



**Submission from the
Truth Justice and Healing Council**

Royal Commission into Institutional Responses to Child Sexual Abuse

**Issues Paper No. 4 | Preventing Sexual Abuse of Children in
Out of Home Care**

15 November 2013



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Justice Peter McClellan AM
Chair
Royal Commission into
Institutional Responses to Child Sexual Abuse

Via email: solicitor@childabuseroyalcommission.gov.au

Dear Justice McClellan

As you know, the Truth Justice and Healing Council (the Council) has been appointed by the Catholic Church in Australia to oversee the Church's response to the Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission).

On behalf of the Council I submit the Church's submission in response to the Royal Commission's fourth Issues Paper: Preventing Sexual Abuse of Children in Out of Home Care.

The Council has consulted widely to ensure the expertise and wisdom of its constituents was taken into account in the preparation of this submission.

Yours sincerely

Barry O'Keefe AM QC
Chair
Truth Justice and Healing Council

15 November 2013



Our Commitment

The leaders of the Catholic Church in Australia recognise and acknowledge the devastating harm caused to people by the crime of child sexual abuse. We take this opportunity to state:

- 1 Sexual abuse of a child by a priest or religious is a crime under Australian law and under canon law.
- 2 Sexual abuse of a child by any Church personnel, whenever it occurred, was then and is now indefensible.
- 3 That such abuse has occurred at all, and the extent to which it has occurred, are facts of which the whole Church in Australia is deeply ashamed.
- 4 The Church fully and unreservedly acknowledges the devastating, deep and ongoing impact of sexual abuse on the lives of the victims and their families.
- 5 The Church acknowledges that many victims were not believed when they should have been.
- 6 The Church is also ashamed to acknowledge that, in some cases, those in positions of authority concealed or covered up what they knew of the facts, moved perpetrators to another place, thereby enabling them to offend again, or failed to report matters to the police when they should have. That behaviour too is indefensible.
- 7 Too often in the past it is clear some Church leaders gave too high a priority to protecting the reputation of the Church, its priests, religious and other personnel, over the protection of children and their families, and over compassion and concern for those who suffered at the hands of Church personnel. That too was and is inexcusable.
- 8 In such ways, Church leaders betrayed the trust of their own people and the expectations of the wider community.
- 9 For all these things the Church is deeply sorry. It apologises to all those who have been harmed and betrayed. It humbly asks for forgiveness.

The leaders of the Catholic Church in Australia commit ourselves to endeavour to repair the wrongs of the past, to listen to and hear victims, to put their needs first, and to do everything we can to ensure a safer future for children.

Authorising Church Bodies

The following Catholic Church bodies have authorised the Truth Justice and Healing Council to represent them at the Royal Commission:

Dioceses

Archdiocese of Adelaide	Diocese of Broome	Diocese of Sandhurst
Archdiocese of Brisbane	Diocese of Bunbury	Diocese of Toowoomba
Archdiocese of Canberra-Goulburn	Diocese of Cairns	Diocese of Townsville
Archdiocese of Hobart	Diocese of Darwin	Diocese of Wagga Wagga
Archdiocese of Melbourne	Diocese of Geraldton	Diocese of Wilcannia-Forbes
Archdiocese of Perth	Diocese of Lismore	Diocese of Wollongong
Archdiocese of Sydney	Diocese of Maitland-Newcastle	Eparchy of Saints Peter & Paul of Melbourne
Diocese of Armidale	Diocese of Parramatta	Military Ordinariate of Australia
Diocese of Ballarat	Diocese of Port Pirie	Personal Ordinariate of Our Lady of the Southern Cross
Diocese of Bathurst	Diocese of Rockhampton	
Diocese of Broken Bay	Diocese of Sale	

Religious Institutes

Adorers of the Blood of Christ	Marist Fathers Australian Province	Sisters of Nazareth
Augustinian Recollect Sisters	Marist Sisters – Congregation of Mary	Sisters of Our Lady of Sion
Augustinian Sisters, Servants of Jesus and Mary	Ministers of the Infirm (Camillians)	Sisters of St Joseph
Australian Ursulines	Missionaries of God's Love	Sisters of St Joseph of the Apparition
Blessed Sacrament Fathers	Missionaries of the Sacred Heart	Sisters of St Joseph of the Sacred Heart
Brigidine Sisters	Missionary Franciscan Sisters of the Immaculate Conception	Sisters of St Joseph, Perthville
Canons Regular of Premontré (Norbertines)	Missionary Sisters of Mary, Queen of the World	Sisters of St Paul de Chartres
Canossian Daughters of Charity	Missionary Sisters of St Peter Claver	Sisters of the Good Samaritan
Capuchin Friars	Missionary Sisters of Service	Sisters of the Good Shepherd
Christian Brothers	Missionary Sisters of the Sacred Heart	Sisters of the Holy Family of Nazareth
Cistercian Monks	Missionary Sisters of the Society of Mary	Sisters of the Little Company of Mary
Columban Fathers	Missionary Society of St Paul	Sisters of the Resurrection
Congregation of the Mission – Vincentians	Oblates of Mary Immaculate	Society of African Missions
Congregation of the Most Holy Redeemer – Redemptorists	Order of Brothers of the Most Blessed Virgin Mary of Mount Carmel (Carmelites)	Society of Catholic Apostolate
Congregation of the Passion – Passionists	Order of Friars Minor Conventual	Society of Jesus
Congregation of the Sisters of Our Lady Help of Christians	Order of Saint Augustine	Society of St Paul
Daughters of Charity	Order of the Friar Servants of Mary (Servite Friars)	Society of the Divine Word Australian Province
Daughters of Mary Help of Christians	Our Lady of the Missions	Society of the Sacred Heart
Daughters of Our Lady of the Sacred Heart	Patrician Brothers	Sylvestrine-Benedictine Monks
De La Salle Brothers	Pious Society of St Charles – Scalabrinians	Ursuline Missionaries of the Sacred Heart
Discalced Carmelite Friars	Poor Clare Colettines	
Dominican Friars	Presentation Sisters – Lismore	
Dominican Sisters of Eastern Australia & The Solomons	Presentation Sisters – Queensland Congregation	
Dominican Sisters of North Adelaide	Presentation Sisters – Tasmania	
Dominican Sisters of Western Australia	Presentation Sisters – Victoria	
Faithful Companions of Jesus	Presentation Sisters – Wagga Wagga Congregation	
Family Care Sisters	Presentation Sisters – Western Australia	
Franciscan Friars	Religious of the Cenacle	
Franciscan Missionaries of Mary	Salesians of Don Bosco	
Franciscan Missionaries of the Divine Motherhood	Salvatorian Fathers	
Franciscans of the Immaculate	Servants of the Blessed Sacrament	
Holy Cross – Congregation of Dominican Sisters	Sisters of Charity of Australia	
Hospitaller Order of St John of God	Sisters of Jesus Good Shepherd "Pastorelle"	
Institute of Sisters of Mercy Australia & Papua New Guinea	Sisters of Mercy Brisbane	
Loreto Sisters	Sisters of Mercy North Sydney	
Marist Brothers	Sisters of Mercy Parramatta	

Other Entities

Australian Catholic Bishops Conference
Catholic Religious Australia
Catholic Church Insurance Limited
Professional Standards Office Tasmania
Professional Standards Office NSW/ACT
Professional Standards Office NT
Professional Standards Office Queensland
Good Samaritan Education and Lourdes Hill College
Good Samaritan Education and Mater Dei
Good Samaritan Education and St Mary Star of the Sea College
Good Samaritan Education and St Patrick's College
Loreto Mandeville Hall Toorak
Trustees of Mary Aikenhead Ministries



The Truth Justice and Healing Council

- 1 The Catholic Church in Australia (the Church) welcomes the establishment of the Royal Commission into Institutional Responses to Child Sexual Abuse as an opportunity to acknowledge the truth about child sexual abuse within the Church, and to have these issues investigated and considered, objectively and publicly. It is an opportunity to bear witness to the suffering of the many victims of this abuse.
- 2 The Church is committed to cooperating fully with the Royal Commission, without reservation or qualification.
- 3 In February 2013 the Australian Catholic Bishops Conference (ACBC) and Catholic Religious Australia (CRA)¹ jointly established the Truth Justice and Healing Council (the Council) to coordinate and oversee the Church's overall response to and appearance at the hearings of the Royal Commission.
- 4 The Council is a body of 12 people, with expertise spanning such fields as child sexual abuse, trauma, mental illness, suicide, psycho-sexual disorders, education, public administration, law and governance. The majority of Council members are lay, two of its members are bishops, and one of its members is a Brigidine sister. Three of the Council members are either themselves victims of abuse or have immediate family members who are victims. The Council provides independent advice to the ACBC and CRA, through a Supervisory Group, which is comprised of the Permanent Committee of the ACBC, and representatives of CRA. The Supervisory Group may accept or reject such advice. The Supervisory Group fully endorses this Submission. The members of the Supervisory Group are listed on the TJHC website [here](#).²
- 5 The Council is chaired by the Hon Barry O'Keefe AM QC, former Chief Judge of the Commercial Division of the Supreme Court of New South Wales and a former Commissioner of the NSW Independent Commission Against Corruption.
- 6 The current members of the Council are:
 - Archbishop Mark Coleridge, Archbishop of Brisbane
 - Professor Maria Harries, Adjunct Professor at Curtin University and Research Fellow in Social Work and Social Policy at the University of Western Australia
 - Mr Jack Heath, CEO of SANE Australia
 - Associate Professor Rosemary Sheehan, Department of Social Work, Faculty of Medicine, Nursing and Health Sciences, Monash University
 - Hon Greg Crafter AO, former South Australian Minister of Education

¹ CRA is the peak body, previously known as the Australian Conference of Leaders of Religious Institutes, for leaders of religious institutes and societies of apostolic life resident in Australia.

² <http://www.tjhcouncil.org.au/about-us/members-of-supervisory-group.aspx>

- Sr Maree Marsh, former Congregational Leader of the Brigidine Sisters and psychologist with Anti-Slavery Australia at the University of Technology Sydney, Faculty of Law
 - Bishop Bill Wright, Bishop of the Diocese of Maitland-Newcastle
 - Professor Greg Craven, Vice-Chancellor of the Australian Catholic University
 - Ms Elizabeth Proust AO, former Secretary to the Victorian Department of Premier and Cabinet, and Chairman of the Bank of Melbourne and Nestlé Australia and member of other boards
 - Mr Stephen Elder, former Member of the Victorian Legislative Assembly and Parliamentary Secretary for Education and currently Executive Director of Catholic Education for the Archdiocese of Melbourne, and
 - Dr Marian Sullivan, child and adolescent psychiatrist.
- 7 The CEO of the Council, Mr Francis Sullivan, has worked in government and private practice and has held positions as Secretary-General of the Australian Medical Association, Chief Executive of Catholic Health Australia and consultant to the Pontifical Council for the Pastoral Care of Health Care Workers at the Vatican. He is also an Adjunct Professor at the Australian Catholic University.
- 8 The Council oversees the Church's engagement with the Royal Commission, including by:
- speaking for the Church in matters related to the Royal Commission and child sexual abuse
 - coordinating the Church's legal representation at, and the Church's participation in, the Royal Commission.
- 9 The Council's role extends to:
- initiating research into best practice procedures, policies and structures to protect children
 - assisting in identifying any systemic institutional failures that have impeded the protection of children
 - providing information to the Royal Commission concerning the various procedures, policies and structures that have been successively put in place by Church organisations over the past 25 years to deal with complaints and instances of child sexual abuse and any improvements which might be made to them to provide greater protection for children
 - seeking to promote lasting healing for the victims and survivors of abuse.
- 10 To date, 31 dioceses and 94 religious institutes (commonly referred to as congregations and orders) have given an authorisation to the ACBC or CRA, authorising those bodies to represent and act for them in the engagement of the Church with the Royal Commission.
- 11 The ACBC and CRA have in turn delegated that authority to the Council. The Council therefore seeks to appear at the Royal Commission for all the authorising bodies, and will speak with one voice for all of them.

