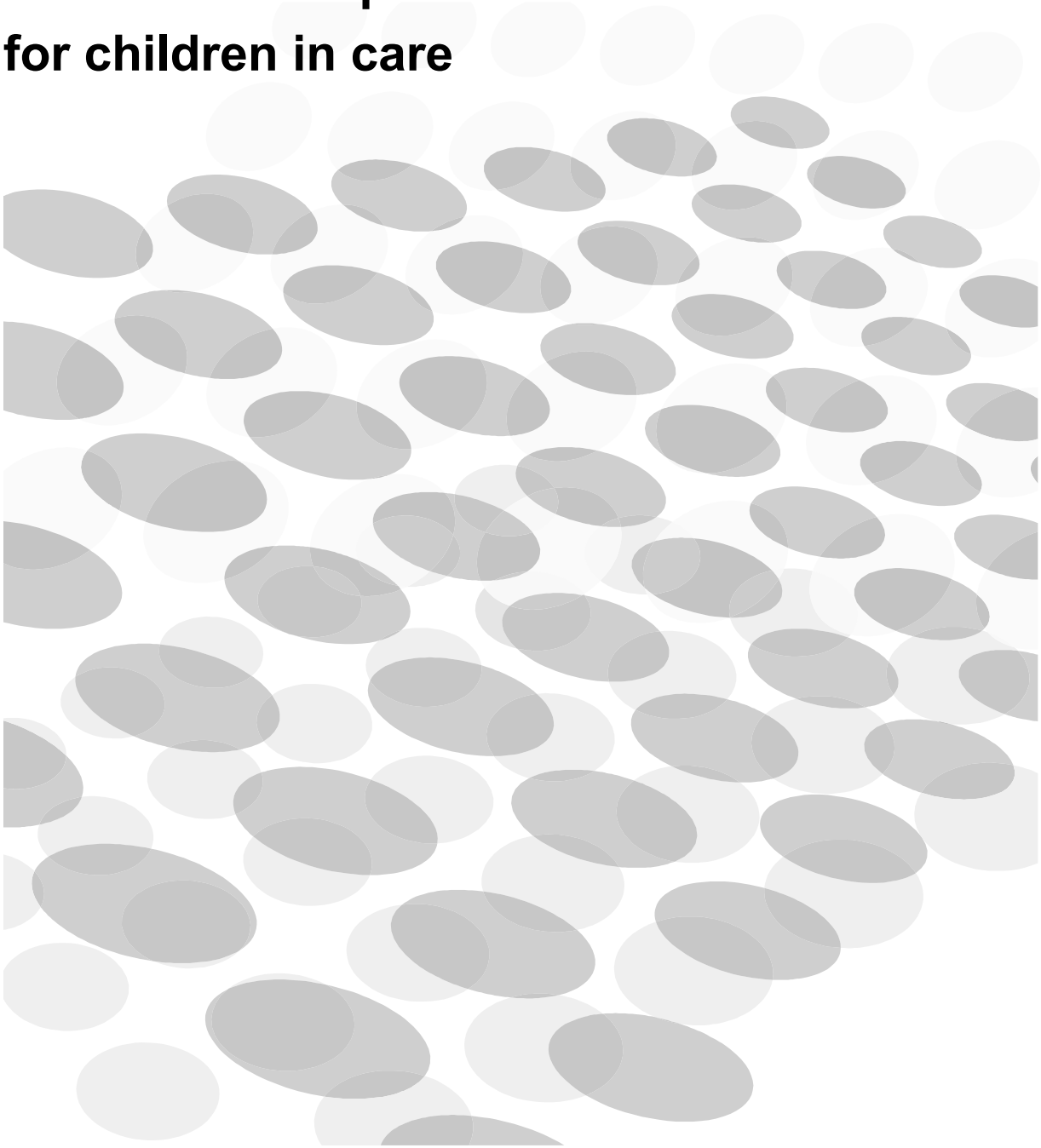
SETTINGS AND SOLUTIONS:

Supporting access to sexuality and relationships information for children in care



FAMILY PLANNING QUEENSLAND

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February 2008

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First published February 2008.

Family Planning Queensland would like to acknowledge the following people who contributed to Settings and Solutions: Supporting access to sexuality and relationships information for children in care:-

Author: Holly Brennan

Librarian: Jill Griffin

Editors: Cecelia Gore, Judy Graham, Jill Griffin and Jo Stewart

Thanks: Jill, Cecelia, Judy, Mitchell, Thecla, Christine and the FPQ Sunshine Coast Team
Andrew Powell and the Sunshine Coast Children in Care Working Group

Funded by: Department of Child Safety, Strategic Policy and Research Branch

fpq
Family Planning Queensland

Queensland Government
Department of Child Safety

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Introduction

In Queensland there are just over 6000 children and young people in care (Australian Institute of Health and Welfare, 2008, p. 56). Currently there is no systematic approach to establishing the sexuality and relationships needs of these children and young people, nor is there a comprehensive approach to meeting these needs. In 2007 the Department of Child Safety funded Family Planning Queensland to conduct a Literature Review of the relevant research in this area. The anticipated outcome is to inform an evidence based approach to assess and meet the sexuality and relationships needs of children and young people in care.

The key focus questions of this review are:

- What are the issues regarding sexuality and relationships for children and young people in care?
- What are the key influences on service provision?
- What model of practice will best meet the needs of children and young people in care and the staff and carers supporting them?

Executive summary

Children and young people in care have poorer sexual health outcomes than peers not in care. They have:

- higher rates of earlier onset of sexual activity
- higher rates of sexually transmitted infections (STI's)
- higher rates of 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 access to sexual health services
- less access to sexuality education and information.

