Safeguarding
Young People in Care

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Background and Framework

COLOFON

This report is one of the products of the Erasmus+ project ‘Safeguarding Young People in Care’.

Safeguarding Young People Care is a collaboration of university partners Absalon University College (Denmark), Amsterdam University of Applied Sciences (The Netherlands), Artesis Plantijn University College (Belgium), University of Strathclyde (United Kingdom) and work field partners Fonden Clemens (Denmark), Spirit / Qpido (The Netherlands) and Vzw Wingerdbloei (Belgium).

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SUMMARY

Over the last decade, many (European) countries have created special committees or conducted special investigations into the occurrence of sexual abuse in residential and/or foster care. Many of these studies concluded that children and young people in care are at a greater risk of being sexually abused, compared to youth growing up at home. However, the extent and scope of sexual abuse which has historically occurred in residential and/or foster care remains contested and is highly controversial.

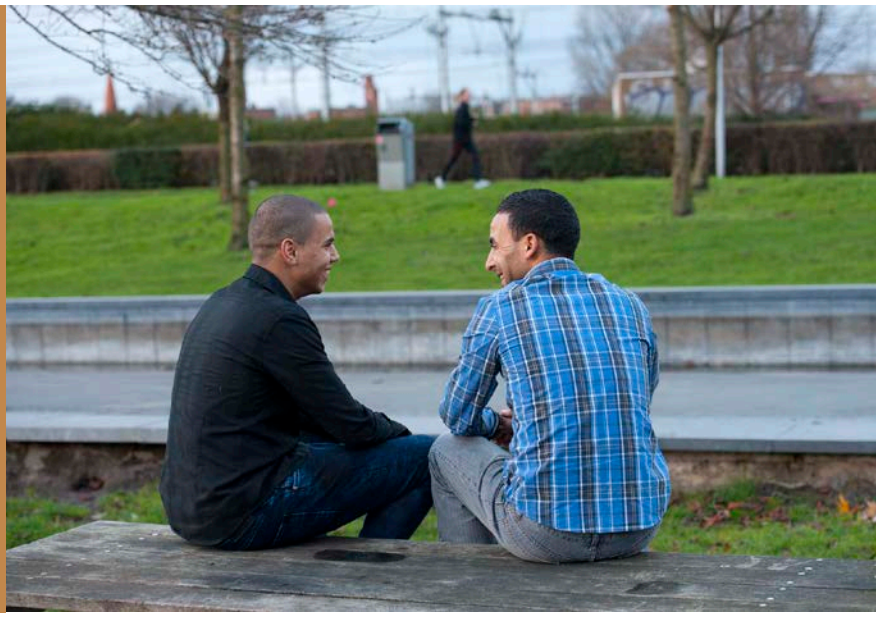
Although a broad range of factors are involved, one issue that is of crucial importance in the prevention of sexual abuse is paying attention to the healthy sexual development of children and young people in care. This sounds easy, but it isn't easy at all. Ideas about relationships, intimacy and healthy sexual development differ between people and countries. It's a sensitive subject that many professionals working in care find difficult to talk about.

As most professionals working in care in Europe graduate from schools of Social Work, social work education should prepare (future) professionals to address this issue. Although some authors have addressed this issue, in general, social work education does not pay sufficient attention to the subject. This project aims to help (future) professionals build competencies on this specific subject by providing the following products:

1. An international summer school on the subject of sex and sexuality, for social work students.
2. An online course on the subject of sex and sexuality for professionals working in residential care or working with foster parents.
3. A website with materials for European lecturers who teach future social workers on the subject of sex and sexuality.
4. A reflection instrument as a tool for on-the-job training on the subject.

These products are based on a set of practice based core competencies that professionals should develop in order to be able to provide care and upbringing on the theme of sex and sexuality. Next to that five central themes were used to order the development of modules.

SAFEGUARDING YOUNG PEOPLE IN CARE



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1 INTRODUCTION

This document describes the background of, and framework for, the 'safeguarding young people in care' project as carried out between 1 September 2015 and 31 August 2018. The goal of the project was to develop educational materials and programs to help (future) professionals build competencies and skills in order to enable the healthy sexual development of young people growing up in care. The project was funded by the European Erasmus+ program and has been conducted through a collaboration of four Universities - Absalon University of Applied Sciences (Denmark), Amsterdam University of Applied Sciences (The Netherlands), Artesis Plantyn University of Applied Sciences (Belgium) and Strathclyde University (Scotland), and three child welfare organisations offering residential and/or foster care (along with other services): Clemens (Denmark), Spirit (The Netherlands) and Wingerdbloei (Belgium).

WHY THIS PROJECT?

The immediate reason for the project lies in the continuing concerns about the sexual abuse of children and young people in care.

From the 1980s, research[1] - mainly in the United States and the United Kingdom - started to provide evidence of the extent of sexual abuse of children and young people in out-of-home care (Kendrick, 1998). While it is generally acknowledged that prevalence rates differ amongst studies because of the different formulation of questions, different definitions of sexual abuse, current figures are known to be underestimates and girls and disabled children and young people are at greater risk of being sexually abused in the general population as well as in care (Radford *et al*; 2017). Research has not only shown that sexual abuse in care occurs but that abuse can be perpetrated by other children and young people in care, children of foster carers, as well as by foster carers and residential staff members (Kendrick, 2011; Timmerman & Schreuder, 2014).

Over the last two decades, there has been increasing political attention on sexual abuse in care because of the testimonies of care leavers, and inquiries and truth commissions (Sköld & Swain, 2015). The first national inquiry took place in Australia between 1995-1997 and was focused on the forced removal of Aboriginal children from their families. This has been followed by a similar inquiry in Canada (1996), and further inquiries in Australia and Canada, and inquiries in several European countries (Sköld & Swain, 2015, pp. 1-2).

These national investigations and reviews have also evidenced the vulnerability of young people in care to sexual abuse. The Samson Committee in The Netherlands reported that the risk of sexual abuse in residential care was twice as high as outside residential care (Committee Samson, 2012). In Scotland, a systemic review of abuse in residential schools and children's homes from 1950 to 1995 also highlighted this issue (Shaw, 2007). As did In Australia, the Royal Commission into Institutional Responses to Child Sexual Abuse started its work in 2013 and has investigated the nature and extent of sexual abuse, and how institutions like schools, churches, sports clubs, government and religious organisations, and residential settings have responded to allegations and instances of child sexual abuse (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017). In Belgium, a helpline for sexual abuse (helpline 1712) has been introduced, in response to a key publication on sexual abuse in Flanders (Final report expert panel 2013). Even though there is little data on the prevalence of sexual abuse in Danish youth care settings, there has been an increased focus in recent years on measures against sexual assaults, according to the National Social Board in Denmark.

[1] See chapter 3 for a more detailed overview of the existing research.

An important conclusion of the inquiries and investigations is that professionals working in care settings often lack the competencies and skills to address sex and sexuality, assist young people's healthy sexual development, and safeguard children and young people from abuse.

As most professionals working in care in Europe graduate from schools of Social Work, social work education should prepare (future) professionals to address this issue. Although some authors have addressed this issue (see for instance, Rowntree, 2014; Bywater & Jones, 2007), in general, social work education does not pay sufficient attention to the subject. This project aims to help (future) professionals build competencies on this specific subject by providing the following products:

5. An international summer school on the subject of sex and sexuality, for social work students.
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2 YOUNG PEOPLE IN CARE

Article 20 of the UN Convention on the Rights of the Child highlights that children who cannot be looked after by their own family have a right to special care and must be looked after properly. Children and young people enter care for a wide range of reasons, and, in 2009, the UN adopted the "*Guidelines for the Alternative Care of Children"*, and, in 2012, the report "*Moving Forward: Implementing the 'for the Alternative Care of Children'"* (Cantwell, *et al.,* 2012) was published.

