



Adolescents with sexually abusive behaviours and their families

Best interests case practice model
Specialist practice resource

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2012

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About specialist practice resources

The Best interests case practice model provides you with a foundation for working with adolescents and their families. *Specialist practice resources* provide additional guidance on: information gathering, analysis and planning; action; and reviewing outcomes in cases where specific problems exist or with particular developmental stages.

This resource consists of two parts: an overview of issues for young people with sexually abusive behaviours, and a practice tool to guide you when working with these young people.

Overview

What is sexually abusive behaviour?

The practice definition of sexually abusive behaviours used by the Therapeutic Treatment Board and therapeutic treatment services is:

A child has exhibited sexually abusive behaviours when they have used their power, authority or status to engage another party in sexual activity that is either unwanted or where, due to the nature of the situation, the other party is not capable of giving consent (for example animals, or children who are younger or who have a cognitive impairment). Physical force or threats are sometimes involved. Sexual activity may include exposure, peeping, fondling, masturbation, oral sex, penetration of a vagina or anus using a penis, finger or object, or exposure to pornography. This is not an exhaustive list.

Sexually abusive behaviours and the Children, Youth and Families Act

According to the *Children, Youth and Families Act 2005* (CYFA) there are two grounds on which child protection intervention may be warranted in cases where a report of sexually abusive behaviour is received:

1. The young person themselves is in need of protection (s. 162); and/or
2. They are in need of therapeutic treatment due to their sexually abusive behaviour (s. 248).

The authority to intervene in a situation involving young people with sexually abusive behaviours is established in the CYFA. Under section 248 of the Act, a court may make a therapeutic treatment order directing young people with sexually abusive behaviours to attend an appropriate treatment program. (Currently, this applies to young people aged 10–15.)

The purpose of the therapeutic treatment order is to ensure young people are able to gain access to treatment.

A therapeutic treatment placement order can be made by a court where the circumstances are such that the young person cannot remain living at home.

Parents may also need assistance protecting other children with whom the young person comes into contact and the safety of siblings needs to be carefully considered.

In cases of young people with sexually abusive behaviours, the families themselves may contact child protection seeking assistance. Where this occurs, it is important to acknowledge that the family has initiated contact and to engage with them respectfully and without blame. Some families may only require a referral to a specialist treatment provider. However, it may be that the sexually abusive behaviours manifest as a consequence of family problems or because the young person is experiencing abuse and/or neglect. Equally, it should be noted that young people from nurturing and protective families can develop sexually abusive behaviours and this may be an indicator of extra-familial sexual abuse experiences or other issues that the young person has not yet been able to disclose. Some young people may be clients of several agencies and so child protection services can be an important point of coordination in the systems around the young person.

Why a resource on young people with sexually abusive behaviours is important

Prior to the 1990s there was widespread ignorance regarding young people sexually abusing other young people (O'Brien 2008), with a system emphasis on father–child sexual abuse (Hatch 2005). It seemed ‘...inconceivable that a child could sexually abuse another child’ (Scott & Swain 2002, pp. 17). Since then, there has been a growing recognition not only of the prevalence of sexual abuse of children by adults, but also that sexual abuse and assault of young people by other young people does occur, and is more than experimentation and curiosity. In fact, research indicates that approximately 30–60 per cent of childhood sexual assault and sexual abuse is perpetrated by other children and young people (Hunter 1999; Weinrott 1996).

Adolescent sexual behaviour: normative through to abusive

Understanding the differences between what is sexually abusive behaviour and what is age-appropriate sexual behaviour can be challenging for professionals and caregivers alike. Those who come into contact with youth need to understand and be able to differentiate between the two (Barnett, Giaquinto, Hunter & Worth 2007). Should the differences not be understood and acknowledged, then there is a risk of varied interpretations being made of the behaviours that may result in ineffective and muddled systemic responses (Staiger et al. 2005). Several publications clarify normal versus problematic and abusive sexual behaviour and development (see, for example, Barnett, Giaquinto, Hunter and Worth 2007)

The following table classifies the sexual behaviour of young people into *age appropriate*, *concerning* and *very concerning* categories.

Age-appropriate sexual behaviour

8–12 years. Pre-adolescent

Age-appropriate sexual behaviours

- Occasional masturbation
- Show me yours/I'll show you mine with peers
- Kissing and flirting
- Genital or reproduction conversations with peers
- Dirty words or jokes with a peer group

Concerning sexual behaviours

- Attempting to expose others' genitals
- Sexual knowledge too great for their age once the context is considered
- Pre-occupation with masturbation
- Single occurrence of peeping, exposing, obscenities, pornographic interest (sources include the internet, pay TV, videos, DVDs and magazines)
- Stimulating foreplay or intercourse with peers with clothes on

Very concerning sexual behaviours

- Compulsive masturbation, including task interruption to masturbate
- Repeated or chronic peeping, exposing, obscenities
- Chronic pornographic interest (child pornography, sources include the internet, pay TV, videos, DVDs and magazines)
- Degradation/humiliation of self using sexual themes
- Degradation/humiliation of others using sexual themes
- Touching genitals of others without permission
- Sexually explicit threats – written or verbal
- Forced exposure of others' genitals
- Simulating intercourse with peers with clothes off
- Penetration of dolls, children or animals

(Ryan 2000 cited in Barnett, Giaquinto, Hunter and Worth 2007)

Age-appropriate sexual behaviour 13–18 years. Adolescent

Age-appropriate sexual behaviours

- Sexually explicit conversations with peers
- Obscenities and jokes within the cultural norm
- Sexual innuendo and flirting
- Solitary masturbation
- Kissing, hugging, holding hands
- Foreplay with mutual informed consent and peer-aged partner
- Sexual intercourse plus full range of sexual activity

Concerning sexual behaviours

- Sexual preoccupation or anxiety
- Pornographic interest (sources include the internet, pay TV, videos, DVDs and magazines)
- Promiscuity
- Verbal sexually aggressive themes or obscenities
- Invasion of others' body space

Very concerning sexual behaviours

- Compulsive masturbation (especially chronic or public*)
- Degradation/humiliation of self using sexual themes
- Degradation/humiliation of others using sexual themes
- Chronic preoccupation with sexually aggressive pornography (sources include the internet, pay TV, videos, DVDs and magazines), child pornography*
- Attempting to expose others' genitals
- Touching others' genitals without permission*
- Sexually explicit threats (verbal or written)*
- Obscene phone calls, exhibitionism, voyeurism, sexual harassment*
- Sexual contact with significantly younger people*
- Sexual contact with animals*
- Forced penetration

* These behaviours are considered criminal and may include offences such as sexual penetration of a child under 16, indecent assault, indecent act and assault

(common law) (Ryan 2000 cited in Barnett, Giaquinto and Worth 2007).

Whether any particular adolescent sexual behaviour is abusive or not cannot always be decided based on the actual behaviour alone; a contextual assessment is of critical importance. Sexually abusive behaviour can include physical contact or may be non-contact in nature, for example, where an older, or more powerful child or young person exposes a younger, less powerful child to pornography, or forces them to watch sexual activity that the older child or adolescent engages in (including being forced to watch masturbation).

It is important to understand the meaning of the behaviours for the victim as well as assessing the appropriateness of the behaviour in itself.

Sexual development is a normal part of childhood and adolescence and as such it is important to recognise that there are distinct differences between abusive sexual behaviour and developmentally appropriate sexual play.

The American National Task Force on Juvenile Sexual Offending (1993) defines sexual abuse as being any behaviour that occurs (a) without consent, (b) without equality, or (c) as a result of coercion. This has become a widely accepted definition (see, for example, Frey & McElrath-Dyer 2006; Ryan 1997; Rich 2003; 2006; 2009). Reflecting on these three factors can help to clarify when behaviour is abusive.

Consent refers to:

- '(a) the understanding that each participant has of the proposed sexual behaviour;
- (b) knowledge of the societal standards related to the behaviour;
- (c) awareness of the potential consequences;
- (d) mutual respect for agreements or disagreements related to the behaviour;
- (e) voluntary participation in the behaviour; and
- (f) being mentally competent'

(Ryan & Lane 1997, pp. 4–5). For example, where a younger child does not understand that the older child or adolescent is gaining sexual gratification from the behaviour, there is no consent.

When all the children involved are under 10, the behaviour is referred to as 'sexualised behaviour' or 'problem sexual behaviours' rather than 'sexually abusive behaviour'. When this is the case, you should refer to the specialist practice resource *Children with problem sexual behaviours and their families*.

It is important to be aware of the laws regarding the age of criminal intent and how they apply when making an assessment. Children under 10 are deemed by Victorian law to be unable to consent to any form of sexual activity. In addition, children under 10 cannot generally be held criminally responsible for their behaviour.

Equality

There is a lack of equality when there are '...differentials of physical, cognitive, and emotional development, passivity and assertiveness, power and control, and authority' (Ryan & Lane 1997, pp. 4). For example, an age difference of more than two years between young people (under 16) is an unequal relationship (and is seen as such within Victorian law). Where one child or adolescent has an intellectual disability, this could also be an unequal relationship; in such cases a younger child or adolescent might be in the position of greater power.