In order to address these poor sexual health outcomes it is essential to engage all key stakeholders. These include:

- children and young people in care
- all carers (including family of origin, foster and kinship carers)
- child protection service providers
- government and non government service providers
- policy makers and legislators.

To meet sexuality and relationship needs, there need to be specific initiatives in the areas of:

- policy and guidelines
- training and supervision
- education programs for young people and their carers
- resource development and dissemination
- research and evaluation.

Overview

This literature review looks at published research and articles pertaining to the sexuality and relationship needs of children and young people in care.

The literature reviewed was published between 1987 and 2008 and includes books and journals as sources. The literature review was confined to resources available in English.

The key words:

> sexuality, sexuality education, sexual health, sexual activity, contraception, safe sex, sexually transmitted infections, pregnancy, parenting, sexual identity, sex work, prostitution, sexual abuse, problem sexual behaviours and sexual health services,

were combined with the search areas:

> children and young people in care, state care, public care, foster care, kinship care, care and protection orders, at risk, in out of home care and the areas of education, training, policy and service provision.

There was a limited amount of relevant Australian literature on this topic. Most sources of information come from the UK and USA, with another study coming from Sweden. Wherever possible statistics and overviews are provided to give an Australian context to the overseas research and data provided.

The Secondary Students and Sexual Health Survey (Smith, Agius, Dyson, Mitchell & Pitts, 2003) is used throughout this review as a reference point for comparison. It was a large national study into the sexual behaviours of young people not in care settings.

Key topic areas

Sexual activity, contraception, safe sex and sexually transmitted infections

> *For some young people, sex may be a way of trying to get some attention, affection, love, excitement or what ever else is lacking in their lives.*
>
> (National Children's Bureau, 2001, p.1)

Children and young people in care are more likely to have earlier onset of sexual activity, have higher rates of engaging in unprotected sex and have a greater number of sexual partners than their peers not in care (Becker & Barth, 2000; Bilaver & Courtney, 2006; Budd, Holdsworth & Hogan Bruen, 2006; Cook 1994; Corlyne & McGuire, 1997; Cyprian, 1998; Mayden, 1995; Polit, Morton & Morrow White, 1989; Risley-Curtis, 1997; Vinnerljung, Franzen & Danielsson, 2007). Children and young people in care show a higher risk of sexually transmitted infections (STIs) and a higher rate of earlier pregnancy and or parenting (Becker et al, 2000; Budd et al, 2006; Cashmore & Paxman, 2007; Cook, 1994; Corlyne et al, 1997; Cyprian, 1998; Maunders, Liddell, Liddell, & Green, 1999; Mayden, 1995; Polit et al, 1989; Risley-Curtis, 1997; Vinnerljung, 2007).

The research does not definitively answer why children and young people in care have poor sexual and reproductive health. However, reasons identified which contribute to poorer outcomes included:

- low levels of self esteem and high levels of peer pressure
- higher rates of engaging in sexual activity whilst under the influence of alcohol and other drugs
- the presence of mental health problems
- the presence of trauma backgrounds including experiences of sexual abuse
- a lack of role models with regards to healthy sexuality or healthy sexual decision making
- an absence of the necessary skills and confidence to negotiate and sustain positive personal relationships (Corylne et al, 1997; Lynch and Blake, 2004; NCB, 2005; Polit et al, 1989; Risley-Curtis, 1997).

Cyprian (1998) noted that 42% of young people in care said that they wished they could change some of their earlier decisions about sexual behaviour and that 25% had never talked to an adult (parent or foster carer) about any issue related to sexuality.

Strategies for addressing these issues for young people in care include access to sexual health services, sexuality education, clarification of the roles of carers and service providers, training for child protection professionals and clear policies and guidelines (NCB, 2005; Polit et al, 1989; Risley-Curtis, 1997).

Sexual activity

Before exploring the statistics specific to the sexual activity of young people in care, it is important to understand what is considered normal or average sexual behaviour in Australia. *The Secondary Students and Sexual Health Survey* (Smith, Agius, Dyson, Mitchell & Pitts, 2003) will be used as an attempt to provide a comparison point for the statistics given.

There are no statistics available regarding children and young people in care in Australia and sexuality or relationships.

Overseas studies have indicated that the incidence of sexual intercourse activity among young people in care ranged from 41.1% to 86% (Bilaver et al, 2006; Cyprian, 1998; Polit et al, 1989; Risley-Curtis, 1997). Mayden (1995) suggested that young people in care are twice as likely as their peers to have had intercourse. Children as young as eight are reported as being sexually active and Polit (cited in Risley-Curtis, 1997) reports that 56.8% of young people in care had had intercourse while in their current foster home (p. 478). Polit et al (1989) also measured dating and kissing with rates for these activities reported as higher compared to national averages in the USA (p. 205).

The Secondary Students and Sexual Health Survey states that a majority of Australian young people in Years 10 and 12 were sexually active in some way. With regards to sexual intercourse they reported that 25.8% of Year 10 students and 46.8% of Year 12 had experienced intercourse (Smith et al, 2003).

Polit et al (1989) noted that young women who remain in their family of origin (with dysfunction) are more likely to engage in sexual activity than teenagers living in foster homes. This study hypothesises that foster parents may provide some teenagers with more stable environments and less need for earlier onset of sexual activity than those in their biological homes who are experiencing abuse or neglect. Polit et al (1989) however reported teenagers in care at higher risk of early age of first sexual intercourse and pregnancy than national averages (p. 207).