The 'Guidelines' acknowledge that all decisions concerning alternative care should minimize disruption and help reintegration with family. Removal of a child from the care of the family should be seen as a measure of last resort and, whenever possible, temporary and for the shortest time possible. There should be a range of alternative care options, and while priority should be given to family and community-based care, placement in residential care should be made where such a setting is specifically appropriate, necessary, and constructive for the individual children concerned and in their best interest.

From research we know that young people in out-of-home care generally speaking stem from troubled backgrounds and have a range of special needs. In this chapter, we briefly describe the characteristics of young people in care.

CHARACTERISTICS OF YOUNG PEOPLE IN CARE

Out-of-home care can roughly be divided in three groups: foster care, (small) family-style group homes and residential care (Leloux-Opmeer, Kuiper, Swaab & Scholte, 2016; Cantwell *et al.* 2012). However, the balance between different forms of care varies markedly in different countries (Ainsworth & Thoburn, 2014) Children enter care for a range of reasons. In developed countries, children and young people can be categorized in three main groups: those who have been subject to abuse and neglect, young offenders and young people with behavioral difficulties, and children and young people who are in care because their parents are not in a position to look after them (for example, because of physical or mental illness, substance abuse, or offending) (Kendrick, 2015; Forrester, Goodman, Cocker, Binnie & Jensch 2009). In developing countries, major events such as disaster and disease have had significant impact, the largest child welfare problem in many developing countries is that of children who are orphaned – through HIV/AIDs, natural disasters or war (Abebe, 2009; Mushunje, 2018).

Leloux-Opmeer, *et al.* (2016) carried out a scoping review of the characteristics of children and young people in care in Europe, North America an Australia[2]. Generally speaking young people in care have to deal with trauma and attachment-related problems related to issues of physical, emotional and sexual abuse, and domestic violence. Children and young people in care have suffered from physical or emotional abuse far more than the average with percentages ranging from 5 to 45 per cent for children in foster care, 28 per cent for children living in family-style group homes and 15-63 per cent for children in residential care. Similarly, figures for sexual abuse range between 10 per cent and 29 per cent for children in foster care and between 10 per cent and almost 50 per cent for children in residential care Leloux-Opmeer et.al., 2016). This study also identified that at least one in three children had a parent with a mental illness and one in five had a parent with an alcohol or drug problem. Children and young people in residential and foster care experienced high levels of) behavioural problems.

DIFFERENCES

Although all young people growing up in care can be characterised as a vulnerable group with special needs, there are differences between young people growing up in the different types of care. Generally speaking, residential care caters for an older age group, predominantly boys with social and behavioural difficulties. Foster care tends to cater for young children who are in care for reasons of abuse or parental absence. Emotional, health and behaviour problems are the most chronic in the group in residential care, and this group shows most difficulties in peer relations (Leloux-Opmeer et.al, 2016).

Del Valle and Bravo (2013) conclude based on a detailed international review that the residential care population is primarily adolescent (around 80 per cent), demonstrates serious behavioural problems, mental health disorders or serious disability issues, and isin many cases from a minority (immigrant) background.

The issue of refugees and asylum seekers has impacted on care system in many countries.These adolescents, from (North) Africa (mainly in the South of Europe) or from war-torn areas like Iraq, Somalia, Syria (Northern Europe) have particular special needs because of trauma, their age, and their cultural backgrounds, and raise new challenges for professionals working with children and young people in care.

3 SEXUAL ABUSE IN CARE

National investigations and inquiries in several countries have generated political and professional attention on the subject of the sexual abuse of children and young people in care. There has also been a range of research on the subject over the past 40 years or so. In this chapter, we highlight some of the key issues, without having the intention to provide a full overview of the existing research on the subject.

DEFINITION

An early framework for abuse of children in care was provided by Gil (1982). She identified three aspects: physical and sexual abuse; programme abuse; and system abuse. Physical and sexual abuse is like abuse which occurs in family situations but is perpetrated by the professional carer, foster carer or other individual. Programme abuse occurs when "programs within a facility are below normally accepted standards; have extreme or unfair policies; or rely on harsh, inhumane, or unusual techniques to teach or guide children" (Gil, 1982, p. 10). Gil suggests that the third type of abuse, system abuse, is the most difficult to define, acknowledge or correct and gives examples of the damaging effect of 'foster care drift' and multiple placements to highlight the abuse "by the immense and complicated child care system, stretched beyond its limits and incapable of guaranteeing safety to all children in care" (Gil, 1982, p. 11). Stein (2006) identified four dimensions in the abuse of children in care: individual direct abuse, programmed or sanctioned abuse, organised/systematic abuse and system/system outcome abuse.

In their study of peer violence in residential care, Barter et al (2004) define sexual violence as: "experienced by young people as abusive and sexual, involving for example, 'flashing', touching of sexual body parts, coerced sexual contact and rape." Radford et. al. (2017) suggest that "children living in care experience similar forms of physical violence, sexual and emotional abuse and neglect as do children living with their families in the community, however there are differences in the nature and possibly the impact of the abuse when this happens to children living in residential or foster care" (Radford et al, 2017). Stein (2006) also highlights that different types of abuse are related and co-occurring, so that for example, children who are sexually abused are also often emotionally and physically abused as well.

GENERAL POPULATION

Studies among the general population show that child sexual abuse is the least frequently reported form of abuse with for instance about 4 per cent for all children and young people in The Netherlands (Alink et.al., 2011) and 2.2 per cent in the UK (Finkelhor *et al.*; 2014).[3] Prevalence rates for child sexual abuse in studies like these (usually as part of wider studies of child abuse) vary because of different definitions of sexual abuse, the different formulation of questions, and differing respondents in the research (Radford *et al*; 2017). It is generally acknowledged that current figures are underestimates (Radford *et al*; 2017).

Studies show significant gender differences in prevalence rates for sexual abuse. With the lifetime prevalence rate for girls for instance ranging between 7.2-13.9 per cent while that for boys being between 2.8-4.1 per cent (Pereda, Guilera & Abad, 2014; Radford *et.al.*; 2017). Some research has found that disabled children may report significantly higher rates of child sexual abuse than non-disabled children, although other research has found little difference in reported rates of abuse (Radford *et al.*, 2017). There is also evidence that children who experience certain types of abuse (physical violence, child sexual abuse or maltreatment) are more vulnerable to experience further abuse and to experience multiple forms of abuse (polyvictimisation) (Radford *et al.*, 2017).

[3] The Dutch study consulted professionals working with children and young people. The UK study was a national telephone survey with a representative sample of 4,503 children, youth and parents/caregivers. In this study sexual abuse by a caregiver was reported by less than 1% of children, 0.7% identifying this during childhood and 0.1% saying it had happened in the past year.

CARE AS A RISKY ENVIRONMENT

In the 1980s, research in the United States started to provide evidence of the extent of abuse of children in out-of-home care. Blatt and Brown (1986) present information on 232 reports of alleged child abuse and neglect incidents made between October 1980 and September 1983 in New York State Office of Mental Health (OMH) operated psychiatric facilities, and 13.8% involved sexual abuse. Groze (1990) collected information from the files of a large southwestern state agency which investigates allegations of mistreatment of children in the custody of the state residing in state-operated and private mental health, child welfare and juvenile correctional institutions. 609 allegations were made in the two years, 1985/86-1986/87, and 110 of these allegations were confirmed. Sexual abuse was alleged in 6.6% of cases, and 22.5% of these were confirmed. This means that 8.2% of confirmed abuse involved sexual abuse.

