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Australia's Response to Sexualised or Sexually Abusive Behaviours in Children and Young People

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EXECUTIVE SUMMARY

Responding to children and young people with sexualised or sexual offending behaviours presents significant challenges across the allied health, child protection, education and juvenile justice sectors. This report maps the specialised therapeutic services designed to effect positive behavioural change and thus divert young people with sexualised behaviours from the juvenile justice system.

Accurate numbers on children with sexualised or sexual offending behaviours are difficult to determine. Recent Australian research cites international data to estimate that sexual abuse by children or young people constitutes between 40 and 90 per cent of sexual offending against children. Even the lower estimate belies the generally held assumption that perpetrators of child sexual assault are adult males. Young people are responsible for a significant proportion of sex offences against children, a fact that continues to go largely unknown. There are several factors contributing to this gap in understanding. These include entrenched ideals about children as inherently innocent, widespread ignorance about developmental sexuality, and the tendency of both young people and parents to deny or minimise incidents when they do occur.

In Australia, data on children with sexualised behaviours are not collected uniformly and non-disclosure contributes to what might be large numbers of offences going undetected. Mandatory reporting requirements apply where children display sexualised behaviours and are thought to be at risk of harm. Yet a general lack of knowledge as to what constitutes appropriate behaviour means that many may respond inappropriately to incidents of sexualised behaviours. This context of confusion, denial and non-disclosure creates a hidden population of children that continues to be at risk. Attention to redressing the contexts for non-disclosure is urgently required to ensure that children in need are provided with specialised therapeutic care.

Scholars and clinicians agree that the ‘earliest possible intervention’ leads to the best rehabilitative outcomes for the young people involved. Clinical studies indicate that recidivism rates are low where a full program of specialised counselling is completed. Despite these positive findings, there are a number of key challenges to the comprehensive provision of tertiary services to young people who have sexualised behaviours.

This report presents qualitative data from interviews with specialised clinicians as well as submissions from service providers in both community and youth justice settings. In mapping the availability of therapeutic services, this report highlights a number of geographic and demographic gaps in service provision, including difficulties with eligibility criteria, referral pathways, funding arrangements and specialised workforce development.

2 An evaluation of the New Street Adolescent Service found that only 1 in 34 young people who completed the program went on to re-offend sexually. Laing, et al.2006. qtd. in McGregor, S. 2008, p. 5. This is one of a number of studies that indicate that recidivism increases where young people commence therapeutic work but fail to complete the program.
3 This is supported by a New Zealand study undertaken by Ian Lambie which identified a greater likelihood of older youth failing to complete treatment programs. Lambie, I. 2007. qtd. in McGregor, S. 2008, p. 6.
The distribution and reach of community-based services is limited by Australia’s geographic vastness. The financial and logistical demands of servicing the nation’s largest states and territories present the most profound challenges to ensuring that young people have equitable access to specialised therapy. The concentration of services in the metropolitan fringe means that the vast majority of children residing in other parts of the country have difficulty in accessing specialised services. Most metropolitan services and the few services located in regional or rural parts of the country report challenges in responding to referral demand.

Attention to Indigenous disadvantage and concern about sexual abuse has featured prominently in the public domain in recent years. Yet the issue of children and young people with sexualised or sexual offending behaviours is not, by any means, exclusive to Indigenous Australians. The challenges presented by children with these behaviours are evident globally. It is important to note that children from all backgrounds comprise the Australian cohort requiring therapeutic response for sexualised behaviours. Experiences of childhood trauma and socio-economic disadvantage are often correlative to children displaying sexualised behaviour.

Mapping of Australia’s socio-geographic disadvantage reveals that 52 per cent of the localities with consistently high indicators of social disadvantage are rural. The challenges to delivering both specialised and integrated services in regional and remote areas are of particular concern when considered against the context of disadvantage experienced by some Indigenous young people. Most clinicians interviewed reported challenges in delivering therapeutic services that effectively engage Indigenous clients. Possible reasons for this include:

- a shortage of Indigenous counsellors, and a need to strengthen the Indigenous social-health workforce
- cultural reasons for a reticence to talk about sexual matters, especially with someone of the opposite sex
- concepts of shame, and the denial of offending
- cognitive delays in children due to profound trauma and/or foetal alcohol syndrome
- geographic remoteness and the logistical difficulties of accessing services.

The study highlights the need for culturally appropriate preventative and therapeutic initiatives to respond to Indigenous children who have been victimised and may be at increased risk of offending themselves. It is important that these services are delivered to Indigenous people within the contexts in which they live. The clinical literature on sexualised behaviours in childhood indicates that therapy is most effective when sensitive to the child’s environment. This allows for therapeutic and strengthening work with the child’s family and school contexts. For all children a contextually sensitive model is preferable to one in which a child is dislocated from their community, treated in isolation, and then returned to their original context of risk.

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5 This study uses the term Indigenous to refer to Aboriginal and Torres Strait Islander peoples.
Children and young people with sexualised behaviours confound understandings of ‘victim’ and ‘offender’ as mutually exclusive categories. A full understanding of the intergenerational cycle of sexual abuse means acknowledging that children and young people with sexualised behaviours are very often children who have experienced harm of some kind, and who then go on to cause harm themselves. Breaking this cycle of victimisation and reducing the numbers of young people entering the juvenile justice system requires a commitment to providing an early and effective response to children who have been victimised.

Specialised therapeutic services in Australia have evolved in a piecemeal fashion in response to the increasing need identified by mental health clinicians and sexual assault counsellors. The geographic and demographic service gaps identified in this study are, in part, a result of this ad hoc evolution of services. This has also resulted in services differing significantly in terms of therapeutic philosophy, referral criteria, staffing expertise and funding arrangements. Without a regulatory body and a national system of accreditation there is enormous variance in the skill and qualification levels of clinicians. At present, professionals exercise enormous discretion in how they respond to children with sexualised behaviours. Where the responses of professionals are ill-informed or unregulated there may be profound risks for the children involved.

There is also considerable debate about whether this work is most appropriately undertaken by psychologists, psychiatrists, social workers or counsellors. Pre-service tertiary training for these disciplines places little emphasis on therapeutic responses to sexualised behaviours or childhood trauma. This means that the already limited and under-funded human services workforce lacks the specialised knowledge required to respond effectively to this specific area of need. Furthermore, as the sector is not nationally unified or sufficiently professionalised, not all agencies fund ongoing professional development for staff. This, and the limited opportunities for clinical research, pose the risk that the therapeutic responses offered to children do not adhere to standards of evidence-based best practice.

Other major challenges to the comprehensive provision of specialised therapeutic services include the need for:

- therapeutic residential placements for young people with sexualised behaviours
- successful engagement and support for the family and community
- holistic and integrated care for all needs faced by the young person’s family
- specialised psychological services for the supervision of youth justice orders
- preventing the stigmatisation of children with sexualised behaviours. These children are not young paedophiles and to refer to them as such risks alienating them further.

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6 A 2006 evaluation of the New Street Adolescent Service found that the majority of young people at the service who had engaged in SABs had experienced harm themselves, including neglect and exposure to domestic violence. Laing, et al. 2006. qtd. in McGregor, S. 2008. p. 5.

7 Whilst this study does not map sexual assault services these are identified to be of enormous importance. In the course of interviews for this study clinicians expressed their concerns regarding the paucity of forensic and counselling services for sexually abused children in regional and remote Australia. There is particular concern about the shortage of culturally appropriate services for Indigenous and culturally and linguistically diverse children and children from war-torn countries who have settled in Australia.
Whilst the study identifies multiple challenges there are also a number of positive initiatives in the provision of relevant primary, secondary or tertiary services. These include:

- school-based respectful relationships programs devised in consultation with young people
- assessment tools that are responsive to the needs of Indigenous children
- the Victorian legislation that mandates treatment for children who may otherwise be ineligible for service
- the unique model of collaborative outreach offered to some young people in regional and remote Queensland
- the NSW system for accrediting counsellors for working with those who have sexually offended
- an innovative mobile service in the NT with Aboriginal therapeutic resource workers and qualified counsellors responding to remotely located Aboriginal children, families and communities suffering any form of trauma related to child abuse, neglect or sexual assault.

There are multiple challenges facing the tertiary services sector, yet the comprehensive provision of specialised services is just one part of the response required. This study emphasises the need for effective primary and secondary prevention to effect a reduction in the numbers of young people requiring counselling in the future.\(^8\) Consistent with the public health model, this report prioritises professional and community education strategies that would ultimately necessitate fewer tertiary services for young people and fewer places in juvenile detention centres.

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\(^8\) There are several broad areas in which prevention and early intervention work might be bolstered. These include redressing contexts of trauma and disadvantage, the need for educational strategies for teachers, child protection workers, and parents, and preventative messages delivered in early school settings to ensure children learn about respectful relationships early.
INTRODUCTION- BACKGROUND TO THE STUDY

This research has been undertaken for the Australian Crime Commission’s (ACC) National Indigenous Intelligence Task Force (NIITF). The NIITF is working to improve the understanding of the nature and extent of issues surrounding violence and child abuse in Indigenous communities. The NIITF was announced in July 2006 as part of a whole of government response to remedy violence and child abuse in remote, rural and urban Indigenous communities. The objectives for the NIITF’s intelligence gathering approach are to:

1. Improve national co-ordination in the collection and sharing of relevant information and intelligence on violence and child abuse in remote and urban Indigenous communities.

2. Enhance national understanding about the nature and extent of violence and child abuse in remote and urban Indigenous communities.

3. Provide related intelligence and other advice to relevant Commonwealth, state and territory organisations on violence and child abuse in remote and urban Indigenous communities, including on organised criminal involvement in drugs, alcohol, pornography and fraud.


Consistent with the fourth objective, this study surveys the availability of specialised interventions to prevent children and young people from sexually offending. The study grew out of concerns about the context of risk for Indigenous children and their over-representation in the juvenile justice system.9

The impetus for the research project was in NIITF intelligence and published reports indicating substantial concern regarding the incidence of sexualised behaviours among Indigenous children. In the last decade each of the states and territories have commissioned Inquiries or Task Force reports which detail the levels of violence and the conditions of disadvantage in Indigenous communities. These reports reveal that Indigenous leaders, community members and health practitioners are concerned that child sexual activity is now becoming the norm.10 These concerns have also been made evident in the media, with a number of stories in recent years of Indigenous children in contact with the juvenile justice system or child protection agencies as a result of their coercive behaviour with other Indigenous children.11

Whilst the attention to Indigenous disadvantage and concern about sexual abuse has featured prominently in the public domain, the issue of children and young people with sexualised or sexual offending behaviours is not, by any means, exclusive to Indigenous Australians. The challenges presented by children with these behaviours are evident globally and, in Australia, the cohort of young people requiring therapeutic response for sexualised behaviours comprises children and young people across the full range of ethnic and socio-demographic contexts.

9 This context of risk is addressed in Problem Sexual Behaviour: A Review of the Literature, a companion publication to this report.


11 Some of these reports refer to recent incidents whereby Indigenous juveniles have been placed before the criminal courts for alleged sex offences: Barass, T. 2007; Chilcot, T. 2008. In terms of the veracity of these claims it is worth noting that these are media reports, not the findings of empirical studies.
This national study is also a recorded action in the National Framework for Protecting Australia’s Children 2009-2020. Strategy 6.2 Enhance Prevention Strategies for Child Abuse lists this study as action 6.2B; ‘Investigate best practice therapeutic programs for children displaying sexually abusive behaviours’.12

The first part of this report was published in September 2009. Problem Sexual Behaviour in Children: A Review of the Literature is available from the ACC website:

This report constitutes the second part of a national study on the specialised therapeutic counselling services for children and young people who demonstrate sexualised or sexual offending behaviours. The purpose of this report is:

1. to map the existing service provision nationally
2. to identify challenges and gaps that might adversely affect children and young people, including Indigenous children and young people
3. to highlight programs and initiatives that may result in positive therapeutic outcomes for children and young people with problem sexual behaviour.

THE FIRST REPORT – THE LITERATURE REVIEW

An initial scan of Australian scholarship on this issue revealed scant Australian clinical and criminological literature, with Australian understandings of childhood sexual behaviours being largely informed by international studies. There are very few empirical studies indicating the prevalence of sexualised behaviours amongst Australian children, and there are none pertaining specifically to the prevalence amongst Indigenous children. Indeed, there is limited Australian scholarship detailing the possible therapeutic response options, measures of program success, recidivism studies, or processes of evaluation for therapeutic or jurisprudential intervention. In short, the early stages of the research project identified a gap within the Australian literature pointing to the need for an increased evidence base for response, particularly given the increasing media attention to these childhood behaviours.

The subsequent review of the largely international literature base of developmental criminology, juvenile offending, and the clinical literature on problem sexual behaviour revealed a number of commonly cited risk pathways to juvenile offending (in general) and problem sexual behaviour (in particular). This literature highlights that children who suffer compounding factors of trauma and disadvantage are at greater risk of engaging in problem sexual behaviours; a context of risk that is ecologically and systemically understood.13

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Several data sets contribute to an understanding of the extent and specificities of disadvantage in Indigenous communities. Concern regarding the extent of this disadvantage is also evident in empirical studies undertaken in Indigenous communities, and in the comments of a number of Indigenous leaders and academics. The scholarship detailing the extent of this disadvantage provides cause for concern when cast against the literature of developmental criminology. This literature indicates that childhood experiences of trauma and disadvantage are likely to result in compromised developmental outcomes for children. Given the profound circumstances of disadvantage in some Indigenous communities, it is likely that the risk pathways to juvenile offending and problem sexual behaviour are significantly increased for some Indigenous children. Recent data indicate that the over-representation of children in the juvenile justice system is worsening. Indigenous children are 28 times more likely to be detained than non-Indigenous children. This deepening inter-generational crisis provided the impetus for this research. Furthermore, a preliminary survey of the service provision to children with problem sexual behaviour pointed to the need for increased services for all young people (including programs that are designed and delivered by Indigenous practitioners in regional, rural and remote communities). The intention of this research is to ascertain what therapeutic services were being delivered to all Australian children, including programs designed to reduce the numbers of Indigenous children before the courts on charges of sexual assault.

**METHODOLOGY**

The primary collection methodology involved a series of semi-structured interviews with professionals who provide specialised therapeutic response to children with sexualised or sexual offending behaviours. These stakeholders included psychologists, psychiatrists, social workers and counsellors in health, child protection, juvenile justice, non-government agencies and private practice. Other stakeholders interviewed included academics, solicitors, representatives from Aboriginal health agencies, justice workers, and those working the sphere of community education of children regarding sexuality or protective behaviours. Meetings were also held with the Commissioner or Guardian for children for each state and territory. A list of those interviewed is provided at Appendix One of this report.

All interview participants were provided with a Research Statement, and were requested to sign consent forms to participate in the project. Over 90 interviews were conducted, with approximately 250 people representing a cross section of agencies from each state and territory.

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20 Not all those interviewed are listed at Appendix One. Where interviewees requested confidentiality this has been respected. Where interviewees did not complete consent forms for the interview data from these meetings has not been used in the study.
The same semi-structured interview was administered to specialised clinicians or program managers identified for interview. Rather than questionnaires or structured interviews, the use of semi-structured interviews provided the flexibility necessary to elicit data from the diverse range of services providing therapeutic response to children and young people with sexualised or sexually abusive behaviours. Participants were invited to provide broad and de-identified data about both the programs offered by their agency and the cohort of clients serviced by those programs. Identifying information about participants or their clients was not collected. Information collected in interviews included:

- Characteristics of the program:
  - the length of time for which the program has been operational
  - the funding structure for the program
  - the facilities and service area for the program (that is; one site, multiple or outreach—regional/rural sites)
  - whether the program offers preventative programs and/or community education or solely secondary or tertiary response programs
  - whether there are evaluation mechanisms in place for the program, whether these are independent or internal, and the outcomes of previous evaluations
  - the numbers of staff associated with the program, requisite qualifications for staff, professional development opportunities, challenges in terms of workforce development, and so on
  - whether the program has aspects designed to be culturally sensitive to Indigenous and culturally and linguistically diverse young people
  - whether the program has residential facilities
  - the structure and theoretical underpinnings of the therapeutic counselling or programs offered.

- Characteristics of the client base:
  - data on the number of clients engaged in the therapeutic program for a specified period
  - broad demographic characteristics of this client base (age range, gender, Indigenous status)
  - completion rates and recidivism rates if these are available
  - referral sources (court mandated, self-registered, and so on)
  - client numbers—whether the programs receive sufficient referrals to fill the program, or whether referrals exceed program capacity.
A further 100 stakeholders were invited to provide written submissions addressing the broad scope covered by the semi-structured interviews detailed above. Invitations for submission were sent to representatives from peak non-government child protection agencies, statutory child protection agencies and the Department of Education in each state and territory. Submissions were also invited from psychologists in private practice, academics and child protection advocates. Commonwealth Government input was sought by invitation to the Department of Health and Ageing (DoHA), Department of Education, Employment and Workplace Relations (DEEWR), the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), and the Attorney General’s Department (AGD).

A call for public submissions was also advertised in the Weekend Australian newspaper on 25 June 2009. Advertisements for submissions were also posted on the websites for the ACC and Australian Policy Online, as well as Crimnet, a discussion list utilised by academics in law and criminology. A list of submissions received is provided at Appendix Two of this report.

In general, the consultative phase of the research project was designed to invite contribution from those working at the frontline with children exhibiting problem sexual behaviours. The semi-structured interviews and call for submissions were designed to obtain data that broadly indicate the demographic and geographic service area for the client base, the referral mechanisms (and whether there are gaps or shortages here), the program design and structure (and whether this includes culturally appropriate and/or gender sensitive programs).

The qualitative analysis of interview transcripts and submissions provides a picture of both the current availability of services to Australian children exhibiting problem sexual behaviour, and also the challenges that persist across the various sectors delivering these services. This report presents the findings of the study and discussion together, so as to more fully identify the themes identified in interviews and submissions.

**Expert Reference Group:** The research methodology was designed in consultation with a group of Indigenous and non-Indigenous people recognised nationally for their expertise in the fields of child protection, youth justice, the delivery of therapeutic services to children with problem sexual behaviour, Aboriginal community controlled delivery of health services and/or research on violence in Indigenous communities. Professor Chris Cunneen, Dr Fiona Arney, Dr Howard Bath, Dr Mick Adams and Ms Marcia Ella-Duncan provided invaluable comment on the draft report prior to publication.

**Human Research Ethics Approval:** Human Research Ethics Approval was granted by the Aboriginal Health Research Ethics Committee. The research was conducted in accordance with both the *National Statement on Ethical Conduct in Research involving Humans* (2007) and the *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Research* (2003).

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21 Crimnet is an initiative of the Institute of Criminology, University of Sydney.
In recent years there has been a significant evolution in research and clinical interventions with children and young people with sexualised behaviours. There is now a greater understanding that young people with these behaviours are more likely to have had adverse childhood experiences. Informed by a body of work on the impacts of childhood trauma, clinicians are mindful of the adverse consequences of physical abuse, sexual abuse and neglect. Awareness about the impacts of caregiver substance abuse, exposure to violence, social isolation, poor engagement at school and poor attachment has contributed to a context in which sexualised behaviours, particularly in young children, are often understood as ‘sexually reactive’ or ‘acting out’ responses to trauma. There is also an increasing understanding of the neuro-biological effects that trauma has on the developing brain, and of the need for specialised responses to children with intellectual disabilities, developmental delays and foetal alcohol syndrome.

Terminology for describing sexualised behaviours in young people is fraught and, in Australia, debate continues as to the most appropriate terms. Whilst this may seem incidental, it is an issue of enormous significance. The terms used as descriptors can become labels that impact on how a young person considers their identity, their future, and their own potential to engage in healthy and positive behaviours. There is a general consensus amongst researchers and clinicians that to refer to juveniles as ‘sex offenders’, ‘perpetrators’, or ‘abusers’ is stigmatising and likely to inhibit the young person’s impetus to change. In general, Australian clinicians rarely use stigmatising language, particularly to refer to children below the age of criminal responsibility (under the age of 10 in Australia). Clinicians now utilise terms that describe the behaviours that a young person has displayed, rather than describing the young person as something that seems pathological and intractable, that is as ‘a perpetrator’, or as ‘a sex offender’. Children and young people with sexualised behaviours are not young paedophiles with a pre-existing or pathological sexual predilection for children. Children and young people with these behaviours are themselves likely to be victims of trauma with a series of complex and intersecting therapeutic needs.

DEFINITIONS OF BEHAVIOURS

DEVELOPMENTS IN CLINICAL PRACTICE – IMPLICATIONS FOR TERMINOLOGY

For a discussion of attachment issues and young people with PSBs or SABs refer to Rich, P. 2006; Boyd, C. 2007. For further information regarding the impacts of childhood trauma refer to Van der Kolk, B. A. 2007. A number of clinicians expressed deep concerns about the stigmatising and life-long consequences for a young person if they are placed on the Australian National Child Offender Register ANCOR, commonly known as ‘the Sex Offender Register’. These concerns are particularly keen with respect to the registration of younger juveniles. Interview with Sue Rayment-McHugh, dated 23 June 2009; Interview with Christabel Charnarette, dated 6 May 2009.
PROBLEM SEXUAL BEHAVIOURS (PSBs) AND SEXUALLY ABUSIVE BEHAVIOURS (SABs)

Children and young people who display sexualised or sexually abusive behaviours are not a homogenous group and terminology used varies from one therapeutic setting to another. In general however, Australian clinicians generally describe ‘children’ as those under the age of culpability. For children with concerning sexualised behaviour, the terms ‘problem sexual behaviours’ (PSBs) or ‘inappropriate sexual behaviours’ are used. Behaviours in this spectrum vary from excessive self-stimulation, sexual approaches to adults, obsessive interests in pornography, and sexual overtures to other children that are excessive to developmental bounds. For some children, these PSBs are highly coercive and involve force; acts that would be described as ‘abusive’ were it not for the child’s age.

For ‘young people’ aged 10–18, the term ‘sexually abusive behaviours’ (SABs) is more readily applied. This terminology also labels the behaviours rather than the young person, and is less stigmatising than the imposition of a label such as ‘sexual abuser’. There is some discussion across the sector as to the most appropriate terminology and many clinicians find the terms in current use to be less than ideal. There are difficulties in describing coercive behaviours in a way that is non-stigmatising but also conveys the seriousness of the behaviours and their impact on victims.

In lieu of agreed terminology many Australian service providers, government departments and schools now apply the terms PSBs and SABs in accordance with the age of criminal responsibility. This is not always appropriate. Some clinicians are careful to exercise discretion in their application of terms regarding particular children. Reference to these two distinct groups of PSBs and SABs as age dependent is most evident in the administration of therapeutic programs (eligibility criteria, program descriptions, departmental protocols and therapeutic approaches). A more nuanced terminology is required to ensure that the distinction between ‘problematic’ and ‘abusive’ is not determined solely according to the age that children are deemed culpable for their actions under the law. There are several reasons for this:

- Children under 10 are capable of using coercion or force to engage other, usually younger, children in sexual activity. To refer to this as PSBs minimises the impacts that this behaviour is likely to have on the victimised child, as well as minimising the urgent need for specialist care for the child responsible for the act. There is a need for a more nuanced structure of terminology here, so there is clarity as to the differences between the behaviour of a child who engages in excessive self-stimulation and, for example, a child who uses force or power to sexually assault another child.

- The principal of doli incapax indicates the law’s ambivalence regarding children’s capability to know that their commission of a crime is wrong. For those aged 10–14, the rebuttable presumption of criminal incapacity means that prosecution of sexual crimes committed by children is unlikely. There is a tension here as to whether a young person with sexually abusive behaviours is also a young person in need of therapeutic care. As Copeland and Goodie argue, ‘young people occupy an awkward social and legal space, in which they can be variously characterised as children in need of legal protection or as adults with legal responsibilities’.