- 12 Pursuant to these arrangements, the Council thus acts for all archdioceses and dioceses in Australia, with the exception of three of the Eastern Rite Eparchies, and for all the major religious institutes. The Council also acts for a number of other Catholic organisations including Catholic Church Insurance Limited (CCI).
- 13 For practical purposes, the Council will ordinarily speak for the whole Church: its dioceses, its religious institutes, its priests and religious, in the Royal Commission.
- 14 The Catholic Church in Australia today is an extensive and diverse religious organisation committed to worship, prayer and pastoral care. It is involved in providing pastoral, educational, health, human and social services across Australia.³
- 15 Notwithstanding that all the dioceses and religious institutes are autonomous and independent, each from the other, with no one central or controlling authority, and with each free to govern its affairs separately and independently, all are united in their support for the principles stated in the Commitment at the head of this Submission.
- 16 Those principles are also fully shared by all the innocent and high-minded priests and religious whose long years of devoted and selfless service have been admirable and who are heartbroken by the revelations of sexual abuse which have emerged in recent decades.
- 17 The Council's aim is to do everything in its power to ensure that the Royal Commission has available to it from the Church all the material that it needs for the work it seeks to do, so as to ensure that a light is shone on dark places and times and events, and to ensure that nothing is concealed or covered up in respect of what Church personnel did or failed to do.
- 18 The Council seeks to fulfil that role, on behalf of the Church, in a spirit of honesty, openness and genuine humility.

³ See Annexure B, TJHC Submission to Royal Commission Issues Paper No 2: Towards Healing, 30 September 2013 <http://tjhccouncil.org.au/media/39435/30549468_2_TJHC-Towards-Healing-submission-30-Sep-2013.pdf>

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Executive Summary

- 1 Australian children⁴ placed in Out-of-Home Care (OOHC) constitute a discrete population group in relation to vulnerability and history of maltreatment which may include sexual abuse. OOHC is a key component of child protection systems world-wide. It provides for alternative direct care of children when parental care is deemed unsafe (or not possible as in the case of abandonment), or when parents voluntarily seek OOHC for their child or children. The need for OOHC is generally assessed by agencies of government. It requires legal intervention and processes to initiate a care placement in order to directly protect a child.
- 2 Children enter OOHC for a variety of reasons, which in Australia most usually relate to direct or significant risk of harm, specifically maltreatment within their family context, which may include physical, sexual or emotional abuse. It is widely recognised and agreed that placement in OOHC should provide a safer, direct-care environment than that which was available prior to removal of a child from their family. Therefore it follows that the safety of children in care, including from sexual abuse, is fundamental and must guide the approach of all Australian child welfare organisations, including government departments and non-government organisations.
- 3 Against this background, the National Standards for Out of Home Care have been developed, several of which are directly relevant to the prevention of sexual abuse in out of home care. A best practice approach to implementation of these Standards is required, one which monitors performance against the National Standards, ensuring that carers are appropriately qualified and skilled and that the OOHC is providing good outcomes including a safe environment for children.
- 4 It is important to recognise that children removed from family and placed in OOHC are vulnerable to further abuse in OOHC, at both an individual and systemic level. No single strategy will be effective in preventing sexual and other abuse in OOHC without attention to the individual needs of children and the strengths and limitations of particular OOHC placement models.
- 5 The prevention of sexual abuse (and indeed all forms of abuse) of children in OOHC, requires comprehensive assessment and recognition of individual child needs within independently accredited OOHC systems. Ensuring organisations providing OOHC are child safe, active planning for safe care within their OOHC systems, and rigorous, independent monitoring and oversight of investigations into abuse allegations as they arise is the best way to ensure ongoing safety for children from all forms of abuse in care. Regulation and monitoring by government and independent agencies is also an important contributor to the prevention of sexual abuse in OOHC.
- 6 The Council submits that this best practice approach to the prevention of sexual abuse in OOHC should feature the following:
 - (a) Ensuring all providers are child safe organisations
 - (b) Placement-matching based on purpose of care and the assessed behavioural support needs of the child
 - (c) A ‘continuum of care’ approach to OOHC service provision (whereby a range of placement types across both foster care and residential care are able to be provided for a child as his/her care needs change over time)

⁴ In this Submission, the terms ‘child’ and ‘children’ include a young person or young people respectively.

- (d) Recognition of particular needs in relation to specific groups of children (for example Aboriginal and Torres Strait Islander children, children from culturally and linguistically diverse backgrounds, and children in kinship care)
- (e) Case management and decision making for OOHC plans which occurs as closely as possible to the child
- (f) Regular reviews of child-related plans, with the full participation of the child
- (g) Strong, independent regulatory, accreditation and licensing systems for OOHC providers
- (h) Rigorous recruitment, assessment and initial and ongoing training of prospective and current paid and volunteer OOHC carers, in addition to working with children checks
- (i) Realistic worker caseloads which allow for regular frequent visits to children in care, and the development of a trusting worker-child relationship
- (j) Clear reporting requirements and independent oversight of investigations into allegations of all forms of abuse (including sexual abuse) of children in OOHC.
- (k) Comprehensive processes for the selection of appropriately qualified, skilled and experienced staff
- (l) Induction arrangements for new staff
- (m) Regular training of caseworkers and carers in policies and procedures and arrangements to ensure these are understood by staff
- (n) Supervision of case workers and carers
- (o) Regular review of policies and updating and training of staff on changes to policies processes and practices.

A. Overview

1.1 A national approach

- 7 As the Council has previously submitted to the Royal Commission, serious consideration should be given to the merits of having a single national regulatory body to ensure consistent oversight of child-related organisations in Australia.⁵
- 8 Although not without difficulty given that child protection is a state and territory government responsibility, and given that legislation, OOHC practice and funding appropriations vary from state to state, the oversight of the review, implementation and monitoring of OOHC policy and practice in Australia should be a function of a national regulator.
- 9 The development of the *National Standards for Out of Home Care* (National Standards),⁶ under the auspices of the Council of Australian Government-endorsed *National Framework for Protecting Australia's Children 2009-2020* (Framework)⁷ is an important step towards this goal that is already in place. Reproduced at Appendix 1 to this Submission, the National Standards, to be progressively introduced by all state and territory governments by 2015, provide an agreed set of standards against which the performance of OOHC nationally may be measured.
- 10 The practical implementation of the National Standards across OOHC in the states and territories is aimed at improving life chances and outcomes for children in OOHC, and achieving a reduction in levels of abuse over time. As discussed at various points in this Submission, several of the principles underpinning the National Standards are directly applicable to the prevention of sexual abuse in OOHC, as follows:
 - (a) health
 - (b) education
 - (c) care planning
 - (d) training and support for carers, and
 - (e) safety, stability and security.

⁵ As submitted by the Council in its Submissions in response to Royal Commission Issues Paper No 1: Working with Children Check, 12 August 2013 and Issues Paper 3: Child safe institutions, 11 October 2013.

⁶ Department of Families, Housing, Community Services and Indigenous Affairs (now Department of Social Services) together with the National Framework Implementation Working Group (2011) *An Outline of National Standards for Out of Home Care*, viewed 1 November 2013
http://www.dss.gov.au/sites/default/files/documents/pac_national_standard.pdf

⁷ Council of Australian Governments *Protecting Children is Everyone's Business, the National Framework for Protecting Australia's Children (2009-2020)*, viewed 14 October 2013 <<http://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/protecting-children-is-everyones-business>>. Collaboration between all levels of Australian government and non-government organisations in enacting the Framework is being undertaken via the Coalition of Organisations Committed to the Safety and Wellbeing of Australia's Children. The Coalition is currently supported by five Church OOHC providers in active membership: Centrecare Inc Perth, CatholicCare Diocese of Broken Bay, Mercy Family and Community Services Queensland, MacKillop Family Services Victoria and Marymead ACT. Catholic Social Services Australia and the Society of St Vincent de Paul are also members of the Coalition, viewed 14 October 2013 <<http://www.familiesaustralia.org.au/coalition/members.htm>>

- 11 Requiring national, annual reporting of progress against the National Standards will increase the level of public accountability and community awareness around the importance of positive outcomes, and the performance of state and territory based OOHC services in agreed key areas within OOHC that drive those positive outcomes.
- 12 The current lack of consistent national data collection and the varying definitions related to OOHC between the states and territories pose a significant threat to this outcome. In implementing the National Standards, it will be crucial to ensure that the data reporting mechanisms through which adherence to the National Standards is to be measured, are well designed and able to be achieved by state and territory governments.

1.2 Contemporary OOHC

- 13 Child protection laws, which provide for the removal of children deemed 'at risk' from parental care (thereby requiring OOHC placement), are a state and territory government responsibility in Australia. Moving a child away from their family and into OOHC is an intervention of last resort. Most children enter OOHC under Court Orders which operate to transfer parental responsibility for the child to the state, through the relevant Minister or department head with responsibility for child welfare. Government departments may then place such children either in government-provided OOHC, or with non-government organisation (NGO) OOHC providers. The proportion of children in government and NGO OOHC varies from state to state.

1.3 Fostering, kinship and residential care

- 14 Historically, children were placed in congregate residential care. Today, the majority of children in OOHC in Australia are placed in home based (family) settings, specifically foster care and relative or kinship placements. This is consistent with contemporary environments in developed countries world-wide. Australian Institute of Health and Welfare statistics indicate that home-based placements constituted 93% of all OOHC in Australia as at 30 June 2012, specifically 44% in foster care, 47% in relative or kinship care and 2% in 'other' forms⁸ of home based care.⁹
- 15 Residential care (including group homes, independent living and 'other') comprised just 7% of OOHC placements Australia wide, with a range of 3% (New South Wales) to 16% (Western Australia). It is of note that Victoria, Queensland and South Australia report the largest proportions of residential care (range 7.7% - 9.7%) but with minimal family group home service type placements, and that Western Australia has an approximately similar proportion of residential care at 9.4% but proportionally split between family group homes (5%) and residential care (4.4%). The proportion of reported independent living placements

⁸ As noted in the Royal Commission's Fact Sheet 4.1, 'other' includes placements that do not fit into the categories described earlier and unknown placement types, including boarding schools and hospitals (discussed at paragraphs 8-15 below): Australian Institute of Health and Welfare (2013) *Child Protection Australia 2011-12* p36

⁹ Australian Institute of Health and Welfare (2013) *Child Protection Australia 2011-12* p78

is small (<1%) and it is also of note that Western Australia and Northern Territory have relatively high proportions of ‘other’ OOHC placements (6%-8%).¹⁰

- 16 As outlined in Appendix 2 of this Submission, the Church in Australia has a long history of providing direct care for vulnerable children. Current service provision by Catholic OOHC agencies reflects the full range of Australian placement types, with most providing family-based (foster and kinship) care; and fewer residential care places. Church residential care providers also provide the full range of residential services, including group home care, standard residential care, and intensive or therapeutic care. It is estimated that around 250 children were provided with residential care by Church agencies nationally in 2011-2012.

1.4 Aboriginal and Torres Strait Islander children in OOHC

- 17 As indicated by the figures provided in the Royal Commission’s *Fact Sheet 4.1 – Preventing Sexual Abuse of Children in Out of Home Care* (Fact Sheet 4.1).¹¹ Aboriginal and Torres Strait Islander (ATSI) children are over represented in OOHC. ATSI children comprise less than 5% of all Australian children aged 0-17 years, yet they constituted nearly 34% of all children in OOHC in 2011-2012. This is ten times the rate for non-ATSI children.¹² ATSI children constitute the largest proportion of kinship OOHC placements. Provisions exist in the care and protection systems of each Australian state and territory to maintain both cultural identity and community connectedness. An ‘Aboriginal Child Placement Principle’ or similar provision is included in legislation and/or policy and regulations.¹³
- 18 Church OOHC agencies work in close partnership with ATSI communities in discrete geographical locations. For example, Marist Youth Care, a current Church OOHC provider of residential care has extensive OOHC experience with ATSI children and youth. Mercy Family Services Queensland has an Indigenous Foster Care Unit in Toowoomba. MacKillop Family Services has also recently taken a leadership role developing partnerships with Aboriginal agencies on the NSW south coast, as part of the current NSW reform agenda for transition of foster care from government to non-government OOHC providers.
- 19 For the provision of OOHC to ATSI children, it is essential to employ staff who are not only trained to recognise and manage issues related to abuse in OOHC, but who are also sensitive to and have experience in working with ATSI children.

¹⁰ These statistics for WA and the NT require further examination to determine whether this high proportion of ‘other’ placements is a result of local arrangements, which may be connected to regional and remote community issues, or alternatively a lack of placement options which could leave vulnerable children who are in need of OOHC at ongoing risk.