Over the years, further research has built on this. In the US, for instance, Spencer and Knudsen (1992) provide data for the state of Indiana between 1984 and 1990 to be calculate a rate for maltreatment in institutions. Sexual abuse was the most frequent form of abuse in residential homes with a rate of 70.20 per 1,000 children compared to 6.14 per 1,000 in state institutions, 8.54 per 1,000 in hospitals and other facilities, and 5.23 per 1,000 in foster homes. This compared to sexual abuse maltreatment rate of 2.42 per 1,000 in the child's family home. (Spencer and Knudsen, 1992, pp. 488 - 489). A more recent study (Baker et. al., 2006) analysed data of 399 young people known to have been sexually abused. The majority (92.8%) were abused by persons outside the residential care system but 26 (7.2%) were sexually abused while in residential care. Boys were found to be more likely than girls to be sexually abused in care, 9.8% of boys being abused while in residential care compared with 3.9% of girls. Other research has shown the prevalence of sexual abuse in foster care, with foster carers being the perpetrators in about 40 per cent of the reported cases. Foster siblings and others were more frequently designated as perpetrators (US: Benedict et al, 1994, p. 580; UK: Hobbs *et al.*, 1999).

PEER ABUSE

While much of the concern about the abuse of children and youth in residential and foster care has focused on abuse by staff and carers, abuse by other children or young people in the care setting is also a major issue (Kendrick, 2011; Timmerman & Schreuder, 2014). Two early studies of abuse in out-of-home care settings in the USA found that a significant proportion of the perpetrators of sexual abuse in care were other children or young people (Rosenthal *et al.*, 1991; Spencer and Knudsen, 1992, p. 488).

A number of studies in the UK have highlighted sexual abuse by other children and young people. Barter *et al*. (2004) studied in detail the nature of peer violence in residential child care, to gain the experiences of 71 children and young people – aged between 8 and 17 – and 71 staff members from 14 children's homes. They found that reports of unwelcome sexual behaviours were low. Girls were three times more likely to report this than boys, and experienced the most serious abuse including rape. Most perpetrators were male and all the incidents involved some degree of coercion. Half of these incidents were not reported to staff, although they were disclosed to other young people. Unlike physical violence, staff did not generally locate incidents of sexual violence in relation to wider power dynamics between the young people concerned, and the lack of confidence expressed by staff in addressing issues of sexual abuse and violence contrasted with the systematic approach they took with racist abuse (Barter et al. 2004, p. 51).

In their study of children's homes in England, Gibbs and Sinclair (2000) asked young people whether anyone had tried to take sexual advantage of them, either before they had moved into the children's home or afterwards. Over a third of the female residents (37%) but only nine of the male residents said that this had happened before admission. Nearly a quarter (23%) of the females and 7 per cebt of the males said that it happened after they were in residential care (Gibbs & Sinclair 2000, p. 251). However, Gibbs and Sinclair also make the important point that the rate of sexual harassment is not greater for residents when they move into the children's home. 22.6 per cent of residents were taken sexual advantage of before they moved into the home compared to 13.4 per cent after (Gibbs & Sinclair 2000, p. 250).

Attar-Schwartz (2014) researched sexual abuse in care by peers and found that 40 per cent of the 1,309 11 to 19 year olds surveyed said they had this experience, with similar rates for boys (40.1%) to girls (38.7%). Radford *et. al*. (2017) point out that this study did not ask young people about

rape or penetrative sex as the researchers considered that this was so rare an experience, it was not necessary to ask about it.4 Working with Children and young People in Care

4 WORKING WITH CHILDREN AND YOUNG PEOPLE IN CARE

We have seen that although most countries provide for residential and foster care, countries differ in the way the child welfare system or child protection is organised, and the balance between residential and foster care (Ainsworth & Thoburn, 2014). Cultural factors play a crucial influence here (see for instance Del Valle and Bravo, 2013). Likewise, definitions of residential child and youth care vary from country-to-country and culture-to-culture. In their overview of residential care in Europe, Islam and Fulcher (2017) use a broad definition of residential care which is applied to homes, orphanages, hostels, schools, centres, residences, colleges, refugee camps or institutions.

As in foster care, the common characteristic is that young people are living there 24 hours a day and are cared for by professionals which help them grow up which " – *fundamentally involves relationships with children and young people through which social competencies are nurtured, personal learning and achievements are promoted, and that opportunities for a 'good up-bringing' oriented towards healthy living and holistic personal development are available for each child – every day".* (Islam & Fulcher, 2017, p,20; see also, Cantwell *et al.* 2012).

CARE, UPBRINGING AND THERAPEUTIC TREATMENT

Professionals as well as foster parents combine care and upbringing and because of the vulnerability and special needs of children in care, they provide therapeutic treatment and education to enable the healthy development of the young people in their care (figure 1). in order to address the serious emotional and behavioural problems of young people in care, most foster parents and professionals working in care also focus on problem reduction by (consciously) applying specific (usually cognitive behavioural) techniques (like for instance modelling). Especially in residential care this will be done within the frame of a care and treatment plan. In addition, young people growing up in care – especially in residential care – may have specific interventions / therapies assigned to them (like for instance EMDR, to reduce trauma related symptoms). Residential care (and to a lesser extent foster care) could be described as being built up from distinct but closely connected, elements: 1) care and upbringing, aimed at healthy development, and 2) therapy and treatment, aimed at problem reduction (figure 1).

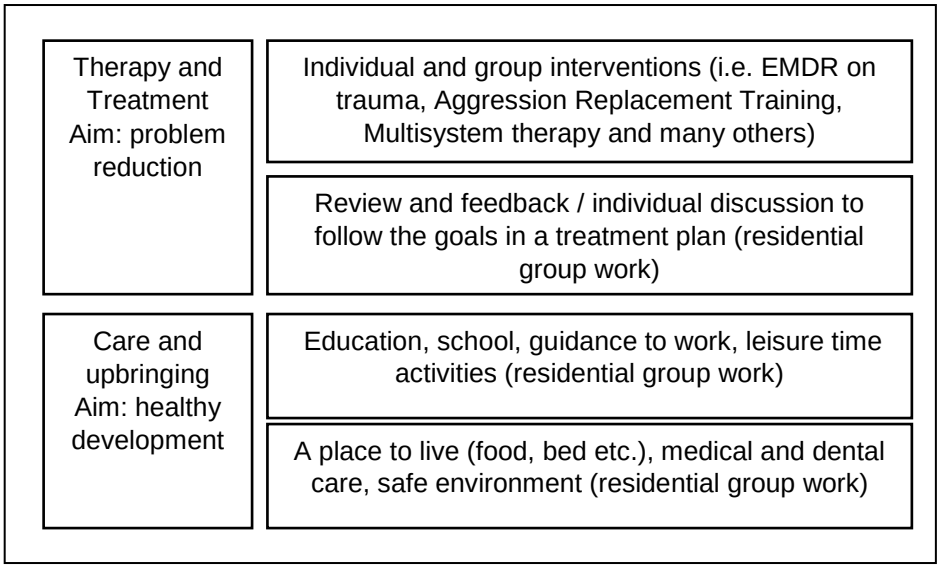

Figure 1: residential care elements (from Boendermaker et. al, 2013, p. 4)

The balance between care and upbringing, and therapeutic treatment will vary in relation to the individual needs of children and young people. Principles for working with children and young people in care involve: ensuring children are safe from harm; working in partnership with families; working with communities, cultures and wider social networks; based on deep personal relationships between children and their carers; and built on evidence-based models or strategies for practice (Whittaker *et al.,* 2016).

PREVENTION

Because of the vulnerability and special needs of the young people living in care, safeguarding and protection is of central importance. Adapting a Public Health model of prevention provides a useful focus. Such a model distinguishes between primary, secondary and tertiary interventions that target universal, at-risk and affected populations respectively (based on Quadara & Wall, 2012, in: McKibbin, 2017, page 376). Based on a scoping review, McKibbin (2017) shows that primary prevention of harmful sexual behaviour in residential care includes relationships and sexuality education for children and young people living in care, as well as training of professionals working in care in providing this.

Two specific educational programs for young people were found in the review, but, as the author states; "effective prevention education indicates that one-off programs are ineffective in achieving attitudinal and behavior change. Instead, prevention education must be delivered flexibly with both formal and informal components, and most take a whole-of-setting approach" (Gleeson et. al., 2015 in McKibbin, 2017, page 380).

