

# Royal Commission: Preventing sexual abuse of children in out of home care

Submission to issues paper 4 – November 2013



## Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide comment to the Royal Commission into Institutional Responses to Child Sexual Abuse on issues paper 4, *Preventing sexual abuse of children in out of home care*.

## General comments

The RANZCP is responsible for training, educating and representing psychiatrists in Australia and New Zealand. It has a significant interest in ensuring optimal mental health outcomes for children and adolescents. Children in out of home care are particularly vulnerable to mental health problems and abuse, particularly child sexual abuse. The RANZCP has previously developed reports, guidelines and submissions for children at risk of abuse, including those in out of home care. These include:

- [Faculty of Child and Adolescent Psychiatry Report: The mental health care needs of children in out-of-home-care](#) (June 2008)
- [The mental health care needs of children in out-of-home care](#) (position statement 59)
- [Child sex abuse](#) (position statement 51)
- [Child Protection Legislative Reform discussion paper](#) (March 2013)
- [Queensland Child Protection Commission of Inquiry](#) (September 2012)

The RANZCP further supports initiatives outlined in the Department of Families, Housing, Community Services and Indigenous Affairs publication [An outline of National Standards for Out-of-home Care](#).

Children are frequently placed in out of home care (OOHC) to protect them from abuse, including sexual abuse. Suffering subsequent abuse in an environment designed to offer protection can have devastating effects for the victim, and leave them vulnerable to psychiatric disturbance and impaired development, which also results in significant social and financial costs. All feasible measures must be taken to prevent this abuse from occurring. Psychiatrists have a critical role in identification, reporting, assessment and treatment of victims of child sexual abuse, many of who are initially referred by general practitioners and others following deliberate self harm, behavioural disturbances, alcohol and drug abuse, depression and post-traumatic stress disorder (PTSD). The RANZCP has provided comments in response to relevant consultation questions to assist in ensuring that there is adequate regulation, preventive intervention and service delivery to protect children in out of home care from sexual abuse.

## Response to consultation 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?**

The RANZCP has identified five general strategies to assist in the keeping children safe from sexual abuse in OOHC settings. Other strategies are addressed as appropriate in response to relevant questions.

### a) Understanding contributing factors

A key measure to preventing sexual abuse is understanding how children placed in OOHC become to be abused in these environments. When contributing factors are identified and understood, prevention strategies can be implemented. This includes increased monitoring, evaluation and research as the foundations of evidence-based practice to ensure that the provision of care and protection to children in OOHC is safe, accessible, relevant, culturally appropriate and cost-effective. There is evidence that reducing mental health problems can be achieved by comprehensive assessments and treatment at point of entry in to OOHC. The New Orleans Intervention, a foster care intervention devised by J.A. Larrieu & Zeanah in 1998, designed to address the developmental and health needs of children under the age of 5 who have been mistreated and placed in foster care, has demonstrated effectiveness.

### b) Screening of OOHC providers

An essential consideration is the appropriate intensity of vetting of OOHC service providers to ensure they do not have a propensity to sexually exploit children, and the ongoing monitoring of such providers to ensure that such sexual exploitation does not occur. Working with children checks will identify previously detected sexually exploitive behaviours but will not identify undetected behaviour, or where a person who is at risk of commencing such behaviour. Providing OOHC to children particularly in the foster care setting is often motivated by altruism. In addition such providers are in short supply. The challenge therefore is to set the right balance such that screening is sufficiently intense to detect risk, but not to the level that creates a disincentive to provide OOHC.

The RANZCP would suggest that more intensive screening of individuals who sign up to provide OOHC is necessary. This should have the aim of ensuring individuals are not at risk of engaging in sexually exploitative behavior but also having enhanced focus on ensuring a good 'fit' between child and placement. This requires further training of assessors to spot potential 'red flags'. As the system is already chronically underfunded and overextended, this is likely to require significant additional resources.

