Literature Review

Young people at high risk of sexual exploitation, absconding, and other significant harms
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Introduction

This literature review examines what is known about young people who have high-risk behaviours, with a particular focus on the phenomena of sexual exploitation and absconding behaviours. This review was initially undertaken as part of a larger project on young people who were known to Child Protection and who had these and other high-risk behaviours. That project and an earlier version of this literature review were commissioned by the Office of the Child Safety Commissioner (now known as the Commissioner for Children and Young People).

The literature review explores four questions:

- Who are the young people with high-risk behaviours and what are their experiences?
- How have these particular experiences of sexual exploitation and running away behaviours along with other problems arisen?
- How have services tried to assist young people to resolve these and related problems?
- What else works or could be tried?

The review canvassed literature and other documents that have informed and influenced policy and practice within Victoria over the past thirty years. This was supplemented by searches of the following databases [APAFT, CINCH, CINCH-ATSISUB, CINCH-Health, DRUG, EconLit, Embase, ERIC, Health & Society, Google, IELHEA, IELHSS, Ovid MEDLINE(R), PILOTS Database ProQuest Central, ProQuest Psychology Journals, ProQuest Social Science Journals, PsycINFO 1987-, Social Services Abstracts, Sociological Abstracts] through the resources of La Trobe University Department of Social Work and Social Policy. Key terms included high-risk adolescents, high-risk youth, prostitution, commercial sexual exploitation, absconding, running away, alcohol and other drug usage, self-harm, youth suicide, out-of-home care, residential care, foster care, treatment, programs and interventions.

1. Who are the young people with high-risk behaviours and what are their experiences?

Overview

Over the years, terms such as wayward youth, troubled youth, street urchins, behavioural or emotional disturbance, uncontrollable, challenging behaviours, behaviours of concern, damaged, high-risk, high needs, multiple needs, high support, multi-service clients, co-morbidity, dual-diagnosis, hard to help, inappropriate, vulnerable, traumatised or complex clients have been used to describe a small but significant group of young people and their behaviours.

Each of these terms denotes one or more aspects of the young person’s experience – characterising their behaviours, inferring a causal explanation, or pointing to the level of service they need. However, any label can obfuscate our understanding of young people, their experiences and their high-risk and other behaviours. Such labels can evoke images that lead society, including workers in various roles within the service system, to feel pessimistic, stuck and even frightened. It is easy to reduce high-risk young people’s experience to a list that brings us no closer to understanding what is happening for them or how to best respond.
The phenomenon of young people behaving in ways that place themselves or others at risk is not new, but the concept of ‘high risk’ (and some of its associated features) is a product of our times. Over the centuries, there have always been some young people who have been sexually exploited by others (Martyn, 2008). Similarly, over the years many have struggled with mental health problems, violence, criminal behaviours, substance abuse and suicide. However, the type and level of drug use, the role of media and social media and, most specifically, the invention then demolition of institutions, are relatively modern features. On a positive note, modern times have also seen greater integration of research into practice and increased access to bodies of knowledge, such as neuroscience.

Before welfare institutions were invented, young people with high-risk behaviours were seen as troublemakers and a risk to public order rather than a risk to self. They were incarcerated through the criminal justice system or left to fend for themselves (Jaggs, 1986). When welfare institutions were at their highest use, many young people with at risk behaviours were hidden from the general public. There were always some who remained on the streets ‘hidden in plain sight’, such as those described in the Burdekin Report on youth homelessness (Human Rights and Equal Opportunity Commission, 1989). With the closure of all youth-specific institutions in the 1980s and 1990s, except youth justice custodial settings, young people with high-risk behaviours have become more visible in the service system and in society. The public continues to view them as troublemakers, troubled or both (Clark, 2000).

The phrase ‘high-risk adolescent’ commonly refers to a young person aged between 12 and 18 years behaving in ways that place him or herself and sometimes others at imminent and significant risk of harm (Aged, Community and Mental Health Division and the Youth and Family Services Division, 1999; DHS, 2001a; DHS, 2006). The World Health Organisation defines adolescence as between the ages of 10-19 years (Robinson & Miller, 2010) and some of the young people identified as having high-risk behaviours in Victoria have been as young as 9 years of age (Frederico, Jackson & Black, 2010). Although adolescents with high-risk behaviours are not only found within the child protection and care and youth justice system, this report focuses on those who are.

Definitions

High risk and severe harms
Child protection uses the term ‘high risk’ differently depending on whether it relates to a young child or an adolescent. High risk in an infant or young child signifies serious concerns that a parent or other adult may place the child’s life or wellbeing in jeopardy. High risk in relation to adolescents usually signifies serious concerns that the adolescent may place their own life or wellbeing in jeopardy (DHS, 2002). Of course, for an adolescent to reach this impasse, it is highly probable that adults have already jeopardised their safety and wellbeing and may be continuing to do so. In relation to sexual exploitation, high risk usually signifies both a concern regarding the young person’s behaviour, and the behaviour of those who are exploiting him or her.

The High Risk Service Quality Improvement Initiative (HRSQII) in 2001 described high-risk adolescents as:

“Young people aged between 12 and 18 years of age, who are clients of Protective Services, and whose behaviour is considered to be high risk ... These young people were characterised by:
- Challenging behaviour at home, in placement and at school
- Substance abuse
- Suicidal tendencies
- Aggression
- Chronic running away
- Prostitution
- Association with paedophiles
- Emerging or diagnosed psychiatric or psychological disorder
- Consistent, escalating offending
- Sexual offending
- Estranged or non-existent relationships with their family.

In addition, these young people may require long term care and substantial support to meet their needs for care and protection.” (DHS, 2001a, 2)

A more recent practice instruction from DHS provides the following description of high-risk young people.

“... young people who are clients of Child Protection, aged between twelve and eighteen years who have multiple and complex behavioural and emotional difficulties and who require long term and substantial support.

Multiple and complex behaviours include:

- Emerging or diagnosed mental illness or psychological disorders
- Suicidal ideation or self harming behaviour
- Serious offending
- Exposure to commercial sexual exploitation (sex-working)
- Association with sex offenders or other dangerous adults
- Repeat risk taking
- High levels of aggression
- Extreme challenging behaviour at home, school, or in out of home care
- Use of drugs and/or alcohol to the extent that a young person’s safety, stability and development is at significant risk
- Inadequate health care resulting in immediate and significant risk, including mental health
- Severe conflict with parents and or family
- Escalating offending
- Repeated running away
- Isolated from family and peers.” (DHS, 2013a)

These two descriptions, written more than a decade apart, have much in common. Most of the differences reflect a change of emphasis and terminology (e.g. multiple and complex behaviours instead of challenging behaviours; and sexual exploitation instead of prostitution).

Some of these behaviours, even when they are not accompanied by other behaviours, equate to high risk from both an assessment and administrative status perspective. An example of administrative status is that knowledge of a young person who is a client of DHS being involved in commercial sexual exploitation in Victoria requires him or her to be placed on the DHS High Risk Youth Register (DHS, 2013b). Another example is the DHS advice regarding critical incident reporting
states that concerns that a young person is involved in sexual exploitation is a category 1 (highest) incident (DHS, 2012).

The term ‘high risk’ denotes danger of some type of harm. Although the DHS specialist practice guide on working with adolescents (Robinson & Miller, 2010) does not use the term high risk, it describes ‘life-threatening behaviours’, acknowledging that the potential harm can be death or serious injury. The concept of high-risk adolescents is both a reference to the level of risk or the likelihood of danger that their behaviours are leading to, and also a reference to the cumulative harms they have already experienced.

Since 2000, every annual report of the inquiries into the deaths of children and young people known to child protection has reported on the death of adolescents attributable to high-risk behaviours, such as substance abuse, reckless behaviours, not wishing to engage with services, mental health concerns, sexual exploitation, suicide or self-harm (Victorian Child Death Review Committee [VCDRC], 2000–2013). The VCDRC (2013) report noted the largest category of deaths for adolescents over the previous 16 years were related to accidents, involving motor vehicle, train or a motorcycle. Although not all, many of these were associated with reckless behaviours of them and/or their peers. The second highest category of death in this age group was substance abuse related deaths and the third highest category was suicide/self-harm and other risk taking behaviours. Other issues noted in the VDCRC reports over the years about these young people during their shortened lives included: limited placement options; not being engaged in school; not being able to access mental health services; and feeling stigmatised by services.

“The committee accepts that those most difficult and at-risk should not be subject to the lock-up facilities of the past, but believe that their needs should be met in such a way that offers them safety and nurturing in a setting that is both emotionally and physically secure.” (VCDRC, 2000, 24)

The When Care is Not Enough Report (Morton, Clark & Pead, 1999) described their sample of 10 young people as having both high-risk behaviours and high and unmet needs. These young people were also described as having extreme levels of emotional and behavioural disturbance.

“The definition of extreme disturbance that evolved in the course of consultations as the most meaningful included:

- Extreme levels of emotional and attachment disturbance such that the young person had few positive relationships and showed clear evidence of severe emotional turmoil; and
- Extreme levels of behavioural disturbance, by early to mid adolescence, such that there was a considerable risk of serious harm to the young person and/or others (particularly staff and carers), and usually to both self and others. This level of disturbance was found to be associated with particularly horrific early experiences.”

(Morton, Clark & Pead, 1999, 22)

Characteristics (in addition to the high-risk behaviours of these young people) often included mental health problems, attachment and relational problems, poor affect regulation, chaotic and unpredictable behaviours, poor academic achievement, and minimal involvement with education and training (Aged, Community and Mental Health Division and the Youth and Family Services Division, 1999; Morton, Clark & Pead, 1999; DHS, 2001a; 2005; 2006).
Commercial child sexual exploitation and prostitution

There is substantial discussion in the literature regarding what to call the phenomena of commercial child sexual exploitation. This is more than an academic or ‘politically correct’ issue, as it reflects society’s attitudes towards young people, sexuality, exploitation, violence and prostitution, which, in turn, influence policy and practice (Melrose, 2004, 2013). This discussion is different when considering language pertaining to children rather than adults, and has moved from a punitive to a welfare or a human rights model (e.g. Chase & Statham, 2005; Cuda, 2011; Cusick, 2002; Gillespie, 2007; Harding & Hamilton, 2009; Lebloch & King, 2006; Martyn, 1998; Melrose, 2004; Nixon, Tutty, Downe, Gorkoff & Ursel, 2002).

Terms used in the literature include: young people in prostitution; young people abused through prostitution; youth prostitution; commercial sexual exploitation of children; survival sex; adolescents selling sex; child sexual exploitation; prostituted teens or prostituted juveniles, sex trade workers, street hustler, hustling sex, trafficked youth; transactional sex; and domestic minor sex trafficking.

Commercial sexual exploitation encompasses different types of exploitation such as prostitution for third party gain (i.e. pimp); other abuse through prostitution (but no known third party where the money or goods is provided to the young person); party house model (party for sex); child pornography; Internet enticement of children for sex; sex trafficking across borders; sex tourism; sexual exploitative relationships and extra familial child sexual assault (Assistant Deputy Minister’s Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Beckett, 2011; Burgess, Mahoney, Visk & Morgenbesser, 2008; Chase & Statham, 2005; Heilemann & Santhiveeran, 2011; Kotrla, 2010; Melrose, 2004, 2013; Mitchell, Jones, Finkelhor & Wolak, 2011; Rafferty, 2008).

“Common to all these scenarios is an imbalance of power in favour of the abuser and some degree of coercion, intimidation, exploitation, violence and/or enticement of the child or young person (adapted from National Working Group definition/DCSF 2009 Guidance).” (Beckett, 2011, 3)

This literature review concentrates on commercial sexual exploitation through prostitution, although it recognises other aspects of sexual exploitation can be a part of young people’s experience, such as pornography, Internet involvement and sexual assault. The commercial aspects of sexual exploitation often relate to money, but can also involve drugs, other goods, shelter or promises or threats. This review uses the term ‘sexual exploitation’ as the broader concept and ‘prostitution’ as a more explicit example of exploitation that includes concerns regarding the young person’s behaviour. This dilemma regarding language and the balance between ideology and practical use has recently been discussed by Melrose (2013), highlighting the difficulty in getting the language right.

What is fairly consistent in the literature is that the terms ‘prostitutes’ and ‘sex work’ are not considered appropriate for children and young people, as this is never a legitimate profession or choice for children – regardless of whether or not it is for adults. It is interesting to note that, in 2010, the Victorian Prostitution Control Act 1994 was amended to use the term sex work instead of prostitution.

The need to define paying children for sex as ‘abuse’ was emphasised by a number of authors (e.g. Fong & Berger Cardoso, 2010; Melrose, 2004; Mitchell, Finkelhor, & Wolak, 2010). In contrast, there is other discussion in the literature as to whether the labels of ‘abuse’ and ‘victim’ let non child
protection specific services off the hook and creates the perception of the young person as passive and unable to be active agents in her or his own life (Pearce, 2006; Phoenix, 2002; 2003).

In the context of this literature review, prostitution is understood as a form of commercial sexual exploitation and for children and young people is never considered a genuine choice. Sexual exploitation through prostitution is simultaneously a high-risk behaviour of the young person (active) and the result of being sexually exploited by others (passive). The active element does not imply that the young person is at fault, but that they may have developed certain behaviours to adapt in a context of survival and constrained choices that we need to effectively recognise and respond to as well as dealing with those who are exploiting our young people. This confusion between what is choice and what is control often confounds policy makers and practitioners alike.

“The difficulty is that when people are frustrated by trying to understand the choices of another person, there’s a whole pile implicit in that frustration. There’s at least two elements to it. One is the assumption of psychological integrity; that they could choose, that they have access to similar reasoning processes as the person looking at it. And with our kids that’s simply not the case. The second is an implicit moral judgement. Implicit in the asking of the question ‘why would they choose to do that’, is ‘because I wouldn’t.’ Both of those things put you in a really bad place for working with these young people (health).” (Beckett, 2011, 80-81)

**Adolescent development and risk**

High-risk behaviours are seen as outside the norm of adolescent behaviour; however, a certain degree of risk taking is common as adolescents explore and extend their sense of whom they are and the world in which they live (DHS, DPCD & DEECD, 2008; Robinson & Miller, 2010; Schmied & Tully, 2009).

Taking risks is not peculiar to young people in the child protection, out-of-home care or youth justice systems and does not always lead to dire consequences. Indeed, most young people who take risks grow up to be healthy adults. Taking certain risks, trying new challenges, testing the limits of our own and other’s expectations are important developmental tasks, particularly in adolescence (Jackson, Waters, Meehan, Hunter, & Corlett, 2013).

Understanding the developmental task of risk-taking from a neurodevelopmental perspective provides further insight into risk-taking in general and for high-risk populations. In infancy and early childhood, these changes are enormous as the brain grows up to 90 per cent of the adult size brain by the age of 4 years (Perry, 2006). Nonetheless, there are further changes and a degree of re-organisation that occurs later in life. A number of these later changes, particularly in the adolescent brain, have relevance for understanding risk in general. There is discussion later in this review regarding what happens if the adolescent did not receive what he or she needed in terms of care and safety earlier in life.

An example of neurobiological changes during typical adolescence is the increase in myelination of neurons. A useful metaphor to understand this process is to think of it as creating more ‘insulation’ for neurons in order to increase the efficiency and speed of communication between them (Child Welfare Information Gateway, 2009; Lenroot & Giedd, 2006; Steinberg, 2009). This increased efficiency of the neural network is associated with improved executive functioning, including the capacity to plan ahead, weigh risks and rewards, consider multiple sources of information and lower
impulsivity. As myelination continues during adolescence and up until the early 30s, adolescence is a key time of development in relation to executive functioning. For healthy adolescents, this capacity for executive functioning is stronger than in earlier childhood, but is not yet at adult levels (Perry, 2012; Steinberg, 2009).

Adolescence is also a time when there is an increase of dopamine (a neural transmitter), which is associated with the experience of reward and pleasure, in the prefrontal cortex. One hypothesis related to the adolescence tendency towards risk taking, is that the increase in dopamine activity in the brain heightens the feeling of reward they experience, such as through thrill-seeking behaviours (Steinberg, 2008). In other words, they are likely to get more pleasure from a particular experience than they had previously or than they would in adulthood. Other activities or substances that can stimulate the neural systems involved with feeling pleasure include: alcohol and other drugs; salty and fatty foods; music and rhythm; doing something consistent with beliefs and values; relationships; sex; generosity to others; gambling; and self-harm (Perry, 2011; Linden, 2011). Some sources of reward reflect potential risk factors (such as alcohol) and others can be used to engage the young person in positive experiences of reward (such as rhythm).

Following is a description of some of the changes in typical adolescence associated with risk and mediated through changes in the brain.

Adolescents are usually:
- More oriented towards seeking rewarding feelings before they have developed the typical adult capacity for self-regulation and decision-making
- More likely to base decisions on immediate or short-term positive consequences (such as potential rewards) compared with longer term negative consequences or costs
- More likely to seek sensations and thrills
- More likely to experience rapid and sometimes extreme mood swings
- More likely to be influenced by peers
- More impulsive than adults, albeit less impulsive than younger children
- Less sensitive to risks and more sensitive to rewards
- Less likely to delay gratification
- Less likely to have synchronised cognition and affect (Gardner & Steinberg, 2005; Steinberg, 2008, 2009, 2010).

Some of these differences, such as being more likely to seek rewards and not worry about the potential costs, were more likely to occur with adolescents when they were with peers (Gardner & Steinberg, 2005). Griffin, Germain and Wilkerson (2012) note that these and other descriptors of some of the neurobiological differences in adolescence have had major influence on recent Supreme Court decisions in the US.

The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA and National Framework Implementation Working Group (NFIWG) (2010, p.16) noted that best practice in working with young people preparing to transition out of the care system should recognise “... the need for the young person to experiment and take risks but incorporate strategies to maintain support when these plans fail.”
High-risk young people have the same needs as other young people, and then some. These are varyingly described as needs (e.g. Morton, Clark & Pead, 1999; Thoburn, 1994); desired outcomes (e.g. DEECD & DPCD, 2008); or rights (Department of FaHCSIA & NFIWG, 2011).

“Research has shown that the wellbeing of . . . children (at risk) depends not only on meeting the basic physical and psychological needs which they share with all children, but on the provision of a ‘sense of permanence,’ and also a sense of their own identity. These two must be kept in balance if the youngster is to develop the sense of self-worth which is essential for satisfying relationships in the future.” (Thoburn, 1994, 37)

These young people share universal human needs and rights with other young people, such as safety, identity, security, cultural connection, health, education, social connection and participation (United Nations Convention on the Rights of the Child, 1990). This group of high-risk young people cannot take these rights for granted and some of their needs may have never or rarely been met. They are likely to have additional needs to supplement or compensate for the accumulated gaps in their life. These additional needs and rights include the right for mental health treatment, alternative care and stability. The Convention of the Rights of the Child (1990) recognises some of these additional rights.

“States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.” (Article 25)

“States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.” (Article 39)

For example, if a young person has not experienced a parent figure who supported them in attending and participating in school earlier in life, they may need a higher level and different type of support in adolescence if they are to fully participate in school. Simply providing them with the ‘normal’ experience may not be enough to bridge the gap. Similarly, the adults in their lives including family members, carers and teachers may require additional support in order to respond effectively to meet their needs.

“It was apparent that mainstream schools experience difficulties in responding to the needs of young people who required integration support and remedial assistance in an environment where these initiatives are not adequately resourced. The additional strain placed on teachers by adolescents with challenging behaviours is a further disincentive for schools to persevere with such students.” (DHS, 2003a, 16)

The Department of Human Services (2005) undertook a study on the high support needs of children and young people who were at risk of placement breakdown due to their behaviours. This study
identified the need to understand the underlying trauma behind the behaviours. It also identified another risk for these children and young people – lack of stability of placement and stability of relationships – and the associated need for people to remain committed to their care and wellbeing over time.

“All of the children presented with diagnosed and undiagnosed multiple high support needs and had experienced repeated placement breakdown. Trauma was the universal, underlying theme of the children’s challenging behaviours, caused by experiences of repeated multiple forms of abuse and neglect... Pre entry to care, legislative pressures and assessment based on risk, rather than on needs, caused the impact of trauma and hence high child support needs to be underestimated, compounding harm to the child.

Lack of information about, and early failure in, recognising and treating high child and family support needs led to presenting problems, i.e. child’s behaviour and practical support needs, rather than the underlying causes, being identified for support and service intervention. It contributed to lack of change, parental powerlessness and disengagement, the child’s heightened anger and distress, and led to the child's entry to care.

Post entry to care, insufficient information and late recognition of the child’s high support/treatment needs resulted in unmet worker needs for child specialist assessment/treatment plans. It also resulted in the wrong type of support being sought, escalation in the child’s challenging behaviours, poor matching of child to placement, underestimation of child, caregiver and school support needs, repeated placement breakdown, multiple placement provision and failed reunification attempts.”

(DHS, 2005, 5)

Complexity and multiplicity
A frequent proposition found in many documents and heard in many forums and hallways is that young people in child protection and out-of-home care are more complex today than previously. This proposition has been mentioned in the literature to explain certain policy reforms, program initiatives and many practice challenges.

“Humanity is complex. We are extraordinary and unfathomable creatures. Yet we are designed to discover, explore and question ourselves and our environment, including using science and the arts to try to understand our own complexity. Complexity is not a vice, but it is a challenge.” (Jackson, 2012, 1)

Complexity is usually associated with the concept of a ‘system’. A complex system is a network of varied components that interact non-linearly, to give rise to emergent and not always predictable behaviour (Rocha, 1999). The human being is an intertwined combination of systems, as is the family, the community and society. In child welfare, complexity is frequently used to describe different albeit overlapping phenomena, such as children and families with multiple problems, difficult to describe situations, high-risk young people, multiple risk factors, multiple and potentially competing services involvement, thorny dilemmas that appear as no-win situations or with unforeseeable consequences, and elaborate sophisticated interventions (Aged, Community and Mental Health Division and the Youth and Family Services Division, 1999; Council of Australian Governments, 2009; DHS, 2003b; DHS, 2003c; DHS, 2009a; Miller, 2007; Morton, Clark, & Pead, 1999).

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A definition of complexity in child welfare developed by the author in consultation with Dr Sandra Radovini (Mindful) is as follows:

“Children and young people and/or their families have multiple and difficult problems across many domains that affect the child, family and system’s ability to cope and respond. The customary or typical responses are likely to be insufficient. Instead these children and their families require enhanced, integrated, flexible and coordinated responses to redress these problems to meet the child’s needs for safety and wellbeing.” (Jackson, 2012, 2)

The term ‘complex’ is commonly used to describe young people with high-risk behaviours, their multiple, interconnected experiences, their needs and the associated service system. For example, ‘multiple risk factors’ is the most common reason for young people being placed on the DHS High Risk Youth Register (DHS, 2006). In another example, the DHS Working Together Strategy (Aged, Community and Mental Health Division and the Youth and Family Services Division, 1999) note that young people involved with multiple services is a signal to the complexity of their situation. Co-occurring symptoms that traverse a number of mental health disorders for the one person is described as symptom complexity (Hodges, Godbout, Briere, Lanktree, Gilbert & Taylor Kletzka, 2013). However, complexity is more than the number of symptoms, problems or services.

[These young people] are someone’s child, brother, sister, cousin, niece, nephew, grandchild; hopefully someone’s friend; and have unknown potential.

Complexity theory recognises that all humans are complex, not just those with high-risk behaviours. It notes that humans are not limited to one identity. High risk is not the only identity for these young people. As with everyone else, they have multiple identities (Kurtz & Snowden, 2003). In addition to being described as high risk (or any other label), they are someone’s child, brother, sister, cousin, niece, nephew, grandchild; hopefully someone’s friend; and have unknown potential. Their behaviours are not limited or predetermined to only being those of high risk. Their past experience has not solely been one of trauma, although this may have been a pervasive experience.

We create concepts and labels to help us see patterns so we can look for order and understanding in a complex world. The concept of high-risk adolescents is useful if it enables us to construct patterns so we can better understand. However, complexity theory cautions against relying on these patterns as the summation of the young person’s or indeed our own experience. We need to be reminded that there will be many aspects of the young person’s identity and experience that we may not see, but are nonetheless as real as those that we do.

Complexity theory, along with ecological systems theory, points to the myriad of ways that a combination of problems can interact with each other. It cautions against looking for simple cause and effect explanations. Both complexity theory and ecological systems theory also point to including a better understanding of the strengths and positive characteristics in the young people’s lives and how these interact with their difficulties.

**Vulnerability and resilience**

Related but separate to their high-risk behaviours, young people in the protection and care system commonly share other experiences. The descriptions of their behaviours are only one side of the
coin. For example, most of the young people described as being at high risk have also experienced the following:

- More likely to live in residential care than with family or in other out-of-home care placements (Barber, Delfabbro & Cooper, 2001; Bath, 2008; DHS, 2001b)
- Multiple placement breakdowns ostensibly due to their behaviour (Barber, Delfabbro & Cooper, 2001; DHS, 2001a, 2003b; Bocker Jakobsen, 2013; Gilbertson & Barber, 2004)
- School exclusion (DHS, 2001a; DHS, 2005)
- Loss of liberty, such as through youth justice and Secure Welfare (VCDRC, 2006)
- More coercive approaches (Souverein, Van der Helm, & Stams, 2013)
- Homelessness (Aged, Community and Mental Health Division and the Youth and Family Services Division, 1999; DHS, 2005)
- Lack of access to health services (DHS, 2005)
- Lack of positive friendships (DHS, 2001a).

As identified in the discussion regarding complexity, these confounding difficulties may be a result of their high-risk behaviours and/or a causal explanation and/or being caused or influenced by other factors. These are all markers of increased vulnerability, which is one way of understanding the multiple implications of suffering trauma of abuse and neglect.

A whole-of-government discussion paper described vulnerable young people between 10 and 25 years as “Young people who, through a combination of their circumstances and adolescent risk-taking behaviour, are at risk of not realising their potential to achieve positive life outcomes” (DHS, DPCD & DEECD, 2008, 14). This paper on vulnerable young people focused on those they described as experiencing additional problems (requiring early intervention) and those who are highly vulnerable (requiring comprehensive and coordinated interventions) rather than those described as at high risk (requiring intensive interventions).

A unifying theme is that, almost without exception, high-risk young people have early-in-life experiences of substantial trauma and deprivation through abuse and neglect. However, this is not to say that all young children who suffer trauma and deprivation will end up with high-risk behaviours. One of the challenges in understanding resilience and risk is that what may be a protective strategy to mitigate one risk (e.g. removing a child from an abusive situation), may be a risk factor to lead to another harm (e.g. low self-esteem, attachment disruption, etc.) (Clark, 2000).

Masten, Best and Garmezy (1990) described psychological resilience as:

1. good outcomes despite high risk status (beating the odds)
2. sustained competence despite the threat (coping) or
3. recovery after the effects of trauma.

Studies point to protective factors that can increase resilience, such as IQ, positive attachment relationships, social support and an internal yet flexible locus of control. In looking at resilience after the trauma of abuse and neglect, the most significant finding was the importance of the quality of the caregiving the child received after the trauma. Given that the absence of a consistent caregiver is often a hallmark of a high-risk adolescent’s experience, this would seem to compound the young person’s problems.
“Children who experience chronic adversity fare better or recover more successfully when (a) they receive good and stable care from someone or, in the case of older children, when they have a positive relationship with a competent adult; (b) they are good learners and problem solvers; (c) they are engaging to other people, adult caregivers for infants, other adults and peers for older children; and (d) they have an area of competence and perceived efficacy, valued by themselves or society, whether it is academic, athletic, artistic, or mechanical.’ (Masten, Best & Garmezy, 1990, 438)

Schofield and Beek (2005) argue for the need to focus on processes and mechanisms to build resilience rather than to simply describe protective or risk factors. The focus is on promoting resilience, rather than simply identifying resilient factors.

The concept of resilience could be applied to our consideration of high-risk adolescents in at least three possible ways:

- High-risk adolescents are by definition not resilient. This is shown by their high-risk behaviours, indicating their high vulnerability and risk of further negative outcomes including death or serious injury
- Some high-risk adolescents may become resilient if they or others can make the changes needed to help them recover from trauma and achieve positive outcomes
- Some high-risk adolescents may already be resilient in the face of some risks by using tried and true survival and adaptive strategies that have kept them alive in an unsafe and cruel world, even though these behaviours look unsafe to others.

The first way of conceiving resilience and high risk is commonly applied and is demonstrated in this quote from the evaluation of the High-Risk Adolescents Strategic Quality Improvement Initiative.

“The resilient child has the capacity to withstand stressors, overcome adversity, achieve higher degrees of self-mastery and self-esteem (Poulsen, 1993). The opposite notion to resiliency is that of vulnerability, which characterises the lives of many children at risk. At risk children are overwhelmed by psycho-social or environmental circumstances that are stressful, and temperamentally difficult children are seen to cope less well with this stress. Vulnerable children have a higher risk of developing into adolescents who offend, abuse substances, leave school, etc.” (DHS, 2001a, 29)

This either/or perception of resilience and vulnerability appears to consign high-risk young people to further adverse outcomes. In other words, if they show high-risk behaviours they are not and cannot be resilient. In contrast, the other two possible relationships between resilience and high risk as described above provide some hope that there is value in promoting resilience for the young person. Indeed, the third way recognises that the young person is trying their best to survive an unsafe world, and that this could provide a clue to how to best help them.

2. **How have these behaviours and other problems arisen?**

“Young people who suffer particularly severe abuse in early childhood are likely to suffer a range of post-traumatic symptoms, and emotional and behavioural disturbance into adulthood, unless they receive intensive therapeutic interventions. The level of disturbance manifested by a child who has been severely abused or neglected may in turn strain the resources of a parent or carer and may provoke further rejection or abuse. Treatment, education and care all become more difficult as the layers of emotional and behavioural disturbance and consequent harm suffered by the young person accumulate.” (Morton, Clark & Pead, 1999, viii)
Frameworks for understanding

...the most useful frameworks have been those that grapple with the complexity of the interacting systems at work

There is strong evidence that child abuse and neglect in young childhood are notable precursors to many (but not all) adolescents and adults experiencing significant problems later in life. However, there remain multiple explanations for how these experiences contribute to later problems.

Explanatory frameworks initially focused on the individual pathology of the young people or their parents. However, the most useful frameworks have been those that grapple with the complexity of the interacting systems at work, such as the ecological systems perspective, attachment theory, trauma theory and neurobiological perspectives.