Coercion

Coercion refers to ‘...the pressures that deny the victim free choice including power and size differences, bribery, threats, and overt violence’ (Ryan & Lane 1997, pp. 5). For example, an older child or adolescent promising to buy gifts for a younger child or adolescent is bribery, a subtle form of coercion.

If a sexual relationship between young people is in any way unequal, non-consensual or coercive, it is abusive. If any one of these features is present, the behaviour is abusive. Any sexual activity where the child or adolescent is manipulated to believe it is ‘normal’ behaviour, or that involves ‘...bribes, secrets, tricks or surprises’, or coercion or force, is abusive (Araji 2005, pp. 25).

Coercion and distress need to be carefully assessed because they may not always be readily apparent. For example, sexually abusive behaviour may be enacted in the context of a ‘game’ where one child or adolescent has manipulated another; alternatively, a child or adolescent may not feel distressed about an incident until they grow older and develop the cognitive capacity to understand the meaning of the behaviour. Practitioners need to be mindful of not minimising these behaviours and critical of faulty gender prescriptions such as ‘no means yes’ and ‘boys will be boys’.

Young people who have been victimised as children by other young people can experience enormous distress and psychological trauma as they develop adult-awareness of sexual behaviour and norms. This can be particularly problematic if they had been ‘tricked’ into participating in ‘the game’. Shame and self-loathing can impact on every aspect of their development as they may later blame themselves, believing they were complicit and therefore ‘stupid’, ‘bad’, ‘deviant’ or ‘dirty’. It is vital that victims and their families receive skilled support and counselling where appropriate, and that any work with children and young people with sexually abusive behaviours holds the experience of their victims respectfully in mind.

If the relationship between the people involved is in any way unequal, non-consensual or coercive, it is abusive. If any one of these features is present, the behaviour is abusive.

Be aware also that some behaviours that might seem appropriate can still be abusive because of the context (such as the nature of the relationship involved). An example of this would be where two 15 year olds undertake seemingly consensual sexual touching in an appropriately private setting. Should one of them have an intellectual disability that results in them being manipulated into the behaviour, then the behaviours would be deemed to be sexually abusive in nature. Alternatively, while some adolescents’ and children’s sexualised behaviours may be upsetting, confusing or cause concern to others around them (such as parents, teachers, and/or peers), it does not necessarily mean it is abusive. An example would be a young person whose chronic masturbation (in private) comes to the attention of their parent or teachers. Although this may cause distress and appropriately raise questions as to why it is occurring, the behaviour is not abusive in nature because it is not directed towards (nor witnessed by) others.

Although some sexualised behaviours may indicate that the child or young person would benefit from a therapeutic intervention, not all concerning behaviours meet the requirements for obtaining a therapeutic treatment order. Therapeutic treatment orders are specifically reserved for sexually abusive behaviours. (See page 14 for further information on *therapeutic treatment orders*.)

Why adolescents sexually abuse

Despite there being numerous studies and books investigating why young people undertake sexually abusive behaviours (see, for example, Rich 2003; 2006; Ryan & Lane 1997; Worling & Curwen 2000) no causal factors have been identified. To highlight the difficulty of identifying what ‘causes’ sexually abusive behaviours, Rich (2003, pp. 136) lists 136 factors named in the literature as contributing to juvenile sexually abusive behaviours. Clearly, the list becomes too big to be meaningfully utilised in any helpful way.

However, having stated that there are no causal factors in regards to adolescents sexually abusing others, there are four dominant risk factors which stand out in cases that come to our attention, and these are:

- being a witness to, or being directly exposed to family violence
- chronic, long-term neglect (cumulative harm)
- inappropriately witnessing sexual activity
- being a victim of sexual abuse.

Many adolescent-focused risk assessment tools and checklists, including the ERASOR (Worling & Curwen 2000), the J-SOAP-II (Prentky & Righthand 2003), and the J-RAT (Stetson School 2000) highlight various domains as being important in identifying ongoing risk. These include family and social functioning, openness to treatment intervention, social skills, antisocial behaviours/orientation, connection to family and society, and past history of sexually abusive behaviours. While not an exhaustive list, this provides some understanding of what areas to look at in terms of protective and risk factors for sexual reoffending.

In the past, the influences of adult principles about sex-offending theory, power and domination were considered to be the primary reason for young people sexually abusing others (Rich 2003). The research and treatment field now recognises that these behaviours are more complex and multifaceted. It is now generally accepted that there are a number of pathways to undertaking sexually abusive behaviours. Rich posits four potential pathways along which adolescent sexually abusive behaviour may be shaped:

- the experience of sexual activity as the primary goal of the behaviour, with violence and aggression being the means to the end behaviour
- the aggression and violence as the primary aim of the behaviours, with sexually abusive behaviours secondary to broader conduct-disordered behaviour
- experimentation and exploration, with a somewhat naïve understanding of larger consequences
- mental illness or cognitive impairment that may result in the young person having little understanding of the appropriateness or consequences of their actions.

The sexually abusive behaviours can also have an anxiety-reducing function. The adolescent who is neglected or emotionally needy may seek comfort and affection and then sexualise this because of their experience of being sexually abused or exposed to pornography.

Additionally, it is acknowledged that, for some young people with sexually abusive behaviours, they are continuing a pattern that had become established in their own childhood. This may reflect a process of traumatic re-enactment of their own sexual abuse experience.

Who is most likely to be victimised?

The most common form of sexually abusive behaviours undertaken by adolescents occurs towards other young people, with the majority of these behaviours being against younger children. Hatch's (2005) Australian-based study of sibling sexual abuse found that access to children was the prevailing factor in who was chosen as a victim of sexually abusive behaviours. If there was a sibling in the home, then they were most likely to be the victim of the adolescent perpetrator. When no sibling was available, then step-siblings, cousins and then family friends were next in line respectively.

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Hatch's (2002) research on sexual abuse ($n = 117$) has also provided some breakdown of sibling versus non-sibling abuse statistics. Sibling victims of abusive young people were more likely to be female (79 per cent versus 49 per cent for non-sibling cases), and ten years of age or younger (84 per cent for siblings versus 69 per cent for non-sibling cases). As well, sibling sexual abuse involved penetration slightly more than non-sibling abuse. Young people who abused a sibling were also more likely to use verbal threats than those who abused non-siblings (52 per cent versus 33 per cent). In regards to duration of the abuse, sibling sexual abuse cases were more likely to have continued for longer than a year compared with non-sibling abuse cases (58 per cent versus 25 per cent).

It is important that practitioners do not minimise the seriousness or impact of sibling abuse. Engage with parents who may be distressed and in shock, or minimise the seriousness through lack of knowledge, or confusion of loyalties to all of their children. The drive to preserve the family may lead parents to deny the impact of the behaviours.

Developmental models of understanding – young people who sexually abuse are not mini paedophiles

As previously stated, from the mid 1980s, through to the early 2000s, most understanding of young people who sexually abused was misguided based on adult sex-offender theory and treatment models (Rich 2003; Creeden 2006). Longo, in his foreword to Rich (2003, pp. viii), reminds us that:

‘...the field of adult sex offender treatment does not take into account developmental stages and moral development.’

It is only relatively recently (perhaps the past decade) that there has been recognition that adolescents who sexually abuse are different from adults who sexually offend (Chaffin et al. 2008), and that treatment outcomes for young people with sexually abusive behaviours are generally very positive.

Adolescents are still developing physically, emotionally, cognitively and behaviourally. During this time (and of course, from perinatal, through birth and into adolescence), when young people are exposed to violence, abuse, trauma and neglect, there are resulting negative impacts. In the past decade, much has been written about these impacts and about the resultant attachment and brain developmental issues that can result (see, for example, Creeden 2006; Friedrich & Sim 2006; Perry 2006; Schwartz et al. 2005). These issues may include cognitive and psychological deficits, and the distortion of the young person's values and beliefs, resulting in a deviation from normal developmental trajectories. One such consequence may be sexually abusive behaviour.

Young people versus adults: recidivism

Prescott and Longo (2006) cite research that shows the base rate of sexual recidivism by young people is considerably lower than among adults (see, for example, Alexander 1999; Prescott 2006; Worling & Curwen 2000). They comment that ‘...the influence of adult models can keep youth in treatment longer than necessary...and youth are often considered to be untreatable and as “predators”’ (pp. 46). This is not usually the case, and it appears that young people who undergo treatment have low rates of recidivism (Chaffin 2008).

Current US-based studies of adult paedophiles indicate that between 40 and 50 per cent reported commencing sexually abusive behaviours in adolescence and that young people commit 30–60 per cent of all child sexual abuse (Hunter 1999; Weinrott 1996). However, it is important to emphasise that the reverse is not true; that is, most young people with sexually abusive behaviours do not go on to become adult offenders.

Treatment is very successful with this age group. Given that most studies indicate that recidivism rates for treated youth are generally between 2 and 15 per cent (Alexander 1999; Prescott 2006; Chaffin 2008), undertaking a timely, meaningful intervention with young people who sexually harm is of vital importance.

Trauma, attachment and brain development

Recent research investigating adolescent disturbance has investigated the complex interactions between experiencing trauma, attachment styles and brain development (see, for example, Creeden 2006; Perry 2006; Rich 2006). This research has offered new perspectives on the negative impact of abusive and neglectful environments on young people's decision-making capacity, emotional regulation fluctuations and other observed behavioural problems.

