Queensland Commission for Children and Young People and Child Guardian

Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse

Issues Paper 4 – Preventing sexual abuse of children in out of home care

November 2013

Introduction

Preventing the sexual abuse of children[1] was key impetus for the establishment of the monitoring and oversight functions of the Commission for Children and Young People and Child Guardian (the Queensland Children's Commission).

Established in 1996 by the Queensland Government in response to community concerns about paedophilia and other forms of child abuse, the Queensland Children's Commission's early focus was on researching abuse and providing advocacy and complaints resolution services for children.

In 1999, its functions were expanded following the Commission of Inquiry into Abuse of Children in Queensland Institutions (the 'Forde Inquiry') which uncovered evidence of emotional, physical and sexual abuse of children residing in government and non-government institutions during the period from 1911 to 1999.

As a result of the Forde Inquiry's recommendations the functions of the Queensland Children's Commission were broadened and strengthened resulting in the establishment of an independent statutory body. In particular, "official visitor" program and complaints handling powers were extended to children in residential care services and detention centres[2] and it was tasked with administering an employment screening program (later to be called the blue card system) for child-related employment.

In 2003, a young person's allegations of physical and sexual abuse while in foster care triggered the Crime and Misconduct Commission's Inquiry (the 'CMC Inquiry') into the abuse of children living in foster care in Queensland. At the same time, the Queensland Government commissioned Ms Gwenn Murray to conduct an audit of foster carers subject to child protection notifications.

Recommendations made in the CMC's 2004 report, *Protecting children: an inquiry into abuse of children in foster care* and in Ms Murray's audit report (2003a, 2003b), aimed to strengthen the protections for children in out-of-home care (OOHC). Notably the CMC recommended increasing the level of external scrutiny given to decisions made by the government's child protection agency, primarily by establishing an additional 'Child Guardian' function within the Queensland Children's Commission.

The Child Guardian function involves independent, external oversight of the services provided to, and decisions, made in respect of, children in state care. Powers include investigating complaints, proactively monitoring and auditing child safety services and other service providers, visiting children in OOHC and advocating either for individual children or, when necessary, to effect system-wide changes.

This submission to the Royal Commission draws on the knowledge and data gathered by the Queensland Children's Commission in the conduct of its statutory functions. Where required, further detail about those functions is provided in our responses to the questions asked in the Royal Commission's Issues Paper.

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[1] The terms "child" and "children" include a young person or young people respectively.

[2] Prior to 1999, the functions of Official Visitors were to inspect residential facilities to determine whether the facilities provided an appropriate standard of care for residents and suggest to the Commissioner ways of improving the effectiveness and quality of care provided in these residential facilities.

General comments on the safety of children in OOHC in Queensland today

It is recognised that the current OOHC system in Queensland is very different from the system described in the Forde (1999), CMC (2004) and Murray (2003a, 2003b) reports. Oversight, advocacy and the safety of children within the system has significantly improved – largely due to the implementation of the recommendations made in those reports.

In comparison to 2004, for example, children today are no longer 'lost' in the system[3] as record keeping systems have improved; carers and adult household members are now carefully screened and are required to hold a valid blue card; there is a systematic process for children in OOHC to be heard, and for their concerns to be reported and addressed; and children are more consistently provided with health and education supports.

To gauge and report on children's safety in OOHC, the Queensland Children's Commission primarily uses three measures: the numbers of substantiated 'matters of concern' (reports of harm to children in care); the issues of concern raised by children with the Commission Community Visitors and children's own views of feeling safe in their placement. Against these measures, the safety levels and trends are as follows:

- Departmental[4] data about substantiated matters of concern show a significant decrease from 2004, where 8.1% of children in care were subject to a substantiated matter of concern, to 2011 (2.3%). In 2012, the rate was 3.7%.

- The above data aligns with the Community Visitors who identified 'serious issues' in slightly less than 2% of their child reports. In the last four years, rates have fluctuated from 1.9% in 2009-10, to 1.45% in 2010-11, 1.8% in 2011-12 and 1.7% in 2012-13.

- High percentages of children surveyed by the Queensland Children's Commission report they feel safe in their current OOHC placement. In 2011, 97.9% of the children and 98.4% of the young people in foster and kinship care who completed the survey reported feeling safe. Almost all of the young people (99.1%) reported they are well treated by their carer. These figures have remained constant since 2006 (Commission for Children and Child Guardian (CCYPCG), 2012a). Among young people in residential care in 2012, 82% of survey respondents reported feeling safe (CCYPCG, 2012b).

These measures are further discussed later in this submission. A fuller picture of the outcomes experienced by Queensland children in OOHC can be found in the annual report: *Queensland Child Guardian Key Outcome Indicators Update: Queensland Child Protection System 2009-12* (CCYPCG, 2013a).

Arguably, the risk of children in OOHC being subject to long-term sexual abuse without detection is significantly lower now than it was prior to the CMC Inquiry. A recent Queensland Children's Commission audit of sexual abuse in OOHC (as yet unreleased)[5] would seem to support this claim when data from recent years (20010-11) is compared to data from a similar audit conducted in 2004 (CCYPCG, 2005).

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[3] Up until 2006, the Commission's Community Visitors were still 'finding' children placed with foster carers for whom the (then) Department of Child Safety had no record and who had not been visited by a child safety officer for years.
[4] Department of Communities, Child Safety and Disability Services
[5] The most recent audit report can be provided to the Royal Commission but has not been publicly released.

Clearly there are still areas that need improvement. Continual improvement requires ongoing internal vigilance and external scrutiny. When OOHC resources are stretched by an increasing number of children in care or entering care, when children exhibit challenging behaviours or high staff turnover reduce professional practice, things can change. Unless there is the capacity to advocate at the individual level, report systematically and to quantify changes, no-one other than the children will know if their safety and wellbeing has been compromised until there is a crisis.

Response to Questions in Issues Paper

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

Keeping children safe in OOHC requires a range of integrated strategies. For the purpose of this submission, strategies have been broadly categorised as those which aim to:

1. create an OOHC environment where the likelihood of harm occurring is minimised
2. reduce children's vulnerability to abuse which is heightened by their pre-care experiences
3. give children a voice and create avenues for their voices to be heard
4. monitor how children are doing, increasing the likelihood of abuse being discovered
5. respond appropriately to allegations or incidents of abuse and alleviate the harm
6. provide oversight of the system, identifying any weaknesses that make children less safe and any improvements that will make them safer.

The following discussion identifies the strategies which the Queensland Children's Commission considers are 'core' in terms of realising these aims. The strategies discussed are not intended to be an exhaustive list. In responding to Question 1, discussion covers some of the topics raised in subsequent questions from the Issues Paper. A notation is made where this occurs.

1.1 <u>Creating an OOHC environment where the likelihood of harm occurring is minimised</u>

The Queensland Children's Commission's submission to the Royal Commission's third Issues Paper: *Child Safe Organisations* discussed the rationale and evidence for a preventive approach to sexual abuse in child-related service environments. Child-related service environments include OOHC. In Queensland, OOHC includes family based care (kinship and foster care), residential care, therapeutic residential care and supported independent living.

A preventive approach requires the implementation of appropriate risk management controls and an ongoing process of review and improvement to minimise the likelihood of abuse.

Core strategies in the OOHC environment include:

1) a comprehensive multi-stage recruitment and approval process for carers
2) employment screening "working with children checks (WWCC)"and daily criminal history monitoring of carers and adults in carer households
3) appropriate carer training and ongoing support
4) matching placement of children to carers, and
5) adequate information provision to carers and children

1.1.1   A comprehensive recruitment and approval process for carers

The Queensland Children's Commission supports a multi-stage recruitment and approval process for both residential care workers and family-based carers, including kinship carers. For family based carers, this process should include, but not be limited to, assessing family history (including criminal and child protection history), family interactions, parenting skills, motivation to provide care and participation in pre-service training.

The application of quality standards for the recruitment, management and training of carers may go some way to providing a high degree of confidence. In Queensland for example, the Department of Communities, Child Safety and Disability Services (the Department) is responsible for foster care certification but the majority of foster carers are recruited, supported and trained by non-government agencies in accordance with quality standards introduced in response to a 2004 CMC Inquiry recommendation (QCPCI, 2013).

Similar quality standards currently do not apply to departmentally supported foster carers however the QCPC Inquiry report has recommended the transfer of all foster and kinship services to the non-government sector. This includes the identification and assessment of kinship carers.

Kinship care: Inherent differences between foster and kinship care can mean recruitment and training are approached differently. In Queensland, for example, kinship carers may undergo less rigorous screening and often receive no induction training due to the need to place a child quickly with kin (QCPCI, 2013).

However to safeguard children, kinship carers need to be adequately screened and receive the same level of resources, training and supports available for foster carers (CMC, 2004). Children placed with kinship carers may be vulnerable to ongoing abuse if the relatives caring for them share similar problems to their abusive parents or allow abusive parents to have continued and unsupervised access to the children; and/or if the children are exposed to ongoing social and economic hardships (CMC, 2004; Rubin, Downes, O'Reilly, McKonnen, Luan & Localo, 2008). Early identification of potential kinship carers, screening and training will help mitigate these risks (CMC, 2004). Kinship placement is not appropriate for all children (Oosterman, Schuengel, Slot, Bullens & Doreleijers, 2007).

1.1.2 WWCC screening and ongoing monitoring

By its very nature family-based OOHC is largely unsupervised which increases the risk of children being subject to abuse or maltreatment while in OOHC. To reduce the likelihood of abuse it is vital that carers and household members are required to have a Working with Children Check (WWCC) to identify those individuals whose criminal histories indicate that they pose an unacceptable level of risk to children.

The Queensland Children's Commission's submission to the Royal Commission's first Issues Paper: *Working with Children Checks* addresses the importance of undertaking appropriate checks to determine the suitability of carers and adults in households providing OOHC. The submission also emphasised the benefits of (i) ongoing monitoring of criminal history and disciplinary information rather than just point-in-time screening, and (ii) the requirement for child-related service environments (for example, residential care facilities) to develop, implement, and maintain risk management strategies which identify and manage risks of harm for children.

In Queensland, carers and adult members of their households require a blue card and are subject to daily monitoring of their criminal history. Their inclusion in the blue card screening regime in 2006-07 has ensured that carers and adult members of their household are subject to the same independent, robust employment screening assessments as those undertaken for individuals working with children in other regulated service environments.

