FPQ Submission to the Queensland Child Protection Commission of Inquiry 2012

Children and young people : Problem sexual behaviours, access to sexual health services, access to sexuality and relationships education

This second submission from FPQ to the Commission of Inquiry addresses two key areas related to the terms of reference:

Effectiveness of Queensland's current child protection system in the following areas.

i. Whether the current use of available resources across the child protection system is adequate and whether these resources could be used more efficiently.

iv. The transition of children through, and exiting, the child protection system

The foundation of this submission is drawn from FPQ's work over 40 years in supporting families and communities throughout Queensland and from the literature review undertaken in 2008 to establish an evidence base for responding to the sexuality and relationships needs of children in care. The full report is available from www.fpq.com.au/library/research.php

Summary points

Young people in out of home care have suffered a great deal of trauma from abuse, neglect, or simple separation from family, friends and community. They are often trying to survive in a system that is suffering from overload. [Sexuality] … is an issue which demands aggressive leadership and a long term commitment toward courage and change.

(Mayden et al, 1995, p. 15, cited in Brennan (2008)

Children and young people in care are first and foremost children and young people. There is clear evidence supporting the need for access to sexual health services, comprehensive sexuality education and clear communication to meet the sexuality needs of all children and young people. There is extensive evidence to indicate that children and young people in care, due to the very reason they are in care and their experience of care, have additional needs and require support to have their needs met. They are consistently represented throughout the literature as enormously at risk.

Compared to other young people, children and young people in care have:

- higher rates of earlier onset of sexual activity
- higher rates of STI's and earlier pregnancy and parenting
- higher rates of sexual abuse including participation in sexual exploitation through sex work
- higher rates of problem sexual behaviours and sexual behaviours that cause concern
- less recorded access to sexual health services and sexual health information.

There is a substantial evidence base that underpins the implementation of effective strategies to meet the sexuality and relationships education and information needs of children and young people in care. Specifically an effective response requires the development and implementation of policy and guidelines, training and supervision and education programs for young people and their carers.

Three specific issues are examined in more detail below:

1. **Problem sexual behaviours**

What appeared to be necessary was advice and support for the caregivers to work actively with these young people to teach them appropriate interpersonal boundaries, to show them how to give and receive affection in non-sexual ways and to involve them in activities which would enhance their self esteem in more socially appropriate ways.

(Farmer et al, 2003, p. 108)

Knowing how to identify and respond to sexual behaviours in children and young people helps adults to support the development of healthy sexuality and protect young people from harm or abuse.

Sexuality is integral to a person's identity and develops throughout life. It is natural for children and young people to express their sexuality through their behaviour. Healthy sexual behaviour may be expressed in a variety of ways through play and relationships and relates to the stage of development. Sexual behaviours are not just about sex. They include any talk, touch, questions, conversations and interests which relate to sexuality and relationships. When children or young people display sexual behaviour which increases their vulnerability or causes harm to another, adults have a responsibility to take action to provide support and protection.

The Crime and Misconduct Commission (2004) reported that 11% of the children and young people in care in Queensland had problem sexual behaviours. Less than 2% of this group were identified as "sexual offenders" (p. 2). In *Managing sexually abused and/or abusing children in substitute care,* of the 36 young people in the study, half had shown "abusing" sexual behaviours (11 boys and 7 girls) (Farmer, 2003, p. 103). Over two thirds of the young people in the study were described by their caregivers as displaying sexual behaviours that were of concern (2003, p. 104). In *Abuse of Children in Foster and Residential Care,* Hobbs et al (1999), stated that the prevalence of emotional, behavioural and developmental problems among children in foster care is well documented and that common problems cited include sexual behaviour (p 1247).

There is a clear rationale for supporting children and young people in care with sexual behaviour problems, as well as their carers and service providers. The literature states that all who come in contact with children who have sexual behaviour histories have a right to be safe from harm. This includes other children in care, siblings, the biological children and grandchildren of foster and kinship carers, and all children and adults in general (Farmer et al, 2003; Hobbs et al, 1999; Family Planning Queensland, 2006)

All involved in the care and protection of children and young people require a framework to identify, understand and respond to sexual behaviours. A clear shortfall within the current system is the absence of uniform uptake of evidence based decision making frameworks. For resources to be mobilised effectively, clear differentiation between behaviours which are developmentally normal and those that are of concern or harmful is required.

One of the available tools to assist with this refinement is the *Traffic Lights* framework developed by FPQ in 2006. This provides both an evidence based conceptual framework, in

addition to practical and specific intervention strategies. It has the potential to resource both professionals and community carers with skills and knowledge in better responding to the needs of children and young people in at risk situations, as well as those in the care system.