¹¹ Royal Commission into Institutional Responses to Child Sexual Abuse (2013) *Fact Sheet 4.1 – Preventing Sexual Abuse of Children in Out of Home Care*

¹² Australian Institute of Health and Welfare (2013) p32

¹³ The Aboriginal Child Placement Principle outlines a preference for the placement of ATSI children with other ATSI people when they are placed outside their family. The Principle has the following order of preference for the placement of ATSI children: (i) with the child’s extended family; (ii) within the child’s Indigenous community; (iii) with other Indigenous people: Australian Institute of Health and Welfare (2013) p42. See also Holzer P & Lamont A (2009) *Australian child protection legislation: Resource Sheet No 14*, Australian Institute of Family Studies

1.5 OOHC children placed in ‘other’ settings

Asylum Seekers

- 20 Some current Church OOHC providers provide services (including direct accommodation and care) to unaccompanied minors, which may include refugee children and asylum seekers. For example, Marist Youth Care established its Unaccompanied Minors Program in 2011.
- 21 Unaccompanied minors are a group of children with particular vulnerabilities both in general terms and in relation to the potential for abuse in care. It is the experience of Church OOHC agencies that these children are extremely reluctant to make complaints (including the disclosure of abuse) due to fear of jeopardising their application for an Australian visa. This reinforces the need to provide an OOHC culture where children feel supported to participate and where complaints are listened to and acted upon. Again, the importance of having appropriate staff with relevant cultural backgrounds is emphasised.

Boarding Schools

- 22 The number of children in state care who are placed in other Church settings (for example in boarding schools) is low compared with other placement types. There are currently 2093 children Church-operated boarding schools in Queensland. Of these, 28 children on Court Orders are living in the schools. This figure represents less than 1.4% of the population of Church boarding school students. These children are covered by the Queensland Catholic Education Commission student protection guidelines,¹⁴ as are all children enrolled in Catholic schools in that state.¹⁵
- 23 Other Catholic education jurisdictions report the following numbers of children currently in Church boarding schools on Court Orders: Northern Territory 4, South Australia 3, Western Australia 6, Tasmania 0, ACT 0, and NSW 0. Catholic education systems apply an extensive range of child protection policies and procedures, as exemplified by South Australia¹⁶ and Queensland.¹⁷
- 24 In Victoria, the *Out-of-Home Care Education Commitment: Partnering Agreement* reflects a shared commitment of the OOHC and education sectors to protecting, meeting the needs and upholding the rights of children who live in OOHC.¹⁸ This Agreement outlines the requirements and responsibilities of all parties to work in co-operation to improve the educational experience and outcomes of children in OOHC. A key component of the Agreement is annual collection of ‘snapshot data’ designed to track and monitor a range of factors for children in OOHC. This data is presented to the Victorian government as part of the overall monitoring and evaluation of the OOHC Partnering Agreement.

¹⁴ Queensland Catholic Education Commission Student Protection resource webpage, viewed 12 October 2013
<<http://www.qcec.catholic.edu.au/catholic-education/student-protection>>

¹⁵ Child Protection Guidelines exist in the Catholic education sectors across all Australian states and territories

¹⁶ Government of South Australia, Child and Student Wellbeing, Policies and Guidelines, viewed 30 October 2013
<<http://www.decd.sa.gov.au/speced2/pages/childprotection/legislationPolicies/?reFlag=1>>

¹⁷ Queensland Catholic Education Commission Student Protection resource webpage

¹⁸ Developed jointly by a partnership between Catholic Education Commission, Department of Human Services, Department of Education and Early Childhood Development and Independent Schools Victoria: State Government of Victoria (2011) *Out of Home Care Education Commitment: Partnering Agreement*, (viewed 31 October 2013)
<https://www.eduweb.vic.gov.au/edulibrary/public/stuman/wellbeing/A4_partnering.pdf>

Hospitals

- 25 Away from direct regulation of OOHC, when children who are subject to Court Orders are being treated in hospitals, an extensive system for their care and protection is demanded by a range of overlapping Commonwealth, state and territory regulatory agencies, health professional accreditation bodies, and the hospitals themselves. Whilst the exact nature of these regulatory and accreditation requirements varies somewhat across the states and territories, the consequence of these stringent requirements is a tested, national framework for the care and protection for all admitted patients, including vulnerable children.
- 26 The national framework is built on the mandatory requirement that all hospitals be licensed to operate. Hospital licenses are open to revocation where conditions, which include the safety of patients, are breached. Hospitals are then accredited on grounds of clinical safety and quality. Assessment of systems to assure patient protection and wellbeing are fundamental to accreditation assessments. Failure to achieve accreditation has consequences for ongoing operations.
- 27 Operational data, particularly in relation to adverse patient incidents, is required to be reported to the National Health Performance Authority, and in some cases is transparently published on the ‘myhospitals’ website.¹⁹ State and territory governments operate health care complaints ombudsman or commissioners overseeing patient safety. This is complemented by the role of the Australian Health Practitioner Regulation Agency, which oversees the admission of health practitioners to their profession.
- 28 For staff, strict standards of professional conduct are required and misconduct can result in removal of health professional accreditation and criminal prosecution. Hospital employers also require working with children checks for staff involved in child care.
- 29 This demanding regulatory environment has contributed to robust protections for children in OOHC when admitted to hospital, supplemented by the fact that the child’s hospital admission requires the continued custodial oversight of the relevant legal custodian, who retains ultimate responsibility for care and decisions in relation to the child.

¹⁹ <http://www.myhospitals.gov.au/>

B Questions posed by the Royal Commission

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

Summary

There are core strategies for keeping children in OOHC safe from sexual abuse. Those strategies relate to:

- ensuring provider organisations are child safe organisations
- the way in which children enter OOHC, permanency planning and case-management of children during their time in OOHC
- particular steps that need to be taken in OOHC placement settings where unrelated children are placed together in foster care or residential care
- ensuring children in OOHC receive protective behaviours skills training
- ensuring staffing consistency and appropriate staff training
- the need for comprehensive processes for the selection of appropriately qualified, skilled and experienced staff, their induction and ongoing supervision and training
- having in place national accreditation systems, and consistent monitoring and oversight mechanisms relating to abuse complaints.

Not all these strategies have evidence to support them. However, there is international evidence supporting strong case management approaches and the models used by some Church OOHC providers are promising.

1.1 Core strategies

- 1 It is imperative that organisations working with children, particularly those providing OOHC services, are child safe organisations.²⁰ As previously submitted by the Council, this requires these organisations to meet child-safe organisation standards, by ensuring their culture, policies and practices meet the following main principles:
 - (a) a protective, child centred organisational culture that empowers children
 - (b) zero tolerance of criminal child abuse

²⁰ The requirement for education and community service providers working with children to be child-safe was recognised as a fundamental requirement for the protection of children in the report of the Victorian Parliamentary Inquiry. See in particular Chapter 11 findings pp253-265 and Recommendation 12.1 p287: Victorian Parliament (2013) *Betrayal of Trust – Inquiry into the handling of child abuse by religious and other non-government organisations*

- (c) governance and leadership informed by an understanding of the developmental needs of children
 - (d) procedures on the employment of new personnel that promote the recruitment of people who are suitable to work with children, invest in their development and monitor their performance
 - (e) a risk management approach that identifies and develops responses to high risk issues in the organisation's operations
 - (f) implementation of a child protection policy
 - (g) processes for investigating, reporting and responding to allegations of criminal child abuse.²¹
- 2 Against this background, core strategies for keeping children safe and secure from sexual abuse (and also other forms of abuse) in OOHC relate to the way in which children enter OOHC systems and are case managed during their time in care. Those care strategies include:
- (a) Comprehensive assessment and permanency planning to determine appropriate placement type
 - (b) Clear identification of child need in the context of presenting safety issues in family of origin, with comprehensive background information provided to OOHC carers
 - (c) Listening to the child, taking the voice of the child seriously and actively encouraging and supporting children to express their experiences of OOHC
 - (d) Creating clear boundaries and expectations via clear policies and procedures
 - (e) Definition of the purpose of OOHC placement at initial entry and subsequent designated key review periods on at least an annual basis
 - (f) Clear and time framed OOHC planning, with an emphasis on developmental as well as psychological outcomes for the child
 - (g) Regular review of OOHC arrangements and the care plan, involving all adults (foster/kinship/residential carers) and with direct participation of the child in OOHC
 - (h) Regular caseworker visits to the child in OOHC placement, including time spent alone with the child in care
 - (i) Realistic OOHC worker caseload allocations which enable placement visitation to occur on a minimum monthly basis, and more frequently than this when required by the needs of the child and the placement
 - (j) Regular professional supervision of all OOHC staff including case workers and those providing direct 'in loco parentis' care in residential and associated settings

²¹ Truth Justice and Healing Council (11 October 2013) *Submission in response to Royal Commission Issues Paper No 3: Child safe institutions* pp10-13

- (k) Comprehensive assessment by an appropriately qualified and skilled professional of all OOHC carers (foster carers, kinship carers and residential care staff) for suitability to provide OOHC, followed by initial and ongoing training and support. Church OOHC agencies are aware that solely relying on police checks is an inadequate way to assess carers.²²
 - (l) Specific training of direct carers regarding the impact of sexual abuse prior to placement in OOHC, and
 - (m) Specific training of direct carers regarding the procedures for investigation and management of allegations of abuse (including sexual abuse) in care.
- 3 The following additional strategies are relevant in OOHC placement settings where unrelated children are placed together in foster care or residential care:
- (a) Minimisation of the numbers of unrelated children together in an OOHC placement, particularly where the individual needs and behaviours of a new child entering such a placement have not been fully assessed
 - (b) Close consideration of the risks in relation to discrete child vulnerabilities, specifically sexual abuse prior to entry to OOHC
 - (c) Careful matching of children requiring OOHC who display sexualised behaviours, to ensure minimisation of the risk of peer abuse and also that carers are adequately trained in appropriate behaviour management techniques
 - (d) Recognition that the establishment of a stable, trusting and caring relationship between case workers and children/young people in OOHC has clear benefits but may also give rise to risks. Recognition too that the risks can be addressed through providing opportunities to hear from the child how they are feeling in any placement and whether boundaries are being blurred leading to the formation of inappropriate relationships
 - (e) Following on from (d) above, those in OOHC supervisory positions should ask regular targeted questions on boundaries in order to assist in early identification of issues and also reduce confusion should boundary related issues arise.

1.2 Permanency Planning: considering the child's requirements

- 4 Recognition of specific OOHC service models and associated care plans made for children is crucially important to preventing sexual abuse in OOHC placements. Distinguishing between the reason for placement (the reason the child has been removed from his or her family) and the specified purpose of care (what the OOHC placement needs to provide for the child) ensures that a placement is planned and is the most appropriate care alternative to meet a child's needs at a particular time.

²² As submitted by the Council in its Submission in response to Royal Commission Issues Paper No 1: Working with Children Check, 12 August 2013: <<http://www.tjhcouncil.org.au/media/35631/120813-FINAL-SUBMISSION-Issues-Paper-No-1-WWCC.pdf>>

- 5 Some Church agencies provide a ‘continuum of care’ approach, whereby a range of placement types across both foster care and residential care are able to be provided for a child as his/her care needs change over time. This approach encourages organisational stability in care and ongoing continuity of relationships. These components are both well recognised components in the delivery of good outcomes for children in OOHC.²³

The reason for placement

- 6 Children are placed in OOHC for a number of reasons. According to recent AIHW data, emotional abuse and neglect are consistently the most common child abuse report substantiation type nationally (37% and 29% respectively in 2011-2012) followed by physical abuse (21%) and sexual abuse (13%).²⁴ However, not all substantiated reports of child abuse lead to entry into OOHC. Decisions about whether or not a child should be removed from family and placed into OOHC are complicated by legislation, court processes, professional judgement and recommendations in relation to child welfare decision-making, child and family dynamics, and also in some cases, availability of OOHC placement.
- 7 A recent international review of the variables involved in decision making for OOHC placement indicates that there is rarely only one problem or reason leading to OOHC placement.²⁵ Criteria for placing children in OOHC vary, but some common reasons include:
 - (a) chronic stress
 - (b) inadequate parenting
 - (c) socio-economic disadvantage and lack of income (generally caused by long-term generational unemployment)
 - (d) inadequate accommodation
 - (e) substance (particularly drug and alcohol) abuse
 - (f) mental health problems
 - (g) lack of community and family support, and
 - (h) disability-related issues.