Evidence from the Queensland Children's Commission WWCC (blue card) data validates the need for OOHC carers and adult household members to be subject to criminal history screening and ongoing

monitoring. OOHC[6] applicants are more likely to have a criminal history compared to other blue card applicants and when compared to all other blue card applicants, are issued with a higher proportion of negative notices. From Queensland's blue card screening for the period 2006-07 to 2012-13:

- *One in four OOHC applications returned criminal history information*
    - 26.97% of blue card applications for OOHC roles returned criminal history information, compared to only 10.83% of all applications[7]

- *One in 200 OOHC applications returned criminal histories containing offences that indicated an unacceptable level of risk to children (negative notices)*
    - 0.56% of OOHC applicants were issued with a negative notice. This proportion is three times higher than that for all blue card applicants (0.17%)
    - 10.8% (n = 301) of all 2,785 negative notices issued since 2006-07 were issued to OOHC applicants.
    - 57 negative notices have been issued to carer applicants. Of these, 78.95% related to offences of violence or drug related offending, 12.28% related to child-sex offences and 5.26% related to child-related offences of violence
    - 75 negative notices have been issued to adult members of foster and kinship carer homes. Of these, 92% related to offences of violence or drug related offending, 5.33% related to child-sex offences and 2.67% related to child-related offences of violence.

- *Ongoing criminal history monitoring has identified subsequent offending for a significant number of carers and adult household members resulting in their blue card being cancelled or suspended:*
    - 89 carers had their blue card cancelled or suspended. Of these 44.94% related to offences of violence or drug related offending, 30.34% related to child-sex offences, 3.37% related to child pornography or internet offences and 2.25% related to child-related offences of violence
    - 58 adult foster and kinship care household members had their blue card cancelled or suspended. Of these 70.69% related to offences of violence or drug related offending; 22.41% related to child-sex offences; and 1.72% related to child-related offences of violence.

Further, as it is a criminal offence for a person with a conviction for a 'disqualifying offence' (including child exploitation offences, child-sex offences and murder of a child)[8] to apply for a blue card, an unknown number of serious offenders have been discouraged from applying for a blue card to care or work with children.

1.1.3   Appropriate carer training and ongoing support

Inquiries into the child protection system in Queensland (CMC, 2004; QCPCI, 2013) have recognised the importance of providing carers with appropriate training and support to enhance the safety, protection and wellbeing of children in OOHC. Having well trained, supported carers decreases the likelihood that children will suffer harm in care and helps provide a stable and optimal environment to enhance children's well-being (Bruskas, 2008; 2010; Chamberlain, Price, Reid, Landsverk, Fisher & Stoolmiller, 2006; CMC, 2004; Fernandez, 2010).

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[6] This includes foster and kinship carers and their adult household members and people working in licensed care services.

[7] This refers to all blue card applications to work with children and young people in regulated child-related service environments, and includes OOHC applicants who make up 3.7% of the total.

[8] Section 174, schedules 4 and 5 *Commission for Children and Young People and Child Guardian Act 2000.*

Consequently, each inquiry has made specific recommendations to provide improved systems for training and supporting carers. For example, in 2004 the CMC Inquiry, which specifically addressed the abuse of children in foster care, recommended that:

− all prospective foster carers undergo compulsory training in parenting
− all training programs be evidence based
− carers be provided with ongoing training, with carers' training needs identified and programs organised during yearly reviews, and attendance be a mandatory prerequisite for carer re-approval
− there be a tiered multi-level approach to training to match carers' competencies with the needs of different children so that carers of children with more difficult behaviours or special needs would receive additional specialised training; and
− carers be provided with additional supports (e.g. mentoring by more experienced carers) to promote increased parenting competence and self-confidence in dealing with children in their care.

Despite these recommendations for improving carer training, the recent QCPC Inquiry (2013) again noted the inadequacy of carer training and support, particularly for kinship carers and those caring for children with complex needs. Carers remain in need of ongoing training so they can build up a repertoire of strategies over time to manage children's challenging behaviours.

Children in care clearly require placement with carers with the skills to deal with the higher rates of behavioural and mental health problems, and particularly internalising (anxiety, depression and withdrawal) and externalising behaviours (attention problems, aggression, rule breaking and delinquency) many exhibit (Bernedo, Salas, Garcia-Martin & Fuentes, 2012; Fernandez, 2010; Rosenthal & Curiel, 2006; Tarren-Sweeney, 2007).

According to researchers, these behaviours can stem from a range of factors including insecure attachments, the cumulative effects of maltreatment, pre-care adversities and complex trauma (Jee, Tonniges & Szilagyi, 2008; RANZCP, 2008). Carers need specific training in understanding these factors and dealing with children's consequent behaviour.

Hence in terms of the components of pre-service and ongoing training the Queensland Children's Commission considers important topics to be attachment and trauma, particularly the impact of trauma on children and how the trauma experienced by children prior to entering care can affect the child's OOHC environment. The specific sexual abuse training needs of all people working with children in OOHC are discussed at Question 5 (see page 31).

Training policies also need to be effectively implemented. The Queensland experience suggests that even when training needs are identified and comprehensive training programs are established, deficits in knowledge and skills amongst carers, care service personnel and caseworkers continue to be noted. In effect, a gap remains between policies on training and support and actual practice. Hence it is important that accurate records of training attendance be maintained.

Intended program recipients may not attend scheduled training sessions because of last minute problems or training is cancelled and not re-scheduled so that recipients miss out on programs. Further, potential participants may lack the time to attend programs, or prioritise other tasks (for example, casework may be viewed as more important than training), or have difficulties in accessing training (for example, lack of respite care for children so carers are able to attend).

1.1.4 Matching the placement of children with carers

The National Standards for OOHC states that "*children and young people are to be matched with the most suitable carers and the care environment according to their assessed needs*". The ideal would be to have a range of placement options with carers with a range of different attributes and skills, which would enable agencies to match children to appropriate placements. Best practice would begin with an assessment of each child's needs and suitability for a particular placement.

In Queensland, the Department has placement matching policies and procedures and children's needs are assessed prior to placement. Unfortunately, however a comparatively small pool of carers and residential care options can make achieving a good match between carers and children difficult.

The research literature indicates that the mismatching of carers and children can increase the likelihood of adverse outcomes for children (Hughes, 2006), placement break down, carer dissatisfaction, and carers subsequently leaving the system (Cashmore, Scott & Calvert, 2008).

Matching children with other children in a placement is also an important consideration, especially if a child is known to display sexualised behaviour. A particularly complex challenge is the placement of siblings who engage in sexualised behaviours within the sibling group, but who have a strong bond and want to remain together.

Matching children with other children is also important in the context of providing a trauma-attachment therapeutic environment where this is required. Trauma recovery cannot commence until a child begins to feel safe and so a critical part of providing an appropriate care environment is cultivating it as a sanctuary.

This is particularly so in the residential care context (Hillan, 2006; Morton, Clark & Pead, 1999) "where creating a safe and soothing environment involves careful consideration of the placement of young people with peers who may generate anxiety or engage in abusive behaviours (Bath, 2008). Even with such consideration, vigilant management of the social environment is considered necessary to ensure young people do not experience it as threatening or participate in traumatic re-enactments with other young people or carers (Bath, 2008; Streeck-Fischer & van de Kolk, 2000)" (CYPCG, 2012c: 10).

In Queensland, residential care service providers have discretion under their service agreements to refuse referrals where the young person's needs and circumstances do not match with program objectives and/or their needs are assessed as likely to conflict with those of existing residents.

Despite this discretion, a shortage of placement options can knowingly drive poor placement decisions. For example, residential care service providers consulted by the Queensland Children's Commission in 2010 commonly reported experiencing pressure from their funding bodies to accept inappropriate referrals with potentially significant adverse consequences for young people[9]. This issue was also raised by service providers during the QCPC Inquiry.

1.1.5 Information provision to carers prior to placement

Adequate information provision to carers about a child before the OOHC placement commences is critical to a stable placement and to meeting the needs of the child. Meeting the needs of a child in OOHC requires an understanding of their history and their problems.

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[9] This consultation related to the Views Residential Care Survey which was under review but it also investigated service providers' views about the things that impact on their ability to provide an environment that effectively meets the needs of young people. An internal report on the consultation is available.

In Queensland, section 83A of the *Child Protection Act 1999* mandates the provision of information by the Department to carers and children prior to, and during, the placement of a child in OOHC. The specified purpose of information provision is to:

- enhance and support stability for children in out-of-home care placements
- ensure carers can provide children in their care appropriate care and support, and
- ensure the safety of the carer and members of the carer's household.

Despite these legislative obligations, evidence suggests that information provision is sometimes insufficient. For example, the Queensland Children's Commission's 2010 Mandatory and Essential Services Audit of a random group of children place in OOHC found, among other things, that the Department's records indicated low levels of compliance with section 83A of the *Child Protection Act 1999* (CCYPCG, 2010a). In reply, the Department indicated that compliance was actually high, but the evidence, in the form of a file record was low, because information is often provided verbally and informally.

In view of ongoing concerns being raised by carers, in 2011 the Queensland Children's Commission conducted a survey of foster carers, kinship carers and residential sites across the state to gauge directly if carers considered they were getting the required information. Carer responses indicated, at best, only partial compliance by the Department with its legislative obligations. Survey findings and recommendations can be found in the survey report (CCYPCG, 2013b).

Departments and agencies often cite confidentiality and privacy as reasons for limiting information provision. The Queensland Children's Commission is of the view that when there is a conflict of interest, protecting a child from abuse should override confidentiality and privacy considerations. This is an area which may need review and clearer directives for child protection staff about their legislative responsibilities and appropriate methods for information sharing.

The Queensland Children's Commission has received a number of concerns where failure to provide sufficient information has contributed to serious adverse outcomes for children. For example, failure to appropriately inform a carer about the known sexualised behaviours of a young person placed with that carer led to the own carer's child being abused. Information provision to carers who are caring for a child who has sexually abused another child is also raised at Question 6 (see page 32).

1.2 <u>Reducing children's vulnerability to abuse</u>

Research highlights the role children's pre-OOHC experiences play in the higher rates of physical, behavioural and mental health problems and poorer psychosocial functioning and school performance experienced by children in OOHC. As a consequence of their pre-care experiences and associated problems, children in OOHC can be more vulnerable than others to further abuse (CCYPCG, 2013c).

<u>Core strategies</u> to reduce this vulnerability include:

1) optimising care factors (e.g. placement stability, felt security and good relationships)
2) providing regular health checks for children in OOHC
3) providing sexual abuse prevention programs and healthy sexuality education, and
4) providing treatment, therapy and /or supports that meet children's needs.

1.2.1 Optimising care factors

A complex interaction of multiple factors can nurture or impede children's wellbeing in their OOHC placement. Some of the factors identified in the research literature are discussed in a focus paper published by the Queensland Children's Commission: *Views of Children and Young People in Foster Care Survey: Health and Wellbeing* (CCYPCG, 2013c).

Care factors which nurture children's wellbeing in OOHC include minimal placement change, feeling loved and care for (felt security) and positive relationships. Some researchers suggest these factors may help protect children from further abuse. As noted by Bruskas, (2008; 2010) and Fernandez (2010), the experience of foster care may provide a 'healing', restorative environment which helps mitigate the risk factors children enter care with and assist them to develop 'assets' or protective factors to promote recovery and facilitate resilience to later adverse events.