25 In some instances the application of terminology takes into account doli incapax. Many services are funded to work with children to the age of 12, and some others make the decision to exclude young people over 12.

To categorise behaviours (PSBs and SABs) according to the age of culpability risks homogenising all those aged 10–18 who have sexualised behaviours as having sexually abusive behaviours; this is not the case. Referrals for casework and therapeutic intervention for those 10 and over may be made for any sexualised behaviours that are determined to be excessive to developmental bounds and likely to place the young person or others at risk of harm. These behaviours might include excessive self-stimulation, an obsessive interest in pornography, inappropriate use of technology to create, store, or send sexually explicit material, public exposure, engaging in or being at risk of engaging in sexual exploitation, sexual harassment, as well as acts of penetrative or non penetrative sexual assault, with or without violence. To conflate these diverse acts as ‘sexually abusive’ is not only likely to be stigmatising but may also inhibit the nuanced responses that are required to ensure the ongoing safety and wellbeing of both the young person and those with whom they interact.

Finally, for definitions and eligibility criteria to pivot around the age of culpability is problematic in instances when the child or young person has an intellectual disability, a developmental delay or cognitive limitations, including where this is due to childhood trauma or foetal alcohol syndrome. In such cases, eligibility to clinical services that are based on the legal age of criminality seem arbitrary and unresponsive to young people’s needs. Consultations for this study revealed clinicians’ deep concerns about effective therapeutic interventions and safe therapeutic placements for young people with intellectual disabilities or developmental delays.

Australian clinicians and researchers are yet to agree on the most appropriate terminology to describe children and young people exhibiting a broad spectrum of sexualised behaviours. The complexities described above are among the factors contributing to this ongoing debate. Whilst the debate continues there is the risk that legislative, policy and therapeutic approaches are predicated on terms that may either stigmatisate or minimise the behaviours. Careful use of terminology is required to ensure that systems can respond appropriately, and with sensitivity, to the broad spectrum of sexualised behaviours and the conditions that are likely to have contributed to them.27

**CONTEXTS OF DISADVANTAGE – CORRELATIVES TO SEXUALISED BEHAVIOURS**

Whilst there is no single cause of inappropriate sexualised behaviours in childhood, clinical data reveal that children with sexualised behaviours are also likely to have experienced, or be experiencing any one, or a combination, of the following:

- experiences of childhood trauma
- compromised educational outcomes
- adverse socio-economic conditions
- homelessness or an unstable home-life (including alternate care)
- intellectual impairment or developmental delays

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27 In this report, the terms PSBs and SABs are used to refer to services for children and young people, respectively. These terms are used in order to reflect the most common descriptors used by service providers. The terms PSBs and SABs are not used as though unproblematic.
- social isolation and/or difficulties engaging with peers at school
- exposure to drug or alcohol misuse.\(^{28}\)

This list is not exhaustive, nor can it be considered prescriptive or causal. These challenges are just some of the conditions of disadvantage that often characterise the childhood stories of those who come to attention for their inappropriate sexualised behaviours. These findings highlight the importance of integrated services as well as specialised therapeutic responses to children and young people with sexualised behaviours. Many clinicians interviewed for this study stressed that it is extremely rare for a child’s sexualised behaviour to be their only behavioural issue of concern, their only indicator of trauma, or their only area of therapeutic need.

Annette Jackson, Knowledge Manager of Take Two at Berry Street Victoria, indicated that, ‘if kids have sexualised behaviour it is often a flag that there are a host of other indicators that they have experienced childhood trauma of some kind’.\(^ {29}\) Take Two provide intensive response to traumatised children generally rather than those with sexualised behaviours specifically, although several staff have the specialised training and expertise to undertake this work. Although Take Two is not established as a specialist service they report that, over time, 24 per cent of the young people in the program have presented with some form of inappropriate sexualised behaviours or display of sexual violence to towards others.\(^ {30}\) This high number of incidental presentations of sexualised behaviours points to both the prevalence of these behaviours in traumatised children and the need for an understanding that sexualised behaviours are very often an indication that the young person has experienced, or may still be experiencing, harm of some kind.

**SPECIALISED THERAPEUTIC RESPONSES**

The services referred to here as ‘specialised therapeutic services’ for children and young people with PSBs or SABs are a heterogenous group of clinical interventions with divergent origins, philosophies, funding structures, treatment models, referral pathways, client placement capacity and clinical expertise. The programs surveyed for this study are those that define themselves as offering counselling services to children who have engaged in problem sexual behaviours or sexually abusive behaviours. This is distinct from counselling services for victims of either adult or child perpetrated abuse, although some of the programs included in this study offer victim services as well. Indeed, in locations where there are few specialised services for children and young people with PSBs or SABs, counselling is provided by forensic child abuse units in hospitals, centres against sexual assault that have traditionally been victim focused and, in some instances, child and adolescent mental health services (CAMHS). There are also a number of generalist counselling services, and private psychologists and counsellors that have stepped into the breach to provide service to children and young people who might otherwise go without.

\(^{29}\) Funded by the Department of Human Services, Take Two is a state-wide intensive therapeutic service for infants, children and young people who have experienced childhood trauma. Interview with Annette Jackson and Megan Pollard, dated 4 August 2009.
\(^{30}\) This refers to 24 percent of the total client group for Take Two since its commencement in late 2003 early 2004. Frederico, M., A. Jackson, et al. forthcoming. Page number not available.
The largely piecemeal evolution of Australia’s response to children and young people with sexualised behaviours has been in response to the increasing need identified by mental health clinicians and sexual assault counsellors. The geographic and demographic service gaps identified in this study are, in part, a result of this ad hoc evolution. This has also resulted in services differing significantly in terms of therapeutic philosophy, referral criteria, staffing expertise and funding arrangements. This variance is found across jurisdictions and also within them and, even now, the sector remains largely unregulated. The professional qualifications and skill level of clinicians varies enormously and, without regulatory requirements for the sector, many agencies are unable to commit to ongoing programs of professional development for staff.

A large number of Australian clinicians have gone to significant personal expense and effort to ensure that they are in step with best-practice recommendations according to the literature and the principles advocated by the professional associations relevant to this sector. 31 It is important to note, however, that the international and Australian literature on response options for children and young people with PSBs or SABs reflects the consensus that this is a separate and specialised field of service provision necessitating specialist training and supervision for clinicians.

To emphasise the specialised and intensive nature of this work is not to suggest that responding to a child’s sexualised behaviours alone will always be sufficient. As indicated, children with sexualised behaviours are likely to experience multiple challenges and, as such, they are likely to require an integrated service response that is attuned to their particular needs. Clinicians stressed that children and young people very often require integrated support in many areas of their lives, including assistance with housing, juvenile justice, mental health, employment services and education. This need for both general and specialised support also applies to young people in contact with the criminal justice system for sex offending behaviour. Professor Stephen Smallbone maintains that as there is a greater likelihood that young people will be re-convicted for nonsexual offences than for sexual offences, ‘treatment programs for sexual offenders should target criminogenic needs relating to both sexual and nonsexual recidivism’.32 What this indicates then, is the importance of acknowledging that providing therapeutic response to children and young people with sexualised behaviours is highly specialised, yet for many children this is but one area of need. As such, a coordinated multi-sectoral approach that works in concert with specialised counselling is likely to be beneficial in supporting children with multiple needs.

31 Both ANZATSA and VOTA promote a code of ethics for clinicians, and promote ongoing professional development in best practice for assessment and intervention.
INITIATIVE – TO CREATE A MEANS OF ASSESSING ABORIGINAL CHILDREN’S SOCIAL AND EMOTIONAL WELLBEING

With assistance from the Victorian Aboriginal Child Care Agency (VACCA), and with funding from the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS), Berry Street Victoria have engaged a researcher to create a tool that clinicians can use to assist in assessing the social and emotional wellbeing of Indigenous children.

The ‘Cultural Yarn Tool’ will soon be piloted as a means of engaging Indigenous children with respect to their cultural identity. It is intended that this will inform assessment and recommendations for therapeutic work. Details of this initiative will be published in the forthcoming Berry Street report, Not One Size Fits All.

UNDERSTANDING SPECIALISED THERAPEUTIC APPROACHES

As there is no nationally agreed treatment protocol each agency offers counselling that is based on its own principles for therapeutic intervention. Accordingly, there is a significant degree of variation in the theoretical underpinnings of the various clinical assessments and interventions that are offered in Australia. In some instances therapeutic interventions are influenced by longer-standing models of practice from the United States, Canada, the United Kingdom or New Zealand. In other cases, the therapeutic model is based on the initial or historical purpose of the agency. For example, centres against sexual assault that now offer response to children with sexualised behaviours may continue to operate within a model that is victim focused, rather than focused on challenging the abusive behaviour.

Despite differing therapeutic approaches, many services are modelled on strengths-based cognitive behavioural therapeutic (CBT) approaches that encourage empathy and provide a positive framework for behaviour. A number of services emphasise the importance of understanding attachment issues and the neuro-biological effects of trauma. Most also emphasise the importance of containing behaviours and devising safety plans. In this approach many therapists identify the importance of thorough and professionally conducted assessments in providing the foundation for the most appropriate therapeutic response. Most services are not strictly time limited and, depending on the behaviours, clinical work might last from a few months of basic psycho-educational work through to a year or 18 months of intensive strengths-based CBT. The principal most uniformly upheld by clinicians is that working with family or caregivers is of paramount importance. Strategies adopted with less regularity include play therapy, art therapy and sand therapy, narrative therapy and skills building camps. Therapeutic sessions may be conducted individually or in groups, and in some cases a combination of both. Across the sector there is significant variance in opinion as to the appropriateness of each.
A number of clinicians highlighted the challenges in ensuring immediate and ongoing safety for young people; both those demonstrating sexualised behaviours, and siblings and other children in their immediate environment. Concerns of safety for children are paramount for staff within school contexts, and many clinicians indicated that this motivates schools to seek out specialised therapeutic care and containment strategies for young people with sexualised behaviours. Most specialised counselling services are funded according to service agreements that allow only for counselling work and, perhaps, some engagement with the family. Nonetheless, most clinicians adhere to the belief that therapeutic work will only be effective if it is ecologically based.33

Systems based or ecological models of therapeutic care derive from Urie Brofenbrenner’s ecological theory of development.34 Informed by sociology, this aspect of developmental psychology has been highly influential internationally. Ecological approaches consider a child’s development and their behaviours in terms of the relationships that they have in contexts such as the family, school settings and with peers.

Consistent with ecological approaches, many clinicians stress that children and young people with sexualised behaviours do not exist in isolation, and their behaviours do not stem from an innate dysfunction, pathology, or sexual predisposition. Clinicians agree that a young person with sexualised behaviours cannot simply be ‘corrected’ as though there were something innately ‘wrong’ with that individual. A young person’s experiences, and the environment in which they develop, have a significant influence on their behaviours. This does not imply a relationship of simple causality in which young people simply act out what they have seen or experienced. Rather, ecological approaches emphasise the need to ensure that the social, familial, educational and socio-economic contexts for children provide a sound framework to support the young person and to allow them to make sound decisions about their place within those settings.

There are inherent therapeutic limitations in working with a young person if the young person is to return to the (unchanged) natural ecology that contributed to that behaviour in the first place. The most recent research advocates that work with the young person is based on an understanding of their interactions with other systems and settings. This means that clinicians are required to work across a number of platforms to ensure effective therapeutic outcomes and a sustainable context for the young person’s wellbeing.35 Such an approach necessitates clinicians liaising with family, schools, other health workers and, where appropriate, child protection and police. This is extremely resource intensive and the time-commitment that clinicians make often exceeds the provisions of the service agreement. Where possible clinicians work closely with schools. However they indicate that this is only possible where the school is willing and adequately resourced. The work undertaken here is necessary to ensure that the safety of other children is not compromised and that the young person is not subjected to onerous and stigmatising supervisory restrictions. Where schools are willing, clinicians undertake intensive work with teachers to devise safety plans so that the young person can remain in mainstream schooling.

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33 This is supported by Australian research which indicates that, ‘[f]or adolescents in particular, being isolated from one’s family as a result of sexual offending can jeopardise the young person’s ability to address such behaviour through treatment’. McGregor, S. 2008. p. 5.


35 Multi-Systemic Therapy MST is a specific model of intensive, time-limited home-based intervention that involves the young person’s family, peers and other relevant networks. The attention to the child’s ‘natural ecology’ emphasises that behaviours are a complex interaction with both proximate and distal ecological factors. NSW Juvenile Justice offer a program based on MST. The Intensive Supervision Program is for young people on community-based orders who reside in the Western Sydney or Newcastle region. Young people who have committed sex offences are ineligible.
CASE EXAMPLE
A manager of a specialised service described one school as consistently and deliberately making decisions that served the therapeutic needs of vulnerable students. In one example, a boy who had already experienced multiple placement breakdowns was commencing a new placement that would have meant that he should change schools. Instead, the school advocated for him to remain enrolled at his current school, with additional support to manage his behaviours.

The school had been the only stable element in the boy’s life for a number of years, a fact identified by educational staff. This advocacy, and the additional practical and therapeutic supports supplied, demonstrates an approach that prioritises the boy’s welfare and respects the importance of attachment and peer relationships.

ECOLOGICAL APPROACHES AND WORKING WITH FAMILY
The vast majority of specialised counsellors in this field also strive to work closely with family or carers. Most clinicians are emphatic that working with families is the only way to ensure therapeutic gains. Australian research based on a cohort of young people with SABs describes the families of these young people as ‘disorganised, uncommunicative and adversarial’. Improved family functioning is a reported outcome where there is sufficient family engagement to complete a treatment program. Where clinicians are unable to engage with families or carers the therapeutic work is often jeopardised.

There are several documented challenges in working with families including difficulties in engaging parents with an intellectual disability and/or patterns of substance abuse. The literature on children with sexualised or sexual offending behaviours indicates that these children are likely to come from contexts of trauma, disadvantage, and compromised social and educational engagement. Clinicians have indicated that when a young person from a chaotic context comes to attention for their behaviours this can place enormous strain on a family that is already barely coping with multiple challenges. If a young person is then excluded from school due to their behaviours, or they are subject to an order to attend therapeutic counselling, the parent/s or carer/s are then burdened with an additional commitment, responsibility and expense. For some families this is prohibitive. Some families experience overwhelming financial, geographic or transportation barriers to regularly attend a service.

Geographic challenges are addressed in detail on page 64 of this report, however, in general, clinicians report that the greater the geographic distance the family residence is from the counselling service the more likely client attrition. The South Eastern Centre Against Sexual Assault (SECASA) has retained data indicating that geographic distance from the service and therapeutic success exist in inverse proportion. Accordingly, SECASA have restricted eligibility to those residing within a two-hour travel radius of the

service. Australian research indicates that children with problem sexual behaviour are more likely to come from very low-income households. This is a circumstance that is also likely to impact on the efficacy of therapeutic interventions, as Julaine Allan reports that families from low socio-economic circumstances face increased challenges in ensuring regular engagement with therapeutic services.

Specialised clinicians working with young people with sexualised behaviours often see their duty of care as extending well beyond the weekly counselling session. This is due to the multiple and complex needs faced by families of young people with sexualised behaviours. This systems work is also consistent with an ecological model of working holistically with the various contexts and supports for each client. Clinicians often described their role as one of advocacy, in which they liaise extensively with schools, medical and mental health services, housing services, and child protection services in a proxy case management role. Clinicians report significant challenges in working with much larger systems to ensure child safety. These challenges are evident, for example, in the urgent need for increased research and a systems-commitment to securing stable alternative placements for young people who are removed from home in instances of sibling sexual assault.

SAFE PLACEMENTS

There are significant challenges in finding safe and stable placements for young people with sexualised behaviours and these children are likely to experience multiple placement breakdowns. Carers often lack the skills or the knowledge to adequately support the young person by monitoring safety plans and maintaining a commitment to therapeutic treatment. Clinicians identify the importance of providing foster carers with support and education so they can ensure the young person’s wellbeing and the safety of other children. There are reported instances in which carers have not been informed of a child’s sexualised behaviours before agreeing to accept the placement of that child. Whether the intention is to maintain the child’s privacy, or simply to secure the placement, the fact that this information is withheld compromises the ability of carers to respond to the needs of the child.

Successful placements are even more difficult to maintain when a young person is of an age where they may be perceived to be culpable and thus at risk of re-offending. In Australia, at the current time, there is one therapeutic residential unit for non-adjudicated young people who have displayed sexually abusive behaviours. New Pathways is based in the NSW highlands and has the capacity to accept six adolescent clients. New Pathways accepts only male clients aged 13–17 years who have high and complex needs. As the only service of its kind, New Pathways cannot possibly respond to the state-wide or nation-wide demand for safe and stable placements for young people with sexually abusive behaviours. Interviews for this study revealed a range of adverse outcomes associated with this gap

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38 This geographic restriction on eligibility is also due to the overwhelming demand on SECASA services. Interview with Russell Pratt and Carolyn Worth, dated 8 April 2009.
40 Allan, J. 2005. p. 55. This concern is echoed by the experience of clinicians who find that young people are often unable to attend the service with any regularity due to the absence of cost-effective and reliable transportation. Gatehouse staff report that that they often receive calls from parents in outlying areas of metropolitan Melbourne indicating that they cannot bring their child because they cannot afford petrol for the car, or the car has broken down and they cannot afford the mechanical repairs required. Interview with Gatehouse staff, dated 12 August 2009.
42 Withington, T. 2009b. p. 34.
in service provision. In instances of sibling sexual assault, for example, it may be that it is the younger child that is removed, a practice that, although rare, clinicians describe as a double victimisation. Clinicians also reported instances in which young people with sexually abusive behaviours have been placed in residential units where they have subsequently assaulted other children, and there are also risks associated with the placement of children and young people in temporary care with young, unqualified or unskilled workers.

**CASE EXAMPLE**

The challenges in finding suitable placements for young people with sexual offending behaviours are evident in each state and territory. In some jurisdictions the shortage of placements means that a significant number of children are accommodated in temporary care in hotels or rented apartments. The living environment bears little resemblance to a family home and the care arrangements mean that a young person would have a roster of carers, many of whom are young or unskilled. Although it is intended that this be a temporary measure, in some jurisdictions the demand for placements means that children can be in care of this kind for extended periods.

In one case, a boy who had sexually offended was placed in care of this kind with a young and inexperienced female carer. After the two smoked cannabis together the boy sexually assaulted the carer, an act that resulted in further charges against him.

Interviews for this study revealed several other cases where inappropriate placements resulted in adverse consequences for the young person and for others.

Safe and secure placements are important for a host of reasons, including the fact that many services restrict eligibility to young people who are in stable care where there are no younger siblings or other children residing. Clinicians report that where the young person is in unstable care the therapeutic outcomes are likely to be compromised. An ecological therapeutic approach necessitates a stable home environment and a commitment from carers to provide an environment that is supportive of the young person’s plan for safety and positive behaviour.

Queensland has recently established six therapeutic residential facilities based in Goodna, Brisbane, Townsville and Cairns. When these services are fully operational there will be a total of 24 therapeutic residential places, comprising beds in residential units and specialised placements with carers. Staff from these services indicated that 24 beds will not be adequate to address the needs within the state, but that provision of additional beds is not the answer. The children who are placed in care of this kind have extremely high needs and experiences of profound trauma. Residential services staff

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43 Research documents the conflicting feelings that may be experienced by the child who has been assaulted. Clinicians report that most children who are assaulted by an older sibling are extremely reluctant for the family to be divided, and they do not want their sibling to be in trouble with the police; they simply want the abusive behaviours to stop. This places enormous pressure on the family, as often there is a decision for one or several children to be removed from the home.
emphasise that the service provided is extremely resource intensive and that all placements need to be therapeutically informed.\textsuperscript{44} The therapeutic practice model that will underpin these residential units has been written by Laurel Downey and is based on an understanding that children in residential services have often experienced abuse and neglect for many years.\textsuperscript{45} Downey’s practice model for therapeutic care is designed to provide a non-professional care workforce with skills and a framework for understanding trauma and the importance of assisting children in forming attachments.\textsuperscript{46}

In interviews, several clinicians called for therapeutic residential settings with theoretical underpinnings such as these. Yet there are practical considerations that restrict placements for children with sexualised or sexual offending behaviours. In Queensland, young people with sexual offending behaviours are categorically ineligible for placement in the new therapeutic residential settings.\textsuperscript{47} Each new referral to the unit is considered in terms of the safety and wellbeing of all children already resident in the unit. As such, children and young people with sexualised behaviours may be excluded on a case-by-case basis. Downey reports that there are approximately 700 children in care in North Queensland, a significant proportion of whom cannot co-tenant because of sexualised behaviours.\textsuperscript{48} Challenges in finding therapeutically appropriate and safe placements for children with sexualised behaviours are evident in each state and territory. Interviews with clinicians revealed widespread concern that the placements for children are rarely therapeutically informed. In most residential units children’s basic needs are met, yet staff are not trained to deliver therapeutic care or to foster attachments with children. Downey maintains that there is a need for the provision of ongoing training to the therapeutic care workforce and that, ultimately, this workforce needs to be professionalised.\textsuperscript{49} In a relevant initiative the Victorian Child Safety Commissioner has recently published a guide to assist residential and foster carers in supporting traumatised children.\textsuperscript{50}

\textsuperscript{44} Interview with Program Managers from Evolve Interagency Services, dated 08 July 2009.
\textsuperscript{45} Downey, L. 2009b. p. 9.
\textsuperscript{46} Downey, L. 2009b. p. 11.
\textsuperscript{47} Interview with Program Managers from Evolve Interagency Services, dated 08 July 2009.
\textsuperscript{48} Interview with Laurel Downey, dated 26 August 2009.
\textsuperscript{49} Downey, L. 2009b. p. 4.
ACKNOWLEDGING THAT CHILDREN WITH SEXUALISED BEHAVIOURS REQUIRE SPECIALISED THERAPEUTIC CARE

NON-DISCLOSURE AND TENDENCY TO MINIMISE IMPACT

Non-disclosure is one of the major impediments to effective therapeutic response. Clinicians report that many adults are unaware or unsure of the distinction between developmentally appropriate and inappropriate behaviours and, consequently, may over-react or under-react to children with sexualised behaviours. Problematic sexualised behaviours are thus sometimes overlooked, or seen as developmentally appropriate or ‘child’s play’. At the other end of this extreme, children’s developmentally appropriate behaviours can be stigmatised as abusive if there is a climate of fear around child sexual abuse. According to the Victorian Law Reform Commission, ‘the lack of a clear distinction between “normal experimentation” and sexually abusive behaviour makes it difficult for parents, teachers, carers and others working with children to know when there is a problem and how to respond to it’.51 This point was reiterated by clinicians interviewed for this study and, almost without exception, they emphasised the urgent need for community and professional education so that parents, carers, teachers, primary and allied health professionals and child protection workers have the confidence to make appropriate referrals in each case.

It is important to understand that the impact of sexual assault perpetrated by a child or adolescent is profound. An unwanted sexual act by a child has the same psychological impact on the victim as if the abuse were by an adult.52 Yet denial is powerful, and Australian clinicians report that both the child displaying SABs and their parents are likely to minimise the severity or the frequency of the incidents and the period of time for which they have been occurring. The Victorian Law Reform commission identified the complexity of non-disclosure of sexually coercive acts between children:

The usual reasons for not reporting, including shame, fear of the repercussions and not understanding what has occurred, may be particularly acute when the victim and the offender are both young people. Adults may minimise the seriousness of the behaviour because they do not know how to deal with it. Sibling sexual abuse presents considerable difficulties for families who must deal with both the victim and the offender. Many parents and family members are reluctant to involve the police or welfare authorities. Some will attempt to deal with the problem within the family, which may prevent the offender receiving assistance to change their behaviour and may expose the victim to further abuse.53

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These conceptual barriers to reporting, and the challenges in effectively identifying and responding to children with sexualised behaviours, mean that the number of children that come into contact with the juvenile justice system, or the referral networks of the child protection and health sectors, are likely to reflect only a proportion of the children displaying problem sexual behaviours. There are likely to be many more children who never reach the attention of authorities and who, therefore, never receive the therapeutic counselling they require.