Contraception and safe sex

Contraceptive use and safe sex practices of young people in care are areas that raise questions and issues of concern. Children and young people in care are at greater risk of contracting STI's and having an unplanned pregnancy than their peers (Cyprian, 1998; NCB, 1998, 2001, 2005; Polit, Morrow White and Morton, 1987, 1989; Risley-Curtis, 1997; Vinnerljung et al, 2007). Research indicates that 33% to 73% of young people in care are reported to not use contraception or practice safe sex regularly (Cyprian, 1998; Polit et al, 1987; Risley-Curtis, 1997).

Polit et al (1989) reported that approx two thirds of the sexually active teens in care had not used contraceptives at first intercourse and 54.8% had not used at their most recent intercourse. Risley-Curtis (1997) reported that more than a third of the young people aged 8 to 18 in their research were not using contraception. Polit et al (1989) also found that 50% had never used condoms and 73% had not used condoms at last intercourse. In the Vermont Department of Social and Rehabilitation Services study 86% were sexually active and only 38% regularly used contraception (Cyprian,1998). Only one survey reports that young people in care are equal in contraceptive use to their sexually active peers. This study reports pregnancy rates as higher than peers not in care (Bilaver et al, 2006).

The Secondary Students and Sexual Health Survey recorded that 65.8% of young people in Year 10 reported always using condoms, while only 51.8% of Year 12 students said they used condoms (Smith et al, 2003).

Sexually transmitted infections

From the figures on contraceptive use and safe sex practices it is not surprising that young people in care are more likely than their peers to contract an STI. Risley-Curtis (1997) recorded that 12.2% of young people already had an STI. Of the 13 to 18 year age group who were sexually active more than 15% had an STI (1997). Risley-Curtis believed this is likely to be under reported. Bilaver et al (2006) recorded that young women in care were significantly more likely to report having partners with an STI than their peers. In another study of teenagers in care, 38% believed that they had a risk of having HIV (Cyprian, 1998).

The *Secondary Students and Sexual Health Survey* reported that only 3.5% of the sexually active students had been diagnosed with having an STI. Fewer than 10% believed that they were likely or very likely to become infected with an STI (Smith et al, 2003).

Pregnancy, pregnancy options and parenting

> *Helping them to become productive, independent adults whose childbearing is planned should be a major goal of child welfare agencies.*
>
> (Polit et al, 1989, p. 208)

Young people in care or young people who had previously been in care have higher rates of pregnancy than their peers (Bilaver et al, 2006; Budd et al, 2006; Cashmore et al, 2007; Cook, 1994; Maunders et al, 1999; Mayden, 1995; NCB, 1998, 2001, 2005; Polit et al, 1987,1989; Risley-Curtis, 1997; Vinnerljung et al, 2007).

Young women in care were reported to be twice as likely to be pregnant than young women not in care (Mayden, 1995). In Polit et al (1989) 37% of the young women had experienced a pregnancy whilst in care and Cook (1994) reports that 60% had given birth to at least one child compared to 24% of the general population. Australian studies also indicate that young women who had been in care have a higher percentage of earlier pregnancy and parenting. In the Cashmore and Paxman study (1996) nearly a third of the young women were pregnant or had a child within 12 months of leaving care (p. 76).

In the comprehensive study, *Teenage parenthood among child welfare clients: A Swedish national cohort study of prevalence and odds*, it was found that one in five to six females had given birth in their teens compared to the majority of the population which was one birth in 35 (Vinnerljung et al, 2007, p. 109). One in 20 males who had been in care became teenage fathers compared to one in 140 of peers without child welfare interventions (2007, p. 109). When the study adjusted these figures to take into account socio-economic, demographic and familial factors the teenagers in the child welfare system were still four to six times more likely to be parents. For those children who had entered welfare before 13 years of age and had been in long term foster care there was only a two-fold increase (2007, p. 109). As noted earlier there is an unexplored research question of the significance of stable long-term placements and the impact of these on pregnancy and parenting decisions.

The Secondary Students and Sexual Health Survey found that 6% of the young women in their survey reported having sex that resulted in a pregnancy (Smith et al, 2003). According to the Australian Bureau of Statistics (2005) the rate of teenage pregnancy in Australia is roughly 16 births per 1000 women aged between 15 and 19. Australia has the fifth highest teenage birth rate in the developed world. Queensland has 22 per 1000 teenagers giving birth, which is a significantly higher rate than the national average.

The use of termination by young people in care as a pregnancy option is difficult to calculate. Generally it is reported that access to and use of terminations is more likely by adolescents from more affluent circumstances compared to those from disadvantaged families (Vinnerljung et al, 2007). Vinnerljung et al (2007) surmises that young women in care may follow this trend and not access terminations as a preferred pregnancy option when compared to more affluent peers.

In Australia, according to Medicare data approximately 11 000 women aged between 15 and 19 had abortions in 2004/2005. Figures for all abortions are not available so it may be higher. There is no record of how many young women in care, or who have been in care, access terminations in Australia.

Some of the reasons for earlier pregnancy and parenting by young people who have been in care included:

- positive attitudes to 'early' parenting and then parenting in general
- positive attitudes to having one's own family
- peer values of accepted early intercourse, pregnancy and parenting
- low expectations for the future
- experience of poverty
- ignorance
- experience of public care
- a history of neglect in supporting young people's sexuality needs including access to contraception and sexuality education (Cashmore et al, 2007; Vinnerljung et al, 2007; NCB, 2001).