Research from the Commission's *Views* foster care surveys[10] lend weight to these suggestions. Analyses of 2011 survey responses found strong associations between key placement variables and children's wellbeing – as measured by their feelings of happiness, happiness in their current placement and whether they reported being better or worse off since coming into care. These analyses found that children with higher levels of wellbeing were more likely to:

- have entered care at a younger age
- have had fewer placements
- have a carer of the same cultural background
- report feeling cared for
- report having fewer worries and being able to get support and assistance with problems
- have positive experiences at school and attended fewer primary schools
- report their current placement is a 'good fit' where they feel safe, their carer listens and treats them well, they feel important to their foster family and are not worried about moving, and
- have positive relationships with their carer, teacher, peers and Child Safety Officer (CCYPCG, 2013c).

1.2.2 Providing regular health checks

A key strategy in addressing children's health needs and preventing further abuse is the provision of regular health checks. These checks should begin with a comprehensive health assessment as children enter care, followed by regular follow-up checks. It is critical that this information is systematically recorded in the child's or young person's *Child Health Passport*.

The Commission's *Views* surveys provide important evidence into the health needs of children in care. In the most recent (2011) survey, 83.0% of young people reported having a health check in the previous 12 months, 8.5% reported having a health problem of concern to them and, of this group, 26.7% had yet to receive help for this problem. Reports from carers of young children indicate that 22.8% of young children had a health problem of concern to the carer and 32.8% did not have a Child Health Passport (CCYPCG, 2013c).

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[10] The Views of children and young people in foster care surveys are conducted biennially. Children and young people in kinship care are included in the survey.

1.2.3 Providing sexual abuse prevention programs and healthy sexuality education to children

Given the increased risk of sexual abuse faced by children in OOHC it is important they receive both ongoing, age-appropriate sexuality education and evidence-based prevention of child sexual abuse programs.

Children who have received sexuality education are 'less appealing' to perpetrators who instead prefer sexually naïve victims who they can manipulate to engage in sexual activity (Bagley, Thurston & Tutty, 1996; Budin & Johnson, 1989; Elliott, Browne & Kilcoyne, 1995). The provision of sexuality education also models the acceptability of discussing sexuality to the child which may encourage disclosure from the child (Sanderson, 2004).

Evidence-based child sexual abuse prevention programs can also decrease children's risk of sexual victimisation. Programs can be effective in improving children's knowledge of sexual abuse, raise awareness of body ownership, assist children to recognise sexual abuse and may increase the likelihood that children will disclose victimisation, particularly if they have received comprehensive prevention education (Sanderson, 2004; Woodward, 1990).

It is important that prevention education is ongoing and does not simply involve attendance on one occasion. The benefits of prevention education are cumulative, with children's knowledge and skills improving with further exposure to these programs (Rispens, Aleman & Goudena, 1997).

1.2.4 Providing treatment, therapy and supports that meet children's needs

Children in OOHC with complex needs require therapy, treatment and/or specialist support such as counselling. In relation to sexual abuse, therapy and support can be a preventive strategy as well as a treatment response to ameliorate harm once abuse has occurred. In this context, those in need include children who were sexually abused prior to coming into care; children exhibiting sexualised behaviours, and children with significant psychological and behavioural problems which may increase their vulnerability to abuse (as victim or perpetrator).

In recent years the capacity of Queensland's child protection system to respond to the therapeutic needs of young people has been enhanced through the establishment of EVOLVE Therapeutic and Behaviour Support Services; options for "flexible funding" to supplement support, and the funding of non-government agencies to provide counselling and support services to children who have experienced sexual abuse.

The Department has also expanded its provision of intensive foster care; increased the number of residential care placements as a proportion of all out-of-home care placements, and established different models of residential care, including the Indigenous Safe House model and the Therapeutic Residential Care model. Despite these positive developments there remains a profound shortfall in appropriate placement and treatment options, especially for children who exhibit behaviours that seriously risk their own safety or the safety of others.

The unmet therapeutic support needs of children in OOHC continue to be a common focus of the individual advocacy work undertaken by the Queensland Children's Commission. In 2012-13 for example, 9% of the total number of locally resolved issues finalised by the Commission's Community Visitors pertained to the provision of therapeutic services including sexual abuse counselling. This was the third highest issue category for all issues locally resolved by Community Visitors during this period.

Notably children themselves report a significant level of unmet need:

- Of the 6% of young people in care visited by Community Visitors in 2012-13 who demonstrated high risk behaviours such as sexualised behaviours and self-harm, only half (52%) indicated receiving effective support from the Department and/or their care provider, 34% reported receiving support that was not effective, while 15% reported that no support had been provided.

- In the 2011 *Views of Young People in Residential Care Survey* (CCYPCG, 2012b), 62% of respondents identified themselves as having behaviour support needs and 22% of these said they need more help with their behaviour. Similarly, 69% reported having emotional/mental health support needs – 23% of these said they need more help.

The Queensland Children's Commission has been a strong advocate for the adoption of a trauma-based therapeutic framework in all residential care facilities. Currently there are four therapeutic and 105 generic residential care facilities in Queensland (QCPCI, 2013: 267). Although the broad practice framework for residential care in Queensland (the Contemporary Model of Residential Care for Children and Young People in Care) centrally recognises the need for trauma and attachment informed care, not all generic facilities operate in this way (CCYPCG, 2012c).

A recent paper released by the Queensland Children's Commission: *Responding to trauma and attachment needs in residential care,* reviews the research literature and summarises some of the things that need to be done in residential care to ensure the placement genuinely responds to the needs of these young people and thereby contributes to their recovery, development and future safety (CCYPCG, 2012c).

Key elements highlighted in the paper include the need to recognise and respond to the impact of chronic childhood trauma and to create 'a sanctuary' in residential care. Research suggests that environments which create a sanctuary for children in residential care:

> *"are characterised by a high level of consistency and predictability often achieved with daily routines, structures, rituals, clear expectations, consistently applied limits, and well-defined roles (Anglin, 2002; Barton, Gonzalez & Tomlinson, 2012; Cairns, 2002; Schofield & Beek, 2006; Stein & Kendall, 2004)"* (CCYPCG, 2012c: 10).

Significantly, the recent QCPC Inquiry (2013) has recommended that the Department partner with non-government service providers to develop and adopt a trauma-based therapeutic framework in all residential care facilities, supported by joint training program and professional development initiatives.

1.3 <u>Creating avenues for children's voice – increasing likelihood of disclosure</u>

Numerous public inquiries into the abuse of children in care in Australia and internationally have identified that *part of children's vulnerability lies in not having a voice* to draw attention to their situation. Children in OOHC do not have a parent willing and able to protect them and are likely to have limited knowledge of how the system works, their rights, or how to complain if they are unhappy about their care. Even if they speak up, they may not be sure if action will be taken.

Children are more likely to speak out about abuse if they have a sense of agency – that is, if they have learned they have the capacity to influence what happens to them.   As a result of their pre-care experiences, many children in OOHC however, may have learned that their words and actions have little or no impact on their experiences. Therefore, they may be reluctant to express their concerns or disclose abuse.

Consequently, it is important to teach children that they do have a sense of agency over their life. To achieve this, children need to feel their opinions are valued and that decision makers will follow through on promises (Bessell, 2011; Cashmore & O'Brien, 2001). Children may then be more likely to take advantage of the opportunities they are given to verbalise their views and concerns.

Core strategies to give children a voice include:

1) Advocacy and child-focused complaints services
2) Children having an independent advocate or supportive adult they trust
3) Children's participation in decision-making.

The need for these strategies extends beyond the child's placement to other settings such as pre-school and school, where children in OOHC may need greater encouragement and support than other children to have a voice and to participate.

1.3.1 Advocacy and child-focused complaints mechanisms

In recognition of the structural vulnerability of children in OOHC, many jurisdictions have established child and youth advocacy services and child-focused complaints mechanisms and there is at least an expectation, if not a requirement, that government and non-government agencies will inform children about their rights in OOHC and what they can expect in care.

In Queensland for example, the *Child Protection Act 1999* establishes a Charter of Rights for Children in Care and a Statement of Standards. When children come into care they are provided with age-appropriate information packages about the Charter of Rights, what they can expect in care and what to do if they have a concern.

Children in OOHC are advised, for example, that they may make a complaint directly to their case worker, to the Queensland Children's Commission either via a Community Visitor or the Commission's complaints service, or to the Queensland Civil and Administrative Tribunal (QCAT).

The Queensland Children's Commission's independent complaints resolution mechanism provides a safety net for children in OOHC by receiving, seeking to resolve and investigating complaints about the services provided to, or required to be provided to, children in the child protection and youth justice systems.

Whilst the Queensland Children's Commission strongly supports informing children of their rights and formal complaints mechanisms, the following observations are made:

- the provision of information must be accompanied by appropriate and ongoing support to ensure children understand the relevance of the information in a personal and practical sense as the need arises.
- children are more likely to raise issues with someone with whom they have a trusting, face-to-face relationship, even if they know the process for making a formal complaint (Cossar, Brandon, Bailey, Belderson, Biggart, & Sharpe, 2013).
- children are more likely to access a complaints service if they already have a sense of empowerment (Cashmore & O'Brien, 2001).
- children will only have confidence in speaking up if doing so improves their situation (Cossar et al., 2013).

1.3.2   Children having an independent advocate or supportive adult they trust

There is a growing body of literature which indicates having a trusting, supportive and, ideally, enduring relationship with an advocate (or other supportive adult) can help ensure that children will talk about abuse or other concerns that they have about their safety or wellbeing. Some of this literature is summarised in a recent focus paper by the Queensland Children's Commission: *Young people's views about the support and advocacy provided by Community Visitors in residential care* (CCYPCG, 2013d).

This paper also reports findings from the 2011 and 2012 *Views of Young People in Residential Care Survey.* Findings support the argument that investing time in relationship building between vulnerable children and their advocates increases the likelihood young people will talk to the advocate about concerns they may have with where they are living.

Advocacy can be provided informally by a significant other in the child's life or through more formal arrangements. Where advocacy is provided formally, research indicates the factors necessary to support effective advocacy services for children in OOHC are that the service:

- is independent from the agency or department responsible for managing children's care so that it can advocate without conflict of interest
- offers children confidentiality, or at least provides clarity about the limits of confidentiality
- is child-focused, or gives priority to the child's views and preferences, not those of adults
- operates from a view of children as competent social actors
- nurtures the development of trusting, supportive and, ideally, enduring relationships between children and their advocates
- demonstrates advocacy founded on an ethic of care, not just an ethic of justice, and
- is adequately and recurrently funded (CCYPCG, 2013d).

In Queensland, the model of individual advocacy provided by the Commission's Community Visitor Program incorporates many of the elements identified above. Under the program, Community Visitors are employed on a casual basis and are required to visit each child and young person in OOHC on a regular basis to monitor and report on their safety and wellbeing and to advocate on their behalf to resolve their concerns and grievances.