Adults minimising or denying the behaviours or lacking the confidence to report is thought to contribute largely to under-reporting. Yet clinicians indicate that children are also very reluctant to disclose. In some cases the developmental age of the victim means that they are too young to disclose the abuse or, even if they are older, they may conceal, deny or minimise the incidents because they are fearful of the sibling or child that has sexually abused them. In some instances, the older child may have groomed the younger child to foster feelings of guilt and complicity. This sometimes results in the victimised child feeling loyalty towards the child displaying sexually abusive behaviours. In yet other cases involving sibling groups, a victimised child may be reluctant to disclose or fully disclose because they do not want their older sibling to be in trouble or removed from the home. For Indigenous children, there are possibly increased barriers to disclosure, including notions of shame, reticence to involve authorities, fear of retribution and culturally specific understandings about obligations to others.

Research undertaken by the Australian Centre for the Study of Sexual Assault (ACSSA) finds that young people ‘rarely use the terms “sexual assault”, “rape” or “sexual abuse” to describe unwanted sexual experiences’.54 This, and a lack of general knowledge about what constitutes developmentally appropriate behaviour, contributes to non-disclosure and the minimisation of childhood sexualised behaviours. The extent of this under-reporting is immeasurable, but indicative that the demand on services reported by clinicians is likely to reflect only a proportion of the need for therapeutic intervention.

**CHALLENGES IN IDENTIFICATION, REFERRAL AND THE ONGOING PROVISION OF THERAPEUTIC CARE**

Gerard Webster, a psychologist in private practice in NSW and President of Australia and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA), reports that whilst severe sexualised behaviours ‘press alarm bells like no other issue’ many of the young people who are referred to him for therapeutic response for sexualised behaviours are young people with multiple challenges who should have received therapeutic response much earlier.55 Several interviewees indicated that children with sexualised behaviours have often had some prior contact with the statutory child protection system (whether as victims of neglect, child abuse, or child sexual assault, or for their sexualised or sexually harmful behaviours). A number of interviews revealed stories of children who were not referred for therapeutic response until their behaviours had escalated to acts of serious sexual harm against others. The minimisation of behaviours until such time as they are classified under the law

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55 Interview with Gerard Webster, dated 23 April 2009.
as sexual assault is far from ideal. To minimise the seriousness of the behaviours prevents the young person from accessing therapeutic counselling to modify the behaviours. The young person may then end up in contact with the juvenile justice system for offences that might have been avoided. Minimisation of behaviours is rarely in the interests of either the young person themselves, or those that they may harm.56

CASE STUDY
A sexual assault counsellor at a non-government agency reported working with children who had been sexually assaulted by older juveniles. In two separate cases it emerged during counselling sessions with the victim that the young person who had caused harm had displayed sexualised behaviours for a number of years. These behaviours had repeatedly come to the attention of the school and in foster carer settings, but the behaviours had been minimised and no therapeutic intervention provided. Unchecked, the sexualised behaviours had escalated over a period of years, culminating in penetrative offences against younger children; one of these occurred in a sibling group and the other in a foster care setting. The severity of these offences, and the (now) advanced age of the young person causing harm, meant that these became police matters. Conceivably, there was scope for early identification and therapeutic work to prevent both the harm caused and to prevent these adolescents from entering the juvenile justice system.

Even where therapeutic care is provided for young people, there are challenges in ensuring the referring body understands that therapy requires a regular and long term commitment. Gerard Webster indicated that at the time of referral a young person’s sexualised behaviours are often so severe that there is a strong commitment on the part of the child protection body to fund the therapeutic service required. There is a risk, however, that funding for the therapeutic care may be withdrawn at any time. Webster reported that this may occur when a young person’s behaviour stabilises slightly. Webster indicated that he has advocated on many occasions for the continuation of therapy for young people who require ongoing support, as his clinical experience indicates that, ‘there is additional trauma to the child in removing them from therapy suddenly’.57

56 Current Australian research aims to better understand the points of contact that children who later display SABs have with the system whilst they are young. This longitudinal research is based on GYFS data, and the research is being conducted by Stephen Smallbone and Sue Rayment-McHugh. Interview with Sue Rayment-McHugh, dated 23 June 2009.

57 Interview with Gerard Webster, dated 23 April 2009.
THE NEED FOR COMPREHENSIVE EDUCATION STRATEGIES

Professor Kerry Carrington maintains the need to ‘challenge our assumptions that children lack the capacity for violence and sexual violence. If we’re aware that this is a possibility we can educate for prevention.’\textsuperscript{58} This points to the importance of witnessed incidents or reports of children engaging in sexualised behaviours being taken seriously by adults, whether they be teachers, parents, carers, health practitioners, child protection officers or law enforcement officers. Gerard Webster maintains that where there is insufficient knowledge about childhood sexual development, and what is and is not appropriate, there is a tendency to either ‘catastrophise or minimise’ the behaviours.\textsuperscript{59} The majority of clinicians interviewed shared their concerns about over or under reactions to incidents of sexualised behaviours. Much of this report focuses on the various means by which concerning behaviours might be overlooked and, thus, not met with the therapeutic response required. Yet several clinicians also expressed concern that assessments of sexualised behaviours might be made too hastily resulting in the pathologisation of developmentally appropriate behaviours. One psychologist identified a concerning trend in which clinicians feel an overwhelming need to intervene with children who have experienced considerable abuse and neglect. This raises concerns about the damage that can occur when developmentally appropriate behaviours are labelled ‘problematic’.\textsuperscript{60}

Clinicians repeatedly identified the need for increased professional and community education for parents, teachers, law enforcement, and child protection and allied health staff. Education is required to build knowledge and confidence as to what constitutes developmentally appropriate behaviour and what is behaviour of concern. Several case examples revealed the need for comprehensive strategies for community and professional education to provide adults with strategies for prevention, early intervention and, where necessary, information regarding referral pathways.

VIOLENCE-PREVENTION EDUCATION – SCHOOL-BASED STRATEGIES

Interviews with clinicians revealed high levels of concern about children who came to attention for inappropriate sexualised behaviours and who were lacking knowledge about the distinction between appropriate and inappropriate behaviours, including behaviours that are coercive or illegal. Concerns focused predominately on young people’s misconceptions about consent, and their lack of understanding of consequences for their behaviours. Clinicians reported an increase in referrals for young people who lack awareness about the consequences of using mobile phones and other technology for ‘sexting’.\textsuperscript{61} In a recent online survey conducted by Kids Helpline, 39 per cent of

\textsuperscript{58} Interview with Kerry Carrington, dated 25 September 2009. Kerry Carrington has recently published a study indicating that whilst boys continue to commit the majority of violent crimes the rates of female youths committing violent crimes are increasing in Australia, the United States, Canada and the United Kingdom. Carrington, K., M. Pereira. 2009.

\textsuperscript{59} Interview with Gerard Webster, dated 23 April 2009.

\textsuperscript{60} Submission from Shona Innes, dated 30 July 2009; Interview with Laurel Downey, dated 26 August 2009.

\textsuperscript{61} ‘Sexting’ refers to the transmission of sexually explicit still or moving images. For research on adolescents use of technology and sexually abusive behaviours see: Quayle, E., M. Taylor. 2006; Gallagher, B. 2005.
respondents reported that they had engaged in sexting. The manager of a Centre Against Sexual Assault (CASA) reported that every school she had visited had experienced at least one scandal in which sexually explicit images of a student (usually a girl) had been circulated to students throughout the school and beyond. Concerns about young people’s lack of education regarding the legal and moral implications of their behaviours are echoed in both academic literature and a host of recent Australian reports. Each identify the school as an ideal site for educating young people about appropriate sexual behaviour. In their submission to this study ANZATSA suggest:

Schools can be at the forefront of primary, secondary and tertiary abuse prevention strategies for addressing problem sexual behaviour amongst children and young people. There are many lost opportunities to prevent problem sexual behaviour by children and young people due to limited structures and programs. This situation would be improved by a national curriculum for primary and secondary students aimed at building self-esteem and respectful relationships.

In their submission to the NT Emergency Response Review, Central Australian Aboriginal Congress articulated the need for education for all young Australians as to what constitutes inappropriate sexual behaviour. ‘Across Australia we are aware that 30 per cent of young people below the age of 16 are engaging in consensual activity—more than ever before. This is also what is occurring in our communities, and while we are concerned about this, it is not sexual abuse but an issue of inappropriate sexual behaviour that needs to be addressed through a range of strategies including education at home and at school.

The community consultations undertaken by the NSW Aboriginal Child Sexual Assault Taskforce (ACSAT) revealed that, “[p]articipants believed that teaching protective behaviours to Aboriginal children and young people was a vital component to addressing child sexual assault in Aboriginal communities and that schools were the ideal place for this learning to occur.” Recommendation 18 of the ACSAT was that the Commonwealth and NSW Governments develop a comprehensive education strategy for children and young people, with regards to ‘protective behaviours, positive relationships/mentoring, [and] self-awareness’. Professor Judy Atkinson, Director of Gnibi, the College of Indigenous Australian Peoples, identifies schools in rural and remote regions as a potential source of support, not only for children, but for whole communities. Atkinson’s concepts of ‘educaring’ restore a focus on the social and emotional wellbeing of a child, their family and the community:

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62 Submission from Boys Town, dated 31 July 2009.
63 Interview with Linette Harriott, dated 10 August 2009.
64 For example, research undertaken by the ACCSA finds that, “[s]chools have a key role to play in primary sexual assault prevention. Schools are where respectful relationships can be most effectively promoted.” Quadara, A. 2008. p. 5.
65 Submission from ANZATSA, dated 17 August 2009.
66 Central Australian Aboriginal Congress Inc, p. 2.
67 The Taskforce also reported that participants stressed that this teaching must be culturally appropriate and, ideally, developed and delivered with community involvement. Ella-Duncan, M., et al. 2006. p. 12.
Some schools are like prisons, with barbed wire, and teachers and counsellors who lack the skills to engage with kids in crisis. The school in every town should be the hub of activities, 24 hours a day 7 days a week – centres of learning for whole communities. They should be a hub of support and activity for mums and babies, community activities for wellbeing, etcetera. This fits much more into the understanding that education is a whole of life experience, as it always has been in Aboriginal culture.69

This emphasis on the value of schools is also expressed by Robbie Lloyd, the manager of Headspace in Central Australia. Headspace in Alice Springs works extensively with Indigenous young people, and Lloyd identifies the value of each school having a social and emotional wellbeing officer.70

In April 2009, the newly formed National Council to Reduce Violence against Women and their Children released their 2009-2021 plan Time For Action. The plan identifies six core areas in which strategies must be implemented to reduce violence against women and children. Two of these six core areas address the need for increased specialised service provision to change the behaviours of those enacting violence through violence prevention education. The relevant core areas are fostering awareness of respectful relationships and strategies to assist perpetrators to stop their violence. Each of these is underpinned by actions to increase education, prevention, early intervention and sustained behaviour change.71

Time for Action identifies the formative role that schools and peer environments play in establishing children’s understanding of gender roles and that, as such, there is scope for schools to act as agents of social change.72 The National Council identify schools as sites where children may be subjected to, or engage in, acts of sexual violence, but they also identify schools as potential sites for young people to learn about respectful relationships.73 The National Council contend that violence prevention education needs to ‘reach children and young people in school settings and other locations where they gather’, recommending that school-based respectful relationships programs be integrated into school curricula.74 The intention is that this approach would reach a broad base of students whilst avoiding the stigmatisation of those who might be at increased risk of violence.75 More specifically, the National Council identified that violence prevention education has traditionally been targeted at high school populations. In the course of their consultations they repeatedly heard of the need for respectful relationships education for children in preschools, childcare and playgroups.76

69 Interview with Judy Atkinson, dated 16 April 2009.
70 Interview with Robbie Lloyd and Natalie Colmer, dated 13 July 2009.
74 The Australian curriculum Assessment and Reporting Authority ACARA is responsible for a national curriculum from Kindergarten to Year 12 in specified learning areas. In developing this curriculum ACARA work collaboratively with a wide range of stakeholders, including education professionals, government, community groups and the broader public.
INITIATIVE – COMMONWEALTH GOVERNMENT COMMITMENT TO DELIVERING RESPECTFUL RELATIONSHIPS EDUCATION TO SCHOOL AGED STUDENTS NATIONALLY

Following the release of Time For Action, the Commonwealth Government has committed funding of $9 million to improve the quality and uptake of respectful relationships programs in Australian schools.77

This year [2009] 31 sites nationally will test 6 different programs. Programs will be implemented mostly in mainstream school settings and will reach up to 8,000 young people over a period of 5 years. Programs will also be implemented in non-school settings and will target vulnerable young people including those with intellectual disability, young people who have left school and young people living in remote communities.

The Australian Government will fund an evaluation of the leading South Australian child protection/protective behaviours program Keeping Safe.78 This program is currently delivered in all South Australian schools. The evaluation will form the basis of further work to develop best practice in the violence prevention education sector.79

Consultations undertaken for this study also highlighted a number of initiatives that extend educational strategies beyond ‘protective behaviours’ and encompass strategies for teaching young people about responsible and respectful relationships. Most notable amongst these initiatives is the work of Associate Professor Moira Carmody. Sex and Ethics is an education program for young people aged 16–25 years that can be delivered in school or community settings. Informed by the views of young people, this program recognises that young people are active agents in their own lives. Carmody maintains that, ‘young people have lots of very worthwhile ideas about sexuality and sexual assault prevention, but they are often told what to do and what to think, and are condemned if they make the “wrong decision”’.80 Rather than imposing a set of prescriptive rules or focusing on the dangers of sexual assault, the program encourages young people to ‘gain knowledge and skills about ethical decision-making in relation to sexual intimacy’.81

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78 Launched in mid 2009, Keeping Safe is a South Australian child protection curriculum with levels relevant for children and young people attending preschool through to senior secondary school. The broad base for the program is protective behaviours and each level is underpinned by an understanding of the developmental stages and needs of young people. PSBs and SABs are not addressed specifically, but the curriculum does focus on rights, responsibilities, relationships and ethical behaviour. Keeping Safe, p. 10. This program has also been adopted by the Department of Education and Training Northern Territory for implementation in NT schools.
81 Carmody, M. 2009a. p. 3.
Another program that has been informed by the views of young people is the school-based education program Love Bites.\(^8^2\) This program was devised by the National Association for the Prevention of Child Abuse and Neglect (NAPCAN) as a less didactic alternative to other programs with similar aims. To ensure that the Love Bites is engaging, young participants are invited to provide input to shape and lead the program. Love Bites is a voluntary program delivered in schools that encourages young people to identify the difference between healthy and unhealthy relationships by challenging the myths associated with sexual assault and assumptions about gender roles.\(^8^3\) The school-based program is followed by a community campaign in which students develop media contacts and promotional materials to encourage a whole of community awareness about sexual assault and the importance of challenging attitudes supportive of gendered violence. This program is notable because of the extent to which it has engaged the interest and commitment of school aged boys in particular. A number of boys involved in the program have gone on to become ambassadors for Love Bites and White Ribbon Day events.

A comparable program that is directed primarily at younger children is Pathways to Peace. Developed by Dr Simon Petrie and Dr Andrea Petrie, Pathways to Peace is a community-based violence reduction program delivered in over 50 Australian schools. Several schools have been running the program for more than 10 years, with recorded improvements in students' behaviours. The program received a Crime Prevention Award from the Australian Institute of Criminology in 2005, and Goodna State School report that in three years the number of serious violent incidents has dropped by 50–60 per cent.\(^8^4\) Simon Petrie identifies language as the foundation of the program. Pathways to Peace comprises a series of resources to reinforce messages both visually and orally. These are tailored to suit the developmental age of the school group, and schools are encouraged to adapt their own resources to saturate the environment with messages that are appropriate to the culture and the interests of the students. As with Sex and Ethics, and Love Bites, Pathways to Peace extends education beyond danger based concepts of protective behaviours by encouraging young people to acknowledge that they have the power to respond ethically and respectfully towards others. Simon Petrie maintains that, ‘it is possible to harness the power of positive peer culture, not negative peer culture’.\(^8^5\) Influenced by developmental criminology, Petrie identifies young people’s positive self-concept to be crucial in changing the culture and changing behaviour.\(^8^6\)

Amongst the general violence prevention programs there are a limited number that are devised as culturally specific programs for Indigenous young people. Family Planning of Western Australia have devised a program specifically for Indigenous children. Mooditj is a sexual health and positive life skills program for 10–14 year old Aboriginal children. The interactive program is designed to be fun and helps young people learn about self-identity, hygiene, sexual issues and sexual rights, emotions and relationships. WA Family Planning have extended their program to offer train the trainer sessions in Alice Springs for

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82 Funding for the program has been provided by the NSW Government and an international foundation. The program is delivered in selected sites in NSW, and the NT. The NSW Government has recently funded Love Bites to develop a whole of school approach to sexual assault and domestic violence prevention in selected remote communities in NSW.

83 Interview with Angela Walsh and Trudi Peters, dated 23 April 2009.

84 Interview with Simon Petrie, dated 26 June 2009.

85 Interview with Simon Petrie, dated 26 June 2009.

86 Interview with Simon Petrie, dated 26 June 2009.
those who work with young Indigenous people. Delivered predominately in Qld and parts of NSW, Red Dust Healing is a program devised specifically to address the healing needs of Indigenous people. The program promotes the importance of making choices in responding to situations, emphasising that there are options that can be based on principles of love, respect, safety and belonging. Testimonials from young Indigenous men who have undertaken this program indicate the positive effect that this has had on their lives. Young men report that the program has provided them with the tools to stop, think and walk away in situations where they might previously have used violence.87

PROFESSIONAL EDUCATION – WORKING WITH TEACHERS

Time for Action identifies that Australia currently lacks a national strategy for the development, implementation and evaluation of broad based violence prevention education.88 Consultations for this study have identified a subset of need for a formalised strategy to educate teachers and parents about the stages of childhood sexuality development. Comprehensive education strategies are required to allow teachers and parents to respond in an appropriate, but non-alarmist way should they identity or receive reports of children or young people engaging in inappropriate sexual activity. Some states and territories do have specific guidelines in place that provide teachers with a clear protocol for response to incidents of sexualised behaviours at school. In Victoria for example, procedures are outlined in Responding to Allegations of Student Sexual Assault, a document that provides educational staff with procedural guidance regarding reporting requirements. Several Catholic Dioceses have also produced guidelines for recognising, reporting and responding to incidents of sexualised behaviours. Guidelines are not in place in all Australian schools however. In the absence of formal guidelines or protocols, response to incidents would depend on the assessment made by the teacher or staff member in attendance.

For children, primary contact with adults is with educational staff and parents or carers. Consequently, it is likely that if sexualised behaviours are to be noticed it will be either in the school or in the home. Schools have an important role in responding to incidents or disclosures of sexual assault amongst students.89 Clinicians interviewed for this study reported that both educational staff and carers experience difficulties in responding to incidents of children displaying sexualised behaviours, or engaging in coercive sexual acts. Clinicians working with children with sexualised behaviours need to liaise regularly with schools. They report that whilst some schools are reluctant to acknowledge incidents of sexualised behaviour amongst children, the vast majority of schools are eager for increased information and assistance in responding. A large number of the therapeutic services surveyed indicated that they regularly receive calls from schools seeking training for teachers or advice on responding to incidents (including referral and placement options for children). The Director of the Australian Institute of Family Studies (AIFS) indicates that teachers ‘would benefit from increased awareness of the issues, and support through resources and guidance in responding to children with sexualised behaviours’.90 This same need is articulated by the ACT Department of Education and Training in their submission to this study:

87 Conference presentation by Tom Powell, delivered in Sydney at Indigenous Young People, Crime and Justice. 1 September 2009.
90 Submission from Professor Alan Hayes, Australian Institute of Family Studies, dated 6 August 2009.
The most significant issue facing education [with regards to problematic sexual behaviours] is developing the knowledge and skills of staff to help schools and students remain safe with regards to problematic sexual behaviours. School specific training is needed, along with resources/guidelines on how to support students. The ACT currently lacks expertise that could support the development of school staff.91

The ACT Department of Education indicate they are keen to develop the knowledge and skills of staff to provide a safe and supportive environment for students. At present, the Department utilise the skills of school counsellors, inclusion support consultants and others to minimise the risk of problematic sexualised behaviours in schools. In their submission the Department indicated an understanding that managing students’ behaviours to ensure safety for others is only part of the required response. At present there is a shortage of expertise in the ACT to assist the Department’s efforts to ensure student safety without resorting to exclusions. In addition to training and expert advice for staff, the Department indicate that they require referral options for young people and their families. ‘Schools cannot have a significant impact on the student’s problematic sexual behaviour without addressing the young person’s whole environment’.92

CASE EXAMPLE

A clinical psychologist in private practice in Victoria provided the following example of the challenges that schools face in responding to children with sexualised behaviours. This case underscores not only the complexities of situations facing teachers, but also the importance of teachers and all school staff being provided with the education necessary to allow them to respond to incidents of sexualised behaviours in an appropriate and timely manner. Contact points for expert advice and formalised protocols for responding, reporting and liaising with families would have been extremely valuable in the following circumstance:

As a private practitioner, working with schools can be challenging. Some schools are happy for this advice and communicate it openly, others have preferred to ignore the problem or completely misunderstand that problem. One school that I worked with responded to a series of incidents (in which an integrated, disabled student was assaulted by another student in the school toilets) by sending the victim back to full time special school and sending their school counsellor off to a course to assist teenagers to ‘come out’ about their homosexuality. History revealed that the youth who had assaulted the other boy, had been asked to leave two other schools following similar behaviours.93
In this case the lack of therapeutic intervention for either boy contributes to a cycle of ongoing risk, not only for the boys immediately involved, but also for other young people. There are likely to be detrimental effects for the young person excluded from school not being provided with therapeutic intervention to address their behaviours. Exclusion from school sends the message that the young person cannot be integrated, that their behaviours are immutable, offensive and indiscriminately dangerous. The likely outcome is a further erosion of the young person’s social and peer attachments. As one Victorian counsellor reported, the exclusion of young people from school is not only stigmatising but prevents the peer attachments that we know to be necessary and protective; this is counter to everything that we strive to attain in our therapeutic work.

Whilst there are few programs to educate teachers in responding effectively to childhood sexualised behaviours, there are a number of broad based violence education programs delivered primarily by centres against sexual assault and non-government child protection agencies. These agencies foreground the role of the community and community education strategies in ensuring the wellbeing of children, as articulated by NAPCAN:

*NAPCAN’s community approach challenges the commonly held view that parents carry the sole responsibility for children’s safety and wellbeing. To date successful solutions to the complex and endemic social problem of child abuse and neglect have only been found by working in a sustained way in partnership with communities. This informs NAPCAN’s belief that children’s wellbeing is everyone’s responsibility and that it takes the whole of a healthy community to prevent child abuse and neglect.*

Lesley Taylor, Northern Territory State Manager for NAPCAN, has trained large numbers of childcare workers in preventing and identifying child abuse, and she reports that all are concerned about how to respond to sexualised behaviour in young children. These child care workers report that there has been a substantial increase in children coercing other children into sexual acts. Consultations undertaken by the National Council also identified concerns about behaviours in preschool and playgroup settings recommending an expansion of “the capacity of teachers and other educators and leaders to provide violence education prevention programs”.