The ecological systems perspective understands that development occurs from the multiple interactions between the individual and her or his environment over time (Bronfenbrenner, 1979). Attachment theory highlights that the most important aspect of the young children’s environment is the relationships that are meant to keep them safe, encourage their exploration and comfort them in times of distress (Bowlby, 1973). Attachment theory helps explain the devastating and dysregulating impacts that can occur when the supposed source of safety and comfort (the parent or carer) is actually the source of danger and the child is left without a strategy for safety, comfort and proximity (Weinfeld, Sroufe, Egeland, & Carlson, 2008). Attachment is not just a theory of early development, but is relevant throughout life. According to Bowlby (1973), adolescence is a time of dramatic increase in differentiating ourselves from others. These and related developmental changes allow young people to consider themselves in the context of multiple relationships and to form an internal relational view of self that is not centred on any one relationship (Golding, 2011).

Trauma theory sheds light on the emotional, mental, physical and social health of the individual when he or she is exposed to a situation or ongoing experience that threatens life and/or sense of security in life. Trauma theory, along with understanding neurodevelopment, helps explain what can happen when the person at the receiving end of this pervasive threat is a child whose brain is in the process of developing and becoming organised. In an unsafe uncertain life, the child’s brain is likely to become organised around helping him or her survive in a world of threat and actual harm (Perry & Pollard, 1998).

“The last 20 years have seen a huge shift in people’s understanding of abuse and neglect, and neurobiology and neuroscience have illuminated the way the brain develops and functions. Consequently, young people who have experienced abuse and neglect and who display complex and difficult thoughts, emotions and behaviours are recognised as being hurt and in pain – rather than as mad or bad. Their defiance, aggression and rejection of adults and adult authority can now be seen as adaptations to their experiences, which have allowed them to survive the chaos, unpredictability and uncertainty that has been in their lives.” (Commission for Children and Young People, 2013, 39)

Sexual abuse, physical abuse, emotional rejection and exposure to family violence are examples of traumatic events, along with other life threatening or invasive experiences (Finkelhor & Browne, 1985; Herman, 1992; Sutherland, 1996). Being traumatised may or may not lead to the specific set of symptoms classified as Post Traumatic Stress Disorder (PTSD) (Herman, 1992). Symptoms or
sequelae from traumatic experiences include dissociation, self-harming behaviours, affect dysregulation, isolation, avoidance, flashbacks, heightened anxiety, poor attention, and hyperarousal (Rowan & Foy, 1993; Herman, 1992, 2003). Children who have experienced multiple types of trauma, such as different types of maltreatment, are more likely to present with symptom complexity (Hodges et al., 2013). As can be seen from this list of possible behaviours emanating from the trauma experience, many trauma symptoms are consistent with the list of high-risk behaviours.

There are multiple ways in which trauma can contribute to the development of high-risk behaviours. For example, abuse can lead to the flight, fight or freeze neurochemical response, which may not be temporary if the abuse is long-term. The child’s baseline level can be altered if they suffer sufficiently repetitive harmful experiences. “If the child has been raised in an environment of persisting threat, the child will have an altered baseline such that the internal state of calm is rarely obtained or only artificially obtained through alcohol or drugs” (Perry, 1996). Prolonged exposure to trauma and deprivation in childhood can lead to problems with memory, learning, regulation of mood and affect following stress, cognitive problems, and increasing resting heart rates (Anda et al., 2006). As noted in other studies (e.g. Herrenkohl et al., 2003; Gibbs Van Brunschot & Brannigan, 2002), there are also cognitive and social learning explanations. The concept of a trauma-bond can help explain some of the mechanisms that underlie greater vulnerability to sexual exploitation. Through the grooming process a person can use coercion to simultaneously instil fear and gratitude in the young person (Jordan, Patal & Rapp, 2013).

Another useful model for understanding some at-risk behaviours, such as running away or child sexual exploitation, is the application of cognitive behavioural and systems theory, such as exploring the push (negative) and pull (attraction) factors (Saphira & Herbert, 2004; Biehal & Wade, 2000; Melrose, 2004). Exploring why young people leave the supposed safety of out-of-home care into a life filled with exploitation and danger that would terrify many adults is an important question.

An important human condition to consider when reflecting on risk, especially associated with abuse and neglect is the different between the healthy moral development task of learning to feel guilt and remorse, in contrast, to being stuck in a shame reaction. Feiring, Taska, and Lewis (1996) in their study of shame and sexual abuse noted that guilt relates to a specific behaviour, whereas shame is a more generalised and pervasive attitude of the self.

Shame is not necessarily used in day-to-day usage as a negative concept. “It can refer to a positive sense of obligation and needing to make things right, similar to guilt. However if the person does not have a healthy way of dealing with shame it can be defeating.” (Jackson et al., 2013, 32). Shame and particularly toxic shame can be understood both through understanding the impact of disrupted attachment experiences as well as through understanding the impact of trauma.

Toxic shame is where someone feels “… fundamentally disgraced, intrinsically worthless and profoundly humiliated in their own skin, just for being themselves.” (Garbarino, 1999, 58)

When a child or adult has experienced relational trauma, toxic shame can be a response to a pervasive sense of helplessness (Herman, 1992).
The question of shame is critical to understanding the lack of self-regulation in trauma victims and the capacity of abused persons to become abusers. Trauma is usually accompanied by intense feelings of humiliation; to feel threatened, helpless, and out of control is a vital attack on the capacity to be able to count on oneself. Shame is the emotion related to having let oneself down.” (van der Kolk & McFarlane, 1996, 15)

This review focuses on commercial child sexual exploitation and absconding behaviours as two examples of high-risk phenomena. These experiences and the associated behaviours are closely intertwined, highly dangerous, sometimes present in our most at-risk client group, strongly related to child abuse and neglect, more likely to occur within the out-of-home care population than the general population, and yet have had comparatively little focus in the policy, program or practice-related literature within Australia.

Retrospective and longitudinal studies
A number of studies have demonstrated the multiple impacts of early repeated exposure to different adverse and traumatic experiences on children as they grow into adolescence and adulthood. Table 1 provides a summary of nine examples of longitudinal studies, eight of which are prospective, and one large retrospective study, with all but one from the USA.

Taussig (2002) described a study of young people when they entered foster care. They were interviewed at baseline approximately 6 months into their foster care placement and then 6 years later. She examined four major risk behaviours of sexual behaviours, delinquent/violent, substance use and suicidal or self-harming behaviours. She found that physical abuse and neglect were related to greater involvement in delinquency and substance use, whereas sexual abuse was not associated with any of the risk behaviours. Being described by carers as having risk behaviours at baseline was predictive in which young people were described with risk behaviours 6 years later. Greater peer group support at school and social acceptance were positively correlated with fewer risk behaviours at the 6-year time period. “It is possible that increasing school achievement and classmate support may reduce engagement in risk behaviors. Targeting youth with high social acceptance for intervention efforts designed to increase their association with prosocial peers may also foster more prosocial behaviors.” (Taussig, 2002, 1193)

Dunlap, Golab and Johnson (2003) described girls’ sexual development through a qualitative study over eight years. The majority of the female participants were African American. They ranged in age from 9 to 85 years at initial interview. The adults were asked retrospectively about their childhood, whereas the children/young people were followed prospectively. This study found that early sexual abuse formed part of a pathway leading to early sexual activity that often involved prostitution, teen pregnancy, early parenthood, early school leaving, limited employment, and drug abuse. Prostitution became a practical means by which some young women were able to support themselves, their drug use and provide for their own children.

The LeHigh longitudinal study involved sample groups of child protection clients, children in high-risk families and general community child care. They found that an early experience of physical abuse was a predictor for violent behaviour in adolescence. However, their analysis showed that most of this could be explained through other mediating factors. For example, they found that abuse can lead to low school commitment and involvement with violent peers, and that these factors can lead
to violent behaviour towards others (Herrenkohl, Huang, Tajima & Whitney, 2003). There is currently a 20-year, follow-up study on this cohort of children who are now adults in their 30s and 40s.

“Our findings suggest that abuse influences what children believe about the uses of violence, which, in turn, affects their involvement with antisocial peers. That violent attitudes predicted violent behavior indirectly through the peer variable suggests that risk for later violence among abused children may be highest for those who are further socialized to antisocial behavior within peer networks.” (Herrenkohl et al., 2003, 1203)

There does not appear to be a ‘point of no return’ beyond which services for children are hopeless – every risk factor we can reduce matters.

Appleyard, Egeland, van Dulmen and Sroufe (2005) found that the number of risk factors experienced early in life predicted the level of externalising behavioural problems and, to a lesser extent, internalising problems in adolescence. These risk factors were physical abuse, physical neglect, emotional neglect and/or sexual abuse, family violence, family membership disruption, low socio-economic status and high parental stress. Risk factors that were not measured in the study may have had more impact on internalising problems. One of the implications of this study was that “…there does not appear to be a ‘point of no return’ beyond which services for children are hopeless, and that every risk factor we can reduce matters” (Appleyard et al., 2005, 242).

Schofield and Beek (2005) undertook a study of children in long-term foster care. Sixty per cent were described as making ‘good progress’ at the 3-year mark when they were able to use their foster parents as a secure base, which, in turn, helped them to settle in other environments, such as at school. They showed a variety of individual and contextual risk factors at baseline, but a common factor at follow up was the sensitive, empathic and available parenting style of the caregivers. There were 27 per cent in the ‘uncertain progress’ group. These children and young people also had a mixture of risk and protective factors although they were all either in the same placement as they had been at baseline or had settled well into a new placement. However, some carers were feeling overwhelmed by the children’s neediness. The children continued to be troubled by their emotional state, lack of flexibility, not adapting to new situations and had developmental challenges. Poor professional support appeared to be a feature for many. The third group of 13 per cent were described as being in a ‘downward spiral’. They had all experienced placement changes since baseline. Although some had very difficult behaviours at baseline, so had some of the other two groups, but the third group continued with these difficulties. Carers were exhausted, parent-child contact was fraught and there was a lack of professional support. Examples of positive turning points noted in some of the ‘good progress’ or ‘uncertain progress’ groups included one-off events that appeared to deflect the trajectory away from the downward spiral.

Tyler, Johnson and Brownbridge (2008) examined the effects of child maltreatment, poor parenting and living in an impoverished neighbourhood on later victimisation by others, criminal behaviour, running away and school engagement. The information was collected from the young person, caregivers and caseworkers at baseline, 12 months, 18 months and 36 months. They found the absence of positive parenting at baseline was associated with poor school engagement and running away behaviours at the 18-month phase. They also found that sexual abuse, neglect and disadvantaged neighbourhoods at baseline were associated with victimisation and poor wellbeing at
the 18- and 36-month phase. The impact of positive parenting on wellbeing and the impact of neglect on being less engaged with school were significantly stronger for females. Males who ran away were more likely to be victimised by others compared with females (although this could be contributed to the sites to which males tended to run away being more dangerous). Although running away increased the likelihood for both sexes to be involved with criminal activity, this was higher for males.

“It seems likely that adolescents who experience higher levels of monitoring and who feel very close to their caregivers may be less likely to run away because they feel wanted and cared about. Additionally, these youth may communicate more with their parents and discuss troubles when they arise and, as such, are less likely to use running away as a coping mechanism” (Tyler, Johnson & Brownbridge, 2008, 516).

Leon, Ragsdale, Miller and Spacarelli’s (2008) study involved young people with sexualised behaviours towards others who had been in care for an average of 8 years and with the average number of placements being 7, ranging from 1 to 23 placements. Just over a quarter were female and the average age at time of follow-up was 13 years. They all had some level of sexualised behaviours and had varying histories of abuse and neglect.

Problems identified at baseline were associated with those problems being more likely to occur at follow-up, although there were some factors that appeared to reduce this likelihood. There was a positive correlation for boys, with positive parenting being associated with a decrease in negative affect problems. When there was high level of agency support for the young people with severe sexual abuse histories, these young people reported relative low sexual ruminations. Whereas when there was low level of agency support, those with severe sexual abuse histories had high levels of sexual rumination. They also found that involvement in clubs was only associated with low levels of sexual rumination for those who had not been sexually abused. It was encouraging to note that positive parenting styles and supportive casework had a helpful impact on this high-risk group of young people over time.

Wilson and Widom (2009, 2010) undertook a longitudinal prospective study of the multiple pathways from the experience of child abuse and neglect to problems later in life. Their sample consisted of 908 children who prior to the age of 12 years old had substantiated histories of physical abuse, sexual abuse or neglect, and a control group of 667 children with no such history. One part of this study looked at the use of drugs in middle adulthood (2009). They found that for women who had been subject to abuse and neglect as a child, later drug usage in middle adulthood was mediated through intermediate problems such as sexual exploitation, homelessness, criminal behaviour and school problems. In other words, child abuse and neglect appeared to predict these risk factors, and it was these factors that predicted later drug usage. However, they found a different pattern for young men who did not show a link, direct or otherwise between child abuse and neglect and later drug abuse. They found that later drug usage was associated with criminal behaviour and school problems for young men. One of the implications of this study is that young men and women may require different interventions.
Young men and women may require different interventions.

In another part of this study, with the same sample and control group, Wilson and Widom (2010) explored the pathway from child abuse and neglect to sexual exploitation through prostitution. They found that children who were victims of child abuse and neglect were at increased risk for multiple problem behaviours in adolescence, such as early sexual activity, running away, crime and school problems, but not for substance abuse. As noted in the earlier study, substance abuse problems became more obvious for women in middle adult life than in adolescence. These problem behaviours, whilst co-occurring, should be considered separately. Early sexual activity was the single strongest predictor of being sexually exploited through prostitution. These findings were consistent across physical abuse, sexual abuse and neglect, although weaker for sexual abuse.

A large retrospective study known as **ACES (Adverse Childhood Events Study)** collected information via questionnaires regarding the number and type of adverse childhood events adults had experienced and compared this with their current health conditions, health history and psychosocial wellbeing. The more adverse events in childhood were associated with more physical, emotional and social problems in adult life. For example, the following problems were found, especially after four or more adverse events in childhood: increased risk of depressed affect, panic reactions, anxiety, hallucinations, sleep disturbance, severe obesity, somatic symptoms, substance abuse, early sexual activity, promiscuity, sexual dissatisfaction, impaired childhood memories, anger difficulties and risk of perpetrating violence. They explored a number of the neurobiological pathways in which early developmental trauma can lead to these problems later in life (Anda et al., 2006).

### Table 1: Summary of longitudinal studies relating to the impact of abuse and neglect on later behaviours

<table>
<thead>
<tr>
<th>Type of study and authors</th>
<th>Sample</th>
<th>Findings</th>
</tr>
</thead>
</table>
| Prospective (Taussig, 2002) | 214 young people (7-12 years old at baseline. In foster care. Second time period was 6 years later) | • Physical abuse and neglect associated with criminal involvement and substance use  
• Sexual abuse not associated with risk behaviours  
• Early risk behaviours were predictive of later risk  
• More peer group and social acceptance, fewer risk behaviours |
| Prospective and retrospective (Dunlap, Golab & Johnson, 2003) | 98 females (9-85 years) | • Sexual abuse associated with early sexual activity, prostitution, drug abuse |
| Prospective (Herrenkohl et al., 2003) Le High Study | 457 children (1.5 to 6 years old) over 15 years. Incl. comparison groups | • Physical abuse associated with violence in adolescence  
• Possible mediating factors include low school commitment, involvement with violent peers |
<table>
<thead>
<tr>
<th>Type of study and authors</th>
<th>Sample</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective</td>
<td>171 at-risk children (12 mths) over 15 years</td>
<td>• Physical abuse, neglect and sexual abuse, family violence, family disruption, low SES and high parental stress all associated with externalising behavioural problems and, to a lesser extent, internalising problems</td>
</tr>
<tr>
<td>Appleyard et al., 2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective (Schofield &amp; Beek, 2005) (UK)</td>
<td>52 children in long-term foster care (10 years old) over three years</td>
<td>• Empathic, sensitive and parenting carers and children who were able to use carers as a ‘secure base’ were more settled in other environments as well including school • Poor professional support associated with less progress • Negative parent-child contact associated with negative progress</td>
</tr>
<tr>
<td>Prospective (Tyler, Johnson &amp; Brownbridge, 2008)</td>
<td>360 high-risk adolescents (11-14 years old). Tracked over 36 months</td>
<td>• Absence of positive parenting, associated with poor school engagement (for girls) and running away behaviours (for boys) • Sexual abuse, neglect and low SES associated with being a victim of violence and poor wellbeing</td>
</tr>
<tr>
<td>Prospective (Leon et al., 2008)</td>
<td>142 young people with sexualised behaviour problems and their carers. (average 11 years). Follow up 1.5 years later</td>
<td>• More problems at baseline, more problems at follow up. • Positive parenting style by carer associated with less negative affect for boys • High level of agency support with those with sexual abuse histories associated with lower sexual ruminations • Involvement in clubs associated with lower sexual ruminations but only for those who not sexually abused</td>
</tr>
<tr>
<td>Prospective (Wilson &amp; Widom, 2009, 2010)</td>
<td>908 children who had had substantiated abuse or neglect prior to age 12, incl. comparison group. Tracked into middle adulthood</td>
<td>• Abuse and neglect associated with prostitution, homelessness, criminal behaviour and school problems, and these problems were associated with mid adulthood alcohol and drug use for women (2009) • Abuse and neglect associated with early sexual activity, running away, criminal behaviour and school problems, and these problems were associated with prostitution, especially early sexual activity • Findings not as strong for sexual abuse as other types</td>
</tr>
<tr>
<td>Retrospective (Anda et al, 2006) ACES study</td>
<td>17,337 adult clients of health insurance company</td>
<td>• Higher number of childhood adverse events associated with higher number of physical, emotional and social problems in adulthood, including depressed affect, panic, anxiety, hallucinations, sleep problems, obesity, somatic symptoms, substance abuse, early sexual activity, promiscuity, sexual dissatisfaction, impaired childhood memories, anger difficulties and risk of perpetrating violence</td>
</tr>
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</table>
Sexual exploitation through youth prostitution as a case in point

Trauma theory has been applied to understand the experiences of those who have been sexually exploited in terms of risk factors for becoming exploited and as a consequence of the experience itself (e.g. Farley, Baral, Kiremire, & Sezgin, 1998; Farley et al., 2003; Herman, 2003; Mansson & Hedin, 1999; Twill, Green & Traylor, 2010; Wilson & Widom, 2010). Farley and colleagues (1998) illustrate how a traumatised perspective of the world can lead to a different view on what is needed for survival, such as through being involved in sexual exploitation.

“When a person holds life-or-death power over another, small kindnesses are perceived with immense gratitude. In order to survive on a day-to-day basis, it is necessary to deny the extent of harm which pimps and customers are capable of inflicting. Survival of the person in prostitution depends on her ability to predict others’ behavior. So she develops a vigilant attention to the pimp’s needs and may ultimately identify with his view of the world.”

Others also describe young people’s involvement in prostitution as part of a survival strategy where they have to balance competing threats and may find the sexual exploitation as the lesser of two dangers (Saphira & Oliver, 2002; Shaw & Butler, 1998; Williams, 2010).

Young people experience abuse through sexual exploitation via a number of pathways, some of which are associated with specific risk factors. No single risk factor is likely to be the cause. Rather, it is a combination of risk factors and what these factors mean for the young person (Brawn & Roe-Sepowitz, 2008; Twill, Green & Traylor, 2010). For all that certain risk factors can be described, they are not predictive of who will and who will not be sexually exploited (Dalla, 2001; Melrose, 2004).

“All those working with young people who are abused through prostitution bear witness to the fact that young people become involved in commercial sexual exploitation for a range of complex and interconnected – even overlapping – reasons and that it is seldom possible to pinpoint a single ‘cause’. Rather, there is a complex interaction between a range of ‘push’ and ‘pull’ factors and between individual and environment factors.” (Melrose, 2004, 22)

Some of these risk factors are relevant for any age group and others are particular to youth. The risk factors may increase the likelihood of the young person being sexually exploited and/or for finding it difficult to escape from this experience. Some risk factors can increase both the likelihood and level of harms associated with sexual exploitation such as violence (Cusick, 2002).

What factors lead young people to being sexually exploited through prostitution?

Table 2 portrays the range of factors discussed in the literature that can lead a young person into and/or sustain their experience of being abused through sexual exploitation, such as through prostitution.
<table>
<thead>
<tr>
<th>Contributing factors to becoming sexually exploited</th>
<th>Research and other literature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child maltreatment and other parenting difficulties</strong></td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Ahrens, Katon, McCarty, Richardson, &amp; Courtney (2012); Assistant Deputy Minister’s Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Beckett, 2011; Biehal &amp; Wade, 2000; Bruce &amp; Mendes, 2008; Busby et al., 2002; Cuda, 2011; Dalla, 2001; Farley et al., 1998; Farley et al., 2003; Hancock, 1994; Hedin &amp; Mansson, 2003; Holger-Ambrose, Langmade, Edinburgh &amp; Saewyc, 2013; Kaestle, 2012; Mansson &amp; Hedin, 1999; Martyn, 1998; Nixon et al., 2002; Potterat, Rothenberg, Muth, Darrow, &amp; Phillips-Plummer, 1998; Saphira &amp; Oliver, 2002; Schissel &amp; Fedec, 1999; Shaw &amp; Butler, 1998; Veysey, 2003; Williamson &amp; Folaron, 2007</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>Biehal &amp; Wade, 2000; Busby, et al., 2002; Martyn, 1998; Nixon et al., 2002; Schissel &amp; Fedec, 1999; Twill, Green &amp; Traylor, 2010; Wilson &amp; Widom, 2010</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>Assistant Deputy Minister’s Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Bloom &amp; Covington, 2001; Busby et al., 2002; Cusick, 2002; Dalla, 2001; Hennessey et al., 2004; Leichtentritt &amp; Arad, 2005; Mansson &amp; Hedin, 1999; Martyn, 1998; Roe-Sepowitz, 2012; Twill, Green &amp; Traylor, 2010; Williamson &amp; Folaron, 2007; Wilson &amp; Widom, 2010</td>
</tr>
<tr>
<td>Neglect</td>
<td>Biehal &amp; Wade, 2000; Beckett, 2011; Brawn &amp; Roe-Sepowitz, 2008; Hennessey et al., 2004; Schissel &amp; Fedec, 1999; Shaw &amp; Butler, 1998; Twill, Green &amp; Traylor, 2010; Wilson &amp; Widom, 2010</td>
</tr>
<tr>
<td>Other family factors</td>
<td>Beckett, 2011; Fredlund, Svensson, Göran Svedin, Priebe &amp; Wadsby, 2013</td>
</tr>
<tr>
<td><strong>Individual behavioural and emotional wellbeing factors</strong></td>
<td></td>
</tr>
<tr>
<td>Alcohol and other drug abuse</td>
<td>Abel &amp; Fitzgerald, 2008; Assistant Deputy Minister’s Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Beckett, 2011; Bruce &amp; Mendes, 2008; Cuda, 2011; Hancock, 1994; Holger-Ambrose et al., 2013; Kaestle, 2012; Melrose, 2004; Potterat et al., 1998; Schissel &amp; Fedec, 1999; Smeaton, 2013; Wilson &amp; Widom, 2010</td>
</tr>
<tr>
<td>Absconding or running away</td>
<td>Assistant Deputy Minister’s Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Barnado’s, 2011; Beckett, 2011; Brawn and Roe-Sepowitz, 2008; Busby et al., 2002; Courteney &amp; Zinn, 2009; Cusick, 2002; Farmer, 2004; Greene, Ennett &amp; Ringwalt, 1999; Kaestle, 2012; Leichtentritt &amp; Arad, 2005; Martyn, 1998; Rafferty, 2013; Roe-Sepowitz, 2012; Saphira &amp; Oliver, 2002; Schissel &amp; Fedec, 1999; Shaw &amp; Butler, 1998; Smeaton, 2013; Taylor-Browne et al., 2002; Willis &amp; Levy, 2002; Wilson &amp; Widom, 2010; Witherup et al., 2008</td>
</tr>
<tr>
<td>Leaving school early</td>
<td>Assistant Deputy Minister’s Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Beckett, 2011; Cusick, 2002; Kaestle, 2012; Schissel &amp; Fedec, 1999; Shaw &amp; Butler, 1998; Taylor-Browne et al., 2002; Wilson &amp; Widom, 2010</td>
</tr>
<tr>
<td>Early sexual activity</td>
<td>Cusick, 2002; Potterat et al., 1998; Wilson &amp; Widom, 2010</td>
</tr>
<tr>
<td>Criminal activity</td>
<td>Cusick, 2002; Leichtentritt &amp; Arad, 2005; Shaw &amp; Butler, 1998; Wilson &amp; Widom, 2010</td>
</tr>
<tr>
<td>Mental health problems</td>
<td>Bruce &amp; Mendes, 2008; Cuda, 2011; Taylor-Browne et al., 2002; Twill, Green &amp; Traylor, 2010</td>
</tr>
<tr>
<td>Self-esteem and other emotional problems</td>
<td>Assistant Deputy Minister’s Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Beckett, 2011; Dalla, 2001; Mansson &amp; Hedin, 1999; Martyn, 1998; Twill, Green &amp; Traylor, 2010; Wilson &amp; Widom, 2010</td>
</tr>
</tbody>
</table>
### Table 2: Factors that contribute to child sexual exploitation, according to the literature

<table>
<thead>
<tr>
<th>Contributing factors to becoming sexually exploited</th>
<th>Research and other literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social skills</td>
<td>Twill, Green &amp; Traylor, 2010</td>
</tr>
<tr>
<td>Boredom and curiosity</td>
<td>Abel &amp; Fitzgerald, 2008; Busby et al., 2002; Williamson &amp; Folaron, 2007</td>
</tr>
<tr>
<td>Prostitution seen as least worst option or choice</td>
<td>Cuda, 2011; Gillespie, 2007; Leichtentritt &amp; Arad, 2005; Phoenix, 2002; Saphira &amp; Herbert, 2004</td>
</tr>
<tr>
<td>Loneliness and isolation</td>
<td>Beckett, 2011; Bruce &amp; Mendes, 2008; Dalla, 2001; Holger-Ambrose et al., 2013; Leichtentritt &amp; Arad, 2005; Martyn, 1998; Smeaton, 2013</td>
</tr>
</tbody>
</table>

**Social and structural factors**

| Poverty                                            | Abel & Fitzgerald, 2008; Assistant Deputy Minister’s Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Busby et al., 2002; Cuda, 2011; Cusick, 2002; Greene, Ennett & Ringwalt, 1999; Hancock, 1994; Martyn, 1998; Phoenix, 2002, 2003; Taylor-Browne et al., 2002; Williamson & Folaron, 2007; Wilson & Widom, 2010 |
| Homelessness                                       | Abel & Fitzgerald, 2008; Cuda, 2011; Cusick, 2002; Hancock, 1994; Kaestle, 2012; Martyn, 1998; Shaw & Butler, 1998 |
| Unemployment                                       | Busby et al., 2002; Cusick, 2002; Dalla, 2006; Martyn, 1998; Schissel & Fedec, 1999; Shaw & Butler, 1998 |
| Peer and social group factors                      | Abel & Fitzgerald, 2008; Assistant Deputy Minister’s Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Bruce & Mendes, 2008; Busby et al., 2002; Cusick, 2002; Farmer, 2004 |
| Stigmatisation and labelling                       | Cusick, 2002; Finkelhor & Browne, 1985; Mansson & Hedin, 1999 |
| Political factors                                  | Mansson and Hedin, 1999; Melrose, 2004; |

**Service system factors**

| Out-of-home care, especially residential care       | Assistant Deputy Minister’s Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Beckett, 2011; Bruce & Mendes, 2008; Busby et al., 2002; Cusick, 2002; Leichtentritt & Arad, 2005; Swann & Balding, 2001; Taylor-Browne et al., 2002 |
| Leaving care                                       | Cusick, 2002; Mendes & Moslehuddin, 2006; Shaw & Butler, 1998. |
| Lack of engagement of services                     | Busby et al., 2002 |
| Services not dealing with sexual exploitation      | Beckett 2011 |

**Features of commercial sexual exploitation**

| Coercion and other features of sex trade           | Bruce & Mendes, 2008; Cuda, 2011; Cusick, 2002; Farley et al., 1998; Holger-Ambrose et al., 2013; Leichtentritt & Arad, 2005; Rafferty, 2008; Saphira & Oliver, 2002; Taylor-Browne et al., 2002; Williamson & Folaron, 2007; Willis & Levy, 2002 |
Family problems and maltreatment

Family problems are pervasive for this group of young people and include every type of abuse and neglect, as well as general family problems. Some children and young people enter a life of sexual exploitation directly from their parents’ care. Some parents have worked in prostitution themselves (Willis & Levy, 2002). Some family members directly exploited their children by coercing or selling their children into prostitution (Abel & Fitzgerald, 2008; Holger-Ambrose et al., 2013; Busby et al., 2002; Farmer, 2004; Mitchell et al., 2011). Other children are removed from their parents’ care due to abuse and neglect, and it is from the placement system that they become sexually exploited.

... abuse degrades and prostitution further degrades.

Although sexual abuse is considered closely linked to prostitution, it is not always a preceding factor. In a ‘direct effects’ model, sexual abuse has been described as a pathway into sexual exploitation, such as prostitution. For example, children and young people who have suffered sexual abuse are likely to have serious problems with self image, sexual attitudes, a need to control or master their environment, damaged perception of self and sexuality and so are more vulnerable to exploitation (Bruce & Mendes, 2008; Twill, Green & Traylor, 2010). Their experience of sexual abuse may have normalised not only the act, but also the view of a debased self as an object to be bought and sold (Dalla, 2001; Schissel & Fedec, 1999; Shaw & Butler, 1998). In other words, “…abuse degrades and prostitution further degrades” (Shaw & Butler, 1998, 185).

Nixon and colleagues (2002) found that some women noted their involvement in prostitution was a means to gain some control over their situation and to stop feeling the powerlessness that stemmed from their experience of childhood abuse.

The act of prostitution may be a form of trauma re-enactment, where the young person re-enacts the sexual abuse, but this time perceiving the experience as within his or her control (Leichtentritt & Arad, 2005). Dalla (2001) discussed the possibility that prostitution provides an opportunity for the young person to re-enact the emotional distancing or dissociation learnt during the earlier experience of sexual assault.

Sexual abuse can also be seen to indirectly increase the risk of a young person entering prostitution (indirect effects model). For example, escaping sexual abuse may lead to running away, which places her or him at higher risk (Dalla, 2001; Schissel & Fedec, 1999; Shaw & Butler, 1998; Twill, Green & Traylor, 2010). However, consistent with a direct effects model, Dalla (2001) reported that when controlling for other variables, early sexual abuse increased the odds that someone who ran away would be at risk of sexual exploitation.

Some studies show neglect as being potentially a more powerful risk factor than other types of abuse.

Many studies have found that other types of abuse, such as physical abuse, emotional abuse and neglect, were also a frequent and powerful feature of these young people’s earlier lives. Physical abuse was found to be a common experience of young people who later were sexually exploited. This appears to occur through their experiences of being traumatised, running away and seeking safety in unsafe places. Wilson and Widom (2010) found that physical abuse was a stronger risk
factor than sexual abuse for sexual exploitation. Neglect, regardless of poverty, was also found to be a common feature. This has been associated with poor supervision and early sexual activity, which has in turn been associated with being at risk of sexual exploitation. Some studies show neglect as being potentially a more powerful risk factor than other types of abuse (Beckett, 2011; Wilson & Widom, 2010).

