This inconsistency in the requirement for registration of different types of carers would not seem to be supported by an evidence base.

## **Recommendation**

9. That comparative research be conducted to provide an evidence base for customizing the assessment process and preliminary training to meet the differing needs of kinship carers and foster carers respectively.
10. That consideration be given to registering kinship carers to ensure consistency between carer types and provide the same checks and balances for children entering into a kinship care placement.

### **Best Practice Example - Overnight Stays**

If a child staying in kinship, foster care or residential care wishes to stay overnight at the home of another, the carers, caseworkers or child protection practitioner must consider the request in light of what would be considered age appropriate for their peers. The DHS policy advice, which describes a range of factors to take into consideration, applies to overnight stays of up to two consecutive nights, beyond which the approval of the child's case manager is required and any additional conditions for approval are made on a case-by-case basis. This advice replaces a previous policy which required police checks be conducted on any adults present in the household in which the young person was intending to stay.

Understandably, this policy requirement caused children in OOHC embarrassment and led to missed opportunities to socialize with friends, and the potential for a police check to be relied upon as the sole basis for a suitability assessment, rather than the assessment being informed by the things a "good parent" takes into consideration when deciding to allow their own child to stay at a friend's home.

*See attached policy guidelines as a best practice example*

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

There are various strengths and weaknesses of models that check OOHC practices using an audit approach, a regular supervisory visit or an irregular visit by someone such as community visitor. In Victoria currently, there is an audit approach which forms part of the quality and regulatory framework for the care provided to children in OOHC and monitoring of CSO performance. The Cummins Review found that this approach to monitoring and reviewing is insufficient to identify, address and prevent the "major and unacceptable shortcomings" in the quality of out-of-home care. The Inquiry recommended that a risk based approach to the monitoring and review of CSO performance should be adopted. It was proposed that DHS should assess the risk of the CSO not meeting performance standards, with a focus on the risk of harm to children in their care. The argument could be made that a combination of regular audits and unannounced inspection visits would be most effective in driving improvement in the quality of OOHC practices.

*See attached DHS Service Standards – Independent Reviews*

Agencies which are funded by DHS to provide OOHC must be registered and meet compliance with standards according to the requirements of the *Children, Youth and Families Act 2005*.

The standards were originally developed and gazetted in April 2007, with revised standards implemented from 1 July 2012, which can be summarized as:

- **Empowerment:** People's rights are promoted and upheld
- **Access and engagement:** People's right to access transparent, equitable and integrated services is promoted and upheld
- **Wellbeing:** People's right to wellbeing and safety is promoted and upheld

- **Participation:** People's right to choice, decision making and to actively participate as a valued member of their chosen community is promoted and upheld.

The CSO's are required to complete two annual internal self-assessments and then submit to an independent review every three years, through choosing one of the IRB's (Independent Review Bodies), which have been endorsed and listed on the DHS website. This approach has the advantage of applying consistent, publicized standards, which are based in legislation, across all CSOs. It would be expected that the three yearly independent reviews would be fairly comparable. However, there is likely to be greater variation in the format and content of self-assessments unless these are standardized. The perceived process of the conduct of an independent review might also be enhanced if the CSO was automatically allocated to an IRB rather than simply choosing a preferred provider.

Whilst the conduct of annual assessments is desirable, an independent review at only three yearly intervals would seem a long period between comprehensive assessments of the quality of service provision. This gap would seem more acceptable if additional assessment methods were being undertaken regularly. There are four Standards, which are broken down into 16 criteria, which include indicators about people being free from abuse and neglect; service providers having policies and processes for responding to potential or actual harm, abuse or neglect; service users knowing their rights and knowing what to do if rights are violated; and service providers having an easily accessible complaints, appeals and feedback system (*Please see Attachment - Overview of the DHS Standards*). The standards and criteria are quite broad and seem cumbersome for the purpose of monitoring daily issues in the quality of out of home care provision, which a regular supervisory or other visit would be more effective in addressing.

### *Visits to Services*

Therefore, a regular supervisory visit offers a complementary approach to assessing the provision of care to children in OOHC, but may experience some difficulties in negotiating the issue of access for home based care compared to accessing residential care units. A regular visit also shares the difficulty of a planned audit approach, in that there is a risk that special attention will be paid to the quality of service provision whilst care providers believe they are "on show", distorting the reality of actual service provision. For this reason, an irregular visit by a person such as a community visitor may be of greater benefit in gaining a more accurate view of service provision. The current Independent Visitor Program in Youth Justice conducted by the Commission would lend strength to the idea that a supported approach to issue resolution can be a very effective tool in uncovering quality of care issues and addressing them in a timely manner. This method also offers the advantage of providing preventative rather than a crisis management approach to issue resolution.