Family and parental factors can also be compounded by child-related behavioural issues which may include adolescent problems, disability and child/adolescent mental health issues.²⁶

- 8 Once it has been determined that a child should enter OOHC, the decision regarding whether a child is placed in a general, intensive or therapeutic foster care placement, kinship care, or some form of residential care is likely to be linked to the age of a child and

²³ Jackson S & Thomas N (2000) *On the move again: what works in creating stability for looked after children*

²⁴ Australian Institute of Health and Welfare (2013) pp11-12

²⁵ Bhatti-Sinclair K & Sutcliffe C (2013) *Challenges in Identifying Factors Which Determine the Placement of Children in Care? An International Review*, pp345-363

²⁶ Delfabbro (2002) in Bhatti-Sinclair K & Sutcliffe C (2013) p357

their behavioural assessment for funding purposes, as well as particular OOHC program and/or contract deliverables in relation to desired outcomes of care, rather than any assessment of the needs of the individual child. This increases risk for some children, as demonstrated by the case study at Appendix 4 of this Submission.

The purpose of placement

- 9 Complementary in terms of OOHC planning, but requiring different and discrete emphasis, is the purpose of placement – specifically what the OOHC placement is required to do and provide for the child. This involves consideration of permanency planning principles as they relate to the child, whether these are family restoration or long-term care. For example, the purpose of placement for a child initially entering OOHC on removal from home due to immediate risk is to maintain the child in stable care while assessments are undertaken and decisions made about whether restoration to parents is possible, or whether more ongoing OOHC is required.
- 10 The impact of poor planning for children at point of entry to OOHC results not only in multiple placements in foster care and compounded instability for abused children, but also increased risks associated with transition through placement types. In this context, permanency planning acts to strengthen carer commitment to protection of the foster child. When planned and implemented in this way, within a well regulated, licensed, accredited environment, foster care can produce good outcomes for children, increasing protective factors against the risk of abuse (including sexual abuse).
- 11 Distinguishing between the reason for placement (why the child has been placed in OOHC) and the specified purpose of placement (what the OOHC needs to achieve for the child) ensures that a placement is planned and is the most appropriate care alternative to meet the child's needs at a particular time.
- 12 A primary purpose of OOHC placement for a child for whom sexual abuse has been a reason for entry to care will necessarily involve assessments regarding preventing further abuse. Similar assessments will apply in relation to decision making about a return to family. Individualised care planning is crucial to minimising the risk of abuse in any OOHC placement over time. Identification of the child's overall care needs for the purposes of planning for their ongoing care, including reduction of risk, requires clear assessment and analysis of the desired short and long term outcomes of the OOHC placement at the initial stage of care planning. Whether remediation of the family situation is possible, or the child needs behavioural management or stability in care, it is most important that care plans reflect the individual needs of the child rather than a 'one size fits all' approach to placement within general categories of foster care or residential care.
- 13 In this way, safety in OOHC is connected with decision making for permanency, as many children who experience instability in OOHC through a succession of placements are likely to display increasingly disturbed behaviour, which in turn may increase the risk of abuse, including sexual abuse. For example, escalating sexualised behaviour in a child who is constantly moving in care will increase risk across a broad range of environmental dimensions, not just within the OOHC placement itself.

NSW transition of foster care to Non-Government Organisations (NGOs)

NSW is in the process of transitioning the provision of foster care from government to NGO providers. Current NSW OOHC contracts provide for foster care or residential care, with ‘general’ and ‘intensive’ categories in each placement type. NGOs have discrete or mixed categories of placement types within their funding contracts, allowing for the movement of children between these categories both within and between NGOs.

The NSW OOHC contracts require NGOs to provide a percentage of OOHC placements for children before the Children’s Court (that is for children who have recently been removed from parental care due to risk of significant harm²⁷) as well as providing placements for those who require more permanent forms of care. However, there is no ability under the NSW OOHC contracts to consider permanency planning for children in care.

This risks systems abuse for children as a result of an inability to consider the purpose of placement and associated case planning for each child. For example, it can mean that children for whom the purpose of placement is very different (for example those who are new entries to OOHC and those with finalised Court Orders for long term care) are placed inappropriately together, risking:

- reduced stability in care
- sequential placement moves, with associated increasing lack of continuity for relationships
- compounded behavioural and emotional distress due to lack of proper attention to child and family assessment needs, and
- escalation of assessed need, leading to unanticipated and sometimes inappropriate placement in more intensive care settings than were indicated or warranted on entry to care.

- 14 Defining OOHC placement types in terms of system time frames and contract definitions rather than placement purpose for children jeopardises best practice case planning and positive child-focussed outcomes for children in OOHC. Positive management of the risk of abuse (including sexual abuse) in OOHC requires the needs of the system (that is for caseworkers to have enough OOHC placements) to be balanced with the developmental and placement needs of the individual child. This needs to be planned in close association with the identified most appropriate care model, which for the majority of children will be foster family or kinship care.

1.3 Education for children

- 15 In relation to direct work with children in OOHC, protective behaviours skills training, which includes building confidence and capacity in children to recognise sexually abusive behaviour, develop self-protection skills and also help-seeking skills including reporting

²⁷ *Children and Young Persons (Care and Protection) Act 1998 (NSW) Part 2 s23*

such behaviour to trusted adults, is crucial to reducing sexual abuse in OOHC. Suggested examples include:

- (a) regular sexuality and relationships education
- (b) protective behaviours training
- (c) rights and complaints mechanisms for children in care, and
- (d) a focus on building adult support and safety networks.

1.4 Staffing consistency and training

- 16 Consistency of OOHC caseworkers responsible for visiting children in OOHC is also of critical importance to ensuring safety from abuse in care, as without the existence of a trusting relationship a child is made more vulnerable by the absence of a caring consistent adult independent of the placement itself. Large bureaucratic OOHC systems are less likely to be able to provide this casework consistency of relationship as staff turnover is generally higher than for less complex systems. Also, the impact of staff absence and associated temporary positions has a cascading effect of disrupting direct casework relationships with children in OOHC as staff act in higher duties positions.
- 17 Core child development training is essential for caseworkers and direct carers. Also essential is professional supervision which focusses on the lessons from OOHC research in relation to practice related issues.

1.5 Case management systems

- 18 International evidence supports a strong case management approach in producing positive outcomes for children in OOHC.²⁸ However in this context there is a lack of research, specifically on factors which prevent sexual abuse in care. There is no evidence that any one single or specific strategy or approach alone will prevent sexual abuse in OOHC.
- 19 Case management systems can play a strong role in keeping children safe in OOHC through the provision of guidance for practice, particularly when combined with external monitoring and oversight mechanisms. Whilst there is no current Australia-wide OOHC case management system, a number of OOHC agencies (including three NSW CatholicCare agencies) currently use the Looking After Children system.²⁹ This specifies designated time frames for important safety measures such as minimum casework visitation frequency to OOHC placements, regular review and planning meeting schedules, and active participation of children in care in all aspects of discussion and decision making regarding current and future care.

²⁸ Maluccio et al (2000); Kluger et al (2000); Schofield & Simmonds (2009) and Fernandez (2013)

²⁹ The Looking After Children (LAC) Project see <www.pdc.org.au/lac>

- 20 Another promising system-based example in operation within the Church OOHC sector at present is the Sanctuary model,³⁰ which is in use at MacKillop Family Services. Originating in the United States, the Sanctuary model is a framework for clinical and organisational change which, at its core, promotes safety and recovery from adversity through the active creation of a trauma-informed community. It recognises that adversity is pervasive in the experience of human beings, including those who seek services and those who provide the services. A founding principle of the model is the commitment to open communication and the creation of transparent organisational practices. The Sanctuary model is an organisation-wide change process, and aims to influence how staff, carers, volunteers, clients, families and other stakeholders engage and work with each other, with the ultimate goal of providing an organisational environment which is safe, supportive and healing for all. MacKillop is implementing the Sanctuary model in all its programs in Victoria, New South Wales and Western Australia.
- 21 MacKillop is also a provider of therapeutic foster care, through the Victorian government Circle Program³¹ in the Geelong region in Victoria. Both the Sanctuary model and the therapeutic foster care program have a strong emphasis on the creation of positive relationships, which are able to be better maintained over time. This emphasis promotes improved stability in care, reducing placement disruption and constant staff movements.

1.6 Provider accreditation

- 22 Standards and accreditation requirements are an important means by which safety in OOHC, including safety from sexual abuse, is maximised. Like the legislation for OOHC, these requirements vary in Australian states and territories. This is a crucial issue, as government departments are generally both funders and providers of OOHC, in addition to funding NGO OOHC providers. Independent oversight of OOHC standards and accreditation is a crucial requirement for child safety maximisation and should be required across all Australian jurisdictions.
- 23 Local state and territory government departments are also predominantly responsible for OOHC approval and/or licensing requirements, except in NSW where OOHC agencies (including the Department of Family and Community Services) must be accredited by the NSW Office of the Children's Guardian (OCG), an independent body reporting directly to the Minister and Parliament. NSW accreditation is issued by the OCG for up to five years on demonstration of agency compliance against the NSW Standards for Statutory OOHC.³²
- 24 The NSW OOHC Standards do not specifically reference sexual abuse in care, but the standard required for carer assessment and monitoring of placements, in addition to strong case planning requirements and levels of direct contact with children in placement, constitutes an intensive risk management approach, particularly for statutory foster care and

³⁰ See *The Sanctuary Model: an integrated theory* viewed 31 October 2013
<<http://www.sanctuaryweb.com/sanctuary-model.php>>

³¹ See Victorian Government (2009) *The Circle Program - a therapeutic approach to foster care- Program Guidelines*. The Circle Program was reviewed in 2012: The Centre for Excellence in Child and Family Welfare, La Trobe University (2012) *Report The Circle Program: an evaluation of a therapeutic approach to Foster Care*.

³² NSW Government, Office of the Children's Guardian (2010) *NSW Standards for Statutory Out of Home Care* viewed 14 October 2013 <http://www.dpc.nsw.gov.au/_external/kidsguardian/CYG_Out-of-home-care.pdf>

kinship care. Whilst standards for OOHC do exist in other states and territories, the NSW system is unique in requiring assessment of OOHC agencies by a body that is independent from funding and direct service provision. This is an important mechanism contributing to the safety of children in care.

1.7 Monitoring and oversight

- 25 The Council submits that monitoring and oversight mechanisms for abuse in OOHC, including sexual abuse, are vital, as is independence of those monitoring and oversight mechanisms from OOHC service providers.
- 26 NSW is the only state in Australia with independent monitoring of reports of sexual abuse. This occurs under the *Ombudsman Act 1974* (NSW). The NSW system requires OOHC agencies (both government and non-government) to report allegations of abuse in care, including sexual abuse, to the Ombudsman's Office within 30 days of becoming aware of an allegation and to subsequently report on the investigation of that allegation, including advising on action taken or proposed. The Ombudsman also plays a role in monitoring the systems that NSW OOHC agencies use to investigate allegations and complaints, and conducts and reports on case file audits on a regular basis.
- 27 A joint investigations model, with an element of independence, is in use in Victoria:

Example: Joint investigation of complaints in OOHC in Victoria³³

In Victoria, designated staff of the Victorian Department of Human Services (Quality of Care Coordinators) take the lead role in the response to complaints of abuse and other quality of care concerns in the OOHC sector.

An Investigation Planning Group (IPG) comprising the relevant Child Protection staff, the NGO manager and the Quality of Care Coordinator is convened to:

- screen all concerns raised
- coordinate any investigation undertaken
- determine, on the balance of probabilities, and based on assessment of information obtained, whether an allegation of abuse is substantiated, and if not, whether the IPG continues to hold significant concerns regarding the quality of care being provided by the carer
- advise the NGO of the findings of the investigation being:
 - no further action is required
 - the matter can be managed through support and supervision
 - recommend action with respect to the carer

³³ This example was also provided in the Council's Submission in response to Royal Commission Issues Paper 3: Child safe institutions, 11 October 2013.

- there are ongoing concerns regarding the capacity of the carer to provide good quality care, or
- there are issues that may involve some form of disciplinary response.

Specific provisions relating to the handling of complaints involving Indigenous children are included. Guidelines formalise the reporting protocols to external agencies such as the police and provide a framework for documenting the process and outcomes of the investigation.

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?

Summary

Although there is a lack of comparative research on sexual abuse risks in discrete OOHC placement types, statistically sexual abuse is more likely to occur in residential care than in foster care. Therefore, additional risk management strategies are required in residential OOHC settings.