Following is a table from Beckett’s 2011 (p.35) study in Northern Ireland of 1101 young people and the underlying vulnerabilities that were associated with sexual exploitation. It shows the power of neglect and breakdown of family relationships for young people.

<table>
<thead>
<tr>
<th>Underlying vulnerability</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional neglect by parent/carer/family member</td>
<td>83.1</td>
</tr>
<tr>
<td>Breakdown of family relationships</td>
<td>80.4</td>
</tr>
<tr>
<td>Lack of positive relationship with a protective/nurturing adult</td>
<td>61.6</td>
</tr>
<tr>
<td>Family history of domestic abuse</td>
<td>59.2</td>
</tr>
<tr>
<td>Family history of substance misuse</td>
<td>58.5</td>
</tr>
<tr>
<td>Family history of mental health difficulties</td>
<td>57.0</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>56.2</td>
</tr>
<tr>
<td>Unsuitable/inappropriate accommodation/placement</td>
<td>38.0</td>
</tr>
<tr>
<td>Isolated from peers/social networks</td>
<td>37.7</td>
</tr>
<tr>
<td>Physical abuse by parent/carer/family member</td>
<td>34.6</td>
</tr>
<tr>
<td>Sexual abuse (known or suspected)</td>
<td>22.4</td>
</tr>
</tbody>
</table>

Other family problems found to be common experiences prior to young people being sexually exploited include family violence, parent separation, parental drug problems, chaotic home life and dysfunctional family patterns (Beckett, 2011). Overt rejection and abandonment was a common theme.

“Absence of positive role models and nurturing relationships in the past (usually also continuing in the present) were also noted to increase young people’s vulnerability to sexual exploitation. Most of the looked-after young people identified as at risk of or abused through sexual exploitation were observed to have seriously fractured family relationships, rejection and attachment issues (sometimes to the extent of attachment disorders) and an unmet need for love and significance. Many consequently sought to fulfill these needs in any way they could, from any person they could.” (Beckett, 2011, 63)

Fredlund and colleagues (2013) in their study in Sweden found that young people who were being sexually exploited through prostitution (or selling sex) had experienced poor care and poorer relationships with their parents and were less likely to confide in others including extended family members and peers.

**Individual behavioural and emotional wellbeing factors**

The literature is clear that the individual characteristics or difficulties of the young person do not cause them to be sexually exploited. They may, however, expose them to those who will entice or force their involvement. Alternatively, these characteristics may make them more susceptible to this pathway when other problems occur that reduce their choices. This section describes some of the problems listed in Table 2 in more detail.
Developmental factors:
Although there is debate in the literature regarding whether or not young people under the age of 18 years can make real and unconstrained choices in relation to prostitution, there is almost nothing written regarding developmental aspects that may make a young person more vulnerable. An exception is the review written by Saphira and Oliver (2002), where they note young adolescents’ cognitive, physical and emotional immaturity and lack of knowledge about their own bodies, sexuality, and how to complain or say no to adults. Bruce and Mendes (2008) also note the naivety of many young people in residential care.

...a young child’s experience of trauma and neglect can be part of a developmental pathway towards high-risk behaviours in adolescence.

From a developmental trauma perspective, a young child’s experience of trauma and neglect can be part of a developmental pathway towards high-risk behaviours in adolescence, including behaviours that make her or him more at risk of sexual exploitation.

In terms of what age was a young person more or less at risk of being abused through sexual exploitation, Beckett (2011) noted in her literature review that the age of highest risk was 14 and 15 years of age although it could begin earlier in life. However, her study in Northern Ireland found that the older the young person, the more likely they were to have been sexually exploited.

Gender:
Although men, women and transgender people can be subject to commercial sexual exploitation, studies consistently report that women are more likely to be involved, including girls. Those with transgender are rarely mentioned with only a couple of exceptions (e.g. Farley et al., 1998; Leichtentritt & Arad, 2005). The prevalence of women who are sexually exploited is also reflected in the many studies that focus solely on their experience (e.g. Busby, et al., 2002; Brawn & Roe-Sepowitz, 2008; Dalla, 2006; Deb, Mukherjee & Mathews, 2011; Dunlap, Golab, & Johnson, 2003; Farmer, 2004; Gibbs Van Brunschot & Brannigan, 2002; Harding & Hamilton, 2009; Hedin & Mansson, 2003; Heilemann & Santhiveeran, 2011; Kotrla, 2010; Kramer, 2003; Nixon et al., 2002; Mansson & Hedin, 1999; Pearce, 2006; Thomson et al., 2011; Vanwesenbeeck, 2005).

Leichtentritt and Arad (2005) was one of the few studies to focus on men. However, one study challenged that view and stated that adolescent young men were more likely to be ‘selling sex’ than young women (Fredlund et al., 2013). Ahrens and colleagues’ (2012) study of young people in care found that a similar number of young men compared with young women were involved in ‘transactional sex’, but that the young women were more susceptible to do so after a childhood experience of sexual assault.

Abuse of alcohol and other drugs are one of the most frequently assumed connections with child sexual exploitation.

Alcohol and other drugs:
Abuse of alcohol and other drugs are one of the most frequently assumed connections with child sexual exploitation; however, there are multi-directional relationships. There are at least four associations between alcohol and other drug use and sexual exploitation, with multiple possible explanations discussed in the literature.
1. Substance abuse preceding exploitation. For example, prostitution may be seen as a means of paying for drugs or the drug use lifestyle and culture may increase other risk factors such as exposure to negative peer group influences that can embroil a young person into a situation where they are sexually exploited. Substance use in general can make them more vulnerable to sexual assault and other forms of exploitation (Beckett, 2011). Abel and Fitzgerald (2008) found that entering into prostitution to fund alcohol and other drug usage was more likely for young people than adults. This may also be a function of the legal system as young people are not allowed to work in managed ‘sex working’ venues and so are more likely to work on the streets, where drug use plays a larger role. Beckett (2011) notes that sexual exploitation through the ‘house party’ scene can be another way a young person is introduced to this experience and alcohol and other drugs can play a part in both enticing the young person and in lowering their defences.

2. Substance abuse and sexual exploitation begin at similar time or are both influenced by other events. For example, sexual abuse leading to both substance abuse and prostitution as different elements of survival, or where those who embroil the young people into prostitution may use drugs as part of their modus operandi. Alcohol or other drug use and prostitution may be self-destructive patterns occurring simultaneously (Melrose, 2004; Potterat et al., 1998; Wilson & Widom, 2010).

3. Sexual exploitation preceding substance abuse; for example, where substance abuse is used to help the young person feel numb as a survival strategy to endure the experience (Martyn, 1998; Potterat et al., 1998; Schissel & Fedec, 1999; Wilson & Widom, 2010). Busby and colleagues (2002) note that some young people have had peripheral drug use prior to being sexually exploited, which then escalated. Herman (2003) noted that traumatisation may impede a woman’s normal capacity to self-soothe and so she may use alcohol or drugs to feel calm. Drugs, such as amphetamines, may be used to help the young people cope with the long and late hours of prostitution (Cusick, 2002). They may also be used to help the young person deal with the fear of violence, whereas other young people may abstain due to wanting to be alert in order to be safe (Busby et al., 2002; Nixon et al., 2002). Leichtentritt and Arad (2005) commented that young men with a heterosexual orientation were likely to use alcohol and other drugs more frequently and to a greater degree whilst involved in prostitution than those with bisexual or homosexual orientations. This was hypothesised to be a means of dealing with any conflicting negative feelings they may have associated with homosexuality.

4. Drug usage as part of the young person’s experience at the same time as being involved in prostitution may increase their exposure and vulnerability to violence (Cusick, 2002).

Absconding/running away:
As seen in Table 2, absconding or running away is a commonly cited risk factor for being sexually exploited, such as through prostitution. Brawn and Roe-Sepowitz (2008) found that regardless of whether the young women who were sexually exploited were using alcohol and other drugs, between a third and a half of the group had a history of running away. Some studies also found that if other factors are controlled for, running away from home was a significant variable in being
abused through sexual exploitation (e.g. Cusick, 2002). There was a link between past experience of abuse, running away and sexual exploitation (Biehal & Wade, 2000).

Absconding or running away is a commonly cited risk factor for being sexually exploited.

Smeaton (2013, 18) found in her study on the co-occurrence of running away and child sexual exploitation that there was

“... no single link between running away and sexual exploitation but identified that there are a number of factors, including bereavement or other loss, social issues relating to the family and a history of abuse, which leads to a young person experiencing both running away and sexual exploitation.”

Running away can lead to the young person needing to gain money for survival (Greene, Ennett & Ringwalt, 1999; Smeaton, 2013; Twill, Green & Traylor, 2010). The experience of being on the street is likely to increase the risks of being sexually exploited (Smeaton, 2013; Cusick, 2002). Identifying patterns of the young person absconding can be used by workers for early detection of increased risk of being sexually exploited (Twill, Green & Traylor, 2010). “Running away can be a response to feeling unwanted, feeling the need to be cared for and seeking attention. Child sexual exploitation is the form that the attention takes” (Smeaton, 2013, 24).

Smeaton (2013) found that although the pattern is more common for running away behaviours to precede sexual exploitation, some young people became known to pimps and other people who perpetrated sexual exploitation through other means and were then encouraged to run away. Perhaps sadder still, some young people run away to avoid being sexually exploited or in response to the reactions of their disclosure of sexual exploitation (Smeaton, 2013). More is discussed about running away or absconding in the next section.

Emotional wellbeing and sense of self:
Child abuse and neglect and other family problems can lead to the young person having low self-esteem and poor self-image. These can add to the young person’s susceptibility when exposed to other risk factors such as early sexual activity and negative peer group pressure. Developing an internalised identity as a ‘prostitute’ and not believing other identities are possible can be a contributing factor that makes leaving prostitution difficult (Williamson & Folaron, 2007).

Some authors point to certain emotional states that lead to a motivation towards prostitution as a perceived positive step. For example, Williamson and Follaron (2007) noted the sense of power, mastery and control over their life that can be sought. Cusick (2002) reported that some emotional states include: a desire to take control over their own life; a strong independent personality; and a desire for attention and acceptance of adults.

Early sexual activity:
Early sexual activity (younger than 15 years) was found to be a risk factor for young people to be later sexually exploited, whether the early activity was consensual sex or abusive. This initiation into early sexual activity was more likely for those who have experienced child maltreatment, including parental neglect. According to Wilson and Widom (2010), beginning sexual activity prior to the age
of 15 years was the strongest predictor of becoming sexually exploited, compared with alcohol and drug use, running away, criminal behaviour or school problems. Sexual abuse was a risk factor for early sexual activity.

**Beginning sexual activity prior to the age of 15 years was the strongest predictor of becoming sexually exploited.**

Criminal behaviour and other risky behaviours:
As a result of other factors, a young person may be involved in a range of criminal behaviours and an associated lifestyle, and it may be this lifestyle that exposes the young person to sexual exploitation. As a consequence of their criminal activity, many of the young people will be cautious, if not frightened of police. This can lead them to avoiding police even though police members may be a potential source of support and safety (Cusick, 2002). Beckett (2011) found that young people involved with youth justice were more likely to have been sexually exploited than other young people.

Leaving school early:
Young people who leave school early are more likely to be sexually exploited through prostitution than those who remain engaged with the education system. This could be linked with other risk factors, such as homelessness and unemployment. It may also be that the young person’s behaviours that place him or her at risk of expulsion may also be risk factors related to prostitution, such as alcohol and other drug usage.

Perceptions of prostitution as the least worst option:
Some young people refer to prostitution as a more ethical choice than other choices before them. No one gets hurt, except themselves, and they are not stealing from others. They are also less likely to end up in the criminal justice system than through other behaviours such as theft. “Although informants described at length the difficulties and the physical and mental suffering associated with sex work, they perceive their occupation as the least dehumanized alternative within their limited options” (Leichtentritt & Arad, 2005, 498). It’s better than begging (Phoenix, 2002). This can give the young people the impression that this is a real choice, rather than one that is seriously constrained (Gillespie, 2007; Saphira & Herbert, 2004).

Loneliness and isolation:
Whether the young person is at home or in care, they may experience an overwhelming sense of loneliness and isolation due to the lack of meaningful connections around them (Leichtentritt & Arad, 2005; Martyn, 1998). Isolation can be linked with the effects of stigmatisation and marginalisation and can lead to feelings of alienation from society, peers and family (Martyn, 1998). Those who are isolated from positive social connections are more vulnerable to a range of other emotional difficulties (Dalla, 2001).

“Participants’ description of loneliness while living at their parents’ home, along with lack of connections with their parents, was similar to the informants’ experiences in the government care systems. The young men described experiences of alienation, loneliness and lack of care.” (Leichtentritt & Arad, 2005, 495)
Intellectual disability:
Although there is evidence to suggest that men and women with an intellectual disability are more at risk of sexual violence and of being manipulated by others, there is little research on people with an intellectual disability and sexual exploitation. In Kuosmanen and Starke’s (2011) study, they found professionals attributed a range of possible reasons for why people with an intellectual disability were involved in ‘selling sex’ and that this reflected as much the professionals’ attitudes about disability as it did their attitude about sexual exploitation.

**Social and structural factors**

Poverty:
There is concern that a focus on risk factors and the perception of youth prostitution as abuse means that this is seen only as the purview of child protection, thereby missing or minimising the social and economic context in which it occurs (Pearce, 2006; Phoenix, 2002; 2003).

The basic need for money in response to poverty is acknowledged as a key driver. Busby and colleagues (2002) found that most women who began prostitution under the age of 18 years of age stated they did so because they had no or minimal access to money to meet their basic needs, such as shelter, clothing and food. There are fewer options for young people to access money through legitimate means compared with adults. Reasons can vary from wanting money to buy extras and seeing prostitution as easy money to a means of survival. “A desire to escape poverty and a lack of opportunity to do so by any other means may lead many young people into prostitution.” (Cusick, 2002, 238)

For whatever reason the young people entered prostitution, the access to money appears to be a large part of the trap once involved (Busby et al., 2002). Martyn’s (1998) overview of sexual exploitation in Australia contends that young people’s involvement is primarily about survival.

Homelessness is a consequence and cause of poverty. Homelessness increases risk, vulnerability and opportunity, as well as decreasing social, practical and financial supports. Some young people may consider that the choice they are making is between homelessness and prostitution.

Youth unemployment can be a factor for entering prostitution in terms of its association with poverty, lack of self-esteem and boredom. It is more difficult for young people to attain employment in general, let alone those who have run away from home or placement and have left school early.

Peer and social group factors:
Being encouraged or coerced by other young people, such as boyfriends, other residents in residential care, house parties, social media or on the streets are some of the pathways into sexual exploitation through prostitution (Beckett, 2011). Abel and Fitzgerald (2008), in a New Zealand study of 17 young people who were sexually exploited through prostitution, found that young people were more likely than adults to have friends involved in prostitution prior to their own involvement. Some were used as ‘minders’ as part of the safety strategy for their friends, which was a first step in becoming more directly involved themselves. For example, young people may begin by taking down the license plates as part of the safety strategy for a friend (Busby et al., 2002).

Not wishing to leave or be different from their friends and associates involved in this sexually exploitative situation can be a factor that inhibits ceasing prostitution once it has begun. It may be
their only sense of belonging and connection to others (Abel & Fitzgerald, 2008). This friendship network or culture can be seen as an unbreakable bond and the source of the most meaningful relationships they have. However, some may see it as superficial, exploitative and abusive (Busby et al., 2002).

Social isolation is a risk factor whereby they may feel they have no one to go to for support. Belonging to a social milieu where prostitution is tolerated or accepted can be a compelling factor.

Labelling and stigmatisation:
Being labelled (as a troublemaker, sexually promiscuous or with another negative label) can help push a young person into sexual exploitation, such as through prostitution. Once someone feels isolated and stigmatised, their behaviours can further separate them from the expected norms in society, including alcohol and other drug use, criminal activity and prostitution. “Many of the women were labeled as ‘whores’ early, often long before their actual entry into prostitution” (Mansson & Hedin, 1999).

Political factors:
Some articles note the context in which sexual exploitation, such as through prostitution occurs or thrives. For example, Melrose (2004) noted the changes occurring in Britain including market reorganisation, welfare retrenchment, globalisation, and technological changes. Mansson and Hedin (1999) also described the impact of the economic recession and a shrinking labour market within Sweden as having an impact for those women leaving prostitution in terms of reduced access to employment and supports.

Service system factors
Out-of-home care:
Being in out-of-home care, including foster care and residential care, was considered a risk factor for sexual exploitation in itself, especially residential care. This could be due in part to the reasons why young people are placed in residential care instead of other forms of care and, secondly, due to their experiences in that care environment, including their contact with other at-risk young people (Biehal & Wade, 2000; Bruce & Mendes, 2008). Multiple placements have also been found to be a feature associated with sexual exploitation (Leichtentritt & Arad, 2005).

The young person’s experience coming into care, the lack of support during care, and the lack of support when they left were all factors that could push a young person to ‘survival’ behaviour, which may lead them to be sexual exploited.

A study based in Melbourne asked workers (residential care staff and management, police, AOD workers) about the possible associations between residential care and young people being involved in prostitution (Bruce & Mendes, 2008). Some noted that the young people had entered prostitution after coming into care, whereas others noted that it was influenced by their pre-care experiences although escalated once in care. Peer influence within the residential unit was a major factor and the inappropriate placement of some young people together. Their search for acceptance and their isolation makes them especially vulnerable. The ‘unnatural’ physical and cultural environment of the residential care setting was also considered to be a contributing factor, including spartan conditions,
locked doors, lack of a home-like environment, staff rosters and staff turnover. Lack of sexual education along with sexual naivety was noted in this study, given that the young people often have a truncated or disrupted school education.

Farmer (2004, 387) found that compared with other young people in care who were at risk, those who were sexually exploited through prostitution had the worse outcomes. “Their needs were not met, their behaviours did not change and they continued to be at high sexual risk. Moreover, when compared with others, this group of young people had the worst impact on other residents.”

Leaving out-of-home care is also a risk factor. This appears influenced by limited access to sources of emotional support and poor skills in independent living skills. Shaw and Butler (1998) report on an earlier study of theirs where they found the young person’s experience coming into care, the lack of support during care, and the lack of support when they left were all factors that could push a young person to ‘survival’ behaviour, which may lead them to be sexually exploited.

The service system’s inability to recognise, record and act effectively in response to indicators that the young person is being abused through sexual exploitation has been noted as a factor that can contribute to the scale of the problem and the difficulties in reducing its prevalence (Beckett, 2011).

**Features of commercial sexual exploitation and the sex trade**

There would not be child prostitution if there were not people, predominantly men, who sought sexual gratification, power, financial advantage and other gains from the commodification of children and sex; that is, paying for sex with children. They are buyers of children (johns), traffickers of children (pimps) and/or power brokers of children (organised crime). Unlike other aspects of child protection practice, there are undoubtedly albeit hidden powerful individuals and organisations that are invested in the continuation of prostitution and other forms of sexual exploitation (Jordan, Patel, & Rapp, 2013; Rafferty, 2013).

There also appear to be legal and system constraints to providing the protection outlined in the legislation. For example, it seems that despite the potential lengthy sentences according to the law, such as 15 years imprisonment in Victoria, and life imprisonment in England for paying a child for sex if under the age of 13 years (or 15 years if the child is between the age of 13 and 15 years), there are few or no prosecutions in this area (Swann & Balding, 2001).

> [There would not be child prostitution] if there were no buyers of children (johns), traffickers of children (pimps) and/or power brokers of children (organised crime).

Young people who are sexually exploited are often groomed, coerced, threatened or tricked by other young people, adult pimps, sponsors, traffickers or paedophiles. There can be an illusion that the pimp will protect the young person, but this relationship is often characterised by threats and violence (Holger-Ambrose et al., 2013).

> “Grooming is when someone tries to build a relationship or gain the trust of a young person with the aim of getting them to take part in some kind of sexual activity, such as sending or viewing sexual images, sexual conversations or some kind of sexual touching. The relationship will usually appear friendly and harmless at first, because of the clever tricks used to gain the young person’s trust but
eventually the person will ask, or even pressure, the young person to take part in some kind of sexual activity.” (Beckett, 2011, 43)

Grooming is considered to be one of the most common means of enticing someone into sexual exploitation; however, a number of studies found that the most common way was being introduced through friends or other young people in the out-of-home care system (Busby et al., 2002; Holger-Ambrose et al., 2013). Nevertheless, it is important to recognise that there are some people who directly target young people considered to be ‘likely prospects’ for sexual exploitation (Rafferty, 2008). Stranger danger may not be a common threat, but it is real. Some particularly target young people in out-of-home care (Farmer, 2004; Morton, Clark & Pead, 1999; Shaw & Butler, 1998). Grooming can occur face-to-face, or through the mobile phone or the Internet, and whilst they are on their own or with friends (Beckett, 2011; Melrose, 2013; Smeaton, 2013).

Diagram 1 is an adaptation of a figure by Widom and Wilson (2010) to highlight some of the pathways to being involved in child sexual exploitation and some of the consequences, noting that these consequences can also perpetuate the young person’s life of exploitation. It also notes that not all of those who have these earlier-in-life experiences are sexually exploited.
Diagram 1: Factors contributing to and consequences of child sexual exploitation

- Societal and structural characteristics relating to childhood, sexuality, poverty, power and gender

- Abuse, neglect and other major family problems and traumas
- Out-of-home care

- Running away
- Early sexual initiation
- Youth crime
- School problems
- Alcohol & drug use
- Mental health & affect regulation problems
- Attachment problems
- Neurodevelopmental problems
- Social skills & isolation
- Poor self concept, shame & cognitive problems
- Homelessness & unemployment
- Perceptions of prostitution

- Features of commercial sexual exploitation trade and the law (local & international)

- Child sexual exploitation

- Youth crime
- Alcohol & drug use
- Mental health & affect regulation problems
- Victim of other violence
- Violence to others
- Health problems
- Isolation & difficult relationships
- School problems
- Homelessness & unemployment
- Early pregnancy
- Poor self-concept, shame
Table 3 provides a summary of some of the underlying factors, as well as the push and pull factors involved with sexual exploitation. It also notes those potential protective factors that, if absent, can increase the likelihood of a young person becoming involved.

### Table 3: Summary of underlying, push and pull factors for entering and staying involved in sexual exploitation through prostitution, and protective factors that if absent can increase risk

<table>
<thead>
<tr>
<th>Underlying factors</th>
<th>Push factors (Pushing young people away and into sexual exploitation)</th>
<th>Other factors that increase likelihood of sexual exploitation</th>
<th>Pull factors (Attracting, coercing young people into sexual exploitation)</th>
<th>Absence of protective (buffer) factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Poverty</td>
<td>• Child abuse and neglect, in all forms</td>
<td>• Early sexual activity and/or naivety</td>
<td>• Alcohol and other drugs</td>
<td>• Parental supervision</td>
</tr>
<tr>
<td>• Unemployment</td>
<td>• Family violence</td>
<td>• Being coerced, tricked or enticed by boyfriend, friends, pimps or family members (a safer option?)</td>
<td>• Being coerced, tricked or enticed by boyfriend, friends, pimps or family members (a safer option?)</td>
<td>• Engagement with school</td>
</tr>
<tr>
<td>• Homelessness</td>
<td>• Other traumas</td>
<td>• Running away</td>
<td>• Perceived glamour</td>
<td>• Positive attachments to adults</td>
</tr>
<tr>
<td>• Sex markets, including customers and sex business</td>
<td>• Rejection</td>
<td>• Alcohol and other drugs</td>
<td>• Access to money</td>
<td>• Positive self esteem</td>
</tr>
<tr>
<td>• Economic drivers in society</td>
<td>• Hunger, cold and need for shelter</td>
<td></td>
<td>• Party</td>
<td>• Experience of being consistently cared for</td>
</tr>
<tr>
<td>• Societal attitudes to violence, sexuality, women and children</td>
<td>• Being labelled, stigmatised by others</td>
<td></td>
<td>• Use of internet and other technologies</td>
<td>• Employment</td>
</tr>
<tr>
<td>• Society’s ignoring of the problem</td>
<td>• Lack of leadership and structures in residential care</td>
<td></td>
<td>• Sense of power and control</td>
<td>• Prosecutions of adults paying for sex or organising others to pay for sex from children</td>
</tr>
<tr>
<td>• Legal system</td>
<td>• Negative experiences at school by teachers, peers</td>
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<tr>
<td></td>
<td>• Boredom</td>
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<td></td>
<td>• Shame</td>
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<td></td>
<td>• Desire for autonomy, agency</td>
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</table>

**Impacts of sexual exploitation on the young person**

“It is difficult to even begin to capture the many ways in which an experience of sexual exploitation negatively impacts upon a young person’s life. It affects his/her health – physical, sexual and mental. It reinforces an inadequate sense of self and compounds existing vulnerabilities. It shapes future relationships, social integration and general life prospects. This is particularly the case when appropriate support is not received, both at the time and on an ongoing basis.” (Beckett, 2011, 70)
There are few surprises in the literature regarding many of the consequences of sexual exploitation. In particular, as portrayed in Diagram 1, a number of risk factors leading to sexual exploitation are also potential consequences, such as alcohol and other drug abuse, homelessness, school problems and low self-esteem. Many young people involved in sexual exploitation are also victims of sexual and physical violence, as well as the exploitation itself being abusive, and so the impacts are cumulative. In a study of young people’s perceptions of the harms associated with sexual exploitation, they talked of ‘the hurts’ (Williams, 2010). In contrast, some young people will not think of prostitution as exploitative or harmful and may be guarded towards those who try to help them leave this situation. This does not mean the experience is not abusive and exploitative, but it will affect how to engage the young person through the process (Beckett, 2011). Table 4 summarises the literature on the consequences of child sexual exploitation.

<table>
<thead>
<tr>
<th>Consequences</th>
<th>Research and other literature</th>
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<tbody>
<tr>
<td>Victim of other violence</td>
<td>Beckett, 2011; Busby et al., 2002; Cuda, 2011; Farley et al., 1998; Farley et al., 2003; Fitzgerald, 1997; Hossain et al., 2010; Martyn, 1998; Nixon et al., 2002; Saphira &amp; Oliver, 2002; Schissel &amp; Fedec, 1999; Shaw &amp; Butler, 1998; Williams, 2010; Williamson &amp; Folaron, 2007; Willis &amp; Levy, 2002</td>
</tr>
<tr>
<td>Violence towards others</td>
<td>Busby et al., 2002; Deb, Mukherjee &amp; Mathews, 2011; Nixon et al., 2002).</td>
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<td>Social isolation</td>
<td>Hedin &amp; Mansson, 2003; Mansson &amp; Hedin, 1999; Williamson &amp; Folaron, 2007</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Farley et al., 1998; Leichtentritt &amp; Arad, 2005; Mansson &amp; Hedin, 1999; Shaw &amp; Butler, 1998; Smeaton, 2013</td>
</tr>
<tr>
<td>Early pregnancy</td>
<td>Busby et al., 2002; Chanon Consulting, 2014; Cusick, 2002; Shaw &amp; Butler, 1998; Taylor-Browne et al., 2002; Willis &amp; Levy, 2002</td>
</tr>
</tbody>
</table>

In the third *Take Two Evaluation Report*, analysis was undertaken of the 27 young people described by child protection at time of referral to Take Two (a therapeutic service for child protection clients in Victoria, Australia) as being involved with prostitution (Frederico, Jackson & Black, 2010). The concerns noted at time of referral for these 27 young people were significantly more likely compared with the general Take Two population and included: minimal sense of belonging; trust;
security; the future or a sense of permanence; distorted sense of sexuality; high levels of risk taking; substance abuse; school refusal and other school problems; attachment problems; absconding; criminal activity; no self-awareness or self-control; suicide; threats to self-harm; sense of helplessness; depression; trauma symptoms; minimal friendships; and isolation. Although it is not possible to say whether these concerns were cause or effect in relation to prostitution, the level of significance is telling given that these young people were compared with other traumatised young people.

Both the factors that place a young person at risk of sexual exploitation, as well as some of the following consequences, can provide indicators for families and workers as to whether a young person is being exploited. Barnado’s (2012) have published a list of such indicators as part of their education campaign. These indicators of vulnerability to sexual exploitation include:

- Going missing for periods of time or regularly returning home late
- Regularly missing school or not taking part in education
- Appearing with unexplained gifts or new possessions
- Associating with other young people involved in exploitation
- Having older boyfriends or girlfriends
- Suffering from sexually transmitted infections
- Mood swings or changes in emotional wellbeing
- Drug and alcohol misuse
- Displaying inappropriate sexualised behaviour.” (Barnado’s, 2012, 5)

**Absconding or running away as a case in point**

There is not the same level of attention in the literature on absconding behaviours compared with sexual exploitation. This section looks at some of the few studies that have had a particular look at this phenomenon, particularly but not only for young people in out-of-home care.

Biehel and Wade (2000) undertook a study of 272 young people involving 2,227 incidents of running away from residential care and foster care in England. Their findings supported other studies that showed young people in out-of-home care were over-represented in those who were runaways on the street. Courtney and Zinn (2009) noted that young people in care were more vulnerable to running away due to their experience of abuse and neglect, and due to their existing disconnection from the concept of home.

In four local authorities with 32 children’s homes, Biehel and Wade (2000) found the proportion of young people (11-16 years of age) who ran away at least once ranged from 25 per cent to 71 per cent. However, the percentage of young people who ran away were concentrated in particular homes. For example, 43 per cent of those who went missing were from 4 out of 32 homes and two-thirds of the incidents of running away were from 7 homes. The numbers of young people running away from foster care are not routinely recorded, although at least 5 per cent of this age group were known to have run away at least once in a one-year period.

In Biehel and Wade’s study, two-thirds of the young people who went missing from care were between 13 and 15 years old, however some (17 per cent) were 12 years old or younger. There were equal numbers of females and males, although females tended to be older. The other gender difference was that more females than males who had run away became involved in prostitution.
Young people with known emotional and behavioural problems constituted 17 per cent of the group who ran away and were twice as likely to be male. “They appeared to be at high risk of going missing often and their careers tended to be both more protracted and more extreme” (Biehel & Wade, 2000, 215).

Absences from placement were often brief, with just over two-fifths missing for less than 24 hours compared with over one in ten of the young people being missing for a week or longer. Those who run away frequently or for longer periods were at risk of becoming detached from school and placement and more likely to have problems with alcohol or other drugs. Fifty-three per cent appeared to leave the placement in order to be with friends or family (mainly friends) whereas 45 per cent appeared to have run away or stayed out past the expected time of their return with no clear destination. Those who ran away, but not to be with friends or family, were more likely to be younger, from residential care, away for a shorter time, more likely to have committed a criminal offence and to have slept rough. Their time away from the placement involved greater risks (Biehal & Wade, 2000).