A number of inquiries undertaken by the Commission have led to a recommendation that random safety audits of OOHC providers be undertaken to assess the ongoing quality of service delivery to vulnerable children. Through a process of engagement of the child, their concerns could be examined in the context of the organization's policy and procedures and recommendations made to achieve continuous improvement. Use of the Charter for Children in OOHC to cover all the domains could provide a foundation for this audit process, perhaps building on earlier work done by the Office of the Child Safety Commissioner, as reported in the *Charter for Children in Out-of-Home-Care Compliance: Registration Standards External Review – May 2010*.

*See attached Charter for Children in Out-of-Home-Care Compliance: Registration Standards External Review – May 2010*

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

The Cummins Inquiry looked in detail at the question of whether DHS should retain responsibility for the regulation of OOHC providers and family services, and concluded that this should continue to be the case, provided that:

- The regulatory function is independent and structurally separated from those parts of the Children, Youth and Families Division responsible for child protection and family services policy and funding of CSOs;
- The director of the unit reports directly to the Secretary; and
- DHS is subject to independent oversight of the conduct of its regulatory function by the Commission for Children and Young People (which at that point it was proposing should be established)

The rationale provided for this position by the Inquiry suggested CSOs have a potential conflict of interest in taking on the role of leading formal care reviews, which they conduct in partnership with DHS. Whilst it was felt to be appropriate for CSOs to use their own internal processes to address minor issues related to placements and carers, the Inquiry believed DHS should take lead responsibility for the review of serious or repeated quality of care concerns. The CSO would support DHS in undertaking the review, which would bring the formal care review process into line with investigations of possible abuse or neglect in care.

The Commission believes that it is essential that regulation operates from the basis that children who are entrusted to the care of the Secretary of DHS are entitled to at least the same level of support and care that 'a good parent' would provide. It is important that the regulators have expertise in child protection practices and are separated from cost and demand issues that create a conflict of interest.

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

The core components of the training needs of those working with children who may have been sexually abused relate to the capacity to undertake trauma informed practice, which relies upon an integration of the theories of attachment, trauma and child development. The more recent developments in provision of therapeutic residential care and therapeutic foster care with their emphasis on reflective practice supported by enhanced skill development will gradually lead to a carer workforce with improved knowledge and skills. When working with children, it is inappropriate to undertake such practice only when the child has a known trauma history, trauma informed practice needs to be the norm to support those children whose trauma history may not be immediately obvious. In addition, trauma informed practice covers responsiveness to the full range of abuse or neglect, with many children experiencing a complex spectrum of abuse rather than simply one form of abuse. However, the experience of sexual abuse may manifest as a variety of sexualized behaviours such as sexual preoccupation, sexual aggression, inappropriate boundaries and active seeking out of sexual interactions.

In recognition of this need, the Commission (as the former Office of the Child safety Commissioner) has produced two resources for those working with traumatized children, *Calmer Classrooms: A guide to working with traumatised children* for kindergarten, primary and secondary teachers and other school personnel, and *From isolation to connection: A guide to understanding and working with traumatised children and young people* for professionals, carers and others to understand the needs of children who have been affected by trauma through abuse and neglect. These resources have been distributed across

Victoria in large volumes and many training workshops have been conducted with professionals such as carers and caseworkers based on these resources.

It is probably not the case that staff from regulatory bodies have usually been exposed to such resources or training. For those carers who are not professionals as such, foster carers may have variable access to this type of training, with accessibility dependent upon the agency with which they are affiliated. Those providing formal kinship care and informal kinship care or kith care, would seem quite unlikely to have access to this type of training. This is concerning given the statistical data demonstrating exponential growth in this care sector, and the much lower provision of support to carers compared to those providing residential care or foster care. A high priority should be given to training in relation to sexual abuse given the particular characteristics of potentially traumatic sexualisation of the child, and as the impacts can be very confronting to carers and debilitating for the child over the life course. However, training in relation to sexual abuse should simply form one component of broader training in relation to trauma informed practice, which should be perceived as essential and mandatory for those involved in working with children in any type of care capacity.