Secondary prevention measures would involve applying a specific group program for young children (under twelve) showing problematic sexual behaviour to prevent further development of harmful behaviour. An example of tertiary prevention is working with specific, individual trauma-based therapy sessions for a young person showing harmful behaviour after being abused at home (McKibbinn, 2017).

THIS PROJECT

This project focuses on the development of educational materials and programmes to help professionals build their competencies and skills and enable the healthy sexual development of young people growing up in care. This means that the project focuses on providing a safe place to live, where a young person is cared for, supported and educated. It is important that work with children and young people acknowledges their characteristics, vulnerability and special needs. Drawing on a public health model, we see the importance of preventive strategies aimed at all children and young people in care. While this project does not focus on the therapeutic interventions that may be needed for victims of sexual abuse and for sexually aggressive children and young people, it is important that professionals understand and recognize these needs and know what interventions and programmes exist to help children and young people.

5 RISK FACTORS IN CARE

What do we know about the causes of sexual abuse in residential and foster care? A recent and detailed literature review commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse in Australia gives a thorough overview of the risk and protective factors involved in sexual abuse in care (Kaufman & Erooga, 2016). The study shows that these can be categorised in terms of factors related to victims, to perpetrators and to institutions.[4] Like the national reviews and inquiries, the authors show that girls, children and young people from troubled families and disabled children and young people are at more risk of sexual abuse. Especially the fact that these vulnerable groups use to live together in residential facilities, with little control over their daily activities is a risk factor. Professionals expect them to be compliant and well behaved, there is a clear power difference between children and care-givers and children "depend on adults for their survival" (page 70). Kaufman et al. (2016) stress the importance of creating a culture where children have a voice regarding what happens to them.

PROFESSIONALS AS PERPETRATORS

According to Kaufman & Erooga, little research is available on profiles of adult perpetrators. So far, no clear profile of a typical sex offender exists. But research does show 1) that selection of professionals based on a criminal record is not effective and 2) that perpetrators turn out to invest in building relationships not only with children and young people but also with their caregivers (including other professionals/colleagues). Behaviours can be non-sexual in the beginning, slowly escalating. Grooming with staff / adults leads to 'desensitization' to perceive potentially risky behaviour as 'risky'[5] (think of being alone with certain children, spend an unusual amount of time with certain children or trying to see a child outside the facility). It is recognised that abuse in these situations is often perpetrated by charismatic and controlling males in positions of power (Timmerman & Schreuder, 2014)

Research and the national inquiries have identified that institutional cultures are important risk factors in the sexual abuse of children in care. The isolation and remoteness of some residential care homes and foster placements further make it difficult for cases of child abuse in these contexts to come to light (Kendrick, 2008). Kaufman et al (2016) comment on the ways in which sexual abuse may be attributed to "the charismatic leadership of men heading an authoritarian, rigidly hierarchical institution. The departmental head of Bryn Estyn Hall was able to sexually abuse many boys over a ten-year period (from 1973 to 1984) by creatinga sexualized culture that was difficult to escape. Power and intimidation were used to maintain a culture of silence, so that the abuse went unnoticed by the outside world for a long time. Grooming went hand in hand with bureaucratic power and leadership (Kaufman et al, 2017). Protective factors in this respect are: value based interviewing when recruiting professionals (are the values congruent with those of the organization?), creating a positive, child centered culture and clarity on what is and what is not considered as appropriate behaviour.

PEER ABUSE

A range of factors in the background of children and youth are important in terms of the risk of sexual abuse. Research on sexual abuse in care consistently suggests that girls are at a greater risk of sexual abuse (Euser et al., 2016). However, Kaufman et al (2016) stress that males are also abused in residential care and they are less likely to report their abuse. Males are also more often abused by other males and harbour fears of being labelled as homosexual and/or as potential offenders (Stein, 2006).

[4] Kaufman & Erooga's study covers a broad range of 'institutions' which includes schools, sporting clubs, religious organisations and for instance day care centres for young children, as well as residential and foster care.. For this chapter, we only report on the factors related to out-of-home care (page 69-74). The authors note that little research is available on home-based family care, like foster or kinship care (page 69).

[5] See Kaufman & Erooga, chapter four, for the existing information on perpetrators and grooming in institutions.

The past histories of this group of young people may have included physical and sexual abuse, either as victims or perpetrators and maltreated children are at greater risk of further abuse, revictimisation and polyvictimisation (Kendrick 2008). In addition, children who have suffered abuse and neglect can experience difficulties in developing positive and supportive relationships with their peers (Price and Brew 1998). Looked after children and young people may have experienced instability and discontinuity of care, involving several care placements and this places them further at risk.

In residential groups, but also in foster families, vulnerable children and young people are placed together. Perpetrators of abuse may be placed alongside victims of abuse (Kendrick 2004) and peer group hierarchies or 'pecking orders' turn out to be a central context in which violence was experienced by young people, and were seen as being most problematic when they were in flux (see also Brannan, Jones & Murch 1993; Parkin and Green 1997).

AVOIDANCE OF THE SUBJECT

A risk factor that Kaufmann et.al. (2016) address on the institutional level is the avoidance or absence of discussions about sex.[6] Caregivers avoid the subject as they feel it as inappropriate and believe they will encourage young people to become sexually active when they do. "Taboos around frank discussions of sex may create an environment where children are uncertain about what is and what is not appropriate or abusive" (page 70).

Also, the lack of expertise on how to best serve children with histories of abuse is noted as a risk factor and an important factor in avoiding discussions on the topic of sex and sexual abuse. Another concern of staff is "how to interact physically with a child, without it being misconstrued as sexual" (pag 70). Staff in out-of-home care settings "may be inadequately or entirely untrained in the finer points of identifying the difference between age-appropriate sexual activity and abuse." (Kaufman et al, 2016). This is particularly problematic as peer-to-peer abuse is often not reported (Timmerman & Schreuder, 2014). Also, the inadequate resources and lack of coaching and supervision of staff in residential care turns out to be a risk factor.

It is suggested in a literature review of Timmerman & Schreuder (2014) that the avoidance of the subject of sex and sexuality is in many out-of-home care settings related to a 'sexist' attitude that 'boys will be boys' and that force is a normal part of male sexuality. This is an important factor in peer-to-peer-abuse. Further, "a culture of silence regarding sex and sexual abuse" may lead to the idea that "sexual exploration includes sexually aggressive and – abusive behaviours" (Kaufman et. al., 2016, page 71). Both in foster- and kinship care and in residential care, regular visits by the child's social worker, turs out to be an important protective factor. It facilitates disclosure of abuse. But even more important as a protective factor is a 'common language' or 'vision' on sex education and the prevention of abuse in a facility. When it is clear (for children as well as professionals) what is and what is not appropriate, children feel more safe and sure to ask for help.

ORGANISATIONAL FACTORS

Creating clear expectations for young people as well as staff, as to what is seen as appropriate behaviour, value based interviewing when recruiting staff and training and coaching of staff were already mentioned as important organisational factors that influence the risk for child sexual abuse in out of home care.

Additionally Kaufman et. al. (2016) identify inadequate resources (in general) as an important risk factor for child sexual abuse in out of home care. This can be linked to lack of training or supervision of staff, poor management and poor hiring procedures. Residential workers are often overworked and underpaid and they have little say in decision-making. Tired caregivers suffering from burnout may abuse children and research has identified the way in which burnout is characterised by increasing negative attitudes towards clients or children including depersonalisation and dehumanisation (Edwards and Miltenberger, 1991; Maslach and Jackson, 1981).