### c) Increased access to health services, particularly mental health support

Children in OOHC experience high rates of developmental and mental health problems. The psychopathology is complex and is currently not well understood, however research suggests that its origin lies in insecure attachments and the cumulative effects of childhood maltreatment. Childhood maltreatment prior to entry into care is common amongst these children. Also, the high prevalence of intellectual disability in this group adds to the complexities of mental health needs. These children warrant special attention and priority access for assessment and treatment by multi-disciplinary mental health care teams that are competent in meeting their complex care needs. Providing this support may assist in children in OOHC to feel more confident in addressing early signs of sexual abuse.

There is increasing recognition that children in out of home care require specialist services. Professor Michael Tarren-Sweeney has outlined the need for dedicated services in his 2010 publication *It's time to re-think mental health services for children in care, and those adopted from care*<sup>1</sup>. Professor Tarren-Sweeney has also developed Brief Assessment Checklists (BAC-C, BAC-A): Mental health screening measures for school-aged children and adolescents in foster, kinship, residential and adoptive care. A further recent paper by Tucker and Mares describes the establishment of The Gumnut Clinic at Redbank House in Sydney, a specialist mental health assessment clinic in Western Sydney for children in out-of-home care<sup>2</sup>. The paper supports the need for specialist mental health services as a step towards improving health outcomes for these children.

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1 Tarren-Sweeney, M. (2010) It's time to re-think mental health services for children in care, and those adopted from care. *Clinical Child Psychology and Psychiatry* 15(4): 613-626.

2 Tucker, R and Mares, S (2013) Establishing a mental health service for young children in out-of-home care: The Gumnut Clinic for 0 to 5 year olds in Western Sydney. *Children and Youth Services Review* 35(2) 205–212

As well as comprehensive assessment, treatment plans should be developed that organise and prioritise interventions in the major areas of a child's life (e.g. home, peers, school), with the emphasis on enhancing strengths through therapy or activities to promote the child's development. Given the complexity of the mental health problems in children in OOHC, specialist multidisciplinary mental health services dedicated to meeting the needs of these children need to be established in all jurisdictions. Evaluations of community based clinics that focus on the needs of children in OOHC have been established in a few instances and those being piloted provide the evidence-base for effectiveness. Access to competent, comprehensive mental health care needs to be a priority for children in OOHC.

In Queensland the Evolve Inter-agency Services (EIS) program commenced in 2005 as an outcome of the Forde inquiry recommendation that there be specialist services for children in care and this has been progressively rolled out across the State. Queensland Health, via district CYMHS, provided the mental health arm of this program, Evolve Therapeutic Services (ETS). ETS, which targets the 17% of children in care with the most severe and complex difficulties, has resulted in improved outcomes for these children. Improvements in mental health and psychological wellbeing, placement, and educational stability and engagement, as well as decreased externalising behaviours have been demonstrated. It is recommended that programs similar to the ETS and the EIS program be continued, and that consideration be given to expansion of ETS to allow further service provision for at-risk children and children in care. Further information on these programs can be found in the RANZCP response to the Queensland Child Protection Commission Inquiry (September 2012) available here: <https://www.ranzcp.org/Files/ranzcp-attachments/Publications/RANZCP-FCAP-Qld-submission-to-Carmody-Inquiry-Fina.aspx>

It is recommended that increased access to health services, particularly mental health support be provided to children in OOHC and should incorporate:

- competent multidisciplinary teams
- multi-modal mental health assessment before entering care
- treatment plans
- trauma informed response.

Further information about the level of support required can be found in the comprehensive RANZCP report on children in OOHC (accessed via [https://www.ranzcp.org/Files/ranzcp-attachments/Resources/FCAP\\_paper\\_on\\_Out\\_of\\_Home\\_Care\\_June\\_2008-pdf.aspx](https://www.ranzcp.org/Files/ranzcp-attachments/Resources/FCAP_paper_on_Out_of_Home_Care_June_2008-pdf.aspx)) and accompanying position statement (accessed via [https://www.ranzcp.org/Files/ranzcp-attachments/Resources/College\\_Statements/Position\\_Statements/ps59-pdf.aspx](https://www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps59-pdf.aspx)).