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

There is simply not adequate and effective training available to the range of carers who are caring for children who have sexually abused other children, either for those who are working within the residential care sector or the foster care, kith or kinship care sectors. The SABTS (Sexually Abusive Behaviour Treatment Service) workforce development funding from DHS provides four practice symposiums annually under the auspice of CEASE (peak body for the Intervention Network for Sexually Abusive Behaviours in Children and Young People), and these professional development sessions are for those who work in therapeutic intervention services and cover topics such as Working with under 10's, Working with adolescents with an intellectual disability, autism and Asperger's, Adolescents in residential care, and Families who do not accept there has been sexually abusive behaviour. DHS has produced the Specialist Practice Resource, *Adolescents with sexually abusive behaviours and their families* which utilizes the Best Interests case practice model to form the foundation for a practice model to guide professionals when working with children and young people who have demonstrated this behaviour (*attached*).

Residential care staff have traditionally had very limited access to training on provision of care to children who have sexually abused other children. In recognition of this, the CPS (Children's Protection Society) proposed the piloting of a program to expand beyond the training and consultation service that it provides to professionals working with this cohort of young people. The *CPS Consultation and Support Project for Residential Services: Managing young people displaying sexually abusive behaviours* involved a partnership with three agencies identified as providing residential care to high numbers of young people displaying these behaviours. The purpose of the project was to offer specialist consultation and support to residential carers working in units requiring specialist input into managing the dynamics of young people living together who had a history of sexually problematic and/or abusive behaviour.

The project had a range of components, including:

- Provision of consultation and support to the Placement Coordination Unit and the Out of Home Care agencies in relation to placement planning and matching. Environmental scanning and assisting in the development of safety plans was also offered.
- A one day training package was offered for all residential care staff across the region, to be repeated four times per year to address staff turnover.
- Additional training packages were to be offered to the three residential care agencies as needs were identified.
- Employment of a Therapeutic Advisor (Sexually Abusive Behaviours) to:

- Provide regular on-site consultation to residential care staff and case managers regarding provision of an environment that promotes safety and minimizes the risk of engagement in sexually abusive behaviours.
- Regular liaison with therapeutic treatment providers working with individual young people placed in residential units, to ensure management plans are consistent with the therapeutic needs of each young person.
- Attendance at care team meetings as appropriate, but not in lieu of the young person's treatment provider.

During the course of the project it was recognized that the role of the Therapeutic Advisor would need to expand beyond provision of support to the original target group of young people aged 10-17 years, as there were an increased number of children aged under 10 years displaying sexualized behaviours being placed in residential care. This led to the scope changing to take into consideration the needs of this specific cohort (*see attached progress report*).

This project has been extended for a further 12 months within the North Division and will be continuing to provide the services as described across the North Metro and Loddon (Bendigo) areas. The CPS is currently awaiting a response as to whether the Western Metro will also be extending the project in that area.

Please see Appendix 4 for CPS Progress Report Recommendations

Those who are providing kith or kinship care are able to access the support agency Kinship Care Victoria, or may be linked into the Kinship Care program operating from their local child and family support agency. The focus of these services has been to assist carers with accessing practical resources such as Centrelink benefits and emotional support groups, with the aim of "providing the minimum level of professional intervention from the formal service system". This focus has meant that carers have not routinely been exposed to extensive training or resources on how to care for children who have sexually abused other children. The carers of those children and young people who are receiving a SABTS service would normally be included as part of the therapeutic intervention, but this would be dependent upon the carers being in this role whilst the child is in treatment. It might be expected that kinship carers could experience particular difficulties given the complexity of caring for children and young people who have been sexually abusive or engaging in problematic sexual behaviours with young members of their own extended family and all of the complex family dynamics this is likely to invoke. There are not usually publically available training sessions on caring for children and young people who demonstrate sexually abusive or problematic sexual behaviours which carers could attend on their own volition.

Carers of children with a disability may also have contact with the Office of the Senior Practitioner – Disability Services within DHS (Victorian Department of Human Services) in the event of the child undertaking sexually abusive behaviour or engaging in problematic sexual behaviour and the potential use of restrictive interventions. This Office is charged with leading best practice in behaviour management strategies and providing specialist expertise and secondary consultations to disability support providers.

