Children in Care Collective Forum

Introduction

The Children in Care Collective is an interagency think-tank formed in 2016 by a number of out-of-home care service providers and leading experts in working with children with complex needs across Australia. It was formed to share experience, discuss best practice informed by research, provide advocacy and learn from policy experts in out-of-home care. The Collective works collaboratively and proactively on a range of issues for children and young people with complex needs living in out-of-home care.

The Children in Care Collective holds forums for leaders in the sector. Past forums and workshops include:

- Professor Judy Sebba, Director of the Rees Centre for Research in Education and Fostering at Oxford University, discussing her research on the *Motivation to foster, peer support for foster carers and the educational progress of children in OOHC* (July 2017)
- Martha Holden, Senior Extension Associate, Project Director, Residential Child Care Project, Cornell University presented on *Children and Residential Experiences (CARE) - Creating Conditions for Change* (September 2017)
- In partnership with The Sydney Policy Lab, University of Sydney, the Collective delivered a policy forum at which academics, service providers and bureaucrats from across Australia discussed critical policy topics in out of home care (March 2018)
- In November 2018, the Collective hosted a forum on *Children in care with harmful sexual behaviours*. Presentations by Professor Helen Milroy, Dale Tolliday and Dr Robyn Miller were followed by a panel discussion of audience questions.

On 16 July a workshop was held about the practical issues of caring for children who are in out-of-home care and who have with harmful sexual behaviours. The speakers were:

Professor Simon Hackett, Professor of Child Abuse and Neglect at Durham University and Chair of the National Organisation for the Treatment of Abuse (NOTA) in the UK and Republic of Ireland

Professor Rachel Skinner, Professor in Paediatrics & Child Health in the Discipline of Child and Adolescent Health, Sydney University, Adolescent Physician at the Children's Hospital Westmead, Deputy Director of Wellbeing, Health and Youth, NHMRC Centre for Research Excellence in Adolescent Health and Senior Clinical Advisor in Youth Health and Wellbeing at NSW Ministry of Health

Peter Goslett, registered psychologist and Head of Operations and Advocacy for My Forever Family NSW.

Caring for children with harmful sexual behaviours (HSB) in out-of-home care

Below is a summary of the panel discussion between Dr Robyn Miller (RM), Professor Simon Hackett (SH), Professor Rachel Skinner (RS) and Peter Goslett (PG)

Note: the answers to questions are supplemented with text from the presentations where this clarifies the conversation

What's the most helpful professional therapeutic tertiary intervention?

This question arises from Prof Hackett's talk and is asked because carers, for a whole range of reasons most of which are entirely understandable, normally want a quick referral to specialist professionals to deal with an acute situation and it is difficult to convince them that in the longer term it will be the power of their supportive relationship with the child and the power of their attachment that will be the biggest help.

SH: I need to preface my remarks and clarify a point that I made in my talk which is that for many children in the research group of my study[1], therapeutic work was important and the experience of good therapy was pivotal. Having said that neither the qualitative research nor discussions in the literature indicate which therapeutic approach is the most important – the modality doesn't seem to make a difference. The study did confirm that what seems to be the most powerful and significant agent for change was someone investing time, holding and containing them and helping them get back in touch with different aspects of their worlds. Unexpected people provided this quality of relationship.

Another consideration is that we rush too fast to refer children with HSB to specialist services. Such referrals are important, especially for those at the high end of the continuum of behaviour, but those in the middle or low end need something a bit different, and associating these children with a specialist service for sexual abusers can in fact be counterproductive.

The approach depends in part on whether HSB is being treated as a symptom or a cause. We can often stop HSB but what underpins the behaviours is a complex issue which probably needs broader thinking about what helps and supports young people with what is, effectively, a symptom.

How best do we ensure there are supports for children in our care to have normal childhood and adolescence, particularly given that the child and the carer may be isolated once any information becomes known about the child's behaviour? And, noting that the experience of many OOHC providers is that it is difficult to find many GPs outside of major

[1] Helen Masson, Simon Hackett, Josie Phillips, and Myles Balfe (2013) 'Looking Back on the Long-Term Fostering and Adoption of Children with Harmful Sexual Behaviours: Carers' Reflections on Their Experiences' *British Journal of Social Work 1–18;* Helen Masson, Simon Hackett, Josie Phillips, and Myles Balfe (2013) 'Looking Back on the Long-Term Fostering and Adoption of Children with Harmful Sexual Behaviours: Carers' Reflections on Their Experiences' *British Journal of Social Work 1–18*

metropolitan centres who will regularly treat these children, how do we find better services for them?