- 1 The change in predominant OOHC placement type from residential to foster care poses specific challenges for OOHC providers. There is a lack of comparative research on sexual abuse risks in discrete placement types. Heightened vulnerability of children who may have been sexually abused prior to entry to OOHC is also compounded by the likelihood and complexity of multiple forms of abuse (including chronic neglect) that they may have suffered over time, prior to their entry into OOHC.
- 2 The benefits of different strategies and approaches for the prevention of sexual abuse in OOHC depending on placement type can be inferred from contrasting approaches to kinship care and foster care, and also between home-based forms of care (kinship and fostering) and residential care. However, these differences are not specific to the potential for sexual abuse, and therefore must be seen as broader risk factors associated with approaches to OOHC.
- 3 For example, whilst Victoria has had a defined service model specific to the management and support of some limited kinds of kinship care since approximately 2010, in NSW such approaches for kinship placements of children in statutory OOHC have been much slower to develop. Kinship carers in Queensland reportedly have less stringent assessment and monitoring of placements than unrelated carers, and training attendance is not compulsory. Submissions to the recent Carmody Review have proposed a dedicated OOHC model for support of kinship care, in recognition of the different risks associated with relatives caring for children.³⁴
- 4 When children are placed with unrelated carers, either in foster care or residential care, greater caution and more rigorous checking and monitoring is arguably required in conducting risk assessments for possible sexual abuse of the children in care, due to the broad range of motivations of individuals making application to provide direct OOHC.

³⁴ Published submissions to the Carmody review are available at <<http://www.childprotectioninquiry.qld.gov.au/submissions/view-published-submissions-a-to-z>>

- 5 Higgins (2013), in a recent presentation in Sydney, discussed the increased organisational risks for sexual abuse associated with family-like organisational environments.³⁵ Extrapolating this to OOHC, it could be argued that family-based care (foster and kinship care) is a very risky environment, as by its very nature it relies on the creation of an alternative 'family' for a vulnerable child. However, the benefits to the child of relational care are well established. In addition, the context of family-based placement types must be considered in relation to the situational risks of sexual abuse for a particular child. This involves assessment not only of child-related risks, but also close consideration of the wider system within which OOHC is regulated, oversighted and managed, including care planning and professional case worker supervision of placements.
- 6 Recognition that sexual abuse is more likely to occur in residential care than foster care means that additional risk management strategies are required in residential settings.
- 7 Available comparative research studies on sexual and other forms of abuse in foster care and residential care highlight the connection between risk of abuse and discrete components of OOHC placement type.³⁶ For example, the following components of residential care are connected with increased risk:
 - (a) Instability of care due to the large number of relationships required for a child in residential care when direct care is provided by rostered shift staff, in an environment where frequent attachment disorder behaviour is exhibited by residents
 - (b) Co-placement with a non-related direct peer group of similarly vulnerable children/young people in care, which may change frequently/regularly
 - (c) A generally larger child to caregiver ratio than is evident in foster care
 - (d) Children with the most severe behavioural problems frequently placed together in residential care due to a lack of readily available, sufficiently skilled foster carers to cater for their behavioural needs, leading to modelling and 'contamination' of behaviour.
- 8 A comparison by Euser (2013) of sexual abuse rates of children in foster care and residential care placements during a one year snap-shot period, via both case worker and direct child self-report, found sexual abuse rates in residential care to be higher than for foster care, with reported rates in the latter group similar to those reported in the general population of children (that is those children not in OOHC).³⁷ Adolescents were more likely to report sexual abuse in care than younger children. This was associated with living closely with unrelated peers displaying similar behavioural characteristics. However, the study was unable to conclude whether the apparent greater risk of sexual abuse in residential group OOHC was caused by characteristics of the residential care placement itself, or factors related to individual characteristics of the children in care (for example

³⁵ Higgins, D (2013) *Making Your Organisation Child-Safe* Presentation to ACWA Best Practice Forum, 1.10.13

³⁶ Euser S et al (2013) *The Prevalence of Child Sexual Abuse in Out-of-Home Care: A Comparison Between Abuse in Residential and in Foster Care* pp1-11 and Hobbs GF et al (1999) *Abuse of children in foster and residential care*, pp1239-1252

³⁷ Euser (2013)

differences in abuse history, attachment-related issues, or severe behavioural difficulties prior to placement).

- 9 Hobbs et al (1999) similarly found that overall, children in OOHC are at an increased risk of abuse compared with children not in care, and that a high proportion of abuse in residential care involved peer perpetration and was sexually related, with clear implications for placing older children with extremely disturbed behavioural patterns together in OOHC.³⁸
- 10 Data in the following table shows reports of sexual abuse allegations as a proportion of total allegations of abuse in OOHC made by a NSW CatholicCare agency under the *Ombudsman Act 1974* (NSW), over the five year period 2008-2013. The data indicates that the risk of sexual abuse is greater in residential care than foster care in the indicated Catholic OOHC agency, supporting the findings of Euser and Hobbs' research.

OOHC Allegations 2008-2013: CatholicCare agency

Foster Care allegations 2008-2013		Residential Care Allegations 2008-2013	
Sexual allegations	0	Sexual allegations	11
Non sexual allegations	6	Non sexual allegations	20
Total Foster Care Allegations	6	Total Residential Care Allegations	31
Total Number of Children in Foster Care during the period 2003-2008	102	Total Number of Children in Residential Care during the period 2003-2008	78
Percentage allegation rate sexual abuse	0%	Percentage allegation rate sexual abuse	14%

- 11 Queensland data on 'matter of concern' notifications³⁹ indicates that 4.4% of total substantiated matter of concern notifications (being 14 out of 316 children and 320 substantiations) in 2011-2012 were for sexual abuse, although this figure is not broken down into placement type.
- 12 A recent review (July 2013) of the Queensland Department of Child Safety's *Assessing and Responding to Matters of Concern* policy has resulted in the release and implementation of a new policy, *Responding to concerns about the standards of care*. The revised policy places greater emphasis on:
 - (a) conducting a review of OOHC Standards in relation to placements when a notification concerns a child in OOHC, and
 - (b) developing solutions via partnerships with carers, regardless of placement setting (foster or kinship carer, or residential care staff, and OOHC agency).⁴⁰

³⁸ Hobbs et al (1999) pp1239-1252

³⁹ In Queensland, a 'matter of concern' is any concern raised about a child in OOHC and where a breach of care standards is in evidence. The term 'notification' refers to information that meets the statutory threshold for risk of harm to a child.

⁴⁰ Queensland Department of Communities, Child Safety and Disability Policy CPD-28 (2013) *Responding to concerns about the standards of care* viewed 31 October 2013
<<http://www.communities.qld.gov.au/resources/childsafety/foster-care/assessing-responding-moc-326.pdf>>

- 13 It is too early to ascertain whether these changes will result in a reduction of notified matters of concern in relation to children in OOHC in Queensland.
- 14 The role of the direct carers of children in OOHC as part of an overall approach to ensuring ongoing safety is of crucial importance. For children in foster care and kinship care this means appropriate assessment, training, supervision and support of carers on both an initial and ongoing basis, in combination with adequate levels of carer payment to enable the costs of care to be covered and also to ensure that the carer has sufficient available time to provide the required level of care (in some cases this will mean increased levels of carer payment to compensate for reduced availability of carer/s to be in the paid workforce as a result of the time needed to meet specific needs of a child in care).
- 15 For residential care, the recruitment of an appropriately trained and experienced direct care workforce to meet the needs of children in care can be challenging given the lack of specific tertiary OOHC qualification in Australia. OOHC is generally not seen as a discrete discipline in the Australian social sciences. Tertiary qualified social workers and psychologists do not readily see OOHC direct care as a desirable career path, preferring more clinical or case management roles. Salary remuneration in residential care is also generally lower than for other professional child welfare-related roles. This diminishes the appeal of this career path for those with tertiary level qualifications. The profile of the direct care role in OOHC therefore needs to be raised, via the availability of specific qualifications and recognition of the crucial importance of OOHC in child welfare, care and protection.
- 16 Appropriate recruitment and assessment processes for carers are crucial in identifying and screening out potential sexual offenders and should not rely predominantly on police checks. Whilst OOHC identified and recommended processes are essential, caution is also required to avoid overly bureaucratic systems which may also deter those who will never commit sexual offences against children from seeking to provide foster care or kinship care.

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?

Summary

Regular supervisory visits by a known case worker who has an ongoing familiar and close relationship with the child in OOHC is the strongest means of ensuring safety from sexual abuse. Irregular visits by community visitors can also be valuable, but in the case of children in foster care, a system of community visitation should be confined to children who are most vulnerable.

3.1 Regular supervisory visits

- 1 Regular supervisory visits by a known caseworker who has an ongoing familiar and close relationship with the child in OOHC is the strongest means of ensuring safety from sexual abuse.
- 2 Some OOHC agencies provide separate caseworkers for the child and the foster/kinship family, or the child and the residential care team. The argued benefits of this practice are that the child does not perceive their caseworker as aligned to the adults who are providing the direct care. Conversely, there are also benefits in supporting placements using a single worker system approach to relationship dynamics (and in foster and kinship care ‘family’ dynamics), whereby one caseworker consistently oversees, supervises and interacts with all parties to the care situation in order to maximise group problem solving and promote commitment to the needs of the child.
- 3 Two examples of audit approaches are first the OOHC case file audit system used by the NSW OCG with accredited OOHC agencies, and secondly the NSW Ombudsman’s irregular audit of OOHC agency management of matters which are not required to be directly reported under the Act, but still require investigation. The advantages of audit systems such as these are that they provide an additional means of external accountability and also the potential for public reporting of data relating to OOHC outcomes and protection of children in care.

3.2 Irregular visits - Community visitors and child advocates

- 4 An advantage of unplanned irregular visits to OOHC placements by independent ‘observers’ such as community visitors or child advocates can be that the visits provide an opportunity to obtain information about the child’s experiences in relation to safety in care. Community visitors can play an essential part in ensuring safety in OOHC and may also be considered an independent monitoring mechanism, depending on the framework within which they provide reports on visits and the context of placement. Disadvantages however can be that in family-based settings and where regular agency OOHC caseworker visits to the

placement are well established, the visits risk infringing the privacy of carers and as a consequence may be potentially disruptive to placements.

- 5 In residential care, the community visitor role is potentially more straightforward than for foster care because the residential care site is more clearly identifiable as an employment site of the OOHC agency and therefore staff are more accessible to unplanned or unannounced visits. To this end, NSW and the ACT have a requirement for community visitors only in residential care settings.
- 6 In foster care and kinship care, where carers are not employees and the nature of OOHC placement is focussed on building family-like relationships, the role of the community visitor is more complex as it has the potential to inadvertently de-stabilise a placement as a result of carer perception of interference or of intrusion on privacy when visits are unannounced. Only Queensland currently has a system of community visitors that includes children in foster care. The recently released Carmody Review of Child Protection⁴¹ has recommended confining the system in Queensland to the most vulnerable children.⁴²
- 7 The Council is not aware of any currently available research evidence indicating that irregular visits result in the prevention of sexual abuse in OOHC.

⁴¹ Queensland Child Protection Commission of Inquiry (2013) *Taking Responsibility: A roadmap for Queensland child protection*

⁴² Possible criteria for vulnerability might include mental health, complex needs and existence of harm notifications, however without a clear definition it is not possible to determine the resource viability of this recommendation.

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?

Summary

It is inappropriate for a child protection department to regulate when it also funds and provides services. Regulation of child safety and standards of care, accreditation and monitoring of allegations should take place outside state and territory child protection departments. Costs associated with increases in regulation must be accounted for to ensure maintenance of ongoing care.

- 1 Where a statutory child protection department both funds OOHC providers and is also a provider, it is inappropriate for that department to also provide the regulatory function. To do so constitutes not only a conflict of interest but also jeopardises the safety of children in OOHC.
- 2 The primary purpose of regulation should be to ensure child safety and standards of care, alongside licensing/accreditation and monitoring of allegations of abuse in care, including those of a sexually related nature. All such functions are ideally performed outside state and territory child protection departments, as has been the case in NSW for some time.
- 3 Regulation increases required organisational compliance costs, and it is therefore important to recognise that any increased OOHC regulation must be accompanied by increased funding for the direct care costs of looking after vulnerable children. Increasing national regulation without attendant imposition of increased OOHC funding by state and territory child welfare departments is likely to result in the unintended consequence of reducing available funds for the direct care of children because money will need to be diverted by OOHC agencies to meeting government regulatory requirements. Associated reduced resourcing directed to case worker allocations for direct supervision of children in OOHC will increase risk and reduce safety for children.

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?