The recruitment and selection of residential and foster carers has been a key issue in a number of reports and inquiries in the UK and internationally. In England, in the early 1990s, the Warner Report 'Choosing with Care' focused specifically on recruitment, selection, development and management of

[6] See also Timmerman et.al.(2012) on this subject

staff in residential child care. Among other the recommendations have to do with choosing selection exercises, involving children and young people, preliminary interviews, visits, written exercises, oral presentations and for instance group exercises). In the Netherlands the 'quality framework for prevention of sexual abuse in youth care' (Jeugdzorg Nederland, 2013) contains amongst others recommendations on the topics to be discussed in job interviews (e.g. the organisation policy on appropriate behaviour).

One of the consistent messages, however, is for improved training and support of residential child care workers and foster carers in relation to the sexual development of children and youth and sexual abuse (Timmerman & Schreuder, 2014; Kendrick, 2014; Kaufman et al, 2016; Jeugdzorg Nederland, 2013; Bernaards et.al, 2017). This includes access to specialist services and consultants, such as psychiatrists and counsellors and is important in providing support and advice to the day-to-day carers of children in care.

To close with, creating a safe environment, for young people as well as staff is seen as a central issue (Bernaards et.al., 2017; Kauffman et. al., 2016). This means giving voice to young people and staff, create an admosphere of trust and stability in groups and teams, having clear policies on what is and is not seen as appropriate behaviour (also concerning sex and sexuality) and reflection on how the work done (Bernaards et.al, 2017).

BUILDING STAFF COMPETENCIES

Improved training and support of residential care workers and foster carers is considered as the most central issue in the prevention of sexual abuse of young people growing up in care. From implementation research we know that training is usually insufficient as it is an isolated measure (Goense, Boendermaker & Van Yperen, 2015). Selection of staff, training as well as on-the-job learning (by reflecting on the application of trained competencies, in coaching or supervision) is necessary. To do this in a proper way, interventions in the organisation are necessary (for instance a quality monitoring data system, facilitative administration and/or system interventions) and depending on the organisation and the changes needs, a specific leadership style is needed (Bertram, Blase, Fixen, 2015).

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6 SEXUALITY EDUCATION[7]

PROTECTION AND RIGHTS

Under the United Nations Declaration of Children's Rights, article 19, which came into force in 1990 and has been ratified by most countries, states declare that they will protect children from all forms of maltreatment by parents or others responsible for the child's care and shall establish appropriate social programs for the prevention of abuse and the treatment of victims. And in article 34, states declare that they shall protect children from sexual exploitation and abuse, including prostitution and involvement in pornography.

Also, the World Health Organization is engaged in the development of sexual rights, which are seen as a specification of Human rights in the area of sexuality.
These sexual rights are: "Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

1. attain the highest standard of sexual health, including access to sexual and reproductive health care services;
2. seek, receive and impart information related to sexuality;
3. sexuality education;
4. respect for bodily integrity;
5. choose their partner;
6. decide to be sexually active or not;
7. consensual sexual relations;
8. consensual marriage;
9. decide whether or not, and when, to have children; and
10. pursue a satisfying, safe and pleasurable sexual life (WHO, 2006).

In many countries – and in this project - these sexual rights are recognized and form the basis for program development. Also, it has been increasingly acknowledged by experts and policy makers, that sexual development is part of the normal developmental pathway of children and young people, and that children have the right to comprehensive sexual education. Comprehensive sexual education is considered to play a fundamental role in the preparation of children to take control and make informed decision about their sexuality and relationships freely and responsibly (UNESCO, 2018).

The WHO states that the training of sexuality educators is one of the key factors influencing the quality of sexuality education programs (WHO, 2010). And therefore, the sexuality educators themselves demand quality training and, in addition to training, a supportive environment in order to deliver sexuality education in an effective, enabling and inclusive way (WHO, 2010).

SEXUALITY EDUCATION

An important starting point for holistic sexuality education is the notion that sexual development is a lifelong process that starts in the early years. The physical, psychosocial and cognitive development may differ between children and are dependent on several factors. There are several developmental phases that can be discerned with regard to sexuality between the ages of 0 and 19 years (Maris, van der Vlught, Deurloo & Lanting, 2014, p.1).

Sexual health problems are the result of conditions, either in an individual, a relationship or a society, that require specific action for their identification, prevention and treatment. In order to assess which sexual behaviour is healthy and which behaviour is not, the Flag systems uses the following six categories to evaluate a situation (Frans & Franck, 2013):

[7] This chapter is based on Walpot, M. & Riss Hansen, G. (2017). *Safeguarding young people in care: summary of six core publications.* Amsterdam: Safeguarding. (http://www.amsterdamuas.com/safe/about/research-output/products.html)

1. Mutual consent
2. Autonomous consent
3. Equality
4. Age-appropriate or developmentally appropriate
5. Appropriate within the context or appropriate for the situation
6. Self-respect

According to the WHO sexuality education means “learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. Sexuality education starts early in childhood and progresses through adolescence and adulthood. For children and young people, it aims at supporting and protecting sexual development. It gradually equips and empowers children and young people with information, skills and positive values to understand and enjoy their sexuality, have safe and fulfilling relationships and take responsibility for their own and other people’s sexual health and well-being. It enables them to make choices which enhance the quality of their lives and contribute to a compassionate and just society.” (WHO, 2010, p.20). Sexuality Education provides opportunities to explore one’s own values and attitudes and to build decision-making, communication and risk-reduction skills about many aspects of sexuality (UNESCO, 2009, p.2).

HOLISTIC APPROACH

According to the IPPF, an international renowned institute that provides sexuality education around the world, “comprehensive sexuality education seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships. It views “sexuality” holistically and within the context of emotional and social development. It recognizes that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes, and values” (IPPF, 2006, p.6).

In the WHO document ‘Standards for Sexuality in Europe’ (2010a), the authors state that it is important for children and young people to be taught both the risks as well as the positive side of sexuality, so that they can take responsibility and have an open, positive attitude toward sexuality. They should be empowered and stimulated to acquire some essential skills at age-developmentally appropriate times, as part of a more general education, since this helps shape their personalities. In the holistic view on sexual education, prevention is seen as part of improving quality of life, health, and well-being and of contributing to health promotion in general. (WHO, 2010a, p. 5). The document also contains detailed information on the content of sexuaity education for distinct age groups (0-4, 4-6, 6-9, 9-12, 12-15, and 15 and up).

The vision on sexual education is based on a holistic view, which contains comprehensive sexuality education. This includes focus on the organisation, on daily pedagogic practice, personal values, personal and sexual growth and development, and on contingency plans (WHO, 2010a).
“Holistic sexual education should be based on the following principles (WHO, 2010a, p.27):
Sexuality education:

- is age-appropriate with regard to the young person’s level of development and understanding, and culturally and socially responsive and gender-responsive. It corresponds to the reality of young people’s lives.
- is based on a (sexual and reproductive) human rights approach.
- is based on a holistic concept of well-being, which includes health.
- is firmly based on gender equality, self-determination and the acceptance of diversity.
- starts at birth.
- has to be understood as a contribution toward a fair and compassionate society by empowering individuals and communities.
- is based on scientifically accurate information.

Sexuality education seeks the following outcomes (WHO, 2010a, p.27):

- To contribute to a social climate that is tolerant, open and respectful toward sexuality, various lifestyles, attitudes and values.

- To respect sexual diversity and gender differences and to be aware of sexual identity and gender roles.
- To empower people to make informed choices based on understanding, and acting responsibly toward oneself and one's partner.
- To be aware of and have knowledge about the human body, its development and functions, in particular regarding sexuality.
- To be able to develop as a sexual being, meaning to learn to express feelings and needs, to experience sexuality in a pleasurable manner and to develop one's own gender roles and sexual identity.
- To have gained appropriate information about physical, cognitive, social, emotional and cultural aspects of sexuality, contraception, prevention of STI and HIV and sexual coercion.
- To have the necessary life skills to deal with all aspects of sexuality and relationships.
- To have information about provision of and access to counselling and medical services, particularly in the case of problems and questions related to sexuality.
- To reflect on sexuality and diverse norms and values with regard to human rights in order to develop one's own critical attitudes.
- To be able to build (sexual) relationships in which there is mutual understanding and respect for one another's needs and boundaries and to have equal relationships. This contributes to the prevention of sexual abuse and violence.
- To be able to communicate about sexuality, emotions and relationships and have the necessary language to do so."