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

### *National Standards*

In 2009, the Council of Australian Governments (COAG) adopted a *National Framework for Protecting Australia's Children 2009-2020*, which led to the development of an *Outline of National Standards for Out-of-Home Care* in 2011. These National Standards seek to drive improvement in the quality of care to the extent that children in OOHC have the same opportunities as other children to reach their potential in life, regardless of where they live in Australia. The first standard requires that "Children and young people will be provided with stability and security during their time in care". The first measure for this standard assesses placement stability, whilst the second measure is "The rate and number of children in out-of-home care who were the subject of a child protection substantiation and the person believed responsible was living in the household providing out-of-home care". The third measure states "The proportion of children and young people in out-of-home care who report feeling safe and secure in their current placement". In relation to the second measure, a very low rate of 0.9% of children in OOHC in Victoria in 2010-2011 were the subject of substantiation of such harm (Cummins Inquiry Report). This measure would seem to be quite blunt as an indicator of the actual rate of sexual abuse of young people in OOHC and of little assistance in developing service quality improvement initiatives.

The rate of sexual abuse of children in OOHC is very difficult to determine due to a range of factors, which may also apply for children in the general population, but are magnified for children living in OOHC, given that they have by definition already experienced trauma and so are a vulnerable young person. The factors include the grooming phase of sexual offending which may initially appear to be essentially positive attention directed towards an emotionally insecure young person, use of coercive techniques by the sexual abuser, sexually abusive behaviour by a peer in OOHC who may have previously demonstrated such behaviour, the sexual abuser may have knowledge that the young person has previously experienced sexual abuse and so is more vulnerable to revictimization, and the belief held by some adult sexual offenders that young people living in OOHC are often "softer targets" for sexual exploitation given they may lack a primary caregiver, have frequent changes of placement, carers and schools. These situational factors make strong emotional attachment to carers and close observation of behavioural indicators and management of risk taking behaviour very difficult.

Clinical research also clearly demonstrates that the young person often may not disclose that they have been sexually abused until many years later, with eventual disclosure dependent upon the circumstances being fortuitous, such as the development of language and knowledge to enable articulation of their experience, a period of stability in their lives – which is countermanded against by the impacts of child sexual abuse which include increased risk of drug and alcohol abuse and mental health issues, being in a safe environment at that stage of their life, someone to confide in who is supportive and non judgmental, and a belief that the disclosure will be responded to positively, when this may be inconsistent with prior experiences they have had.

### *Exit Interviews*

Given these complex issues, any reports of substantiated claims of abuse of young people in OOHC, especially in relation to sexual abuse, are highly likely to be unreliable as an accurate, comprehensive measure of the rate. Whilst an exit interview for young people leaving care, or at the time of changing placements, may elicit some disclosures of previously unreported sexual abuse, on condition the young person was able to articulate what had occurred and felt safe to do so, this procedure would still provide an under-representation of the actual rate. Any professional conducting such an exit interview would need to be highly trained and skilled to elicit such sensitive information from the young person, and

would have the added challenge of building rapport if they did not already have a trusted relationship with the young person. This method would also usually only provide a record of historical abuse, providing limited benefit to the affected young person, who could still be linked in with support services, which it would have been preferable to have achieved in a more timely way.

Ascertaining the rate of sexual abuse of young people in OOHC is perhaps also not the most critical issue, as this would change continually in any case, especially as some young people experience high revictimization rates. It is perhaps more important to provide trauma informed practice in the care of young people in OOHC, as though any or all may have experienced sexual abuse at any point in their lives. It is therefore critical that those caring for young people are aware of and trained to detect behavioural indicators of possible sexual abuse and are able to sensitively explore their concerns with the young person, with the caveat that this exploration would not negatively impact upon any subsequent police investigation. It would therefore be helpful if residential carers were given basic training in forensic child interview techniques to enable them to understand the essential principles underlying this approach to prevent them unintentionally contaminating evidence.

### *Incident Reports*

In Victoria, there is an Incident Reporting system, which compulsorily requires all DHS staff and the staff of all CSO's funded by DHS to provide out of home care, to report to DHS any incidents that involve or impact upon clients. This is to ensure that DHS meets its legal obligations, insurance obligations and public expectations of accountability. The responsibility for management of the incident lies at a local level. Home based caregivers and residential care staff are required to report incidents to their CSO, whilst kinship carers and lead tenants report incidents directly to DHS. The incident report forms are primarily completed by the most senior member of staff or carer present at the incident. A representative of the agency's management then reports on action taken in response to the incident to address any safety risks and what will be done to prevent the incident from happening again.