A previous history of abuse, rejection, neglect and lack of stability were considered factors associated with running away from placement.

The young people’s previous history of abuse, rejection, neglect and lack of stability were considered factors associated with running away from placement. Other influential factors were the culture and routines of the individual placements. Biehal and Wade (2000) found that factors associated with high numbers of young people running away from residential care included senior management not offering clear leadership; low staff morale; and staff lacking hope about their ability to keep the young people safe or to control their behaviour.

“In more disorganized homes with high rates of absence, a sense of fatalism about how to challenge young people’s behaviour was more pervasive. In such contexts, whether enticed or coerced, young people’s careers of going missing appeared to proceed unchecked” (Biehal & Wade, 2000, 223)

Another placement related factor, especially for those who frequently went missing, was the level of placement instability. “Those who had persistently gone missing in the past were less likely to have formed a positive attachment to their current carers and were more likely to be experiencing problems in their placements” (Biehal & Wade, 2000, 218). Other influential factors included the social geography and local policies of the placement, and individual histories and patterns of behaviour, such as criminal offending behaviours.

The reasons for running away are dynamic and change over time. Young people may begin running away from placement because of bullying or because they want to see their friends, but as they grow older, missing from placement may become a pattern (Biehal & Wade, 2000).

“Although it is not possible to distinguish cause and effect in this network of relationships, it is clear that going missing often is one element of a process whereby young people’s link with key centres of adult authority are gradually weakened. Their careers are likely to be unstable and their attachments to carers weak. They are less likely to attend school, more likely to be involved in offending and in subcultures of substance misuse. Young people assessed as having emotional and behavioural difficulties...
Some young people had a history of running away before they came into the care, whereas others began to run away after coming into care. Those who began this behaviour prior to coming into care tended to have more entrenched problems, which did not appear to be greatly influenced by their experience in care. Although the young people who began running away whilst in care went missing less often and were less detached from the placement and other relationships, there was a core of young people who went missing often, were more likely to offend and were more likely to experience placement instability (Biehal & Wade, 2000).

Fasulo, Cross, Mosley and Leavey (2002) explored the characteristics and predictors of running away for a sample of 147 young people in specialised foster care placements. These were therapeutic placements specifically for young people with at-risk behaviours. They found that 44 per cent of the young people ran away at least once and 22 per cent ran away permanently (did not return to that or another placement). Two-thirds began running away in the first 6 months of placement. Forty-four per cent ran away to a family member; 39 per cent ran to a friend and an additional 17 per cent ran away to a friend or family member who lived in their original community. In terms of those who ran away permanently, there was a spike in the 16-year old age group, with no other clear pattern by age. Girls were more likely to run away than boys. A history of sexual abuse was not associated with permanent running away, nor was the length of placement. However, the number of psychotherapy sessions, regardless of length of placement, was related to a reduced risk of running away.

In a small study by Karam and Robert (2013), they identified three needs that running away met for 10 high-risk young people in residential care:

1. Reconnecting with their natural environment, as an attempt at returning to what was normal and who was familiar
2. Regaining control of their lives
3. Expressing their feelings, such as grief and stress.

Some young people may have experienced all three needs in their life. Karam and Robert (2013) conclude that running away should be understood as part of a young person’s attempt to cope, and that this may lead to more therapeutic and effective responses. They referred to Fasulo and colleague’s (2002) findings of the association between reduced running away and the intensity of the therapeutic relationship and note:

“There could be numerous benefits for the youth: the development of a sense of security in their environment, a sense of ownership to the therapeutic approach, a better understanding of the situation, expression of emotion instead of acting on them, etc. Furthermore, all of these may lead to stopping runaway behaviour.” (Karam & Robert, 2013, 78)

Similar to the understanding of sexual exploitation, the literature speaks of child characteristics, family characteristics and system characteristics that can lead a young person in care to run away. Courtney and Zinn (2009) undertook a study of 14,282 young people in care and known to have run
away at least once in Illinois (USA). Child characteristics included that they were more likely to be older at the first time of running away and at the time they came into care. However, if the child was under 12 when they first ran away, there were more likely to run away again. Females were significantly more likely to run away the first time and slightly more likely to run away again. The presence of a developmental delay or disability was associated with a decreased likelihood in running away in the first instance, but this finding was not present for those who ran away more than once. Diagnosed mental health problems showed mixed findings. For example, those with schizophrenia or other forms of psychosis were at substantial less risk of running away, and those with anxiety, somatoform, dissociated and personality disorders were at moderate less risk of running away. However, those with a ‘general’ mental health condition were at higher risk of running away. Those with alcohol and other drug use were at substantial risk of running away in general, and in a repeated pattern.

Ching-Hsuan’s (2012) study of 8,047 children who had run away from foster care in the US found that children who were female and older were similarly at risk of running away as found by Courtney & Zinn (2009). In contrast to Courtney and Zinn’s study (2009), this study found that children with a diagnosed disability were at risk of running away.

In terms of family characteristics, Courtney and Zinn (2009) found that young people who had been sexually abused were less likely to run away in the first instance, but this was not a finding for those young people who ran away more than once. Young people exposed to neglect through lack of supervision were at increased risk of running away. Slesnick, Guo, Brakenhoff, and Feng (2013) found that lack of family cohesion was a risk factor, but interestingly, not family conflict.

Young people exposed to neglect through lack of supervision were at increased risk of running away.

System factors included that young people in residential care were more likely to run away than those in foster care, and those in foster care were more likely to run away than those in kinship care. Those with multiple placements were at higher risk (Courtney & Zinn, 2009). Clark and colleagues (2008) noted that running away can place pressure on the placement and be a reason for placement change. The presence of a sibling in the same placement dramatically reduced the likelihood of running away from all placement types. Courtney and Zinn (2009) noted other system factors such as: changes in the permanency plan, whatever the decision; instability and uncertainty regarding their plan; and the degree of warmth, responsiveness and respect from residential care staff and foster parents. They concluded that those young people with a history of running away should be a particular target of intervention.

In an Israeli study of Jewish and Arabic teenagers in care, nearly half the young people reported that they had run away or attempted to run away at least once. Some of the system factors that increased the likelihood of absconding behaviour were: the larger the size of the institution; the length of stay; physical violence from peers and staff; and experiencing the staff as strict and unsupportive. This study also noted some differences based on the young person’s cultural identity (Attar-Schwartz, 2013).
Courtney and Zinn (2009) found that the length of time absconding varied, with just under 50 per cent being away for less than a week. However, a quarter of the young people were away for five weeks or longer. They found that young people were more likely to run away in the first few months of coming into care; however, after two years of being in care, the likelihood of running away increases again. Witherup and colleagues (2008) found that the duration of the time the young person was running away was more critical than the number of times he or she ran away.

In considering the potential causes or contributing factors to running away, it is useful to consider what the young people are running away from (push factors). A number of studies report that many of these young people are running away from abusive or neglecting situations or family violence at home (Leichtentritt & Arad, 2005; Reid, 2011; Wilson & Widom, 2010). Interestingly, in relation to sexual exploitation, it is only the article focusing on young men that mentions that some are ‘thrown out’ from home, rather than it being their choice to run away (Leichtentritt & Arad, 2005).

Beckett (2011), Biehal and Wade (2000), Ching-Hsuan, 2012; Clark and colleagues (2008), Smeaton, 2013; and Tyler, Johnson and Brownbridge (2008) describe some of the push and pull factors leading to running away from care. Some of the push factors include: being unsettled in the placement; restrictions placed on the young person in placement; no one seeming to care about them and feeling alienated; lack of safety and abuse by caregivers; bullying by other young people at school or in the neighbourhood; participating in group escapes; non-attendance at school and boredom; maintaining links with a previous neighbourhood; and avoiding rules and expectations held by others.

Some of the pull factors described in the literature include: the desire to access greater control and autonomy; being with family members and friends; attending teenage activities and parties; drug use; to commit offences; peer recognition for beating the system; sense of excitement and freedom; or to demonstrate that they are adults and able to care for themselves. Specific triggers or antecedents for running included: peer pressure or influence; an incident of abuse or unfairness; avoiding consequences; a positive or negative phone conversation with a parent or sibling; and a feeling of loneliness and depression.

3. How have services tried to assist young people to resolve these problems?

Overview of policies and other initiatives

Society has always grappled with troubled youth. Yet the past three decades have increasingly highlighted the phenomenon of adolescents with high-risk behaviours. Their behaviours are not necessarily new, but the constructs that inform the way we think, plan and act are a feature of this era.

Across this time, we have seen changes in: the role of government; the role of non-government; the perception of the client; new science; new technology; world events that shaped local policies; paradigm shifts; practice approaches; the types of services available; and legislation.

Although Table 5 starts with the 1980s, what went before has been part of the journey. For example, the feminist movement in the 1960s and 1970s and the Vietnam War and the returning veterans were major social phenomena that continue to impact on social and health policies today. Other
Social changes over this time included: changing family and household structures; increasing percentage of children living in poverty; the ageing population; increased substance abuse; increased gambling problems; increased prevalence of mental health problems; increased family violence; and the deinstitutionalisation of mental health, disability, alcohol and drug treatment services and child welfare (DHS, 2003c; DHS, 2003d).

**Table 5: A scan of policies, events and key documents along with theoretical frameworks and overall themes that have influenced protection and care field in Victoria, Australia**

<table>
<thead>
<tr>
<th>Decades</th>
<th>Key events</th>
<th>Theories, research</th>
<th>Themes/Eras</th>
</tr>
</thead>
</table>
- Child protection mandate transferred to government (1985)  
- Progressive closure of institutions, increase in no of community-based small residential units by NGOs  
- Expansion of CASAs  
- Child and Young Person Act (CYPAA) legislation developed, Mental Health Act,  
- Professionalisation, e.g. family support, child protection, residential care, use of supervision, police checks, referees  
- Improved income security  
- Increased funding accountability for CSOs  
- Collaboration through protocol development between services | - Permanency planning principles  
- Ecological systems  
- Child development  
- Social justice, rights, normalisation  
- Consumer participation | - Professionalisation  
- De-institutionalisation  
- Normalisation (participation in community, schools and family-like environments)  
- Localisation compared with centralisation  
- Minimal intervention |
| 1990s   | - CYPAA-proclaimed  
- More formal case planning and reviews  
- Daniel Valerio child death (media), Fogerty review (1993), mandatory reporting (1993), child protection manuals  
- Complete deinstitutionalisation, including moving from congregate care to community,  
- Adolescent Community Placements (1991)  
- Secure Welfare Service (1992)  
- Family preservation (1992)  
- VACCA – DHS protocol (1992)  
- CREATE (formerly Australian Association of Young People in Care established (1993)  
- Prostitution Control Act, 1994  
- Auditor-General’s report on child protection (1996)  
- Adolescent client of child protection involved in murder of taxi driver, court case and media leading to HRA register (1996)  
- High Risk Adolescent strategy (HRASQII), ICMS, brokerage, 1:1 placements (1998)  
- Amalgamations of services and regions | - Trauma (decade of the brain)  
- Research re Aboriginal people’s historical and current lack of safety and wellbeing in Australia | - Family preservation  
- Risk  
- Working together  
- Competitive tendering  
- Information technology  
- A big world  
- Management/ business paradigm |
<table>
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<tr>
<th>Decades</th>
<th>Key events</th>
<th>Theories, research</th>
<th>Themes/Eras</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000s</td>
<td>Modernising children’s court</td>
<td>Trauma</td>
<td>Therapeutic (trauma-informed)</td>
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<tr>
<td></td>
<td>Purchaser/provider, competitive tendering, privatisation/outsourcing (e.g. residential care)</td>
<td>Updating attachment</td>
<td>Quality</td>
</tr>
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<td></td>
<td>Child death inquiry panels</td>
<td>Resilience</td>
<td>Evidence and knowledge</td>
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<td>Suicide Taskforce Report (1997)</td>
<td>Perry</td>
<td>Aspirational leadership</td>
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<td>Child and Adolescent Mental Health Framework</td>
<td>Hughes</td>
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<td>YAFS redevelopment (1998)</td>
<td>Best interests</td>
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<td>Intensive Mobile Youth Outreach Services (IMYOS) (1998)</td>
<td>Evidence-based practice</td>
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<td>Turning the Tide Strategy Against Drug Abuse</td>
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<td></td>
<td>CASIS – computerised client case management system</td>
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<td></td>
<td>Substantial increase in DHS central office re policy development</td>
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<td>Face to Face (young people in care and sector conversations)</td>
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<td>Working Together Strategy, e.g. When Care is not Enough, regional panels, Stargate (1999)</td>
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<td>Series of reports on child protection and care, e.g. Audit on kinship care (2001); Audit on residential care (DHS, 2001); Audit on home-based care (DHS, 2001); Integrated Strategy (DHS, 2002); Public Parenting (DHS, 2003); Child Protection Outcomes Project (Allen Consulting, 2003); Report on Panel to oversee consultation on protecting children (Kirby et al, 2004), Auditor General’s Report on OoHC (2005)</td>
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<td>Best Start (2001)</td>
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<td>Alcohol and Drug Youth Consultants, Youth Mental health consultants to child protection and ICMS</td>
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<td>Senate Inquiry into children in institutional or out-of-home care (2003)</td>
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<td>Take Two – Therapeutic service for child protection clients (2004)</td>
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<td>Victorian Youth Homelessness Strategy (2004)</td>
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<td>Office of the Advocate of Children in Care (2004)</td>
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<td>Decades</td>
<td>Key events</td>
<td>Theories, research</td>
<td>Themes/Eras</td>
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| • Strengthening Families pilots, Innovations Pilots and Child FIRST (2007)  
• Establish Centre of Excellence in Child and Family Welfare (previously CWAV)  
• Minimum standards - quality, Working With Children checks  
• More research on children in care  
• Quality assurance and CSO registration  
• Principal practitioner roles,  
• Ready access to internet and world wide web  
• Principle Practitioner roles  
• CRIS/CRISSP  
• New ACSASS protocol  
• Kinship care funded  
• Charter of Human Rights, 2006  
• Charter for Children in Out-of-Home Care, 2007  
• Therapeutic foster care and therapeutic residential care (2007)  
• Sanctuary training (2008)  
• Every Child Every Chance reforms  
• Best Interests framework (Miller, 2007)  
• Stolen Generations apology (2008)  
• Forgotten Australian’s apology (2009)  
• National framework for protecting Australia’s children (FaHCSIA, 2009)  
• DHS Leadership Strategy (Atkinson Consulting, 2009)  
• Ceasing most RP1s (family group homes)  
• Global financial crisis (2008)  
• National Mental Health Strategy (2008)  
• Victorian Mental Health Reform Strategy (2009)  
• Workshops and forums regarding youth prostitution  
• Ombudsman investigation re Child Protection (Ombudsman Victoria, 2009)  
• Victorian wide bushfires (2009)  
• Child and Youth Mental Health Reforms | • Trauma  
• Attachment  
• Neurodevelopment  
• Resilience  
• Best interests  
• Evidence- | • Transition  
• Compliance  
• Standards  
• youth engagement  
• Person-centered  
• Joined-up |
| Recent | • Ombudsman investigation re Out-of-Home Care (Ombudsman Victoria, 2010)  
• Forums in relation to child sexual exploitation  
• Stronger Families Victoria pilots (2010)  
• Victorian wide floods (2011)  
• Vulnerable Children’s Inquiry (2012)  
• Victoria’s Vulnerable Children’s strategy | }
### Table 5: A scan of policies, events and key documents along with theoretical frameworks and overall themes that have influenced protection and care field in Victoria, Australia

<table>
<thead>
<tr>
<th>Decades</th>
<th>Key events</th>
<th>Theories, research</th>
<th>Themes/Eras</th>
</tr>
</thead>
</table>
| • Reviews of some individual CSOs’ residential care services (2011)  
• Priority Access to Mental Health (2011)  
• National out-of-home care standards (2011)  
• VERSO evaluation on Therapeutic Residential Care (2011)  
• La Trobe University’s evaluation on Therapeutic Foster Care (2012)  
• Change of DHS divisions and broader restructure (2012)  
• Sustainable Victoria (reduction of public service) (2012)  
• Change to the DHS Child Protection operating model (2012)  
• Shergold Review into service sector reform (2013)  
• National Disability Insurance Scheme  
• Pilot of intensive therapeutic service within Youth Justice custodial setting (2013)  
• Joint workshops between DHS and VicPol re child sexual exploitation (2013)  
• Services Connect | based practice and practice elements  
• Implementation science and translational research | |

As seen in Table 5, there have been various influencing theories and frameworks over the decades. The sands have shifted at times from a focus on bottom lines – such as standards, compliance, registrations, and risk – to more aspirational goals, including such concepts as leadership, knowledge development and reforms. The changing emphasis has sometimes been driven by a specific crisis or level of scrutiny, such as a focus on risk in relation to young children after the death of a child or on young people after the manslaughter by a young person of a taxi driver. The aspirational focus has sometimes been at a time of relative calm where leadership was able to introduce new concepts, such as the **Best Interests** framework and therapeutic care. At any given time in the context of child protection and out-of-home care, there is a need for attention to bottom-line and aspirational thinking, although any shift in emphasis is usually based on external factors.

There are many policy and programmatic threads over these decades relating directly or indirectly to high-risk adolescents. The main threads that are explored here are: high-risk adolescent initiatives; **Best Interests** framework; out-of-home care with a focus on residential care; therapeutic services including therapeutic care; care teams and collaboration; multiple and complex needs initiatives and mental health services. (There were other relevant initiatives not discussed due not being in the scope of the terms of reference. These included alcohol and other drugs, homelessness, youth justice and disability.)
There have only recently been some specific initiatives mentioned in relation to child sexual exploitation. This began with some workshops and forums in 2009 and 2010 sponsored by the then Office of the Child Safety Commissioner and DHS, and was followed by several projects: a project by the Commission to undertake a group analysis of high risk adolescents (which included an earlier version of this literature review), and a more recent initiative led by the Office of the Principal Practitioner and the Victoria Police. There has not yet been any obvious system strategy in relation to absconding, although the Therapeutic Residential Care evaluation noted that reducing absconding was one of the achievements of therapeutic residential care (VERSO Consulting Pty Ltd, 2011).

**High risk adolescent initiatives**

Concerns regarding adolescents with multiple high-risk behaviours have been under consideration from different viewpoints, including youth justice, disability and child protection. There has been a consistent understanding that the State Government has a duty of care for the young person, especially if they are on a Guardianship or Custody order and that there is also a duty of care for the community around safety and prevention of future risk. However, it is not always clear how to fulfil these obligations (Morton, Clark & Pead, 1999).

The focus of the discussion at the time of deinstitutionalisation was the need for some type of secure facility once Winlaton, Baltara and Turana were no longer available. The Secure Welfare Service was established in 1992 to coincide with when young men and women were no longer able to access those other facilities and when the *Child and Young Person’s Act 1989* required that youth justice and child welfare functions were separate. This service was to provide a certain level of coercion and secure containment when there was concern about the young person or other’s safety. The function of Secure Welfare is to provide a time-limited opportunity to manage high-risk situations for up to 21 days. There is a 10-bed unit for young men and one for young women, with the highest demand being for the Young Women’s unit.

In the third evaluation report of Take Two, the following Secure Welfare data was provided for the time period 2004 to 2006. The mean age was 14.5 years; 64 per cent were female; 80 per cent were from a metropolitan region; 16 per cent were Aboriginal; and 22 per cent were on Interim Accommodation Orders, with the remaining being on Custody or Guardianship orders (Frederico, Jackson & Black, 2010). Morton, Clark and Pead (1999) noted that coercive and secure options did not have the strongest research backing, although they acknowledged that the Secure Welfare Service was an important adjunct to intensive therapeutic intervention, just not sufficient on its own.

It would seem that a major turning point occurred in 1996 following significant media attention during a criminal trial of a young person who was a client of child protection and who as part of a group was convicted of manslaughter of a taxi driver. As the case of Daniel Valerio’s death was a lightning rod for concern about mandatory reporting, this high profile manslaughter case garnered attention for adolescents with high-risk behaviours. It was acknowledged that although adolescents with high-risk behaviours are small in number, their public profile creates a lack of confidence in the system. It was also understood that high-risk young people involved substantially higher costs for their care and protection compared with other child protection clients (DHS, 2006). This not only represents costs in terms of direct funds required, but also costs on other parts of the system such as overwhelmed carers, Workcover claims and low morale. The other driver for change has been when young people have died as a direct or indirect result of their behaviours, such as overdose,
suicide or accident. As such, drivers for the improvement of policies and programs relating to high-risk adolescents have been a combination of: unacceptably high risks to the young person; negative public opinion and low public confidence; substantial drain on resources with little confidence that it reflected an investment in something positive; and limited vision about what a solution may look like.

**High Risk Adolescent or Youth Register (1996)**

One of the steps immediately taken by DHS after the manslaughter court case was to establish the High Risk Adolescent Register (now known as High Risk Youth Schedule) where every child protection region was asked to develop and maintain a working list of young people with multiple risk factors. These lists were kept locally and, apart from general criteria, each region developed their own processes and criteria.

An internal DHS report (2006) of the HRA Register provides interesting insight into the use of the register and some of the issues confronting the young people and the service system around them. There were 178 adolescents on the register, of whom 86 per cent were in out-of-home care. This represented 4 per cent of the out-of-home care population at the time. Just over half on the register were females and more than half were aged 15-16 years old. Two-thirds did not come into care until they were 12 years or older. Sixteen per cent were Aboriginal, which was higher than the over-representation of Aboriginal young people in the broader protection and care system. Approximately one in seven young people on the list had an intellectual disability, but more probably had other cognitive impairments. More than half of the young people were on the register for longer than 6 months, with 19 per cent being on the list for longer than 12 months.

Issues listed for the young people included their alcohol and other drug use (84 per cent), challenging behaviours (79 per cent), suicide attempts (12 per cent) or ideation (28 per cent), self-harming behaviours (26 per cent), aggression (48 per cent), absconding (33 per cent), prostitution (10 per cent), sexualised behaviours (25 per cent), mental health problems (24 per cent), escalating criminal offending (38 per cent) and estranged or non-existing relationship with family members (25 per cent).

More than a fifth of the young people had run away more than 10 times in the previous 3 months. In one region as a sample, they found that 90 per cent of the incident reports were in relation to young people on the HRA Register. This is consistent with a common practice where incident reports were used to alert management as to whether young people should be placed on the register. This analysis compared the data to that reported in the *When Care is Not Enough* report (Morton, Clark & Pead, 1999) where they found an increase in drug-using behaviours as well as suicidal behaviours, mental health problems and sexually inappropriate behaviours.

Sixty per cent of the cases were contracted to Community Service Organisations, primarily Intensive Case Management Services (ICMS). Nearly two-thirds of the young people in the Secure Welfare Service were on the High Risk Register. There was concern that a number of them had increasing behavioural problems upon discharge from Secure Welfare, especially if the discharge plans were not followed through. Twenty-three per cent of the young people on the list were clients of Take Two (DHS, 2006).
Forty-seven per cent of the young people on this register were in residential care, with the larger group (23 per cent) surprisingly placed in RP1 family group home type of placements, followed by RP3s (17 per cent) and then RP2s (5 per cent). After residential care, the next highest group were living with one or both parents (14 per cent), Youth Justice custodial setting (7 per cent), Adolescent Community Placement (ACP) (7 per cent), Kinship Care (5 per cent) and Complex Home-Based Care (5 per cent).

What is not clear from this report is what being on the HRA Register entailed for the young person. In some regions, it led to regular (fortnightly or monthly) meetings with senior management across child protection, placement coordination units and youth justice for high-level scrutiny of cases and to provide consultation and direction when required. Some regions met with out-of-home care providers regarding the young people on the list. Overall, the focus of the Register appeared to be on accountability and the monitoring of practice and decision-making. The policy and procedural documents regarding the High Risk Youth registers have recently been updated (DHS, 2013a, 2013b).

High Risk Adolescent Strategic Quality Improvement Initiative (HRASQII) (1998)

In 1998, DHS funded the High Risk Adolescent Service Quality Improvement Initiative (HRASQII). These funds went to Community Service Organisations, most of whom already had experience in working with this client group.

“Informed by a substantial body of research and focusing on known best practice, the High Risk Adolescent Service Quality Improvement Initiative (HRASQII) was an attempt to provide an intensive and highly resourced response to young people who present with serious personal or community risk issues and pose difficult management problems. It is estimated that, at any point in time, there are 200 young people within the Protection and Care population of the Department of Human Services (DHS) who are high risk, registered with the Protection and Care High Risk Schedule.” (DHS, 2001a, vi)

There were three main strategies within the HRASQII. Intensive Case Management Services (ICMS) were a main platform for this strategy, some of which began from scratch while others were a redevelopment of other services working with this population. Another key element of HRASQII was the funding of one-to-one home-based care options for young people who could not be placed in traditional foster care, ACP or residential care. HRASQII also provided brokerage funds that were either managed through ICMS or DHS. Finally, each high-risk adolescent was required to have an Individual Placement Plan (IPP), in which the brokerage funds might assist. Although not specific to HRASQII, most child protection regions also had specialist Adolescent Protective Teams in order to provide specialisation and continuity from investigation through to long-term involvement.

The objectives of ICMS are:

- To provide an integrated case management and brokerage service response, including outreach and afterhours crisis support to high-risk young people
- Provide and promote innovative practice
- Develop and improve links with education, mental health, alcohol and other drug services, youth justice and general youth services to enable young people to receive integrated and coordinated care and support
- Facilitate coordination and access to accommodation support services, recreational and vocational services, police, family support and the young person’s family
• Provide integrated and flexible support and care options in a holistic and multi-disciplinary framework
• Ensure the service delivery is innovated and informed by reviews and evaluation (Centre of Excellence in Child and Family Welfare, 2006).

Caseloads have been usually capped at 4 to 6 clients and they can be involved for up to 2 years. ICMS teams may include alcohol and other drug workers and mental health workers as well as the case managers. In their description of case management during the evaluation of the HRASQII, the following was stated:

“There needs to be some sort of underpinning belief in the resilience or regenerative nature of the human spirit, that regardless of how difficult or negative the past experiences of these young people have been, and how challenging the current behaviours, there is the possibility for positive change and growth. A high level of commitment is also necessary, because the varied and complex demands of the role include often needing to respond to a crisis, and being available after hours or for extended hours.” (DHS, 2001a, 37)

Findings from the evaluation of HRASQII included (DHS, 2001a):
• Age of entry to care: The younger a young person was when they first entered child protection, the more difficult it was for them. This appeared to relate to the impact of early-in-life trauma and the difficulties associated with redressing harms that have been left unabated
• Previous experience: CSOs with experience in working with high-risk adolescents were more able to move quickly and with minimal difficulty into HRASQII
• Strengthen partnership approach: Some aspects of partnership need to be improved particularly when the DHS purchaser provider role was seen as a ‘hands off’ approach
• Risk management and accountability require more shared understanding, as DHS appeared to focus on risk and CSOs appeared to focus on need
• Although HRASQII was evidence-based, CSOs did not all have a coherent practice framework.

**Working Together Strategy (1998)**
The Working Together Strategy was formed largely due to concerns raised regarding the inadequate collaboration between the different services involved with high-risk young people. Coronial inquiries, program reviews, child death inquiries, Auditor General’s review of child protection, and outcomes of court cases highlighted problems with cooperation between services (Aged, Community and Mental Health Division and the Youth and Family Services Division, 1999).

“In order to improve the quality and consistency of outcomes for clients of Drug Treatment, Juvenile Justice, Mental Health and Protection and Care services, the Working Together Strategy will:
1. Identify best practice for clients requiring access to two or more services.
2. Determine effective service relationships.
3. Ensure understanding of existing programs and program innovation.
4. Establish ongoing inter sectoral discussion, program innovation and processes for continuous service improvement.” (Aged, Community and Mental Health Division and the Youth and Family Services Division, 1999, 1)
The *Working Together Strategy* aimed to provide a framework for improving inter-sectoral service provision between mental health, child protection, drug treatment services and youth justice. It later involved the police, education and disability services. It had a quality improvement focus as well as reviewing the strengths and weaknesses of cross system service delivery and the building and sharing of knowledge. There were a series of joint initiatives at a central and regional level. Each region provided some examples of case studies to assist with exploring the system issues and barriers. Some regions developed local responses, such as multiservice panels to discuss complex cases. The Western region was funded to pilot the *Stargate* program, which undertook assessments of children and young people entering care. *The When Care is Not Enough* report (Morton, Clark & Pead, 1999) is probably one of the major legacies of the *Working Together Strategy*. Many, but not all, of the recommendations of this report have been enacted to some degree, as shown in Table 6.

<table>
<thead>
<tr>
<th>Gaps identified and recommendations</th>
<th>What has happened since</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-sectoral, multi-disciplinary assessment and case planning;</td>
<td>• Initial health assessment pilot (Eastern region)</td>
</tr>
<tr>
<td></td>
<td>• Current Department of Health working group</td>
</tr>
<tr>
<td></td>
<td>• Increased access to cognitive assessments for DHS clients through schools in planning phase</td>
</tr>
<tr>
<td></td>
<td>• Care teams</td>
</tr>
<tr>
<td>Early identification of children and adolescents, entering protection and care, who have suffered severe abuse and/or neglect and who show high levels of emotional disturbance</td>
<td>• Take Two’s role, although few referrals are received for early identification</td>
</tr>
<tr>
<td>Consultation, training and intensive support for kith and kin, carers, or staff providing specialist placements for young people with extreme levels of disturbance</td>
<td>Introduction of Circle and Therapeutic Residential Care pilots Training: RCLDS, Fostering Hope, kinship care</td>
</tr>
<tr>
<td>Intensive specialist therapeutic interventions for young people in care who manifest severe emotional and behavioural disturbance</td>
<td>Take Two’s role</td>
</tr>
<tr>
<td>Specialist therapeutic outreach services in rural regions</td>
<td>Take Two’s role</td>
</tr>
<tr>
<td>Therapeutic residential group care for young people with extreme levels of disturbance</td>
<td>Therapeutic residential care pilots in each region</td>
</tr>
<tr>
<td>Specialist intensive therapeutic residential or day programs</td>
<td>Not occurred</td>
</tr>
<tr>
<td>Alternative educational programming for young people not able to be supported in mainstream schools</td>
<td>Some CSO initiatives have continued, e.g. Berry Street’s school</td>
</tr>
<tr>
<td>Mandatory community-based intensive therapeutic options as an alternative to custody, or as an enhancement of community-based correctional orders, for young people with extreme levels of disturbance convicted of violent crimes or drug offences</td>
<td>Not occurred, except in relation to the introduction of Therapeutic Treatment Orders in relation to young people with problem sexual behaviours</td>
</tr>
</tbody>
</table>

This strategy identified that every service system had its own history, constraints, paradigms, information systems, drivers and eligibility criteria. It appeared that each system needed leadership and communication to champion cross-service responses for these young people.