Summary

Those working with children in OOHC need training in:

- the protocols for OOHC procedures
- the identification of age appropriate sexual behaviour of children in OOHC
- role boundaries
- statutory reporting requirements
- grooming behaviour
- techniques for interviewing children, and
- OOHC policies, systems and practices

- 1 Training regarding sexual abuse in care should sit alongside all other training components in relation to the needs of children in OOHC, with a required emphasis on the specific vulnerabilities of abused and neglected children, attachment-related and behavioural issues, and the impact of OOHC. Core components of training for carers should include the following:

5.1 Child development and concomitants of positive parental care

- 2 Case workers and carers equally require a sound knowledge of child development and the concomitants of positive parental care in order to contribute to the development of individualised OOHC plans for children. All workers and carers require training in identification of age appropriate and also inappropriate sexual behaviour of children in care, and also ways to respond to disclosures of sexual abuse and associated reporting obligations.

5.2 Appropriate boundaries and behaviour management

- 3 Core training for caseworkers and carers must also cover issues related to appropriate role boundaries for the OOHC contextual environment.
- 4 There is a particular need to train foster carers, including members of the extended foster carer family, in the consequences of overtly sexualised behaviour displayed by a child in care, with the goal of ensuring appropriate carer responses to the child and the protection of other children. Ongoing training in particular in-depth areas such as management of

trauma-related and complex sexual behaviours should be made available as required by particular circumstances and placements, but will not generally be necessary as part of routine ongoing training and support.

5.3 Statutory reporting requirements

- 5 Training should separate out the statutory requirements for child abuse reporting from other requirements in relation to investigation of allegations, including those of a sexual nature. In particular, it is important that all carers and workers are comprehensively trained in policies and procedures for the management by OOHC agencies of allegations of abuse in care.

5.4 Grooming

- 6 Whilst sexual abuse has been recognised for many years as a crime, it is only more recently that 'grooming' has been recognised as a criminal offence and 'grooming behaviour' towards a child identified as an unacceptable risk factor increasing the likelihood of abuse. Grooming behaviour (which usually involves a pattern consistent with gaining the trust of a child in order to prepare them for inappropriate sexual activity) can also be consistent with crossing professional boundaries, reinforcing the need for mandatory training in this area for OOHC staff and carers. This is a particularly difficult area of sexually related abuse in OOHC as some behaviours which could be indicative of grooming (for example having a 'special' relationship with a child) constitute an important component of OOHC case planning in creating strong attachments with the goal of enabling children to form close relationships as appropriate, to enable emotional development, resilience and psychological strength.

5.5 OOHC systems, protocols and procedures

- 7 In relation to employment of staff and foster and kinship carer assessment, safety for children is maximised by clear protocols and procedures. For example in NSW all OOHC agencies use the 'Step By Step'⁴³ guidance for assessment of foster carers, followed by the standardised training program 'Shared Stories Shared Lives'.⁴⁴
- 8 Staff working in regulatory bodies will additionally require particular training in OOHC systems and practices in order to understand the risks associated with allegations of sexual abuse in care and the associated factors for all concerned, including the risk of disruptions to placements.

⁴³ Association of Children's Welfare Agencies (2010) *Step by Step: A resource package to assist foster care agencies in assessing potential foster carers* viewed 31 October 2013
<http://www.acwa.asn.au/Step_by_Step11.html>

⁴⁴ Association of Children's Welfare Agencies (revised 2010) *Shared Stories and Shared Lives Training modules for foster carers*, viewed 31 October 2013 <http://www.acwa.asn.au/Shared_Stories_Shared_Lives11.html>

5.6 Interviewing children

- 9 Core training for staff in OOHC agencies and regulatory bodies should include interviewing techniques for children who may have been sexually abused.

5.7 General

- 10 All training must incorporate specific considerations in relation to culture. This is especially important if a child is placed in a different cultural context than their own, that is, with carers who are not of the same cultural background and origins as the child placed in their care.
- 11 In considering prioritising of training in sexual abuse in OOHC against other forms of abuse it is noted that AIHW 2012-2013 data indicates sexual abuse to constitute 12%-13% of all substantiated abuse reports. The majority of cases involved family members or persons known to the child and family. It is therefore likely that of the reported number of cases of substantiated abuse in OOHC (which is not differentiated by type of abuse) only a limited number were sexually abused in care. This highlights the difficulty making decisions about OOHC training when non-sexual forms of abuse and neglect in OOHC may actually be more prevalent.

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

Summary

There is a need for foster carers to receive comprehensive information about the history of the child being placed into their care. Carers should also receive training in the consequences of overtly sexualised behaviour displayed by a child in OOHC.

Useful training guidelines, though not specifically written for carers of children in OOHC, are those used by Catholic Schools in NSW and South Australia. It would be useful to trial a pilot program for children who have abused other children whereby carers are employed to care for such a child in their own home and have the time to commit to training and implementing a therapeutic model of foster care. This is a gap in current service provision

- 1 It is well recognised across Australian jurisdictions and internationally that foster carers rarely receive comprehensive information about a child's history prior to placement. No amount of training can replace inadequate information exchange about a child.
- 2 Many Catholic schools report that they are told very little about the backgrounds of OOHC students. The student's enrolment form would indicate they are in OOHC but usually no information is given about a child's background or behavioural history, or number of placements in OOHC. Schools report that it is generally only when an OOHC student comes to the attention of the Principal (usually as a result of behavioural issues) that more information is provided by the OOHC agency. Schools also note that frequently, carer families themselves have very little background information about an OOHC child in their care.
- 3 Research into the impact of prior sexual abuse as a reason for entry to OOHC and subsequent impact on placement is limited. Fernandez (2013) reports that sexualised behaviour displayed by children in short-term care adds complexity to the process of finding a suitable carer for a child's specific needs, particularly in relation to the suitability of placement with other children, and also challenges planning for stability in placement while court processes are taking place.⁴⁵ Extreme behaviours displayed by children who experience sexual abuse prior to entry to OOHC can also heighten the awareness of risk by carers and OOHC workers that allegations of abuse in care may be made as a result of a child's overtly sexualised behaviours in broader settings (for example schools and public places).

⁴⁵ Fernandez, E (2013) *Accomplishing Permanency: Reunification Pathways and Outcomes for Foster Children*

- 4 Fernandez highlighted particularly the need to train foster carers, including members of the extended foster carer family, in the consequences of overtly sexualised behaviour displayed by a child in care, with the goal of ensuring appropriate carer responses to the child and the protection of other children.
- 5 Training needs for this group of carers should particularly include behavioural triggers, appropriate response alternatives, and re-education techniques aimed at assisting the child to learn more appropriate behaviour. Depending on the age and developmental level of the child, the establishment of connections with relevant professionals and also guidance regarding the sharing of information and risk management of behaviours outside the home will be necessary. Ongoing one-to-one training and support by way of de-briefing, respite care, and access to additional resources in order to allow closer carer supervision of the child are also likely to be required in these placements.
- 6 The NSW Catholic Education Commission has developed, in close consultation with Church OOHC agencies⁴⁶ *Guidelines on Dealing with Children Who Display Sexually Concerning Behaviour*. Whilst these Guidelines are not specifically written for children in OOHC, they do have relevance and are used by Catholic schools in most NSW dioceses. Similar guidelines, developed by the SA Department of Education and Children's Services, Catholic Education South Australia and the Association of Independent Schools SA, are in place in South Australia.⁴⁷
- 7 As noted in response to question 5 above, in NSW all OOHC agencies provide an introductory course to foster care 'Shared Stories Shared Lives'⁴⁸ which carers are required to complete prior to being authorised.
- 8 Caring effectively for children who have sexually abused other children can be complex. These children have come from backgrounds of trauma and abuse and carers need to understand and meet the children's need for safety, healing and connection, as well as the specifics of managing sexualised behaviours. The therapeutic care models being adopted in residential care are being extended to foster care.⁴⁹ Such courses in therapeutic care require a considerable time commitment from carers.
- 9 Currently, across Australia, foster carers are volunteers who have the right to determine which young people they accept into their homes and the ultimate right to decide what training they will undertake after they are authorised. Agencies encourage attendance at post authorisation training and try to offer a variety of training delivery methods. However it is difficult for volunteer carers with family and work commitments to attend training of several days duration several times a year as is required to cover all aspects of therapeutic care.

⁴⁶ Via the long standing Catholic Education and Social Welfare Coordinating Committee

⁴⁷ Government of South Australia (2010) *Responding to problem sexual behaviour in children and young people: Guidelines for staff in education and care settings*.

⁴⁸ Association of Children's Welfare Agencies (revised 2010)

⁴⁹ Currently Marist Youth Care is delivering a therapeutic model based on Victorian experience with Cornell University's Therapeutic Crisis Intervention System: viewed 13 November 2013
<http://rccp.cornell.edu/tcimainpage.html>

- 10 A therapeutic foster care model where suitably qualified, trained, supported and remunerated carers support the child or young person through the process of healing from trauma is emerging and requires support. One barrier to the adoption of this model of foster care is the Australian industrial relations implications of employing carers rather than supporting them as volunteers. Under current industrial awards, employing someone to care for a young person in their home 24/7 is very expensive as they are subject to all the award conditions of rostered residential staff.
- 11 Placing young people with complex behaviours arising from trauma, including sexualised behaviours, in foster care households is often risky. Yet placing such young people together in residential settings results in less satisfactory outcomes, including higher rates of sexual abuse between residents while in care.
- 12 It would be useful to trial a pilot program for children who have abused other children whereby carers are employed to care for such a child in their own home and have the time to commit to training and implementing a therapeutic model of foster care. This is a gap in current service provision.

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?

Summary

The National Standards for OOHC should require the reporting of substantiated claims of all types of abuse, broken down by type of abuse and type of OOHC placement.

- 1 Determining rates of sexual abuse in OOHC at the national level could be achieved via reporting against the National OOHC Standards, by requiring a breakdown of types of abuse in care. It would also be necessary to differentiate between abuse rates in different types of placement (foster care, kinship care, residential care). This would require states and territories to develop additional data collection mechanisms and hence would be challenging to achieve.
- 2 Exit interviews for young people leaving care could only be a useful means of capturing information if rigour were able to be applied in the interview schedule/s used across OOHC agencies and jurisdictions. This would be difficult to achieve with consistency due to the wide range of OOHC agencies and arrangements across Australian states and territories at the present time. It is arguable that an exit interview is not the appropriate method of monitoring the rate of sexual abuse in OOHC in any event.
- 3 Currently state-based Commissions for Children and Young People or equivalent bodies (including the NSW Ombudsman) have a role in working with child protection authorities to aggregate data on the prevalence of sexual abuse in OOHC. The Council submits that in the future this function should be subsumed by a national regulatory and accreditation body. This should be supplemented with data on abuse matters reported to police and data on the outcomes of police investigations.
- 4 With the limited data currently available regarding sexual abuse rates in OOHC it is difficult to see how anything other than a well-resourced and comprehensive longitudinal research project could determine whether changed (improved) OOHC practices are in evidence over time. It cannot be assumed that increased information on child sexual abuse will result in improved OOHC practices. In fact, the reverse may result if resources for the collection of data are diverted from direct care and support costs for children.

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?

Summary

There is a range of measures in place across the states and territories. The NSW Ombudsman system requires interviews with children, ensuring the direct voice of children is heard. The following principles underpin the Victorian approach:

- The best interests of the child will always be paramount
- Children and young people will be listened to and heard
- Carers will be treated fairly, honestly and with respect
- Parents will be told about concerns for the welfare of their child
- Child Protection and community service organisations will work together in a spirit of partnership, collaboration and cooperation to ensure fair and transparent investigation and decision-making and
- Decision making, investigation and formal care review processes will be well informed, clearly communicated and timely.

- 1 As indicated by the description of the systems for handling of complaints described in the Royal Commission's Fact Sheet 4.1,⁵⁰ investigation processes for investigation of more serious complaints, which would include investigation of allegations of sexual abuse, differ between the states and territories. There are some common aspects, including:
 - (a) investigation being undertaken by the relevant department
 - (b) interview of the child
 - (c) the availability of support and natural justice being accorded to the carer, and
 - (d) the availability of appeal processes.