While some young women and men who have been in care may view earlier parenting as a positive choice, the literature reports a multitude of health, social, emotional, employment and educational implications for the child, parent/s and carers involved (Budd et al, 2006; Cook, 1994; NCB, 2005). Cook (1994) states that those who had given birth had poorer outcomes than those who had not and Budd et al (2006) report that young mothers who had been in care were more likely to demonstrate serious parenting problems. Mendes et al (2004) reports that a number of Australian young women who had been in care have also experienced child protection interventions with their own children (p. 334). Cook (1994) stated that "for some youth becoming a parent is the first time they had established a strong family tie", but that the outcomes for some young people who chose to parent were negative and complex (p. 220).

Sexual abuse and sexual abuse prevention

> *Probably just because I looked easy to him, probably he thought, 'Och, she doesn't mean anything to me'. I don't know why, I don't know.*
>
> (Dillane, Hill & Munro, 2005, p. 28)

> *Sexually abused and abusing children in out-of-home care placements, are more vulnerable to emotional, educational, behavioural and sexual difficulties, than their counterparts who have not had those experiences.*
>
> (Department of Child Safety, 2007, p. 112)

Accurate statistics regarding children in care and sexual abuse can be difficult to establish. This is due to several factors including high rates of non disclosure of sexual abuse, sexual abuse not being recorded in child protection statistics when the sexual abuse is not the primary reason for child protection orders and the under reporting of incidences of sexual abuse (CCYPCG, 2007; Legosz, 2003; Queensland Crime Commission and Queensland Police, 2000).

Many children and young people in care have experienced sexual abuse prior to going into care (Australian Institute of Health and Welfare, 2007; Commission of Children, Young People and Child Guardian, 2007; Farmer & Pollock, 2003, Mendes & Moslehuddin, 2004). It is also believed that children and young people in care or who have been in care are at greater risk of experiencing sexual abuse than their peers who are not in care (CMC, 2004; Edmond et al, 2002; Hobbs et al, 1999; NCB, 2005; Leslie et al, 2004).

In Queensland 6.4% of the children and young people in care have a recorded history of sexual abuse. Of the Aboriginal and Torres Strait Islander children and young people in care 4.9% have a recorded history of sexual abuse (AIHW, 2008, p. 31). 97.6% of children and 97.7% of young people in care reported that they feel safe in their current placement in the *Child Guardian: Views of Children and Young People in Care Queensland 2006* (CCYPCG).

To get an accurate picture of the numbers of children in care who may have experienced childhood sexual abuse it is important to be aware of the general statistics. It is reported that one in three girls and one in seven boys have experienced sexual abuse (ABS, 2006). The highest rates of substantiated sexual abuse occur between the ages of 5 to14 years of age (Goldman and Padayachi, 1997).

Generally, children and young people in care are recognised as an enormously vulnerable population with a high rate of need for services (Leslie et al, 2004, p. 709). In the report *Managing sexually abused and/or abusing children in substitute care*, information about the abuse of the 42% of the children in the study who had experienced abuse was not given to the carers (Farmer & Pollock, 2003, p. 104).

Edmond et al (2002) reported that sexually abused girls are 12% more likely to have had intercourse, are more likely to have more sex partners (4.8 compared to 2.9), to have sex under the influence of drugs and alcohol (57% of sexually abused girls versus 28% of non sexually abused girls in care) and be more likely to have had sex for money or goods.

The Queensland Department of Child Safety, *Child Safety Practice Manual* (2007) provides guidelines for supporting children and young people in care who have sexual abuse histories (p. 109-112). All children with an adverse sexual history have been deemed by the Department of Child Safety to have special needs that require input and specialised care. This care includes needs assessments, targeted placements, "active assistance and education to grow toward healthy sexual development and positive relationship skills", opportunities to talk, therapeutic support and ongoing supervision.

There is a clear rationale for addressing the needs of children and young people who have experienced sexual abuse. This includes that children and young people who have been sexually abused are:

- at greater risk of further sexual abuse
- experience more moves whilst in care
- experience greater attachment problems
- at risk of earlier sexual activity
- believed to be more vulnerable to involvement in unwanted sexual activity, exploitative and/or abusive relationships
- at higher risk of long-term emotional, psychological and physical health consequences, substance abuse and social and economic hardship (Cashmore et al, 2007; Edmond et al, 2002; Farmer et al, 2003; Hobbs et al, 1999; Legosz, 2001; NCB, 2005; Polit et al, 1989; QCC et al, 2000).

There is a growing body of research into programs to prevent childhood sexual abuse (Finklehor, 2007; Finkelhor, Asdigian & Dzuiuba-Leatherman, 1995; Gilgun, 1986: O'Connor, 1991; Rispens, Aleman & Goudena, 1997; Sanderson 2004). There is very limited research regarding the prevention of sexual abuse that occurs to children and young people in care. Literature available in this field confirms the recommendations from the *Child Safety Practice Manual* (DCS, 2007). The recommendations in *Managing sexually abused and/or abusing children in substitute care* summarised in the *Queensland Child Safety Practice Manual* is one of the few papers that tackles this issue (Farmer et al, 2003). The four recommendations outlined for the management of children who have been sexually abused are:

- supervision
- adequate sexuality education
- modification of inappropriate sexual behaviours
- addressing the child's underlying needs (DCS, 2007, p. 111 – 112).

Obstacles to effective support regarding sexual abuse issues for children and young people in care include the denial and minimisation of sexual abuse and the development of high thresholds before action is taken by foster carers and child protection professionals (Farmer et al, 2003). All of the literature maintains that something positive can be done when service providers and carers are aware of the issues, have adequate support and access proactive ongoing training and interventions.