Category One incidents are defined as the most serious, and include an allegation of or an actual sexual assault of a child or young person living in OOHC, regardless of whether the alleged abuser is the carer, a member of the carer's household or a client in the same or another placement. Such reports must be completed within 24 hours and sent to DHS. In 2010-11, there were 1,134 category one incident reports to DHS relating to child protection clients. This represented an 82% increase on 2008-09 when there were only 621 category one incident reports, which had increased to 912 category one incident reports made in 2009-10. Alleged sexual assault at 21% is the second highest ranked after alleged physical assault at 27% in terms of the proportion of total category one incidents in 2010-11 categorized by type. For 2010, 40% of the category one critical incidents involving child protection clients related to clients in residential care (Cummins Inquiry Report, p.498). This data suggests that the most common type of incident involves alleged sexual assault of young people in residential care.

Although DHS undertakes quarterly analysis of critical incident data, it does not report publicly on critical incidents, despite a recommendation of the Cummins Inquiry that category one critical incident data should be reported annually by DHS, including a breakdown by region, by incident type and by the placement or service type in which incidents occur. The Commission (and formerly the OCSC) ceased conducting a quarterly analysis of the critical incident data in 2010, as this was seen to be a duplication of the analysis done by DHS. However, the Commission continues to identify concerns for individual clients, together with any emerging themes or patterns. Inquiries undertaken by the Commission suggest the classification of alleged sexual assault would benefit from review.

By definition, such an incident reporting system is not a preventative measure, but may allow early intervention to prevent the occurrence of more serious sexual assaults of either the same child or young person or other peers, by holding the offender accountable for their behaviour and engaging support for the victim/survivor. On a systemic level, incident reporting should assist in improving the quality of service provision through analysis of reporting data, enabling trends to be identified and effectively

managed through the use of preventative strategies and the strengthening of responses to adverse events.

### *Abuse in Care, Registration of Carers and Suitability Panel*

In cases of alleged sexual abuse, Child Protection is required to immediately report the information to the police in accordance with the *Protecting Children Protocol (2012)* between DHS and Victoria Police, with the police being responsible for the criminal investigation of such matters. Furthermore, the *Children, Youth and Families Act 2005* requires the person in charge of a registered OOHC service to report to DHS within seven days if he or she has received, or becomes aware of, an allegation that a registered carer (either a foster carer or a residential carer) has sexually or physically abused a child placed in his or her care, and the person is satisfied that an investigation of the allegation by the Secretary is warranted. The OOHC service is not precluded from making inquiries into the allegation, but must report details of those inquiries when it reports to DHS. Other independent review bodies (IRB's) are required by contract to notify DHS if they suspect, or receive a complaint or allegation, about abuse or risk to a service user in the course of their reviews of service providers.

The Secretary of DHS decides if an independent investigation is warranted, and if so, an authorized investigator is appointed and reports back to the Secretary. DHS will then decide whether to refer the matter to the Suitability Panel for a hearing to establish if there has been misconduct by the carer and whether the carer poses an unacceptable risk of harm to children. If this is the case, their registration as a carer will be removed and the child (and possibly any other children residing in the placement) will be removed from their care. In the case of a residential care worker, the carer would be removed from the unit. Notice of the Suitability Panel's findings are given to the carer, DHS and where the law requires, immediately to the Department of Justice (DoJ). The carer can apply to the Suitability Panel after 12 months to have the disqualification removed, with notice of the findings being provided to the same parties.

In 2009-10, there were allegations of possible abuse or neglect relating to 363 clients in OOHC, with 279 reported incidents and 15% of the allegations related to sexual assault. Children in residential care were much more likely to be involved in allegations of possible abuse or neglect than children living in other placement types. Guidelines require DHS to complete investigations within 28 working days of the allegation being received by the Department, but the Cummins Inquiry found only 61% of the completed investigations were done within this timeframe. Of the investigations that were completed in 2009-10, the relatively low rate of 30% were substantiated. In 2009-10, in 26% of completed investigations, the carer's approval was withdrawn and for 25% of investigations, a change in placement for the child resulted. Overall, the Cummins Inquiry expressed concern that the current DHS database did not allow for the recording of all quality of care concerns that were reported to the Department. It was recommended that DHS should record and report on the number of quality of care concerns raised, the number of investigations of abuse in care and the number of formal care reviews, including the outcomes of investigations and reviews, and their timeliness.

### *Changed Practices*

To ascertain if information gained about child sexual abuse experienced by young people in OOHC has resulted in changed practices, data collection might consist of surveys, interviews or focus groups to establish:

- if young people felt comfortable about reporting experience of child sexual abuse
- who they might report this to if it had/did occur to them
- what had happened if they had previously disclosed
- what they expected might happen if they disclosed now
- what resources and support services they thought were available for people who had experienced sexual abuse, and

- what they would like to be available.