#### d) Better support for foster and kinship care families

The need for training is covered in more detail by responses to questions 5 and 6. However, there is a further need for increased support and incentives to encourage appropriate foster parents to become involved in supporting children in OOHC. This requires a shift in community attitudes towards OOHC from funding bodies so that carers and staff are treated as valued members of the system, and recruited and paid accordingly. This would include:

- improved incentives for individuals with pertinent expertise to work with children in out-of-home care
- increased funding to provide adequate remuneration and support to foster and kinship carers.

In providing this support there is need to acknowledge the difficulty of OOHC carers being 'employees' which arguably fundamentally changes the relationship between carer and child, carer and community services, and between carer and NGO (where applicable). This fundamental aspect of the relationship means the 'employer' (often being community services) may be seen to have a conflict of interest, in supporting the child against holding on to the precious resource of another carer. There is a need to consider a strategy for managing any potential adverse outcomes arising from these relationships.

## e) Maintenance of positive relationships

A strong emphasis on ensuring positive, safe, long-term relationships for young people must be maintained. This will provide young people with trusted adults to whom they may disclose child sexual abuse. This might occur through maintaining a school placement with foster placements changes, and should include more than one person to allow for a safety net. As part of developing these relationships, children in OOHC need to be educated about their right to feel safe and who to tell if they do not feel safe. Making child sexual abuse a subject which can be spoken about is a crucial step. Where appropriate, maintenance of positive relationships with biological parents (or other close and reliable family members such as grandparents) should also be encouraged. All children should be offered psychoeducation in protective behaviour programs to assist in developing these skills.

### **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?**

The RANZCP is not aware of any evidence of different strategies. However, the strategies that should underpin keeping children in OOHC safe from sexual abuse include the appropriate screening of people volunteering to become foster carers. Further training to allow carers and child safety officers to recognise the potential signs of potential problem sexual behaviours in each different setting would further assist.

In all settings maintenance of positive relationships within OOHC and broader child protection services is important. This includes collaborative engagement of carers and support with a network of agencies. Different settings may need different strategies which consider the level of family involvement. There is a need to and foster a feedback mechanism for concerned involved carers (particularly family) who may refrain from speaking up if formal services are already involved. Kinship care is an area where research and evaluation, and consequently evidence, is very poorly developed and this should be addressed.

### **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?**

The RANZCP has no particular preference for models that check OOHC practice. However members have noted that in some States community visitors are prevented from having contact with those providing services to the young person. Whilst the aim is to provide impartiality, the reality is that they are separated from the system and so lack information that would assist them in supporting the young person and understanding issues, strengths and weaknesses in a placement. Whatever model is implemented needs to be collaborative.

### **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?**

Child protection departments across the country are generally working at capacity responding to child protection concerns. Appropriate assessment of all OOHC providers is necessary and whilst child protection departments would offer greater continuity of care, it is unlikely they will have the capacity to regulate OOHC providers comprehensively. A potential option to circumvent this challenge would be if this regulatory function was undertaken by a separate body such as a Children's Commission or Children's Guardian depending on relevant jurisdiction.

### **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?**

Training of OOHC providers is a crucially important component of prevention. This training should be available at an initial stage and provided in an ongoing manner. Training needs to articulate that children in OOHC are in general a vulnerable group, and those who have experienced prior sexual abuse are

especially vulnerable. They may behave in ways that give encouragement to people who seek to sexually exploit children. OOHC providers need to be aware of such behaviours and where appropriate give feedback to the young people. At the same time they need to be vigilant to the effects the behaviours may be having on fellow out of home care peers.