Child sexual exploitation

> *They offered us money. They offered us, like booze and poppers, which is drugs. They offered us a house to stay in and stuff.*
>
> (Dillane et al, 2005, p. 27)

> *the experience of living in care itself is said to put young people at a particular risk of entry to prostitution because of social stigma, marginalisation and 'otherness' related to being in care*
>
> (Kirby cited in Cusick et al, 2003, p. 5)

There is a growing movement in research to use the term "child sexual exploitation" in reference to children under the age of consent who are involved in sex work, opportunistic sex work or prostitution. The literature and research available in this area is limited and mainly from the UK, with a small number of studies from Australia. The literature identifies that young people in care or running away from care, are at greater risk than their peers of being involved in child sexual exploitation or prostitution (Cusick et al, 2003; Dillane et al, 2005; Farmer et al, 2003; Fitzgerald, 1997; Mendes et al, 2004; NCB, 2005).

Cusick et al (2003) found that the mean age of first experience in sexual exploitation or prostitution was 13.8 years of age. 52% of the sex workers in the study had been in care during some point in their lives. Dillane et al (2005) found that 32% of youth in care had been involved in sexual exploitation. Five of the 36 young people in care in Farmer et al's (2003) study were involved in sexual exploitation or prostitution and a few were even collected by the 'client' from their care residence. Some of the young people in the study were also involved in the making of child pornography or child sexual exploitation videos (p. 104). Cusick et al (2003) also stated that 78% of sex workers who were also problematic drug users had been in care and 71% of this group had been in care or on the run from care when they first started participating in sex work. 83% of these young people who were in care and involved in sex work or sexual exploitation did so as outside sex workers (Cusick et al, 2003, p.28). There are implications regarding safety as these young people are at greater risk than those working in organised premises or brothels. Research in Australia confirms that children and young people in care are more likely than their peers to be involved in child sexual exploitation and to engage in activities in high-risk locations (Fitzgerald, 1997; Mendes et al, 2004).

When talking about young people who are sexually exploited, Pitts (1995) stated that the lack of support that some young people receive while in care has the effect of "putting onto the street ill-prepared, poorly educated and emotionally fragile people, many of whom had been received into care because of abuse, neglect, self harm or their violent, aggressive behaviour" (Pitts in Cusick et al, 2003, p 5). Only 21% of the young people in the Dillane et al (2005) study had spoken to staff about their experience of exploitation and even those who did had not gone into detail. One young person is quoted as saying, "I didn't want care staff thinking that I was horrible as well. After a while it just went away and that was it" (Dillane et al, 2005, p. 32).

There are many implications for foster carers, youth workers, educators and child protection professionals when looking at how to support young people at risk of or involved in child sexual exploitation. The available literature suggests that there is a great need for staff to increase their understanding of sexual exploitation generally and more specifically to identify the behaviours used to target young people. They also need to receive training regarding alcohol and other drug mis/use, sexuality education strategies, safety strategies and be to able to facilitate open communication as well as respond to disclosures from young people (Dillane et al, 2005).

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)

It is difficult to find clear information in the literature regarding children and young people in care and problem sexual behaviours. It is only recently that a body of research has been available regarding all children and young people and problem sexual behaviours (Australian Childhood Foundation, 2005).

The Crime and Misconduct Commission (2005) 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).

Hobbs et al (1999) stated that children were perpetrators in 20% of incidents of sexual abuse of other children in care (p. 1249). Seven of the 36 young people in the Farmer et al (2003) study sexually abused other children whilst in their placement. Information about 53% of the young people who had been sexually abusing others (previous to care or whilst in care) was not given to care providers. It was stated that when information was shared, important details were often omitted including the extent and severity of the cases (Farmer et al, 2003).

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). Information giving is an essential part of meeting the needs of these young people and their carers.

The *Child Safety Practice Manual* highlights the need to support children in care who engage in sexually abusive behaviour (DCS, 2007). The recommendations are the same as those that were also made for children with sexual abuse histories. The four recommendations for the management of children who have a history of problem sexual behaviour are supervision, adequate sexuality education, modification of inappropriate sexual behaviours and addressing the child's underlying needs (2007, p. 111 – 112). The need for therapeutic support was suggested by several sources (ACF, 2005; Farmer et al, 2003; FPQ, 2006; Jones, Ownbey, Everidge, Judkins & Timbers, 2006; Macdonald & Turner, 2005). Support for foster carers and service providers was also seen as paramount (DCS, 2007; Farmer et al, 2003; FPQ, 2006; Hobbs et al, 1999; NCB, 2005). Child protection professionals require information and support that is informed, evidence based and functional in practice in order to recognise and meet the need of young people, carers and professionals. Farmer et al (2003) also called for the elimination of the culture of denial and minimisation that had historically occurred with this issue.

Sexual identity

> *She actually wrote it in my file when I told her. [She wrote] I 'expressed desire to be bisexual.' They don't write it in your file if you are heterosexual.*
>
> (Ragg, Patrick & Zeifert, 2006, p. 252)

> *And just because there is a gay girl and a straight girl, they can't share a room together. They're afraid the gay one will hit on the other. Most queer kids in the foster care system…I know for myself am not interested in looking at them sexually or anything because I wanted to be safe. I was not thinking about sex…I needed a safe place just like they needed a safe place.*
>
> (Ragg et al, 2006, p. 252)

The literature regarding children and young people in care acknowledges the vast array of skills that carers and professionals require when working with them. There is also research available that highlights the need for recognising and supporting children and young people in care who may identify as gay, lesbian, bisexual and/or transgender (GLBT). The literature comes from the UK and USA (Craig-Oldsen, Craig, & Morton, 2006; Mallon, Aledort & Ferrera, 2002; NCB, 2001; Ragg et al, 2006).