⁵⁰ Royal Commission into Institutional Responses to Child Sexual Abuse (2013) *Fact Sheet 4.1 – Preventing Sexual Abuse of Children in Out of Home Care* pp15-17

- 2 Responsibility for investigatory oversight of these complaints should lie outside the OOHC system (and be independent of OOHC agencies) in order to ensure independence of the monitoring function.
- 3 The current NSW Ombudsman system for dealing with allegations of abuse in care generally requires interviews with children, thereby ensuring that the direct voice of the child is heard. This is a fundamental aspect of any complaint process.
- 4 However, caution is urged with respect to inferring disclosures from child behavioural changes, as there are a wide range of factors which must be considered. These are covered by statutory care and protection legislation in each state and territory government jurisdiction. Inappropriately seeking of sexual abuse disclosure by a child in OOHC based on the interpretation of behavioural changes (which require expert interpretation because such behaviour may have many causes) risks disclosure evidence not being able to stand the test of legal scrutiny.
- 5 There is a tension here between supporting carers (who are vulnerable to allegations of abuse) and protecting and ensuring the safety of the children in OOHC, most particularly in foster care when a child has been stable in care for an extended period and allegations of abuse threaten to disrupt the placement. Disturbing the security of a child in care and instigating separation from a carer who may have become a child's psychological parent is at the best of times an extremely difficult decision. The challenge for all involved parties in these circumstances is to above all keep the focus on the child.
- 6 Foster and kinship carers are not employees but volunteers, and as such their financial livelihood is not generally threatened as result of allegations made against them (in the way that the financial livelihood of an employee might be). This is relevant in the consideration of appropriate appeal processes for carers as reputational risk is under greater threat here.
- 7 In the case of residential care workers the situation is made clearer by the existence of an employee-employer relationship which can be dealt with not only via administrative appeal processes but also by employment tribunals.
- 8 The Victorian approach to dealing with allegations of sexual abuse, detailed in the *Guidelines for responding to quality of care concerns in out-of-home care*⁵¹ is outlined below. The principles that underpin the Guidelines are:
 - (a) The best interests of the child will always be paramount
 - (b) Children and young people will be listened to and heard
 - (c) Carers will be treated fairly, honestly and with respect
 - (d) Parents will be told about concerns for the welfare of their child

⁵¹ Victorian Government, Children, Youth and Families Division, Department of Human Services, (2009) *Guidelines for responding to quality of care concerns in out-of-home care*

- (e) Child Protection and community service organisations will work together in a spirit of partnership, collaboration and cooperation to ensure fair and transparent investigation and decision-making and
- (f) Decision making, investigation and formal care review processes will be well informed, clearly communicated and timely.

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?

Summary

A comparative study could be undertaken using measures such as numbers of sexual abuse allegation reports, substantiation rates, and the impact of allegation reports over time in terms of placement changes for impacted children.

- 1 All Australian states and territories currently have independent administrative oversight bodies providing third party monitoring of abuse in care. However, there is variance in the types and numbers of such bodies and also in discrete oversight components. This and differences in definitions across the jurisdictions make the assembly of statistics on a national scale difficult.
- 2 A comparative study could be undertaken using measures such as numbers of sexual abuse allegation reports, substantiation rates, and the impact of allegation reports over time in terms of placement changes for impacted children. The latter would however require information to be provided to the oversight body on the outcome of sexual allegation reports over time, and this may be difficult to achieve given the numbers and wide range of government and non-government OOHC providers. National data comparisons also require consistent definitions which poses ongoing difficulties in relation to the lack of specific definitions across jurisdictions and state and territory boundaries in OOHC.

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

Summary

The role performed by the NSW Ombudsman has the strength of being independent from service providers. An independent process similar to NSW should be put in place Australia-wide.

- 1 NSW is currently the only Australian state with specific monitoring of reports of sexual abuse in OOHC,⁵² this function being undertaken by the NSW Ombudsman, along with other functions in relation to complaints, service reviews, and general oversight of government agencies.
- 2 The particular strength of the NSW model lies in its combination of Ombudsman OOHC oversight with an accrediting body which is also completely independent of any direct service provision of OOHC, the Office of the Children's Guardian. Whilst all other Australian child welfare jurisdictions do have standards for OOHC and some also have independent audit requirements, OOHC approval processes which rely solely on the government department which is not only responsible for approval of OOHC but is also a service provider itself jeopardises transparency of processes developed for keeping children safe from sexual abuse in OOHC.
- 3 An independent process similar to NSW should be put in place Australia-wide.

⁵² Note that Victoria also has a monitoring system but it has broader application, it is not specific to complaints of sexual abuse.

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

Summary

Delayed reporting of child sexual abuse can lead to inadequate records for the purpose of providing evidence for criminal charges. Access to OOHC records may also be reduced if a child has moved many times during OOHC. The Find and Connect website has been established to bring together historical resources relating to institutional care in Australia.

- 1 Delayed reporting of child sexual abuse in OOHC may mean that records relating to time spent in care are incomplete if reporting of the abuse was delayed. In such circumstances, the records may be inadequate in terms of the likelihood of providing supporting evidence for criminal charges which may be subsequently laid against a perpetrator. Access to OOHC records may also be reduced if a child has moved many times over their time in OOHC. The movement of a child across a number of OOHC settings is likely to result in incomplete records and a lack of consistency in their maintenance.
- 2 That said, under the current NSW system delayed reporting still allows the matter to be investigated and reported to both police and the NSW Ombudsman, and therefore recorded on the child's file.
- 3 Implementation of consistent case management systems has the potential to assist in this area, via the provision of guidance for minimum standards with respect to general record keeping, and particularly information concerning details of all those involved with a child throughout the duration of a placement. These improvements will assist with investigation of any delayed reporting of child sexual abuse.
- 4 Consistency of linkages and processes with police for matters of delayed reporting is beneficial, allowing for better capturing of information about the extent of sexual abuse in OOHC, both at the time of current placement and also in after care or later adulthood. Similarly, any delayed disclosure will supplement any current investigation, providing a cumulative understanding of an alleged perpetrator, which may assist with the protection of any other children who may be at risk.
- 5 Another related aspect of record keeping relates to provision of support for adults who have spent some or all of their childhood in institutional or out of home care, whether or not they were subjected to child sexual abuse.
- 6 To facilitate access to records, the Find and Connect website has been established to bring together historical resources relating to institutional care in Australia. Find and Connect can be used to read information about, and view images of, children's Homes, get help to find personal care records and to connect with support groups and services in each state and

territory.⁵³ Approaches have also been developed by Church OOHIC agencies. There is a continuing commitment by the Church to support of care leavers for vulnerability experienced as a direct result of living in OOHIC in childhood, including by providing former recipients of OOHIC supported access to their OOHIC records.⁵⁴

⁵³ www.findandconnect.gov.au

⁵⁴ For example the MacKillop Family Services Heritage and Information Service assists people who lived as children in the children's homes run by MacKillop's founding religious institutes, by providing supported access to records and facilitated family reunifications, see <http://www.mackillop.org.au/HeritageService>

Conclusion

- 1 Children placed in OOHC are a child welfare population group characterised by particular vulnerabilities, generally the result of previous family history of abuse and neglect and notification to statutory government departments over extended periods prior to placement into care. Some, but not all, children in OOHC will have experienced sexual abuse prior to removal from family and placement in OOHC. As such, like all children, this particular group requires protection from ongoing further abuse and harm, including sexual abuse, while in care.
- 2 The prevention of sexual abuse of children in OOHC, as with other forms of abuse, requires comprehensive assessment and recognition of individual child needs, within independently accredited OOHC systems. Active planning for safe care within such systems in combination with rigorous independent monitoring and oversight of investigations into abuse allegations as they arise is the best way to ensure ongoing safety for children from all forms of abuse in care. Whilst regulation and monitoring by government and independent agencies is an important contributor to the prevention of sexual abuse in OOHC, no single strategy will be effective without attention as well to the strengths and limitations of particular placement categories and models (for example foster care, kinship care, residential care, intensive/therapeutic care) in general terms, and also in relation to the individual needs of children.
- 3 The majority of children placed in OOHC in Australia today are in home-based models of care, being foster care and kinship placements, providing positive close alternative attachment opportunities for children and the chance of remediation from the impacts of past abuse and neglect. The risks for sexual abuse must therefore be carefully assessed prior to the placement of children in any private home. Risks should not be assessed solely or principally on the basis of police record checks. Tensions exist between the need to promote permanency options for children via family based forms of OOHC and balancing caseworker frequency of visits to the child in placement, whilst at the same time maintaining strong partnership relationships with carers to ensure consistency in putting in place individual child focussed case plans. Carer training, supervision and support needs must be identified and met by OOHC agencies on an ongoing basis. The discrete needs of kinship carers also need to be recognised and met.
- 4 Whilst residential care now comprises only a small proportion of the total number of children in OOHC, it is apparent that the risk of allegations and incidence of sexual abuse is higher than for family based forms of care. This may be linked to the nature of group care for unrelated children in rostered shift settings, and also to the fact that children with more difficult and complex care needs tend to be more frequently placed in residential care settings due to the lack of availability of suitable or sufficiently skilled home based carers. Peer sexual behaviour including abuse may also be more common in residential settings than in home based care. The recent and ongoing development of specialist therapeutic residential OOHC programs, including by Church agencies, provides an opportunity for further exploration of the needs of young people in this area but also requires close attention to safety measures for the prevention of sexual abuse in care with a highly disturbed sub-set of the OOHC population group.

- 5 The extensive experience of Church OOHC providers past and present indicates a range of factors, as outlined in this submission, as most crucial to the promotion and maintenance of child safety from sexual and other forms of abuse in OOHC. Whilst OOHC is inherently risky, it is possible to build strong systems for the prevention of abuse, including sexual abuse, in OOHC.
- 6 The Royal Commission provides an important opportunity to identify and make recommendations about future practices to protect children in OOHC from sexual abuse. To this end, the Council believes that the experiences of current Church OOHC providers can assist in achieving better outcomes for children in care.

Appendix 1 - National Standards for OOHC and their measures⁵⁵

Standard 1

Children will be provided with stability and security during their time in care.

Measures

- 1.1 The proportion of children exiting OOHC during the year who had 1 or 2 placements, by length of time in continuous care preceding exit.
- 1.2 The rate and number of children in OOHC who were the subject of a child protection substantiation and the person believed responsible was living in the household providing OOHC.
- 1.3 The proportion of children in OOHC who report feeling safe and secure in their current placement.

Existing and proposed measures for development/improvement

- 1.1 *The proportion of children exiting OOHC during the year who had 1 or 2 placements, by length of time in continuous care preceding exit. (Existing but flagged for improvement).*
- 1.2 *The rate and number of children in OOHC who were the subject of child protection substantiation and the person believed responsible was living in the household providing out-of-home care. (Existing but flagged for improvement).*

Safe reunification and/or permanency. (Proposed broad measure for development)

Standard 2

Children participate in decisions that have an impact on their lives.

Measure

The proportion of children who report that they have opportunities to have a say in relation to decisions that have an impact on their lives and that they feel listened to.

Existing and proposed measures for development/improvement

Whether the child's view has been taken into account in case planning and the means by which this was done. (Proposed broad measure for development).

⁵⁵ Based on Department of Families, Housing, Community Services and Indigenous Affairs (now Department of Social Services) together with the National Framework Implementation Working Group (2011) *An Outline of National Standards for Out of Home Care*

Standard 3

Aboriginal and Torres Strait Islander communities participate in decisions concerning the care and placement of their children.

Measure

- 3.1 The proportion of Indigenous children in OOHC placed with the child's extended family, with the child's Indigenous community, or with other Indigenous people, by carer type.
(See also Measure 10.1: The proportion of ATSI children who have a current cultural support plan)

Existing and proposed measures for development/improvement

- 3.1 *The proportion of Indigenous children in OOHC placed with the child's extended family, with the child's Indigenous community or with other Indigenous people, by carer type. (Existing but flagged for improvement).*
3.2 *Aboriginal and Torres Strait Islander participation in decision making. (Proposed new measure).*

Standard 4

Each child has an individualised plan that details their health, education & other needs.

Measure

The proportion of children who have a current documented case plan.

Existing and proposed measures for development/improvement

Relevant persons participated in care planning decisions, in particular family members and Aboriginal and Torres Strait Islander community representatives. (Proposed broad measure for development).

Standard 5

Children have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way.

Measure

- 5.1 The number and proportion of children who have an initial health check of their physical, developmental, psychosocial and mental health needs within a specified period of entering OOHC.

Existing and proposed measures for development/improvement

- 5.2 *Comprehensive health assessment – specialist service. (Proposed new measure).*
5.3 *Identified health needs are attended to. (Proposed new measure).*

Future measure to report on health outcomes. (Proposed broad measure for development).