Both Creeden (2006) and Perry (2006) suggest that the problems resulting from sub-optimal early life child-primary carer interactions (attachment relationships) include deficits in neuro-development, neurological functioning and language development. Significantly, the '...security of attachment bonds seem to be the most important mitigating factor against trauma induced disorganisation' (van der Kolk 2003, pp. 294). Thus, the neurobiological impacts associated with insecure attachment patterns and traumatic experiences in childhood may create difficulties in regard to regulating emotions, developing intimate relationships and maintaining interpersonal connections (Creeden 2004).

Put simply, ongoing neglect and trauma experienced by the child whose parent is unable to provide a secure emotional connection often results in problematic behaviours and poor awareness of the impact of their behaviours on others. Hence the relationship between the adolescent and their parents is of central importance in your analysis, planning and intervention.

Therapeutic treatment orders and criminal charges

The *Crimes Act 1956* states that allegations of sexual abuse committed by a person aged 10 years and over are criminal matters and need to be investigated by police. This means that police need to be notified of any incident of sexually abusive behaviour engaged in by a child aged 10 years or over, and that young people aged 10 years or over can face criminal charges in the Criminal Division of the Children's Court.

Prior to the proclamation of the CYFA, legal options for managing sexually abusive behaviours were non-existent. The aim of therapeutic treatment order provisions within the legislation is to enable early intervention for young people who exhibit sexually abusive behaviours to help prevent the potential for ongoing and more serious offences.

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Therapeutic treatment orders are made in the Family Division of the Children's Court. The CYFA allows the Family Division of the Children's Court to order a child into therapeutic treatment and, where necessary for that treatment, to place the child in out-of-home care. There is capacity under the CYFA to apply to the Children's Court for a therapeutic treatment

placement order; however, most children and young people who have accessed treatment for their sexually abusive behaviours have remained living at home. This is an important early intervention process to reduce the likelihood of the child or young person continuing the abusive behaviours into their adulthood.

If the child or adolescent has pending criminal matters, the Criminal Division of the Children's Court can request child protection to assess the suitability of a therapeutic treatment order.

Where the matter has come directly to the Criminal Division of the Children's Court, the court may refer the matter to the Department of Human Services with a view to assessing the viability of applying for a therapeutic treatment order in the Family Division. These referrals must be directed to the Therapeutic Treatment Board for advice.

The orders are intended to supplement and not replace voluntary access to treatment. It is preferable for parents to connect a child or adolescent exhibiting sexually abusive behaviours to treatment on a voluntary basis and avoid exposing them to potential court process.

If the department recommends that a therapeutic treatment order is appropriate, and the court makes the therapeutic treatment order, the matters in the criminal division relating to the sexual offences will be adjourned for the duration of the therapeutic treatment order (CYFA 2005; s. 352). If there are other charges not related to the sexually abusive behaviour, these can still be heard in the Criminal Division of the Children's Court.

What happens at the end of the therapeutic treatment order?

Prior to the cessation of the therapeutic treatment order, the Criminal Division of the Children's Court can dismiss the charges relating to the sexually abusive behaviour if the court is satisfied that the child has attended and participated in treatment (CYFA 2005, s. 354 (4)). However, where there is an existing youth justice order related to other offences, this will not be suspended because of a therapeutic treatment order.

Remain mindful of the victim's needs

While the purpose of a therapeutic treatment order is to ensure that the child or young person receives treatment, all parties involved should remain mindful of the rights and wishes of the victim and their family. Victims and their families who want to pursue criminal charges should always be supported. However, they should be informed that, where a therapeutic treatment order is in place, the Criminal Division of the Children's Court must adjourn the criminal proceedings for the period of the therapeutic treatment order. If, at the end of the therapeutic treatment order period, the court is satisfied that the child or young person has attended and participated in the treatment, it must discharge the child or young person without any further hearing of the criminal proceedings relating to the sexually abusive behaviours.

Therapeutic treatment orders and therapeutic interventions

Victoria is the first state in Australia to have legislated a fully funded service response to children and young people engaged in sexually abusive behaviours, based on the understanding that a therapeutic response is more helpful to the child or adolescent than a criminal response.

It is likely, based on the patterns established over the first two years of the therapeutic treatment order legislative practice changes, that most young people will enter into treatment with an agency funded to administer therapeutic treatment on a voluntary basis. Agencies funded under the therapeutic treatment order framework have found that in the majority of cases an actual therapeutic treatment order has not been necessary because the young person and their parents/carers have voluntarily accessed an appropriate treatment program. There are key agencies providing this treatment in each region in Victoria, situated within the local Centre Against Sexual Assault (CASA) or other regional agencies.

A therapeutic treatment order is not required if the young person is subject to a protection order. Keep in mind that any disclosures made during treatment relating to previously unreported sexual offences will not be protected from criminal investigation unless a therapeutic treatment order is in place (as set out in CYFA 2005, s. 251). However, in practice new information that emerges in treatment is managed sensitively within the therapeutic process, unless there are safety issues for others or the young person.

Therapeutic Treatment Board

To assist child protection in the therapeutic treatment order process, a board has been established to provide advice to the department regarding the appropriateness of issuing therapeutic treatment orders and therapeutic treatment placement orders on a case-by-case basis. The Therapeutic Treatment Board is made up of representatives from Victoria Police, the Office of Public Prosecutions, community services and the Department of Human Services. The role of the board is twofold: to evaluate and advise the Minister on children and young people in need of therapeutic treatment and to provide advice to the departmental Secretary regarding the suitability of therapeutic treatment orders for children and young people exhibiting sexually abusive behaviours.

Child protection workers must refer to the Therapeutic Treatment Board for advice before applying to the Family Division of the Children's Court for a therapeutic treatment order, if a therapeutic treatment report has been received from the police, or the Criminal Division of the Children's Court. If a therapeutic treatment report has been received from a member of the community, including a therapeutic treatment service, child protection may also refer the matter to the board for advice.

In providing their advice to the Secretary, the board relies on a report primarily from the department as well as reports gathered during the normal course of assessment. These may include a copy of the police brief of evidence (if the original report has come from the police or Criminal Division of the Children's Court), psychological reports from other services and previous child protection reports.

Where a therapeutic treatment order is being sought, the Therapeutic Treatment Board will assess whether a particular young person's behaviour is sexually abusive and whether a therapeutic treatment order is the best pathway for treatment, in order to enable access to services that will help the young person cease the behaviours.

A note on electronic and internet pornography

Many young people, particularly males, view some pornography during their teenage years. In the pre-internet era, this would most likely be in the form of videos, magazines or pictures.

However, the explosion of internet-based pornography means that it is now possible for anyone with web access to view hundreds of thousands of hard-core pornographic images. The vast majority of these images denigrate and humiliate women, presenting them as 'objects' for men's pleasure and sexual gratification. Professionals and caregivers who suspect a young person of undertaking sexually abusive behaviour should be alert to the possibility of them having viewed a lot of web-based negative sexual images, and make every effort to stop their access to this material. These images can distort healthy sexual development and embed images and fantasies that link violence, control and humiliation with sex.

Signs of problematic exposure to pornography could include:

- indications that pornography is interfering with day-to-day activities
- less interest in human face-to-face interaction and more time spent at the computer
- a tendency to utilise the internet in private and to block or hide content from others when they engage with the young person at or near the computer
- obsessive deletion of the browsing history
- suggestions or comments that are indicative of a knowledge of sexual content above age-appropriate levels
- obsessive or harmful (injurious) sexual activity (including obsessive masturbation)
- fetish-like interests of a sexual nature
- an obsessive or high degree of anxiety, frustration or anger when denied access to pornographic websites.

Remember, the accessing of child pornography images by anyone of any age is illegal. Should a child or young person access child pornography, it would be seen as a form of sexually abusive behaviour and would need, under Victorian law, to be reported to the police. Where the young person is exposing other children to this material (or exposing other, more vulnerable children to any pornographic material) or using any technology to photograph, film or record children and adolescents in sexual/nude situations, and is viewing or distributing these images in any way (such as through a web-cam facility or mobile phone), police should be notified, and the young person may be deemed to be in need of therapeutic treatment.

Check internet use, access to child and other pornography as well as violent/aggressive DVDs, videos and other material.

Aboriginal young people with sexually abusive behaviours

Cultural competence, sensitivity and respect are essential in any intervention with families. For Aboriginal and Torres Strait Islander children and families, the impact of historical and ongoing dispossession, marginalisation, racism, colonisation, poverty and the stolen generations have led to high levels of unresolved trauma, depression and grief. (Human Rights and Equal Opportunity Commission 1997). Other key individual, family and community problems associated with unresolved trauma in Aboriginal and Torres Strait Islander communities have also been associated with child abuse and neglect and include: alcohol and drug abuse, family violence, pornography and overcrowded and inadequate housing (Berlyn & Bromfield 2010).

For example, the vast majority (78.6 per cent) of adults in Victorian Aboriginal families, reported having themselves (or family or friends) experience one or more major life stresses. (For example, death of a family member or close friend, serious illness or alcohol/drug related problems). This is almost double the rate for non-Aboriginal Victorians. (Department of Education and Early Childhood Development, 2010 pp. 22). In this context Aboriginal and Torres Strait Islander children, or any children living in such circumstances may be more vulnerable to cumulative harm.