The role of Community Visitors is discussed further at 1.4.2 (see page 17) and at Question 3 (see page 26). The influence a child's relationship with a trusted professional can have on disclosure is discussed at Question 8 (see page 34).

1.3.3   Children's participation in decision making

There is often a gap between the policy on children's participation and actual practice, with evidence indicating their participation at times is tokenistic, or occurs within age-based power hierarchies (Bessell, 2011; Fernandez, 2009).

In such instances children may see the child protection system as unresponsive and failing to 'care' about their welfare (Gaskell, 2010). They may be left believing their views are not valued, so that they feel excluded, disillusioned, powerless and frustrated at having no control or say in their lives (Bessell, 2011; Fernandez, 2009; Fox & Berrick, 2007).

Standard 2 of the National Standards for OOHC recognises participation is "*critical to [a child's] emotional development and self-esteem*" and requires that "*children and young people participate in decisions that have an impact on their lives".*

In practice however it can be challenging for case workers to involve children in OOHC in decision-making. Children's participation may be viewed as time consuming and competes with other demands on case workers and workers' skills in engaging with children vary, with often limited opportunity to acquire these skills (Office of the Guardian for Children and Young People, 2009). If a service is truly child-focused however, participation should be a high priority.

In Queensland, children's responses to the *Views* surveys indicate there are ongoing challenges for the Department in involving children in meaningful participation in decisions about their lives (including case planning) and providing them with explanations for decisions. For example:

- In the 2011 foster care survey, 38% of children and 32% of young people report they do not have a say in what happens to them and a total of 43% indicate they are not confident the Department will follow through on promised actions. Fewer than half (46%) of young people indicate they have a case plan, and just over half of these (54%) report knowing what is in it. (Notably, these proportions have improved since 2006 when the surveys commenced) (CCYPCG, 2012a; CCYPCG, 2013c).

- In the 2012 residential care survey, 50% of young people report they do not have a say in what happens to them and 34% report they were not involved in developing their case plan (CCYPCG, 2013e).

1.4. Monitoring how children are doing increasing the likelihood of harm being discovered

A conclusion drawn from both the Forde (1999) and CMC (2004) inquiries was that limited or inadequate monitoring increases the chance for child abuse and neglect to occur and go unreported. On the other hand, excessive monitoring can be counter-productive if it diverts resources away from a focus on the child to a focus on compliance with processes and administration (Munro, 2011; QCPCI, 2013).

From the child's perspective, monitoring should be about checking on how they are doing: are things happening that are supposed to be happening and if not, why not; are they having problems, feeling unsafe or concerned about something; are there things that could be better? From a systems perspective, monitoring is also about checking OOHC practices: are they delivering the expected outcomes, are there deficiencies in the policies underpinning practice, are changes translating into improvements, are things better or worse for children, carers and families.

The Queensland Children's Commission's experience is that having a range of monitoring activities which target different sources of information and different perspectives enables a holistic and robust assessment to be made about how well things are working at both the individual and systemic level.

For example, the triangulation of (i) administrative data from the Queensland Children's Commission's monitoring agreements with service providers, together with (ii) assessment reports from community visitors and (iii) survey responses gathered directly from children on their lived OOHC experience, provides a child-focused evidence base on which to make an assessment of the outcomes for children.

Accordingly, the Queensland Children's Commission supports a range of complementary monitoring strategies, and considers there should be independent external monitoring of the OOHC system in addition to internal monitoring by the child protection agency.

Core strategies should include:

1) regular supervision of individual placements by a caseworker
2) regular visits by an independent person whose focus is purely the child's best interest
3) a systematic way of consulting with children about their in-care experience, including their perceptions of being safe and looked after, and
4) up-to-date record keeping, appropriate data collection and efficient information systems for data analysis and reporting on measures and trends.

1.4.1   Regular supervision of individual placements by a child safety officer

It is rightly expected that caseworkers, known as Child Safety Officers (CSOs) in Queensland, will have frequent and regular contact with children in OOHC for whom they have casework responsibility, and that contact will be in accordance with legislative and practice obligations. This regular and frequent contact is an important mechanism for monitoring OOHC placements and the safety and wellbeing of individual children.

In Queensland, it is the Department's responsibility to monitor OOHC placements to ensure the care provided is consistent with the Statement of Standards in the *Child Protection Act 1999.* As part of that responsibility, all children in OOHC are allocated a CSO who are required to maintain regular contact with the child in their care environment and take preventative action to resolve any concerns before they escalate.

Whilst it could be assumed that the contact will be face to face in the child's placement, this is not always the case. Departmental evidence presented to the QCPC Inquiry confirmed that all children in care are to be contacted by their CSO every month, and some more frequently as needs arise, but also confirmed that contact is not always a face-to-face visit (QCPCI, 2013: 415). Sometimes it is a phone call. It was suggested in departmental evidence that the main requirement of regular contact is to give the child an opportunity to talk privately (QCPCI, 2013: 415).

The Queensland Children's Commission is strongly of the view that children are more likely to talk about any serious concerns they have in the course of a face-to-face conversation with their CSO, and if the relationship between the child and CSO is a positive one. To this end, the Queensland Children's Commission considers it vital that CSOs sight and engage with the child during placement visits and not simply engage with the carer. CSOs failure to sight the child during visits was an issue raised in the CMC Inquiry (2004). Moreover, *Views* survey data has consistently shown that most children want to 'see' their CSO. The survey findings regarding children's views about their CSOs are discussed in response to Question 3 at 3.2 (see page 28).

1.4.2   Regular visits with children in care by an independent person

In addition to providing advocacy, regular visits by an independent person can serve an important oversight role by monitoring the safety, well-being and quality of services delivered to children in OOHC. Supervisory visits by Child Safety Officers (CSOs) and Community Visitors (CVs) in Queensland perform different yet critical and complementary functions in relation to monitoring OOHC practices and these functions are compared and contrasted in detail in the response to Question 3 (see page 26).

The visiting program operating in Queensland is recognised as 'best practice'. For example, Associate Professor Leah Bromfield Deputy Director of the National Child Protection Clearinghouse at Australian Institute of Family Studies, stated in 2005:

"The Clearinghouse considers the Queensland's Community Visitor Program to be an example of best practice in monitoring the wellbeing of children in care, providing children in care with an independent advocate and ensuring the needs and opinions of young people are given a voice" (Bromfield, 2005: 22).

The Queensland Children's Commission considers the visiting program one of the most important components in continuing to keep children in OOHC safe. As such, the comments made about CVs throughout this submission are made in the Queensland context.

Queensland's CVs are employed by the Queensland Children's Commission and not the Department and their functions are specified in the Commission's governing legislation. The CV's legislative basis and independence from the service delivery system are central to their efficacy.

In accordance with the legislation, the Queensland Children's Commissioner makes arrangements for each visitable location to be visited by a CV regularly and frequently. Visitable locations include foster and kinship care, residential care, detention centres and mental health facilities. Visits are arranged at a time when the child is going to be present and normally arranged well ahead of schedule. Visits to residential services incorporate a mix of scheduled and unannounced visits.

Visits take place at the visitable location enabling CVs to report on the child's living conditions, relationships within the home and any other factors which may impact on their wellbeing. Visits are no longer than 45 minutes except when the location has more than one visitable child living there. Key CV obligations are to engage with children, report on their safety and advocate for them by facilitating resolution of their concerns and grievances.

Engaging with children enables CVs to hear about each child's experiences in care, however engagement is voluntary and any decision by a child not to engage is respected. CVs come from a wide range of professional backgrounds and are skilled in using a variety of age appropriate activities to develop trusting and supportive relationships which encourage children to share their views. Appropriate strategies that facilitate observation, assessment and monitoring are used to develop relationships with pre-verbal children and children with limited communication due to a disability. Care providers may also provide relevant information in relation to issues impacting on the child.

As soon as practicable after visiting a location, CVs must prepare and forward to the Commissioner a report about the visits. Reports provide a snapshot of the child's experiences and circumstances at the time of the visit and are based on the Key Outcomes Indicators developed by the Commission and the Statement of Standards for OOHC specified in the *Child Protection Act 1999*. Any issues identified within the report must be accompanied by appropriate and accurate contextual discussion.

If during the course of a visit, the CV becomes aware of information indicating a child has been harmed, is being harmed or at risk of harm, CVs as mandatory reporters are obliged to raise an alert immediately with the Department or the Queensland Police Service. Resolution and advocacy for less serious concerns or grievances is attempted locally with service providers in the first instance.

For the period October 2011 to September 2013, the Commission's CVs reported close to 500 harm issues for children in OOHC related to a current or possible risk of sexual harm. Approximately 96% of these sexual harm issues resulted in the Department being informed of the issue within 24 hours of the CV becoming aware of it. This data suggests that CVs provide an effective system for the early detection and timely reporting of harm once it is disclosed or a possible risk of harm identified.

The following case studies demonstrate the benefit of the advocacy and monitoring roles performed by CVs in Queensland's OOHC system.

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1. Sexual abuse Case Study

A Community Visitor (CV) conducted a visit to verify the safety, health and wellbeing of a child at a new placement. The child being visited was removed from their parents' care due to substantiated allegations of sexual harm perpetrated by their father. The child had weekend overnight contact with their grandfather and brothers. The carer reported concerns to the CV of the child's pleas to not go to weekend overnight contact and the child's escalating behaviours on return from the weekend contact. The CV also reported that no therapeutic support had been implemented for the child. The CV met with the child privately where the child disclosed to the CV that both of their older brothers came into the child's bed when it was dark and touched the child's "wee wee", and that the child had also seen their father during the weekend contact. The CV advised Child Safety Services of the child's disclosures. The information was also referred to the Queensland Police Service for investigation. All contact with the grandfather and brothers ceased for a period of time and therapeutic support/intervention was provided to the child. Ongoing monitoring of the situation by the CV at monthly visits continued, and the carer and child both appeared more settled and relaxed once contact arrangements were changed, and support was provided.

2. Disclosing past sexual abuse Case Study

During a visit the child disclosed for the first time, to the CV, that they had been sexually abused by various different men, whilst in the care of their mother. The child requested the CV be their support person during the interview with the Child Protection and Investigation Unit. The CV was able to attend the interview with the child and support the child through the interview process. The CV continues to visit with the child and build on their trusting and positive relationship. The child received therapeutic services in regards to the child's past abuse.

3. Access to therapeutic support to address sexual abuse Case Study

During a visit the carer indicated to the CV that the child being cared for had been sexually abused before coming into the care of Child Safety Services and the carer felt that the child required more effective therapy that could assist with behavioural and anger management issues as well as sexualised behaviours displayed by the child. The carer also believed that the child may be displaying signs of Post-Traumatic Stress Disorder, given the abuse the child had suffered in the past. The CV advocated to Child Safety Services for specialised services to support the child. As a result of this advocacy the child received counselling.

1.4.3   Systematically consulting with children

Children have a unique perspective on the functioning of the OOHC system and on their own wellbeing; a perspective which is frequently overlooked but critical to a full understanding of what is going on and how things could be improved.