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95 Interview with Lesley Taylor, dated 16 July 2009. A number of clinicians reported the concerns of child care workers. Child Wise provide training to child care workers across Victoria and they report that workers attend training in the evenings, in their own time, expressing enormous interest in the information. Child Wise report that child care workers regularly comment that the training should be compulsory. Interview with Karen Flanagan and Jacqui Morse, dated 03 September 2009.
INITIATIVE – GOVERNMENT ACTION IN RESPONSE TO RECOMMENDATION TWO OF TIME FOR ACTION

As a component of its response to ‘Respectful Relationships’, the second core recommendation of the National Council’s Plan of Action, the Australian Government has committed to a review of the National Safe Schools Framework with a focus on the following:

- teacher training in positive student management
- responses to victimisation and abuse
- teaching of values and the emergence of technologies and their impact on student wellbeing and protection. 98

Teaching staff in Indigenous communities have also indicated they need guidance in responding to sexualised behaviours amongst children. Taylor reported that in an Arnhem Land community a primary school teacher resigned from his post and left the community because girls in grade one and two were pelvic thrusting and saying ‘she’s sexing you sir’.99 In the absence of broader knowledge for teachers, parents and children about sexually appropriate and inappropriate behaviours, such behaviours may leave professionals vulnerable to claims of having sexually abused children. Taylor asserts that, ‘teachers are lacking confidence to respond’ and often call with requests for training.100

One request came from a Central Desert Community who were unsure how to respond to the increasingly common occurrence of sexualised behaviours in the school. The behaviours were said to have spread through the whole school, with the primary trend being older children sexually harming young children.101 Such reports of sexualised behaviours in Indigenous communities underscore the need to develop an Indigenous teaching staff that is cognisant of the dynamics of child sexual assault and confident to provide the support necessary for students, their families and the school. ACSAT identified the need for additional Aboriginal staff in schools, suggesting that further research is required about the specific support needs of Aboriginal children in these contexts and the best ways to provide this support.102

99 Interview with Lesley Taylor, dated 16 July 2009.
100 Interview with Lesley Taylor, dated 16 July 2009.
101 Interview with Lesley Taylor, dated 16 July 2009.
INITIATIVE – STRATEGIES FOR TEACHERS IN RESPONDING TO CHILDREN WHO HAVE EXPERIENCED TRAUMA

In 2007, the Victorian Child Safety Commissioner published a guide for teachers on working with traumatised children in the classroom. Produced by Berry Street Victoria, Calmer Classrooms assists educational staff in working with children and young people whose lives have been affected by trauma. Suitable for kindergarten, primary and secondary teachers, the resource provides evidence-based explanations for children’s behaviours as manifestations of childhood trauma, as well as providing relationship-based practices to assist traumatised children to stay in mainstream schooling. This is a broad based guide for responding to children who have experienced trauma and, whilst the publication doesn’t provide guidance on responding to sexualised behaviours specifically, the content builds teachers’ knowledge regarding the possible contexts for children’s behavioural difficulties in general.

Schools can be an extremely important point of reference for children whose lives are marred by abuse and neglect. A strong attachment to their school can provide a child with stability in an otherwise unstable world: offering relationships, maintaining friendships, providing positive and enjoyable learning opportunities and ultimately building resilience and hope.  

FUNDING FOR CALMER CLASSROOMS IN VICTORIA.

Although all State and Catholic schools in Victoria have been provided with a copy of the publication, Berry Street report that additional funds are necessary to train teachers and support schools. Berry Street have received a number of training requests from schools, particularly where they have children whose lives have been affected by trauma. For this response to be comprehensive, and for this approach to fulfil an early intervention and protection function, there is the need for funding for the delivery of state-wide training to classroom staff at all levels of schooling—kindergarten, primary and secondary.
COMMUNITY EDUCATION – WORKING WITH PARENTS

*Time For Action* identifies the need to assist parents in developing the knowledge, skills and confidence to teach their children about respectful relationships. Whilst the National Council acknowledge that many parents already do this, they also indicate that the prevalence of physical and sexual abuse in Australia may mean that many parents have unresolved experiences of trauma, or current experiences of abusive partnerships. The National Council concludes that, ‘respectful relationships education needs to consider how to support parents and caregivers with positive parenting skills at key transition points in their children’s lives’. Kids Helpline report that from 2004 to 2008 they received 840 calls from parents and carers concerned about the sexual behaviour of their child. Issues ranged from enquiries about whether behaviour was developmentally appropriate to severe distress about a child’s inappropriate sexual behaviour.

Clinicians interviewed also reported experiences in which parents lacked either the skills or the engagement to assist their children in developing an understanding of developmentally appropriate boundaries and respectful relationships. Most services reported regularly receiving calls from parents and carers requesting advice as to whether their children’s behaviours were developmentally appropriate. A number of clinicians also reported working with adults who had experienced sexual abuse as a child and who lacked a framework to guide their assessment as to whether their child’s sexualised behaviours were problematic. This can result in parents overlooking abusive situations or, on the other hand, mistaking appropriate developmental behaviour as a sign that their child has been sexually abused.

EDUCATION REGARDING MEDIA CLASSIFICATIONS

In 2007, the Northern Territory Attorney-General requested that the Department of Justice (NT) conduct educational workshops in Indigenous communities to raise awareness as to the significance of media classifications. The intention of these workshops was to communicate the importance of the classification system and the responsibilities of individuals to protect children from exposure to pornography. The workshops were also designed to provide participants with an opportunity to discuss issues regarding pornography and its potential harms, including problematic sexual behaviours where children have been exposed to pornographic material. Lesley Taylor was involved in facilitating the workshops with women in the communities (men’s groups were convened separately). In each community that she visited, Taylor found that, ‘women indicated their concern about the sexualised behaviour in children, and their inability to do anything about it’. Indigenous women articulated their concerns about the negative effects that explicit magazines and films had on children’s thinking, relationships and behaviour. Whilst Taylor met with women who went to

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106 Submission from BoysTown, dated 31 July 2009.
107 Bryant, C. and M. Willis. 2009. p. vii. The authors note that concerns about Indigenous children’s exposure to pornography have been recorded in a number of government inquiries, and that *Little Children are Sacred* included a recommendation that an education campaign be designed to inform Indigenous communities about the importance of media classifications.
109 Interview with Lesley Taylor, dated 16 July 2009.
enormous efforts to regulate what children were watching, the vast majority of women repeatedly said that they felt powerless to stop children from watching these films. Taylor reported that one of the challenges for these women is that they are likely to suffer retribution from men in the community if they speak out to protect children.\textsuperscript{110}

The AIC undertook a process review of the workshops held in Indigenous communities, concluding that educational strategies are the key to long term change:

\begin{quote}
Education, integrated with other initiatives aimed at increasing understanding about violence, sexual abuse and healthy sexual relationships will be integral to the long-term effectiveness of any strategy that aims to decrease pornography-related harms in Indigenous communities.\textsuperscript{111}
\end{quote}

NAPCAN also maintain that, for child protection generally, the focus must be on prevention and on providing parents with the education and the resources they require to parent effectively. ‘We must unselfishly acknowledge the social and economic hardships that lead to intolerable stress levels facing so many parents and lend them a hand. Only then will the horrific cycle of child abuse and neglect be prevented.’\textsuperscript{112}

\section*{PROFESSIONAL EDUCATION – BUILDING AWARENESS}

It is not only teachers and parents who are unsure about appropriate responses to children with sexualised behaviours. Many clinicians and service providers reported that increased awareness and education for statutory child protection staff would assist in the early identification of children with sexualised behaviours. Moreover, interviewees repeatedly highlighted the need for child protection workers to be fully cognisant of the risks associated with sibling sexual abuse and childhood acts of coercive sex more generally.

The challenges faced by statutory child protection systems are well documented. In November 2008, the Honourable James Wood presented his Report of the Special Commission of Inquiry into Child Protection Services in NSW in which the Department of Communities was identified as but one of a number of the statutory agencies experiencing difficulties in responding to the demand for services. ‘The contemporary challenge facing all child protection systems in Australia, and in particular NSW as the largest, is sufficiently resourcing flexible prevention and early intervention services so as to reduce the numbers of children and young people who require the state to step in to keep them safe.’\textsuperscript{113}

The number of children in out-of-home care has escalated in recent years, with a national increase of 9.3 per cent from 2008 to 2009. As at 30 June 2009, there were 34,069 children in out-of-home care in Australia.\textsuperscript{114} The shortage of stable alternate care placements and challenges in ensuring integrated and ongoing case management are enormous systemic challenges in each Australian state and territory. Within this, there are also reports that child protection workers would benefit from additional pre-service and in-service training regarding the identification and appropriate response

\begin{footnotesize}
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\item[$\textsuperscript{110}$] Interview with Lesley Taylor, dated 16 July 2009.
\item[$\textsuperscript{111}$] Bryant, C. and M. Willis. 2009. p. ix.
\item[$\textsuperscript{113}$] Wood, J. 2008. p. i.
\item[$\textsuperscript{114}$] AIHW. 2010. p. 38.
\end{itemize}
\end{footnotesize}
to children with sexualised or sexually abusive behaviours.\textsuperscript{115} There are a number of reports that statutory child protection agencies currently lack the skills, knowledge, procedural requirements and referral pathways to respond to such children in a timely manner. Attention to these issues is crucial in ensuring effective therapeutic outcomes and maintaining safety for other children. The Department of Health and Human Services (DHHS) in Tasmania reports, ‘a clear professional development gap for agency staff in defining appropriate/inappropriate sexualised behaviours and in knowing what to do if there is identified behaviour that needs attention’.\textsuperscript{116}

Clinicians reported that sometimes schools or child protection agencies become aware of a child with sexualised behaviours but aren’t sure of how they should respond. Many expressed concerns that notifications to statutory child protection agencies about children with sexualised behaviour would be unlikely to receive response. In some cases the sexualised behaviours do not indicate that the child is at risk of harm and/or the report fails to meet the definition or threshold required for a child protection investigation. Taylor maintains that statutory child protection workers in the Northern Territory ‘seem to work to a prototype of what an offender looks like, and this doesn’t include attention to the risks posed by children with sexualised behaviours’.\textsuperscript{117}

In Victoria, the Australian Institute of Family Studies is working with the Victorian Department of Human Services (DHS) to develop a specialist practice guide for child protection workers and other child and family welfare workers. The objective is to increase the skills of welfare workers responding to children with sexualised behaviours, and to provide guidance for practice that is based on research evidence.\textsuperscript{118}

The Wood Inquiry into child protection services in NSW identified a number of challenges facing the child protection workforce. The Inquiry found that the recruitment and retention of a ‘skilled diverse workforce to provide services in all parts of the state is an issue for DoCS, as it is for all other justice and human services agencies in NSW and for non-government organisations working in the welfare sector’.\textsuperscript{119} This Inquiry also identified the need for increased training for those in sectors where mandatory reporting is a requirement. Recommendation 6.5 indicated that NSW professionals in law enforcement, health and education require targeted training on the circumstances in which reports need to be made, and the information required to ensure the relevance and quality of reports.\textsuperscript{120} Within this, there is an identified need for mandatory reporters to be confident to report sexualised behaviours as a likely indication that the child has experienced harm of some kind.

Those interviewed for this study repeatedly noted the importance of increased education for child protection workers (and case managers in particular) around issues of trauma, attachment, and the effects of neglect and abuse. A number of recent reports also identify concerns regarding the limited extent of specialised pre-service training for those who will work in the child protection sector.

\textsuperscript{115} The Australian Qualifications Framework produces national guidelines for each of the current national qualifications issued in the higher education sector. For further information see: http://www.aqf.edu.au/.

\textsuperscript{116} Submission from Department of Health and Human Services, Tasmania, dated 14 September 2009.

\textsuperscript{117} Interview with Lesley Taylor, dated 16 July 2009.

\textsuperscript{118} Submission from Alan Hayes, Australian Institute of Family Studies, dated 6 August 2009. This guide is still in development but will be publicly released on the National Child Protection Clearinghouse website: http://www.aifs.gov.au/nch/.


ACSAT found that the human services courses, welfare courses and counselling courses being offered through TAFE need to include teaching about child sexual assault in Aboriginal communities. Similar concerns have also been raised with regards to the training offered across a number of disciplines in the tertiary sector. The National Council recommended that all undergraduate students in the disciplines of law, medicine, social work and allied academic courses should ‘undertake compulsory course work covering the nature and dynamics of sexual assault and domestic and family violence, and relevant law’.

The Australian Centre for Child Protection has recently published two reports that identify the importance of specialised pre-service tertiary training for professionals working with children. The first report mapped the extent to which issues of ‘prevention, identification and response to child abuse and neglect are currently addressed within teacher education programs’. This research found that more than three quarters of the teacher education programs in the sample did not include any discrete child protection related content. This study recommended that child protection remain ‘on the agenda for universities, teacher registration and accrediting bodies, schools and governments’. A similar study of the child protection content in nursing and midwifery education in Australia made a number of recommendations to enhance the skills and knowledge base of nurses and midwives in meeting the needs of vulnerable children and families. Notably, this report recommended a ‘consideration of the broader notions of child protection, including prevention, early intervention, proactive strategies and overall child well-being’.

In a move to address one aspect of child protection training for the professional workforce, Professor Judy Atkinson has reported that Gnibi, the College of Indigenous Australian Peoples at Southern Cross University, is intending to offer a Graduate Certificate with a focus on developing qualifications and specialist skills for working with children and youth who display sexualised behaviours as a result of abuse and trauma.

*Each unit aims to build a professional knowledge and understanding of problem sexual behaviour within historical, cultural, familial and personal perspectives. Students are assisted in applying what is known about child abuse, trauma, and the cycle of abuse from research conducted across the world to the problems that exist in their local communities. Students are then supported in developing culturally appropriate programs in consultation with communities and local elders that are designed to deliver culturally competent services. Students will be able to upgrade to a Grad. Diploma level, with the additional unit(s) being dedicated to a supervised research project that focuses on developing culturally relevant and safe programs in consultation with communities and local elders that are then delivered in a culturally competent and safe manner.*

127 Correspondence from Judy Atkinson, dated 23 December 2009.
CHALLENGES FOR PRACTITIONERS IN THE DELIVERY OF THERAPEUTIC SERVICES TO YOUNG PEOPLE WITH SEXUALISED BEHAVIOURS

Most counsellors in this specialised field report challenges in balancing the demand for services with existing staffing ratios, and the need for ongoing professional development and provisions for intensive and/or external supervision for clinical staff.

DEMAND ON SERVICES

Almost all specialised services in Australia responding to children with PSBs report that demand far outweighs their capacity to respond and, consequently, large numbers of referrals are declined. There is great variance in how this unmet need is managed and, as a result, quantifying the extent of demand is difficult. Some agencies manage their own waitlists, and for some agencies these are lengthy. A number of the agencies surveyed provide counselling to children who have been sexually assaulted, as well as those with PSBs. Several of these agencies report significant stress in balancing dual waiting lists where they must weigh the needs of a traumatised child against the needs of a traumatised child who may have the potential to cause ongoing harm. Other agencies choose not to run a waitlist as they feel that to decline referrals would breach their duty of care. These clinicians reported that they are constantly working beyond the provisions of their service agreement and that this practice entails several risks. These possible risks include worker burnout, vicarious trauma, staff attrition and compromised services to young people. Compromised service might mean a reduction in the frequency of therapeutic sessions, or ceasing interventions prior to treatment gains being fully realised in order to free places for new clients or clients with higher needs.

Whilst agencies that manage their own intake can quantify the referrals received, other agencies, primarily those funded by the state, are likely to have their referrals managed centrally. Where referrals are managed by the funding body it is impossible to quantify unmet demand with any accuracy. Even if data were available, and comparable across agencies and jurisdictions, there would be several limitations in relying on this as a measure of the demand on the sector. Foremost limitations are minimisation, under-reporting and the need for professional and community education. The general lack of awareness as to what constitutes developmentally appropriate, problematic and abusive behaviours means that behaviours requiring therapeutic intervention may be overlooked. It is not possible to quantify this unreported demand, nor the need for services for those who are reported to the statutory child protection body yet fail to meet the thresholds for investigation and therapeutic intervention. Although the systems are not currently in place for capturing this data uniformly, indications from agencies are that there is a great deal of unmet demand. Services report that they receive calls from police, child protection, and families requesting counselling services for young people with PSBs or SABs. Moreover, agencies in each state and territory report that preschools and schools are seeking staff training and practical assistance in managing sexualised behaviours.

128 Interview with Gatehouse staff, dated 12 August 2009; Interview with Jenny Wing, dated 14 August 2009.
MEDICARE REBATES FOR PSYCHOLOGICAL SERVICES

In November 2006, the Australian Government introduced new Medicare items for psychological treatment by registered psychologists.\(^{129}\) The provision under this scheme is for 12 sessions per year per client, with an additional 6 sessions in exceptional circumstances. Better Access to Mental Health Care is reported to have improved access to psychological services for some young people with PSBs or SABs, yet several clinicians expressed reservations about this scheme being misunderstood as bridging the service gap to children with PSBs or SABs.

For young people to access the Medicare rebate for psychological treatment they need to visit their GP who would need to agree that psychological services were required. A young person or child needs to have a diagnosable mental illness to qualify for the rebate, and most children and young people with sexualised behaviours do not fall under this category. If the GP wanted to refer to a psychologist they need to identify a locally based, and Medicare registered, psychologist specialising in ‘conduct disorder’ or ‘sexual disorders’. Of those ‘clinically diagnosable disorders’ that are eligible for the rebate, these are the two closest descriptors that may be utilised to provide a rebated service to young people with sexualised behaviours. Providing such a psychologist were available, the young person would be entitled to a Medicare rebate for up to 12 individual sessions per calendar year (with provision for 18 in exceptional circumstances) and 12 group sessions per calendar year (providing these are available and deemed appropriate by both the referring doctor and the psychologist). To utilise all 12 or 18 individual sessions within the calendar year necessitates a return visit to the GP who assesses progress and determines whether ongoing psychological visits are required.\(^{130}\)

Clinicians have reported that this Medicare reform provides access to much needed additional services,\(^{131}\) but that these services are not equally available to all young people. Even for those who can access these services, the number of sessions that can be rebated under the new scheme would be insufficient to deal with the young person’s therapeutic needs.\(^{132}\) ANZATSA’s submission to this study highlighted that, ‘in many cases, a thorough response to problem sexual behaviour (particularly those of older children and young people) requires far more than the 18 sessions supported by Medicare’.\(^{133}\) In keeping with the views expressed by a number of interviewed clinicians, ANZATSA articulated their concern that the rebate applies to individual sessions, and there is no provision for the family work that is often essential in responding to problem sexual behaviour.\(^{134}\)

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\(^{131}\) Access to psychological services under publicly funded schemes such as CAMHHS is also problematic in some states. Problem Sexual Behaviour is not diagnosable mental illness according to the DSM-IV. Young people who present with PSBs as the primary therapeutic need are, in most cases, not identified to be eligible for CAMHHS. This varies from one jurisdiction to another, with most jurisdictions providing therapeutic counselling to address PSBs when this presents as a behavioural manifestation of a diagnosable mental health disorder.

\(^{132}\) Interview with Gerard Webster, dated 23 April.

\(^{133}\) Submission from ANZATSA, dated 17 August 2009.

\(^{134}\) Submission from ANZATSA, dated 17 August 2009.
WORKFORCE DEVELOPMENT

Funding limitations are reported to be a major contributing factor to the inability to meet referral demand. Yet in instances where funding is available for additional clinical staff, there are reported difficulties in recruiting adequately trained and experienced therapists. In many cases male staff are preferred. The majority of clients are male (particularly in the adolescent age range) and their general preference is for a male therapist. Some agencies identify the benefits of having both male and female clinical staff as this provides opportunities for modelling positive gender roles and respectful collegial relationships. Most agencies report that securing a gender-balanced workforce of culturally diverse clinical staff continues to prove unattainable. These difficulties are manifold when it comes to recruiting Indigenous counsellors or counsellors from culturally and linguistically diverse backgrounds. This results in a situation where some agencies recruit lesser qualified staff, or graduate staff with ‘potential’ rather than specialised expertise and clinical experience.

WORKFORCE DEVELOPMENT IN THE ABORIGINAL HEALTH AND SOCIAL HEALTH SECTORS

The Wood Inquiry found that, ‘Aboriginal communities remain over represented in the child protection system and culturally appropriate interventions for Aboriginal children, young people and their families are not widespread in any of the agencies that are expected to work with them’. Clinicians interviewed for this study also identified the shortage of Indigenous clinical staff to be of significant concern. Agencies indicated that Indigenous psychologists are very likely to be in great demand by a host of services, so attracting and retaining Indigenous counsellors is extremely difficult.

This highlights the need for developing the Indigenous social and mental health workforce; a point that was raised in a number of the consultations for this study. The ANZATSA submission asserts that, ‘the training and development of Aboriginal and Torres Strait Islander workers and professionals is most likely to bring about culturally relevant and appropriate support and treatment programs’. This view is supported by Judy Atkinson who is emphatic that, ‘those who don’t have qualifications should not be working with children who have sexualised behaviours’. Atkinson identifies the need for skilled people with a sound theory base to work in such sensitive areas. To this end, Atkinson advocates an investment in educating Indigenous people to attain the formal qualifications required. ‘It is vital to slow the process down so that Indigenous people can be the ones to work in healing our own people.’

Greg Telford leads Rekindling the Spirit, a NSW based program to work with Aboriginal families and communities to achieve ‘positive, lasting change’. As with Atkinson, Telford sees the support for Indigenous-led programs as a way forward. ‘We need the opportunity to develop our own ways of working with our people, but we need the support and resources to do so’.

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136 There may also be aspects of the work that present challenges for Aboriginal staff. For example, issues to do with kinship, or re-traumatisation if staff have experienced abuse.
137 Submission from ANZATSA, dated 17 August 2009.
138 Interview with Judy Atkinson, dated 16 April 2009.
139 Interview with Judy Atkinson, dated 16 April 2009.
140 Rekindling the Spirit report that 97 percent of program participants have not re-entered custody within two years of completing a Rekindling program. Rekindling the Spirit 2007, p. 1.
141 Interview with Greg Telford, dated 16 April 2009.
There are a number of measures implemented by non-Aboriginal agencies to redress this shortage of Indigenous clinical staff. Existing staff allocations have been reappropriated to create designated positions for Indigenous counsellors at both New Street and Cedar Cottage (the affiliated diversionary scheme for adults). These positions are not currently filled, due to a freeze on recruitment, but it is intended that once these positions are filled staff will collaborate with the Aboriginal counsellor at Rural New Street and the Aboriginal team at the Education Centre Against Violence (ECAV) so as to create for NSW a team of Indigenous clinicians with specialist expertise. Other agencies reported initiatives to create positions for unqualified Indigenous workers and to provide support to these workers to pursue a Certificate IV in Aboriginal and Family Health at ECAV, followed by support for tertiary study.¹⁴²

INITIATIVE

Berry Street in Victoria has an Aboriginal clinical team of five staff. This team has implemented a number of initiatives to build capacity within the Indigenous social-health workforce. In collaboration with La Trobe University, the University of Melbourne and VACCA, Berry Street has introduced two new graduate qualifications in child and family practice. The Graduate Certificate in Child and Family Practice, and a Graduate Diploma in Child and Family Practice Leadership has been offered since August 2009, and there are 32 funded places for Indigenous students in each program.