This approach would effectively provide snapshot data about the incidence of child sexual abuse of young people in OOHC, which would be a continually changing rate dependent upon the cohort within OOHC at any one time, and the experiences of those at highest risk of sexual abuse and sexual exploitation.

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

It is very important that the voice of the child is heard when an allegation of sexual abuse by a carer has been made. There is a great imbalance in power in the relationship between a carer and a child, which is exacerbated when the child does not have other significant people in their life upon whom they could rely for advocacy and support. Unfortunately, the child's previous history of sexual abuse may increase their risk due to the nature of revictimization – where abusers perceive a survivor of prior sexual abuse as less likely to be seen as credible if they made an allegation. These factors need to be taken into consideration when trying to manage very carefully a discussion with the child about the allegation, keeping in mind that grooming tactics involving inducement or coercion may also have been employed.

Whenever considering the issue of allegations of sexual abuse against carers, the principles of natural justice also need to apply. Namely, the carer needs to be provided with and respond to any information about the allegations being made against them, that decisions are made free from bias, and that a proper investigation is conducted and all the evidence is considered. In Victoria, any person may report abuse to the Department of Human Services (DHS) alleging physical or sexual abuse by a residential or foster carer towards a child or young person aged under 18 years at the time of the alleged abuse. DHS will then decide if the matter is to be investigated, but only if the alleged abuse occurred on or after 7 December 2002. Given the issue of historical sexual abuse and the frequently protracted time before disclosure is made, it may be more appropriate to remove this eligibility requirement.

An independent investigator conducts an investigation and reports to DHS. It is critical that this investigator is well trained in forensic investigative interviewing of children and skilled in building rapport with them, as the role demands that the investigator have the child's trust and willingness to discuss what has occurred. This is despite the child having experienced trauma and a breach of trust in being abused or neglected, resulting in their placement in out of home care in the first place.

DHS will then decide whether to refer the matter to the Suitability Panel for a hearing to establish if there has been misconduct by the carer and whether the carer poses an unacceptable risk of harm to children. If this is the case, their registration as a carer will be removed. Notice of the Suitability Panel's findings are given to the carer, DHS and where the law requires, immediately to the Department of Justice (DoJ). The carer can apply to the Suitability Panel after 12 months to have the disqualification removed, with notice of the findings being provided to the same parties.

Whilst these processes would seem to be essentially fair, being bound by principles of natural justice, it would seem important that kith and kin carers were also registered and subject to the same procedures, rather than the current two tier system where kinship carers are not subject to the same support or scrutiny as other "professional" carers. Under the current system, the carer against whom the allegation has been made is entitled to be present at the hearing, make submissions and be legally represented. If the carer disagrees with the findings or determination of the Suitability Panel, they may apply to VCAT for

a review. This model offers an appeal system to protect carers, but it is a somewhat cumbersome and expensive process.

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

Allegations of sexual abuse are very challenging to investigate given their nature and the heightened sensitivity for all those involved. There is a need for specialist expertise in understanding not only child development and the nature of sexual abuse, both the behaviour of offenders and the impacts on the victim, but also forensic investigation techniques. The handling of allegations relating to children in OOHC therefore requires a range of skills and careful assurance that the voice of the child is privileged over the interests of the organization and its staff. For this reason, independent oversight of the process is very important to prevent conflict of interest occurring when a CSO or departmental agency is put in the position of investigating itself. This independent oversight could potentially be achieved by having an independent expert on the planning group conducting the quality of care investigation. Given the ethical difficulties of conducting prospective research into the effectiveness of this independent oversight, perhaps the best measure that could be adopted would involve a comparison with cases from recent history when such a mechanism has not been in place.

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

Please see responses to questions 1, 3 and 9.

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

Previous work in the area of sexual offence policy and procedural reform by the Victorian Law Reform Commission, *Sexual Offences: Law and Procedure Final Report 2004*, found that sexual offences needed to be treated differently to other crimes, as survivors would usually disclose and report the offence many years later. This pattern is consistent with other research, and has implications for rules around a statute of limitations for reporting, prosecuting and compensating such crimes. Similarly, delays in reporting of child sexual abuse have implications for record keeping and access to records. The standard policies around record archiving and destruction may need to be revised to reflect these differing future access requirements.