The Queensland Children's Commission's *Views* survey series provide a good example of how children's views can influence policy and practice development processes. Moreover, the longitudinal nature of much of the data enables changes in children's experiences of OOHC to be monitored over time and can be used a measure of the efficacy of policy or practice changes on the outcomes for children.

The *Views* surveys are the largest, repeated cross-sectional longitudinal study of its kind in Australia involving the direct participation of children in OOHC (and youth detention). To date there have been five foster care surveys (2005, 2007, 2009, 2011, 2013) and four surveys of young people in residential care (2007, 2008, 2011, 2012). The surveys are administered by Community Visitors and ask children about a range of matters including how safe they feel in their placement, participation in decision making, family connection, family contact, relationship with caseworker (CSO), and leaving care.

Similarly, the National Standards for OOHC recognise the importance of consulting directly with children. To enable reporting on children's outcomes against the Standards, a national survey of children in OOHC will obtain their views on, and gather data about, eight of the thirteen measures identified in the Standards. The Queensland Children's Commission has been extensively consulted on the nature and scope of the National Survey and many of the survey items to be included are drawn from the Commission's own instruments.

Some of the questions asked in the *Views* surveys which help to assess children's subjective sense of safety are listed in Appendix A. As noted earlier, survey findings have consistently shown that the majority of children in care feel safe in their current placement. If a child's response to a survey item indicates there is a problem, the Commission follows up through the child's Community Visitor, and depending what the concern is, the Community Visitor may take it up with the child's caseworker[11].

1.4.4   Up-to-date record keeping and efficient data collection systems

Child protection departments and agencies need to foster a culture that values record keeping. It is not just a question of compliance with processes. In Queensland, the Department's record keeping and information systems were raised in the CMC Inquiry (2004) and whilst there have been considerable improvements since 2004, issues were still noted during the QCPC Inquiry (2013).

Good record keeping and information systems that allow for the quick retrieval of information enable access to relevant data to support good decision making at the individual level. The ability to analyse the data and have confidence in its accuracy also supports good decision making at the systemic level. Data sets capable of interrogation to identify trends and patterns of service delivery are also necessary for effective oversight of the system.

If record keeping is not prioritised, it may be done poorly. This can result in a poorly recorded history of the child which in turn compromises good casework and may ultimately lead to poorer outcomes for the child. For example, the Queensland Children's Commission has noted in some of its investigations that when an incident occurs with a child, there is often no examination of past history of incidents or complaints.

Deficiencies in record keeping can also impede investigations, for example into allegations of abuse, if file and case notes are not properly completed or completed well after the event. This issue is also discussed at Question 11 (see page 37). Data collection in relation to rates of abuse is discussed in the response to Question 7 (see page 33).

1.5 *Timely and responsive processes - so degree of harm is minimised*

Clear policies and processes are required for the timely reporting of allegations and incidents of child abuse, for proper investigation, and for taking appropriate action to ensure perpetrators are held to account and victims are provided with justice and support services.

Core strategies should include:

1) A clear definition of sexual abuse to facilitate reporting and a documented reporting process
2) Mandatory reporting of allegations or incidents of sexual harm
3) Independent and timely investigation of allegations and incidents of abuse, and

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[11] Children are advised before completing the survey, that if they indicate concerns about their safety or the safety of others on the survey, the Commission will take follow up action.

4) A published policy that provides support to children and young people who have experienced sexual abuse whilst in care.

1.5.1   An understanding of abuse and documented reporting processes

A pre-requisite for reporting is for all parties in the OOHC system to have a clear understanding of what constitutes sexual abuse. A definition helps to develop a common understanding and the Queensland Children's Commission advocates for a nationally agreed definition (although the difficulties of getting agreement on a definition are acknowledged).

Sexual abuse varies on a continuum of severity and it is important that the definition of sexual abuse be broad enough to encapsulate grooming behaviours. Child sexual abuse often involves a grooming process where, over a prolonged period of time, the child is progressively desensitised to sexual behaviours (Bagley et al. 1996; Conte, Wolf & Smith, 1989).

Understanding and identifying grooming behaviours is particularly important as intervention potentially can occur before the abuse has progressed to a more serious level (Sanderson, 2004). Early detection and reporting of sexual abuse is vitally important in ensuring that children receive timely intervention, therapeutic support and appropriate redress which are important to the healing process.

To ensure all relevant parties have a clear understanding, carers, care service personnel and regulatory staff working with children in OOHC should receive training about sexual abuse and the various types of behaviours that may be exhibited by children who have been, or are being exposed to sexual abuse or grooming behaviours. (Training is discussed further at Question 5, see page 31).

Documented procedures should also be developed for, and made readily available to, carers and service personnel working with children in OOHC to guide them in knowing:

- how to respond to a child if they make a disclosure about sexual abuse
- who the disclosure, suspicion or allegation of sexual abuse needs to be reported to
- how the report should be made and in what timeframes
- what details are to be documented in each circumstance
- what will happen after the report has been made and when – for example what support will be offered to the child and people involved, and when people will be notified of what is happening, and
- the process for appeal if an allegation is made against a carer, a member of a carer's household, or care service staff member.

1.5.2   Mandatory reporting

Mandatory reporting refers to the legislative requirement imposed on selected groups of people to report suspected cases of child abuse and neglect to government authorities. Whilst all jurisdictions in Australia have mandatory reporting, there is some variation in who is mandated to report.

The Queensland Children's Commission's view is that multiple reporting decreases the likelihood that a child with fall through the cracks. Whilst process issues which create tensions around mandatory reporting should be addressed, solutions should not compromise child safety.

1.5.3   Independent and timely investigation of allegations and incidents of abuse

The 1999 Forde Inquiry into the abuse of children in government and non-governments institutions determined that independence in the investigation of allegations and incidents of abuse is crucial. The Queensland Children's Commission concurs. In support of the independence of investigations, the Forde Inquiry report proposed that:

> *"[a]n institution which has failed to protect a child to the extent that abuse may have occurred should not be relied upon to investigate the incident. Indeed, even the supervising authority or department is not well placed to investigate abuse because of their role in child placement, monitoring and supervision. To ensure that investigations are rigorous and objective, the response must be as structurally and functionally independent as political and economic constraints will allow"* (Forde, 1999: 26).

Similarly, the 2004 CMC Inquiry into abuse in foster care recommended that the investigative functions of the Department be conducted by trained staff who are independent of the casework process. It was argued that having someone who is responsible for the casework process also responsible for the investigation may consciously or unconsciously prejudge the allegation or outcome of the investigation on the basis of past relationships and experiences with those involved (CMC, 2004: 152).

Further, the CMC recommended that the Department ensure an appropriate procedural framework be established for responding to allegations made against foster carers. The Department subsequently established a specific process and procedures for the handling of allegations, and these can be found in Chapter 9 of the Child Safety Practice Manual.

In addition to independence, the Queensland Children's Commission considers timeframes and accountable decision-making to be important elements to identify in the investigative process, as delays and/or lack of information about decisions can cause more harm and adversely impact all parties involved in the alleged incident. Procedural fairness and the availability of an appeals process should also be clearly articulated.

Currently in Queensland, if a child in OOHC is harmed or there is a breach in the standards of care, the carer or care service must notify the Department who investigates the matter to determine what action is required including whether the child is to be removed from the current placement. In cases of sexual abuse, the police must be notified.

Moreover, under the current oversight framework, the actions of the Department are open to independent review by the Queensland Children's Commission. In this regard, the Commission is strongly of the view that an external oversight and review mechanism in relation to how allegations of sexual harm of children in care are assessed and dealt with by child protection agencies or Departments is necessary to ensure the response is rigorous and objective. It also provides for transparency and accountability which in turn generates public confidence.

1.5.4   A published policy that provides support to children abused whilst in care

The Royal Commission's Terms of Reference reflect the need to have effective redress policies and, more importantly, the imperative to put them in to practice. In this regard, the Queensland Children's Commission is of the view that child protection agencies and service providers should have documented 'response to allegations of sexual abuse' policies for children who are subject to abuse in OOHC, and that the application of those policies should be subject to external scrutiny.

In Queensland the Department has had a documented response policy in place since 2011 (currently named the *Response to children and young people sexually abused whilst placed in care Policy*). The need for a policy was identified in 2005 when the Queensland Children's Commission recommended:

> *"the Department develop, document and publish a comprehensive policy on redress to assist and support decision making in instances of maladministration leading to detriment."*
> (CCYPCG, 2005: 3).

The recommendation came out of the Commission's first audit of the Department's handling of sexual abuse allegations. The aim was to ensure there was a formal and accountable commitment to an appropriate response, including an acknowledgement and expression of regret for the abuse and resultant harm, and to give children access to legal services and therapeutic support services.

Equally important to the development of a policy is its incorporation into practice. The Queensland Children's Commission's second audit conducted in 2012 found that the Department's policy was followed in only one case. While there may be legitimate reasons for this, the benefit of having the policy subject to external scrutiny provides greater accountability in relation to the actions taken in response to the sexual abuse of children in OOHC.

1.6 *Systemic oversight*

Removing children from their parents and placing them in alternative care is a serious undertaking and the government and the public need to be confident that a child is actually safer in their alternative care placement. Past failures have cast doubt on the OOHC system's capacity to keep children safe from harm and led to calls for improved oversight to identify systemic weaknesses that make children less safe and recommend any improvements that will make them safer.

The fundamental elements of oversight such as monitoring, investigation, audit and review are intended to assist organisations to reflect on practices, recognise what is working well and what is not, and promote ongoing improvements. Oversight can occur:

> *"through external bodies with specific responsibilities for review, audit and investigation as well as internally through corporate governance, which includes the structures, systems and process used to manage an organisation in an open and transparent way"* (QCPCI, 2013: 395).

Whilst the value of rigorous internal oversight and even high levels of Ministerial accountability cannot be overestimated, the Queensland Children's Commission is strongly of the view that there also needs to be formalised **independent external oversight of the OOHC system**.

The confidential and personal nature of child protection information, the serious implications if practice failures go unidentified and the multiple agency involvement in the OOHC system, warrant the need for independent oversight by an external body **invested with the powers** to gather information and compel service delivery agencies to seriously consider the findings of oversight activities and any recommendations made.

Moreover the Queensland Children's Commission is of the view that **a single specialist agency** with the required expertise and the capacity to be informed from multiple sources is better able to provide a more comprehensive picture of the outcomes for children in OOHC than one or more generic oversight bodies. In the absence of independently acquired and systematically evaluated information, there is a risk that past failures may be repeated.

Finally the Queensland Children's Commission considers that accountability and public confidence in the OOHC system is bolstered by **annual public reporting against a comprehensive child-focused outcomes framework**, and the ability of the oversight agency to report without any potential for interference. Oversight, and the status of oversight in Queensland is also discussed at Question 10 (see page 36).

Question 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?