Standard 6

Children in care access and participate in education and early childhood services to maximise their educational outcomes.

Measures

- 6.1 The proportion of children achieving national reading and numeracy benchmarks.
- 6.2 The number and proportion of 3 and 4 year old children who participate in quality early childhood education and child care services.

Existing and proposed measures for development/improvement

- 6.1 *Proportion of children achieving national reading and numeracy benchmarks. (Existing but flagged for improvement).*
- 6.2 *The number and proportion of 3 and 4 year old children who participate in quality early childhood education and child care services. (Existing but flagged for improvement).*

Standard 7

Children up to at least 18 years are supported to be engaged in appropriate education, training and/or employment.

Measure

- 7.1 The proportion of young people who complete year 10 and the proportion who complete year 12 or equivalent Vocational Education & Training.

Existing and proposed measures for development/improvement

- 7.2 *Youth employment (Proposed new measure).*

Standard 8

Children in care are supported to participate in social and/or recreational activities of their choice, such as sporting, cultural or community activity.

Measure

The proportion of children who report they may choose to do the same sorts of things (sporting, cultural or community activities) that children their age who aren't in care do.

Standard 9

Children are supported to safely and appropriately maintain connection with family, be they birth parents, siblings or other family members.

Measures

- 9.1 The proportion of children in OOHC who are placed with relatives and kin.
- 9.2 The proportion of children who report they have an existing connection with at least one family member which they expect to maintain.
- 9.3 The proportion of children (as age-appropriate) and young people who report having contact with family members, by the reported frequency of contact, by their reported satisfaction with contact arrangements.

Existing and proposed measures for development/improvement

- 9.1 *The proportion of children in OOHC who are placed with relatives and kin. (Existing but flagged for improvement).*
- 9.4 *Family contact plan. (Proposed new measure).*
- 9.5 *Sibling co-placement. (Proposed new measure).*

Standard 10

Children in care are supported to develop their identity, safely and appropriately, through contact with their families, friends, culture, spiritual sources and communities and have their life history recorded as they grow up.

Measures

- 10.1 The proportion of ATSI children who have a current cultural support plan.
- 10.2 The proportion of children (as age-appropriate) who demonstrate having a sense of connection with the community in which they live.

Existing and proposed measures for development/improvement

Cultural support planning for Culturally and Linguistically Diverse (CALD) children. (Proposed broad measure for development).

Children have life history records. (Proposed broad measure for development).

Standard 11

Children in care are supported to safely and appropriately identify and stay in touch, with at least one other person who cares about their future, who they can turn to for support and advice.

Measure

The proportion of children who are able to nominate at least one significant adult who cares about them and who they believe they will be able to depend upon throughout their childhood or young adulthood.

Standard 12

Carers are assessed and receive relevant ongoing training, development and support, in order to provide quality care.

Measures

- 12.1 The number of foster carer households with a placement at 30 June, by number of foster children placed, and number of foster carer households with a placement during the year.
- 12.2 The number of foster carers at 30 June, and the number of new approvals of persons as foster carers and the number of persons who cease to be approved foster carers during the twelve months to 30 June.
- 12.3 The proportion of foster carers and kinship carers (who had at least one placement during the year) who report feeling supported in their role and who feel their developmental needs relevant to their role are catered for.

Existing and proposed measures for development/improvement

- 12.1 *Number of foster carer households with a placement at 30 June, by number of foster children placed, and number of foster carer households with a placement during the year. (Existing but flagged for improvement).*
- 12.4 *Foster and kinship carer training. (Proposed new measure).*

Capacity to report on the number of separate sibling groups placed within the same carer household. (Proposed broad measure for development).

Capacity to report comprehensive data about foster carer and kinship carer retention, pool size and attrition rates and reasons. (Proposed broad measure for development).

Standard 13

Children have a transition from care plan commencing at 15 years old which details support to be provided after leaving care.

Measures

- 13.1 The proportion of young people aged 15 years and over who have a current leaving care plan.
- 13.2 The proportion of young people who, at the time of exit from out-of-home care, report they are receiving adequate assistance to prepare for adult life.

Appendix 2 – Church provision of OOHC

A tradition of caring for vulnerable children

- 1 The Church in Australia has a long history of providing direct care for vulnerable children. Hundreds of thousands of children have been looked after in OOHC by Church organisations since the mid nineteenth century, and those that continue to do so today have significant experience regarding child safety in OOHC.
- 2 Early charitable works of many religious orders included education and the institutional care of orphaned and destitute children. Residential care for unwed mothers with no means of financial or physical support was also provided. This early provision of OOHC services sat within the social context of largely unregulated systems throughout Australia, and operated alongside other non-religious and state-operated large scale residential and institutional congregate child care. While there are obvious failures in the way it was handled, the Churches and in particular the Catholic Church and The Salvation Army took on the care of children when they had been failed by their parents and families and government and the community did or could not take up this responsibility.
- 3 The Church in Australia currently provides a large number of social welfare services, child welfare and OOHC. These services range from individual and family counselling to community work, poverty relief and advocacy. Services are provided by Catholic organisations, including religious orders, dioceses and lay groups.⁵⁶
- 4 The National Catholic Welfare Committee was established in the mid twentieth century. Prior to this the Church had no organisational social welfare network.⁵⁷ Church-run orphanages and children's homes were the individual activities of congregations of religious sisters and (to a lesser extent) brothers.⁵⁸ Attempts to co-ordinate Church provided OOHC by diocesan-based Catholic Welfare Bureaux⁵⁹ emerged in the mid to late 1970s.⁶⁰ The Bureaux initially provided administration for the admission of children to the children's homes run by the religious orders. This later developed into assessment and support services for children in OOHC and their families.
- 5 By the mid twentieth-century emerging knowledge in relation to the care of vulnerable children, notably the work of John Bowlby⁶¹ and others on attachment theory, was impacting OOHC practices. For Church OOHC providers, some additional factors impacting those practices from the late 1960's to mid-1980's were:
 - (a) pressure on religious orders to conform with increasing state/territory government regulations and rules regarding the care of vulnerable children, often associated with

⁵⁶ Camilleri P & Winkworth G (2003) *Disparate and Diverse: Mapping Catholic Social Services in Australia*

⁵⁷ Camilleri P & Winkworth G (2003) p12, see also Gleeson DJ (2008) *The Foundation and First Decade of the National Catholic Welfare Committee*.

⁵⁸ Hughes L (1998) *Catholics and the care of destitute children in late nineteenth century New South Wales*

⁵⁹ Catholic Welfare Bureaux were established in the Archdiocese of Melbourne in 1935, followed by Sydney in 1940 and Adelaide in 1942

⁶⁰ Fox M (1994) *The Catholic System of orphanages in NSW 1881-1981*

⁶¹ Bowlby R & King P (2004) *Fifty Years of Attachment Theory: Recollections of Donald Winnicott and John Bowlby*

the availability of government funds which had not previously been available to non-government organisations for the provision of OOHC

- (b) the decline in religious vocations which meant reduced availability of a religious workforce to provide OOHC in the residential setting that had previously been the predominant OOHC service type, and
- (c) employment of professional social workers by an increasing number of Church operated Family Welfare Bureaus, which operated under the direct control of a diocesan Bishop.

Current Church-provided OOHC

- 6 Whilst many Church-operated children's homes closed from the mid twentieth century and a number of the religious congregations stopped providing OOHC for children, other Church agencies made a renewed commitment to new and often expanded forms of social services delivery and social care, including fostering and other forms of OOHC service delivery. Church organisations continuing to provide OOHC today generally do so as part of a range of related child and family programs.⁶²
- 7 In Australia today there are fourteen independent Church OOHC providers, including nine diocesan CatholicCare and Centacare agencies and five organisations established by religious institutes.⁶³ Two of the latter group, MacKillop Family Services Victoria and Mercy Family Services Queensland, are large OOHC providers, caring for 600 and 250+ children respectively in the 2011-2012 financial year.
- 8 Current Catholic OOHC providers collectively care for approximately 1300-1400 children and young people each year in Queensland, New South Wales, Victoria, South Australia, Western Australia, and the Australian Capital Territory. There are no Church providers in Tasmania or the Northern Territory.
- 9 The Church provides the full range of contemporary OOHC placement types, including but not limited to foster care, relative/kinship care, family group homes, residential care (general and intensive therapeutic residential care) and independent living for children aged 0-18 years.⁶⁴ Most agencies provide a range of OOHC placement types. After care services and support following care into adulthood, the latter being largely unfunded by government, are also provided.

⁶² Including supported accommodation, aged and disability care, family violence, general family/youth/child support, counselling, mediation and employment services. Member organisations of Catholic Social Services Australia are listed at www.cssa.org.au

⁶³ See Appendix 3 for list of current Church OOHC organisations.

⁶⁴ The extent that Church organisations are also providing care for hospital and boarding school-based care for children in OOHC is discussed at paragraphs 6-16 below.

Appendix 3 – Church OOHC providers 2013⁶⁵

NSW	<ul style="list-style-type: none">■ CatholicCare Diocese of Broken Bay http://www.catholccaredbb.org.au/■ CatholicCare Hunter-Manning http://www.catholiccare.org.au/■ CatholicCare Sydney www.catholiccare.org■ CatholicCare Wollongong http://www.catholiccare.woll.catholic.org.au/■ Dunlea Centre – Australia's Original Boystown http://www.boystown.net.au/home.htm■ MacKillop Family Services (based in Victoria) http://www.mackillop.org.au/■ Marist Youth Care http://www.maristyc.com.au/■ St Joseph's Cowper http://sjc.org.au/
Victoria	<ul style="list-style-type: none">■ CatholicCare Melbourne http://www.ccam.org.au/■ Jesuit Social Services http://www.jss.org.au/■ MacKillop Family Services http://www.mackillop.org.au/
Queensland	<ul style="list-style-type: none">■ Centacare Brisbane http://www.centacarebrisbane.net.au/■ MercyCare http://www.mercycare.com.au/
South Australia	<ul style="list-style-type: none">■ Centacare Adelaide http://www.centacare.org.au/
Western Australia	<ul style="list-style-type: none">■ Centrecare Perth http://www.centrecare.com.au/■ MercyCare http://www.mercycare.com.au/
ACT	<ul style="list-style-type: none">■ Marymead http://www.marymead.org.au/

⁶⁵ This is a list of Church OOHC providers who are members of Catholic Social Services Australia

Appendix 4 Case study: inadequate OOHC placement planning

Eldest of five siblings, Sarah⁶⁶ aged 11 years at time of entry to OOHC lived with her siblings in a family well known to child protection agencies in three states. Reports included domestic violence, parental intellectual disability combined with drug and alcohol abuse leading to inability to cope, physical abuse, medical neglect, child behavioural problems including sexualised behaviour and unsubstantiated allegations of sexual abuse.

When Sarah was removed from parental care in mid-2012 and placed in OOHC, her parents suggested that a neighbour may have ‘interfered’ with her and also reported inappropriate touching by her paternal grandfather (who lived in the family home). Neither was able to be proved.

Sarah had eleven foster placements in the six month period July to December 2012 while a Care Application was made in the Children’s Court. Inappropriately assessed as requiring ‘general foster care’ level of placement, Sarah was placed with a succession of government foster carers who could not meet her need for high level supervision and support. This resulted in Sarah displaying sexually abusive behaviours towards other children in the foster care placements, and making escalating allegations of sexual abuse against each subsequent foster family with which she was placed. She was referred to a child sexual assault unit and also for mental health assessment, but neither unit would see Sarah until she was “settled” in OOHC placement.

Sarah was referred to CatholicCare following a funding level re-assessment which indicated ‘intensive residential care’. Placed in a therapeutic unit with two other children and with a clinical behaviour management plan in place combined with a structured 1:1 program of care during waking hours, Sarah had settled within 10 weeks. While behavioural incidents occurred regularly during this time, no sexualised behaviour was in evidence either towards staff or other children. After six months of stable continuous care Sarah demonstrated age appropriate socially acceptable behaviours, was seeing a clinical psychologist and attending school regularly. No further allegations of sexual abuse in care had been made over the time Sarah was placed in therapeutic OOHC. CatholicCare was consequently able to provide a clear assessment of Sarah’s needs to the Children’s Court and plan for future care. Her sexualised behaviour had been managed in the OOHC placement and behaviour management plans put in place to guide recruitment of foster carers who could be appropriately trained and supported to provide safety in care for her over time.

⁶⁶ Child's name changed to protect their identity

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