In a second initiative, VACCA and the Manager of Aboriginal Service Development at Berry Street have developed a training package for Indigenous and non-Indigenous people working with vulnerable Aboriginal and Torres Strait Islander children.¹⁴³ The publication provides ‘an explanation of trauma and attachment theories, from an Indigenous perspective . . . looking at ways of healing by focusing on healing ourselves, healing our children and families and healing our communities’.¹⁴⁴

ACCREDITATION OF COUNSELLORS

There is also some discussion within the sector as to the most appropriate tertiary training for clinicians working with children and young people with sexualised behaviours. A lack of uniformity and agreement as to the requisite skills or training for those working in this sector means that the services offered are likely to vary greatly across the country. Interviews for this study revealed that therapeutic counselling to children with sexualised behaviours might be offered by social workers, psychiatrists, psychologists or experienced (but unqualified) counsellors. There is enormous variance as to whether these staff have undertaken specialised training in responding to children or young people.

with sexualised behaviours. Some staff are highly trained and experienced, and others have no training except what they may have gleaned from published texts. There are risks associated with a lack of parity in a sector that remains unregulated and almost entirely without a system of accreditation. In NSW, the Child Sex Offender Counsellors Accreditation Scheme (CSOCAS) is a public register of counsellors administered by the NSW Commission for Children and Young People. Clinicians in NSW and elsewhere indicated that, in principle, this scheme is an excellent mechanism for ensuring that counsellors in this field meet minimum standards in qualifications, supervised clinical experience and ongoing professional development. This scheme provides the statutory authorities in NSW with a readily accessible list of accredited clinicians to whom referrals can be made. Wherever possible the Department of Communities refer children with sexualised behaviours to CSOCAS accredited counsellors.

A number of clinicians from other jurisdictions indicated that they regularly call on accredited counsellors from NSW to provide consultation, advice, training and supervision due to a lack of specialised skills in their state or territory. These clinicians also indicated that they would appreciate the opportunity to become accredited with CSOCAS, or an equivalent scheme, but that there are several challenges to this. The first is that CSOCAS accreditation at Associate level requires the applicant to be supervised by an accredited counsellor. This is reported to be extremely difficult for clinicians located some distance from an accredited counsellor, in which case the counselling service must meet the cost of fees and travel. Accreditation at clinical level necessitates a significant commitment to professional development on the part of the applicant. As it is many clinicians interviewed reported that they personally fund or supplement their professional development. Whilst interviews with clinicians nationally revealed a high level of interest in accreditation, for many services the small budgets for professional development and external supervision currently make accreditation impossible.

CSOCAS is a NSW initiative and there are no comparable schemes in other jurisdictions. Nor is there currently a national scheme for accrediting counsellors and ensuring an agreement to protocols, assessment guidelines and treatment principles. This results in a situation where the experience of a child with sexualised behaviours who is referred for specialised therapy in one jurisdiction is likely to differ vastly from the experience of a child in another jurisdiction. The risk is, of course, differing outcomes of therapeutic success, a circumstance that ANZATSA identify as in need of redress:

Concerns are held about the absence of a national approach to counsellor accreditation as this exacerabates inequities in the quality of services provided, particularly to those in remote communities. . . . A national scheme for counsellor accreditation would set benchmarks for minimum qualifications and experience for working in this specialist field, and require ongoing professional education and clinical supervision, as well as maintain the regulatory function that is responsive to concerns about an individual’s clinical or ethical practice.

146 Submission, NSW Department of Community Services, dated 16 August 2009.
147 ANZATSA necessitates members adherence to a Code of Ethics.
148 Submission from ANZATSA, dated 17 August 2009.
In addition to those outlined here, the benefits of a national accreditation scheme are identified as including:

- accreditation for Medicare provider status
- a centralised mechanism for the provision of agreed response protocols for schools
- clinical assessment guidelines
- an access point and network for those seeking accredited training providers
- a centralised list of accredited counsellors facilitating ease of referrals for statutory bodies, schools, community agencies, and those who wish to self-refer.

A well funded, multi-disciplinary accrediting body with a strong research base and links to tertiary institutions could contribute to the knowledge base for the sector nationally, and inform tertiary curriculum development for the disciplines of psychology, social work, education and nursing. Such a body might also provide oversight for the development and implementation of guidelines and processes for regular independent evaluations of specialised services.

A national accrediting body might also maintain links to primary and secondary schools to provide guidance with some of the previously identified challenges faced by educational staff. Such a body could assist schools by informing sex education and protective behaviours curriculum, and by providing a centralised list of accredited training options and consultants to advise on containment strategies and safety plans. An additional function of a national body might be to assist with the development of consistent protocols for schools. Consistent protocols would function to create conditions within schools that provide for:

- the safety of all students
- timely, appropriate and non-stigmatising response to incidents
- effective engagement with families in managing behaviours
- appropriate referrals to specialised therapeutic counselling
- guidelines for managing the media and reactions from other parents and students
- strategies to allow the young person to remain at school, and as much as possible within their existing classroom environment.

SPECIALISED SUPERVISION AND PROFESSIONAL NETWORKS

Across the sector there are some good examples of interstate collaboration in establishing new services and/or supporting existing services. However, clinicians report that increased opportunities for mentorship and professional support are required. This is reported to be particularly important in circumstances where one therapist works in isolation or where staff have excessive client loads. Vicarious trauma and worker burnout are identified as threats to the professional capacity within the sector. In extreme cases trained clinical staff have left the sector for less stressful employment.
The majority of clinicians reported that funding for professional education is extremely limited, and a number of those interviewed indicated that they fund their own attendance at conferences to ensure their knowledge and professional networks are maintained.

Within the sector there are two associations that provide opportunities for professionals to come together to advance their own professional development and the Australian knowledge base in this field. The Victorian Offender Treatment Association (VOTA) is an incorporated not-for-profit organisation that promotes the development of a ‘consistent, well informed approach to the behaviour, treatment and management of sex offenders’. The association hosts regular seminars, a biennial conference, and provides awareness raising, advice and consultation to relevant authorities regarding the effective management and treatment of sex offenders.

ANZATSA promotes professional standards and evidence-based interventions that address the needs of children and young people who have engaged in problem or criminal sexual behaviour. ANZATSA has approximately 200 members across Australia and New Zealand, with professionals from government, non-government and the private sector working in the disciplines of psychology, psychiatry, social work, child protection, community education and professional education. Membership to ANZATSA at a clinical level requires a tertiary qualification in psychology, psychiatry, social work or counselling, as well as a minimum of two years supervised experience in the field. ANZATSA encourages ongoing professional development for members and provides an important professional network for clinicians in the various sectors that are likely to respond to the needs of young people with problem sexual behaviour. ANZATSA also fulfils a role in advocacy and community education regarding ethical and evidence-based interventions that address the needs of children and young people who have, or who are alleged to have, engaged in problem or criminal sexual behaviour.

150 For further information on VOTA see http://www.vota.org.au/index.html.
151 Submission from ANZATSA, dated 17 August 2009. Appendix One. For further information on ANZATSA see www.anzatsa.org.
YOUTH JUSTICE: CHALLENGES TO RESPONDING TO YOUNG PEOPLE WITH SEXUALLY ABUSIVE BEHAVIOURS

The weight of this report focuses on community-based services designed to fulfil an early intervention or diversionary function. The clinical and criminological literature on adolescents who have committed sexual offences indicates that the pathologisation of the young person and a labelling or overly punitive response is likely to be more harmful than rehabilitative. The vast majority of clinicians interviewed, including those in youth justice contexts, expressed the view that therapeutic counselling and diversionary schemes are preferable to custodial terms in most instances. In instances where an adolescent’s sexually abusive behaviours are thought to pose an ongoing risk to the community, there is the need to balance the therapeutic needs of the young person against concerns for the safety of others. In such cases, clinicians identified the benefits of comprehensive therapeutic care for the young person in which, ideally, the family are involved and, where appropriate, the young person has the opportunity to understand their offence and the therapeutic work according to their own culture.

SERVICES FOR YOUNG PEOPLE WHO ARE REPORTED BUT NOT CONVICTED OF SEXUAL OFFENCES

The number of young people convicted of sex offences is very small. The processes that contribute to so few convictions for juvenile sex offenders are complex, as articulated by the Victorian Law Reform Commission:

*A prosecution is unlikely unless the complainant would be a competent and credible witness. If the complainant is a child who is too young to testify effectively a prosecution is unlikely. When the offender and victim are siblings, the family and the victim child are likely to be reluctant for one sibling to testify against the other. The cumulative effect of these difficulties, as well as the difficulties of proof and the general community perception that sexual assault by children and young people is less serious than sexual assault by adults, results in a small number of prosecutions and a smaller number of convictions in cases of sexual assault by young people.*

Increased convictions and custodial terms for juveniles with SABs are not advocated in any sphere. Yet clinicians expressed a series of complex concerns regarding young people who come into contact with the justice system but who, without a conviction, remain ineligible for the therapeutic responses made available by a court mandate. In several jurisdictions therapeutic services for adolescents necessitate a conviction or a guilty plea.

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The Victorian Law Reform Commission expressed concern regarding the high numbers of cases in Victoria of non-rape sexual offences that are struck out of the Children’s Court. Prior to the introduction of the Therapeutic Treatment Order (TTO) legislation this would mean that in cases with insufficient evidence the young person exits the criminal justice process without a ruling and without a directive for therapeutic intervention. In Victoria the TTO provides a mechanism for the family division of the Children’s Court to direct a young person to therapeutic service, yet there is no such legislation in other states and territories.153 Interviews for this study revealed concerns for young people who were charged with sexual offences but for whom the charges were plead down to lesser charges. Such instances preclude the young person’s eligibility to mandated services.154 This is of particular concern in jurisdictions where there are few services for adolescents besides court-mandated services. Clinicians also expressed concern about services for young people who come to police attention, but who are cautioned rather than charged, or who are charged and the charges are subsequently dropped.155

Several interviewees commented on the fact that the risks are exacerbated in circumstances where the young person is from a small community that is generally aware of both the offence and the young person’s police involvement. In circumstances where the charges are dropped or plead down, the young person is often returned to the community. This is of particular concern in Indigenous communities, where community divisions may arise as a result of the offence, and there is little in place to protect either the victim or the offender once the offender returns to the community.156 These concerns would also apply to young people who are returned to their community to serve non-custodial orders for sex offences.

Moreover, there are concerns that young people that are not prosecuted ‘are not afforded judicial safeguards that ensure that their rights will be protected’. ANZATSA contend:

*The absence of a judicial structure for making decisions often results in the most important decisions about a child or young person’s mental state and risk of re-abusing being left to police officers or other government personnel. Such professionals are unlikely to have the expertise to make such assessments and the consequences of erroneous judgments may be life-long for the child, young person and, not least of all, vulnerable members of the community.*157

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153 In NSW the legislative definition of a child at risk of harm indicates that a child between the age of 10 and 14 years who exhibits sexually abusive behaviour is explicitly considered by the legislation as the potential subject of care applications and orders. If the Children’s Court is satisfied that a young person requires a care order, and where the child is under the age of 14 years, and has exhibited sexually abusive behaviours an order of the Children’s Court can be issued ‘to ensure his or her access to, or attendance at, an appropriate therapeutic service.’ Children and Young Persons Care and Protection Act 1998 NSW s 71.

154 Interview with Mary Culhane-Brown, dated 17 July 2009.

155 These concerns include those voiced by Victoria Police to the Advisory Committee for the Victorian Department of Justice’s Sexual Assault Reform Strategy. These concerns have resulted in the funding of an additional 40 therapeutic places across the state for adolescents aged 15-17 who have sexually abusive behaviours. Interview with Janice Watt and Natasha Habjan, dated 24 July 2009.

156 Judy Atkinson, in particular, emphasised the need for extensive work with both the victims and the offenders in these circumstances. Interview with Professor Judy Atkinson, dated 16 April 2009; Interview with Louise Bromly and Sarah Dina, dated 6 May 2009.

157 Submission from ANZATSA, dated 18 August 2009.
One of the primary concerns articulated by ANZATSA pertains to decisions to remove a young person from the family home. ANZATSA express concern that without the formal processes of review afforded by judicial decision making ‘a situation of separation may go on indefinitely’. In general terms, ongoing separation from the family is likely to inhibit the young persons therapeutic gains, and further erode the positive attachments that are known protective factors. ANZATSA contend that failure to address the problem behaviour may ‘result in the child or young person’s prognosis deteriorating and exacerbating the risk of harm to others’.

SERVICES FOR YOUNG PEOPLE CONVICTED OF SEX OFFENCES

Each state and territory has provisions for youth justice clients serving custodial or community orders for sexually abusive behaviours. In each jurisdiction the governance arrangements differ, as does the degree to which corrective services can offer specialised psychological supervision of an order. In Tasmania, Victoria, South Australia, the Australian Capital Territory and Queensland, youth justice clients are the responsibility of the Human Services Department. In the Northern Territory, the responsibility for young people on community-orders transferred to NT Families and Children in February 2010, yet juvenile custodial clients remain the responsibility of the Department of Corrective Services (NTCS). Since 2005, the ACT has also had a dual arrangement whereby youth justice sits under the Department of Housing and Community Services (DHCS), yet therapeutic care to both community and custodial youth justice clients with SABs is provided by Corrective Services who receive DHCS funding for this purpose. In Western Australia, juveniles are managed by the Department of Corrective Services, whether they are serving a custodial term or community-based order. In NSW, juveniles are managed by the Department of Human Services, Juvenile Justice (Juvenile Justice NSW).

With attention to jurisdictional variance in governance, referral pathways and geography, this section broadly maps therapeutic options for adolescents who are either serving custodial sentences, or fulfilling community orders for sexual offences.

VICTORIA

In Victoria, youth justice clients who are convicted of sex specific offences and detained or placed on community Youth Justice orders receive therapeutic services from the Male Adolescent Program for Positive Sexuality (MAPPS) at the Adolescent Forensic Health Service, which is part of the Royal Children’s Hospital. Funded by the Department of Human Services to specifically work with young people in the Youth Justice System, MAPPS is a service for young people aged 10–21 who have been found guilty of one or more sexual offence. This long-running program coordinates specialised group and individual psychological services for young people and was successfully evaluated in 1998. Although the name appears to suggest otherwise the Male Adolescent Positive Sexuality Program is also open to girls aged 10-21 who have been found guilty of one or more sexual offence. Interview with Dr Irene Fanagopoulos and Lynne Evans, dated 22 July 2009.

MAPPS ensures that all young people on Youth Justice Orders for sexual offences are provided with attention to jurisdictional variance in governance, referral pathways and geography, this section broadly maps therapeutic options for adolescents who are either serving custodial sentences, or fulfilling community orders for sexual offences.

158 Submission from ANZATSA, dated 18 August 2009.
159 Submission from ANZATSA, dated 18 August 2009.
160 Although the name appears to suggest otherwise the Male Adolescent Positive Sexuality Program is also open to girls aged 10-21 who have been found guilty of one or more sexual offence. Interview with Dr Irene Fanagopoulos and Lynne Evans, dated 22 July 2009.
161 The 1998 evaluation of the program revealed a 95 percent success rate, with only 5 percent of the 158 young people accepted to MAPPS between 1993 and 1998 re-offending sexually. Makepeace, Tidmarsh & Lancefield, 2001.
treatment regularly by a team of experienced clinicians. For MAPPS clients, the therapeutic model is based on assisting young people to increase their understanding of themselves and others and take responsibility for their actions and choices. Young people are supported to develop an understanding of the deliberate pattern of their offending, as well as developing victim awareness and empathy. MAPPS encourages young people to take responsibility for choosing a positive lifestyle that does not incorporate offending or abusive relationships.

**WESTERN AUSTRALIA**

Providing specialist supervision for all juvenile justice orders proves a challenge in some jurisdictions. The Department of Corrective Services in Western Australia strives to provide psychological counselling for juvenile offenders in both community and custodial settings, whether convictions are for sex specific or generalist offences. Departmental staff explained that whilst there are psychological services in place for young people in custodial settings, and for those within the inner metropolitan region, there are difficulties in providing services to those who are on community orders who reside some distance from Perth’s centre.

As an accompaniment to individual counselling, the Department has now commenced group work with young people serving community orders for sex offences. This necessitates clients travelling to attend the metropolitan-based service, and the Department appreciates that for remotely located young people this is likely to be prohibitive.

Young people in the metropolitan area may also experience difficulties in accessing psychological services for specialised supervision of their order. The metropolitan area is approximately 90 kilometres wide and, under the Young Offenders Act 1994, young people can only be compelled to travel 30 kilometres for an order. For young people residing in regional areas, there are psychologists located in Albany, Geraldton and Kalgoorlie. Psychological services also provide an outreach service to Bunbury and Northam. There are, however, a number of other locations in Western Australia in which access to a Department psychologist is not an option.

The Department has taken steps to increase the delivery of specialised counselling in remote areas. In April 2008, the WA Department of Corrections established the Critical Response Team following media coverage of juveniles charged with sex offences in Halls Creek. The mandate for this team was to provide psychological services to young people residing in the Kimberley region of WA who were serving community orders for sexual offences. This involved the preparation of psychological assessments for court reports, and departmental psychologists and the Aboriginal consultant travelling to relevant communities to provide psychological counselling to young people on orders. Part of this practice involved engagement with the school and, where possible,

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162 As with other jurisdictions, this occurs only when counselling is recommended in the psychological assessment prepared for court.


164 This team comprised a Juvenile Justice Officer, a Community Corrections officer, two psychologists from Juvenile corrections, a program officer and an Aboriginal Consultant. Interview with Louise Bromly and Sarah Dina, dated 6 May 2009.
the young person’s family.\footnote{Staff from WA Psychological services reported that schools were generally very cooperative, but there were often challenges in effectively engaging families. Interview with Louise Bromly and Sarah Dina, dated 6 May 2009.} A psychologist from the Critical Response Team reported that there was also the opportunity to engage in prevention and early intervention work that was incidental to the primary purpose of their visit but nonetheless valued by the community. In one community the CEO, parents and the school expressed concern about the sexualised behaviours of a group of six and seven year old boys. Coinciding with their scheduled visits every three or four weeks to supervise orders, Psychological Services began working with the young boys individually to deliver psycho-educational preventative messages.

Funding for the Critical Response Team was discontinued in April 2009, one year after the commencement of the service.\footnote{The team were funded to effectively conclude sessions with clients in instances where duty of care would prohibit a sudden termination of therapy. Interview with Louise Bromly and Sarah Dina, dated 6 May 2009.} Some positions within this team have remained, yet these fulfil administrative rather than therapeutic functions. The discontinuation of the outreach services of the Critical Response Team means that now, if a young person commits a sexual offence in a remote location in the north of the state, a psychologist will still travel to that location to prepare the assessment, but the report to court would be unlikely to make recommendations for treatment options. For a young person in this situation the likely therapeutic response would be limited to the basic psycho-sexual education that could be provided by juvenile justice officers located in country areas.\footnote{Juvenile justice officers are no longer required to be tertiary qualified, due to the difficulties in staffing country areas. Interview with Louise Bromly and Sarah Dina, dated 6 May 2009.}

Queensland

Queensland faces similar geographic challenges in delivering specialised services to remotely located youth justice clients. In response to this challenge, the Griffith Youth Forensic Service (GYFS) have devised a unique field-based collaborative model of community outreach.\footnote{See Smallbone, S., S., Rayment-McHugh, et al. 2008.} GYFS is funded by the Queensland Department of Communities to provide specialist state-wide assessment and intervention services for those aged 10–17 who are convicted of sex offences.\footnote{GYFS also receive in kind funding and support from Griffith University.} Based in Brisbane, and with a new satellite office in Cairns, GYFS has five full time (equivalent) therapeutic staff who service a geographic area stretching from the Gold Coast in the south of the state to the Torres Strait in the north. For a staff of this size to provide a state-wide service to all youth justice clients presents significant logistical challenges, and GYFS report that they are consistently unable to meet the need for specialist service provision across the state. In light of this referral demand, GYFS and the Department of Communities have agreed on a protocol for prioritising referrals according to two key considerations. Firstly, clients with the greatest risk and criminogenic need are prioritised and, secondly, referrals for remotely located young people are prioritised over those from metropolitan areas.\footnote{Interview with Sue Rayment-McHugh, dated 15 June 2009.} ‘That is to say, priority is given to higher-risk cases, to more complex, higher-needs cases, and to cases where alternative services are less likely to be available.’\footnote{Submission from Stephen Smallbone, dated 7 August 2009.} Consistent with these priorities, 85 per cent of GYFS clients are based outside of...
south-east Queensland and 40 per cent of current cases involve Indigenous youth. GYFS Manager Sue Rayment-McHugh reports that this prioritisation increases the workload for staff in two ways. Firstly, the greater the needs and risks for the client the more complex and difficult the work and, secondly, the more remotely located the client the greater the demands on staff in terms of travel.

The recently established GYFS office in Cairns aims to lessen the demands of staff travelling from Brisbane to far north Queensland and across Cape York. The intention is that this will provide a base to increase the scope of services in North Queensland, particularly to Indigenous youth and their families in remote Cape York Communities. Fundamentally though, GYFS endeavour to meet the demand in regional and remote areas through their unique field-based model of collaborative partnerships in which they strive to build community capacity that will outlast the service that GYFS can provide.

‘Collaborative partners are identified on a case-by-case basis, following an assessment of the young person’s sexual offending in the context of their unique social ecology, and typically include youth justice or mental health professionals, community counsellors, youth workers, or respected members of the local Indigenous community.’ This approach is highly individualised, and in each case the young person assists in identifying partners that can be engaged in their support. GYFS acknowledge that whilst clinicians offer specialist psychological expertise in responding to sexual offending behaviours, they are not the only component required to support the young person. ‘Collaborative partners bring experience and expertise in their own field and often have a good understanding of local cultural and community systems, but usually have no prior experience in providing interventions for young people who have committed sexual offences.’ GYFS clinicians maintain primary responsibility for identification of treatment goals and overall planning and intervention. The sustainability of their work is achieved by implementing a bottom-up approach that builds capacity in the community to support the young person. The potential benefits of this model are that it:

- provides for continuity in the provision of services in regional and remote settings without the need for the continual presence of a specialised GYFS clinician
- engages more broadly with the youth’s natural social ecology, for example by including local responsible adults in the process of intervention and risk management
- builds the capacity of local professionals, paraprofessional and community members to respond effectively to present and future cases, by drawing on existing knowledge and skills and imparting new knowledge and skills.

173 Interview with Sue Rayment-McHugh, dated 23 June 2009.
177 A component of this work is to utilise the time in communities to encourage community driven prevention efforts, although GYFS is not currently funded to undertake this work. Interview with Sue Rayment-McHugh, dated 23 June 2009; Submission from Stephen Smallbone, dated 7 August 2009.
GYFS is in the unique position of being able to generate research, a luxury that many clinicians described as impossible within their current funding agreements. Professor Stephen Smallbone maintains that, ‘because GYFS is based within a university environment it has the capacity to generate knowledge through rigorous theoretical and empirical research. . . . This provides a strong foundation for ecologically valid, practice relevant research, and for innovative, evidence-based practice’.179 GYFS recently surveyed collaborative partners in relevant communities to garner opinions about whether their practice model had been effective in achieving its objectives over time. The outcomes were favourable, with participants indicating that skills, knowledge and confidence were significantly increased by the collaboration, and that this was associated with perceived improvements in client outcomes.180

This is not to say that the GYFS team do not identify challenges in their practice or in the state-wide provision of specialised services. Aside from the overwhelming demand for services, GYFS articulate their concern that in some instances they are delivering therapeutic services to those who have sexually offended and yet there are no therapeutic services available to victims within that community.181 As with Victoria’s Male Adolescent Program for Positive Sexuality (MAPPS), the services of GYFS are available only to those referred by the courts and, whilst Smallbone acknowledges that not all court-referred clients can be serviced by GYFS, he also identifies ‘unmet needs in Queensland for youth sexual offenders diverted to youth justice conferencing’.182

Youth residing in the south-east of Queensland who are charged with sex offences and diverted to youth justice conferencing are likely to receive therapeutic counselling via the Mater Family and Youth Counselling Service (MF&YCS). Funded by the Department of Communities, this Brisbane based service sits under the Child Protection Unit of the Mater Children’s Hospital. All referrals to this service are through youth justice conferencing (YJC) and MF&YCS and YJC jointly provide a diversionary pathway that has yielded positive outcomes.183 MF&YCS work closely with staff from YJC to develop a conference plan to ensure the young person’s readiness for conference and to support the young person, the harmed child/ren and family members during the conference process.