2.1   Evidence of different rates of abuse in different care arrangements

The Queensland Children's Commission is not aware of any evidence to verify differences in the rates of sexual abuse between various care types as Child Safety Services in Queensland is not able to disaggregate its data in a way that allows conclusions to be made.

As part of the Commission's recent sexual abuse audit, the Commission sought data from the Department on a breakdown of distinct children placed in OOHC (per section 82(1) of the *Child Protection Act 1999* (Qld)), subject to substantiated Matter of Concern Notifications for sexual abuse disaggregated by carer type. One purpose for seeking this data was to determine whether there are any differences in the rates at which children are the subject of substantiated matters of concern for sexual abuse in the different care environments.

The Commission subsequently learnt that this type of assessment cannot be made over time as there have been changes in the way the data has been captured and reported. Specifically, at different times over the last 10 years the Department has reported the "carer type" as the type of care placement (e.g. foster care, kinship care, residential care) that the child is residing in at the time the allegation of harm is made, which may not necessarily be the same as the OOHC placement type in which the child experienced the harm or risk of harm.

The lack of appropriate data draws attention to the merit of data collection and specifically data on:

- the type of alleged and substantiated abuse
- the type of care arrangement where the abuse occurred, and
- the relationship between the child and the perpetrator.

Over a longer period of time, data of this nature would help identify if children in particular care arrangements are more vulnerable to sexual abuse and the particular context when abuse is occurring and help to track trends over time. This raises the possibility that consideration could be given to a nationally consistent approach to data collection to facilitate improved learnings in relation to the different care environments, which may then facilitate identifying strategies that contribute to reducing the occurrence of sexual abuse for children in OOHC. (Data issues are also discussed at Question 7, see page 33).

In the absence of hard data, there are different views, based largely on anecdotal evidence, about which group may be more vulnerable to abuse. Hence the Queensland Children's Commission would argue that the 'core' elements should extend to all types of OOHC including kinship care. In other words, while different strategies may be needed for different environments, the core elements of

the strategies must remain the same: a focus on safety, supervision, communication, appropriate action when a child discloses and so on.

What we do know from the Queensland Children's Commission's own work is that children in different care contexts have different vulnerabilities and we need to recognise these in order to minimise their impacts. For example, reference has already been made earlier in this submission to:

- the potential for children to be exposed to ongoing abuse if placed with kin who are not appropriately screened or monitored, and
- the therapeutic needs of children in residential care.

2.2 Children's views of safety by care type

Whilst the Commission's *Views* surveys do not ask children about their experience of abuse, the surveys do ask questions more generally about feelings of safety and experiences in their placement.

Contrary to much of the literature, the *Views* survey data consistently finds that the type of family-based placement – that is, foster care or kinship care – has little bearing on children's and young people's feelings of safety and happiness (CCYPCG 2013c). Reports from children and young people in foster care and kinship care indicate that they feel equally safe and happy in their placement and feel that their carer treats them well or is nice to them. Feelings of being loved and cared for, however, do appear to be influenced by placement type with young people in kinship care significantly more likely than those in foster care to report feeling loved and cared for all of the time.

By contrast, the *Views* data reveal that young people in residential care are considerably less likely than those in family-based care to report feeling safe. As noted in the most recent *Views* residential care report, 18% of young people in residential care reported not feeling safe. This compares with only 1.6% of young people in family-based care (CCYPCG, 2013e).

Comments from young people in residential care shed light on the factors that contribute to them feeling unsafe. Analysis revealed three primary categories which are presented as follows in order of frequency along with examples of comments. As can be seen, most comments related to people within and outside of the care environment (CCYPCG, 2013e).

People or circumstances inside the residential care environment:

- *Creepy; too big.*
- *Too much yelling and swearing.*
- *I don't trust all youth workers.*
- *Other client is violent.*

People or circumstances outside the residential care environment:

- *Area we live in, drug dealers in next street.*
- *Because of crime rate.*
- *Boy in neighbourhood says he will bash me.*
- *Too far in bush, too many animals/insects/snakes.*

Own behaviours or choices:

- *Because they don't wanna listen keeps to a point you feel you're gonna hurt self or someone else.*
- *Me (lavahead).*
- *But if I don't get out of this f**king place I'll f**king kill myself.*

2.3 Young people in youth detention and adult prisons

The Royal Commission's Issues Paper 4 does not include youth detention centres and children housed in adult prisons as being in scope. However, the Queensland Children's Commission is of the view that strategies are required to ensure young people in youth detention and 17 year olds in adult prisons are not unduly at risk of sexual abuse either from other residents or adults by virtue of their environment.

Local, national and international data consistently show that young people in detention are an especially vulnerable group of young people. There is clear evidence to show that a majority have a long and complex history of disadvantage, and many will have experienced child abuse and neglect. For example, evidence presented at the QCPC Inquiry indicated that 22% of young people in detention in Queensland on 21 August 2012 had a current Child Protection Order.[12] Further research references and a description of the particular vulnerabilities of 17 year olds in Queensland's adult prisons can be found in the Queensland Children's Commission papers:
- *Removing 17 year olds from adult prisons and including them in the youth justice system* (CCYPCG, 2010b), and
- *Contesting the justifications for keeping 17 year olds in adult correctional facilities* (CCYPCG, 2012d).

In Queensland this Commission has a strong oversight role in relation to the youth justice system – a role which had its origins the Forde Inquiry. The Forde Inquiry's findings indicated that young people in detention centres are particularly vulnerable to mistreatment in the absence of independent monitoring and advocacy mechanisms, and highlighted the need at the time for urgent change in the way Queensland's youth detention centres were operating.

The current oversight role in Queensland provides monitoring and advocacy across the youth justice system, including by conducting regular visits to detention centres to assess the safety and wellbeing of young people, operating a confidential telephone complaints service for young people in detention centres and conducting investigations and audits of areas of particular concern.

A strong and independent oversight role is not however available to all young people in youth detention in all Australian jurisdictions. The Queensland Children's Commission therefore requests that the Royal Commission expand the scope of its investigations into children in the care of the state to include youth detention centres, boot camps and adult prisons.

Question 3.

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

The Queensland Children's Commission considers all three models to be complementary processes. The weakness of one model can be moderated by another. Collectively they are able to provide a more accurate picture of what's happening on the ground by filling in any "gaps" between what is being reported. Checks can identify where practice falls short of policy and help to evaluate the

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[12] Queensland Child Protection Commission of Inquiry, transcript, Stephen Armitage, 27 August 2012 (page 10-22).

efficacy of policies. The Commission would also add 'systematically surveying children' as another model of checking OOHC practices.

3.1   The importance of the different roles Child Safety Officers and Community Visitors perform in a child's life

While there may be strengths and weaknesses of supervisory visits by Child Safety Officers (CSOs) and Community Visitors (CVs) when considered independently of each other, they both are necessary as they perform different yet critical roles in contributing to the safety, health and wellbeing of children in OOHC.

In Queensland, CSOs are responsible for carrying out or coordinating direct service delivery functions in accordance with the *Child Protection Act 1999*, while CVs, who are independent of government departments and service providers, monitor the provision of these services in accordance with statutory requirements and service standards and advocate on behalf of children when issues arise.

Children in OOHC can have a variety of service providers involved in their life given the complex needs often experienced by these children. The CV's monitoring and advocacy roles ensure the promotion and protection of the rights, interests and wellbeing of these children.

While it can be argued that CSOs have the same motivation, a fundamental distinction is that CSOs are part of the service delivery system. As such, there may be a perception that a CSO could be less objective in evaluating practices and more reluctant to acknowledge practice failures. CVs on the other hand are independent of the service delivery system and verify, through direct engagement, the safety, health and wellbeing of each child they visit.

As the CV's focus is solely the child or young person, their time is devoted to building a trusting, supportive and enduring relationship with the child. CVs are not required to advocate for anyone else's views or wishes or engage in any case management activities. In contrast, a CSO must take a holistic view, listen and incorporate the views of all stakeholders involved, and manage all aspects of the case, including conducting assessments, attending court, and organising support services. CSOs also have a legislative responsibility for conducting investigations into child protection concerns. This is not part of the CVs role, although CVs are mandatory reporters of harm.

A crucial CV role is that of independent advocate who can identify that an issue is causing concern for a young person and work with service providers to ensure the issue is heard and addressed. In a sense, CVs act as an early warning system and provide much needed advocacy and support to children when the standards of care are not being met or are being met poorly. Inversely, one of the criticisms made of CVs is that some of the issues they raise are regarded as 'low level' from a systems perspective and in terms of CSO priorities. However, the issues are ones identified by the children as important to them. By taking their concerns seriously CVs give children a sense of agency.

The single focus by CVs on issues important to children is essential for relationship building. It is the building of trust and rapport that has proven over time to be one of the most important benefits of CVs as children are empowered to disclose to a 'trusted outsider' when their safety, health and wellbeing needs are not being met. CSOs can, and often do, have similarly strong relationships with children. However the historically higher turnover of CSOs in comparison to CVs does impact on the enduring nature of these relationships. The stability and consistency of CV visits and relationships can mediate the effects of frequent CSO changes and /or poor relationships with CSOs.

In Queensland, CVs complete assessment reports on their visits and all issues raised with CVs are recorded in a Queensland Children's Commission's database which enables the data to be interrogated for systemic monitoring and oversight purposes. In this way the CV visits help to inform the department about service delivery and practice, supplementing the information collected by CSOs.

To derive the benefits of CV visits, visits must be **regular and frequent**. The Queensland experience is that irregular visits are much less effective. The Official Visitor program operating at the time of the Forde Inquiry is evidence of this. Moreover, recent data from the *Views of children and young people in foster care surveys* suggests that many children are unlikely to be satisifed with irregular supervisory visits. Since the Queensland Children's Commission decreased the frequency of CV visits for the majority of children in care in 2010 from monthly to every two months, more children now report being dissatisifed with the amount of contact they have with their CV and indicate wanting more frequent visits[13].

3.2   Children's perceptions of their CSOs (Caseworkers) and CVs

The Commission's *Views* foster care surveys ask children and young people a series of questions about the relationship, and nature and frequency of contact they have with their Child Safety Officer (CSO) and Community Visitor (CV). Responses indicate that children perceive both roles to be important.

Child safety Officers: The vast majority of children and young people reported that their CSO listens to them and is helpful. The nature of support that children and young people receive is extremely varied but typically relates to family contact, school and training issues, sports, activities and holidays, helping to find, or move to a good placement or into kinship care, help with guardianship or a stable placement, acquisition of possessions, organising medical and dental care and/or counselling, and transition from care and case plans and accessing government benefits.

Some young people specifically commented on the importance of their relationship with their CSO who had helped them by listening, supporting and assisting them with their anger and other problems. Nevertheless, in the most recent survey in 2011, only 52.3% of young people and 39.6% of children reported being satisfied with how often they saw their CSO. Many reported wanting more frequent contact, and more than one quarter (28.3%) of young people reported having difficulty contacting their CSO when they had needed to (CCYPCG, 2012a).