It is generally estimated that 5 – 10% of the population is gay or lesbian (Craig-Oldsen et al, 2006). *The Secondary Students and Sexual Health Survey* (Smith et al, 2003) found that approximately 2% of the most recent sexual encounters of the students surveyed were same sex encounters. Therefore of the nearly 6000 children and young people in care in Queensland there may be between 120 to 600, gay, lesbian, bisexual and transgender young people or young people whose most recent sexual encounter was with someone of the same sex. Many of the articles available identify that GLBT children and young people are over-represented in care and may therefore make up a higher percentage than estimated in the whole of community. Reasons for this over representation in care are clearly presented in these studies through the use of young GLBT people's voices quoting their own tales of harassment, assault, disapproval and/or rejection by their family of origin and consequently their move into care (McHaelen, 2006; Mallon et al, 2002).

All of the available literature discussed issues of prejudice and the difficulties for GLBT young people in care. The issues for the young people included: abuse by peers, mental health concerns, over sexualisation of their identity, placement breakdowns, rejection, religious abuse, limited number of professionals and carers who understand and accept them, rejection by religious carers and foster care organisations and lack of safety (Craig-Oldsen et al, 2006; Mallon et al, 2002; McHaelen, 2006; NCB, 2001; Ragg et al, 2006).

McHaelen (2006) noted that 78% of GLBT young people were removed or ran away from their placement as a result of hostility toward their "inherent sexuality, gender identity or gender expression" (p. 408). It also reported that 20 to 42% of homeless youth are believed to be GLBT. Mallon et al (2002) in a study where young people and professionals were interviewed recorded that 78% of young people and 88% of child welfare professionals reported that it was not safe for gay and lesbian young people in care.

Studies have found that lesbian and gay youth in out of home care:

- received fewer services
- were generally at higher risk of verbal harassment and physical violence
- experienced multiple placements
- were generally separated from their siblings
- had experienced a high incidence of homelessness
- had difficulty attending community based education programs
- had difficulty accessing mental health services that affirm their identity and meet their needs (despite higher incidences of mental health issues, self harming and suicidal tendencies)
- were at risk in their home, foster home and communities
- had high worker turnover
- lived with service providers that have policies and protocols that can be non-conducive to their well-being (Mallon et al, 2002; Ragg et al, 2006).

A variety of strategies were recommended to address the needs of GLBT children and young people in care (Craig-Oldsen et al, 2006; Mallon, 2002; Ragg, 2006; McHaelen, 2006). These recommendations included pre service and in-service training for carers and training for staff. Craig-Oldsen et al (2006) also recommended training for managers of services in order to address the policy and systems levels of service provision. Craig-Oldsen et al (2006) asked staff and services to concentrate on skill development that focused on the "universal issues of safety, well-being and permanence for children and young people in foster care to assist with promoting healthy growth and development, lessen threats to safety and assist carers with preparing for general challenges and strategies to build support systems" (p. 273). These "universal issues" need to be met for all children in care and are the basis of good practice for any service trying to provide the best service possible (p. 273). "We need to be good at meeting all children and young people's needs" (Craig-Oldsen et al, 2006, p. 272).

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)

Children and young people in care have poorer health outcomes than their peers (CCYPCG, 2007, p. 70). In the *Child Guardian: Views of Children and Young People in Care Queensland 2006* which surveyed young people in care, only 6.7% of young people and 13.8% of children reported that they felt they had unresolved health issues. These issues were not specified as being related to sexual health matters (CCYPCG, 2006, p. 27). The literature reviewed from the UK and USA discussed barriers to accessing sexual health services for young people in care and overall rated the facilitation of access as poor (Becker and Barth, 2000; Farmer, et al, 2003; Mayden, 1995; Polit, 1987, 1989; NCB, 1998, 2005). Only one survey rates young people in foster care as more likely to receive sexual health services than their peers (Bilaver et al, 2006).

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; Polit et al, 1987).

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). The foster carers who appeared to meet the need of the young people in care accessing services were those who had their own experience of having children and thus were acting out of lived experience rather than explicit training or practice support (Farmer, 2003).

The *Child Safety Practice Manual* outlines procedures and practice for developing Child Health passports and health plans for children in care and notes sexual health matters and decision-making guidelines (DCS, 2007). The literature reports a need for further guidelines, training and role clarification as well as access to sexual health service providers. Traditionally collaboration between sexual health services and child protection services has not occurred. Polit et al (1987) stated that the “time was right” for sexual health services to play a leading role in helping overworked child protection workers, social workers and foster carers by providing expertise, resources, training and service provision.

Access to sexuality education

> *Due to the nature of out of home care and the events precipitating placement, youths in out of home care may change schools frequently and have substantial lapses in school attendance, thereby missing much of the sexuality education delivered in traditional schools.*
>
> (Becker et al, 2000, p. 270)

The *Child Safety Practice Manual* calls for the provision of sexuality education (DCS, 2007). It clearly states that whilst it can be a delicate issue, "children need to know about safe touch and safe sex, including information about contraception" (p.111). A number of the young people in Dillane et al (2005) research also suggested sex education at an earlier age in order to prevent sexual exploitation (p. 40). Sanderson, in *Child-focused sexual abuse prevention programs: How effective are they in preventing child abuse?* (2004) identified the need for appropriate sex education (p. 6). She also noted the "more divergent the programs are from children's real lives the less successful prevention programs may be" (p. 6).