As with any young person who presents with sexually abusive behaviours, it is important to assess their history for any trauma or abuse, particularly child sexual abuse, and to assess that the young person is currently safe from abuse or neglect. Talking about past trauma, abuse and violence are culturally sensitive issues for many Aboriginal people. Involving an Aboriginal Child Specialist Advice and Support Service (ACSASS) practitioner is essential for planning a culturally sensitive assessment and intervention.

When assessing, do not make assumptions. Many Aboriginal families in Victoria are resilient, thriving and strong within their culture. "They have an enduring and essential connection to country and have survived in the face of this painful history, adapting to include Aboriginal people whose traditional country is elsewhere in Australia and those who have lost or never known their traditional identity". (Department of Education and Early Childhood Development, 2010 pp. 9).

In practice give priority to:

- holistic family healing approaches that plan to provide for the physical, mental emotional and spiritual wellbeing of the child, and their family
- the healing value of culture, which affirms identity and connection to community as protective factors that encourage resilience.
- seeking advice from Aboriginal cultural experts. **Child protection practitioners must consult with ACSASS.**

Section 12(a) pages 26–27 of the CYFA provides guidance on principles for engaging Aboriginal families. The Best Interests Case Practice Model Summary Guide lists and discusses these principles.

Refer to the *Aboriginal cultural competence framework and Working with Aboriginal Children and Families: A Guide for Child Protection and Child and Family Welfare Workers* VACCA, 2006 to guide you.

Culturally and linguistically diverse young people and their families

Refugee and migrant communities may have fled from war or oppression and been forced to flee to refugee camps and seek asylum. Young people may have been exposed to trauma, violence and sexual abuse.

Refugee and migrant communities may be struggling with unresolved trauma, grief and loss after fleeing from war or oppression. Adjusting to a new culture and way of life can also put further stress on families and increase the young person's vulnerability.

Ethnic and cultural issues need to be understood from the intake phase and throughout your practice with families, as reported sexual behaviour varies widely in relation to reporter characteristics and cultural variations will widen the differences in the way sexually abusive behaviours are viewed (Friedrich, 2005; Mitchell, 2005).

It is wise to be curious about the meaning the parents and wider family and community attach to the sexually abusive behaviours, and how their beliefs will impact on the youth and other children who have been victimised. It is of central importance that you do not make assumptions and that you remain open. Be explicit that you come from a position of 'not' knowing the subtle complexities of the specific culture and how that has influenced the family in regard to these problems.

Gender differences can be marked in many cultures in relation to sexually abusive behaviours and the notion of victim and/or offender can equate with shame and rejection from the community in some instances. These issues may underpin the families' apparent denial or minimisation of the behaviours.

Consultation and advice is critical. Some parents may deny or minimise issues claiming this is 'cultural', when in contrast cultural experts may inform us that the behaviour is not culturally acceptable. Good partnership with cultural experts is critical to weighting your assessment and decisions in an ethical, balanced and culturally competent manner.

Section 11(g)–(j) of the CYFA provides guidance on principles for engaging families from other cultures. These are listed and discussed in the Best interests case practice model Summary guide.

Issues of safety and cumulative harm for young people should not be minimised. However western cultural expectations can impact unfairly upon parenting assessments when working with Aboriginal families and families from other cultures. Consultation with cultural experts helps us to balance the needs of young people and complex family issues. Seek advice and supervision.

Practice tool

Adolescents with sexually abusive behaviours and their families

The aim of this tool is to provide some additional guidance about specific things you might consider when working with young people who exhibit sexually abusive behaviours, and their families.

Information gathering

In this resource, we provide specific tips and guidance for gathering information regarding youth exhibiting sexually abusive behaviours.

Information gathering is ongoing throughout the life of the case, and includes gathering information from existing case files, professionals involved with the family and, most importantly, from the young people and families themselves. Information also needs to be gathered about previous attempts to resolve the problems within the family – by the family themselves, and by professionals and agencies involved with the child or adolescent and their family. Refer to the Best interests case practice model for general tips and guidance on gathering information.

Initial contact regarding a young person with sexually abusive behaviours is often initiated by a parent, caregiver, close family member or another involved person. In the initial presentation or call, the caller may be shocked, upset, sad and/or angry. Generally, this will be a situation they have not imagined could occur in their family or school. At this time, it is important to:

- acknowledge the situation in a calm manner and normalise their shock and distress
- affirm to the caller that they have taken the right choice of action
- reassure the caller that they will receive the services they need to deal with the situation and that help will be available for the victim, young person and their families.

Once the caller has been reassured, ask about what has occurred. Take a detailed narrative history of the situation. This should include the following issues, listed under the *Behaviour* section that follows.

Behaviour

Within the story of what happened, ask the following:

- How did the behaviour come to light?
- Was force used? If not, how did the young person get the victim/s to do what they wanted? (tricks or treats, fear or force?)
- What are the characteristics of the person or persons at whom the behaviours are directed? (age, gender, family, stranger) Have there been injuries? How are the victims and their families coping?
- Are there other concerning behaviours? (explore the context of the behaviour – sexual only, or among a whole range of negative/conduct disordered or criminal behaviours)
- What is the known duration of the behaviours? (What is the history of sexually abusive behaviours?) Are there concerns/suspicious in regard to other victims?
- Has there been escalation (or not) of behaviours? (they may have been less serious when first noted but have progressed in seriousness/frequency)
- Are there any obvious triggers for the behaviours? (jealousy, school failure, bullying, drug/alcohol issues, anger/contempt for victim, change of family circumstances/pornography use)
- Has the young person been a victim of sexual abuse or family violence?
- Has the young person been sanctioned before for these behaviours?
- What (initial) interventions can be/have been made to minimise the risk of further abuse being committed?
- What is the current response of the parents/carers?
- What is happening for the young person at this point in time?

After initial information gathering, a decision will need to be made regarding whether to proceed further. This guide assumes that the behaviours warrant investigation rather than closure at the initial call stage.

At the investigation stage, more comprehensive information is required. In gathering this further information, it is essential to talk to:

- the young person
- their family/caregivers and siblings
- if necessary, the referrer or notifier of the behaviour
- key school staff, where the sexually abusive behaviours have been school-based
- any other counsellors, therapists or professionals involved – this includes Department of Human Services practitioners from services such as youth justice, child protection, housing and/or disability services.

Additionally, check CRIS to review prior department involvement. This will assist in providing context (cumulative harm, family history, prior sanctions, treatment already received, other agency involvement). This file review may also provide prior neurological, risk, educational and other assessments. The file review should list any known trauma or harm that has been experienced by the young person and any other episodes of sexually abusive behaviours or other violent or concerning behaviours. This history will be very useful in your analysis of the situation.

If child protection, Child FIRST or youth justice are involved with the victim or other family members, ensure you consult with the relevant practitioner(s) involved.

Key areas to consider while information gathering

In this section of the guide, consideration is given to the key areas of a young person's life that you should include when gathering information. Consider what information you need to adequately understand the life domains of the young person you are concerned about.

Family and social environment

During adolescence, peers and social networks external to the family become very important to the young person. Be aware of this when gathering information regarding the young person because a developmentally informed assessment is important. However, gathering information regarding the young person's familial experiences both past and present (remember cumulative harm principles) is critically important information. What in this young person's environment could be enabling or supporting their sexually abusive behaviour? Were other family members aware of the young person's potential for, or actual perpetration of, sexually abusive behaviours?

What is the reaction of family members? Depending on the setting for the sexually abusive behaviours (for example, within the family, towards a family friend or acquaintance, towards a peer or younger child in a school setting), adult family members may have varied responses to the behaviour. Initial reactions of anger or revulsion are understandable, particularly if other children within the family have been victimised. These reactions may change after the initial shock has diminished. Take the context of the behaviours into account when considering the response of family members during information gathering.

Build rapport with the parents and explore the sense they make of the young person's behaviour. What do they understand to be the meaning of the behaviour? Their views about 'How come?' and 'What's driving the behaviour?' are very important. Remain sensitive to their possible distress and shame.

Note if they are minimising the seriousness of the issue or if they are in denial. Alternatively some parents can become so distressed that they may be at risk of negative outcomes themselves and require immediate assistance. If there has been sibling abuse they may be overwhelmed and feel torn between the needs of each child.

Witnessing or being a victim of family violence – traumatic experiences

Witnessing or experiencing family violence and its traumatic impacts has been found by some researchers to be a common risk factor among young people who sexually abuse (Atkinson 2002; Cavanagh-Johnson & Doonan 2006; Lovell 2002; Memmott et al. 1999; 2001). It is not necessarily a cause of the behaviour but is a frequently occurring contextual precursor for young people with sexually abusive behaviours.

However, most young people who witness or experience family violence do not sexually harm others (O'Brien 2008; Prescott 2006; Rich 2003; 2006; 2009). From a child-safety perspective, family violence is an issue in its own right. In addition, any therapeutic intervention with the young person regarding their own abusive behaviour is unlikely to be effective if the abuse they themselves have experienced, or past trauma, remains unaddressed. A contextual assessment is required that will indicate whether treatment will be required to address any trauma or past abuse suffered.