Eligibility criteria for the service stipulate that the young person must be aged 10–16 years at the time of the offence, but for clients who meet these criteria counselling may continue as long as they are under 19 years of age.184 Utilising a ‘holistic, multi-dimensional service delivery model’,185 the therapeutic approach utilised by MF&YCS clinicians is tailored according to the developmental needs of the young person. Therapeutic work is family based and eligibility to the service is contingent on the involvement of family or carers.186 Treatment goals are informed by a rigorous assessment process,
and MF&YCS may require a commitment to counselling of between six months and two years.\textsuperscript{187} MF&YCS currently have 2.7 FTE staff and based on this capacity the service has accepted referrals for 22 young people and their families within an 18 month period.\textsuperscript{188}

There are limited diversionary options for young people outside the metropolitan region of south-east Queensland. Karen Aspinall, manager of Laurel House on the Sunshine Coast, reports that Juvenile Justice and Community Conferencing would like to refer clients, but Laurel House are unable to accommodate this additional client load.\textsuperscript{189} At present, Juvenile Justice refer adolescent clients to Phoenix House in Bundaberg. Uniquely, this specialised service is located in a regional area—five hours north of Brisbane. Phoenix House Manager, Kathy Prentice, expressed concerns about the lack of sexual assault and specialised PSB and SAB services between Bundaberg and Cairns—a distance of over 1,300 kilometres.\textsuperscript{190}

Victoria and Queensland are unique in that they each have state funded specialist services for responding to custodial and community-based youth justice clients. In each other state and territory, services are provide predominately by professional staff within the public sector, whether the governing body be the human services/child protection department or corrective services/juvenil justice. This specialist care offered by public service professionals is, in some instances, supplemented by state funded services to which the courts and the statutory body regularly refer. For example in South Australia, the state funded and community-based service Mary Street\textsuperscript{191} provides services to non-adjudicated young people who are referred by the statutory body, schools or self referred, but this service also undertakes assessments for Youth Court, and provides counselling to young clients on youth justice orders.

**TASMANIA**

In Tasmania, there is not a designated program or team for responding to young people convicted of sex offences. There is one youth justice forensic psychologist to service the needs of all custodial and community-based clients in the state. In the north and north-west of the state, youth justice make referrals to this psychologist via the Ashley Youth Detention Centre. In the south of the state, Youth Justice outsource this work to a private forensic psychologist.\textsuperscript{192} DHHS Tasmania report, ‘the available resources are not sufficient, resulting in a waiting list for young people to enter the assessment phase.’\textsuperscript{193} The psychological needs of this client group are varied and diverse, particularly as the client profile commonly includes childhood histories of abuse, neglect and/or multiple placements.\textsuperscript{194} Any therapeutic intervention provided is tailored to the individual young person’s needs and considers their specific circumstances, including protective factors. There is no application of a standardised model or ‘one size fits all’ therapeutic approach.\textsuperscript{195}

\textsuperscript{187} Mater Misericordiae Health Services 2009. Mater Family and Youth Counselling Service Service Brochure.
\textsuperscript{188} Queensland Department of Communities, 2009. p. 3, 9.
\textsuperscript{189} Interview with Karren Aspinall, dated 2 July 2009.
\textsuperscript{190} Interview with Kathy Prentice, dated 24 June 2009.
\textsuperscript{191} This service is also referred to as the Adolescent Sexual Abuse Prevention Program, and is funded by CAMHS, SA.
\textsuperscript{192} Interview with Jennifer Thain, and accompanying document, dated 20 March 2009.
\textsuperscript{193} Submission from Department of Health and Human Services, Tasmania, dated 14 September 2009.
\textsuperscript{194} Interview with William Doudle, dated 18 March 2009.
\textsuperscript{195} Submission from Department of Health and Human Services, Tasmania, dated 14 September 2009.
NEW SOUTH WALES

NSW youth justice clients are managed by the Department of Human Services, Juvenile Justice (Juvenile Justice NSW). In December 2009 Richard Parker was appointed to Juvenile Justice NSW as Manager of a suite of programs for offending behaviours, including the Sexual Offending Program (SOP). Under Parker’s direction the newly revised SOP is currently being piloted and feedback from an internal evaluation of the pilot phase will be used to improve the program. Where young people have been convicted of committing sexual offences, SOP delivers CBT-based individual counselling. Delivered in both community and custodial settings, this program aims to address the criminogenic needs of the young person and thus reduce recidivism.196

In NSW there are a large number of juvenile justice clients in regional areas, a proportion of whom are on orders for sex offences. Parker reports that community orders are monitored at different rates according to the type of sentence.197 Juvenile Justice NSW are currently reviewing this system, with the intention of relating the frequency of supervision to the risk of re-offending and intervention needs, rather than the type of order alone. As with the youth justice response in other jurisdictions, Juvenile Justice NSW reports challenges in ensuring that all clients convicted of sex offences receive specialised counselling. 198

With only 10.5 specialist SOP counsellors across the jurisdiction, it is inevitable that many young people are allocated to a non-specialist counsellor. The problem is more acute in regional areas, but there are metropolitan offices without a SOP counsellor. In regional areas, all counsellors (specialist or generalist) are supervised by a clinical supervisor who is familiar with sexual offender work.199

Further, Parker reports difficulty in attracting appropriately qualified staff to the roles, particularly in regional areas. An associated challenge is the cost of delivering training and professional supervision to SOP counsellors located across the vast geographical area of the state.200

Engaging the families of young people who have sexually offended proves a challenge for juvenile justice services in several jurisdictions. As the clinical research and evaluative data in this sector continues to evolve the approaches that were first implemented in responding to young people with sexualised behaviours are modified or superseded by new understandings of best practice. Working with the family is now widely documented as best practice for working with young people convicted of sex offences. Yet there are systemic difficulties that mean that family and contextual work is likely to be even more difficult for youth justice clinicians than it is for clinicians working in community settings.

Professor Smallbone identifies the tension between isolated individual therapeutic approaches and ecological approaches that work with the multiple contexts in which a young person lives. He contends that ecological work rarely occurs within the youth justice sector:

196 Submission from Richard Parker, dated 8 March 2010.
197 Submission from Richard Parker, dated 8 March 2010.
198 An interview with a Juvenile Justice NSW SOP psychologist located in regional NSW indicated that a typical week in supervising youth justice orders would necessitate travelling a distance of 1000 to 1500 kilometres. Interview with Ian Nisbet and Jeannette Liva, dated 24 April 2009.
199 Submission from Richard Parker, dated 8 March 2010.
200 Submission from Richard Parker, dated 8 March 2010.
Programs for youth sexual offenders were originally modelled on those developed for adult sexual offenders, and many youth programs in Australia (and elsewhere) continue to operate according to this adult model. Many programs still provide highly prescriptive group-based psychotherapies that more or less exclusively target individual level-factors.201 Parker reports that the SOP delivered by Juvenile Justice NSW does provide scope for family work, but families cannot be directed to participate in the program. Consequently, the involvement of families is contingent on their willingness to become involved.202

NORTHERN TERRITORY

The Northern Territory’s vastness also presents significant geographic challenges to the provision of specialised supervision to young people on youth justice orders for sex specific offences.203 NTCS are currently undergoing significant reform. Following a Coronial Inquest, NTCS received funding to establish new positions and increase training to strengthen the community corrections response. Implemented in the last 18 months, these reforms mean that where youth justice orders were previously supervised by non-specialist and non-clinical staff, parole and probation officers can now work in consultation with the newly appointed intensive case managers. There are six positions within this new allocation and the intention is that these positions provide clinical support to the existing workforce of corrections officers who service youth justice clients, with outreach from key centres in the Territory. In response to Little Children are Sacred, the NT government provided $4.4 million in additional funding to NTCS to expand sex offender services. This has allowed for the appointment of additional clinical staff within NTCS. These new clinical staff provide services to both adults and juveniles serving custodial sentences for sex offences. Prior to the establishment of this clinical workforce there were no specific violence or sex offender services at Don Dale, the Youth Detention Centre in Darwin. In the past, if therapeutic intervention were required for a young person the services of a private psychologist would be secured, or therapeutic counselling would be provided by the social worker employed by the detention centre.

In 2008, NTCS commissioned a report to inform the model for the delivery of therapeutic services to young people serving orders for sex offences in community settings. Professor Stephen Smallbone provided a report to NTCS in January 2009, and NTCS are now in the process of implementing a community-based model of therapeutic intervention that is similar to that utilised by GYFS in Queensland. Smallbone’s report recommended that any sex offender treatment provided should ‘acknowledge the diversity among the various language and cultural groups, and . . . engage in meaningful and constructive ways not only with individual offenders but also with their families and their local communities.’204 The model implemented by NTCS will provide therapeutic support for both adults and juveniles on orders, and will work with both the family and the community. The intention is

201 Submission from Stephen Smallbone, dated 7 August 2009.
202 Submission from Richard Parker, dated 8 March 2010.
203 Northern Territory Corrective Services NTCS report that approximately 80 percent of their clients are Indigenous. This refers to both adult and juvenile clients cumulatively. Interview with Dr Shirley Grace, dated 16 July 2009.
204 Smallbone, S.W. 2009. p.17.
to link the intensive case managers with generalist staff to ensure that services cover the geographic expanse of the Territory. As of February 2010, NT Families and Children are responsible for supervising youth justice clients on community orders.\(^{205}\) Responsibility for juvenile custodial clients has been retained by NTCS.

AUSTRALIAN CAPITAL TERRITORY

In the ACT, Youth Justice fits within the portfolio of the Department of Disability, Housing and Community Services. ACT Corrective Services (ACTCS) is, however, funded to provide therapeutic care to both community and custodial youth justice clients with sexually abusive behaviours. Responsible Respectful Relationships (RRR) was implemented by ACTCS in 2000. RRR is a treatment program for young people convicted of sex offences. There is a written manual for its delivery, allowing suitably experienced staff to deliver it with limited specific training. RRR is derived from ACTCS’ group program for adult sex offenders. It is currently delivered on a one-to-one basis but can also be delivered in a group format by two group facilitators. The program is also available to young people with sexually abusive behaviours who are not involved in the criminal justice system.

With the 2009 opening of the ACT’s first prison, the Alexander Maconochie Centre, ACTCS is experiencing a period of growth and reform. This circumstance will result in improved responses to young people convicted of sex offences. With the appointment of new staff, ACTCS is eager to ensure that the therapeutic response offered to young people is developmentally appropriate and, as such, is in the process of developing a program that is designed for young people rather than adults. ACTCS is currently studying the therapeutic programs offered in other jurisdictions, and is looking to ANZATSA for guidance as to the best model to implement in the ACT. The revised therapeutic approach will prioritise working with families, and will incorporate group work and individual work as required.

OVERVIEW

Each state and territory experiences challenges in ensuring equitable and comprehensive therapeutic services are available to custodial and community youth justice clients. Jurisdictions with the largest geographic service areas face enormous challenges in providing specialised supervision for community-based orders. At present there are several jurisdictions where orders for regionally and remotely located clients cannot include therapeutic provisions as there aren’t specialised staff to service those areas. This means that in some jurisdictions a young person convicted of a sexual offence will serve the duration of a youth justice order without receiving specialised counselling to assist them in modifying their behaviours.

\(^{205}\) The office with specific responsibility for community youth justice clients beyond February 2010 will be the newly established Family Support Centre, which has offices in Alice Springs and Darwin. These centres have been established for this purpose and for the administrative implementation and oversight of the Family Responsibility Agreements. Interview with Mary Culhane-Brown, dated 17 July 2009.
More positively, several jurisdictions are undergoing significant reform, with efforts focused on shifting dated and stigmatising organisational culture, recruiting qualified staff and funding best-practice programs that work with families. Professor Smallbone’s assertion that youth justice rarely works ecologically is an accurate reflection of the current circumstance in most Australian jurisdictions. Clinicians in each state and territory express a desire to work more closely with the families and carers of young clients in community settings, citing funding and geographical challenges as major impediments. In most jurisdictions there is an awareness that juveniles convicted of sex offences require a different therapeutic response to that traditionally offered to adult sex offenders. Where manualised group programs exist there is generally a desire to replace these with more individualised approaches.

LEGAL PROCESS AND THE PROVISION OF THERAPEUTIC SERVICES TO YOUNG PEOPLE ON REMAND

Clinicians report therapeutic and ethical reservations about imposing offence specific treatment prior to a young person being convicted or pleading guilty of a sex offence. Moreover, each state and territory proscribes the provision of specialised sex offence counselling to young people prior to sentencing. This means that whilst a young person is on remand they are ineligible for counselling specific to their alleged offence, even if clinical staff assess that there is a pressing need for therapeutic intervention. Several clinicians expressed concerns about lengthy remand terms and the consequences that this has for a young person’s therapeutic care. In some jurisdictions one year is a standard remand term, and in other cases a young person might be on remand for up to two years. A lengthy remand term may result in a young person being released soon after sentencing, having served the majority of the sentence already. Where delays in sentencing delay the commencement of counselling, specialised treatment may be available to a young person for a very short period of time. It is reported that this may compromise the young person’s success at a bail hearing, as the clinician’s court report is likely to indicate insufficient treatment gains.

Delays in evidentiary and legal process, and delays in securing sentencing dates, are reported to be the major impediments here. In some instances the burden on youth justice psychologists, and/or the necessity to outsource to a private psychologist, might result in a further delay between the conviction and the commencement of therapeutic work.

Indeed, sentencing and sentencing referrals were issues identified by several clinicians. The primary concerns were that in several jurisdictions Magistrates had expressed frustration at the lack of referral options for young people charged with sex offences and the need for eligibility to programs that do not necessitate a conviction. In some jurisdictions this is simply because there are few referral options for non-adjudicated clients, as is the case in Queensland. This is a circumstance that Ian Berry, President of the Queensland Law Society, identifies as creating deficiencies in service response. Whilst Berry commends the provision of services for adjudicated clients in Queensland, he finds it

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206 Interview with Ian Nisbet and Jeannette Liva, dated 24 April 2009; Interview with Dr Shirley Grace, dated 16 July 2009; Interview with Mary Culhane-Brown, dated 17 July 2009; Interview with Sue Rayment-McHugh, dated 23 June 2009.
207 Interview with Mary Culhane-Brown, dated 17 July 2009.
208 Interview with Mary Culhane-Brown, dated 17 July 2009.
‘unsatisfactory that adolescents must enter the criminal justice system in order to access treatment’. Berry identifies the need for therapeutic services for young people to prevent them coming into contact with the criminal justice system:

The absence of pre-offence diversionary programs is a serious gap in the provision of services. I would suggest that police be allowed to issue diversions to adolescents to attend pre-offence sexual offender programs which would function to address at risk adolescents before they commit crimes. If such a program is successful, the benefits would be immeasurable.

Whilst referral options for police and magistrates are a source of concern, there is also a perception that justice workers would benefit from increased education and awareness regarding the complexities of adolescents with sexually abusive behaviours. In Tasmania, the Youth Justice Services team have identified a number of challenges in the pursuit of therapeutic jurisprudence:

An area that requires thought is the role of the Courts in determining a therapeutic response to young people with problem sexual behaviour. With an increasing evidence base for the benefits of therapeutic jurisprudence, the impact of the Victorian Therapeutic Treatment Order would be very interesting to other states and territories. The importance of having youth specific courts, with Magistrates trained in Youth Issues, is an area that would be highlighted particularly in the area of problem sexualised behaviour, as the administration of justice in this regard would be dependent on a thorough understanding of what can be considered normal adolescent sexual experimentation as opposed to problem sexual behaviour. Generally, communities are not wellversed in this distinction.

The need for a range of referral options is indicated by clinicians’ reports that Magistrates may understand a young person to have therapeutic needs that are only sex offence specific. These clinicians stress the need for acknowledgement that the young person is likely to have multiple and complex needs and serious behaviour problems beyond those of the offence. Indeed, clinicians report that all young people with PSBs or SABs are likely to have a host of practical and therapeutic needs. This applies to young people in the youth justice sector, as well as those who seek community-based therapeutic care.

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211 Interview with Jennifer Thain, and accompanying document, dated 20 March 2009.
COMMUNITY-BASED SERVICES: THE NATIONAL CONTEXT AND GENERAL INITIATIVES TO ADDRESS RISK

As with the delivery of therapeutic care to youth justice clients, the spread of community-based services is limited by Australia’s geographic vastness. The financial and logistical demands of servicing the nation’s largest states and territories is the most profound challenge in ensuring that young people have equitable access to specialised therapy. These challenges are evident in each state and territory and, although the specific challenges differ, clinicians repeatedly stressed concern for those children unlikely to receive specialised therapeutic care for their behaviours.

Specialised PSB or SAB services in metropolitan centres all report an inability to respond to referral demand. At the present time it is not possible to quantify the unmet need in Australia. Most metropolitan services keep a log of the calls they receive from parents, schools or police in regional and rural areas who are seeking therapeutic service for children or young people. Whilst these calls are indicative of the general need, they would be an under-representation of the extent of demand from non-metropolitan areas. Non-metropolitan demand is more difficult to measure as the paucity of services outside metropolitan areas means that formal referral networks to specialised services are not in place. In general terms, children residing in parts of Sydney, Melbourne, Brisbane and Adelaide have a greater chance of being referred and accepted to specialised treatment than children residing in most other parts of Australia. Agencies in other capital cities lack the capacity to service the resident population, and programs in regional, rural and remote areas are all but absent. This concentration of services in the metropolitan fringe means that the vast majority of children residing in other parts of the country would have difficulty in accessing specialised services. The few specialised services located in regional or rural parts of the country also report difficulties in adequately servicing the surrounding areas.

Recent data that maps the socio-geographic distribution of disadvantage in Australia demonstrates that child maltreatment is more likely to come to notice in areas where there is disadvantage resultant from limited education, deficient labour market credentials, poor health and disabilities, low individual and family income, and engagement in crime. Tony Vinson’s report indicates that 52 per cent of the Australian localities with consistently high indications of social disadvantage are rural. This highlights

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212 There are further challenges in accurately measuring the extent of the unmet demand for specialised services. Some services don’t accurately record data on referrals that cannot be accepted, and others don’t manage their own intake or referral lists – these might be managed by the statutory child protection agency, for example, and the service only receives the number of referrals according to the service agreement. There would, of course, be overlap within this data set too, as there would be instances in which a referrer might contact multiple agencies in pursuit of an accessible service. A number of clinicians reported conversations that they have had with parents or police officers in which the caller has indicated that they have called every other service in the region or state, only to find that the young person does not meet the eligibility criteria.

213 Phoenix House, based in Bundaberg, receive calls from all over the state from parents, teachers and police seeking counselling for children with sexualised or sexual offending behaviours. Although Phoenix is funded only to provide services to the Bundaberg area they do offer telephone counselling, simply because of the extent of the need. Interview with Kathy Prentice, dated 24 June 2009. Rural New Street Adolescent Service was established in 2008 following a recommendation in the ACSAT report that there be increased and culturally appropriate services to non-mandated youths with sexualised behaviours in rural NSW. Based in Tamworth, this service does offer outreach, and is described as being a state-wide service. Program staff report limitations in responding to the demand, both in rural areas, and also from the bulk of referrals from Newcastle. Interview with staff from Rural New Street Adolescent Service, dated 21 April 2009.

214 Vinson, T. 2007, p. xii.

the need to include rural and remote areas in the delivery of specialised services to children and adolescents with sexualised behaviours. Professor Smallbone writes of the need for services for young offenders in regional and remote Australia:

In Australia the most serious social disadvantage and youth crime problems are often concentrated in small regional and remote communities, including remote Indigenous communities, and there is a much stronger legislative and policy emphasis on restricting the use of incarceration as a last resort for youth offenders. As the recent ‘Little Children are Sacred’ report attests, sexual violence and abuse is especially concentrated in some remote Indigenous communities, often involving local youth as perpetrators (Wild & Anderson, 2007). Treatment for youth sexual offenders in Australia therefore needs to reach clients in regional and remote areas, to include services for high-risk offenders in community settings, and to be appropriate to the particular needs and circumstances of Indigenous youth and their families.216

There are a number of reasons why centralised and office based models of service delivery are problematic for residents of outlying areas. For many regionally or remotely located families, the costs associated with travelling to metropolitan centres for therapy would be prohibitive. Treatment for PSBs or SABs is not a short-term undertaking. Families would need to commit to attending weekly sessions for at least a year, and ongoing support may be necessary for a significantly longer term. The practicalities and the expense associated with relocating an entire family to a metropolitan area are likely to make this impossible, even for families that are completely committed to their child’s rehabilitation.

Relocation of a young person is also less than ideal. Ecological models of therapeutic intervention highlight the importance of family involvement in the successful rehabilitation of children and adolescents with sexualised behaviours. As Professor Smallbone suggests, ‘the ecological validity of centralised services is seriously compromised because practitioners will often have a very poor understanding of the social ecological context in which the young person lives, where their offences occurred, and of course where the potential risk of further offending is presented’.217

In a submission to this study, DoHA identified the challenges in providing specialised services, in particular to Indigenous people in regional and remote communities. The challenges identified by DoHA include:

- Limitations of the predominately anglo-western, rather than Indigenous, models of therapeutic response to reduction of sexual assault related trauma and associated problem sexual behaviour.
- Prevalence of many concurrent adverse socio-economic and social determinants of health including poverty, homelessness, overcrowding, and limited or inequitable access to education and health services affecting children and young people.
- Complexities in providing both protective and therapeutic services in an atmosphere of trust and support, when the inter-generational trauma of past forced removals of Aboriginal and Torres Strait Islander people have negatively impacted entire communities.

- Delivery of services in geographically dispersed and remote locations.
- Workforce challenges, including the availability of mental health workforce and specialised allied health practitioners necessary to respond to and treat these sexualised behaviour presentations.218

The Australian Government does not take a direct role in the provision of specialised services to children and young people with sexualised behaviours at a national level, yet there are a number of funded initiatives that seek to address the underlying circumstances that contribute to the context of risk for some children. DoHA fund ‘an innovative model in the Northern Territory that provides culturally safe services to Aboriginal children, young people and their families affected by sexual abuse, or problem sexual behaviour, where the latter may be indicative of sexual assault’.219 Furthermore, DoHA and FaHCSIA both fund initiatives that aim to address the challenges faced by families who experience disadvantage.

FaHCSIA fund several programs aimed at addressing family violence, as well as a host of services under the Family Support Program. For example, the Family Relationship Services assist ‘disadvantaged and at-risk families to improve family functioning and safety, and reduce the impact of family breakdown, family violence and substance abuse’.220 Services of this kind aim to lessen the adverse circumstances that exacerbate risks to PSBs, but they also provide for the outward referral of children to specialised services where required. FaHCSIA report that this secondary referral function will be strengthened under the National Framework for Protecting Australia’s Children (National Framework).221 ‘The National Framework is a vehicle to help link up initiatives, such as those under the Closing the Gap agenda, with services for children and families at risk.’222 DoHA report, for example, that FaHCSIA will be provided with information on relevant health programs that, ‘contribute to keeping children safe by supporting families with vulnerabilities such as substance abuse and mental health concerns’.223 FaHCSIA and the Australian Research Alliance for Children and Youth (ARACY) are currently developing a Common Approach to the Assessment, Referral and Support for Children and Families in Australia. This initiative follows on from the release of the National Framework and also

Inverting the pyramid: enhancing systems for protecting children.