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SPECIAL REQUIREMENTS IN CARE

An important requirement for sexuality education is that young people should always feel safe: their privacy and their boundaries are to be respected. Because of the special needs of young people in care, sexuality education is to be seen as relationship and sexuality education (Hyde et. al., 2017). Issues like self-awareness, self-confidence and self-esteem are very much intertwined with the social and emotinal aspects of relationships and therefore with sexuality. The poor self-esteem of young people in care and their common inability to recognise and express emotions stresses the importance of a safe environment, "without the tread of negative responses from those with authority"(Hyde et.al., 2017, page 198).

Next to this, social skils education is largely intertwined with sexuality education, a these skills are necessary to be able to maintain mutual respectful relations, negotiate in relations in general and sexual relationships in particulair (consent, safe sex). And especially because of the lower intelligence of many young people in care, factual sexuality education is important and 'clear language' (Hyde et. al., 2017).

7 CORE COMPETENCIES

The preceding chapters show the importance of knowledge and understanding of the troubled backgrounds of young people in care, the risk of sexual abuse in care, and the importance of relationships and sexuality education for young people in care. The first year of the project was dedicated to gathering information on the core competencies needed to underpin the materials and outputs to be developed.

PROJECT RESEARCH

Two research projects were undertaken. The first one involved a review of publicly available materials in Denmark, Belgium and The Netherlands in order to search for information about the essential competencies for professionals working in care and providing relationships and sexuality education. Materials that were reviewed included: guidelines, policy documents, interventions, training programmes for professionals, educational programs, tools, and websites (Bernaards, Walpot, Riis Hansen, Moentjes, 2017). In order to be included in the review, materials needed to have been developed for residential care and/or foster care. Materials developed for other purposes, such as school interventions, were not included. After a process of collection and selection, a total of 31 items (involving 36 separate publications) were included in the review (14 guidelines/policy documents, 7 interventions, one training programme for professionals, one educational program, five tools and instruments and 3 websites).

Using a uniform coding scheme, in each of the three countries information was gathered on the knowledge, skills, and attitude required for professionals to support the healthy sexual development of young people in care;and directions for professionals on how to acquire the required knowledge, skills and attitude and behavioural characteristics (i.e., observable behaviour that displays the required competencies).

In the second research project, professionals working in care settings, and policy makers and researchers working in the field of sexuality and/or residential and foster care were interviewed. In each of the three countries, the interviews were conducted using a semi-structured interview manual, with the following main topics/questions:

1. characteristics of young people living in residential and foster care,
2. their special needs with regard to sexuality and sexuality-related issues,
3. differences with young people growing up in ‘normal’ families with regard to sexuality,
4. necessary competencies of professionals working with young people living in residential and foster care, with regard to sexuality,
5. organisational preconditions, and,
6. difficult situations for professionals with regard to sexuality-related issues.

Altogether six experts (in the field of sexuality) and seven policy makers at the institutional level were interviewed. Focus groups were carried out with 23 professionals working in residential care and 12 professionals working in foster care (Walpot, Riis Hansen, Moentjes, Bernaards, 2017).

In addition to this, small scale student research projects were used to gather information from young people themselves (Walpot, 2017). The information from these three sources is combined and integrated into five core competencies, and these were split into 17 separate elements.[8] See the next page for the five competencies and the elements. Explanation on the elements can be found in the reflection instrument at the ‘about’ page of the safeguarding website.

[8] For more information on the research and the process to get to these five competencies and 17 elements please find the two reports and a factsheet with the input of young people at the safeguarding website: http://www.amsterdamuas.com/safe/about/research-output/products.html.

CORE COMPETENCIES

1. Discussing sexuality
2. Supporting young people's needs concerning sexual development
3. Dealing with sex and sexuality in a professional way
4. Dealing with differences in values and cultures regarding sex and sexuality
5. Recognising and responding to harmful sexual behaviour

DISCUSSING SEXUALITY

1. The carer, social worker or other professional has knowledge of healthy sexual development
- Uses correct information
- Applies knowledge of the special needs of this group

2. The carer, social worker or other professional talks about sex and sexuality in a calm and positive way
- Uses neutral (non-accusatory) expressions
- Uses open and non-concealing (explicit) language
- Is visibly comfortable when talking about sexuality
- Normalises the experiences of young people

3. The carer, social worker or other professional uses existing methods and materials
- Uses methodologies
- Uses games
- Uses materials
- The professional chooses the right moment for this use

SUPPORTING YOUNG PEOPLE'S NEEDS CONCERNING SEXUAL DEVELOPMENT

4. The carer, social worker or other professional takes the young people's needs as a starting point
- Uses the knowledge of core questions of young people
- Creates relaxed situations
- Connects to the young person during conversations
- Takes the (dis)abilities of the young person into consideration

5. The carer, social worker or other professional recognises the importance of social media for young people
- Shows awareness of what's 'in' on social media
- Can explain the risks to young people in a calm way
- Supports young people in the case of social media problems

6. The carer, social worker or other professional encourages young people to form their own opinions
- Encourages young people to talk about their ideas and experiences on daily live matters
- Explains that ideas on sexuality differ between people

DEALING WITH SEX AND SEXUALITY IN A PROFESSIONAL WAY

7. The carer, social worker or other professional considers distance–proximity
- Only talks about his/her personal life when this contributes to the young person's development
- Respects the young person's privacy
- Respects the young person's personal space, and secrets

8. The carer, social worker or other professional uses language appropriate to the situation

- Checks what language the young person finds comfortable
- Uses humour appropriately.

9. The carer, social worker or other professional reacts to young people's emotions in an appropriate and respectful way

- Acknowledges emotions and thoughts
- Is available to the young person, the social worker is easy to access.

DEALING WITH DIFFERENCES IN VALUES AND CULTURES REGARDING SEX AND SEXUALITY

10. The carer, social worker or other professional knows how to deal with his/her own values and prejudices

- Shows awareness that his/her own background influences his/her behaviour
- Shows respect for different opinions
- Is aware of the difference between expressing personal opinions and providing information
- Asks for assistance in difficult situations

11. The carer, social worker or other professional knows how to deal with other people's values and prejudices

- Is sensitive about cultural and religious differences
- Corrects negative remarks
- Corrects negative behaviour

12. The carer, social worker or other professional knows how to deal with sexual diversity

- Applies his/her knowledge of sexual diversity
- Teaches young people that gender roles are not necessarily fixed
- Responds to negative remarks
- Corrects negative remarks
- Corrects negative behaviour
- Encourages young people to develop their own identities

RECOGNISING AND RESPONDING TO HARMFUL SEXUAL BEHAVIOUR

13. The carer, social worker or other professional knows the signs of harmful sexual behaviour

- Uses knowledge of risk and protective factors
- Uses knowledge of trauma-related behaviour in sexually abused children and young people
- Uses knowledge of the sexual development of children and young people with special needs

14. The carer, social worker or other professional recognises and discusses harmful sexual behaviour

- Recognises signs of harmful sexual behaviour and discusses these with colleagues
- Recognises signs of harmful sexual behaviour and discusses these with (foster) parents
- Recognises signs of harmful sexual behaviour and discusses these with children and young people

15. The carer, social worker or other professional responds adequately to the disclosure of harmful sexual behaviour (towards both victim and perpetrator)

- Knows and applies the local policy on sexual abuse
- Does not promise confidentiality
- Responds in a sensitive way.
- Does not deter (scare) the young person from talking further
- Judges the behaviour as objectively as possible
- Condemns the behaviour, not the individual
- Is aware that the emotional conditions can alter the story during time