2. Access to sexual health services

Usually, by the time professionals took action, such as arranging a visit to a Family Planning Clinic, it was too late and the pregnancy was a fait accompli.

(Farmer et al, 2003, p. 106)

Some of the reasons for poor access to sexual health services for children and young people in care included: numerous placements, not knowing new communities, unfamiliarity with service providers and young people not knowing people who they felt comfortable seeking sexuality advice from (Farmer, et al, 2003; Mayden, 1995; Polit et al, 1987; NCB, 2005). Another issue that was seen as a serious problem was the poorly defined role of foster parents and the issue of who should assume responsibility for the sexual health of a young person; the foster parent, the caseworker, the biological parent or the school system (Becker et al, 2000; Farmer, 2003).

Becker et al (2000) found more than half of the young people exiting child protection were neither offered, nor did they use, sexual health services while in care. Farmer et al (2003) also reported that care providers and service providers experienced a great deal of confusion, fear and lack of power with regards to whose responsibility it was for helping young people to access sexual health services. They reported that care providers did not wish to be seen as condoning sexual activity especially for young people under the age of legal consent (Farmer et al, 2003, p. 106).

In 2011, FPQ had direct experience of the confusion present in the current system when approached for advice by a general practitioner working in a remote location of Queensland. The GP had been asked by a case worker to provide contraception for a 14 yr old. The difficulty encountered in this situation was inconsistent interpretation of the policy contained in the Child Safety Practice Manual (CSPM) as to what process is required to obtain consent (and from who) in this situation. Two clear issues emerged in our discussions with the Department – firstly that the policy contained a number of ambiguities about decision implications about different contraceptive methods, and that there was very limited awareness among case workers and clinicians about its content. Given the previously noted higher rates of poor sexual and reproductive health outcomes among young people in care, there is a need to ensure that the policy document supports the rights of young people to access services and that all involved in their care are clear about the consent pathways required.

3. Access to sexuality education

Research demonstrates that sexuality education programs are more effective when given before young people become sexually active, and when the programs emphasise social norms and skill development. Sexuality education does not encourage increased or early sexual activity. Comprehensive sexuality education programs have been shown to help delay first intercourse, and increase the adoption of safer sexual practices in sexually active youth (Grunseit & Kippax, 1997, McLaughlin & Thompson, 2007; Mueller, Gavin & Kulkarni, 2008).

Australian research into children and young people in care regarding educational involvement confirms that children in care are more likely to miss school than their peers, are less likely to have school programs that target their emotional, social, behavioural and learning needs and are more likely to have lower educational outcomes than peers (Australian Institute of Health and Welfare, 2007; CCYPCG, 2007; Mendes et al, 2004).

Foster and kinship carers are often given the responsibility of meeting all of the needs of the children and young people in their care. Parents are seen as primary sexuality educators of their children (FPQ, 2007). Polit et al (1989) discussed the foster carer's perceived role as a substitute parent with the same expectations of parental responsibility as biological carers. After reviewing the literature, questions remain about whether foster and kinship carers are meeting the role, are able to meet the role, are expected to meet the role or are even permitted to fulfil the role of sexuality educator with the young people in their care (NCB, 2001; Polit et al, 1989; Risley-Curtis, 1997; Vinnerjlung et al, 2007). Only one quarter of foster parents of sexually active teenagers had talked directly to young people about sexuality issues or referred them to services (Polit et al, 1989). In this study, two thirds of caseworkers believed that providing contraceptive information was the foster parents responsibility not their own (Polit et al, 1989).

Farmer et al (2003) concludes that the inability of foster carers and other workers to meet the sexuality needs of children in care is based on fear and passivity. The study quotes one worker as saying, "We've got leaflets. We've got a whole pile of stuff they can look at. But we're not going to say, "I'm going to talk about this now." (Farmer et al, 2003, p.106)

Other studies cited that carers believed that due to either the sexual abuse, problem sexual behaviours or early onset of sexual activity of children and young people in care that the young people were already sexually aware and experienced and that their input, as carers, with regards to sexuality information was not required (Farmer et al, 2003; NCB, 1998). Research regarding sexuality education found that young people want to talk about sexuality with someone that they trust (Smith et al, 2003). "For many fostered children and young people their relationships with their foster carer are the closest relationship they have known" (NCB, 2001, p. 2).

From the literature, strategies for overcoming the resistance to addressing the sexuality needs of young people in care are comparable. Common solutions include:

- policy and guideline development
- pre and post service training for staff and carers
- ongoing supervision and support
- the development of resources and curricula (Becker et al, 2000; NCB, 2001; Mallon et al, 2002; Mayden, 1995)

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