“...In this demanding environment, practitioners seek clinical and practice solutions to impacts of severe abuse and neglect, significant emotional and behavioural disturbance and extreme risk taking behaviour. It is likely that no one clinical or practice framework can provide the practice innovation increasingly needed. It is possible that some of these clients need new approaches to their problems. Programs and practitioners must ask, ‘Does the coexistence of each of these problems change the nature of the response required?’” (Aged, Community and Mental Health Division and the Youth and Family Services Division, 1999, 12)

**Best Interests framework and related case work initiatives**

In the last decade, the policy development regarding adolescents within the protection and care system occurred through the broader lens of the *Best Interests* framework. This framework is based on understanding the needs of young people within a developmental trauma and attachment-informed perspective. It developed (not coincidentally) alongside the new role of the principal practitioner. The increase in number of principal practitioners supported the application of these perspectives.

Rather than focusing on high risk behaviours, this approach focused on the young people’s needs, including those they share with all young people and those that are particular to their own situation (Miller, 2007). This framework was introduced through the *Child Wellbeing and Safety Act 2005* and *Children, Youth and Families Act 2005*, which placed the best interests of the child and young person front and centre of practice. This framework included a focus on outcomes as developed through the statewide children’s outcomes framework.

The *Best Interests* framework highlighted the need for a consistent focus on the age and stage of life, culture and gender of the young person, their need for safety, their need for stability, and the importance of promoting their development. In comparison with earlier policies, this framework was more strengths-focused, although it continued to pay attention to risks and vulnerability. In order to provide specific advice and guidance for adolescents, specialist practice guides have been developed (e.g. Miller & Bromfield, 2010; Pratt & Miller, 2010; Robinson & Miller, 2010).

The NSW Department of Community Services published a literature review of effective strategies for adolescents in a child protection context (Schmied & Tully, 2009). Although it understandably makes no reference to the Victorian system or the *Best Interests* framework, it draws on a number of similar conclusions. It emphasises the need for building relationships with young people through proactive and persistent engagement strategies that demonstrate a commitment to the young person. They recommend: seeing the young person rather than the behaviour; getting the young person’s own perspective; being solution and future-oriented in practice; setting and reviewing achievable goals; facilitating the young person’s involvement with school; and being practical and active. They also comment on the importance of working with the young person’s family, working proactively with other services, and being culturally sensitive.

**Out-of-home care**

As stated earlier, young people with high-risk behaviours in the child protection system are more likely to live in out-of-home care than with their parents, and are more likely to be in residential care than other types of care. As such, tracing the history and current state of residential care in particular, and out-of-home care in general, provides a perspective on how the system has grappled with issues relating to young people with high-risk behaviours. Bullock and colleagues (2006) in their
discussion regarding the question of whether or not the corporate state can parent children in out-of-home care concluded “The overwhelming empirical evidence from numerous studies is that in all countries ... troubled and troublesome adolescents is the one whose needs the state most often fails to meet.” (Bullock et al., 2006, 1353)

*Tracing the history and current state of residential care in particular, and out-of-home care in general, provides a perspective on how the system has grappled with issues relating to young people with high-risk behaviours.*

The numbers of children in residential care, including institutions, peaked in the late 1960s, after which the policies of deinstitutionalisation led to a substantial decrease in numbers. The trends of children in out-of-home care in general initially decreased from the 1960s due to the focus on family support and the introduction of Single Parent Benefit (DHS, 2003c; 2006). However, from 1992 onwards, numbers of children in care in Victoria and across Australia have increased (Australian Institute of Health and Welfare (AIHW, 2013).

This increase of children in out-of-home care, particularly foster care and kinship care, at the same time as the decrease in residential care, reflects a reshape of the care system. For example, numbers of children estimated to be in out-of-home care in Australia was 17,000 in 1982 compared to 28,441 in 2008. In contrast, the number of children estimated to be in residential care was 7,140 (42 per cent) in 1982 compared with 1,247 (4 per cent) in 2008 (Bath, 2008a). The numbers of children in residential care appear to have stabilised, with the numbers in Australia as of 30 June 2012 at 2,042 (5.2 per cent of care) and 478 in Victoria (7.7 per cent of care) (AIHW, 2013). Nearly a quarter of Australia’s children and young people in residential care are in Victoria.

*With the increase in the trend to keep children with their families, those who came into care were more likely to have difficult behaviours.*

Three national surveys of non-government out-of-home care (*Particular Care; Particular Care Reconsidered; Changing Particular Care*) provided a glimpse of the changing perspectives about children with behavioural problems in care, although the concept of high risk adolescents was not mentioned (Gregory & Smith, 1982; Szwarc, 1985; 1992). Each survey noted one of the reasons for entering care was the child’s behaviour, although this was a small percentage in each survey (Gregory & Smith, 1982; Szwarc, 1985). The third survey was the first to overtly discuss children with behavioural problems, regardless of whether this was noted as reason for entering care. Szwarc (1992) found that 64 per cent of the children in care had behaviour problems requiring specific attention although ‘behaviour’ was only listed in 2 per cent of cases as a primary reason for entering care. Szwarc found that approximately 60 per cent of those with behavioural problems were 13 years or older and were more likely to be in residential care than foster care. They were less likely to be Aboriginal. With the increase in the trend to keep children with their families, those who came into care were more likely to have difficult behaviours. This report concluded there was a need to develop more out-of-home care options, including therapeutic care and general access to therapeutic services.
A number of drivers have had a major impact on the landscape of out-of-home care in Victoria, Australia over the past four decades. These included: the application of theories of child development and attachment into practice and program design; media accounts of abuse and neglect in institutional care; recognition that institutions were negatively impacting on the culture of Indigenous peoples through their children; the increasing costs of residential care; and the broader ideology of de-institutionalisation across a variety of fields leading to closure of disability, alcohol and drugs and mental health institutions as well as child welfare institutions. Children with behavioural problems began to be placed in foster care, instead of residential care. The demands presented by children with behavioural problems in foster care coincided with the diminishing pool of carers due to socio-economic factors (Bath, 2008a).

In the US, moderate to large size residential treatment centres became a feature in the 1960s, the like of which have not been seen in Australia. At that time, when Australian States were beginning to close down large institutions, the US States were retaining many institutions, but changing their modality from institutional care to treatment models. The residential treatment centres either became mental health, correctional, substance abuse or child welfare focused, depending on their histories and primary funding sources. Some US State governments also developed small residential homes in the community that are similar to the Australian style of residential care. A residential treatment centre visited by a number of Victorian DHS and CSO managers is the Andrus Children’s Center in New York State. This centre, along with others, has adopted the Sanctuary Model and includes a school along with a number of 12-bed residential units on the one campus. It is the Sanctuary Model developed by Sandra Bloom (2002; 2005) that has influenced Victorian policy and program development.

Some challenges facing the out-of-home care sector and government in Australia include increased client complexity, such as young people having aggressive behaviours, being system savvy, having sexualised behaviours, and substance abuse problems (DHS, 2003b). “Children and young people are seen to be entering care later and more damaged, displaying more complex and multi-problem behaviours” (DHS, 2003c, 14). Other challenges include: a declining volunteer base making recruitment and retention of foster carers more difficult; fewer carers choosing to care for adolescents, workforce sustainability pressures; Aboriginal children’s over-representation; and adverse public opinion (DHS, 2003b; 2003c). Clark (2000) noted that the move from institutions to community-based settings, whilst laudable, increased some risks. For example, it is easier to run away, to access drugs and alcohol, and to not attend school when living in the community.

The pattern of children with more difficult behaviours requiring care in the community lead to specialised foster care programs, such as Specialised Home-Based Care that began in the mid 1990s (Bath, 2008a; Smyth & Eardley, 2008). Currently in Victoria there are three levels of foster care in terms of funding and consideration of complexity:

1. General foster care, which is set at 60 per cent of home-based care
2. Intensive foster care, which has subsumed specialised home-based care and innovative home-based care, and targets children and young people where previous placements have been inappropriate or unsuccessful perhaps because of the young person’s behaviour (set at 30 per cent of placements)
Complex foster care for those considered at very high need for intensive support and higher levels of reimbursement (set at 10 per cent of placements) (Smyth & Eardly, 2008). One-to-one care is an example of complex care. This is also sometimes described as individualised care or a ‘wrap around’ approach. Adolescent Community Placements are the general home-based care option where carers are recruited specifically for young people.

This push to place young people with at risk behaviours in home-based care is considered a major factor leading to high placement breakdown rates (Bath, 2008a; Senate Community Affairs References Committee, 2005). The young person’s experience of multiple placements in foster care has replaced the experience of multiple staff in institutions, with the result of fewer costs in the short-term, but similarly difficult problems in the long-term (Senate Community Affairs References Committee, 2005). Some of the consequences of these multiple placements for young people have been a sense of failure, lack of stability, lack of security and lack of consistent relationships.

"Evidence is that children who have been in out-of-home care: have poor life opportunities; miss out on education; feature highly in homeless populations and the juvenile justice system; do not always receive adequate dental or medical care; often gravitate to substance abuse; and are more likely than their contemporaries not in care, to have thought of or attempted suicide.” (Senate Community Affairs References Committee, 2005, 76)

Residential care became seen as a last resort (e.g. Young and Matrix Organisation Support, 1997). In contrast, foster care was seen as something to try at all costs – to the detriment of both care options.

"The result of this process is that more troubled children and young people are being placed in foster care, with residential care serving as a default option, reserved for those with complex needs and entrenched, challenging behaviours. Unfortunately, these more needy and behaviourally troubled young people are placed into a care modality that has been run down and neglected and thus struggles to respond to the demands placed on it.” (Bath, 2008a, 8)

The Senate Inquiry noted that residential care remains the less preferred option for care, although noted that the Victorian Government recognised this may not be the case for all children (Senate Community Affairs References Committee, 2005). As stated in the Public Parenting report (DHS, 2003), home-based care is not always appropriate for children and young people with major behavioural, emotional and mental health problems. Other research has supported this conclusion (e.g. Barber, Delfabbro & Cooper, 2001).

The nature of residential care has changed. Soon after de-institutionalisation of the large child welfare institutions in Victoria in the late 1980s to early 1990s, short-term units were established with up to 12 beds, whereas family group homes with cottage parent models were the mainstay. Over time, the larger units closed, as did most of the family group homes (known as RP1s). Today, residential units (known as RP2s or RP3s) have an average of four young people with rostered staff. The residential care system in Victoria uses contingency units that spring up when demand requires and are not part of core funding. They are outside of the planned budget process and are often more expensive due to use of casual or agency staff. Use of contingency units is usually a reflection of the placement system being at full capacity and with no inbuilt capacity for dealing with surges in placement demand. The planning for young people in these placements is usually constrained by the
temporary nature, court phase and push to place them elsewhere, in cheaper more sustainable options.

“It is not unusual for essentially untrained staff members to be caring for young people with significant abuse histories, long juvenile justice records, serious substance abuse issues, histories of sexually exploiting other children, and/or frank psychiatric symptomatology, all together in the one small and isolated residential unit.” (Bath, 2008a, 9)

The complexity and variability of the needs of young people placed in residential care are seen as one of the major reasons why they struggle in this type of care. For example, research has shown that it can be contraindicated to place together children and young people with oppositional defiant disorders, conduct disorders and attention deficit hyperactivity disorders. However, this may be due in part to poorly managed, unstructured and unsupervised group interactions rather than simply living together (Bath, 2008a).

The placement system being at full capacity also makes it difficult to match young people when they are in care in order to avoid inappropriate combinations. Not all studies found the combination of young people in care to be a problem. For example, some studies reported that the young people in residential care found staff and other young people to be helpful and were positive influences in their experience in care. Some studies noted that young people resented attempts to make the residential care into a family environment whereas others felt a sense of belonging to a family style setting (Little, Kohm & Thompson, 2005).

The complexity and variability of the needs of young people placed in residential care are seen as one of the major reasons why they struggle in this type of care.

In 2001, an audit was undertaken on approximately 430 children and young people in residential care in Victoria. At this time, the purported population in residential care were sibling groups or adolescents with complex needs who have had multiple placements. However, during this audit, approximately a third of the children were between the ages of 2 and 12 years (DHS, 2001b). This audit concluded that the nature of the client group had changed significantly over the last decade, (such as the prevalence of mental health and alcohol and other drug problems), but that they were living in a care environment that was designed for a different population. Approximately one in five young people in residential care had been placed in Secure Welfare at least once. One client had been in Secure Welfare approximately 40 times, with the next most frequent rate of admission being 12 times. Secure Welfare was a part of a number of the young people’s ongoing crisis management plan (DHS, 2001b).

Over time, there has been a change in policy to reconsider residential care from a last resort to an option available to meet particular needs (Smyth & Eardly, 2008). Colleen Clare (past CEO of Centre of Excellence in Child and Family Welfare) wrote . . .

“...it is no longer appropriate to conceptualise or talk about [residential care] as worthy only of a last resort and it is no longer appropriate to identify young people in residential care as worthy only of a last resort intervention. For many of them such a label, coming on top of a history of abuse and
neglect, is the last straw that breaks their already battered esteem and further weakens their resilience.” (Centre for Excellence in Child and Family Welfare inc., 2006).

Staff need to feel valued in order to sustain their commitment in such a challenging environment and for the young people to feel valued in turn.

In a study exploring the factors that lead to high turnover of residential care staff, the concept of residential care as being the last resort was considered a significant issue. Colton and Roberts (2007) argued that for some children, high quality residential care should be considered a positive choice and a part of the system that makes an important contribution. Consistent with Anglin’s (2002) discussion about congruence in residential care, staff need to feel valued in order to sustain their commitment in such a challenging environment and for the young people to feel valued in turn.

In an evaluation of training needs for residential care staff (as part of the Residential Care Learning and Development Strategy [RCLDS]), residential care staff, managers and other stakeholders identified issues that affected their work and the broader field. This process captured reflections on when residential care may be the preferred option for some young people:

- There is complexity of individual need and past trauma;
- There is a therapeutic need for challenging behaviours to be tolerated (for a time)
- The young person may need intensity and consistency of therapeutic care that is not possible in a family setting
- The young person is not responsive to the family-like intimacy of a foster home with ‘surrogate parents’ (Success Works, 2006, 8)

Residential care was also described as a possible way of helping a young person to eventually transition into home-based care. However, the report found that the dominant model of residential care in Victoria was not customised to the needs of this group and was more driven by a cost effective paradigm. The report explored some of the principles of therapeutic residential care such as: responding to pain-based or traumatised behaviours in positive ways; not adding to the trauma experience; and looking through, but not ignoring, the difficult behaviours to understand the trauma behind the behaviours and responding therapeutically. “Best practice in residential care honours both sides of this equation: by responding empathetically whilst also challenging and channelling behaviours that are unhelpful to the child’s development and to their best interests” (Success Works, 2006, 9-10). A trauma-sensitive and therapeutic approach was strongly endorsed by the residential care staff and management, which would entail residential care workers working closely with therapeutic specialists in:

“...the development and activation of consistent, negotiated, safety-aware and safety-promoting, non-violent, planned but flexible individualised care plans. These teams of specialists also provide advice, training and supervision for frontline residential workers. The focus of the care response is on the trauma behind the behaviour and not on the behaviour itself, except in so far as there is a need to promote mutual safety.” (Success Works, 2006, 10)

A literature review by MacKillop Family Services published by the Centre of Excellence in Child and Family Welfare (2006) noted the call for a paradigm shift to combine a treatment focus with care. They recommended: the involvement of psychologists, social workers and others with the residential
program; a careful and comprehensive intake assessment that identified the needs of the young person and to develop meaningful plans; to have more flexible care options and group sizes ranging from 5 to 1 young persons; comprehensive training for staff; and strong linkages with other services.

Along with enthusiasm, residential care staff expressed some anxieties about going out on a limb if there was major change, and needing clarity about their roles and responsibilities and training. There was also an understanding that some staff may have their own histories of trauma that could be reactivated through the trauma experiences of the young people. This highlighted the need for self care to be a component of any model and training (Success Works, 2006).

“Three decades ago the ‘typical’ child referred to residential care was considered to be dependent, in need of care and protection due to parents not being able to meet development and protection needs. Today, a young person is almost certainly referred because of challenging behaviours and in particular, aggressive behaviours. All the least restrictive options have been tried, as have interventions with parents who as research informs us, are likely to be influenced by substance abuse and/or psychiatric disorders. Most have been abused and neglected, many sexually. Most have experienced placement breakdowns and have impaired abilities to attach and trust. Most have educational problems and delays. The behavioural, developmental and psychiatric problems experienced by young people in residential care are varied and complex and they need to be carefully considered in the design of care and educational programs.” (MacKillop Family Services in Centre of Excellence, 2006, 42)

The evaluation of the HRASQII (DHS, 2001a) cited Semmen’s (2000) best practice principles for future development of out-of-home care options for high-risk adolescents. These principles included:

- Increase one-to-one care options in order to limit the negative influence of peers and to provide opportunities for attachments to develop
- Create a flexible pool of funds to purchase individually planned placements rather than using funds to support established models of care
- Strengthen the remaining residential care and reduce the size of the units
- Recruitment of carers to include strategies drawing on young people’s networks, including kith and kin, and relationships with trained staff as well as recruiting carers by more traditional means
- Carers to be heavily supported and viewed as the primary person in the young person’s support system.

In a reform paper by DHS (2009a), it was noted that the increase in the overall number of children in care was not due to increased numbers coming into care, but because the average length of stay in care was increasing. This was seen as a consequence of the increasing complexity of the needs of children in care. In addition to increased funding for general residential care, this reform included the continuation of the therapeutic residential care reforms and expanding training for residential care workers in dealing with trauma. A recent resource published by the Commission for Children and Families (2013) was written to assist residential care implement trauma-informed practice.

The other call for a change to residential care has been the need to continually work towards congruence. This is both between structure and culture (Little, Kohm & Thompson, 2005) and between the external environment, the management, the staff and the young people (Anglin, 2002; Centre for Excellence in Child and Family Welfare, 2006). This also requires leadership and
commitment to the model. Little, Kohm and Thompson (2005) note the need to develop robust logic models and theories of change so that we know why some children will benefit from residential care and in what way it should be shaped to maximise those benefits.

**Therapeutic services and therapeutic care**

Policy and program development activities over the past three decades, such as the HRASQII, the *Best Interests Framework*, the *Working Together Strategy* and changes to the out-of-home care system, have pointed to the need to provide access to therapeutic services for young people with high-risk behaviours, as well as to provide therapeutic models of care. Other Australian reports recommending or advocating for a change to residential care and/or foster care to involve a therapeutic or treatment role include: Bath (2008a); Centre of Excellence in Child and Family Welfare, 2006); DHS (2003b); Little, Kohm and Thompson (2005); Smyth and Eardly (2008); Success Works (2006); and Szwarc (1992).

...[there is a] need to provide access to therapeutic services for young people with high-risk behaviours, as well as to provide therapeutic models of care.

There have been four primary theoretical influences on the growth and development of therapeutic services, particularly on therapeutic care in Victoria. These are Anglin’s (2002) work in Canada in relation to residential care, the Sanctuary model in the USA, which has been applied to residential treatment centres, schools and other services (Bloom, 2003; 2005); Bruce Perry (2006) and the Child Trauma Academy’s work in disseminating knowledge about how a neurobiological understanding of development, trauma and attachment can help what happens in the day-to-day experiences of the young person; and Hughes’ (2004) work on attachment-informed practice for children and young people in out-of-home care. There are many other influential bodies of work and individuals, but these are the most commonly espoused references, particularly in relation to the various therapeutic residential treatment models currently implemented in Victoria.

Anglin’s (2002) definition of treatment or therapeutic intervention within residential care has been adapted and endorsed by Take Two as:

1. “Guided by a research-informed theoretical and practice framework
2. Informed by a suitably comprehensive and in-depth assessment of the history and current situation
3. Attempts to bring about directed change in a child and/or in those who have a major influence on the wellbeing of the child

**The Berry Street Take Two program**

The creation of Take Two as an intensive therapeutic service for child protection clients was a response to a recommendation from the *When Care is Not Enough Report* (Morton, Clark & Pead, 1999) and supported by other government reports. A growing body of interstate and international research argued for the need for accessible and targeted therapeutic services for the child protection and care client group (e.g. Guglani, Rushton, & Ford, 2008; Higgins & Katz, 2008; Leslie,
Hurlburt, Landsverk, Barth, & Slymen, 2004; Sawyer, Carbone, Searle, & Robinson, 2007; Tarren-Sweeney & Hazell, 2006; Walker, 2003).

This body of literature found that some children and young people, including those described as high-risk adolescents, had fundamental needs that were not being met despite their involvement with multiple services. Indeed, the high-risk behaviours of many of these young people who were clients of the protection and care system remained unabated or worsened.

Gaps in access to certain services have also been noted in the literature, particularly mental health and education. Reports, such as *When Care is not Enough* (Morton, Clark & Pead, 1999) and the *Evaluation of the High Risk Services Quality Improvement Initiative* (Success Works, 2001) noted that most young people whose behaviours endangered their and sometimes others’ lives, could trace their histories of trauma, disrupted attachment experiences and the emotional and behavioural consequences back to very early in their lives. It was recognised that the knowledge and skill needed to provide such therapeutic services were not held within any one field. It was also clear that more knowledge was needed to contribute to the broader service system’s ability to meet their needs. It was acknowledged that not only was there a need for high quality clinical skills, but also to learn more through field research and training.

Take Two was funded to provide an intensive therapeutic service for children and young people of all ages who were clients of child protection. In addition to providing a clinical service throughout the state, the service was also required to undertake research and evaluation and to provide training to workers in protection and care services. It formed through a consortium with Berry Street, Austin Child and Adolescent Mental Health (CAMHS), La Trobe University, Department of Social Work and Social Policy and Mindful – Centre for Training and Research in Developmental Health. In 2007, the Victorian Aboriginal Child Care Agency (VACCA) joined the partnership. More recently, Berry Street has direct access to a child psychiatrist and so Austin CAMHS is no longer a formal partner.

The idea of a program such as Take Two fitted with a change of focus from being solely on risk to one that also aimed to promote children and young people’s healthy development. Take Two’s key objectives are two-fold:

1. To provide a high quality clinical service for child protection clients
2. To contribute to the broader service system in order to better meet the needs of these most vulnerable children.

Take Two’s target client group, according to DHS, is to work with children who had suffered trauma through substantiated abuse and neglect and who were demonstrating or at risk of demonstrating emotional and behavioural disturbance. It is also expected to work with children of all ages (Frederico, Jackson & Black, 2010). In other words, its focus is not only on high-risk adolescents, although they are considered a key group for Take Two services.

Despite the intent of Take Two to work with children of all ages, it receives few referrals regarding infants and young children and many of its clients present with multiple high-risk behaviours (although not all of these are adolescents). Take Two’s therapeutic staff within Secure Welfare have a specific focus on high-risk adolescents.
Take Two works with approximately 9 per cent of the substantiated child protection population each year. The age range is from 0 to 17 years with a mean age of 11.8 years. There was a roughly even gender split and 16 per cent of the Take Two client group were Aboriginal. Two-thirds of the children and young people were on Custody or Guardianship orders at the time of referral, but all were child protection clients. Eighty per cent were in some form of out-of-home care with the mean number of previous placements of 6.9 (range from 0 to 45). Ninety-six per cent had experienced two or more different types of maltreatment and 82 per cent had experienced three or more types. Emotional abuse, neglect and physical abuse were particularly high. When just looking at the data for adolescents, the picture of emotional rejection and blame was striking (Frederico, Jackson & Black, 2010).

The challenge for Take Two is to develop a research-informed therapeutic practice, even though the evidence base is limited as most research exclude children and young people with multiple traumas and multiple developmental, emotional and behavioural problems. Take Two has a focus on safety, recovery from trauma and reconnection with significant people in the child or young person’s world. Much of Take Two’s work is through outreach and working with the young person’s carers, teachers and family members, as well as with the young person themselves.

“Take Two intervention emphasises understanding the children and how they experience trauma and disrupted attachment within their life context, including cultural identity. Take Two aims to intervene at multiple levels to harness resources available to the children and to build on their strengths.” (Jackson, Frederico, Tanti & Black, 2009, 199)

Take Two operates on a number of principles, including the importance of working in a care team approach and that the responsibility for engagement with the young person is Take Two’s, not the young person’s. As such, it often requires a persistent and creative approach that aims to engage the informal and formal systems around the young person, as well as with the young person directly (Jackson, Frederico et al., 2009). As described recently in an AIFS information exchange paper, Take Two “stresses the importance of safety, security and the development of supportive relationships” (Price-Robertson, Rush, Wall & Higgins, 2013, 9).

Therapeutic Foster Care

As noted repeatedly in discussions about the future of residential care and home-based care, there has been a consistent call for therapeutic care in Victoria over a number of years. The initial work undertaken on this was primarily around therapeutic foster care.

Therapeutic foster care as an alternative to residential care is a growing concept in the US that had its origins in the 1990s. It usually aims at providing home-based care for children and adolescents with significant emotional, behavioural and mental health problems. Some common characteristics of therapeutic foster care are: professional status of foster parents; limited number of children in placement; case managers have small caseloads; specific training regarding treatment skills for carers; foster carers implement the treatment plan; foster carers are provided with professional and emotional support; 24-hour crisis service available; assessment and achievement of educational plan; and coordination of the child’s service system. There is usually a higher reimbursement for the carers (Curtis, Alexander & Lunghofer, 2001).
The Victorian version of therapeutic foster care is known as the Circle program. It began formally in 2007 and then expanded so there is now a pilot program in each of the eight regions that involves a partnership between a foster care agency and a therapeutic service (either Australian Childhood Foundation or Take Two). The model involves: specific recruitment of foster parents; greater access to support for foster care workers; additional training focusing on trauma and attachment; and access to a therapeutic consultant to provide assessment and ongoing consultation and advice regarding the child. There are guidelines regarding how children are selected into this program and it is not limited to any age group, although it usually involves younger children.

Although the evaluation of the Circle program did not have access to quantitative data, the qualitative findings provided ‘rich stories of success, stability and hope’ (Frederico, Long, McNamara, McPherson, Rose, & Gilbert, 2012, 77). However, the evaluation also showed that very few of the children in the Circle program were adolescents. A local initiative in the Northern rural part of the Eastern Division of Victoria has been piloting an adolescent specific therapeutic foster care model, known as the Equip model. This has some teething problems related to uncertain funding, recruitment of carers, and recruitment of clinicians. Nevertheless, some early findings indicate it is a promising area to build upon (Lunken, Jackson, & Black, 2014). The state government has announced further roll out of Circle programs, but no details are as yet available. In comparison with the therapeutic foster care models more common in the US, the Circle program does not equate foster carers as professionals and the caseloads for case managers and therapists are not small.

**Therapeutic Residential Care**

Around the same time as the development of therapeutic foster care, DHS developed a pilot therapeutic residential unit known as Hurstbridge Farm. They enlisted Take Two to assist in the program design of two 4-bed units located on the same campus in an outer suburb. The aim of Hurstbridge Farm is to make a difference to the lives of young adolescents who have been traumatised and suffered disrupted attachment. “The program’s approach is based on understanding that staff will not become over focused on what these children do but rather that they understand and respond to what they do as a symptom of what has been done to them” (Holmes, 2007, 22). The model includes the farm environment, additional training of staff, a trauma and attachment-informed model and a therapeutic specialist from Take Two. The program began to accept clients in June 2007.

A working group was established by DHS for Improving Outcomes for Children and Young People in Residential Care. It involved senior representatives from CSOs, the Centre of Excellence, the Office of the Child Safety Commissioner and DHS staff. The following year, DHS began a tender process across each region to seek interest from CSOs regarding piloting other therapeutic care models of residential care. A description of the essential elements of a therapeutic residential care service was developed. Each pilot was expected to meet these, albeit with a range of clients and other additional features they wished to add. These essential elements were informed by the program design and operational work of Hurstbridge Farm, the Circle program and other models.

In addition to the normal project management and organisational elements, other essential elements included a clearly articulated organisational culture and values statement that demonstrated: commitment to the therapeutic approach; a staffing model; a service model for day-to-day operations; a referral system and criteria; articulated role of the therapeutic specialist; care
planning approach; identification and response to high-risk issues such as mental health problems, alcohol and other drug problems; education and use of Secure Welfare; and a therapeutic model that is informed by trauma and attachment theory, resilience theory, Aboriginal culture, Best Interests Case Practice model and “...how the therapeutic service model will provide children/young people with a holistic, dependable, predictable environment, where every interaction is approaches as part of a therapeutically intentional plan” (DHS, 2008, 6).

Ten pilots were established, including one per region and two Aboriginal Community Controlled Organisations. There are eleven therapeutic residential care pilots, in addition to Hurstbridge Farm, all but one of which involves Take Two as the therapeutic specialist. The VERSO Consulting Pty Ltd (2011) evaluation concluded that the results of these ten pilots, along with the Hurstbridge Farm pilot, were very promising. Since then, further therapeutic residential care programs have been funded.

Take Two and Westcare have been funded by the Centre of Excellence to provide the training strategy known as With Care to support the pilots and to provide training for all residential care staff regarding trauma and attachment (Jackson, 2010).

At the time the pilots were tendered, five CSOs who were not successful in receiving funds for a pilot were given funds for a therapeutic specialist. This provided an opportunity to see whether increased access to consultation and therapeutic assessments adds value to the ability of the residential care service to meet the needs of young people; however, this aspect was not evaluated. These therapist-only pilots have now been adapted to full therapeutic residential care programs. Since then, there have been at least four additional programs where a therapeutic specialist role has been funded by a CSO or by the DHS region, such as the Equip model discussed in the therapeutic foster care section.

There are different therapeutic residential care initiatives in other states and territories in Australia, each with some degree of variation that is specific to their jurisdiction. There is, however, a pull towards the goal of all residential care becoming therapeutic, rather than just focusing on the high-risk, more intrusive aspects of care.

“Although it sits at the more intrusive and support-intensive end of the continuum of out-of-home care, there are moves to position therapeutic residential care as a mainstay placement option, rather than simply a last resort for the hardest cases.” (McLean, Price-Robertson, Robinson, 2011, 6)

Definition of therapeutic care
An important question that occurred during the development and implementation of the therapeutic residential care pilots, the Circle pilots, the training, the evaluation and the ongoing service system design is the definition of therapeutic care and in what way it is different from good quality care. The definition appears to change over time as the nuts and bolts of what this phenomenon is becomes clearer. Following is a definition developed through the With Care training process.