RS: It is really important that all children are given the opportunity to go through all the developmental stages and normal life experiences that adolescents need in order to become functional adults. Adolescence is a time of great change, with much development and physical growth, and important social relationships.

The best service for a child depends on the nature of the issue that has led them to engaging in HSB. From experience with vulnerable young people generally, a multidisciplinary team approach is needed. GPs may not have access to allied health professionals to work as a team, or specific training in adolescent health, let alone more complex issues. Much work is needed by the medical profession to provide training to medical practitioners to understand adolescent health and development generally and provide better services to them. This would go some way to improving services. NSW Health does provide some services for young people that are specifically designed, being youth health services with a multidisciplinary model, though not in every location. We would then also talk about isolation as we really need to be engaging in experiences of young people or we will compound issues.

SH: For some young people with HSB, social isolation has been one of the underpinning conditions that have contributed to the behaviour in the first place. If as a professional system, we put young people in situations where this is compounded, we are replicating the contextual factors that have influenced them in the first place rather than challenging these factors. For all people, connectedness and belonging is important for self-esteem.

It is very important for these young people to have positive intimate sexual experiences that are not defined by abuse. Our orthodox approach is to take them away from this opportunity and think any kind of relationship they have in that context is likely to be risky. Sometimes we choose to manage them in a way that undermines their ability to make these kinds of relationships. This is a critical point.

Often when we do safety planning, we're particularly focused on managing their relationships with other people in the family or in the community. Perhaps we should be thinking more about their safety and how we can help them exist in the contexts in which they are connected in safe and healthy ways. This is one aspect of safety planning that's not often advanced.

RM: It is important to remember that symptomatic behaviours have points of transition. Professionals are perhaps too risk averse. There is a tension between overly optimistic practice and overly risk averse practice: when do you have to tell the new school, swimming instructor, carers at sleepovers what behaviours have occurred? There are issues about privacy and not demonising these children but at the same time ensuring our duty of care to make sure all children are safe. This is often like walking a tightrope.

PG: What causes the behaviour? We need to be careful to manage any possible impact of the stigma and isolation of being in out-of-home care which could lead to a range of acting out behaviours. Carers and kids in care are invariably isolated and this impacts on their ability to continue caring, as well as on the recruitment of new carers.

SH: HSB is not a thing. It is a diverse set of issues that are categorically not related to each other. So, children need very careful assessment and understanding of needs and risks and a very tailored individualised response rather than one blanket liberal or risk-averse approach. In the UK context, the big challenge is educating professionals about this issue so they don't take the blanket approach of squashing everything to do with that child's sex, sexuality and sexual behaviour - which is probably counterproductive anyway.

This means we need better assessments, better tools, a range of services, a balanced approach – services commensurate with the behaviour demonstrated.

Adolescents and risk taking: to what extent are the behaviours of these children out of step with notion of adolescent interest in sex and risk taking? Some adolescents are going to get it wrong and not because they have any underlying predilection for being abusers of children, but just because they get sex wrong. Don't we need to educate and support them about how to do it properly and correctly?

RS: Education about normative sexual behaviour is essential. All young people engage in sexual behaviour of some description and it's important they do so and counterproductive to prevent it completely – although the balance is difficult. Don't leave them entirely unsupervised but understand what's normal and should be supported. It's probably not a big part of carer training – what is normal sexual behaviour and exploration, the importance of romantic relationships, that young people need to practice when growing up. There's no focus on this in adolescent medicine; the focus is on outcomes, the worst outcomes, e.g. teenage pregnancy. Healthy developmental steps – and the space to develop – is really important.

Looking at some of the data presented today, are there particular factors that make A&TSI and CALD children particularly vulnerable to risky sexual behaviours?

RS: Having sex at an earlier age can indicate risk and there are complicated reasons why young people might start their sexual experience at a younger age. Generalising, Aboriginal children are not more likely to have sex at a younger age, but they are more likely to experience the adverse outcomes e.g. higher rates of STI and teenage pregnancy. This is probably more about cultural norms and lack of services.