Other family factors

Other family-related factors that should be noted include:

- a highly sexualised family environment (for example, pornography accessible to children, parents/adults engage in sexual activity in front of children, discussions about sex beyond what is developmentally appropriate for the child or young person)
- distorted expectations about gender, particularly where the family culture links masculinity to positive views of aggressive sexual activity and the denigration or devaluing of women and children – this can lead to the young person holding distorted, disrespectful attitudes that manifest in over-entitled, bullying behaviours
- if any adults have been charged with sex offences in the family network or in their social network
- if there have been any allegations or any previous disclosures regarding any adults being sexually abusive or inappropriate that have not resulted in any legal activity
- a permissive and disempowered parenting style, where the young person has not learnt to respect boundaries and has inappropriate power and lack of empathy or care for others
- parent-child interactions that are sexually inappropriate (such as prolonged kissing on the lips, overtly sexualised interactions)
- poor personal boundaries (such as adolescents expected to shower or dress without privacy, or adolescents in homes with younger siblings where showering and toileting spaces are shared)
- environmental neglect

- lack of appropriate supervision
- any history of substance abuse
- an emotionally unavailable or disengaged parent
- an insecure or disorganised attachment pattern – if the parent has been frightened, frightening or erratic
- a parent's unresolved history of sexual abuse and how this impacts upon the adolescent; for example, if they had experienced childhood sexual assault these current difficulties may trigger extremely painful feelings and memories for them.

The way you gather information is of critical importance. Remain calm and empathic with the parents. Respect that they may be in shock and frightened, or angry at your involvement. Your non-blaming and non-judgemental attitudes will be quickly intuited by the parent. Remain calmly reassuring that their children and they as parents will be helped.

Social factors

Environmental influences outside of the family could include:

- young men's peer and social groups (including at school) may condone and even encourage sexually aggressive behaviour
- peer groups that include antisocial influences or condone antisocial attitudes and beliefs
- a history of conduct disorder/antisocial-type behaviours (not restricted to sexually abusive behaviours)
- bullying behaviour or experiences of being a victim of bullying
- adults in the young person's life who might also promote irresponsible attitudes around sexual behaviour.

Also consider:

- Has there been a previous history of fire lighting?
- Has there been a history of harming animals or sexual activity with animals?

Sexual abuse history

It is often assumed that all young people who engage in sexually abusive behaviours must have been sexually abused themselves. This belief has persisted in the minds of the general public and professionals involved with child protection for many years (Cavanagh-Johnson & Doonan 2006). Research over the past two decades does not support that this is the case (Hanson & Slater 1988; Rich 2003; Ryan 1997) but does indicate that the prevalence rates of childhood sexual abuse for young people undertaking sexually abusive behaviours are high. Additionally, young people may not disclose sexual abuse until adulthood, if ever. Secrecy is normative due to the fear and shame associated with being abused.

Although sexual victimisation does not inevitably lead to sexually abusive behaviours, it is a risk factor. Investigating the young person's abuse history (sexual abuse and other traumatic experiences) is a necessary requirement of any assessment. Past abuse is an injustice in itself, with potentially traumatic impacts that may never have been acknowledged before. If past abuse is disclosed, it may be necessary to take appropriate action in line with child protection

practice standards. The young person will need assistance in their recovery from their own abusive experiences as part of any intervention. Treatment should be holistic and focus on the lived experience of the young person as part of their family and social system.

Criminal history

Are the sexually abusive behaviours embedded in a spectrum of other antisocial or criminal behaviours or is the young person's sexually abusive behaviour an isolated concern? Assessment of the young person's overall behavioural patterns (globally conduct-disordered or antisocial behaviours that include some sexually abusive behaviours versus generally prosocial attitudes and behaviours, with the sexually abusive behaviours standing out as the seemingly only criminal or antisocial behavioural indicators of dysfunction) should indicate whether the young person will require treatment and support for other problematic issues. Sexually abusive behaviours are serious of themselves, but if the young person has a complex history of cumulative harm then the treatment response will need to be planned differently.

Mental illness

While some young people who engage in sexually abusive behaviours have a mental health diagnosis, there is no evidence that mental illness is a significant risk factor for sexually abusive behaviours. However, good assessment should be inclusive of other mental health issues, and depression in young people should not be overlooked. Young people who do have a diagnosed mental health condition may need specialised intervention, which may include a referral to a child and adolescent mental health service (CAMHS), a general practitioner or a mental health clinician.

A consideration is whether the mental illness or the sexually abusive behaviour is the primary presenting issue. Johnson (2006, pp. 179) states that:

Although one should not merely ignore the sexually inappropriate behaviour and assume it is only secondary to [the co-morbid condition], doing just the opposite and only focusing on the sexual offense without treatment of the co-morbid disorder leads to a great disservice for the adolescent.

In this scenario both the issues are treated; however, the professionals involved need to make informed decisions regarding the response required that does not ignore or minimise either problem.

Currently recognised co-morbid conditions that occur with some frequency are conduct disorder (CD), attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), oppositional defiance disorder (ODD), depression, anxiety disorders, bipolar disorder and substance abuse (Johnson 2006). The possibility of complex post traumatic stress disorder (PTSD) being present should not be overlooked.

It would therefore appear that disorders that lower inhibitions, create problems regarding affect control and impulse control issues, and alter mood, have some potential to lower internal inhibitions to sexually abuse others. Furthermore, it is common for many of these disorders to exist in a context of family conflict, abuse and/or neglect. Understanding this context and the often traumatic circumstances of the young person's environment is critical to any assessment of the young person.

The recommended treatment plan requires review in light of any new or emerging behaviour symptomology, so that informed and specialist assessment and treatment is taking place. This review process would be best facilitated through an ongoing case conference process that encompasses all key family and professional representation as part of the care team.

Intellectual disability

The literature regarding the specific needs of young people with intellectual disabilities who commit sexually abusive behaviours is sparse indeed. It seems from what has been written that adolescents with an intellectual disability may be over-represented in the cohort of youth who do sexually abuse others (O'Callaghan 2006). As with the case of mental illness, sexually abusive behaviour should not be minimised or assumed to be an inevitable part of an intellectual disability but may result from other causes. While particular challenges are present when working with young people with an intellectual disability who have engaged in sexually abusive behaviours, treatment can be highly effective, and as such it is important to gather information regarding the intellectual disability to assist in case formulation.

O'Callaghan (2006) provides a framework for gathering information regarding young people with an intellectual disability who sexually abuse, and recommends covering the following domains:

- family-of-origin factors
- personal health history
- developmental history
- care history
- educational history
- assessment of general cognitive functioning
- social functioning
- psycho-sexual history
- history and meaning of sexually abusive behaviours.

Many young people with an intellectual disability have not received proper sex education and this requires exploration. In addition, make an assessment of whether the reported behaviour is sexually motivated, as some behaviours may reflect unmet non-sexual needs and may be attention seeking or indicative of distress (O'Callaghan 2006).

Disability may also be a risk factor for victimisation. Young people with a disability may be particularly vulnerable to abuse and neglect, both past and present, due to issues such as extra stress on caregivers arising from discrimination, or characteristics such as aggression or hyperactivity. Communication difficulties, in particular, increase vulnerability, as a young person may have difficulty identifying perpetrating behaviour. Likewise, different stages of development, such as a young person who needs intimate physical care, may also increase vulnerability (Daniel, Wassell & Gilligan 1999).

Carers may also experience fatigue from the ongoing multiple demands of caring for a young person with a disability, and there is consistent evidence that caring is associated with poorer mental health, particularly depression (Robinson, Rodgers & Butterworth 2008). It is important to take these issues into consideration, and get some assistance to understand their impact when gathering information about the young person.

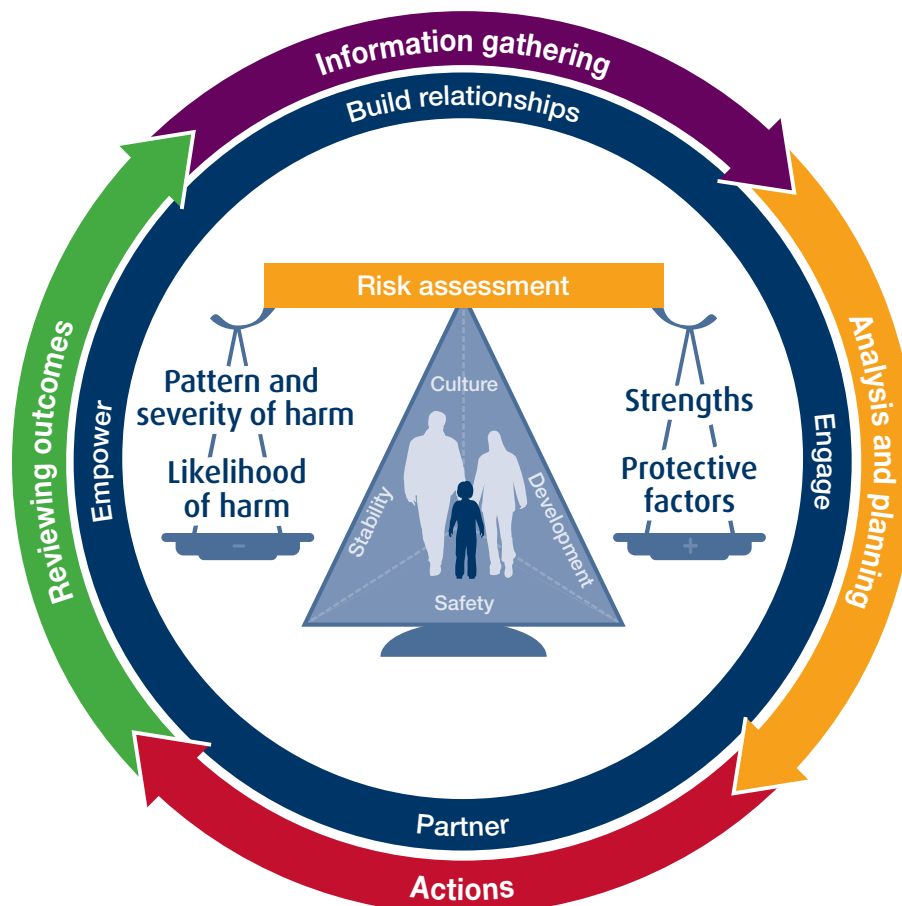
History of prior sexually abusive behaviours