The intention is that a common approach to protecting children will include mechanisms for needs identification and information sharing.224

Under the Indigenous Early Childhood Development National Partnership, the Commonwealth has committed to improving access to sexual and reproductive health care, specifically for young Indigenous women. Amongst the aims for this funding is the support for young Indigenous women to make informed decisions about their sexual and reproductive health.225 These Commonwealth initiatives to fund more general preventative or early intervention services are a crucial component of responding to children and young people with sexualised behaviours. The immediate therapeutic

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218 Submission from DoHA, dated 3 September 2009.
219 Submission from DoHA, dated 3 September 2009. Further information on MOS Plus is provided in a later section of this report.
220 Submission from FaHCSIA, dated September 2009.
221 Submission from FaHCSIA, dated September 2009.
222 Submission from FaHCSIA, dated September 2009.
223 Submission from DoHA, dated 14 September 2009.
225 Submission from DoHA, dated 14 September 2009.
needs of children with PSBs or SABs are pressing, but so too are the underlying contextual issues that contribute to childhood experiences of disadvantage and adversity.

There are also several national organisations that work more directly in the provision of mental health services for children and young people. The National Youth Mental Health Foundation, Headspace, was launched in July 2006. Funded by DoHA, Headspace is tasked with ‘delivering improvements in the mental health, social wellbeing and economic participation of young Australians, aged 12 to 25 years, experiencing mental health and related substance abuse problems’. There are 30 Headspace centres nationally that provide youth specific early intervention services for young people presenting with a complex array of mental and physical care needs. Whilst Headspace see relatively few young people with sexualised behaviours, they identify the need for ‘intensive, holistic and longitudinal intervention to address the underpinning psychological, physical, social and cultural aspects of care’.

Headspace maintain that this work is best undertaken by ‘a well resourced, multi-disciplinary team with a dedicated case coordinator’. Headspace identify that additional education and training opportunities would greatly increase their capacity to deliver culturally appropriate and evidence-based responses to children, young people and families affected by sexualised behaviours.

Kids Helpline is Australia’s only national 24/7 telephone and online counselling service for young people aged between 5 and 25. In 2008, Kids Helpline provided almost 300,000 online and telephone interactions with children and young people. As such, Kids Helpline provides a source of support for children and young people who may be otherwise reluctant or unable to access community-based services. Where appropriate, Kids Helpline refer children and young people to community-based services. They report that eligibility to many SABs programs requires a criminal conviction, and that there are very few options available for self or inter-agency referrals. DoHA is funding an extension of the mainstream Kids Helpline Program, with the aim to ‘improve Indigenous children’s access to telephone counselling and online support’. This will see the establishment of safe and secure telephone and internet access for children in four pilot communities (one based in each of the following states: SA, WA, QLD, and the NT). Funding is also being provided to ensure that Kids Helpline staff receive training to assist them in responding with cultural sensitivity when receiving calls from Indigenous children.

DoHA are also funding the development of the Australian Child and Adolescent Trauma Loss and Grief Network which is based at the Australian National University. As children from Aboriginal or Torres Strait Islander background are identified as being at greater risk of experiencing trauma loss or grief, the
network is developing a set of resources and information specific to issues faced by Indigenous youth. The network is working in close partnership with key Indigenous representatives to develop a resource hub that focuses on topics such as ‘social justice and human rights’, ‘loss and grief’, ‘resilience’, and ‘cultural awareness’. These culturally sensitive resources are important, and the network is designed as a community resource for parents and caregivers, as well as being a professional resource for practitioners, policy makers, educators, researchers, and child and family advocates.

GEOGRAPHIC CHALLENGES TO SPECIALISED SERVICE DELIVERY

The largest Australian states and territories experience the greatest challenges in providing services to those in regional and remote areas. Tables 1.1-1.8 provide a reference for the availability of specialised community-based programs in each jurisdiction. These tables provide an understanding of the nuanced eligibility criteria for services, and the possible means by which young people might be ineligible, even if they do reside in an area where services are available. Interviews with clinicians involved countless reports of young people who reside in metropolitan areas, but who cannot access a specialised service. Reasons include the young person failing to meet the program’s eligibility criteria, lengthy waiting lists, or the young person residing some distance from the service thus necessitating a commute of several hours each week. Several clinicians stressed that whilst there are certainly major challenges in servicing clients in regional and remote parts of Australia, this does not mean that there are no gaps or challenges in the provision of specialised services within metropolitan centres.

The services available vary from one jurisdiction to another, as do the challenges. In the Northern Territory for example, where 43 per cent of the total juvenile population is Indigenous, the newly expanded MOS Plus provides culturally safe services to Aboriginal children, young people and families where trauma or sexualised behaviours result from child abuse, neglect or sexual assault. Yet in some jurisdictions the only available program is that offered by juvenile justice, which clearly excludes those young people whose behaviours have not been brought to the attention of the criminal justice system. This is the case in the ACT for example, where there are community-based services for children under the age of 10, but there is currently no permanent service for those over the age of 10 unless they are court mandated.

COMMUNITY-BASED SERVICES

AUSTRALIAN CAPITAL TERRITORY

Funded by ACT Health, the Child At Risk Health Unit (CARHU) offers child centred and family focussed responses to children under 10 who display sexualised behaviour and/or are sexually harming other children. A child 10 years or over would be ineligible for this service, and in the ACT there are few other referral options. CARHU Clinical Coordinator, Josephine Alchin, indicated that CARHU regularly receives calls from police and child protection professionals who are seeking counselling.
for adolescents in Canberra. The recommendation is that they contact New Street Adolescent Service (based in Parramatta NSW, with a new rural service based in Tamworth). For adolescents from Canberra to receive therapeutic services from New Street they would need to travel approximately 700 kilometres as a round trip. For weekly counselling sessions this is likely to be prohibitive, and Alchin confirmed that due to the demands of commuting adolescents from Canberra rarely seek therapeutic services via New Street.

The only remaining referral option for non-mandated youths in Canberra, and the ACT generally, is to access the services of a private practitioner. Unless young people were eligible under Medicare’s Better Access scheme, there would be significant costs in utilising the services of a private practitioner. As indicated previously, clinicians have raised concerns about the extent to which private practitioners can, in practical terms, undertake the systems work required for an ecological treatment model. With the exception of very few private practitioners operating in Canberra, there are currently very limited specialised therapeutic services for community-based clients over the age of 10. Alchin expressed concern about the absence of referral options for those over 10 years of age, but she indicated that whilst CARHU are in a position to offer services to young children, there are specialised skills required for working with adolescents. Alchin maintained that professional development and supervision requirements need to be provided to facilitate the development and maintenance of this specialised skill base.

Issues of workforce development such as training, accreditation and supervision are fundamental in understanding the gaps and challenges to the delivery of specialised services. Until 2008 the Canberra based service, Thomas Wright Institute (TWI), offered therapeutic service to children and adolescents with sexualised behaviours, but due to workforce demands this specialised aspect of the Institute’s service has been discontinued. Dr Howard Bath, Clinical Psychologist and the Northern Territory Commissioner for Children, has been involved in the provision of services for young people with complex needs and challenging behaviours since the early 1970s. As the former Director of TWI, Dr Bath facilitated counselling services for children and young people with sexualised behaviours. Dr Diana Boswell, Director of TWI, explained that with Dr Bath’s appointment as the first Commissioner for Children for the Northern Territory, TWI encountered difficulties in fulfilling their commitment to providing comprehensive service to young people with sexualised behaviours. Dr Boswell indicated that the Institute maintains a firm commitment that services provided to young people with sexualised behaviours be both specialised and comprehensive. With the small numbers of clinical staff now at TWI, the Institute has had to refine its scope of services, and counselling for sexualised behaviours by TWI staff has been discontinued. This does not indicate a decline in the demand for this specialised service provision. Attention to exactly what services are in place in Canberra reveals that there are serious challenges in meeting the needs of young people residing locally.

237 Interview with Josephine Alchin, dated 4 June 2009.
238 Interview with Josephine Alchin, dated 4 June 2009.
239 A fuller discussion of the challenges to workforce development and professional practice within this sector is provided in an earlier section of this report.
240 The Thomas Wright Institute TWI is a not-for-profit agency of the Catholic Archdiocese of Canberra and Goulburn and is part of the Marymead Child and Family Centre in Canberra. TWI continues to offer counselling services to children and young people, although their specialised counselling for children with sexualised behaviours has been reduced to one day per week. Interview with Dr Diana Boswell, dated 02 June 2009.
241 Interview with Dr Diana Boswell, dated 02 June 2009.
At the time of the interview for this study TWI had not offered services of this kind for more than a year, yet Dr Boswell reported that she would regularly receive calls requesting counselling for young people with sexualised behaviours. These enquiries included regular requests from schools seeking advice and training for teachers who encountered young people with sexualised behaviours. Dr Boswell also reported receiving enquiries from families in rural NSW who were seeking specialised counselling for children with sexually inappropriate behaviours: the shortage of specialised services in rural NSW means that some families look to Canberra as a service hub. In response to this ongoing demand, TWI have now arranged for Dr Jenny Howell, a highly experienced and CSOCAS accredited counsellor, to provide services in Canberra one day per week and at other times on request. In addition, TWI associate, David Zilber, now provides services for young people with an intellectual disability and sexualised behaviours.

### TABLE 1.1 COMMUNITY-BASED SERVICES – AUSTRALIAN CAPITAL TERRITORY

<table>
<thead>
<tr>
<th>Location</th>
<th>Service name</th>
<th>Age of eligible clients</th>
<th>Referral pathways</th>
<th>Eligibility exclusions and other challenges</th>
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<tbody>
<tr>
<td>Canberra Hospital</td>
<td>Child at Risk Health Unit, (CARHU) ACT Health.</td>
<td>Children under 10</td>
<td>Any source</td>
<td>Young people ineligible if they:</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>• are over 10 years of age</td>
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<td></td>
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<td></td>
<td></td>
<td>• are deemed to be unsafe (by Care and Protection), or</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• have a severe intellectual disability.</td>
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<tr>
<td>Canberra (Narrabundah)</td>
<td>Thomas Wright Institute (TWI)</td>
<td>Up to 18 years of age.</td>
<td>Any source</td>
<td>Due to staffing limitations, TWI discontinued counselling services to children and young people with sexualised behaviours in 2008. In 2010, in response to ongoing demand for services, TWI has arranged for Dr Jenny Howell to provide services in Canberra one day per week and at other times on request. Additionally, TWI associate, David Zilber, now offers services to young people with an intellectual disability and sexualised behaviours.*</td>
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<td></td>
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<td>Counselling is sometimes also provided for young adults.</td>
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<tr>
<td>Canberra</td>
<td>Forensic Community Outreach Service, Forensic Services Mental Health</td>
<td>Most clients are aged 17 or 18.</td>
<td>All referrals come from mental health, whether from community teams or from mental health clinicians working with young people in custody.</td>
<td>This is not a specialised program for young people with sexualised behaviours. Some clients who meet the eligibility criteria for the program also display sexualised behaviours. Eligibility is restricted to clients who have a moderate to severe mental illness, and are at risk of offending. As with mental health services in most jurisdictions, clients who have conduct disorder as the sole presentation are ineligible. Mental health services to young people with conduct disorder is identified as a major gap in service provision.</td>
</tr>
</tbody>
</table>

* Interview update provided by Dr Diana Boswell, dated 14 March 2010.

242 The ACT Department of Education and Training confirm that they do seek specialist advice from TWI, and that there is currently a shortage of such specialist advice in the ACT. Submission, ACT Department of Education and Training, dated 6 August 2009.

243 Interview with Dr Diana Boswell, dated 02 June 2009.

244 Interview update provided by Dr Diana Boswell, dated 14 March 2010.
QUEENSLAND

In Queensland, access to most specialised services for sexualised behaviours is contingent on the young person being the subject of either a child protection or youth justice order. This means that there are few referral options if a young person comes to the attention of their parents, a general practitioner, a sexual assault counsellor, or educational professionals, unless that child is already the subject of an order. Queensland community-based services are detailed in Table 1.2. This table indicates that there are limited services for non-adjudicated clients over 12 years of age. The two specialised sexual assault services that do respond to adolescents are Phoenix House (based in Bundaberg) and Sunshine Cooloola Services Against Sexual Violence Inc, (based in Gympie and Maroochydore). Both services report challenges in responding to demand, an issue discussed in more detail below. There are also challenges in providing therapeutic service to those aged 12 years and under. The Department of Communities - Child Safety fund several centres against sexual assault, including Sunshine Cooloola Services, to provide counselling to children under 12 years of age. Yet most of these services are based in the southeast of the state, and it is reported that eligibility is often restricted to children aged 5–10.

Sunshine Cooloola Services Against Sexual Violence Inc, known as Laurel House (based in Maroochydore) and Laurel Place (based in Gympie), offer specialised counselling to children under 12 who display sexual behaviour problems. The funding agreement for this service prioritises referrals from the Department of Communities – Child Safety. Referrals from other agencies can be accepted if the service has capacity. Karren Aspinall, Manager of the service, reported that, ‘the biggest gap is in the provision of services to adolescents—we aren’t anywhere near meeting the demand’. This is a fact identified by the Queensland Department of Child Safety, who in 2008 approached Laurel House to extend their service provision to young people with sexualised behaviours to include those over the age of 12. Laurel House have agreed to do so, but the introduction of this service has been slow and cautious due to Aspinall’s commitment that the service be delivered appropriately and effectively. Accordingly, all counselling staff have been trained by a CSOCAS accredited counsellor and Laurel House have made a commitment that counsellors be allocated to work with no more than one adolescent client in addition to their usual caseload. Based on current staffing levels this will mean that Laurel House can accept a maximum of four adolescent clients through this program at any one time.

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245 Recent changes to the referral criteria for Sunshine Cooloola Services mean that referrals can now be accepted from agencies other that Child Safety, yet only once the needs of Child Safety clients have been met. This is a change only to the referral criteria, not the funding arrangement. As with all services there is a limit to the number of referrals that Sunshine Cooloola Services can accept.

246 Interview with Tania Withington, dated 15 June 2009. Withington indicated that most services will only work with children who are verbal thus the informal lower limit of 5 years, and most services are reluctant to work with children over the age of criminal responsibility (in Queensland this is 10 years of age).

247 A recommendation of the recent Wood Inquiry in NSW is that ‘the availability of counselling or other similar services from other agencies should not be dependent upon a risk of significant harm report being made to DoCS, or DoCS having allocated the report/case’. Wood, J., Recommendation 10.4.e., p. xix. Although this refers to the NSW context the circumstance is relevant for each Australian jurisdiction.

248 Interview with Karren Aspinall, dated 2 July 2009.

249 CSOCAS is a public register of counsellors administered by the NSW Commission for Children and Young People. This NSW scheme is unique within Australia, and ensures that accredited counsellors are appropriately qualified, experienced, and that they receive appropriate supervision. Further information on the scheme and a list of accredited counsellors is available from http://www.kids.nsw.gov.au/kids/working/offendercounsellors.cfm.
The limited client load means that this service will not cater fully to the demand for services for adolescents within the Sunshine Coast and Gympie region. The service agreement for the new adolescent service offered by Laurel House prioritises referrals of adolescents on child protection orders, yet referrals from other agencies will be accepted providing the service has the capacity. Given the client load within the adolescent program is currently limited to four, it is anticipated that this extended service will address only a small proportion of the need.

INITIATIVE – INTER-AGENCY REPORT ON SPECIALISED SERVICES IN QUEENSLAND

The extent of need for specialised services is something that Queensland State Government agencies are taking seriously. In 2008 a number of incidents of young Queenslanders with sexualised behaviours and/or sexual offending behaviours were featured in the media. This resulted in an acknowledgement that there were several systemic challenges to effective response in instances such as these. The outcome was a joint initiative of what were (at the time) five government agencies. The key agencies involved in the Scoping Project included:

- Queensland Health (Evolve Therapeutic Services)
- Department of Child Safety
- Department of Communities (Youth Justice Services)
- Department of Education, Training and the Arts, Queensland
- Disability Services (DS) Queensland (Child Safety Behaviour Support Teams).

Collectively these agencies commissioned a report to identify existing Queensland services for young people with sexualised behaviours. The intention was that the report provide an understanding of existing service gaps and ‘enhance the current service system capacity’ in responding to children and young people with sexualised behaviours. This scoping exercise provided an analysis of the needs and gaps within this service provision, information on the most effective ways of responding (including training needs) and the specific needs for carers and those in Indigenous communities.

Whilst the report revealed several strengths in the current system response, it also highlighted a number of gaps in the services available to children and young people with sexualised behaviours. The report states:

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250 The Scoping Project states, ‘The Project arose due to reports of increasing concern in multiple contexts of numbers of children and young people with sexually abusive behaviours and the service systems’ apparent inability to fully respond to the needs of these groups’. Withington, T. 2009b. p. 5.

251 Withington, T. 2009a. p. 1. The agency structures have now changed and Disability Services sits within Department of Communities.


253 Interview with Tania Withington, dated 25 June 2009.
State-wide consultation revealed a number of service strengths including the presence of evidence-based and collaborative practices, and localised interagency collaboration. The service system gaps identified were numerous and included issues with regard to:

- **Service availability**
- **Service knowledge, skill and access to training**
- **Service availability and knowledge with regards to special needs groups such as disability and mental health**
- **Indigenous Issues**
- **Carer Issues**
- **Legislation and policy issues**.\(^{254}\)

The scoping exercise identified limited referral options across the state, finding urban fringe areas, regional areas, rural and remote areas to be particularly disadvantaged in accessing specialised services.\(^{255}\) The report included a number of recommendations regarding increased service provision and the coordination of comprehensive training for professionals.\(^{256}\) With recommendations for the adoption of a common language protocol and the development of standardised data collection methods, the report intends to ‘provide a benchmark against which . . . the performance of the service system in responding to the relevant needs can be measured’.\(^{257}\)

Evolve Interagency Services is a state-wide network providing multi-system response to those under 18 who are on a child protection order and who have severe and complex needs. This service is the result of an inter-agency agreement between Education, Health, Disability and Child Safety. Evolve offers intensive case management and positive behaviour support strategies. This intensive approach necessitates low caseloads for clinicians, and Evolve consistently has difficulty in meeting demand for services. Evolve Managers identify a further difficulty in servicing young people in the west and far north of the state.\(^{258}\) Evolve interagency services were introduced to respond to Child Safety clients who have psychological and behavioural problems of a severity that impacts on their daily functioning and developmental needs. As such, Evolve is not a specialised service for children with sexualised behaviours. Whilst problematic sexual behaviours are unlikely to be the primary reason for referral to Evolve, available data indicate that 58 per cent of Evolve clients have sexually abusive behaviours (either present or recorded in their case history).\(^{259}\)

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\(^{254}\) Withington, T. 2009b. pp. 4-5.
\(^{255}\) Withington, T. 2009b. p. 32.
\(^{256}\) Withington, T. 2009c.
\(^{257}\) Withington, T. 2009b. p. 5.
\(^{258}\) Interview with Program Managers from Evolve Interagency Services, dated 08 July 2009.
\(^{259}\) Withington, T. 2009b. p. 18.
<table>
<thead>
<tr>
<th>Location</th>
<th>Service name</th>
<th>Age of eligible clients</th>
<th>Referral pathways</th>
<th>Eligibility exclusions and other challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundaberg</td>
<td>Phoenix House</td>
<td>2-17 years for those who have sexualised or sexually abusive behaviours. There is no upper age limit for those seeking counselling for sexual abuse.</td>
<td>Child Safety, Police, Self-referrals, Juvenile Justice also refer young people as part of their conferencing.</td>
<td>Referrals will only be accepted in instances where no child is being harmed. Phoenix House is only funded to work with children and young people in Bundaberg. Referrals are regularly received from Mt Isa, Rockhampton, Gladstone and other parts of the state. Although not funded to offer services outside the Bundaberg area, Phoenix House offer telephone counselling to outlying areas in response to the demand.</td>
</tr>
<tr>
<td>Cairns, Townsville (to service Mackay and Bowen), Rockhampton (to service Emerald and Gladstone), Sunshine Coast, North Brisbane, Logan.</td>
<td>Evolve Interagency Services</td>
<td>Under 18 years</td>
<td>Young people must be: under the Guardianship of the Minister on a child protection order in need of a multi-system response to service high and complex needs.</td>
<td>Evolve work intensively with young people with high and complex needs for 18-24 months per young person. To ensure effective integration of services for each young person case loads must remain low (6-8 clients per worker). Evolve continue to experience issues in meeting demand. Evolve managers also report extreme difficulties in providing services to Western Queensland and the Cape York Peninsula.</td>
</tr>
<tr>
<td>Maroochydore, Sunshine Coast servicing also Caloundra</td>
<td>Laurel House The incorporated name is: Sunshine Cooloola Services Against Sexual Violence Inc.</td>
<td>Children under 12 years who present with sexual behaviour problems. Adolescents aged 12-17 years who have sexually abused (service now commencing, with capacity to accept only four clients). Children and young people up to 18 years who have experienced sexual abuse.</td>
<td>Child Safety, Referrals can be accepted from other agencies, after Child Safety client needs are met.</td>
<td>Sunshine Cooloola Sexual Assault Services are not funded to accept self-referrals although they do receive many requests. Children are not eligible for counselling if they’re living with the identified person who has caused harm.</td>
</tr>
<tr>
<td>Gympie, Sunshine Coast, servicing also Noosa.</td>
<td>Laurel Place</td>
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<td></td>
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</tr>
</tbody>
</table>

In addition to the services above, the Department of Child Safety fund a number of services to provide counselling to children aged 0-12 who display sexualised behaviours. Wide Bay Sexual Assault Service is based in Maryborough. All other services are based in the south-east corner of Queensland. Services include: Barambah Regional Medical Services; Abused Child Trust Incorporated; Lifeline (Gold Coast); Mercy Family Services Toowoomba Sexual Abuse Counselling Program; Lifeline Community Care; and Bravehearts. Family Planning Queensland offer educational services to teachers, parents and school children. A component of this is on healthy sexuality and, for professionals and parents, correctly identifying and responding to children with sexualised behaviours. Family Planning education regarding sexualised behaviours is underpinned by the Traffic Lights Model.*

In recent years the Victorian Government has implemented a suite of legislative and policy reforms across the child protection and criminal justice sectors. A 2004 study by the Victorian Law Reform Commission highlighted the need for an improved response to children and young people with sexualised behaviours. The Commission concluded that, ‘currently neither the criminal justice system or the child protection system responds adequately to young people who sexually assault others’. The implementation of recommendations from this report, and other legislative and policy reforms, have contributed to what is now regarded to be an improved response to both children with sexualised behaviours and those who are victims of sexual assault.

In 2004, the Victorian Law Reform Commission presented their review of the legislative provisions relating to sex offences with a view to making the criminal justice system more responsive to the needs of complainants. For a report with this scope, a review of programs to sex offenders was considered ancillary, yet Sexual Offences: Final Report did include a chapter on ‘Dealing with Juvenile Sex Offenders’. The Commission decided to direct attention to this issue for two reasons. Firstly, because available information indicated that there may be a large number of juvenile sex offenders and, secondly, because such a small proportion of these are dealt with by the criminal justice process. At that time, the Commission identified an area of service provision need, suggesting that demand for specialised programs in Victoria is high and some services have lengthy waiting lists. ‘There are limitations on access to programs in much of regional Victoria and there is little provision for specialised responses for young offenders with a cognitive impairment.’

The Commission made a number of recommendations to improve the scope and the referral pathways for services based on their view that, ‘policies which rehabilitate young offenders and support their families in responding to such behaviour will benefit the whole community including other children and young people who may be prospective victims of abuse’. These recommendations coincided with the culmination of a concerted grassroots effort by Victorian clinicians to raise the profile of this issue. DHS staff and several clinicians reported that from the late 1990s there was a small but determined group of clinicians advocating for an improved systems response to children and adolescents with PSBs and SABs. The legislative change detailed below is the result of a long-term commitment on the part of clinicians and DHS to work together to improve services, and to create cultural change regarding the responses to young people with sexualised behaviours.