There is a lack of knowledge and skill generally in assessment and understanding what is developmentally acceptable and what is of concern. Carers are often unsure what response is appropriate, and information about interventions that are part of an overall, integrated treatment and support plan are lacking. To help address this core components of training are:

- a basic understanding of the normal development of young people and attachment theory and practice - this would assist carers, caseworkers and staff of regulatory bodies working with children who might be sexually abused recognise the early warning signs or signs and symptoms of young people who are at high risk of further abuse in care
- an understanding of the complex nature of the psychopathology experiences by these children and the compounding effect of neurological, psychological, emotional, behavioral and most importantly relational sequelae which is important to the provision of care.

Training in these areas should be mandatory and tested for retention of knowledge. While the topics that such training would cover would be sensitive and would require experienced facilitators, it is crucial to ensure the best outcomes for children in out-of-home-care.

In delivering this training the reparative parenting training model is a concept which should be embraced with foster carers given specific training on how to develop safe relational environments which encourage secure attachments.<sup>3</sup>

#### a) Problem sexual behavior (PSB)

Additional training should also be available both for foster carers and youth workers in group homes and secure care facilities, and also for therapeutic staff working with children in care who exhibit problem sexual behaviour (PSB). Often, when sexualised behaviour is present, it causes great anxiety and either becomes the whole focus of an intervention for a child, ignoring the child's other needs and difficulties, or is ignored while the developmental and attachment and other needs are addressed. It is important to be mindful that children with these behaviours are children first and foremost and that with appropriate treatment and targeted intervention, they have a good prospect of returning to a healthy developmental track.

Between 35 and 50 per cent of children with PSB have experienced sexual abuse, and around the same proportion have experienced physical or emotional abuse or neglect or have witnessed parental violence. Up-skilling carers to discuss and respond to problem sexual and other intimate behaviours and needs, and skilling professionals to develop appropriate and targeted interventions as part of an integrated care plan are necessary. The Victorian Department of Human Services has a useful resource on this matter. While designed for specialist clinicians, it provides background to what problem sexual behaviour is, how it is manifested, and what its causes can be. It is a good starting point for foster carers and youth workers seeking to understand this issue and can be read online:

<http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/plans-and-strategies/children,-youth-and-family-services/children-with-problem-sexual-behaviours-and-their-families>.

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<sup>3</sup> Chambers, Megan. Reparative Parenting: a challenge for foster and kinship carers. Mental Health Coordinating Council Trauma Informed Care and Practice Conference 2011 Presentation.

<http://www.slideshare.net/mhcc/megan-chambers>

PSB can cause alarm in all care situations and the need for an integrated and comprehensive treatment and support plan becomes critical when they occur. Many foster carers do not have a clear narrative about the child's past to be able to understand why the child might be presenting with certain behaviours and is then unable to respond in a sensitive and attuned way. Part of the initial assessment then needs to address their capacity and willingness to be able to both reflect on the child's predicament and work as a part of a Therapeutic Care Team. Skilling up carers to comfortably discuss and respond to sexual and other intimate behaviours and needs, and skilling professionals to develop appropriate and targeted interventions as part of an integrated care plan are necessary.

Responding to PSB is currently an area of specialist knowledge and skill and more funding for development and training in this area and wider dissemination of this knowledge to the child protection and alternate care and therapeutic services workforce is required.

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

This is a complex, specialised care of care and approaches differ from region to region. In some states, the responsibility for children who have sexually abused children is divided among different government agencies, which can be confusing to carers. For example, in New South Wales, children aged ten to fourteen who engage in sexually abusive behaviour may be treated in designated health programs such as the New Street Service, while children under ten who engage in sexually abusive behaviour if they are a victim of a sexual assault become the responsibility of sexual assault services, while if they are *not* a victim of sexual assault become the responsibility of child and family teams or child and adolescent mental health services. This fragmentation of services is confusing to carers and clinicians.

Clinicians have reported that, of the adolescents coming through the New Street Adolescent Service (a program which provides a coordinated, consistent, quality response to children and young people aged 10–17 years who sexually abuse), approximately 50% of their victims are siblings. If this pattern generalises to OOHC settings, then it might be predicted that unless/until sexually harmful sexual behaviour is extinguished, those displaying it are more likely to harm those in OOHC with them than children outside of OOHC settings. This issue needs to be acknowledged. Complicating this issue is the already scarce resource of OOHC places, and also the situation that individual carers (in NSW) are able to register with multiple agencies. This can lead to a situation where separate agencies may send children to a placement with no knowledge of who else might already be in the placement.