It is common that when initially discovered, the young person will deny or minimise the nature and extent of the sexually abusive behaviours. As such, there may be other, unreported or undisclosed sexually abusive behaviours against the known victim and/or other children. If there is no specific sexually abusive behaviour-focused intervention, the behaviours may continue, or escalate into increasingly intrusive abuse. It may not be until a more comprehensive assessment is undertaken that the full extent and history of a young person's sexually abusive behaviours is discovered. Where possible, the following information should be gathered:

- Does the young person acknowledge any previous sexually abusive behaviours?
- How many incidents have the victim(s) disclosed, and does this tally with what is known from the young person or the reporter?
- How far back do these incidents go? (When did the behaviours commence, and is this consistent with the youth's account?)
- Have the victim(s) indicated that there have been other victims they are aware of? Is it possible to speak with them or their families?
- Has the young person being assessed indicated that there are other victims?
- Have family members or others seen or heard anything that, in the light of the current discovered behaviour, may indicate prior sexually abusive behaviours?

What factors in this young person's environment could be enabling or supporting their sexually abusive behaviour?

Analysis and planning



Risk assessment

To formulate a risk assessment, you need to be a critical thinker and to consider multiple competing needs, prioritising the young person's safety and development. Careful attention needs to be given to the balance of risk and protective factors, strengths and difficulties in the family. Your assessment needs to be forensically astute; and you should consider all sources of information such as observation, previous assessments, advice from all significant people and professionals. Do not rely on phone assessments or parental self report where there are suspicions of non-accidental injury, or where there have been previous concerns or offending behaviour.

Synthesise the information you have gathered about the current context and the pattern and history; and weigh the risk of harm, against the protective factors. Keep in mind that the parents' desire to change dangerous or neglectful behaviours does not equal the capacity to change; and that strengths and protective factors need to be sustained over time. The best predictor of future behaviour is past behaviour. Hold in mind the urgency of the young person's timeframes for safety and secure attachment relationships. Imagine the child's experience of cumulative harm. Remember, other than the family's characteristics, the quality of the relationship you form with the family is the single most important factor contributing to successful outcomes for the young person.

Characteristics to consider when assessing risk

Based on examination of file records and other data relating to over 1500 children, Reid et al (1995) identified three important organising principles consistently associated with occurrences or recurrences of child abuse or neglect for children:

1. The first and most important dimension of caregivers' characteristics that should be considered, is their prior pattern with respect to the treatment of children. The number of maltreatment events they have initiated, their severity and recency are the most basic of guides to future behaviour. In the absence of effective intervention these behaviour patterns would be expected to continue into the future.
2. If an individual believes that they are correct in their opinions about children, they will attempt to continue their behaviour so long as they are not prevented from doing so.
3. The third dimension concerns the presence of 'complicating factors', most significantly, substance abuse, mental illness, violent behaviour, and social isolation. The relevance of complicating factors is the extent to which they, singularly or in combination, diminish the capacity to provide sufficient care and protection to the child or young person.

The Best interests case practice model is underpinned by a strengths based approach that assesses the risks, whilst building on the protective factors to increase the child's safety.

Attention to safety factors within the risk analysis recognises that:

1. Both the potential for harm and for safety must be considered to achieve balanced risk assessment and risk management
2. Strengths which increase the potential for safety are evident in even the worst case scenarios and these are fundamental building blocks for change
3. A constructive approach to building safety can be taken which may be different to efforts to minimise harm
4. A strengths perspective can be actively (and safely) incorporated into what may otherwise become a 'problem saturated' approach to risk assessment and risk management

(cf. Turnell and Edwards, 1999)

Current risk assessment

Current risk assessment highlights the fact that it is made at a *point in time* and it is therefore limited and will require modification as further information comes to light. Your risk assessment should address the following key questions: Is this child/young person safe? How is this child/young person developing?

1. Given all the information you have gathered, how do you make sense of it?
Consider the vulnerability of the child and the **severity** of the harm:
 - What harm has happened to this child in the past?
 - What is happening to this child now?
2. What is the **likelihood** of the child being harmed in the future if nothing changes?
Hold in mind the **strengths and protective factors** for the child and family.
3. What is the **impact** on this child's safety and development, of the harm that has occurred, or is likely to occur?
4. Can the parents hold the child in mind and prioritise the child's safety and developmental needs over their own wants and constraints?
5. From the point of view of each child and family member, what needs to change to enable safety, stability and healthy development of the children?
6. If the circumstances were improved within the family, what would you notice was different – what would there be more of? What would there be less of? Who would notice?

Analysis is the process of thinking critically about the information gathered in order to make sense of what is now known about the child or young person's situation.

Planning involves making decisions about what actions to take regarding the child or young person's needs and sexually abusive behaviours in relation to family strengths and capacities. Planning should consider how to meet those needs and manage that risk posed by the young person to others or to themselves.

Analysing the information you have gathered will guide you to create a plan for intervention that aims to result in the following:

- cessation/containment of the sexually abusive behaviours
- safety for the actual victim/s
- safety for any potential victims
- creating understanding of how and why the behaviours have come about
- the creation of a comprehensive and practical safety plan, which includes assessing the appropriateness of residential placement for the youth exhibiting sexually abusive behaviours
- assessing what interventions need to be provided to allow the young person who has been sexually abusive, their victim/s and their families to manage the situation and to heal
- an assessment of who needs to be involved in this process (including the young person, family members, community members, professionals)
- assessment of the capacity of parents to learn structured behaviour-management skills to manage both sexual and non-sexual issues.

Principles of intervention

Therapeutic intervention with young people with sexually abusive behaviours is based on the overwhelming evidence that early intervention can interrupt such behaviours, and prevent them from becoming more entrenched, intrusive and serious (Chaffin 1998; 2008; Losel & Schumaker 2005; Marshal et al. 1991; Worling & Curwen 2000; Worling & Langstrom 2006). Most young people with sexually abusive behaviours do not continue the behaviours into adulthood; however, the (US) National Task Force on Juvenile Sex Offending (1993) reports that 60–80 per cent of adult sex offenders report offending as adolescents.

When planning interventions, community and victim safety, family/carer involvement and input from the victims and their families are guiding principles.

Intervention works. Current research indicates that recidivism rates for treated adolescents are consistently reported at between 2 and 15 per cent. The earlier intervention occurs, the better, for both the young person and any potential future victims. Early intervention can interrupt the entrenchment of sexually abusive behaviours (Chaffin 1998; 2008; Losel & Schumaker 2005; Marshal et al. 2000; Worling & Langstrom 2006; Worling, Littlejohn & Bookalam 2010).

Community safety

The safety of known and potential victims of the sexually abusive behaviour is always the priority. The young person's own safety must also be assessed, and viewed in terms of both child protection issues and the current risk of them undertaking further sexually abusive behaviours. Where there has been sibling abuse the needs of the victim need to be privileged and sensitive engagement and planning is crucial. The parents and therapists of the victims need to be engaged in any decision making regarding the young person who has been sexually abusive and the potential for the young person to remain in the home.

Where a young person is subject to a therapeutic treatment order, you may also need to consider whether a therapeutic treatment placement order is needed to assist the young person to reside in appropriate accommodation that enables and supports the therapeutic treatment. To make this decision, you will need to consider whether potential or actual victims reside in the family home, the assessed risk level, and whether the family is able and willing to put in place a strong and effective safety plan.

Ask if the parents/caregivers are open to ongoing monitoring and support. Are they supportive of treatment taking place? Additionally, consider how they will manage the demands of supervision and whether they have realistic expectations of how demanding this will be. Finally, what plan is in place when the demands become 'too much'? Contingency and respite planning is important.

The young person's family/carers are powerful allies in the process of safety planning, support and therapy. Support and engagement of them is a core component that leads to good outcomes.

Placement decisions

Treatment providers will also contact you should the young person and/or their families fail to comply with treatment. The treatment should be based on a thorough assessment that has been reported and discussed with the young person and their family.

In addition, the assessment report will indicate whether it is appropriate for the adolescent to reside at home or whether an out-of-home placement is required. If the recommendation of the assessing clinician is for the young person to reside outside the family home then generally family-based foster care would not be appropriate due to risks to the foster family's children, particularly if they are younger or vulnerable in any way. A safety plan will need to focus extensively on the home environment with clear expectations in place should young children visit the home. The assessment report needs to be discussed with the young person and his or her caregivers, who need to be alerted to the potential risk factors that trigger the young person's sexually abusive behaviours.