“In addition to providing high quality care for the infant, child or young person in care, therapeutic care:
• Responds to the complex consequences of abuse and neglect and the impact of separation from family through positive healing relationships in a trauma and attachment-informed and developmentally focused framework.

• Supports carers to provide informed care and guidance beyond what is commonly expected by a parent or carer, to assist in addressing an infant/child/young person’s everyday and exceptional needs and/or developmental delays that impede healthy functioning.

• Provides the infant/child/young person with restorative experiences through safe, nurturing relationships in an emotionally regulated and consistent environment, promoting their capacity to experience and recognise safety in relationships with others.

• Focuses on hearing the infant/child/young person’s voice, responding to their unique ‘presence’ and understanding their experience and the multiple possible meanings behind their behaviours.

• Aims to strengthen the infant/child/young person’s positive connections with their family, community and culture.” (McKenzie, Jackson & Bristow, 2009 cited in Jackson, 2010)

### Care teams and collaboration

A common theme regarding children and young people at risk, such as evidenced in all the child death inquiries, is the important yet elusive nature of effective collaboration between services (Schmied & Tully, 2009). This was a major driver for the Working Together Strategy and was raised in the When Care is Not Enough report. As summarised in the second Take Two evaluation report, some constraints for achieving collaboration include: lack of recognition of others’ expertise and knowledge; competing tasks and priorities; role confusion; complexity of client group; lack of interdisciplinary training; unrealistic and incompatible expectations of others; territorial disputes; demand management and tight gate keeping; insufficient and irregular contact among professionals; histories; and unchallenged beliefs about each other (Frederico, Jackson & Black, 2006). Care teams are seen as a major strategy in improving collaboration.

Care teams are now considered a key element of practice in Victoria.

In addition to recognising the importance of the ecological systems in which the young person’s behaviour needs to be understood, care teams are consistent with the principle of therapeutic web as coined by Bruce Perry (2006). This is where those in the day-to-day life of the child need to come together to support a predictable, nurturing, responsive and safe approach to mitigate the chaotic, negative experiences of their past. Care teams reflect the reality “...that no service is able to effectively plan for, support, nurture, care, teach and/or work towards recovery in isolation” (Frederico, Jackson & Black, 2006, 155).

Care teams are now considered a key element of practice in Victoria, as is evident from VCDRC reports (e.g. VCDRC, 2009) and documents related to the Best Interests Framework (e.g. Miller, 2010). These are regular meetings with a key but small group of people in order to reflect, discuss, share and coordinate roles in supporting the young person and carer and/or family. A care team is distinct from a case conference and more akin to an ongoing working group wrapped around the young person and sometimes involving the young person. Care teams may make decisions regarding day-to-day practice, but they are not a formal decision-making body. Because of the frequency of planned meetings, care teams do not need to be reactive to a crisis, but have more opportunity to be proactive and to comment on positive changes as well as giving attention to ongoing risks (Downey, 2009). Case conferences still play an important role, especially when other professionals
who have a less frequent but nevertheless key role need to meet with those working closely with the young person to share information and to discuss issues of risk and planning.

Reeder and Cowie (2001) described the care team approach as important to effect positive, sustained change with young people at high risk. They described key components of a care team as: regular professional meetings; interagency planning; use of key workers, where one is designated to work alongside the young person and others are there to support the key worker; secondary consultation when additional expertise is needed; and a coordinator or case manager who ensures everyone is clear regarding their tasks and responsibilities.

Take Two describes a core goal of a care team is to help keep the child in mind. Although meetings vary in frequency, a care team may meet as frequently as weekly or fortnightly if the issues facing the young person and the system are heightened (Frederico, Jackson & Black, 2006). Although care teams are a mainstay of the therapeutic residential care pilots, they are now seen as requisite practice across all types of care.

Following is a quote from a working party document on care teams in the Gippsland region that is cited in the second Take Two evaluation report.

“A well functioning Care Team could provide the ideal opportunity for creating environments to encourage reflective practice, to develop and test hypotheses about behaviours and to allow those involved with the child/young person to better develop an understanding of the purpose of the behaviours. It was viewed that this would give the team a greater opportunity to modify and change behaviours.” (Gippsland Care Team Working Party, 2006, cited in Frederico, Jackson & Black, 2006, 27)

Multiple and Complex Needs Initiative Project

An initial profiling exercise for the Multiple and Complex Needs Initiative funded by DHS in the early 2000s found 208 clients of DHS and the funded sector (child protection, youth justice, housing, disability, mental health, health and drug treatment) who met the criteria of multiple and complex needs, whose challenging behaviours placed themselves or others at risk and who required a long-term solution. Of these, 24 per cent were under the age of 18 years, with two under the age of 12, twelve between the ages of 12 to 15 years and 23 being 16 or 17 years old (DHS, 2003e). The over-representation of males was especially noted in the younger population.

“The project arose in response to continuing poor service outcomes for a small but significant group of people in Victoria whose complex needs challenge existing policy and legislative frameworks and service systems. This group of people are those adolescents and adults who may experience combinations of mental illness, intellectual disability, acquired brain injury, behavioural difficulties, family dysfunction and drug and alcohol abuse. For many reasons, they often require a service response that is too complex to be met or sustained within existing service frameworks.” (DHS, 2003d, 3)

This project undertook a literature review that included discussion on the various dual or co-occurring problems including mental health – substance abuse; mental health – intellectual disability; and intellectual disability – substance abuse. Although young people were included in this initial profile (including 14 under the age of 16 years of age), the subsequent service design of the Multiple and Complex Needs Initiative excluded this younger age group. This was due to the belief that as most (88 per cent) of these young people were on Custody or Guardianship Orders, DHS had
the authority and capacity to respond to their needs. This project was being finalised at the time of the development of Take Two as the new intensive therapeutic service aimed to provide a response to children and young people with high needs. The advent of Take Two was another rationale for the Multiple and Complex Needs Initiative not including the younger age group. The 16 and 17 year olds were included due to the transition issues into the adult systems.

The Multiple and Complex Needs Initiative not including young people under the age of 16 years, may have been due to an overly optimistic perception of what being a client on a Custody or Guardianship Order entails for a young person with highly complex needs. In particular, it may reflect the lack of recognition of the problems the out-of-home care system has with this population.

It is also worth noting that 12 per cent (n=6) were not clients of child protection (of this group, two were under the age of 16 years of age.) As such, they would not have been eligible for the Take Two program. The rationale of excluding younger adolescents from the Multiple and Complex Needs initiative also appeared not to acknowledge that the younger children had to meet extremely concerning criteria that were geared towards older populations, and yet still met those criteria, highlighting their extreme vulnerability. Nor does this exclusion acknowledge the likely trajectory of these younger people if substantial action is not taken earlier in life.

In looking at the profile of this sample of young people in the two age groups (and compared with the adult population in Table 7), there is certainly no evidence of less complexity for the younger population in the Multiple and Complex Needs Initiative (DHS, 2003e).

| Table 7: List of issues for people in Multiple and Complex Needs scoping project by age group |
|-----------------------------------------------|----------------|----------------|----------------|
| Type of issues                                | Under 16 years (n=21) | 16 and 17 years (n=30) | Adults (n=157) |
| Disabilities                                 | 11 (52%)          | 13 (43%)          | 80 (51%)       |
| Mental health                                | 20 (95%)          | 24 (80%)          | 131 (83%)      |
| Substance abuse                              | 16 (76%)          | 24 (80%)          | 120 (76%)      |
| Youth and adult criminal justice              | 10 (48%)          | 15 (50%)          | 58 (37%)       |

Note: No children under the age of 12 years were described as having substance abuse problems or involvement with the youth justice system.

Child and Youth Mental Health Services

The National Mental Health Strategy (2008) is described as aspirational. Its aims include: promoting mental health throughout the community; reducing the impact of mental health problems including the stigma often associated; promoting recovery; and ensuring the rights of those with mental health problems are upheld. The strategy recognises the additional risks that can be associated with adolescence. A major focus of this strategy is for services to adopt a recovery-oriented approach. Recovery is defined as: “A personal process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability” (Australian Health Ministers Conference, 2008, 31).

The Victorian mental health reforms have a major agenda of delivering more accessible, earlier intervention for children and young people within a 0-25 years framework. It includes more
accessible services for young people with emerging moderate or severe mental health conditions through a network of youth service hubs that are co-located with health, drug treatment and youth support services. Two 4-year demonstration projects regarding this reform are underway.

A particularly relevant aspect of this reform for high-risk adolescents is to “Provide tailored, flexible services to highly vulnerable young people who have experience significant abuse and trauma – especially those involved with youth justice, the Children’s Court, child protection and youth homelessness services” (DHS, 2009b, 14). As part of this reform, there will be a review of how mental health services can be consolidated and enhanced in order to build on the success of the Intensive Mobile Youth Outreach Services (IMYOS) and Take Two.

IMYOS is a mental health service designed to work with young people with complex and severe mental health problems, who are at high risk, such as of suicide and who are unlikely to engage with office-based services. Schley, Radovini, Halperin and Fletcher (2011) provide a description of one of the metropolitan IMYOS teams, where the client group reflects many of the high-risk factors listed throughout this literature review. Compared with the Take Two population, the degree of known trauma is slightly less, but still high. However, the degree of mental health problems, including risk of suicide, is higher. The major difference with the Take Two population is that the mean age is 17.4 years, with a range from 14-25 years. IMYOS works on a number of key principles such as: safety first; use of assertive outreach rather than coercion wherever possible; understanding the therapeutic relationship is a key aspect of intervention; and a holistic approach (Schley et al., 2011).

Priority access for out-of-home care is a relatively recent initiative through the Office of the Chief Psychiatrist. This initiative aims to ensure that all referrals of children and young people to a mental health service who are clients of the protection and care system will be provided with a streamlined service response to best meet their needs (DoH, 2011). It was developed in recognition of the vulnerability of this population given their experiences of trauma and attachment disruption. It has instituted a Priority Access Service Response (PASR) mechanism to enable the referral and intake process to work more effectively. A key distinction from business as usual in these guidelines is the articulated message that all behaviour has meaning, rather than just those that fit within criteria for particular diagnoses.

“In the case of children and young people in OoHC, service access is not governed by existing requirements that the referred person should meet criteria for a likely diagnosis of a mental illness. The mental health service will also provide a helpful response when the referred infant, child or young person is experiencing significant developmental delay, emotional and psychological distress, and/or functional impairment.” (DoH, 2011, 8)

As there are not additional funds for mental health services in relation to these priority access guidelines, they need to continue to deal with demand and capacity within any given service. However, training has been provided regarding aspects of the protection and care system and the implications of trauma and attachment for the staff involved in the PASRs. There are also some locally based initiatives that may provide increased access to particular services.
4. What else works – Does anyone know?

General principles and practices

*There is much that is not knowable when we deal with complexity.*

The question of what works best with whom continues to beset child welfare, mental health and many other human service fields. There are questions regarding what is best practice, what is good practice, what is evidence-based practice and what is research-informed practice? The reality is we know more in this decade, thanks to the latest science and our more engaged approach to integrating knowledge and practice. Nevertheless, there is much that is not knowable when we deal with complexity.

Kessler, Gira and Poertner (2005) describe five common definitions of best practice: namely, practice wisdom; emulating similar systems; use of expert advice; professional guidelines and evidence-based practice. They argue for a move in child welfare towards evidence-based practice, whilst acknowledging the evidence in this context may not meet some definitions of evidence (such as randomised clinical trials). Berry (2005) has a pragmatic definition of evidence-based practice in a child welfare context:

- *You use techniques that are grounded in prior tests of their effectiveness*
- *You gather information as you practice to test the effectiveness of what you are doing*
- *You look for objectivity in claims of treatment effectiveness*
- *You glide between skepticism and confidence. You know what you know and you know what you don’t know.* (Berry, 2005)

The other caveat to the notion of evidence-based practice is that no single program or intervention is able to meet the varying needs and difficulties for every high-risk young person (DHS, 2001a). Robin Clark (2000) noted the hallmarks of effective case practice included:

- Goal-directed practice
- Holistic assessment of the young person and their family
- The iterative and circuitous nature of assessment and planning
- Holding the responsibilities associated with public parenting carefully
- Learning from research and evidence-based practice
- The importance of case records
- Effective use of authority
- Empowering practice
- Unconditional care.

A number of therapies and practice approaches are recommended for particular behaviours. For example, there are volumes written in relation to treatment for alcohol and other drug use and for various mental health problems. Little is written specifically in relation to treatment relating to sexual exploitation and absconding, as they are not mental health conditions but behaviours in
response to certain circumstances. The focus is on policy and systemic practice, both of which are discussed later in this review.

In addition to their system and program recommendations, many of which have been implemented and which are discussed in the previous section, Morton, Clark and Pead (1999, x) noted the trend in the evidence-based practice literature, “...towards community-based multi-systemic therapeutic interventions and the use of complex interventions that require a high level of skill and expert supervision to successfully implement.”

They mentioned three key principles for best practice, namely: establish physical and emotional safety; provide and support relationships that offer possibility of secure attachments; and address the aftermath of trauma. They also provided a description of characteristics for successful treatment responses for high-risk adolescents such as:

- Creating a safe, non-intrusive and empowering context and aiming to avoid reinforcing or recreating situations of helplessness
- Respect for the young person as a survivor and acknowledging that many of their behaviours may have some adaptive, survival functions, even those that appear to be the opposite such as self-harming behaviours
- Work towards integrating the young person’s awareness of the present and the past and being able to tolerate conflicting emotions
- Reprocessing their understanding of the trauma that challenges self-blaming, powerlessness and fear so that they can integrate their thoughts and emotions
- Addressing particular symptoms related to post traumatic stress
- Modelling and teaching positive psychosocial skills and challenging aggressive behaviours towards others
- Providing a developmentally appropriate balance between empowerment and limit setting
- Reinforcing positive behaviours rather than punishing negative behaviours
- Effective use of consultation with other services.

Morton, Clark and Pead (1999) strongly recommended that in every case, staff should use engagement and empowerment strategies to facilitate the young person’s ability to self-regulate. These strategies include: meaningful incentives and rewards; engagement around the young person’s goals; intensive outreach when required; strategies for enhancing commitment; motivational interviewing; making empowerment a reality, and not just rhetoric; tracking moment to moment changes in staff-young person interactions associated with staff’s lack of empathy; and acknowledging and repairing mistakes.

*The most critical factor in terms of a program’s success for treatment and care for young people with high-risk behaviours is to ensure there are opportunities for them to develop meaningful relationships with others and to develop positive attachments.*

The internal review of high-risk adolescents undertaken by DHS (2006) found that the most critical factor in terms of a program’s success for treatment and care for young people with high-risk behaviours is to ensure there are opportunities for them to develop meaningful relationships with
others and to develop positive attachments. It was also essential to focus on the young person as a whole and in all areas of their life, not just the high-risk behaviours. They cautioned that this requires readiness on behalf of both individual staff and the overall system.

Evidence-based practices that are commonly mentioned in the literature for working with high-risk adolescents include Multidimensional Treatment Foster Care (MTFC) (Chamberlain & Reid, 1991; 1998); Multisystemic Treatment (MST) (Henggeler, 2003); and Motivational Interviewing (Miller & Rolnick, 1991). These and others are listed in Appendix One with descriptions and their classification or otherwise as evidence-based practice.

There are other evidence-based practices, such as Trauma-Focused Cognitive Behavioural Therapy, that are designed to help young people resolve some of their trauma symptoms. However, they would rarely be suggested for the high-risk adolescent population due to their life situation being contraindicated. For example, TFCBT requires a consistent carer in the young person’s life to be an active participant and this population rarely have a consistent person in their life, let alone a carer (Jackson, Frederico et al., 2009).

In order to redress the impact of repetitive and pervasive harmful experiences, the young person needs repetitive, persistent nurturing and other positive experiences.

The literature review carried out in the evaluation of the HRASQII (DHS, 2001a) found that expectations of what can be achieved must be realistic and within the context of assessment of risk and resilience. Perry (1996, 2006) provides some direction as to how to realistic achieve change for young people who may appear to have intractable high-risk behaviours. In learning how the brain develops from in utero through to the adult brain, case managers, therapists, carers and young people themselves can learn that in order to redress the impact of repetitive and pervasive harmful experiences, the young person needs repetitive, persistent nurturing and other positive experiences.

Neuroscience provides insight into therapies that are based on cognitive and emotional changes, acknowledging the impact on the developing brain that can occur due to neglect and trauma, such as poor executive functioning, impulse control, affect dysregulation, and problems with relationships. However, neuroscience also guides therapies to target lower parts of the brain responsible for more physiological and sensory areas that have been affected by early trauma. A recent guide on trauma-informed care highlights the need for therapeutic interventions targeting the brain from a top-down and bottom-up approach, as well as education of organisations needing to be top-down and bottom-up, especially in the context of complex trauma (Kezelman & Stavropoulos, 2012).

Some of what the science and other types of research tell us may require counterintuitive parenting or casework. For example, the young person may be operating at multiple ‘ages’ in terms of their cognitive, emotional, social and sexual development and will require an age-respectful but developmentally ‘in-tune’ response. They may not learn from mistakes the way most children do. Their experience of shame may involve an internal view that they and all they do is wrong. Accordingly, what may be a simple correction to others may reinforce every bad idea they ever thought about themselves and the world. By understanding examples such as this, carers, teachers
and others can pick up clues that guide their response so they can help the young person predict their own responses.

Perry (2011) describes the following core elements of positive developmental, educational and therapeutic experiences for children and young people who have experienced trauma and neglect:

- **Relational** – Providing positive, safe relational experiences for the young person in a way that doesn’t further increase their stress response or overwhelm their defenses
- **Relevant** – Ensuring that the approaches are developmentally matched to the young person, not just by age, but also with an understanding of their developmental strengths and gaps
- **Repetitive** – Providing a level of repetition that is required by the brain to make and sustain the changes
- **Rewarding** – Building on the young person’s interests and what they find pleasurable so that the reward centre of the brain receives positive stimuli, instead of just harmful stimuli, such as drugs
- **Rhythmic** – In order to resonate with the young person’s neural patterns. This is particularly important if they have had a neglectful and traumatised early childhood, which may have altered their rhythmic patterns and thus disrupted their ability to self soothe or be soothed by others
- **Respectful** – Of the young person, their family, their placement and their culture.

Robin Clark (2000) in her work on exceptional practitioners with high-risk adolescents discusses the question of whether it can be too late to achieve change. She notes that the key ingredient is for the young person to have a nurturing adult in their life, but recognises that the adult may need a tremendous amount of support in order to sustain this.

In terms of service system and models, key elements of success for the HRASQII were (DHS, 2001a):

- Strong leadership and management
- Staff supervision, on-call and after hours support, recruitment strategies
- Models of service practice, including outcome-focused, client participation, ICMS, etc.
- Service systems relationships
- Documentation and accountability, including risk assessment and individual placement plans
- Service delivery and practice, including case management, the role of carers, use of brokerage, well managed exit process and supporting transitions.

**Sexual exploitation as a case in point**

The literature points to the need to have approaches that help prevent young people being sexually exploited, improve safety and reduce harms for those who have already been sexually exploited, support young people to escape or leave that situation and redress the long-term harms associated with all types of sexual exploitation (in addition to other harms they have experienced).

**Policies and legislation**

Commercial sexual exploitation – and youth prostitution, in particular – has a peculiar interface with the law. It is one of the few areas where both the perpetrators (pimp, john and others) and the victim (young person being exploited) are potentially subject to prosecution, yet this rarely happens for either. Although the law is clear that it is illegal to pay for sex from a young person, there are almost no prosecutions. On the flip side, in Victoria, it is not illegal for a young person to engage in
prostitution but it is illegal for them to loiter with intent. Despite this, it is rare for a young person to be arrested for a crime related to prostitution in Victoria, although this still occurs in other states in Australia and in the USA (Jackson, Dwyer et al., 2009). Interestingly there has been a recent Yale Law Review arguing for the change of federal and state laws in the US to no longer enable the prosecution of children and youth for sexual exploitation (Annitto, 2012).

In Victoria, the Prostitution Control Act 1994 states that paying a child (under 18 years) for sex or receiving payment from someone else paying a child for sex carries a maximum sentence of 15 years. Causing or inducing a child to become involved in prostitution is punishable by ten years. It is not a defence to say that the adult did not know the young person was under 18 years, unless they had overt reasons to believe they were an adult, such as if they used a false ID.

In 2000, the relevant government authorities in England and Wales developed a systematic and integrated policy approach known as Safeguarding Children Involved in Prostitution (SCIP). SCIP outlined an inter-agency approach for all agencies that work with children where there were concerns about sexual exploitation (Cusick, 2002; Dalla, 2001; Swann & Balding, 2001).

Prior to SCIP, between 1989 and 1995, 4000 young people were charged with prostitution in England and Wales (Gillespie, 2007). Although initially there were no changes to the legislation and prostitution is still a criminal offence, the changes in policy through SCIP led to no more young people being prosecuted, except in unusual situations or if they were 16 years old and above. Instead, the focus moved to charging adults who pay or coerce children to be paid for sex. However, there was no major increase in adults being charged and convicted for these crimes (Scott & Harper, 2006; Swann & Balding, 2001). Subsequent changes to the legislation in UK increased the penalties for paying a child to have sex (up to life imprisonment) or for inciting, controlling or facilitating their involvement with prostitution (Gillespie, 2007). More recently there have been some high profile prosecutions in relation to large groups of young people with multiple offenders, but there is still no systemic change to prosecutions of offenders (Barnado’s, 2011, 2012).

Scott and Harper (2006) argued that the barriers and constraints to prosecuting adults who pay children or organise others to pay children for sex should be examined. Some areas to examine include: rules of evidence; difficulties in obtaining evidence; organisational risk for police or child protection not to be seen to act; and police, court and societal attitudes (e.g. not really a crime) (Cusick, 2002; Mitchell et al., 2010). Martyn (1998) noted that police in Australia wanted to prosecute adult offenders, but that it was very difficult when the young people would not bring charges against the adult.

Phoenix (2002, 2003) notes that it is still in the guidelines in the UK to consider criminal action if the young person is 16 years or older and persistently and voluntarily continues to be involved in prostitution. She argued that this continues the emphasis on the individual motivation rather than the broader systemic factors, and has increased the punitive response to young people aged 16 years or older.

In addition to changing the focus of legal sanctions, one of the SCIP objectives was to ensure that systems were in place in each local area to more accurately and systematically count the number of young people involved in sexual exploitation, to help with more effective policy and service
development (Swann & Baling, 2001). The importance of establishing an accurate means of gathering data about sexual exploitation has since been recognised in other studies and jurisdictions (e.g. Barnado’s, 2011; Beckett, 2011). Another key element was the development of protocols between services regarding a response to young people who were being sexually exploited and an accompanying dissemination of information and training. The importance of accurate and timely sharing of information cannot be underestimated (Barnado’s, 2011; Beckett, 2011; Smeaton, 2013).

In a subsequent study related to SCIP, it was recommended to the British Government to remove the provision to prosecute young people who ‘persistently and voluntarily’ return to prostitution, but the British Government declined to do so (Scott & Harper, 2006).

In Australia, Martyn (1998) recommended there be uniform laws on age of consent for males and females and uniform decriminalisation of prostitution across all Australian jurisdictions. Martyn also recommended the decriminalisation of the loitering laws to prevent the prosecutions of young people who are involved in prostitution on the streets. Cusick (2002) noted that arresting young people for prostitution adds to their financial burden, further isolates and marginalises them and further damages their self image.

There was a Victorian Law Reform Commission (2001; 2004) on sexual offences that included sexual offences against children. However, this Commission deliberately did not cover prostitution, as it stated that this was being considered by other government reviews. However, this author could locate no ‘other’ reviews.

It is also worth noting that in Australia there has been a Parliamentary Joint Committee inquiry (2004) into trafficking women for the purposes of sexual servitude, but apart from the comment that it can never be seen that a child has a choice under such circumstances, there is no other reference to children or to the issues of child sexual exploitation in Australia.

Cuda (2011) argues that government policy discussion on child sexual exploitation should occur in the light of the larger context, such as in relation to poverty, homelessness and broader issues of vulnerability. She argues that sexual exploitation should not be isolated as a problem to be fixed but rather agrees with Saphira and Oliver (2002) that it requires a multi-agency approach with prevention and intervention as key elements. However, Saphira and Oliver (2002) appear to have a more decisive view that child prostitution must be stopped. Governments and other bodies should take into account the factors that push young people into prostitution – for example: alcohol and other drug use; factors that encourage others to pay them for sex; societal and structural factors; the impacts of trauma that lead young people to prostitution and that arise from it; and the generational cycle of abuse. Cuda also argues for the need for more research in Australia so that policies and program development can be better informed. Those who may disagree with Cuda’s relatively benign perception of youth prostitution may still agree with her recommendations as to what to examine in terms of policy. It is of concern that a lack of data and government oversight of
child sexual exploitation through prostitution was mentioned in a study in Melbourne 20 years ago (Hancock, 1994), and little appears to have changed.

A positive shift has occurred in the last five years in Victoria through initiatives from the Commissioner for Children and Young People and the Office of the Principal Practitioner (DHS). In particular, there have been a number of different forums involving child protection, police, residential care services and others to meet and discuss the challenges and possible strategies as part of developing a shared understanding. More recently, in 2013, DHS and police ran a series of workshops throughout the state as a collaborative effort to help skill different workforces to identify and respond to sexual exploitation (DHS and Victoria Police Sex Crimes Squad, 2013).

Areas for suggested policy and potential legislative review based on the review of literature regarding child sexual exploitation include:

- Developing a shared framework across child protection, youth justice, the out-of-home care and case management sector, the police and health services. This framework needs to have the young person at the centre and not be hindered by a compliance culture (Beckett, 2011)
- Developing shared data sets between child protection, youth justice, police and the courts regarding the prevalence of youth prostitution and other types of commercial sexual exploitation, attempts at prosecution of adults, and outcomes of such prosecutions
- Exploring the role of the Commissioner for Children and Young People in terms of child protection, police and the Attorney General’s Office being more accountable regarding collecting and sharing relevant data
- Examining any constraints to the successful prosecutions of adults who pay for or organise others to pay children for sex
- Examining specific push factors relating to sexual exploitation
- Examining specific pull factors relating to sexual exploitation
- Piloting programs and initiatives with a focus on child sexual exploitation, as well as ensuring that more generic program responses to high-risk adolescents include awareness of these issues
- Embedding training programs in local areas so that new workers can receive the necessary knowledge and skills in a timely fashion
- Articulating research questions and methods and supporting research that can inform policy, program and practice
- Sponsoring conferences and workshops including: government and non-government; police; child protection; health; education; out-of-home care; courts; Attorney General Departments; mental health; youth justice; outreach programs; public education campaigns; drug and alcohol services; sexual assault services; and Aboriginal organisations. Conferences can be used, for example, to initiate / lead a process towards policy change.
- Continuing cross-sector, cross-discipline workshops that can be used to gather information from the field and provide direct assistance in practice to workers.

Primary prevention, public education and advocacy

_The issue of sexual exploitation and the broader context regarding commercialisation of childhood and sexuality cries out for an advocacy approach._
Some of the literature argues for the need for public education regarding the ‘intrinsic violence of prostitution’ as well as information about the service system (Beckett, 2011; Farley et al., 1998; Martyn, 1998; Saphira & Oliver, 2002). This is complicated but necessary in the context of the broader decriminalisation of prostitution. There is also discussion about how to get messages to youth to dispel some of the illusions and discuss the realities and the lack of glamour (the myth of Pretty Woman) in sexual exploitation (Mitchell et al., 2010; Nixon et al., 2002) and their rights (Saphira & Oliver, 2002). Public education messages should be tailored for young people, parents, other family members and the general community (Beckett, 2011).

The issue of sexual exploitation and the broader context of the commercialisation of childhood and sexuality cries out for an advocacy approach. Barnardo’s (UK) have provided a strong and effective example of advocacy and education in relation to sexual exploitation since the mid 1990s. This approach has helped to redefine the problem and inform the argument for changes in legislation and the service system (Barnado’s, 2012; Barnado’s, Stade Advies & the Tartu Child Support Centre, 1997). Barnado’s has a number of public education campaigns and resources, such as a recent guide for young people and families funded by the Welsh government and created by young people themselves (Barnado’s Cymru, 2013). This and a number of other materials can be found on www.barnados.org.

Barnado’s public and professional education approaches have been developed and tested over time, and recommendations have followed. These include:

- One-off sessions for schools and residential care settings may be limited and consideration should be given to extending these over time
- Messages for young people directly such as information about the grooming process may need to be reinforced over time
- The strategy needs to consider ways of dealing with potential homophobic reactions by the young people that can impede open discussions (Skidmore & Robinson, 2007).

Secondary prevention strategies

The research demonstrates that young people who have been subjected to abuse and neglect, who are clients of child protection and in out-of-home care are at heightened risk of becoming involved in sexual exploitation through various pathways. As such, specific strategies should be considered for this group to prevent sexual exploitation. In particular, young people with other risk factors such as absconding behaviours, early sexual activity and alcohol and other drug usage should be a focus of secondary prevention strategies.

Nixon and colleagues (2002), whilst noting the public education strategy within schools, contend that a secondary prevention strategy targeting young people at particular risk, such as those in out-of-home care will be more effective. In the SCIP initiative, the main prevention strategy was for the young people who run away or go missing from home or out-of-home care (Swann & Balding, 2001). More effective leaving care supports are also a secondary prevention strategy (Mendes & Moslehuddin, 2006).
Young people who have been subjected to abuse and neglect, who are clients of child protection and in out-of-home care are at heightened risk of becoming involved in sexual exploitation.

Expanding efforts to maintain young people at risk within the education system, including tutoring and after school programs is an important strategy (Brawn & Roe-Sepowitz, 2008). Similarly, it is important to provide housing and outreach and support services for high-risk youth, such as those who are homeless or using alcohol and other drugs (Fitzgerald, 1997; Martyn, 1998).

Tertiary service response

“The overriding message that emerges from all elements of the research is that, despite the efforts of many dedicated professionals, in some cases we are failing in our duty to safeguard children and young people from sexual exploitation.” (Beckett, 2011, 85)

For those who have already experienced abuse through sexual exploitation, a wide gamut of service responses needs to be considered. There is an identified need for holistic, multi-sectoral policies and services for young people, including access to income security, employment, training and housing (Abel & Fitzgerald, 2008; Beckett, 2011; Cuda, 2011; Taylor-Browne et al., 2002).

Workers may not know how to recognise indicators that a young person may be being exploited or may not realise the importance of sharing this information through appropriate channels (Beckett, 2011). They may be reluctant to proactively identify young people who are at risk of sexual exploitation if there are no services available for them (Scott & Harper, 2006). In the context of the SCIP initiative, a range of practical resources was identified, such as safe houses, drop in centres, time out spaces, appropriate placements and alcohol and other drug treatment services (Swann & Balding, 2001).