"Sexually abused children often have the dual disadvantage of premature sex, coupled with a profound lack of knowledge and cognitive distortions about relationships and sexual development" (McFadden, 1987 cited in Farmer et al, 2003 p. 106). For programs to be successful they need to take into account the specific needs of children in care, especially those who have already experienced sexual abuse and who are at even higher risk of re-victimisation.

All of the literature reviewed regarding the sexuality education needs of children and young people in care reported these needs were not being met (Becker et al, 2000; Bilaver et al, 2006; Cyprian, 1998; Mayden, 1995; NCB, 2001, 2005; Polit et al, 1987, 1989; Risley-Curtis, 1997; Vinnerljung et al, 2007). Evaluations of children and young people in care's knowledge of sexuality information measured their knowledge as being consistently lower than peers (Becker et al, 2000; Farmer et al, 2003; Mayden, 1995; Vinnerljung et al, 2007). With regards to access to sexuality information 43% of the young people in Farmer et al (2003), had not been given any information about how their bodies change as they grow up and a third felt that they did not know enough about the dangers of unprotected sex or about contraception.

In the UK, the National Children's Bureau (2005) stated that school is often cited as a major source of information for children regarding sexual and reproductive health. This correlates with *The Secondary Students and Sexual Health Survey* where school programs are reported as a highly valued source of information by the Year 10 and Year 12 students surveyed (Smith et al, 2003). NCB (2005) reported children in care experience gaps in schooling due to the nature of their care, placements and other related care issues. When a sexuality education program does exist in the school that could meet the sexual and relationship needs of children in care, they are often absent from it.

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; Create, 2006; Mendes et al, 2004). International studies reviewed found similar access, participation and educational achievement issues for children in care (Becker et al, 2000; Dillane et al, 2005; Edmond et al, 2002; Gallagher et al, 2004; Mayden, 1995). In Dillane et al (2005) 46.4% of the young people missed weeks of school at a time and only 17.9% said that they rarely missed school. 57% of the young people interviewed stated that they often had trouble concentrating even when they did attend.

Even when school sexuality education programs do exist and young people in care attend them, the literature questions whether these standard school programs always meet the needs of young people in care. In focus groups conducted by Becker and Barth (2000) in USA, many of the young people stated that when they received education within schools, it was only "marginally meaningful to them" (p. 272). The young people perceived many of the program's "themes and messages as irrelevant to their living and social situations and more suited to youths residing in stable, single family homes, with clearly identifiable and accessible parent figures with whom they could discuss material" (p. 272).

Children and young people in care have a high need for sexuality information, they are less likely to access school sexuality education programs and are less likely to have the same sexuality knowledge base as their peers. The literature indicates that sexuality information and education programs are not being systematically approached from within the child protection system in Australia or elsewhere. It is rare to find available programs that target the needs of this extremely vulnerable group (Farmer et al, 2003; Mayden, 1995; Vinnerjlung, 2007).

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 (Bilaver et al, 2006; 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 as being 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 represent carers' and workers' resistance to meeting the sexuality needs of young people in care as stemming from:

- overwork issues
- lack of clarification of roles
- lack of training and resources
- lack of policy, guidelines and managerial support
- that they believe sexuality education is seen as controversial
- that they believe it may distress young people who have experienced sexual abuse
- that they did not wish to be seen as condoning sexual activity
- that some were just too shy or embarrassed (Becker et al, 2000; Cyprian, 1998; Farmer et al, 2003; Mayden, 1995; NCB, 1998, 2001, Polit et al, 1989; Vinnerjlung, 2007).

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).

Polit et al (1989) reported that few officials in child protection leadership positions have ever formally considered their responsibility to ensure that children in their care receive adequate sexual guidance (p. 20). Strategies from the literature 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; Nixon, 1997; Polit et al, 1989).

Most emphasise the importance of involving all key stakeholders in the design of policy, programs and training. This includes young people, carers, service providers and sexual health services (Bilaver et al, 2006; Mallon et al, 2002; Mayden, 1995; NCB, 2001). It is also highly recommended that legal support regarding clear guidelines and confidentiality be considered (FPQ, 2007; NCB, 2001).

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. It is also important to acknowledge that 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, Kirby, 2002, McLaughlin & Thompson, 2007; Mueller, Gavin & Kulkarni, 2008). Surveys also show that there is community acceptance of the need for comprehensive sexuality education (Jones, Purcell, Singh & Finer, 2005; Mueller et al, 2008; Sundstrom, 2006).

Whether delivered through education, child protection or sexual health services, the curricula must address the specific needs of children and young people in care. Some of the needs discussed by Becker et al (2000) include the recognition that some young people in care may have "an intense need for affection, the absence of a dependable family or social network, the desire to possess something of their own that they do not have to share, exposure to sexual abuse and violence and limited skills in identifying and marshalling resources to support them now and in the future" (p. 272). There are many sexuality education programs for mainstream children and young people that are able to be adapted for children in care (National Guidelines Task Force,1996; FPQ, 2007). There are also a few programs from the USA specifically written for children and young people in care (Becker et al, 2000; Cyprian, 1998; McHaelen, 2006). Many of these programs need to be updated and translated into the Australian context if they are to be used. The development of programs must to be firmly based in current research and evidence, involve key stakeholders and include interactive, practical skill building activities.

Polit et al (1989) stated that there is "compelling evidence that child welfare clients constitute a high-risk group of teenagers who merit special attention among family planning and child welfare policy makers and service providers" (p. 207).