Family involvement

As is the case with all the work of child protection practitioners, it is critical to engage with the families of young people with sexually abusive behaviours. Even in situations where the young person is living away from home, the family continues to play an important role in the intervention process. Parental support in assisting the young person to acknowledge or 'face up' to their abusive behaviour is critical to them taking responsibility for the behaviours and developing awareness of the impact of the behaviours upon their victims (Jenkins 2005).

Areas where parental input and support are especially important for these young people include: strengthening emotional connection; safety of younger siblings; safety of the young person; and the role and capacity of the family in supporting therapy.

Attachment

While the role of differing attachment styles in the development of sexually abusive behaviour may be a contentious issue, enhancing connection and relationships is integral to any effective intervention with young people (Rich 2006). Treatment needs to focus on strengthening the attachment connections that can then impact positively to alter future behaviours. This highlights the critical importance for practitioners to positively engage the family/carers/ community members in the change process. Extended family members can be valuable supports in the healing process. Connection to culture is healing and is of critical importance for Aboriginal young people.

Safety of younger children and siblings

Younger or less powerful siblings might be at risk of sexual victimisation by a young person who has engaged in sexually abusive behaviours. This can also include other young children in the wider family and social network.

Supervision can be an extremely demanding and exhausting job for parents/caregivers and a meaningful initial safety plan must consider parents' capacity to do this. Developing a realistic safety plan is essential so that caregivers, other family members, professionals and, most importantly, the young person are clear about how to manage specific risk issues and behaviours. Safety plans are most effective when developed in collaboration between professionals, caregivers and the young person being assessed.

School

School can be an important source when gathering information about the young person's presentation and history of sexually abusive behaviours. Careful consideration needs to be given to liaison with appropriate people within the school environment, to develop a safety plan so that there is appropriate supervision, if it is assessed that this is required. Every effort should be made to maintain the young person's engagement in school and any history of being bullied or bullying others needs to be assertively followed up and proactively addressed. Good communication is essential between child protection, therapeutic treatment services and the school and, while safety is a priority, the young person's privacy should be respected and positive engagement with their peer group encouraged.

Constant line-of-sight supervision is recommended when young people with a history of sexually abusive behaviours who are assessed as being a risk to younger children are engaging with them. Mindfulness on social occasions, such as family celebrations, is essential. Following successful treatment this can be modified.

Safety of the young person

As previously stated, parents' initial reactions to discovering that their child has engaged in sexually abusive behaviours against another child, or has been accused of doing so, can vary widely. Some parents' reactions might put the young person themselves at risk of harm, physically and/or psychologically. It is important to acknowledge that parents' and others' feelings of anger, disgust and fear are all understandable. While acknowledging these, the focus should be on how well the parent/caregiver is equipped to support their children, and what support they need to be able to do so. Parents will need support to handle their own reactions responsibly.

In addition, extended family and social networks learning about the young person's behaviour might also threaten the young person and/or their family, or can become important sources of support. Remember to be attentive to other family issues that the young person may have previously or currently be experiencing, such as neglect, rejection, violence or isolation. Helping a parent separate their feelings regarding the young person and the behaviour (the young person is not the behaviour) can help them manage anger and sadness. Talking them through what can be discussed and with whom it can be discussed, will help to safeguard information that could be damaging to both the young person and the family does not leak to inappropriate sources.

Reassuring the parent again that help is available and that the great majority of these situations have good outcomes can also help to avoid inappropriate responses that are not helpful.

Key Considerations

Do parents/caregivers have appropriate support, where they can safely identify and work through their own feelings and responses to the young person's sexually abusive behaviour?

Have the behaviours 'triggered' responses related to the parent/caregiver's own history that might impact upon their capacity to support the young person?

What needs to happen to enable the young person to be safe from violence and recriminations?

Victim input

Another aspect of intervention that may be possible and appropriate in some (but not all) circumstances is liaising with the support system of the victim(s), including their counsellor. This must be sensitive to the victim's wishes and to their own best interests. A child victim of sexual abuse may disclose further details of abuse over the course of their own counselling. If some communication is possible and ethical, it may shed new light on the extent and nature of the abuse that has been committed by the young person, which in turn is useful for understanding the pattern and duration of the sexually abusive behaviours. Communication must be negotiated sensitively because the first priority is the victim's best interests and right to safety and confidentiality. The role of child protection practitioners may be to facilitate communication across the various parts of the system. Professionals case conferencing on these complex issues is highly recommended and is good practice.

Involving professionals

A number of therapeutic agencies are now funded to provide therapeutic services to youth exhibiting sexually abusive behaviours (see the appendix at end of this document for a contact list of services). It is your role to ensure that a referral is made to the appropriate service. This is generally a geographical choice. The service will require a comprehensive summary of all the information you have gathered, as well as your analysis of the information, and any planning you have completed. Additionally, inform the service of any action already undertaken.

Staff at the sexually abusive behaviours treatment services have undertaken training to comprehensively assess the risk and needs requirements of young people and their families. In practice, they will be your contact to determine whether young people and their families are complying with recommendations regarding safety planning, placement and treatment. They are vital members of the care team and can provide valuable advice to carers so that strategies are consistent.

Action

Treatment

What does treatment aim to do?

The treatment phase of an intervention incorporates a comprehensive strategy designed to engage a young person to stop their sexually abusive behaviours and manage any further motivation to reoffend. While this guide is not a 'how to' document, the following information is provided in an attempt to 'de-mystify' the therapy process.

Treatment is not primarily undertaken with just the young person who has perpetrated the behaviours. Rather, a systems approach is emphasised, such that the young person, their families, their caregivers, their schools and their extended networks all play a role in the young person's ongoing management of the sexually abusive behaviours.

Treatment aims to:

- *engage* the young person to have a positive identity as a respectful young man or woman who values the rights of others and their own right to be safe
- *stabilise* a young person and the systems around them so that they are able to manage their behaviours (through implementing a care-team approach where all involved parties meet regularly to review the situation and strategies)
- *teach* a young person and relevant others effective management strategies so that they are in control when the environment is heated or problematic (teach the young person about emotions – how to recognise facial and body expressions that reflect emotions and voice tone)
- *teach* the young person effective management strategies through breathing skills, distraction techniques, cognitive behavioural interventions and recognising early warning signs in their body
- *inform* and *teach* the young person about specific skills to manage sexually abusive behaviours (healthy versus unhealthy sexuality/sexual contact, consent, power and control issues, awareness of others/empathy, moral and legal rules and laws around sex and sexual contact)
- *unify/re-unify* family systems in healthy, respectful ways (rights and responsibilities, family conferencing, family therapy, personal boundaries and personal safety for all)
- *model healthy* masculinity (the majority of clients are male – control and power, from boy to man, modelling prosocial and respectful relationships)
- *have a definable endpoint* (finishing the work, honouring the work, what I know now, strategies for keeping myself and others safe).

Working in partnership

A key role of the child protection practitioner is to ensure that the various systems and members of the care team are working consistently towards a common goal. This includes family, ACSSAS workers, other culturally specific consultants, therapeutic service providers, youth justice workers, residential care workers, therapists/counsellors, schools and the child protection system itself. It is important, for example, that young people in treatment continue to have healthy social interactions with peers. This needs to be balanced with the possible safety and supervision requirements related to the risk that the young person may present to others.

At this stage of the process, it is important to liaise with the therapeutic treatment provider for an opinion regarding these issues. Regular care-team meetings are essential to promote safe decision making.

Success in treatment

When a young person has successfully finished treatment they should:

- have attained the skills to manage their sexually abusive behaviours
- recognise the thoughts, feelings and behaviours that have previously led to their sexually abusive behaviours
- demonstrate their capacity to enact their safety plan
- have achieved any goals identified during assessment
- demonstrate respectful behaviours towards past victims
- no longer be attempting to have any of their needs met through sexually abusive behaviours towards others.

In addition, the family should:

- have clear parental expectations and boundaries
- show commitment and warmth to the young person while not minimising the past behaviours
- maintain appropriate supervision and engagement with the young person
- remain sensitive to the needs of victims, particularly at anniversary times or at different developmental stages (eg a little sister who was assaulted as a young child may need to revisit the issues and be supported differently when she is an adolescent or becomes a mother herself).

You should consult with the treatment provider regularly in order to gain a clear understanding of what stage of the treatment progress the young person is at regarding the above processes. They will be able to provide you with a report following their assessment of the young person that clearly outlines the following.

Risk

What is the assessed risk level of the potential for the young person to commit further sexually abusive behaviours over the next 12 months (low, medium or high)? An understanding of the pattern and history of the sexually abusive behaviours is critical and also of the likely triggers, that is, thoughts, feelings and behaviours that preceded the sexually abusive behaviours.

Needs

What does the young person need in terms of therapeutic and practical interventions to enable that he/she learns to successfully manage his/her behaviours?

What is the capacity of the family to attentively respond to the needs of the young person and any other of their children who have been victimised? What resources will they need to support this?

Responsivity

This refers to the 'right treatment at the right time for the right client'; in other words, a practical and achievable plan for the young person and his or her family to achieve a successful outcome.