There is no good Australian data on population level outcomes for CALD young people. Vulnerability may be due to limited access to services or education, or there may be a great stigma about sexual activity which could inhibit appropriate healthy sexual behaviour.

Vulnerability is not just about sex and early sex – mental health, drug and alcohol use and childhood trauma can also indicate risk behaviours, including sex.

SH: In the UK we talk about black and minority ethnic young people rather than CALD. A young black person who has demonstrated HSB is far more likely to be convicted or to find themselves in custodial or locked residential settings, is less likely to be supported in the community and less likely to have access to specialist services. These are the other ways in which racists systems compound the issues for children from ethnic and minority backgrounds.

Referring to the UK police authority data in Professor Hackett's presentation, 1) Does the police force in question take a community/education/universal approach? 2) Were there organisations that were supporting carers and workers in a way that was particularly effectively, and what were they doing?

SH: It's not uncommon for about half of all reports of sexual abuse in any police authority to relate to children and young people. Only a tiny proportion make it to action in the criminal justice system – most behaviour is managed in the community. However, there has been a significant increase in cases coming to the attention of the criminal justice system. Much of this can be attributed to children's online sexual behaviour – what they do is visible in a way it once wasn't. There has also been a huge explosion in reports from schools, particularly about peer based sexual behaviour.

There are some quite innovative practices but the picture across the UK is very patchy – and services are often maxed out. Of the 511 cases in the study, the vast majority were not given any kind of service. Not all of them needed a service, but it's far from clear that proper assessment had indicated who needed a particular kind of service. This applies to those who were victimised as well. Access to services can be pretty random.

In relation to the very young age of children being reported as committing sexual crimes, these are likely to be misattributed abuse stories. The younger the age of the so-called suspect, the more likely the child has been abused and lost in the system.

What evidence is there of particular teaching of practical behaviour management and safety skills that resonates with carers?

SH: Hesitant to say anything definitive about what works, but we do know quite a bit about behaviour management generally and strategies for managing challenging behaviour. Those interventions, together with good parenting skills, are likely to work with children's sexual behaviour as much as with their general behaviour. We need to question why we isolate sexual behaviour as being fundamentally different form other aspects of a child's presentation and think we need something unique to manage it.

One aspect that does need work with parents and carers is how to support a child beyond the confines of the house and into the community. Lack of supervision and guidance about navigating peer groups is significant.

There is a danger for professionals and carers immersed in dealing with HSB that they lose sight of what is normal and healthy. It is always possible for a carer (or, indeed, any parent)

can catastrophize about things which are really normal, like evidence of masturbation, and think this is the end of the world because it's risk behaviour. Because of anxiety about what they are managing at home, they can be off the scale risk averse and very relieved to find out what is normal.

The training proposed by MFF to assist carers understand about sexual behavior and children and young people in OOHC, should include information about sexual development, how you support children in their sexual development, and sexual education. It is critical to equip carers not to lose a sense of balance about what's normal.

RM: MacKillop's action research partnership with University of Melbourne is looking at what works in terms of prevention, including empowering kids with knowledge about normal development, prevention of dating violence and sexual exploitation for example. And you think you've trained your carers (in residential care) but then you find you haven't because they're all a bit embarrassed to talk about sex. It's someone else's job to 'do the sex ed'. So one aspect is training carers to feel confident to use the words like penis and vagina, and to talk about condoms and bring out the resources at the opportune time. We call these 'brave conversations.'

Do agencies need to focus on training staff to conduct basic assessment and screening so support can be provided for lower level behaviours without requiring specialist assistance?

SH: there are tools for screening different levels of sexual behaviour, e.g. traffic light tools that emerged from Australia and there's been some progress on this. In UK, there is, for example the Brook Sexual Behaviours Traffic Light Tool.

The key, however, is having a system where assessment processes can be matched with levels of concern. Some of the more forensic assessment tools in this area are only derived from research on those at the higher end of the continuum. It would be wrong and inappropriate to use them on children whose expressions of problematic sexual behaviour is at the lower end of the continuum. They probably only need good general assessment, good developmental assessment. We've got some tools – the question is matching them to the levels of behaviour appropriately – finding the right tools for the presenting problem.