- Creates room for young people to admit their mistakes
- Acts to prevent immediate reoccurrence
- Applies suitable consequences, to prevent consequences in the longer term
- Gives the young person a chance to a fresh start

16. The carer, social worker or other professional responds to on the spot (not severe) situations

- States what he/she is observing
- Investigates the situation, and asks what it's like for the young person in question and the others involved
- Explains what is and isn't right about the situation, and states what behaviour he/she would like to see
- Sets rules with the young person, and gives consequences as required
- Discusses the incident with colleagues
- Guides the young person in complying with the agreed upon rules

17. The carer, social worker of other professional responds to on the spot (severe) situations

- Acts to stop the behaviour immediately
- States what he/she is observing
- Explains what is and isn't right about the situation, and states what behaviour he/she would like to see
- Sets rules with the young person, and gives consequences as required
- Discusses the incident with colleagues and reports according to the rules in the organisation
- Guides the young person in complying with the agreed upon rules/consequences
- Asks what it's like for the young person in question and the others involved

8 PRODUCT DEVELOPMENT

Based on the preceding chapters, the project partners used five central themes to order the development of modules, where the competencies and their operationalization in 17 elements formed the basis of learning goals as a first step in the development of teaching materials.

CENTRAL THEMES

1. Values, rules and regulations
The way we deal with sexuality within care is largely determined by our own set of values and personal experiences. However, it is also shaped by the context within which we work: the team, the organization, and also the community in which we live. Rules, ideas, ethical standards, professional code of conduct all have an influence on our actions concerning sexuality within care.

This theme was based on the information gathered on organisational risk factors (chapter 5), the knowledge that many young people come from migrant background or are unaccompanied refugees (chapter 2), and the understanding that countries differ in the way the child welfare systemand child protection is organised. Cultural factors play a crucial influence here (chapter 4). Therefore (future) professionals need to acknowledge these ‘organisational’ and ‘cultural’ factors when starting to work with relationships and sexuality education in care.

2. Knowledge about sexual development
Research shows that many people have misconceptions concerning the development of healthy sexual behaviour. In order to react in an appropriate way, it is necessary that we know which behaviours can be expected at different levels of development.

The World Health Organization’s information shows the importance of knowledge on sexual development and offers a lot of information on this subject (chapter 6).

3. Sexual identity
Sexuality has many different aspects. As professionals, we need to be alert to the various sexual identities of our clients. We should have special concern for the LGBTQIA-group within care. Another issue of concern is the influence of the cultural and religious background of those involved.

The World Health Organization’s information (chapter 6) highlights the goal of relationships and sexuality education, to respect sexual diversity and gender differences and to be aware of sexual identity and gender roles.

4. Harmful sexual behaviour
Young people in care may be at risk of sexual abuse because of the reasons they are in care. Children and young people in care are not only at risk but also may present risky sexual behaviour. It is this combination that makes it difficult for professionals to address risk behavior in an appropriate way.

The information on the characteristics of young people in care, their (in many cases) troubled background (chapter 2), knowledgeabout abuse in care (chapter 3), and risk factors in care (chapter 4), show the importance of knowledge on the early recognition of sexually harmful behaviour of young people, and the skills needed to react to it and to deal with it (chapter 7).

5. Talking about sexuality with clients
Talking about relationships, intimacy, and sexuality can be very difficult because of a range of issues: the taboos surrounding sex and sexuality are important to acknowledge, as is the very personal nature

of the issues involved. It is important to take account of the many social and cultural prejudices involved, along with the context in which we have to work. As a professional, you need tips and advice to help find the best ‘language’ for your discussion. You also need “courage” - and an open, transparent, and supporting attitude.

This is the core theme of the project; although the other themes form the basis for it. The project’s research shows how important it is to be open and transparent and have an supportive attitute (chapter 7).

INTRODUCTION COURSE

The summer school and online course offer an introduction to the subject of relationships and sexuality education.

A summer school usually takes one or two weeks, in which students not only follow classes and study, but also travel to another city or country, meet other students and gain new experiences. Building competencies on a subject such as this requires active learning methods: role play, practice and reflection (Goense, Boendermaker & Van Yperen, 2015). Therefore, the content of a one- or two-week course can only be an introduction to the subject of relationships and sexuality education in care.

The summer school developed for this project is a two week international summer school (3 ECTS), for students who have finished their internship in residential or foster care.

The children’s services partners in the project stressed that professionals working in care usually work in teams and are under a lot of pressure (chapter 5). They do not have much time to train, reflect and learn. In addition, it is the team that has to develop a safe and open atmosphere to be able to work on relationships and sexuality education. Therefore, the children’s services partners suggested the development of an online course consisting of distinct modules of between 60 to 90 minutes, to be worked through as a team, for instance, during the weekly team meeting.

It was planned that a third output of the project would be an educational programme for social work students. However, early in the project, it became clear that the programmes of schools of social work differ to a great extent and it would be difficult to develop common programmes or modules. Contact with lecturers in the participating schools of social work established that resources and materials, to be used by lecturers in their own modules and programmes, would be very welcome. Therefore, all resources and materials developed for the summer school and online course have been made available for use on social work education programmes..

In order to ensure the value and quality of the summer school and the online course, a pilot exercise was carried out, and the evaluation of the pilot exercise was used to develop the final versions of the summer school and the online course. The evaluations can be found at: http://www.amsterdamuas.com/safe/about/evaluations/evaluations.html.

9 SUMMER SCHOOL

The summer school can be accessed via this link:
http://www.amsterdamuas.com/safe/lecturers/organizing-a-summer-school/organizing-a-summer-school.html

In the past decade, many programmes and tools have been developed to support professionals working on relationships and sexuality education and the healthy sexual development of children and young people. However, training programmes covering the basic competencies for professionals working in children's services scarce (Rowntree, 2014; Bywater & Jones, 2007). In this project, the focus is not only on the content of sexuality education (the 'what'), but also on ways to teach relationships and sexuality education as part of the care and upbringing in care (the 'how').

The five themes in the Summer school
Training competencies and skills in relationships and sexuality education is not very common in social work professional education at bachelors or masters level. Therefore, we developed a Summer School program of 3 ECTS, open to international social work students as an extracurricular activity during the summer vacation. The learning outcomes of the summer school are based on the five themes.

Following the summer school, students can:

- Identify and describe personal and professional values regarding sexuality and sexual education, and describe how they influence their work with young people in child care
- Assess the age-appropriateness of sexual development and sexual behaviour of young people in care, in order to align their interventions to the appropriate developmental stage.
- Deal with the specific needs and issues of young people in care with diverse sexual identities and from diverse cultural backgrounds
- Identify sexual health risks and risky sexual behaviour, and able to address these issues adequately to safeguard young people in care from sexual abuse
- Talk about sexuality and sexual issues with young people in c care, their parents and their colleagues in a respectful, yet clear manner.

The programme involved a variety of teaching methods and learning activities in order to address students' diverse learning styles. This included:

- Classroom activities: interactive lectures including teacher presentations and (small) group activities, such as role play, group discussion and reflection.
- Self-study: web lectures, reading, writing a theoretical underpinning, and reflection.
- Field visits
- Group, and individual, assignments such as creative assignments, a video assignment, and the development of a tool to help talking about sexuality (How to be an ambassador for sexuality education)
- A presentation of the tool which was developed with a theoretical underpinning

The themes are spread over different days to allow a learning curve. Table 1 gives an overview of the learning activities, and the time dedicated to the different themes during the curriculum of the summer school.. All materials mentioned in Table 1 can be found on the Safeguarding website.