Beckett (2011) in her study noted that once a parent or a carer identified risk of sexual exploitation, a range of proactive protective measures was put in place for some young people, but no such response was available for other young people. Examples of proactive measures included:

“... removal of mobile phones and/or Internet access where relevant, pursuit of a third-party complaint by a parent/carer, use of harbouring notices to disrupt contact between young people and their abusers, proactive police investigations, use of civil orders to place prohibitions on abusers’ behaviours and provision of therapeutic support for the child. In many of the other cases in which sexual exploitation was noted to occur over a prolonged period, there was a clear absence of such factors. High tolerance of risk was observed in several of these cases, with situations allowed to escalate to very concerning levels before any concerted effort was made to address them.” (Beckett, 2011, 86)

There is a need for a balance between mandated services, such as child protection and secure accommodation, and voluntary services and responses (Busby et al., 2002).

Child protection

Pearce (2006) advocates for child protection to work collaboratively with community-based services that can assist with housing, family violence programs, sexual health and mental health services, rather than focusing on their statutory role. Pearce (2006) and Phoenix (2002, 2003) note that as
many young people who are being sexually exploited are 16 or 17 years old, child protection has fewer options and needs to rely on more voluntary services.

Scott and Harper (2002) in their study in London reported that the most proactive local authorities had a senior child protection officer who held a coordinating role, an active protocol on sexual exploitation, and were working on cases where both known and suspected prostitution was involved.

**Out-of-home care services**

Given that some push factors described in the literature are a feature of young people’s experience in out-of-home care, it is important to consider these when thinking about prevention or intervention in relation to sexual exploitation.

Apart from the strategies suggested later relating to absconding, there is little written regarding what out-of-home care placements can do to assist young people who are being or are at risk of being sexually exploited. Beckett (2011) notes the need for stability of placement, but this appears to be unattainable for too many young people in care. Farmer (2004) suggests that sometimes it is appropriate to place young people outside their area so they are less exposed to a network that reinforces their behaviour and may try to coerce their involvement. Bruce and Mendes (2008) note that some residential care staff are proactive in obtaining information such as the number plates of people who are picking or dropping off the young people and providing this information to the police. They also noted the value of providing sex education for this population, given their disrupted school education.

Beckett (2011) described the important role played by some of the therapeutic residential programs in relation to young people who were at risk of sexual exploitation.

> “Some of the therapeutic approaches being implemented in residential units ... were also observed to be contributing to a greater sense of safety and security for young people within units. They were also observed to be greatly enhancing staff capacity to work with young people in a more effective and less reactive manner, which in turn improved relationships within the units. A further example of promising practice observed across a number of different units was a flexibility to adopt the composition of units according to the needs of the young people within them.” (Beckett, 2011, 89)

**Use of secure accommodation**

Some saw secure accommodation as a useful option, but only if in the context of a wider plan that included follow-up when they left the secure environment (e.g. Beckett, 2011; Farmer, 2004; Gillespie, 2007; Morton, Clark & Pead, 1999). For example, Gillespie (2007) contends that if secure accommodation is to be appropriate, it must aim to address the issues placing the young person at risk of sexual exploitation and not just provide a breathing space.

Beckett (2011) highlighted the potentially positive and negative aspects for using or relying on secure services to respond when a young person is at risk of sexual exploitation.

> “Professionals highlighted a number of potential benefits associated with a period in secure accommodation, including the possibility of breaking a cycle of behaviour, the opportunity to deliver services (both practical and therapeutic) to a young person and respite from the influence and demands of abusers. In situations of serious risk, a period of secure accommodation was often felt to be the only way to ensure the immediate physical safety of a young person.” (Beckett, 2011, 91)
“Enforcing behavioural changes by restricting liberty is not the same as achieving meaningful change. As one residential manager observed, ‘Compliance is not the same as progress’, particularly where any degree of freedom or choice has been removed from the equation. This was noted to be especially pertinent for young people with multiple experiences of secure accommodation, a number of whom were described as knowing how to work the system in order to ensure their release. As one health professional observed: ‘Secure should be a launching pad for changing the lifelong trajectory of a child’s life, but it is simply an interruption, a plaster, an occupational hazard.’” (Beckett, 2011, 91)

Secure accommodation can be over-relied on and may reinforce some of the risk factors, especially regarding punishment, shame, low self-esteem and negative influences from others (Beckett, 2011; Harper & Scott, 2005; Morton, Clark & Pead, 1999). Another concern was that the threat of being placed in a secure setting may lead to young people not seeking help from services and going underground into less protected environments (Busby et al., 2002).

If secure accommodation is to be appropriate, it must aim to address the issues placing the young person at risk of sexual exploitation and not just provide a breathing space.

Scott and Harper (2006) commended one local authority for being able to avoid the use of secure accommodation completely. They recommended at the end of their study that: “Social services departments should avoid the use of secure accommodation as a response to sexually exploited young people. Resources should instead be deployed to provide community-based responses involving early intervention, intensive support, safe accommodation and continuity of care.” (Scott & Harper, 2006, 323). Another concern raised by Phoenix (2003) was that the presence of a secure setting made it an easier option for deflecting or delaying risk, rather than dealing with the issues leading to risk.

Police and courts

There is discussion in the literature regarding the role of police in relation to young people and sexual exploitation in general (e.g. Beckett, 2011; Cusick, 2002; Harper & Scott, 2005; Martyn, 1998; Mitchell et al., 2010; Scott & Harper, 2006; Smeaton, 2013). As mentioned earlier, any effective strategy must include increasing the state’s ability to successfully prosecute the offenders involved in sexual exploitation (Barnado’s, 2011).

In the light of the highly organised aspects of commercial sexual exploitation of children, where there are sophisticated systems that cross state and national borders, a specialised and resourced area of policing is also required (Barnado’s, 2011; Rafferty, 2013).

In addition to potential changes to legislation, police standing orders and their general approach should be explored. Some suggestions include specialised training and roles for police who are able to connect more effectively with the young people, together with greater access to victims of crime services for the young people (Beckett, 2011; Mitchell et al., 2010).

Beckett (2011) lists other promising practices to enable the system’s ability to prosecute the offenders. These include: proactive intelligence gathering by police; proactive police investigation even when the young person is not making a complaint; pre-prosecutorial advice to the police; police developing relationships with young people and providing them with a flexible approach in
how they can disclose what is happening; and different ways to help vulnerable and/or intimidated witnesses give evidence.

**General voluntary non-government services**

There was discussion regarding the need to fund non-government based services that offer scope to provide flexible, holistic, responsive, non-punitive service response to the young people (Busby et al., 2002; Smeaton, 2013). A mixture of generic and specialist services, including availability of gender specific services, is considered important (Busby et al., 2002).

“... the one unified message we received from survivors and service providers alike is that one model does not service all! Policy makers need to ensure that program variety exists and this can best be achieved now by providing more secure funding to the NGOs that provide a range of voluntary services along the ‘harms reduction’ and ‘advocacy’ continuum. These are the programs that children/youth find most accessible and most acceptable. Yet they are the most insecurely funded.” (Busby et al., 2002, 116)

**Education and training**

As mentioned earlier, involving young people in education opportunities is a key strategy for both prevention and for helping those wishing to leave prostitution (Brawn & Roe-Sepowitz, 2008; Cusick, 2002; Saphira & Herbert, 2004; Smeaton, 2013).

Kraestle (2012), in her longitudinal study on risk and protective factors associated with sexual exploitation, found the protective benefit for young people who were more connected and happier with their school experience.

“These results underscore the benefits of school connectedness factors and should be considered in youth interventions and policy decisions. Schools may be able to identify risk factors that are associated with individuals feeling disconnected and target them for services (Bonny et al. 2000). Training school teachers and administrators to recognize at risk students and reach out with services could have broad benefits for public health goals.” (Kraestle, 2012, 320)

Saphira and Herbert (2004) caution that a traditional 9-5 educational program with fortnightly social security payments is unlikely to be sufficient to counter the pull of the lifestyle and money found in prostitution. “Courses that begin later in the day, utilise the former hours of work and give rewards at shorter intervals may engage a person leaving commercial sexual activities.” (Saphira & Herbert, 2004, 6).

**Specialised services and interventions focused on sexual exploitation**

Scott and Harper (2006) wrote of the benefit in further funding specialist services that worked within a multi-agency framework, but did not provide details of what these services might entail. In an earlier work, Harper and Scott (2005) noted:

“Where specialist services exist, they play a vital role in engaging this hard-to-reach and vulnerable group of young people; facilitating access to other services; and in developing and disseminating expertise in working with sexually exploited young people. Services need resources. If all agencies proactively identified sexually exploited young people as they should, current services would need to expand to meet the demand.” (Harper & Scott, 2005, 9)
The multiple issues facing these young people required services that could respond to these multiple issues.

Phoenix (2003) noted there were 41 voluntary organisations funded specifically to work with sexually exploited young people in the UK. Taylor-Browne and colleagues (2002) noted that single-issue services had a role to play – for example, through providing non-judgemental advocacy for young people involved in prostitution. However, they noted that the multiple issues facing these young people required services that could respond to these multiple issues.

As young people who have been sexually exploited often have a self perception as survivors not victims, and their past experiences have taught them not to trust adults, service provision needs to show them both safety and some meaningful control over their lives (Williams, 2010).

Taylor-Browne (2002), Taylor-Browne and colleagues (2002) and Fitzgerald (1997) recommend that specifically designed services for young people who have been sexually exploited should engage their participation in the design of such services. Fitzgerald (1997) recommended that these services include education strategies through support networks, outreach teams and educational materials. Taylor-Browne and colleagues (2002) explore different ways in which young people can directly participate in decision-making that is not tokenistic. They drew the link between such participation and increased social inclusion.

Barnado’s (2011) has established a number of specialist services for young people at risk of sexual exploitation in England. Their model of working is known as the four As: Access (ensuring an inviting space, including kitchen, bathroom, self-referral, etc.); Attention (support, listening, key worker model, etc.); Assertive outreach; and Advocacy for the young people as required.

Thomson, Hirshberg, Corbett, Valila, and Howley (2011) describe a residential treatment program in the US that works with young people who had experienced sexual exploitation. Their model is called ACT (Acknowledge, Commit, Transform) and is based on Prochaska and DiClemente’s (1983) transtheoretical model of change. Though this article was based on a small number of cases, there were early signs that this new approach has led to better outcomes than their previous approach. This approach is predicated on the young person already having made a commitment to change aspects of their behaviour and so would not be directly applicable for other types of residential care.

Holger-Ambrose and colleagues (2013) conducted a study on what young people who were sexually exploited wanted from outreach workers.

“They wanted street outreach workers to ‘be real and respectful,’ ‘build up their trust with girls,’ ‘be brief and not push themselves on people,’ ‘provide us with resources,’ ‘be nonjudgmental, listen, be in a place without bars on the windows,’ and ‘care’. Participant also wanted professionals to use ‘soft words’ (meaning using the terms they use or gentler terms for sexual exploitation versus the clinical terms used by professionals in law enforcement, medical fields, and social service fields).” (Holger-Ambrose et al., 2013, 334)

Saldanha and Parenteau (2013) describe an outreach model in Toronto called STAND, which reinforced many of these messages about the importance of outreach, particularly those focusing on young people who live in one way or another on the streets. Their article:
“...underscored the need for outreach workers to be attentive to the power and dynamics that operate on the street in subtle and not-so-subtle ways influencing these youth. The path of change in the lives of community members is not linear, and the moment of change cannot be predicted. Even so, the outreach worker must deliver on the promises made to help community members change or exit street life, following through when they are ready.” (Saldanha & Parenteau, 2013, 1283)

The diagram below is an example of a model developed specifically for working with prostitution. It is used by a not-for-profit Canadian organisation called Prostitutes Empowerment, Education and Resource Society (PEERS). They work to improve the safety and working conditions of those involved in prostitution, help those who desire to leave, and increase public awareness (Smith, 2005, 3).
Shaw and Butler (1998) note that if youth prostitution has a range of motivations, including survival, then there needs to be a range of service responses that aim to prevent abuse, prevent youth running away, provide shelter and address employment issues. These appear similar to the responses developed in the PEERS network (Smith, 2005). However, Shaw and Butler (1998) also contend that such services should be fully integrated with general services so as not to be stigmatising and to meet the variety of the young people’s needs, not just those in relation to the prostitution.

Exiting prostitution on its own, similar to escaping family violence, does not ensure a ‘better and safer world.’

The PREVENT strategy is documented by Willis and Levy (2002) as a means of mitigating the health risks of child sexual exploitation. It stands for Psychological counselling, Reproductive health services, Education (regarding safety from violence and unsafe sex), Vaccinations (such as Hep B), Early detection of health risks, Nutrition and Treatment regarding infectious and other health needs.
It is important to understand that exiting prostitution on its own, similar to escaping family violence, does not ensure a ‘better and safer world.’ This highlights the importance of a wrap around process and access to positive social networks continuing well after the young person has left prostitution. Building a positive social network is a key goal (Hedin & Mansson, 2003).

**Therapeutic and mental health services**

Despite the plethora of information about the emotional and mental health consequences of child sexual exploitation, less is written about the role of therapeutic services in working with young people who have been sexually exploited. Indeed, Jordan, Patal and Rapp (2013) recently stated that there is no effective intervention that has yet been developed for this population, and so services have adapted their approach from other traumatised populations. Given the prevalence of PTSD and other consequences of traumatisation for those who are sexually exploited, trauma and related concepts should be a part of any treatment program’s framework (Saphira & Herbert, 2004).

Rafferty (2013, 568) noted the important role of mental health workers for the treatment of children who have been sexually exploited:

> “Mental health providers can also play a vital role with regard to the appropriate assessment of children’s clinical and health care needs, as well as in the implementation of effective strategies to provide trauma-informed and culturally competent physical, psychological, and social rehabilitation services. Thus, effective intervention strategies will demand intensive resources to ensure that intake procedures are based on empirical support, include a comprehensive assessment of physical, mental health, sexual, and reproductive health (IOM, 2009), and require that services are made available to address each of the immediate and long-term needs.”

Hossain and colleagues (2010) in their study on girls and women who are trafficked and sexually exploited, comment on the need to evaluate therapies used for anxiety, PTSD and mood disorders in these contexts. They note that some, but not all, of these women may require psychiatric care. Nixon and colleagues (2002) advocate for the need for a treatment service focusing on the long-term effects of their past sexual abuse in order to prevent the development of trauma symptoms and being at risk of sexual exploitation through prostitution. Willis and Levy (2002) noted that mental health treatment options should be part of a response to mitigate the consequences of sexual exploitation.

Hedin and Mansson (2003) found that women who had left prostitution spoke of the need for therapy and therapists they could trust. “Following the break with prostitution, the women were vulnerable, exposed, and in need of various forms of assistance such as crisis sessions, psychotherapy and resource mobilization” (Hedin & Mansson, 2003, 232). This highlights the value of therapeutic services in the aftermath of sexual exploitation. They also note that therapists need to be educated about the phenomenon of sexual exploitation, and prostitution in particular, so that they are helpful, not harmful. Mansson and Hedin (1999) reported that after the crisis reactions, the women were able to begin a cognitive process of working through their difficulties.

Scott and Harper (2006) recommend a change of language from ‘exiting prostitution’ to ‘recovery’, but do not further articulate what may constitute such a recovery, other than ceasing involvement in that lifestyle.
Judith Herman (2003), a leader in the field of trauma, wrote some clinical observations about the challenges in working with women involved with prostitution. She noted that the secrecy about prostitution due to the shame and stigma could be a serious obstacle in forming a therapeutic alliance. Another obstacle is the complex trauma reaction – a result of their experiences – that hinders their ability to form cooperative relationships. “Moreover, the realities of their daily lives are often so precarious and dangerous that without sustained and well-organized social intervention, ordinary therapeutic measures are unlikely to have any meaningful effect” (Herman, 2003, 4).

Herman states that it is important to clearly explain the rules of engagement in psychotherapy, such as honesty, fairness and respect. Treating people with dignity includes an expectation that they take reasonable responsibility for their actions. Ensuring the climate is accepting, warm and non-judgemental is also important. Safety must be established as a key to the therapeutic approach. Understanding that the young people may attempt to leave prostitution before they finally leave, needs to be taken into account in the therapeutic context. In conclusion, Herman (2003, 12) cautions that, “The dishonor attached to prostitution is so profound that it affects all social interactions, including the therapy relationship.” She emphasises the need for therapists to not work in isolation, but to ensure they have their own support network in order to be effective in this work.

In a model that is similar to Herman’s, according to Jordan, Patal and Rapp (2013), the International Organization of Medicine indicates that treatment should have three goals:

“This first goal is to examine and help victims feel safe and regain a sense of control over their lives. Oftentimes, victims of trafficking have been told what to do and when to do it and these could include simple tasks such as eating and toileting. Regaining these tasks, although they seem minor, can be difficult for victims. Once a victim feels safe, exploring the trauma with the victim and how it has manifested in changed mental health status is critical. As with all trauma work, this is not a short process, and victims should be able to do this in their own time with support and encouragement. The last phase involves reintegration into society—whether that is back to their home of origin or in their new surroundings. This can prove to be difficult given the lack of a process and funding for this.” (Jordan, Patal & Rapp, 2013, 364)

In their study in India, Deb, Mukherjee and Mathews (2011) found that psychological interventions for young women who had been sexually abused and trafficked were helpful in resolving their aggression, enhancing their life chances and increasing their positive social activities. Social skills group work was also considered helpful in working on aggression.

Music therapy is one particular example of a therapeutic modality applied with young women who had escaped sexual exploitation in Cambodia (Schrader & Wendland, 2012). This creative therapy approach involved training staff about music therapy principles, instrument lessons, group music activities and how support the young women through the process both individually and as a group. It was a non-threatening opportunity for the girls to begin the healing process.

Smeaton (2013) noted the possibility of embedding mental health workers within specialist services focused on sexual exploitation who could respond to meet the needs of this population.
Any therapeutic or treatment approach should consider the whole developmental and mental health experience of the young person, not just their experience of sexual exploitation.

As noted earlier in this literature review, sexual exploitation rarely comes in isolation from other trauma and deprivation, particularly for children. As such, any therapeutic or treatment approach should consider the whole developmental and mental health experience of the young person, not just their experience of sexual exploitation. In fact, it may be that from a developmental perspective, there will be other treatment priorities before this particular aspect of their life can be explored.

Working together/collaboration

Joined up systems are needed, as effective intervention is beyond the scope of any one service (Barnardo’s, Stade Advies & the Tartu Child Support Centre, 2007; Cusick, 2002; Harper & Scott, 2005; Melrose, 2004; Mitchell et al., 2010; Swann & Balding, 2001; Taylor-Browne, 2002). There need to be integrated partnerships across service systems, including police, child protection, youth justice, housing, youth homelessness, education, health, mental health, secure, outreach programs, drug and alcohol services, sexual assault services, Aboriginal organisations and legal services.

These partnerships need to occur both at a central policy level and at a local service delivery level, providing wrap around services. There is a need for agreed-upon protocols, including confidentiality and its limits, the role of police, risk transfer and risk sharing (Melrose, 2004; Swann & Balding, 2001). Agencies are working out strategies to distinguish between those in immediate danger and those who are not in terms of information sharing, so as to not unnecessarily reduce their ability to visit the young people when they are involved in prostitution (Phoenix, 2003).

An integrated service system should not focus on single issues (such as sexual exploitation), but on a holistic understanding of these young people’s needs. However, in relation to sexual exploitation there are multiple goals.

“The body of research evidence ... clearly indicates that an effective response to the issue of sexual exploitation requires a multi-faceted, multi-agency approach that proactively addresses three core areas: the prevention of sexual exploitation, the protection of sexually exploited young people and the prosecution of abusers.” (Beckett, 2011, 5)

Given the nature of human trafficking across international borders, there is also an important role for international collaboration and there are a number of examples of these being developed. One such collaboration that has involved research, training and sharing of information is between the UK, the Netherlands and Estonia (Barnardo’s, Stade Advies & the Tartu Child Support Cent, 2007).

Alcohol and other drug usage

Attention to alcohol and other drug treatment must be a part of any strategy regarding sexual exploitation (Farley et al., 1998). This could include access to a specialised, fast track, drug treatment service, residential detoxification and rehabilitation service, providing: child care for those with children; flexible services that respond to their chaotic lifestyle; and specialist accommodation that takes into account drug addiction problems (Taylor-Browne, 2002).
Harm reduction
Harm reduction involves a balance between understanding the young person as a victim and as a survivor — where she or he needs both protection and empowerment (Busby et al., 2002; Pearce, 2006). It is informed by the harm reduction approaches in the alcohol and other drug fields (Shaw & Butler, 1998). It can be delivered by outreach workers or peer educators (Cusick, 2002; Holger-Ambrose et al., 2013; Taylor-Browne, 2002). It needs to include: clear confidentiality principles; access to safe houses; access to materials that increase safety, such as condoms; and education strategies regarding health and safety for the young people – written in accessible language (Busby et al., 2002; Fitzgerald, 1997; Martyn, 1998; Shaw & Butler, 1998).

“They undertake a complex balance of recognising the dangers and respecting the child/youth’s autonomy, resisting ‘for the child’ decisions and facilitating ‘decisions by the child’. Their emphasis is upon reducing the harms associated with prostitution without necessarily taking steps to stop the child/youth’s involvement immediately. Services often include provision of condoms, needle exchanges, bleach kits, street-wise workshops and ‘bad date’ sheets.” (Busby et al., 2002, 114)

If the young person is able to recognise their need for support, even if they are not yet ready to leave a sexually exploitative situation, this can be a means of reducing harm in the meantime (Pearce, 2006). It can be the first step in towards the young person realising they can leave that experience behind and begin a journey of recovery. It is nonetheless ethically and politically challenging and would require system-wide leadership.

“While it may seem counterintuitive to help sexually exploited girls and young women by providing supplies that may allow them to continue being exploited, meeting their identified needs is an important means of establishing trust. Such nonjudgmental care may encourage them to seek out street outreach workers again for referrals to other services. This can be likened to the “precontemplation stage” in Baker, Dalla, and Williamon’s (2010) model of women exiting prostitution, which was adapted from the transtheoretical stages of change theory. In the earliest “precontemplation” stage, outreach workers connect with youth who may not be considering leaving situations where they are exploited. During this time, providers can assist with meeting their immediate needs, providing health education, and engaging them in safety planning.” (Holger-Ambrose et al., 2013, 336)

Health promotion
Health promotion and monitoring strategies should be part of the range of services available. Issues of consent for health assessment and treatment, especially if the young person is in secure accommodation, should be treated carefully, given the intrusive nature of many of the assessments, such as gynaecological examinations and blood tests (Busby et al., 2002). Health promotion needs to be both in the physical and mental health areas (Pearce, 2006).

Economic approaches
Economic strategies for dealing with poverty and the pull towards access to money are frequently mentioned but few practical examples were found (Cusick, 2002). Some suggestions arose from a study of adult men and women involved in prostitution across five countries. These included job training, legal assistance and housing (Farley et al., 1998). Martyn (1998) recommends ensuring adequate income security even for those younger than the current age requirement.
Farley and colleagues (1998) note that genuine choices need to be available for those involved in prostitution to be able to leave. These include economic choices, as well as an examination of the social conditions in their lives that may eliminate or constrain other meaningful choices.

**Professional development, training and support to staff**

There is a need for professional development to ensure the general and specialist workforce has a strong knowledge base skills relating to trauma and attachment, social network interventions, and engaging with young people. Scott and Harper (2006) write of the need to train workers in proactively identifying those young people who are at risk of being abused through sexual exploitation.

Shaw and Butler (1998) note the stressful nature of working ‘on the edges’ for those working directly with young people who are at risk of sexual exploitation and their networks, especially when doing outreach work. In addition to training, they recommend: supervision; protocols as to when to work solo or in pairs; and access to information regarding the law and issues of safety and confidentiality.

Barnado’s have developed a number of booklets and DVDs that are useful for both professional development and public education messages.

**Principles and practice requirements across all services**

The UK SCIP and related policy approach operates under a number of big-picture principles as summarised by Beckett (2011, 9):

- *Multi-agency responsibility for prevention, identification and response*
- *The importance of prevention and educative work*
- *The primacy of the welfare and safety of the child*
- *The principle of victimhood – a child cannot consent to be sexually exploited*
- *A recognition of the dynamics of grooming and dependence on an abuser*
- *The need for support and effective rehabilitation for victims of abuse*
- *A responsibility to investigate and prosecute those who coerce, exploit and abuse children in this manner.*

A project involving the UK, Netherlands and Estonia defined best practice as focusing on the early identification, immediate protection, harm reduction and long-term recovery of children and young people who are victims of sexual exploitation (Barnardo’s, Stade Advies & the Tartu Child Support Centre, 2007).

From a practice and program perspective, all services working with these young people need to include:

1. Listening to the young person, including clear disclosures, flippant comments, and other indicators that they may be at risk or already being sexually exploited (Beckett, 2011)
2. Persistence in approach, not short-term solutions. “The ‘persistence’ of such young people will require redoubled persistence on the part of practitioners if they are effectively to engage and work with them.” (Melrose, 2004, 18)
3. Engagement with young people through creative flexible strategies, including assertive outreach and establishing trust (Melrose, 2004; Saldanha & Parenteau, 2013; Scott & Harper, 2006; Smeaton, 2013)

5. Proactive strategies to avoid or reduce young people running away from home or placement (Beckett, 2011).

6. Disruption strategies when the young person is known to have returned to a sexually exploitative situation. These include monitoring the abuser’s behaviour, court orders in relation to the abuser, if they are on a corrections order and issuing a harbouring notice or an abduction order (or their equivalent) in relation to harbouring a young person. These strategies require police and DHS collaboration (Beckett, 2011).

7. Not making assumptions, but providing careful assessments of issues such as co-existence of other problems, including alcohol and other drug usage (Brawn & Roe-Sepowitz, 2008).

8. Respecting the ‘survivor’ identity of the young person rather than putting them in a victim role (Beckett, 2011; Williams, 2010).

“To escape this life, teens need a safe place to stay with nutritious food and services that respect their ‘survivor’ status and foster resilience. But often there are no services that meet the needs of the teens. Some teens see the streets as less harmful and more likely to help them ‘survive’ than the programs offered in their communities.” (Williams, 2010, 252)


10. Family support and intervention, including extended family supports.

11. Some young people exit prostitution gradually, where it loses its pull and they become attracted by positive alternatives and distracting activities that they find more fulfilling and of interest, such as offers of work, housing and different types of education possibilities.


13. Supporting opportunities to imagine a better future (Mansson & Hedin, 1999; Smeaton, 2013). Marshalling and making the most of potential turning points. According to the literature, turning points may provide an opportunity to intervene and help a young person to exit prostitution (Cusick, 2002). In these ‘ah hah’ moments, a traumatic or positive event may lead the young person to re-evaluate their situation and make a safer choice. The service system needs to be responsive at these moments and to follow through on new signs of motivation.

**Absconding or running away as a case in point**

*The discussion regarding push and pull factors for sexual exploitation should be considered more broadly, particularly in terms of how to reduce or avoid a pattern of absconding.*

Strategies that prevent absconding or running away should be part of the suite of approaches to reduce the risk of sexual exploitation as well as being an important goal in its own right (Biehal & Wade, 2010; Smeaton, 2013; Taylor-Browne, 2002; Taylor-Browne et al., 2002).
“For young people who are looked after, the provision of a stable placement where attachments can grow is crucial, together with an early response if they start to go missing. Equally, in view of the fact that so many first go missing while living at home, good preventative services targeted at older children and teenagers are needed to address this issue in an attempt to prevent the breakdown of relationships that may precipitate an admission to substitute care. An inter-agency response is also likely to be necessary to address the ways in which going missing, offending and non-attendance at school (through exclusion or truancy) tend to reinforce one other.” (Biehal & Wade, 2010)

The discussion regarding push and pull factors for sexual exploitation should be considered more broadly, particularly in terms of how to reduce or avoid a pattern of absconding.

There needs to be greater clarity and training for residential care staff on how to prevent young people from running away and what to do if they have run away. Farmer (2004) noted that residential care staff did not always recognise their responsibility for when young people leave the unit.

“In spite of the many examples of promising practice observed across some units, one key issue was repeatedly identified as conspiring against the effective protection of young people in residential care – the limited ability staff felt they had to stop young people leaving a placement, even when they knew that they were going to an abuser who would cause them serious harm. While there are options available to professionals in these situations, many residential staff did not feel sufficiently equipped and/or supported to effectively protect the children in their care.” (Beckett, 2011, 89)

Proactive strategies include harm reduction strategies, setting clear boundaries for their behaviour, effective supervision, following the young person and continuing to talk with them (when staff rosters allow), messages that their safety is important, and going and looking for the young people if they do not return. Recording the young people’s activities, including any absences, is important (Beckett, 2011; Farmer, 2004).

“Even when they knew that children were going out to engage in high-risk behaviour, they would not attempt to stop them, although they might counsel them to desist. If they did not return on time, the police would routinely be called. This replicated the home situations of girls who had never been made safe.” (Farmer, 2004, 384)

The VERSO Consulting Pty Ltd (2011) evaluation of therapeutic residential care illustrated through a case example the role residential care workers can take in reinforcing to the young person that they are not going to leave them in an unsafe situation but letting them run away.

Beckett (2011) acknowledges the work underway in Northern Ireland to try to develop a means of keeping accurate records regarding young people who are missing as an important step in not only working with them, but in improving the system’s responsiveness to this elusive risk. Taylor-Browne (2002) recommends a network of services and strategies for young people who run away, including: a systematic recorded interview to assess the reasons for the running away; mediation; family group work; respite care; early intervention through schools regarding truancy; and a strategic response to those who run away from out-of-home care. Fasulo, Cross, Mosley and Leavey (2002) noted the value of therapy for young people in avoiding or reducing running away behaviours.
Clark and colleagues (2008) did a small comparative study of young people who had a history of running away and reported that their behavioural analysis intervention led to a decrease in running away behaviour. This intervention includes:

- Informal functional assessments of the young person’s interests, preferences and reasons for running away
- Someone who listened and talked with the young person each day in a non-judgemental fashion
- Safe access to family and others
- Enhancing the reinforcing positive features of the placement through activities and time with people
- More active communication with schools and other supports, e.g. around homework tasks
- Acting on what the young person wants in terms of placement in the short and long-term
- Assisting leaving care planning for older young people.

This study in concert with Fasulo and colleague’s (2002) finding of the impact of psychotherapy on reducing running away behaviours highlights the importance of a therapeutic and relational approach.