Further analyses reveal important associations between satisfaction with contact and other survey variables. For example, those who reported being satisfied with how often they saw their CSO, were able to contact their CSO when needed and had a CSO who was helpful and listened to them, were more likely to report greater levels of wellbeing; being listened to; being involved in, and/or informed of, decisions about their lives, and confidence in the Department following through on its promises (CCYPCG, 2013c)[14].

Community Visitors: Children's and young people's responses to the *Views* surveys also provide invaluable insights into the important and trusted role that CVs play in their lives. Children and young people overwhelmingly report that their CV listens to them, that they talk to their CV about things that are important to them and that their CV has been able to help them with something (CCYPCG, 2012a).

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[13] Unpublished analyses

[14] Apart from analyses on wellbeing, other analyses are unpublished.

Analysis of young people's comments reveals that the types of help most commonly provided by the CV centre on family contact, listening, friendship, understanding and doing things together, and following up on departmental issues. Some examples of these comments are:

- *Contact with my real family.*
- *When I didn't want to see Mum and letter to magistrate.*
- *Seeing my brothers.*
- *Tells CSO I want less contact with Mum.*
- *She is my friend, she listens to me.*
- *She helps me with my problems.*
- *Making me feel better in foster care.*
- *Trying to sort out my case plan.*
- *Get things through the department.*
- *Contact with CSO when needed.*

Findings from the 2011 and 2012 *Views* Residential Care surveys revealed similar findings. Furthermore, analysis of data found that young people's anticipated willingness to talk to their CV about problems increases with the length of time they have known their CV and with the frequency of visits. Young people who reported knowing their CV for more than six months compared with those who reported knowing their CV for a shorter length of time, and young people who reported seeing their CV on a monthly basis compared with those who reported seeing their CV less often were more likely to:

- regard their CV as available when needed
- regard their CV as "easy to talk to", "a good listener" and "very caring", and
- anticipate talking to their CV about problems arising either in their placement or in relation to their child safety officer or the Department, and
- rated their CV's helpfulness more highly (CCYPCG, 2013d).

These findings lend weight to claims from previous qualitative studies about the critical importance of investing time in building trusting, supportive and, ideally, enduring relationships between children in care and their advocates in the interests of safeguarding children and ensuring their participation and voice (e.g. Bell, 2002; Boylan & Braye, 2006; Boylan & Ing, 2005; Dalrymple, 2005; Knight & Oliver, 2007; Munro, 2001; Rolfe, 2008; Pithouse & Crowley, 2007).

It suggests that having access to an advocate is not necessarily enough when children are experiencing problems with their care – they need to be able to trust that the advocate cares about them, respects their views and opinions, will understand their concerns and will represent them effectively without making their situation worse.

3.3   Audit approach

An audit approach should not replace visits by a child safety officer or Community Visitor. Audits should be used to augment the information gathered from visits to individual children and are a useful method of systematically reviewing and reflecting on practice across the system.

Often the aim of an audit is to confirm that the claims being made about practice are accurate (for example that practice aligns with policy) and to identify where improvements can be made. The

focus is usually on a specific issue (for example, information provision to carers) and a specific time period using pre-determined audit criteria.

A perceived strength of an audit approach is its objectivity. It is a good way of getting 'a second opinion' about practice, and can engender confidence about any claims made if the audit produces high quality data. Repeated audits over time (such as biennial) can help to monitor trends. Audits can be very helpful at the systems level by providing practical information to build service capacity.

The quality of the audit depends on the methodology used (e.g. desk audit, file reviews), elements evaluated (e.g. process compliance, documentation, the application of standards, outcomes) and the collection of sufficient and appropriate data to enable conclusions to be made. Problems can arise if:

- the counting rules or definition of what it is in scope is not consistent – for example if reviewing incidents of abuse, and abuse is not consistently defined, it is not possible to monitor trends, or
- the methodology results in misleading conclusions – for example using file reviews to audit information provision to carers which in practice is not recorded on the file.

In regards to the latter point, the QCPC Inquiry report (2013: 428) notes that audits can sometimes give little insight into causal factors contributing to practice behaviour and therefore may wrongly assume that a lack of compliance is due to poor practice and make recommendations accordingly. The report proposes there would be greater value in having an understanding of why a policy has not been complied with (which may be based on a sound practice decision) as this may lead to different, and more effective, solutions.

Question 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?

This issue has been considered in the past three inquiries into the child protection system in Queensland. The CMC Inquiry (2004) recommended that the Department should have responsibility for licencing/approving OOHC providers. The QCPC Inquiry (2013) has also determined that responsibility for regulation should rest with the Department.

One of the perceived weaknesses of the Department having regulatory responsibility for OOHC providers is that the Department also has a business interest in the work of providers which can conflict with their responsibilities to promote the safety, wellbeing and rights of young people in care. The QCPC Inquiry report (2013) however argues that other departments operate with potentially conflicting service delivery and regulatory functions.

No matter which regulatory model is adopted the Queensland Children's Commission advocates for a child-focused independent oversight mechanism to identify early alerts in the system.

Question 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?

General training needs have been previously discussed in this submission at 1.1.3 in response to Question 1 (see page 7). The following discussion specifically focuses on training about sexual abuse.

5.1   Sexual abuse

Training programs need to be comprehensive, covering the definition, recognition of, and appropriate response to sexual abuse. Programs should include a definition of sexual abuse which focuses on both contact (e.g. fondling, kissing, sexual intercourse), and non-contact (e.g. exposure to pornography, exhibitionism) abuse.

Trainees should also be alerted to the signs and symptoms that may be indicative of sexual abuse or grooming and how these may vary given the developmental status, or previous experiences of the child. This facet of training is particularly important as children who are sexually abused are more likely to come to carers' and workers' attention because of their behaviour, rather than as a consequence of disclosing their victimisation (Cossar et al., 2013). Hence, trainees should also be encouraged to report any suspicions of sexual abuse early to enable early intervention to stop the abuse and provide the child with necessary therapeutic support.

Given many children's reluctance to report abuse, training programs also need to alert participants to the barriers to children's disclosure. Firstly, some, and particularly younger, children may not recognise that what they are experiencing is abuse. Secondly, as a result of their previous experiences, some children may not be confident they will be believed, or that they will receive assistance if they do disclose (Cossar et al., 2013). Further, perpetrators often use threats and/or intimidation to encourage children's silence about their victimisation (Budin & Johnson, 1989; Gilgun & Connor, 1989).

Therefore, carers, caseworkers and agency staff cannot unduly rely on children to be willing to discuss their abuse. However, by building a trusting relationship with the child, carers, caseworkers and agency staff can increase the likelihood the child is willing to trust and to feel comfortable in discussing their victimisation (Cossar et al., 2013).

It is also essential for trainees to have knowledge of children's age-appropriate sexual behaviours. Adults who understand healthy sexuality can recognise inappropriate sexual behaviours and can model being comfortable talking about related topics so children are more likely to feel they can disclose any concerns they have (Sanderson, 2004).

If children do disclose abuse, it is important that trainees are aware of the importance of providing an immediate supportive response which enhances both the short, and long-term benefits for these children (Cossar et al., 2013). Hence, there needs to be clear, documented procedures to be followed when children disclose.

Training also should cover children's possible responses to abuse such as hypersexualised behaviours and also alert trainees that some children may have positive responses to abuse (i.e. sexual touch may 'feel good') (deYoung, 1988; Whetsall-Mitchell, 1995; Wurtele, 1987).

There are also particular challenges in providing training about sexual abuse related to the over-identification of sexual abuse and possibility of false allegations. While trainees should be encouraged to be attuned to children's behaviour, training also needs to achieve a balance between sensitising trainees to the possibility a child may be sexually abused without leading to the over-attribution of signs and symptoms of distress as always indicative of sexual abuse.

Hence, trainees need to clearly differentiate behaviours that indicate a child is stressed (e.g. nightmares, anxiety) which can occur because of abuse or other stressors from those behaviours that are more directly linked to sexual abuse (e.g. hypersexualised behaviours, age inappropriate sexual behaviours) (Sanderson, 2004). Lastly, programs need to discuss managing false allegations.

5.2   Priority for training about sexual abuse

While children in OOHC are more vulnerable to sexual abuse, they are also more vulnerable to other types of maltreatment. Therefore specific training about sexual abuse should be delivered as a component of training about child maltreatment.

Question 6.

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

6.1   Adequacy of training for carers

As noted at 1.1.3 in response to Question 1, many carers in Queensland are still not receiving the comprehensive training they need to provide placements that match the needs of children in their care. This is despite recommendations for improved carer training made following the CMC Inquiry (CMC, 2004).

For example, many carers have inadequate knowledge about normal sexual development so they are often not identifying children's inappropriate sexualised behaviours and consequently children are not receiving the therapeutic support they require.

Carers require ongoing training, with more specialised training available for those who are caring for children with special needs or challenging behaviours. Further, carers should be able to access additional, specific training targeted to addressing the child's behaviours if they become aware a child has additional, unexpected needs after they become more familiar with the child in their care (e.g. discovering the child has been previously sexually abused).

Carers who are dealing with children with severe behaviour problems or intense trauma reactions as a consequence of their previous experiences may also benefit from regular professional supervision to support them in managing the child's behaviours and help increase the likelihood of a stable, safe and beneficial placement for the child (Barton, et al. 2012; Sullivan, Faircloth, McNair, Southern, Brann, Starbuck et al., 2011; Cairns, 2002; Hughes, 2006). Failing to provide adequate training for carers not only disadvantages the children in their care but also makes it difficult to retain carers in the system.

6.2 Adequacy of information

Despite legislative amendments to the *Queensland Child Protection Act 1999* to enable sharing of information with carers enacted in response to recommendations of the previous CMC Inquiry (CMC, 2004) information provision to carers is still not always adequate.

Departments continue to use confidentiality as a reason for not sharing information between departments or with carers and it appears that some departmental officers are unaware of their legislative obligations to share information about a child. As noted earlier in this submission (at 1.1.5, see page 9), such failure to provide carers with comprehensive information about the child placed in their care has contributed to serious negative outcomes for other children in these homes.

It is clear that legislative provisions alone are not effective in ensuring that carers are provided with the comprehensive information they require to provide a safe and beneficial placement for the child and to ensure the safety of other children in the home.

To improve compliance, departmental officers require training in their legislative responsibilities and appropriate methods for sharing information. There is also a need for ongoing independent oversight of departmental compliance with legislative information sharing provisions (e.g. audits of departmental records, surveys of carers).

Question 7.

How should the rate of sexual abuse of children in OOHC be determined, noting that the National Standards for OOHC 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?

7.1 Determining the rate of sexual abuse

Firstly it is necessary to have a standardised definition of sexual abuse across jurisdictions and it would be beneficial to break the definition into types of abuse. For example (i) non-contact sexual abuse such as making sexual remarks to a child or showing a child sexual images and (ii) contact abuse e.g. inappropriate touching or sexual activity. The definition needs to be consistently applied.