Table 1: themes, timed dedicated to themes and learning activities

Learning goal/theme	*Day*	*Hours*	*Activities*
Values, rules and regulations	1	3	Group activity: values game, statement game Teacher presentation Video on comprehensive sex education Small group assignment using WHO document Reflection
	1	2	Field visit [9]
	3	1	Group activity: exercise
	6	2,5	Introduction to individual assignment: How to be an ambassador for sexuality education
	10	2	Self-study, individual assignment: How to be an ambassador for sexuality education (design of a tool, proposal, advice)
Sexual development	?	3,5	Teacher presentation Group activity exploring differences in one's sexual development Sexual development puzzle Web lecture Small group assignment involving short case histories: identifying signs of unhealthy sexual development in cases of children and young people in care
Sexual identity and cultural diversity	5	3,5	Classroom assignment Teacher presentation Video Group discussion Guest lecture by experience expert Reflection
		2,5	Field visit
	8	3,5	Teacher presentation Group assignment Self-assessment Small group assignment Field visit to Reflection

[9] Examples of field visits in Amsterdam are: visit to the Amsterdam Sex museum, to Pretty women (organisation for girls at risk of being forced into prostitution), to Qupido (Dutch knowledge center on sexuality and youth care, special LGBT tour Amsterdam.

Harmful sexual behavior	3	2,5	Teacher presentation: flag system Small group assignment: working with the flag system Teacher presentation: the flag system for residential youth care Small group assignment: assessing sexual behaviour of young people with special needs
	4	3	Teacher presentation: sexual health and harmful sexual behaviour
	4	3,5	Field trip
Talking about sexiality with clients	3	2,5	Self-study, individual assignment: How to be an ambassador for sexuality education (design of a tool, proposal, advice)
	6	3,5	Teacher presentation Group exercise Small group assignments using PLISSIT model and case histories Demonstration of materials, games, tools to talk with children and young people Reflection
	7	3,5	Teacher presentation on sexuality education for traumatized children Web lecture on how to work with traumatized children and group assignment Reflection Web lecture on brain development in traumatized children Classroom exercise Guest lecture and discussion with expert
	7	3	Creative assignment on sexual trauma Reflection
	8	3	Field visit
	9	4	Self-study, individual assignment: How to be an ambassador for sexuality education (design of a tool, proposal, advice)
	10	3,5	Student presentation on: How to be an ambassador for sexuality education

10 ONLINE COURSE

The online course can be accessed via this link:
http://www.amsterdamuas.com/safe/professionals/professionals.html

The free online course is designed for use in teams, to support the building of team values and norms, and to initiate a team effort in providing comprehensive relationships and sexuality education. In this way, the course not only builds individual competencies and skills, it also helps to create a supportive and collaborative environment (see: organisational issues, chapter 6).

The main purpose of the online course is to equip professionals and foster carers with the knowledge and tools safeguard and protect children and young people in care, and to support vulnerable young people in the development of safe and healthy sexual behaviour.
In the online course, the five themes are designed as five separate modules. Each module contains a range of resources and materials: short movies, online presentations, information to read, and exercises for the team. A course manual and a self-reflection instrument are also available. For an overview of the themes, learning goals and activities, see table 2.

Each module ends with a 'THINK PLAN ACT' step to help professionals and teams to work with relationships and sexuality education in between the modules, . A Reflection instrument (see toolbox) can be also used to reflect upon the issues being addressed.

Table 2: Overview of the online course

Theme	*Hours*	*Learning goals*	*Activities*
Values, rules and regulations	1 hour	**By the end of this module,** You will have knowledge about international principles. You can describe and reflect on your own frame of reference (in terms of culture, religion, sexuality and social roles) concerning intimacy, relations and sexuality. This is an essential part of a good quality of life.	Knowledge and reflections on appropriate and inappropriate contact. Knowledge and reflections on human sexual rights; Discussions on values and how values have an impact on our behaviour in addressing sexual issues THINK PLAN ACT: considerations and decisions about what the team are going to do in relation to the new knowledge and reflection on the issues
Knowledge about sexual development	1,5 hour	**By the end of this module:** You will be able to identify healthy sexual behaviour as appropriate to different age groups You will be able to identify signs of unhealthy sexual development You will be able to define goals for supportive actions, keeping the needs of vulnerable young people in mind	Knowledge about healthy sexual development; videos and exercises. Knowledge and skills about the Flag system; text, video presentation and exercises Skills in recognizing unhealthy sexual development: cases, exercise and reflection THINK PLAN ACT: considerations and decisions about what are the team going to do on behalf of the new knowledge and reflection on the issues

Sexual identity and cultural diversity	1 hour	**By the end of this module,** You will be able to create a safe environment in which children and young people are able to develop their sexual identity and orientation. You will be aware about assumptions on sexual identity.	Knowledge about the importance of being aware of sexual identity; video interview and reflection Knowledge about, and how to address, prejudices and myths about sexual orientation and sexual identity;:exercises Knowledge and skills about how professionals are addressing sexual orientation and identity: video presentation and reflection THINK PLAN ACT: considerations and decisions about what are the team going to do on behalf of the new knowledge and reflection on the issues
Harmful sexual behaviour	1,5 hour	**By the end of this module,** You will have knowledge about signs and indicators of harmful sexual behaviour and about the social complexity of situations in which signs of harmful sexual behavior emerge. You will have skills to demonstrate a reflective ability to analyze signs and indicators in order to respond to harmful sexual behaviour.	Knowledge about harmful sexual behavior and the impact of childhood trauma: video, case study and reflection Skills on how to react and what to do as a professional, including rules and regulations: video presentation, templates and reflection Knowledge and skills on prevention of abuse in residential care and skills on how to work on a safe environment; video and reflection THINK PLAN ACT: considerations and decisions about what are the team going to do on behalf of the new knowledge and reflection on the issues
Talking about sexuality with clients	1,5 hour	**By the end of this module**, You will be aware of your approach and attitude towards vulnerable children You will be able to discuss sexuality, intimacy and relationships in a calm and positive way	Knowledge about the importance of addressing and talking about sexuality with children and young people; video, text and exercises Skills in having courage and a sensitive approach in talking about sexuality THINK PLAN ACT: considerations and decisions about what are the team going to do on behalf of the new knowledge and reflection on the issues

11 WEBSITE FOR LECTURERS

The resources and materials for lecturers can be accessed via this link:
http://www.amsterdamuas.com/safe/lecturers

On the project website, all resources and materials that have been developed during the course of the project are made available. The materials include descriptions of exercises, short case histories, videos, literature, and teaching guidelines to support the learning process.

- The exercises are sorted by the five themes. For each exercise, the learning objective is specified, and a short hand-out is provided which describes practical issues and all the steps in the exercises.
- The case histories are sorted by the context: residential care and foster care. For each case, brief information about the central issue is given on a tile, and via a link the file with the complete description can be accessed. The case histories reflect situations with a range of complexity.
- Video material is provided which can serve a number of purposes such as awareness raising, explaining theory, addressing stereotypes, and giving instructions. Each video is provided with a short introductory text which explains the central theme and objective.
- Relevant literature on relationships and sexuality education can serve as inspiration or as background for lessons. This is made available through short descriptions of the content, with links to full downloads of texts that are publicly available.
- Background material that supports the teaching process is made available in the same way: a short description of the content leads to a linked document that provides more information. There is background material on classroom rules that offer a safe space for learning; on safely discussing sexuality, on the learning process of young people and on the different levels of prevention.

12 CONCLUSION

In the project “Safeguarding young people in care’ a set of practice based core competencies was developed, that professionals should have in order to be able to provide comprehensive sexuality education to young people in residential and foster care.

These competencies are clustered in five themes, and these five themes are the ‘backbone’ of the programs that were developed in order to support students and professional teams to build these competencies. For students, a summer school program has been developed which will be offered by Amsterdam University of Applied Sciences, and for professionals a free online team training program is accessible through the website. All materials are also made freely available through the project website.

Hereby, the project ‘ safeguarding young people in care’ has contributed in a sustainable way to a recognized but difficult to address need. Sexuality education is often missing because of a lack of competencies in professionals who work with vulnerable young people.

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