Particularly taking account of the systemic issues, there definitely is an unmet need in regard to training and information provision for those caring for children in this domain. Greater development and funding of specialized services for children and younger people in OOHC with complex behaviours, such as problem sexual behaviours is required. Specialised expertise in managing problem sexual behaviours should be incorporated into training for foster carers and the services delivered so that the need of the child is managed as a whole [see response to question 5 for further details]. Currently training differs from region to region and in some rural areas there may be no training available, and minimal information for carers.

It is further important to recognise that children who become perpetrators of abuse were often victims of abuse themselves. For these children, a comprehensive risk assessment and management is crucial. Denial of the issues or unhelpful stigmatisation of these children in these services is unhelpful. There is a need for integrative approaches to treatment dealing with their victimisation and perpetration in the same psychological therapy.

Child and adolescent psychiatrists are essential contributors in a number of roles with much to offer in providing knowledge about the aetiology and manifestation of mental disorders associated with child maltreatment and or disrupted attachments to enable these issues to be addressed appropriately. This includes provision of information to the courts so judges can make informed decisions based on knowledge of the individual child's situation.

As stated in response to question 1, access to competent, comprehensive mental health care needs to be a priority for children in OOHC, especially those children who have sexually abused other children.

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

Prevalence of the rate of sexual abuse in children in OOHC is difficult to determine accurately. There are likely to be a number of unreported incidents because of the criminal sanctions against it, and the young age and dependent status of the child,

Standard 1.2 of the National Standards for Out-of-Home Care requires this reporting:

*1.2 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.*

It is important to involve children to participate in their own care, and for their opinions to be heard and acted upon where appropriate. An exit interview may assist in capturing this information. Ideally though, early intervention will mean that capturing such information can happen *before* an exit interview takes place. It is important to ensure that children have the confidence in their support network and are encouraged to report any abuse as soon as it occurs.

Anecdotally (from Sexual Assault Services) a majority of children who have suffered sexual abuse in OOHC don't disclose until well after the placement has broken down, and they have a perception of safety. Taking this into account, there may be a role for sexual assault services to capture this information.

**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?**

These practices should not differ greatly from recognised practices regarding eliciting histories from child victims of sexual abuse who are not in OOHC. Appeal processes for the carers are outside the remit of RANZCP.

The critical nature of research based best practice in interviewing child victims (appropriately training and resourcing for investigative staff) to give the best chance of obtaining reliable and valid disclosures should be recognised. There is also need for appropriate mental health support for carers facing such allegations, particularly given suicide risk.

There is some further information from the Department of Human Services (Victoria) resource document on problem sexual behaviours document regarding allegations and disclosure which may assist:

<http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/plans-and-strategies/children,-youth-and-family-services/children-with-problem-sexual-behaviours-and-their-families>.

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

The RANZCP has no response to this question.

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

Multiple levels with multiple checks are important to ensure vulnerable individuals are not being missed or left in abusive situations. Judicial monitoring can also lead to many caring families ending up with multiple professionals and others visiting the home which becomes intrusive and impairs the family from having a 'normal' schedule. When organising oversight mechanisms an appropriate balance needs to be reached that allows for multiple checks whilst allowing children in OOHC to be in as safe and homely setting as possible.

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

The specific relevance to RANZCP is the length of time psychiatrists should retain health records of their patients. For those in public practice this would be mandated by the service.

For those in private practice, this should be for at least as long as the statute of limitations. In practice, this may create a burden on practitioners for the storage of files. State funded services have been called upon to produce material fifteen years or older in relation to claims of child sexual abuse and record keeping is a major issue as not all institutions have electronic records. As, however, changes in developmental trajectory may become more understandable on disclosure years later, it is an issue which needs to be considered carefully.