Secondly, rate should be reported not just number (as currently happens in Queensland) and there needs to be consistency in data collection to allow for comparison of rate over time.

Thirdly, data collected should enable rate to be disaggregated by:

   – type of abuse
   – placement type
   – who was the abuser and their relationship with the child.

In Queensland, data extraction issues results in some of the reported abuse being identified against the carer even though they are not always the perpetrator. However, it is fundamental to have an accurate understanding of the person who commits the abuse. Responses can then be tailored to abuse that has already happened and appropriate measures taken to prevent abuse going forward.

A further complicating factor is that in Queensland children who witness the abuse are often identified as subject children – however they require a different response than the victim. Data systems need to identify the actual victim. Child perpetrators can be considered as victims as well.

7.2   Would a form of exit interview assist?

The Queensland Children's Commission has serious doubts about the value of capturing relevant information on an exit interview and advocates instead for efforts to be focused on early identification, providing avenues that support disclosure and reporting. Retrospective reporting also places heavy demands upon children's capacity to accurately recall information and events and could exacerbate existing trauma. Data capture on exit would require a clearly articulated process for responding to and reporting disclosures and providing assistance to the child.

7.3   Ascertaining whether information is resulting in changed practices

As the authorities responsible for placing children, the Departments in each state and territory should be closely monitoring incidents and trends and mapping them against relevant child protection changes in practice to see what may be having an impact. As an important cross-check, the data should also be made available to an independent external oversight body for auditing and monitoring purposes. In the Commission's experience there can be significant discrepancies between how the data is interpreted and reported by the different parties.

Other methods which could usefully gauge if information on sexual abuse is resulting in changed practices include:
- assessment reports by Community Visitors and analysis of changing rates in issues of concerns raised, and the types of issues raised
- longitudinal research with children and carers; for example, by conducting surveys on practice, and
- monitoring changes in the rates and types of complaints over time and mapping against practice changes.

Question 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?

8.1   Inferring abuse and enhancing children's participation in disclosure

As noted in the response to Question 5, children who are sexually abused are more likely to come to carers' and workers' attention because of their behaviour, rather than as a consequence of explicitly telling someone. However, care needs to be taken when using behavioural changes to infer sexual abuse as many of the behaviour changes may also occur because of other stressors in the child's life and their age. A further challenge with children who have already suffered previous sexual abuse relates to differentiating if behaviours relate to previous experience or are indicative of current abuse. Hence, behaviour change should be regarded as requiring further investigation about the source of the child's problem rather than clearly indicative of sexual abuse.

Research would suggest that one of the most useful approaches to increase the likelihood of children's participation in disclosure is having a trusting relationship with a professional who the child perceives is supportive and effective. A recent study in the United Kingdom, commissioned by the Office of the Children's Commissioner, has found that if a trusted professional responds sensitively and shows concern for the child they may then begin to talk about their underlying problems (Cossar et al., 2013).

Young people in the study described how talking things through over time and receiving help from a trusted professional prompted recognition of abuse and telling. Not surprisingly, their past experiences of professionals were found to influence their level of comfort and willingness to trust and talk to other professionals. Based on the study's findings, the researchers developed a framework for understanding recognition, telling and help from a child's perspective which may be helpful for practitioners working in the OOHC environment.

Question 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?

Note: Information provided in the Royal Commission's Fact Sheet, 9.1 states–

> "*New South Wales is the only state or territory that has third party monitoring and oversight of the handling of reports of sexual abuse*".

By way of clarification, the Queensland Children's Commission does have an oversight and monitoring capacity, although the Commission does not oversee the handling of each report of sexual abuse. The Commission has conducted two audits of the department's handling of reports of sexual abuse. The audits examined the pre-placement processes (e.g. carer approval), investigation and the outcomes (e.g. did the young person receive therapeutic services).

Response to Question

Given the number of cases involving sexual abuse allegations is usually small there may be capacity for an external body to scrutinise every case which has already undergone an internal (departmental) review. An external body comprised, for example, of a panel of experts from the fields of paediatrics, forensic pathology, investigations and child protection, could provide an independent expert assessment of the handling of sexual abuse allegations.

If reported cases of sexual abuse were further scrutinised by an independent body, departmental handling of allegations may be enhanced. For example, the Department may introduce measures to ensure responses to specific cases are thorough and well documented. The independent body could systematically look at issues and make recommendations.

A possible weakness of an external case review process is the danger that the whole child protection system can be moulded by a small number of cases which ended badly, to the detriment of the vast majority of children. Moreover reviews which focus solely on shortcomings and human error can have a tendency to propose more and more procedural and administrative compliance rather than examining the context in which the errors occur and identifying the underlying factors of poor outcomes (Munro, 2005; Munro, 2011).

There are some things that can be done to avoid these pitfalls, such as setting up the review process with explicit terms of reference that require the review to go beyond the narrow circumstances of individual cases and procedural compliance. It can also be beneficial to undertake case reviews for various types of cases and not just cases that went wrong – to identify good practice so positive elements of the system are not undermined by attempts to respond to critical incidents.

Question 10.

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

A number of inquiries into child protection in several Australian jurisdictions have examined the strengths and weaknesses of different oversight mechanisms for keeping children safe in OOHC. The conclusions arrived at have in part reflected the standards of probity, accountability and operational sophistication within the department responsible for child protection at that point in time (QCPCI, 2013). In Queensland for example, the QCPCI report (2013: 400) notes that the 1999 Forde and 2004 CMC inquiries:

> "*described the then Department of Families as at an embryonic stage of governance capability, with few reliable supervisory mechanisms, poorly developed and inadequate complaint mechanisms and no visible links between performance measurement on the ground and senior executive's goals and objectives.*"

Both the Forde and CMC Inquiries determined that in order to keep children safe there was strength in oversight from external bodies (as well as improving internal governance) and made recommendations to this affect. Consequently, the Queensland Children's Commission was given powers and functions to oversight the services provided to, and decisions made by the Department in respect of, children in OOHC. In effect, the Commission became the specialist independent oversight body for the OOHC system.

The Queensland Children's Commission provides oversight by:

- regularly visiting all children in OOHC to verify they are safe and receiving the services necessary to meet their individual needs
- receiving complaints in relation to service delivery to children
- monitoring, auditing and reviewing services provided to children in OOHC
- providing secretariat support to the Child Death Case Review Committee and
- maintaining a register of the deaths of all children in Queensland.

In terms of keeping individual children safe from sexual abuse, the Queensland Children's Commission would suggest that the most effective early detection mechanism in its suite of functions is the Community Visitor program. However, the combination of functions drives systemic monitoring and improvement which in turn help keep children safe. Enhancing children's overall safety is important as 'unprotected' children are more vulnerable to being targeted for victimisation.

The strength of having all of these oversight functions under the auspices of one body is the ability it provides to "join the dots". It has enabled the Queensland Children's Commission to develop an overarching, outcomes-based oversight framework which has safety and security in care as a key objective. The Commission uses this framework to report annually to government and the general community on the performance of Queensland's child protection system. The latest report is available (CCYPCG, 2013a).

From experience, the Commission would strongly argue that effective external oversight requires independence – in perception as well as actuality – and the legislative powers to enable the oversight body to carry out its functions. Independence provides credibility and objectivity and lowers the risk of interference, while having a legislative basis for functions provides the necessary powers and authority. For example, the Department is obliged to provide information to enable proper oversight and to consider any resulting recommendations.

Since 2004, the Commission's oversight has revealed systemic weaknesses, raised departmental awareness of deficiencies and contributed to capacity building by the Department and other agencies. These benefits are acknowledged in the QCPCI Report (2013: 410). Moreover it appears that substantiation of sexual abuse has reduced since the Queensland Children's Commission has had responsibility for oversight.

On the other hand, perceived disadvantages of a specialist external oversight mechanism include duplication and cost and, it has been argued: "*can divert resources from the agencies delivering the services*" (QCPCI, 2013: 411). It might also be argued that changing a system from without occurs less quickly than change effected from within.

Different oversight mechanisms for Queensland's child protection system were again examined by the recent QCPC Inquiry (2013). The Inquiry concluded that the Department today is in a better position to provide internal oversight than it was at the time of the CMC Inquiry, having developed internal controls and mature corporate governance and performance management arrangements. Consequently the QCPI Report recommends many of the external oversight functions which currently sit with the Queensland Children's Commission be devolved back to service delivery agencies or generic oversight bodies such as the Ombudsman. The government has yet to respond.

In other jurisdictions, such as Victoria, oversight of the OOHC system is going in a different direction with the establishment of the Victorian Commission for Children expanding on the former Child Safety Commissioner's oversight functions. Clearly, determining the strengths and weaknesses of oversight mechanisms requires consideration of a range of issues that are not always static, and there will likely be different views.

Question 11.

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

If reporting is delayed, then it is harder to investigate, but if good records are kept over time (including observations of the child) a successful investigation is more likely. Without accurate and detailed record-keeping it will be difficult, if not impossible, to investigate claims of historic abuse.

This issue highlights the need for thorough records to be made of each visit by a caseworker or a Community Visitor to a child in OOHC. Contemporaneous records can help to identify who the perpetrator may have been and the circumstances surrounding the alleged abuse. There is also a strong argument for centralised records of child sexual abuse.

**Some of the questions asked in the *2012 Views Survey of Young People in Residential Care*
which help to assess children's subjective sense of safety.**

--- Do you feel safe here? Yes/no
--- *How often do you feel safe here?* (10 point scale with one end being never feel safe and the other being always feel safe)
--- *What makes you feel safe here?* (open-ended)
--- *What makes you feel unsafe here?* (open-ended)
--- *Some young people here make me feel nervous* (very true/a bit true/not at all true)
--- *Some young people here are bullies* (very true/a bit true/not at all true)
--- *Workers here often fight with each other* (very true/a bit true/not at all true)
--- *I'm scared of breaking the rules because of what happens* (very true/a bit true/not at all true)
--- *When young people behave in the wrong way, the workers often yell at them* (very true/a bit true/not at all true)
--- *I'm careful about what I say to workers because of how they may react* (very true/a bit true/not at all true)
--- *There's often fighting between young people in this place* (very true/a bit true/not at all true)
--- *Do you get along with the workers?* (all the time/most of the time/not very often/never)
--- *Do you get along with the other young people?* (all the time/most of the time/not very often/never)
--- *Do you have enough privacy?* yes/no
--- *The place feels warm and friendly* (very true/a bit true/not at all true)
--- *Young people are made to feel welcome when they come into this program* (very true/a bit true/not at all true)
--- *When kids fight, the workers help calm them down and show them how to sort things out* (very true/a bit true/not at all true)
--- *Young here get try to help each other with problems they are having* (very true/a bit true/not at all true)
--- *I get enough time on my own with workers to talk about things* (very true/a bit true/not at all true)

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