Agencies who have been tasked with providing care of children and young people, and particularly those residing in out of home care, need to ensure that they keep comprehensive records, that are maintained appropriately and can be accessed into the future through being transferred to various media formats as these evolve and are updated. Children and young people may make allegations of child sexual abuse much later in their lives and this will mean that these records may need to be accessed to verify details of contacts, placement, whereabouts – such as when the young person has absconded, etc. This may lead to criminal prosecutions and compensation claims, making clear the need for specific details, accuracy in recording (such as where the young person was located) and storage of records.

The Cummins Report alludes to an additional benefit of this improved record keeping, whereby the *Who Am I?* Project on OOHC record keeping enables children to access all records of relevance and, as appropriate, be provided with a personal record when leaving care. This project has found that such records play an important role in the health, wellbeing and identity construction of young people in care, and those adults who were in care as children.

## Appendix 1 - Residential Care Staff

### Selection

The assessment for residential care staff includes:

- Confirmation of experience and qualifications
- Confirmation that the applicant possesses the skills, personal attributes and competences required to fulfil the role they have applied for
- Direct contact, either face-to-face or by phone, with two referees to confirm the applicant's suitability (including contact with their most recent employer)

The CSO must also register all residential carers on the DHS Carer Register, and make sure that carers are not disqualified or under investigation. The potential residential carer must also successfully complete a police record check and a Working with Children Check prior to commencing work in a residential care unit, and ensure the currency of the check is maintained. The CSO must ensure that any residential carers employed through a labour hire agency have been subjected to a police check, and these checks must be updated every three years for all residential care workers.

## Appendix 2 – Home Based Care

### *CSO Recruitment Strategy*

An effective carer recruitment strategy is expected to have the following features:

- Being based on the individual, age, cultural and special needs of their client group
- Maximizes opportunities to match a child with an appropriate carer
- Enables the CSO to meet placement demand and service agreement obligations
- Deals promptly with enquiries from prospective carers, and
- Provides the carers with timely and accurate information about the skills and personal attributes required, roles and expectations of carers/CSOs/DHS, support and training carers can expect to receive, review procedures and conditions of approval.

### *Assessment of Potential Foster Carers*

There are a range of suitability and screening checks which the CSO must also conduct when assessing a foster carer application:

- Contact with DHS to ensure that the prospective carer has not been disqualified from being on the *Register of out-of-home carers* (known as the Carer Register).
- Ensuring that there is an up to date Working with Children Check for the prospective carer and any adult member of the household that will have a parenting role with the child must also complete this.
- Direct contact must be made via a face-to face or telephone interview with three responsible people who can act as referees for the applicant. These referees must have known the applicant for a minimum of two years, must still be in contact with the applicant, must not be directly related to the applicant and must have observed the applicant's interaction with children.
- If the applicant has previously provided care through another CSO in Australia, the current CSOP must contact the other CSO/s to seek advice regarding the applicant's suitability and competencies.
- A new police check is required for every prospective carer and all members of the household who are 18 years of age and over who reside in the household, or regularly stay overnight, upon application to a CSO.
- For those applicants and members of their household aged 18 years of age or over, who have spent 12 months or more overseas during the past five years, an international police check must be conducted. In the situation where this is not possible, three additional referee checks from people who knew the applicant whilst they were in that country, must be conducted.
- If the CSO becomes aware that a prospective or current applicant/or adult member of their household has a "disclosable" police record, the current DHS policies must be followed.
- Prospective carers must also provide medical evidence that they are medically fit, including a medical report from their GP.
- At least one home visit must be conducted to undertake a 'home and environment check', with any issues identified requiring a plan to address them before approval can proceed.
- Thorough assessment of carers and families must be undertaken to ascertain whether they possess the attitudes, skills, cultural competence and personal attributes required for caring.
- Potential carers are assessed on the four key competencies of
  - Provides a safe environment that is free from abuse

- Demonstrates a personal readiness to become a carer
- Promotes the positive development of children in care
- Has the ability to work as part of a team
- The process of assessing suitability to become a carer involves all household members, including children, attending at least one information session. Full assessment of both adult partners (including new partners) is mandatory.
- Unsuccessful applicants are to be provided with a rationale for this decision.

### *Foster Care Panel*

The components of Step by Step Victoria/Step by Step Victoria Aboriginal assessment tool presented to the panel are:

- A coversheet
- Confirmation of background checks, interviews and training checklist
- A genogram
- Summary report including evidence of the four key competencies
- A life history
- The applicant's preferred options
- A final report with recommendations regarding an appropriate accreditation status.