**Meta-analyses and reviews of evidence-based practice**

As a result of a program being designated evidence-based, it is usually subjected to systematic and independent reviews according to a range of criteria. The Cochrane Collaboration is an international not-for-profit organisation that provides a system of reviews of the available evidence upon which health treatments, including mental health treatments, are based. The Campbell Collaboration is an affiliate of the Cochrane Collaboration and focuses more on child welfare services. Some meta-analyses are not focused on whether or not a service or intervention is evidence-based, but provide more of an overview of the research as it relates to particular client groups. The following are examples of meta-analyses or specific reviews that relate to programs mentioned in this literature review or have been described elsewhere as appropriate for high-risk adolescents. A summary of these and other programs are listed in Appendix One. None of the studies that were subject to a meta-analysis were explicitly focused on sexual exploitation or absconding.

A meta-analysis of child and adolescent mental health interventions by Jensen, Weersing, Hoagwood and Goldman (2005) found that most interventions described as evidence-based did not meet the criteria to justify that claim. In their analysis, 52 out of 4000 research papers met the gold standard of evidence-based practice, most of which did not involve the child protection population. Although they are strong exponents of evidence-based practice, the reviewers concluded that to make a real difference in the real world, therapeutic services should not focus solely on evidence-based manualised therapies to the exclusion of well-timed, empathic support approaches.

Landahl, Kunz, Brownell, Tollefson and Burke (2010) undertook a meta-analysis of motivational interviewing techniques used with a range of populations including young people with major behavioural problems. They found 119 studies that met the criteria for an evidence-base. From their review of these studies, they concluded that motivational interviewing contributes to positive outcomes of counselling. They described it as having a small but significant impact, and being more
potent in some situations, such as when directed at increasing healthy behaviours, decreasing risky behaviours and increasing the client’s engagement in the process.

Macdonald and Turner (2008) undertook a review of treatment in foster care under the Cochrane Collaboration. Although they found a number of studies about treatment in foster care, only five met the criteria as evidence-based. They concluded that treatment in foster care might be a useful intervention for children and young people with emotional and behavioural problems who are at risk of being placed in residential care. They described it as a promising intervention and commented that it is often described in more robust and ambitious terms than the evidence so far suggests.

Multisystemic Therapy (MST) is one of the most frequently described evidence-based practices, especially for the youth justice population. Littell (2004) conducted a meta-analysis of research and other reviews of research in relation to MST under both the Cochrane and the Campbell Collaboration. Littell’s systematic review concluded that studies can be superficially reviewed and reported upon leading to misconceptions of the validity and strength of the findings. In her review of MST, Littell’s preliminary conclusions are contrary to most earlier reviews. She concludes that the evidence does not demonstrate that MST achieves its stated outcomes. Littell’s review is not a critique of MST as a practice, but rather of the rigour and validity of the evidence upon which its claim to be evidence-based practice is founded.

In terms of broader reviews of therapeutic and case work interventions that can be used specifically with adolescents, two recent examples are: the literature review regarding child protection clients in NSW (Schmied & Tully, 2009); and a briefing by the Australian Family Relationships Clearinghouse on what family based treatment that works with adolescents with problem behaviours (Robinson, Power & Allan, 2010).

**Reflections**

A simple answer to how to prevent adolescents having high-risk behaviours — yet one that remains elusive for too many— is to ensure they have a good childhood.

The author of this review was asked to provide some general reflections based on the literature and her own experience in the field in relation to a series of questions that can be summarised as the following:

1. How can we intervene early to prevent adolescents having high-risk behaviours?
2. Despite extensive policies, frameworks and practice guidance, what are the constraints and barriers that get in the way of good practice in relation to child protection practice, case management and case planning in terms of prevention, early intervention and tertiary intervention?
How can we intervene early to prevent adolescents having high-risk behaviours?

A simple answer to how to prevent adolescents having high-risk behaviours — yet one that remains elusive for too many — is to ensure they have a good childhood. Although some young people are at risk of mental health problems and other difficulties due to genetic factors, those who enter the child protection system are notably those whose childhood is replete with examples of rejection, trauma and chaos. Equally disheartening is that their childhood is also usually filled with examples of missed opportunities for safety, stability, healthy development and recovery.

If we stepped back and looked at what children need when they are growing up, rather than focusing on what the services currently provide, we could ask ourselves:

- What has the service system done to ensure this child’s safety from preventable harm?
- What has the service system done to ensure this child has predictable, dependable nurturing relationships that provide him or her with a positive sense of identity, stability and future?
- What has the service system done to ensure this child’s developmental milestones are achieved to the maximum of his or her potential?
- What has the service system done to redress past harms so that the child has had the opportunity to recover from trauma and neglect?

This last question is often ignored, as the focus is most often on risk rather than on redressing the harmful consequences of what has already occurred. We need a system that can do both. Bruce Perry’s work is one of the few approaches that overtly aims to help a child recover from the negative consequences of trauma and neglect on his or her development.

As outlined in Table 8, Perry’s six core elements of positive developmental, educational and therapeutic experiences for children and adolescents are not necessarily costly or complex, although they require persistent commitment on the part of the individuals and the system — yet we often look for more complicated solutions.

We begin with the therapeutic web, such as the placement, school, child protection, recreational organisations and other key areas that need to come together to collectively support the child/young person and those in the child/young person’s life.

The second domain of family and other relationships highlights the importance of supporting or establishing positive healthy relationships for the child beyond the formal service system. The individual domain is often the system’s primary focus with an emphasis on the high-risk behaviours rather than the young person. However, Perry’s model emphasises the therapeutic web as where most responsibility lies for reducing risk and redressing harms. It is not easy to change the system, but trying to change the young person without having the necessary supports in place is nigh impossible.

In Table 8, mention of the ‘child’ rather than just focusing on the adolescent is based on the premise that the more that can be achieved earlier in childhood with these six elements across each domain, the less likely and less severe will be most of the problems later in life. However, each element is still relevant for adolescents as they can redress harms as well as build on potential.
<table>
<thead>
<tr>
<th>Core elements for children/adolescents</th>
<th>Therapeutic web (Context)</th>
<th>Family/ relational</th>
<th>Individual</th>
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<tr>
<td>Relational</td>
<td>Positive, safe relational experiences that are rewarding and provide co-regulation</td>
<td>Ensure child/adolescent has access to healthy relationships with a network of people in placement, school and other settings</td>
<td>Work with family members and other potential positive or negative relationships to increase positive experiences and to help child/adolescent use relationships to help regulate their stress and reward systems</td>
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<td>Relevant</td>
<td>Developmentally matched, not just by age but also with knowledge of developmental strengths and gaps</td>
<td>Provide education and support to placement, school and others regarding child/adolescent’s developmental history and current functioning and the implications of this for how to help the child/adolescent feel cared for, learn and self-regulate over time</td>
<td>Provide education and support to parents, siblings and other family and informal relationships regarding child/adolescent’s developmental history and current functioning and the implications of this for helping child/adolescent feel cared for, learn and self-regulate over time</td>
</tr>
<tr>
<td>Repetitive</td>
<td>A level of repetition required by the brain to make and sustain changes</td>
<td>Ensure predictability and continuity in the child/adolescent’s life. Provide access to recreational, creative, educational and nurturing activities that can sufficiently stimulate areas of the brain to help child/adolescent’s cognitive, relational, sensory integration and self-regulatory functioning</td>
<td>Ensure predictability and continuity in the child/adolescent’s life. Educate and support key people to be involved with child/adolescent regarding recreational, creative, educational and nurturing activities that can sufficiently stimulate areas of the brain to help child/adolescent’s cognitive, relational, sensory integration and self-regulatory functioning</td>
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<tr>
<td>Rewarding</td>
<td>Building on child/adolescent’s interests and</td>
<td>Scan the child/adolescent’s environment for</td>
<td>Scan the child/adolescent’s family life and other</td>
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<td>Core elements for children/adolescents</td>
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<tr>
<td>what they find pleasurable</td>
<td>potential pull factors or attractions that are negative and harmful and reduce/cease child/adolescent’s access to these. Increase positive, healthy opportunities in child/adolescent’s life that they find rewarding and pleasurable</td>
<td>relationships for potential pull/attractions that are negative and harmful and reduce/cease child/adolescent’s access to these. Increase positive, healthy opportunities in child/adolescent’s life that they find rewarding and pleasurable</td>
<td>Aim to replace negative rewards (e.g. drugs, self-harm) with positive rewards (e.g. relationships, doing something consistent with beliefs, etc.)</td>
</tr>
<tr>
<td>Rhythmic</td>
<td>Resonant with child/adolescent’s neural patterns which may be dysregulated due to chronic trauma or neglect &amp;/or due to current stress state</td>
<td>Provide access to recreational, creative, educational and nurturing activities that provide a predictable rhythm that the child/adolescent finds comforting and calming to help sensory integration and self-regulatory functioning</td>
<td>Educate and support key people to be involved with recreational, creative, educational and nurturing activities that provide a predictable rhythm that child/adolescent finds comforting and calming to help sensory integration and self-regulatory functioning</td>
</tr>
<tr>
<td>Respectful</td>
<td>Of child/adolescent, their family, their placement and their culture</td>
<td>Ensure that child/adolescent has access to positive contacts with those who share beliefs, culture and other interests. Ensure system demonstrates respect for child/adolescent as an individual as well as their broader human rights</td>
<td>Support and educate key people in child/adolescent’s life regarding what is important to the child and how to strengthen their sense of personal identity and self-efficacy</td>
</tr>
</tbody>
</table>
We run the risk of emphasising the sensational behaviour or ‘political’ issue, rather than paying attention to the persistent, less interesting, wearisome issues that can plague our attempts to achieve what we know is needed for the individual and collective client.

Although there are important areas to learn about each of the high-risk behaviours, including sexual exploitation through prostitution and absconding, this learning needs to be integrated into a holistic approach to each young person. We should not respond to the absconding behaviour or the sexual exploitation in isolation. Rather, we aim to keep the young person safe and strengthen his or her emotional, developmental and relational functioning. Knowledge about these and other high-risk behaviours should inform the overall assessment and plan, but not be a sole focus. We run the risk of emphasising the sensational behaviour or ‘political’ issue, rather than paying attention to the persistent, less interesting, wearisome issues that can plague our attempts to achieve what we know is needed for the individual and collective client. For example, if a young person is involved in absconding and prostitution yet does not have a place to call home or relationships he or she can trust, this is where we need to focus our attention, at the same time as responding to their immediate safety.

What are the constraints or barriers that get in the way of good practice?

Young people subjected to early life trauma and deprivation and who have extreme and persisting high-risk behaviours have a complex combination of unmet needs and difficulties for which a single, time-limited strategy will inarguably be insufficient to redress all the harms and reduce future risks. Consistent, nurturing and tailored approaches to their day-to-day experience as well as their long-term needs are essential. The earlier such an approach can occur and the longer it can be sustained is instrumental in achieving better outcomes. So why does it not consistently occur?

The question about constraints or barriers to good practice implies that something has gone wrong, or not been done, and that an adolescence with high-risk behaviours is avoidable. Although this may not always be the case, there are undeniably too many examples across many jurisdictions where high quality case planning, practice and care are not sustained, whether it is for young children or adolescents.

There are major dilemmas that should be discussed, debated, examined and otherwise wrestled with rather than minimised or overly simplified, such as:

Constraints and dilemmas that influence early intervention in a tertiary context

1. Children, especially young children, have very specific time-sensitive developmental needs. If these needs are not met in a timely way this can impact on their developing brain and their life trajectory, including adolescence. In contrast, many parents involved with child protection need significant time to make life-changing transitions, such as dealing with alcohol and other drug addiction, violence and/or mental health problems. So this is a mismatch.

2. Parents may make a number of attempts before they can sustain major changes. Yet each attempt may be experienced by the child as a false start, failure, further abuse and neglect, re-traumatisation, disrupted attachment experience, rejection and placement change. Here is another mismatch.
3. Some parents cannot make the requisite changes in order to effectively and safely protect and care for their children. However, it is rarely possible to determine this without providing them with genuine and tailored support, and taking considerable time.

4. Australia’s history of removing children from families – even when purportedly in their best interest – has been proven on occasion to cause serious harm, such as with the Stolen Generations and Forgotten Australians. As indicated in the United Nations Convention on the Rights of the Child, there must be a limit to the State’s power to intervene in the lives of families and a high degree of accountability should be commensurate with such power.

5. The Children’s Court adversarial approach in Victoria, Australia has a direct and indirect influence on outcomes for children, including the realised or unrealised capacity to interrupt or prevent a childhood characterised by ongoing maltreatment and multiple placements. Most cases are resolved through consent, and child protection is successful in a number of contested applications. It is also clear that if child protection was always successful in contested matters, it would be a concerning reflection on the court’s independent decision-making role. However, there are repeated calls from child protection and community service organisations regarding systemic problems, especially in placement and access decisions during interim order hearings. These decisions made early in the legal process have minimal time allowed for presentation of the issues, usually done without calling witnesses (including child protection) and yet often constraining the future options available. An indirect influence is when a child protection worker or team leader develops a pattern of second guessing the court or is told by their own legal representation to not run a particular argument for fear of losing the case, rather than due to the assessment of risk and harm to the child. These difficulties are most obvious in court matters regarding infants and young children, which can then set the scene for patterns of multiple exposures to abuse and neglect; instability of placements; inappropriate approach to access visits; and delays in permanency planning decisions.

6. Effective case planning is reliant on information gathered and analysed; workers implementing previous decisions to maximise realistic and supported opportunities for the family; the case planner being informed by the information provided as well as their own access to the files; and their skills in decision-making and communication. If case planning is not privileged through professional development for the decision-makers, and the necessary time to make these important decisions, then it is more likely that some decisions will be flawed. However, the essence of an effective case planning process is also in the implementation of these decisions. Many decisions made early in a child’s pathway in the statutory system relate to particular tasks that the parents are required to do in order to work towards change. If these focus too much on compliance with tasks rather than on evidence of actual change, then it undermines what is trying to be achieved. Similarly, if the focus is on the decisions and not on the implementation, then the best case planning will still be ineffective. Case planning in Victoria is meant to be informed by permanency planning principles, so that all decisions take into account the child’s long-term future, not just the immediate situation. However, it is questionable how much these processes support such a long-term view.
Constraints and dilemmas regarding workforce and other aspects of the system

7. Unfortunately, no system can guarantee that every child will receive a sustained, high quality child protection and care service. Systems need strategies to maximise the quality of the service; to identify and prevent potential problems; to respond when actual difficulties occur; to measure meaningful processes and outcomes; and to review and reform the system in response to intransient or new problems along the way.

8. Barriers to good practice in child practice have been well documented and include: change of workers; worker’s or supervisor’s health and wellbeing; surges or unsustainable workload; workers’ professional knowledge and skills; demoralised workforce if they feel part of a system that is doing harm; lack of effective leadership; ineffectual teams; focus on crisis rather than ongoing issues; difficulty in recruiting new staff; poor retention; and lack of collaboration with other services.

9. The balance between professional autonomy and regulation in child protection is pivotal and frequently changing. It is not the system doing a home visit, but a person, usually on his or her own. Despite access to a supervisor through a mobile phone, it is what the workers see, hear, think and do that we ultimately rely on. Effective child protection practice requires a mixture of skills and capabilities such as professional judgement; capacity to relate to children, adolescents and adults, including those distressed, angry and anxious; emotional intelligence and capacity for reflection; technical and legal knowledge and procedures; balanced personal and professional authority; collaborative approach with others; and capacity to recognise and manage their own stress reactions; just to name a few. Given what is required in these roles – the high level of accountability and the large child protection workforce — an emphasis on supervision, teamwork, review systems, guidelines and frameworks is required.

10. The child protection system requires a workforce that has access to strong positive leadership; evidence and research-informed frameworks, guidelines and policies; well-informed training and professional development; regular reflective supervision; sufficient resources to meet predictable demand and strategies to respond to unpredictable demand; effective and efficient systems; and support to develop their own professional judgement and approach.

11. Despite the difficulties within the child protection system, if equal attention is not paid to the family support system and placement system, then positive and sustainable systemic change is not possible. Each system is reliant on and influenced by the other. The workforces within the family support and placement systems share many of the same requirements regarding skills and capabilities and many of the same challenges as child protection. Although there are some differences, it is the same client group, the same broader context, often similar roles and similar constraints if not more in the community sector regarding access to resources.

12. Similarly, if adult services (such as mental health services and alcohol and other drug services) and child and family services (such as child protection, family services, placement services) do not more effectively collaborate with each other, the cycle of intergenerational trauma and disruption will continue unabated.

13. There are increasing pressures on the placement system, such as increased demand without a commensurate growth in resources; difficulty in recruiting foster parents; children entering the care system with significant emotional and behavioural problems; delays in court outcomes
leading to drift and uncertainty; the time it takes before decisions to permanently place the child away from family; complex family dynamics with some kinship care placements; and the structures and processes of residential care.

14. There is a question of the ethics of removing a child from a family due to their inability to meet the child’s needs, unless we are able to ensure that the child placed in care will have their needs met. We need to improve the system at multiple target points, such as more supported and resourced family support to prevent some children being removed in the first instance and other children being reunited in a more timely and effective manner; and a stronger out-of-home care system that is better able to meet the needs of children who are in care for either a short or long time. As mentioned in this paper, these children’s needs are the same as all children, but will be include additional needs due to the accumulation of gaps and assaults on their development throughout their life.

15. Measures of compliance with regulations, standards and key performance indicators are an inevitable element in a statutory system that can wield enormous power over the lives of individuals and families. However, an excessive focus on compliance can emphasise what is being measured rather than what is important. It can over-simplify expectations so that practice becomes process driven rather than outcomes driven.

**Conclusion**

There are many lenses that one can use to view young people with high-risk behaviours.

The first of these is the lens of the **young person**. What has happened to them? What is happening to them now? How do they see themselves, their past, their present and their future? Although the focus of this review is on their high-risk behaviour, it is unlikely that this alone is what the young person sees when they look in the mirror. The young person may be in a perpetual state of fear because of the dangers surrounding them; a state of denial and disconnection; a state of bravado and determination to survive; or may be flitting between these states – an important consideration those who are trying to care for them and keep them safe. Some of our most effective interventions may involve challenging the view the young person holds of him or herself. The key is to look beyond the way a young person behaves.

There is the lens of **adolescence**. This review has briefly touched on issues relating to normal development, healthy risk-taking, identity, self, peers, sexuality, resilience, social media, and the transition from dependence to independence or interdependence. Nowhere is this more loaded than in the discussion regarding youth prostitution. Is it a denial of their human rights not to do more to stop young people being sexually exploited? Or is it a denial of their human rights to not understand that, for some, this is a choice they **wish** to make?

[Working out when a young person] is old enough to make their own mistakes, is magnified to an almost incomprehensible degree when dealing with young people whose lives have skewed their concepts of choice, safety and relationships.
In the view of most of the literature, and this author, when this question relates to children and young people, there is no actual choice. Understanding youth prostitution within the construct of child sexual exploitation makes this clear. While parents may agonise over when a young person is old enough to make their own mistakes, this dilemma is magnified to an almost incomprehensible degree when dealing with young people whose lives have skewed their concepts of choice, safety and relationships. The role of the State in terms of societal, media and political risks are also part of this fraught issue.

The lens of culture has been largely hidden in this review of the literature, which reflects how little has been written on this issue. Some studies from the US, Canada and UK included analysis of the cultural backgrounds of adolescents. However, there were such different and unpredictable results from one study to the next that it was not possible to form conclusions or generalise to the Australian context. Victorian data shows the over-representation of Aboriginal young people in the high-risk population; accordingly more local research should be undertaken into how these problems have arisen, and what can be done to prevent and intervene more effectively.

The lens of gender is clearer in some aspects of high-risk behaviours than others. Most studies show that young women are more likely to be at risk or visibly at risk in relation to sexual exploitation and, to a lesser extent, absconding behaviours than young men. When examining the data regarding criminal activity and other indications of externalising problems, young men are more likely to be at risk. These differences are evident when seeing the over-representation of young women in Secure Welfare and the over-representation of young men in youth justice custodial services. Young men and young women are at risk of homelessness for different reasons, but all are subject to the experiences of trauma and neglect. Our approach to interventions may need to differ depending on gender and gender identity.

The lens of family and relationships is largely obfuscated by the discussion regarding the prevalence of abuse and neglect. Nevertheless, families and family identity remain important to most young people and should continue to be an element of planning and practice.

The lenses of risk and harm are overt in the concept of high-risk behaviours, but the lens of resilience also needs to be included. Understanding the common sources of harm for many of these young people gives insight into what may increase the probability of future harm. It certainly provides a means of understanding some of their current behaviours. The concept of cumulative harm is palpable when looking at the lives of many of these young people. As the meaning of high risk is often different for adolescents than it is for young children, so is the issue of whether optimistic or pessimistic practice is considered the greater challenge. The focus on resilience is important in thinking about how to promote resilience and as a means of engaging the whole young person and not just their behaviours.

The lens of out-of-home care and residential care has shown the program and policy development associated with high-risk adolescents, particularly the shift from institutional and closed systems to community-based and more open systems. Any strategies to respond effectively to young people with high-risk behaviours must take into consideration the out-of-home care system and how it can better meet their needs. Meeting their needs will more likely reduce their risks.
The lens of the **statutory service system** is another key feature of this review as it is the State Government’s involvement that has created some of the constructs, such as High Risk Youth Schedule, Secure Welfare Services, the role of the Commission for Children and Young People and the State as a parent. It is this lens that taps into the public perceptions and media perspective – both in terms of blaming the young person and/or blaming the system. This entails organisational and political risks that cannot be ignored, but that should not drive practice or be equated with the risks to the young person.

The statutory service system also involves the Community Service Organisations (CSO) contracted by the State to provide most of the care for these young people, some of the case management and some of the therapy. Whether it is the State or a CSO, this review has pointed to the importance of leadership and strong management as a part of any viable long-term strategy.

The lens of **history** has provided an overview of how we have changed the way we use research, the nature of the service system and the way we understand risk and adolescence. It is also the lens by which young people may view their own lives and the reasons for their limited or lack of choices.

The lens of **science** is increasingly available as we integrate knowledge and practice. One of the tough questions is: are there young people for whom it is too late, for whom we cannot hope to have a positive or safe future?

Studies from neuroscience provide a particular lens for this question. On one hand, this body of science tells us of the crucial importance of the early years and the imperative for early intervention. The same science, however, shows that the brain is plastic and the human capacity for change is immeasurable. This science guides us in that canyon between hope and pessimism by exploring the question of how we can use our understanding of the brain to increase the chances of positive change and growth.

The lens of the **future** is, of course, where we hope to be. How can we use research, practice-wisdom, opportunities and our increasing body of knowledge to tackle complexity? What are the goals we are aiming for with this high-risk population? For example, is our goal to have fewer young people whose behaviours place themselves and others at risk? Or is our goal to more effectively respond to the needs of those young people who have high-risk behaviours in order to provide them with their own sense of a positive future? Presumably it is both these goals and more.

*Science guides us in that canyon between hope and pessimism by exploring the question of how we can use our understanding of the brain to increase the chances of positive change and growth.*
References


Barnado’s (2011). *Puppet on a string: The urgent need to cut children free from sexual exploitation*. Barnado’s, Essex.

Barnado’s (2012). *Cutting them free How is the UK progressing in protecting its children from sexual exploitation?*, Barnado’s, Essex.


Berry, M. (2005a) “Why do we need evidence in our practice? How do we do it?” University of Kansas (paper on Berry Street Victoria website (www.berrystreet.org.au)


Chanon Consulting (2014). The range of health impacts which can result from child sexual exploitation, Barnado’s, [www.barnado’s.org](http://www.barnado’s.org)


Clark, R. (2000). *It has to be more than a job: A search for exceptional practice for troubled adolescents*. Deakin Human Services Australia, Malvern.


Department of Human Services and Victoria Police Sex Crimes Squad (2013). Working with adolescents who are at risk of sexual exploitation, Melbourne, PowerPoint presentation.


Morton, J., Clark, R., & Pead, J. (1999). *When Care is Not Enough: A review of intensive therapeutic and residential service options for young people in out-of-home care who manifest severe emotional and behavioural disturbance and have suffered serious abuse or neglect in early childhood*. DHS, Victoria


Phoenix, J. (2002). In the name of protection: Youth prostitution policy reforms in England and Wales, Critical Social Policy, 22(2), 353–375.


## Appendix One: Examples of Evidence-Based Practices

<table>
<thead>
<tr>
<th>Practice/ Interventions</th>
<th>Websites/Publications where it is listed as some level of evidence-based practice and/or meta-analyses that review the evidence</th>
<th>Client group</th>
<th>Description of practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivational Interviewing (Miller &amp; Rollnick, 2002) or Motivational Enhancement Therapy</td>
<td>Lundahl et al (2010) reviewed 119 studies relating to Motivational interviewing shows it has a small but significant positive effect regarding range of problems, not just AOD problems., eg gambling, and general wellbeing</td>
<td>All ages</td>
<td>Short-term counselling approach to help people explore and resolve ambivalence towards behavioural changes.</td>
</tr>
</tbody>
</table>
| Promoting Alternative Thinking Strategies (PATHS) | • Blueprints for Violence Prevention ▲  
• Oregon mental health website ▲  
• Center for Substance Abuse Prevention - SAMHSA ▲  
• Milhalić & Aultman-Bettridge ▲  
• Center for Mental Health Services ▲  
• Communities that Care ▲  
• Department of Education ▲  
• Sherman et al – Preventing Crime ▲  
• Surgeon General’s report on youth violence ▲  | 5-12 year olds at school | School based program promoting emotional and social competencies and reducing aggression and behaviour problems. Teachers include 3 X 30 minute sessions a week. Based on the ABCD (Affective-Behavioural-Cognitive-Dynamic) model of development. |
| Multidimensional Treatment Foster Care | • Blueprints for Violence Prevention ▲  
• Oregon mental health website ▲  
• Center for Substance Abuse Prevention – SAMHSA ▲  
• Department of Education ▲  
• Strengthening America’s Families ▲  
• Surgeon General’s report on youth violence ▲  
• Supported by a meta-analysis by Macdonald and Turner (2008) but some caution re over-generalisations of findings | 3 to 18 year olds | Treatment Foster Care that provides close supervision, care team including carer, mentoring adult, 24/7 access to support |
| Multisystemic Therapy (MST) | • Blueprints for Violence Prevention ▲  
• Oregon mental health website ▲  
• Center for Substance Abuse Prevention - SAMHSA ▲  
• Strengthening America’s Families ▲  
• Saunders et al-Child Physical & Sexual Abuse Guidelines ▲  
• Surgeon General’s Report on youth violence ▲  
• However, a meta-analysis has cautioned against overly stating this as evidence-based (Littell, 2004) | 10 to 18 year olds with problem behaviours | Outreach service targeting the young person’s ecology, multiple interventions, 4 to 6 months |
| Trauma Focused CBT | • NCTSN ▲  
• Kauffman Report ▲  
• Oregon mental health website ▲  
• Center for Substance Abuse Prevention - SAMHSA ▲  
• Saunders et al-Child Physical & Sexual Abuse Guidelines ▲  | Children with trauma symptoms – 3 to 18 year olds and/or their parents/carers. | CBT, designed to reduce negative emotional and behavioural responses and correct maladaptive beliefs. Also supports non abusive parents/carers. 12 – 16 sessions |
| Brief Strategic Family Therapy | • Blueprints for Violence Prevention ▲  
• Oregon mental health website ▲  
• Center for Substance Abuse Prevention - SAMHSA ▲  
• Communities that Care ▲  
• Strengthening America’s Families ▲  | 6-17 year olds and their families at risk or already with behaviour problems | Techniques used are joining (engaging family system), diagnosing family difficulties & strengths) & restructuring (transforming maladaptive interactions) |
| Functional Family Therapy | • Blueprints for Violence Prevention ▲  
• Oregon mental health website ▲  
• Communities that Care ▲  
• Strengthening America’s Families ▲  
• Surgeon General’s report on youth violence ▲  | 10 to 18 year olds with conduct and/or drug problems. | 8 to 12 one hour sessions. Can be up to 30 sessions. Office, school or home based settings. Engagement, behaviour change and generalisation phases. |
| Multidimensional Family Therapy | • Oregon mental health website ▲  
• Center for Substance Abuse Prevention – SAMHSA ▲  
• Strengthening America’s Families ▲  
• Communities that care ▲  
• National Institute of Drug Abuse ▲  | Substance abusing adolescents | Home based family based program at multi levels, working with parents and YP together and separately. Solution focused |
<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Target Group</th>
<th>Key Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Transitions Program</td>
<td>Center for Mental Health Services ▲, Communities that Care #, National Institute of Drug Abuse #, Strengthening America’s Families Δ</td>
<td>11 to 18 year olds</td>
<td>Parent training sessions involving 12 parent group meetings and 4 individual family meetings</td>
</tr>
<tr>
<td>Families and Schools Together (FAST)</td>
<td>Oregon mental health website #, Center for Substance Abuse Prevention - SAMHSA ▲, Center for Mental Health Services Δ, Strengthening America’s Families</td>
<td>4-14 yr old children and their parents via schools</td>
<td>A multifamily group intervention aimed at reducing anxiety &amp; aggression and increasing social skills</td>
</tr>
<tr>
<td>Abuse Focused CBT D. Kolko, et al.</td>
<td>NCTSN Δ, Kauffman Report ▲, Saunders et al-Child Physical &amp; Sexual Abuse Guidelines Δ</td>
<td>Children and adolescents and their physically abusive parents</td>
<td>CBT skills to enhance emotional control and reduce violence; 12 - 24 sessions; clinics or alternative residential settings</td>
</tr>
<tr>
<td>Home Based Behavioural Systems Family Therapy</td>
<td>Oregon mental health website #, Center for Substance Abuse Prevention – SAMHSA Δ</td>
<td>6 to 18 year olds involved in or at risk of juvenile justice and drug abuse</td>
<td>A modification of functional family therapy to work with higher risk youth and families. Less directive and more empathic in earlier stages.</td>
</tr>
<tr>
<td>Eye Movement Desensitisation Reprocessing (EMDR) F. Shapiro (<a href="http://www.emdr.com">www.emdr.com</a>)</td>
<td>Oregon mental health website #, Saunders et al-Child Physical &amp; Sexual Abuse Guidelines</td>
<td>Children and adults who have traumatic memories with PTSD</td>
<td>Multi-component therapy using desensitisation/ reprocessing, positive cognition. 2 - 3 sessions</td>
</tr>
<tr>
<td>Aggression Replacement Training (ART) (<a href="http://www.uscart.org/new">www.uscart.org/new</a>)</td>
<td>Department of Education Δ, Sherman et al., - Preventing Crime #</td>
<td>Children and adolescents with aggressive behaviours</td>
<td>Teaches a curriculum of prosocial, interpersonal skills; anger control training; and moral reasoning training.</td>
</tr>
</tbody>
</table>

▲ = model or highest ranking in various evidence-based classifications; 
Δ = promising or second highest ranking in evidence-based classifications; 
# = evidence-based, but not distinguished in terms of level of evidence; 
No symbol = third or lower ranking in evidence-based classifications