Sexuality policy and guidelines

> *There is some indication that the needs of many children are going unmet because everyone believes that someone else is taking the responsibility for the child's family life education.*
>
> (Bremer & Hillian, 1994, p. 22)

> *in the absence of policy, … other caseworkers are afraid to even say the word sex and cannot communicate effectively with their clients or with foster parents about sexuality.*
>
> (Polit et al, 1987, p. 22)

There is support for a systematic organisational approach to meet the sexuality, relationship and reproductive health needs of children and young people in care (Bilaver et al, 2006; Bremer et al, 1994; Cook et al, 1994; Mayden, 1995; NCB, 1998; Polit et al, 1987). The "importance of agencies having guidelines to assist staff in tackling situations cannot be stressed highly enough, as without these, staff working in this area are either unsupported or undermined by their employing organisations." (Bremer et al, 1994,p. 61). Recommendations included the need for: legislation, policy and guidelines, organisational manuals, working agreements and position descriptions that took into account the issues associated with sexuality and young people in care and clarified roles and responsibilities (Becker et al, 2000; Bilaver et al, 2006; Bremer et al, 1994; Cook et al, 1994; Mallon et al, 2002; NCB, 1998, 2001). Comprehensive training was high on the agenda, as was the appeal for clear and accurate record keeping and research (Bilaver et al, 2006; Cook et al, 1994; Mayden, 1995; NCB, 1998; Polit et al, 1987; Sanders et al, 1995).

Few of the sources could point to comprehensive approaches that have been undertaken that could be used as best practice examples in the child protection field. Reviews of child protection providers in the USA noted that less than one third had training in human sexuality and less than one fifth of foster carers received training (Mayden, 1995). Only 9 out of the 48 states reviewed by Polit et al in 1987 in the USA had policies addressing the sexuality needs of young people. Many of the articles noted that despite the high priority that sexuality issues warranted there appeared to be no comprehensive approach to support young people, their carers or child protection professionals.

Reasons given by organisations in the Polit et al (1987) survey for the lack of a comprehensive policy or training approach to addressing sexuality issues varied. Some departments stated that there only needed to be good social work practice present for issues to be addressed, others did not want to draw attention to the issue and some had never thought about the issue of sexuality and young people in care at all. Of the 48 states surveyed, none maintained case management records related to sexual development, sexual health service access or pregnancy. Polit et al (1987) and Mayden (1995) point to the belief that services saw their role in the area of sexuality as a reactive one and that services, staff or carers only responded when they had to because of the presence of a problem. A few

organisations stated that they would address the issue of sexuality proactively after participating in the survey process (Polit et al, 1987).

The most frequently cited barriers to program and policy development were political opposition, legal constraints and funding constraints (Cook et al, 1994; Mayden, 1995; Polit et al, 1987). The political opposition argument was that sexuality was seen as a sensitive issue and the rights of the family (biological) and foster carer were viewed as controversial (Mayden, 1995). Legal issues noted in the literature included matters regarding notification and guardianship issues as well as confidentiality, consent to information, medical treatment and consent to sexual activity (NCB, 1998; Polit et al, 1987). The funding issues included the difficulties that child protection workers have meeting their basic role functions without also meeting what may be viewed as supplementary or non-compulsory roles. "Even if a policy to address the sexual development needs of child welfare clients were in place, … it would be virtually impossible to carry out such policy because of personnel shortages" (Polit et al, 1987, p. 22). In order to meet further needs it concluded that funding needed to increase.

Bremer and Hillian (1994), reported that generally sexuality education and support was not being done and workers needed opportunities to work through their own issues with guidelines and policies to support them. The National Children's Bureau (1998) in the UK supported policy development as an essential means for supporting best practice as it provides a clear framework for content, organisation, role clarification, legal issues as well as communication processes with parents and carers. To be effective, staff and carers need to feel supported, know what they are able to do and how to do it and children and young people need to know what they are entitled to (NCB, 1998).

The literature suggests that successful child protection programs need to:

- see children in the context of their families, neighbourhoods, schools and communities
- include young people's ideas
- be comprehensive, flexible, responsive and persevering
- support confidentiality
- have short and long-term goals
- include values frameworks and prevention frameworks
- have competent, committed and skilled managers
- have well trained supportive staff
- encourage ongoing skills development (Bilaver et al, 2006; Bremer et al,1994; Mallon et al, 2002, NCB, 1998).

To achieve this, services need to develop good practice policies, principles and guidelines and involve all key stakeholders. They also need access to clear data and research to inform this development.

Conclusion

> *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)

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.

Much of the literature asks who should assume the responsibility for meeting the sexual health and relationship requirements of children and young people in care. Is it the designated task of parents, foster and kinship carers, service providers, education, child safety or sexual health service providers? Is it a government or community responsibility? Without dedicated energy and resources to answering this question, children and young people continue to be neglected and expected to sort out the answers for themselves. Children and young people in care are carrying the responsibility for their sexual and relationship needs with the ad hoc support of well-intentioned carers and workers. Sometimes with success and frequently with much associated hardship.

The key people recognised as essential to mapping and meeting the needs of children and young people in care include: parents and carers, child protection professionals and the multitude of service providers including those in the fields of education, health and law. The development of new programs and processes needs to include input from practitioners in sexual and reproductive health services. To achieve meaningful solutions children and young people in care must be consulted and involved.

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
- education programs for young people and their carers
- resource development and dissemination
- research and evaluation.

It is essential that the sexuality and relationships needs of children and young people in care be recognised, recorded and evaluated. All key stakeholders need to contribute to the processes and programs that are undertaken. Children and young people in care have the right to sexual and reproductive health. This outcome can be achieved through clinical services, education, research and policy development that is targeted. Young people in care have a right to dedicated leadership, collaboration and commitment to address their sexuality and relationships needs.

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