Out-of-home care

When assessment of the family situation leads to the young person being placed in out-of-home care for a period of time, there are strong roles for the child protection practitioner, the placement and support unit and the placement agency staff to play. A well-functioning care team is essential to obtaining good outcomes for the young person. This is particularly so when a suitable 'kinship' placement cannot be found, and a department-organised placement is the only suitable placement option. Some service providers might require removal of the young person exhibiting sexually abusive behaviours from home before providing a service or commencing their assessment. Where out-of-home care is being considered, the following questions should be explored to assist in determining whether appropriate care can be provided:

- Do the potential out-of-home carers (kin, foster carers, residential staff) know about the young person's sexually abusive behaviour problems? Carers cannot provide appropriate care and supervision if they don't know what potential risks the young person might present to other children. They should be fully informed and understand any triggers and patterns around previous sexually abusive behaviours.
- Is the proposed placement appropriate? Will it place other children at risk? Will it place the young person at risk?
- Is there adequate supervision for the young person such as if the young person is placed in a residential unit. Will staff actively supervise 24 hours a day?
- What is the mix of other young people in the placement (particularly residential units)? Are there other children or adolescents who are placed due to their sexually abusive behaviours? Are other children or adolescents within the unit victims of sexual abuse? How are these issues managed by unit management and staff? (Do they have a realistic management plan to keep everyone safe)? This requires clear strategies around supervision and structure.

Ongoing communication between residential care staff or carers, specialised treatment providers, family members, members of the care team and the child protection practitioner is essential in making sure that the young person's progress is adequately monitored and to help plan for possible difficulties. Difficult therapeutic issues may require more intensive support and supervision in the out-of-home care environment. If residential care staff are not informed in advance, they will not be aware of this need. Likewise, the residential care staff may notice that the young person is distressed or engages in difficult behaviour after certain therapy sessions. Such information could be extremely useful to the therapist in guiding the direction of therapy. It is your role to ensure information such as this is disseminated to the right people.

Where the young person has been removed from home, a reunification plan should be developed that is implemented from the commencement of treatment. All parties need to be working together to give the family and the young person the greatest chance of treatment success regarding the family being reunited, while managing the risk of further sexually abusive behaviours occurring. The child protection practitioner can play a crucial role in ensuring that a consistent approach comes from the various parts of the treatment network or support team.

The duration of treatment

All therapeutic treatment services are funded to provide treatment for up to 12 months, with the possibility of an extension for a further 12 months under the therapeutic treatment order legislation. This applies to both ordered and voluntary clients. It is generally the case that 12 months is an adequate treatment length. Some clients may receive a shorter duration of treatment; however, a small number of therapeutic treatment order clients will receive significantly longer than 12 months of treatment (there would generally have to be a review that indicated significant ongoing risk to the community for this to occur – although this may still vary from agency to agency).

Sexually abusive behaviour treatment services should be able to provide some indication of treatment duration as a part of the assessment process (and logically this should be linked to assessed risk in terms of low risk equalling shorter treatment through to high risk equalling longer treatment). The child protection practitioner should ensure that regularly scheduled reviews occur between the department, the therapeutic treatment service, the family and young person, and all other identified members of the care team.

Returning home

When young people have been removed from the family home as a result of their sexually abusive behaviour, plans for reunification should always incorporate a thorough assessment of any potential risk of sexually abusive behaviours re-occurring. Specialist sexually abusive behaviours treatment service providers are best placed to conduct this assessment, and should as a matter of course prepare a written treatment progress or outcomes summary addressing the matters related to reunification. The service should also be able to assess the best form of contact while the young person is not residing with their family.

When considering a reunification plan, any ongoing risk posed by the young person themselves must be assessed in light of the family's capacity to provide appropriate supervision. Younger children should never and would never be put in the position of being responsible for their own safety or preventing further abuse from being done to them. It is good practice in these situations, however, to recommend a 'protective behaviours' model be utilised with younger siblings so that they can recognise risk and be empowered to inform responsible adults should they feel unsafe. House rules and clear boundaries need to be accepted by the sexually abusive young person and any form of verbal intimidation of younger siblings should not be tolerated.

A progress or outcomes report should provide an indication of the assessed capacity of parents to support the young person's return, and to help them sustain changes with the assistance of identified support services.

Practitioners in child protection, placement and support and out-of-home care agencies have a vital role to play in ensuring that the activities of all family members and professionals involved with the young person are coordinated around issues that can contribute to increasing and/or minimising the further risk of the sexually abusive behaviours.

Reviewing outcomes

Initial assessments are based on the integration of knowledge available at the time and should be regularly reviewed, modified and changed as new knowledge emerges, rather than rigidly defended as the 'truth' about this young person and family. Good practice requires competence and courage about what we do know but an openness and humility about what we might not know.

As case practice unfolds, practitioners will learn more and more about the family and their history. This learning may well shed a whole new light on the meaning and weighting we give to different aspects of the concerns, and open up new possibilities.

The importance of regular supervision, peer review, reflective practice and sound judgement cannot be overestimated.

Review is the continual process of being curious about our effectiveness. We need to constantly review and reflect on both the circumstances of the child and the family, in the light of emerging information, and the outcomes of our actions. If we make sure that interventions remain purposeful, positive outcomes for the young person and family can be achieved.

Child protection practitioners should regularly communicate with professionals and the family to monitor a young person's progress, particularly in the early stages of intervention. If a therapeutic treatment order was not sought because the young person and family were willing to engage in treatment, then the funded therapeutic service should notify the department if they do not engage. This may result in a request from the treatment provider for a therapeutic treatment order. The treatment provider would report to child protection about the reasons why they consider a therapeutic treatment order to be appropriate. It is then child protection's responsibility to assess this request.

When treatment is progressing well, regular communication between professionals and family/carers should still be seen as crucial. Regular meetings should be held and a care-team approach adopted, particularly to review progress through treatment.

Review of progress should be ongoing. For young people who are subject to a therapeutic treatment order, 12 months is a crucial revision point. Specialist therapeutic treatment providers should know well in advance whether the young person is on track to successfully complete treatment by the 12-month mark. They should also inform you in adequate time as to whether there is a need to apply for a 12-month extension of the therapeutic treatment order. A court can grant one 12-month extension to a therapeutic treatment order.

Young people subject to a therapeutic treatment placement order, and their families, may be particularly anxious about this decision as it may affect whether the young person can return home. Thus, the purpose of regular communication, meetings and review is to allay these anxieties regarding the progress of the young person through treatment, and to work to correct any issues that may impede the smooth resolution of the sexually abusive behaviour issues and the resulting orders in place. Obviously, heightened anxiety results in raised risk – work hard to manage anxiety through the above outlined processes.

Celebrate success along the journey and acknowledge the strengths and progress of the young person to their parents and other significant adults. Holding a realistic and positive attitude helps to allay anxiety and to create good outcomes.

Remember, careful documentation of meetings, agreements, therapeutic reports, and other relevant communications is crucial. It will be necessary to refer to such documentation in planning ongoing interventions and reviewing the young person's care plan and outcomes.

Other relevant resources

- CEASE 2010, *Standards Of Practice For Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Programs – February 2010* <www.secasa.com.au/Workers/Counselling_Issues>
- Children in need of therapeutic treatment: Therapeutic orders facts: Retrieved from <www.office-for-children.vic.gov.au/__data/assets/pdf_file/0019/79102/ecec_cntt_factsheet.pdf>
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Appendix: Sexually Abusive Behaviours Treatment Service Agencies in Victoria

The following agencies have completed training for the delivery of therapeutic treatment services to children with problem sexual behaviours and young people with sexually abusive behaviours and their families in Victoria.

Sexually Abusive Behaviours Treatment Service Agencies in Victoria

Barwon South West	Barwon Centre Against Sexual Assault (CASA) 0 – 15 year olds	291 La Trobe Terrace, Geelong	5222 4318
	South Western (CASA) 0 – 15 year olds	299 Koroit Street, Warrnambool	5563 1277
Eastern Metropolitan	Australian Childhood Foundation 0 – 15 year olds	579 Whitehorse Road, Mitcham	9874 3922
Gippsland	Gippsland (CASA) 0-15 year olds	6 Victor Street, Morwell	5134 3922
Grampians	Ballarat (CASA) 0 – 15 year olds	115A Ascot Street, South Ballarat	5320 3933
	Wimmera (CASA) 0 – 15 year olds	9 Robinson Street, Horsham	5381 9272
Hume	Berry Street Victoria (Hume Region) 0 – 18 year olds	5/125 Welsford Street, Shepparton	5822 8100
	Upper Murray (CASA) 0–15 year olds	38 Green Street, Wangaratta	5722 2203
Loddon Mallee	Mallee Sexual Assault Unit 0 – 15 year olds	Suite 1, 144-146 Lime Avenue, Mildura	5025 5400
	Loddon Campaspe (CASA) 0 – 15 year olds	48 Wattle Street, Bendigo	5441 0430
North Western Metropolitan	Children's Protection Society 0 – 15 year olds	70 Altona Street, Heidelberg West	9450 0900
	Gatehouse Centre 0 – 15 year olds	Level 5, South East Building, Royal Children's Hospital, Flemington Road, Parkville	9345 6391
Southern Metropolitan	AWARE South East (CASA) 0-18 year olds	11 Chester Street, East Bentleigh	9928 8741