The foster care panel, when approving a carer, must specify the accreditation status of the carer's approval:

- Type of care (respite or general pool)
- Numbers, ages and genders of children
- Any special conditions attached to the approval
- Identification of priority training needs
- Level and type of support to be provided by the CSO or other organizations
- Review process

## Appendix 3 – Kinship Care

### *Preliminary Assessment Requirements*

A Preliminary Assessment (Kinship Care Assessment Form A) as a minimum requires that:

- Criminal history checks are completed for potential carers and all other household members aged over 18 years or older who reside in the house or sleep there overnight
- A check of the *Client Relationship Information System (CRIS)* to ascertain if there is information relating to the prospective carer and household members as carers
- Checks on the suitability and fitness of the proposed carer
- Discussion with the carer, facilitated by an ACSASS (Aboriginal Child Specialist Advice Support Services) worker when an Aboriginal child is to be placed, about whether the child will be safe living with them, and whether they are willing to co-operate with DHS to help the child and their parents.
- Where the child is aged under 2 years, discussion of SIDS (Sudden Infant Death Syndrome) factors.

If the child is to be placed with a suitable person subject to an IAO (Interim Accommodation Order), DHS must prepare a verbal or written report for the children's court on the proposed carer's suitability, using the prescribed criteria of:

- The criminal records and history of the person
- The previous history of the person as a carer of children
- The capacity of the person to promote a child's safety, wellbeing and development
- Any criminal records or history of the usual members of the person's household

The minimum assessment is to include a home visit as soon as possible, generally within the first week of placement, to identify:

- The suitability of the accommodation available for the child
- The carer's capacity to provide the child with adequate day to day care
- The carer's understanding of the child's needs, including access with their family of origin
- Supports required by the carer, which may include bedding, financial support or specialist support
- Any health and safety issues such as appropriate fencing of a pool, storage of firearms, medications and poisons

### *Comprehensive Assessment Requirements*

The framework for this comprehensive assessment covers:

#### ***Family Background***

- Positive and negative family experiences
- The nature of discipline used in the family of origin
- Stability or instability in the family during the carer's childhood

#### ***Current family life and relationships***

- Relationships to the child's family
- Stability of the marriage or defacto relationship, and relationship with their own children

- Child rearing practices – attitude to discipline, general approach to child management
- Communication skills, including their ability to resolve conflicts and ability to deal with stress
- Discipline – how the carer plans to establish limits and discipline the child

### ***Out of home care issues***

- Motivation for applying to care for this particular child
- Type of placement being considered – emergency/respice/long term permanent care
- Expectations of the placement – do the potential carers have:
  - Realistic expectations of the child's behaviour and ability to relate to them
  - Realistic expectations of the child's potential and level of performance, such as in school or at sport
- An understanding of and ability to deal with behavioural issues
- Attitude and ability to work with the family of origin, frequency and nature of access, concerns about issues in the family background (eg. sexual abuse, drug abuse)
- Capacity to work with DHS and cooperate in developing and implementing case plan goals, including permanency goals where these are appropriate
- Previous or current experiences with DHS and how this may impact upon the placement

## Appendix 4 - CPS Progress Report Recommendations

A number of recommendations were made based on the findings of this project, namely:

1. That a structured intake process occur as a way of 'gatekeeping' requests for the Therapeutic Advisor role. Team leaders of the residential unit would be responsible for making contact with the Therapeutic Advisor.
2. Ensuring clear communication processes to promote consistent care giving practices which employ strategies to manage sexually harmful behaviours.
3. A Roundtable symposium model is adopted whereby representatives from all residential care service providers attend to discuss common themes and develop common values and best practice strategies that address the needs of young people in their care who have engaged in sexualized behaviours.
4. Residential case unit meetings occur where professionals providing support to each young person attend a collaborative case meeting to assist in providing a more holistic approach to the care of each young person who resides in the unit.
5. The role of the Therapeutic Advisor be extended to also address the issues of placement matching of young people who have engaged in sexualized behaviours.
6. The Therapeutic Advisor to provide a more focused response by working intensively with six units at any one time (two from each of the identified services).
7. The Therapeutic Advisor participate in engaging the family system around the young person and assist in planning for other services to enhance family functioning and increase the opportunities for the young people to return to their family of origin, where appropriate.
8. A greater clarity of roles to ensure that practitioners identified as experts within a particular field provide advice on those particular themes.

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