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262 Victorian Law Reform Commission, p. 466.
INITIATIVE TO IMPROVE REFERRAL PRACTICES AND INCREASE SPECIALISED SERVICES

In Victoria, the implementation of the Children Youth and Families Act 2005, included new provisions for DHS to receive reports for children requiring therapeutic treatment. The introduction of the TTO legislation allows the family division of the Children’s Court to formally order a young person aged 10–14 to undergo therapeutic counselling for their sexualised behaviours. This legislation facilitates access to services for children whose behaviour is reported to authorities but, for whatever reason, not pursued through the courts. This legislative provision for mandated referral, and the accompanying funding for increased specialist services, assists in redressing the gaps in service provision for children and young people with sexualised behaviours who are not the subject of either a youth justice or child protection order.

These legislative changes have been accompanied by increased funding to a select number of counselling services. What this means is that there is now a network of 13 centres against sexual assault across Victoria that are providers of counselling services under the TTO scheme. Counsellors at all Centres Against Sexual Assault (CASAs) that were to become therapeutic providers under the TTO scheme have been provided with specialised training and ongoing professional support in working with young people with inappropriate sexualised behaviours. The funding agreement for the TTO providers has stipulated that an evaluation be conducted. Agencies are encouraged to use a standardised assessment tool and employ a multi-systemic ecological approach to the therapeutic care provided.

The TTO provision is for 12 months of compulsory therapeutic counselling, but orders are only issued in instances where families and/or children do not voluntarily undertake therapy. DHS staff report that young people and their families often undertake therapy voluntarily, knowing that they will be issued with a TTO should they fail to do so. Since the introduction of the legislation in 2007, approximately 19 children have been placed on TTOs and over 300 young people and their families have accessed a therapeutic treatment program on a voluntary basis. The introduction of the legislation is informed by an understanding that voluntary involvement results in better therapeutic outcomes. In some circumstances families and/or young people need comply with a treatment order to ensure not only the safety of other children, but also the long term safety and wellbeing of the child that is subject to the order. Counsellors report an increase in referrals to their services, and they state that they are certainly now providing therapeutic services to young people that they would not have otherwise.

The introduction of the TTO legislation has several reported benefits. These include an increased

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265 This training has been provided by Dr Russell Pratt of the South Eastern Centre Against Sexual Assault SEASA and Helen Kamboundis and Vicki Quinton of the Gatehouse centre.

266 Submission from DHS, Victoria, dated 22 September 2009.

267 There is provision for extension of an order, subject to the recommendation of the TTO Board and the Magistrate’s final decision.

268 Submission from DHS, Victoria, dated 22 September 2009.

269 Interview with Jenny Wing, dated 14 August 2009; interview with Russell Pratt and Carolyn Worth, dated 08 April 2009; interview with Gatehouse staff, dated 12 August 2009.
awareness amongst child protection and law enforcement professionals regarding children with sexualised behaviours and the services that are available in response. In addition to this positive cultural change amongst professionals, TTOs have reduced the time that it takes for child protection to respond to young people, and training for child protection staff has reduced the labelling in instances where young people do not face court on account of their behaviours. DHS staff report that the orders encourage an awareness of the seriousness of the issue and underscore the efficacy of therapy. For some young people the knowledge that there is legislation to encourage therapy indicates that they are not alone in their behaviour, and that the broader systems of society see these behaviours as something that can be changed. Another clear benefit is the increase in funding for the 13 Victorian CASAs that are now therapeutic providers under the TTO scheme. This makes possible the delivery of specialised service provision at sites across the state, as well as allowing for a long-term investment in the professional development of the existing counselling workforce to provide services in this specialised area.

Prior to these legislative and service arrangement reforms there were serious difficulties in identifying referral options for Victorian young people with sexualised behaviours, unless they were either the subject of a care and protection order or a juvenile justice order.270 There are three predominate, but not mutually exclusive, cohorts of young people who are now better served under the TTO legislation. The first comprises those young people whose behaviours are reported to the police but not pursued through the courts. The second cohort of young people who are now more likely to receive therapeutic care under the TTO legislation are those who come to the attention of the statutory child protection agency for their behaviours. This cohort is likely to be much larger, as the proportion of sexually abusive behaviour by juveniles that is reported to police is small.271 The third cohort are those children who appear as defendants in a criminal proceeding in the criminal division of the Children’s Court. In cases where the Court considers there is *prima facie* evidence that grounds exist for making an application for a therapeutic treatment order, the Court may refer the matter of a TTO application to the Child Protection program within DHS.

In keeping with the documented trends of under-reporting and the attrition of sexual assault reports within the criminal justice system more generally, coercive sexual acts committed by juveniles, where they are reported, are rarely pursued through the courts. The Victorian Law Reform Commission found that only one in seven reports against children resulted in charges being laid.272 The reasons for this vary, but charges will not be pursued in instances where police don’t think that the charges will hold up, either because of *doli incapax* or the practical and evidentiary limitations associated with child victims providing verbal statements. In such instances young people with SABs may be cautioned, but there is little scope for follow up with the young person. Prior to the introduction of the TTO there were few options for referral to therapeutic counselling for cautioned clients. DHS Victoria report that children aged 10–14 years (inclusive) are of sufficient age to be charged for their behaviours but, because children this age are not always developmentally able to appreciate the seriousness of their

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270 Interview with Annette Jackson and Megan Pollard, dated 4 August 2009.
behaviours, convictions are not always the most appropriate outcome. The capacity for the criminal justice system to respond to children in this age range is tempered by *doli incapax* and by a general understanding of the adverse longer term consequences of criminal justice involvement for children of this age. Interviews conducted nationally for this study highlighted clinicians’ concerns regarding the lack of services for non-adjudicated young people. In Victoria, at least, the TTO legislation now works as a mechanism to secure therapeutic intervention for young people aged 10–14 who come to attention for their behaviours, but who are not required to appear before the criminal court.

The legislation is also a useful mechanism for therapeutic intervention in circumstances where child protection are aware of the sexualised behaviours but are unable to take action because there are not other children at risk in the home. It is reported that prior to the legislative change, child protection would be unlikely to deal with children with sexualised behaviours unless it were a clear case of sibling abuse in which the parents were not protecting the victim. DHS staff reported that prior to the TTO legislation and the new referral pathways there was a large cohort of young people with sexualised behaviours, yet child protection workers, police, and sexual assault counsellors felt that their hands were tied. The 2004 report by the Victorian Law Reform Commission also found that, ‘the typical [child protection] response to an allegation that a young person has committed a sexual assault focuses on the needs of the victim. Where the victim is outside the offender’s family or home and where the victim’s parents are considered to be acting protectively, child protection is likely to do little after the initial assessment. The fact that a young person displays sexually abusive behaviour does not of itself necessarily indicate that the abuser is at risk of harm according to child protection guidelines.’

This legislative change and the accompanying funding have gone a significant way towards redressing the gaps in service and referral protocols within Victoria. Yet this is not to say that the implementation of identical reforms would be similarly beneficial in other jurisdictions. The TTO referral procedures are only effective where there are adequate services to which a young person can be referred or, if necessary, ordered for treatment. In Victoria the network of CASAs have been funded to provide therapeutic services for these clients. In other parts of Australia it may be that a greater investment would be required, particularly where geographic and funding challenges hinder the provision of even general sexual assault counselling services. The TTO legislation is unlikely to be the solution, for example, in areas where there are no services, or the existing services are already stretched to capacity.

Victoria has more specialised services for young people with PSBs or SABs than any other Australian

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273 Submission from DHS, Victoria, dated 22 September 2009.
274 The Children, Youth and Families Act 2005 also provides for the establishment of the TTO Board. This comprises representatives from Victoria Police, Public Prosecutions, DHS and one or more health services the Minister considered appropriate. The board evaluates and advises the Minister on specialised therapeutic services available to children, and provides advice to child protection regarding the suitability of a TTO for a child aged between 10 and 14 years. Submission from DHS, Victoria, dated 22 September 2009.
275 Interview with Lisa Rodda and Madeleine Oakes, dated 14 May 2009.
276 Interview with Lisa Rodda and Madeleine Oakes, dated 14 May 2009.
278 There are also reported challenges in ensuring that those CASAs that have been largely victim oriented sexual assault services now have the specialised skills and the insight necessary to work with young people who have engaged in sexual acts that might be harmful to others. For some counsellors there are philosophical challenges in providing counselling to ‘offenders’. For other counsellors across this CASA network there are challenges presented by the isolation that they feel in perhaps being the only counsellor at the service and within their region to provide this specialised therapeutic response. Interview with Russell Pratt and Carolyn Worth, dated 8 April 2009.
jurisdiction. [T]he legislation and funding of services now provides the opportunity for all those within the service system to integrate various aspects of the system into a cohesive and consistent continuum that ensures children engaged in these behaviours are provided a therapeutic pathway for treatment.279 As already indicated, this was not always the case. Whilst the increased funding has significantly improved service availability there are a number of challenges that persist. Clinicians in the metropolitan region of Melbourne articulate the same concerns as those in other parts of Australia, although for those who have been working in the sector for some time there is a clear acknowledgement that the TTO legislation and increased funding has resulted in a vastly improved capacity to respond to these challenges. The major challenges or gaps that do persist are reported to be in the need for increased community education, and professional education for teachers and child protection workers. There are also calls for increased services to young people with intellectual disabilities who have PSBs or SABs, and services to young people in metropolitan Melbourne’s growth corridors, particularly the western region including Werribee and Hoppers Crossing.

In Victoria, the Male Adolescent Positive Sexuality Program (MAPPS) is part of a suite of programs offered by the Royal Children’s Hospital’s Adolescent Forensic Health Service. MAPPS is open to young people280 aged 10–21 who have been found guilty of one or more sexual offence. This long running program has been successfully evaluated,281 and coordinates specialised group and individual psychological services for young people serving custodial sentences, as well as those on court orders. Unlike juvenile justice ‘sex offender’ programs in some other states, MAPPS ensures that all young people on Youth Justice Orders for sexual offences are treated regularly by a team of experienced clinicians. Ensuring that all Youth Justice clients are provided with specialised therapy is something that proves a challenge in other jurisdictions. For MAPPS clients the therapeutic model is based on assisting young people to increase their understanding of themselves and others, and take responsibility for their actions and choices. They are also supported to develop an understanding of the deliberate pattern of their offending, develop victim awareness and empathy, and create a positive lifestyle that does not incorporate offending or abusive relationships. Adolescents who are not in receipt of a Youth Justice Order are ineligible to receive therapeutic counselling via MAPPS.

Although their treatment needs may be similar, there are therapeutic and practical reasons for not providing combined therapy for non-adjudicated young people and those in receipt of a Youth Justice order for committing a sexual offence. As such, MAPPS provides therapeutic services to only those young people who have been convicted of committing a sex offence. The specialised counselling MAPPS provide to this group is crucial, yet it is important to note that there are service requirements also for young people who aren’t charged or convicted for their behaviours. This is particularly the case given the small numbers of young people who are convicted for having committed sexual offences.282

To redress this gap, the Victorian Department of Justice has funded 40 additional treatment places

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279 Submission from DHS, Victoria, dated 22 September 2009.
280 Although the name appears to suggest otherwise the Male Adolescent Positive Sexuality Program is also open to girls aged 10-21 who have been found guilty of one or more sexual offence.
281 The 1998 evaluation of the program revealed a 95 percent success rate, with only 5 percent of MAPPS clients committing sex specific offences. Makepeace, Tidmarsh & Lancefield, 2001.
282 Court ordered therapy is contingent on a number of factors, including: the behaviour being taken seriously and reported to the police; there being either physical evidence or a verbal witness statement sufficient for prosecution; the charges being pursued through to the courts without the charges being plead down to lesser charges; and then the young person being found guilty of these charges and issued with either a custodial sentence or a community order. There are many points at which the process might fail or be abandoned, in which case MAPPS cannot be considered a therapeutic option for the adolescent concerned.
per annum over two years for 15–17 year olds with SABs. This initiative is part of a broader reform agenda established in response to the recommendations of the Victorian Law Reform Commission’s report of 2004. The Victorian Government’s Sexual Assault Reform Strategy intends to create ‘significant and lasting reform of the criminal justice system’s response to sexual assault’. Janice Watt, Manager of the Sexual Assault Reform Unit, reports that there is an absolute commitment at the highest levels to ensuring systemic, legislative and cultural change, and there is a realisation that long-term and ongoing cultural change cannot happen without the engagement and commitment of those at senior levels. One of the benefits of the long-term and consistent representation of senior judicial and law enforcement officials on the advisory committees has been the opportunity for police and others to raise their frustration at the lack of referral options for those aged 15–17 with SABs. Police also reported concerns for the long-term welfare of these young people in matters where Victoria Police is of the opinion that it is not viable to proceed with prosecution. Watt reports that it was possible for police to raise concerns in such a forum because of the governance structures and collaborative model that has been established for the reform strategy. For senior Justice and DHS staff to be made aware of this service need is a benefit that might not have been possible without the Advisory Committee’s agenda for reform. The awareness, at the highest levels, of this referral gap for those aged 15–17 has enabled a commitment to improve the availability of services, a circumstance that might not be possible in other jurisdictions.

The gap in service that was thus identified was for 15–17 year olds with SABs who would not otherwise be prosecuted, due either to the victim not reporting or lack of sufficient evidence. In consultation with DHS, the Department of Justice decided that an investment in existing services and the use of existing expertise was preferable to establishing a new service. The result has been the allocation of 40 additional treatment places, for voluntary clients, per annum for two years. Funding for this purpose has been allocated to selected Victorian services that were already providing service to clients in this age range. The South Eastern Centre Against Sexual Assault, Children’s Protection Society (CPS) and Berry Street Shepparton have each been allocated funding for additional treatment places. The therapeutic work undertaken under this initiative will be independently evaluated as part of a broader systems evaluation under the Sexual Assault Reform Strategy. The Department of Justice has indicated that the independently conducted system-wide evaluation will be extremely useful in indicating how each unit is responding to clients, but also how well units interact and collaborate with one another. Watt reports that one of the most positive benefits of the reform strategy has been that collaboration has now become an entrenched way of working. The collaboration between Justice, DHS and the police has been fundamental to the successful implementation of the TTO legislation, as well as the funding of the additional 40 places for young people with SABs. The evaluation of this work, and the intention to share the learnings about the effects of these additional treatment places, will contribute to a greater understanding of the best means to deliver the specialised treatment services required in Victoria.

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283 Funding for these additional treatment places beyond the initial two-year period is yet to be determined. Interview with Janice Watt and Natasha Habjan, dated 24 July 2009.
284 The Advisory Committee for the reform strategy, chaired by Penny Armytage, comprises high-level judicial officers, police, and representatives from the Department of Justice.
286 Interview with Janice Watt and Natasha Habjan, dated 24 July 2009.
### TABLE 1.3 COMMUNITY-BASED SERVICES - VICTORIA

<table>
<thead>
<tr>
<th>Location</th>
<th>Service name</th>
<th>Age of eligible clients</th>
<th>Referral pathways</th>
<th>Eligibility exclusions and other challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melbourne, with clinical locations in Mildura, Wangaratta, Bendigo,</td>
<td>Berry Street – Take Two Program.</td>
<td>0-18 years</td>
<td>Department of Human Services (Child Protection).</td>
<td>Child Protection is the referring agency, and possible referrals are identified by child protection case managers or Community Service Organisations. Child Protection decide whether referrals will be forwarded. Take Two staff indicated that whilst they can't measure unmet demand, they are aware that Child Protection would refer more children were additional places available in the program.**  Take Two is not a specialist service for young people with sexualised behaviours (although clinicians are trained and experienced). Take Two is a service for children who have experienced significant trauma and, based on this criteria, the service experiences high referral demand. The extent of this demand may mean that a young person whose major presenting issue is sexualised behaviour will not be referred to Take Two.</td>
</tr>
<tr>
<td>Seymour, Campbellfield, Box Hill, Dandenong, Morwell, Flemington,</td>
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<tr>
<td>Geelong, Horsham, and Ballarat.</td>
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* The Victorian Secure Welfare Service is the only one of its kind in Australia. It was established in 1992 following the de-institutionalisation of the large centre in Melbourne that had previously housed both youth justice and child welfare clients. Funded by DHS, the Secure Welfare Service provides short term secure accommodation for those aged 10-17 years who are deemed to be placing themselves at serious and immediate of harm. Take Two Berry Street, Victoria provide consultation and therapeutic intervention for these young people, and report that amongst other challenges, a significant number of these young people have sexualised behaviours, sexually violent behaviours, or are at risk of sexual exploitation. Interview with Annett Jackson and Megan Pollard, dated 4 August 2009.

** Interview with Annette Jackson and Megan Pollard, dated 4 August 2009.
<table>
<thead>
<tr>
<th>Location</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Shepparton</td>
<td>Berry Street Sexual Abuse Prevention Program (SAPP)</td>
<td>0-14 years</td>
<td>Any source</td>
<td>Referral demand is particularly strong for this age group.</td>
</tr>
<tr>
<td></td>
<td>Berry Street Sexual Abuse Prevention Program (SAPP)</td>
<td>15-17 years</td>
<td>Any source</td>
<td>There are no eligibility exclusions. If a young person has been convicted of committing a sexual assault they will receive counselling via MAPPS.</td>
</tr>
<tr>
<td></td>
<td>In October 2008 Berry Street received funding from the Department of Justice for 10 additional places per annum (over two years) to provide service to those aged 15-17 years inclusive.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melbourne (eastern metropolitan region)</td>
<td>Australian Childhood Foundation (ACF) - Transformers Program</td>
<td>Up to 14 years (inclusive)</td>
<td>Department of Human Services (Child Protection).</td>
<td>Eligibility is restricted to children residing in the 6 local government areas of Monash, Boroondara, Whitehorse, Yarra Ranges Maroondah, Manningham. There is a 2–5 month waiting list (during this time containment work is undertaken).</td>
</tr>
<tr>
<td></td>
<td>Australian Community Support Organisation (ACSO) Problematic Sexual Behaviour Service (PSBs)</td>
<td>12 years of age or over</td>
<td>Referrals will only be accepted from Disability Services (DS) or DS funded Clients Services (for example, Anglicare).</td>
<td>Clients must have an intellectual disability to be eligible. There are other eligibility criteria determined according to a compulsory developmental psychological assessment, or a test of socio-sexual knowledge. There is one psychologist funded for this program, so program numbers are very small.</td>
</tr>
<tr>
<td>Melbourne</td>
<td>Gatehouse Centre, Melbourne Royal Children’s Hospital</td>
<td>Up to 14 years (inclusive)</td>
<td>Department of Human Services (Child Protection) Police Self-referrals or family.</td>
<td>Gatehouse report significant demand on their services. Not all clients can be accepted.</td>
</tr>
</tbody>
</table>
Melbourne (south-eastern metropolitan region)

South Eastern Centre Against Sexual Assault (SECASA) AWARE program (previously SAID and SOBI).

AWARE offers a mainstream program for children and young people with PSBs and SABs. In addition, there is a service for children and young people with intellectual disabilities or intellectual capacity difficulties who are displaying PSBs or SABs.

In October 2008, SECASA received funding from the Department of Justice for 15 additional places per annum (over two years) to provide service to those aged 15–17 years.

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</thead>
<tbody>
<tr>
<td>Melbourne (south-eastern metropolitan region)</td>
<td>South Eastern Centre Against Sexual Assault (SECASA) AWARE program (previously SAID and SOBI).</td>
<td>4-18 years</td>
<td>▪ Department of Human Services (Child Protection) in Southern Metropolitan Region ▪ Youth Justice ▪ Parents ▪ Schools ▪ Community organisations ▪ Police ▪ TTO referrals (a small number of these referrals are for children on orders. The majority are voluntary clients under this legislation).</td>
<td>Clients must live within a two hour travel radius of the service.*** SECASA report an overwhelming volume of referrals.</td>
</tr>
</tbody>
</table>

Melbourne (north-western metropolitan region)

Children's Protection Society (CPS) Sexual Abuse Counselling and Prevention Program (SACPP)

In October 2008 CPS received funding from the Department of Justice for 15 places per annum for those aged 15-17 years. This funding is for two years.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Melbourne (north-western metropolitan region)</td>
<td>Children's Protection Society (CPS) Sexual Abuse Counselling and Prevention Program (SACPP)</td>
<td>10-17 years</td>
<td>▪ Department of Human Services (Child Protection) ▪ TTO referrals ▪ police ▪ family.</td>
<td>Clients must reside in the north-western region of metropolitan Melbourne. The young person must have engaged in sexually abusive behaviours that have been reported to the police. The young person must be residing in a safe placement and they must not have unsupervised contact with any victims or potential victims.</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Melbourne (north-western metropolitan region)</td>
<td>Children's Protection Society</td>
<td>0-10 years</td>
<td>▪ Department of Human Services (Child Protection) ▪ Police ▪ Schools ▪ Parents / carers ▪ Self-referrals.</td>
<td>Children must reside in the city of Banyule, Darebin, Whittlesea or Yarra, or in the Shire of Nillumbik. There must be no unmanaged protective concerns.</td>
</tr>
</tbody>
</table>

The introduction of the TTO legislation has allowed for the provision of specialised training so that the following centres can offer therapeutic response to children with SABs:

Ballarat CASA, Barwon CASA, Berry Street Victoria (Hume Region) (10-15 years only), Gippsland CASA, Loddon Campaspe CASA, Mallee SAU, South Western CASA, Upper Murray CASA and Wimmera CASA. (Unless specified, service is provided to children aged 0-15 years). This is in addition to the services provided by ACF, CPS, SECASA (Aware) and the Gatehouse Centre. In total, there are 13 centres comprising the Victorian TTO referral network.

*** SECASA report an increasing pressure to take on clients from rural areas. The eligibility criteria of a two hour travel radius is in place not only because of the demand on services, but because clinical staff report a marked decline in therapeutic outcomes for young people the further they are located from the service. Interview with Russell Pratt and Carolyn Worth, dated 8 April 2009.
NEW SOUTH WALES

In 2006 the NSW Attorney General’s Department published the report of the Aboriginal Child Sexual Assault Taskforce (ACSAT), chaired by Marcia Ella-Duncan. Although not the primary focus of the report, Breaking the silence: creating the future, addressing child sexual assault in Aboriginal communities in NSW, reported that sibling sexual abuse was rife in NSW. ‘Communities expressed consistent concern about the high incidence of sibling abuse.’287 The Task Force heard diverse explanations for these behaviours, ranging from the sexualised behaviours of siblings comforting one another in circumstances of violence, to much more deliberate strategies for long-term sexual assault of siblings:

It’s not just men against women and men perpetrating against children, it’s sibling groups as well. We have, you know, siblings who actually sexually abuse their siblings and I’m finding that those kids they have... that they quite cleverly, through a process of grooming, can be the perpetrator for a very, very long time.288

The ACSAT responded to these community concerns by identifying the need for improved and increased services to young Aboriginal people with sexualised behaviours. The taskforce found that current sex offender programs offered to young detainees needed to be evaluated as it was not known whether they were working. The report also identified the need for additional and improved services for young people who are not involved with the criminal justice system.289

At that time, the Taskforce reported that New Street was the only publicly funded treatment program for non adjudicated adolescents with SABs. The Taskforce noted that the program was resourced to take only a small number of participants and few Aboriginal young people had engaged with the service.290 Funded by NSW Health, the long running New Street Adolescent Service provides therapeutic counselling to young people aged 10–17. New Street prioritise clients aged 10–14, consistent with their commitment to early intervention and also because of doli incapax, the presumption that a child under 10 is incapable of a crime under common law. In an effort to cater to the demand for services for those that aren’t prosecuted for their behaviours, New Street accept referrals from any source.291 New Street report that demand for service continually exceeds their capacity to respond,292 echoing the ACSAT’s finding that New Street is ‘resourced to take a small number of participants’.

289 The ACSAT found that, ‘the Department of Juvenile Justice has a role to play in developing prevention and treatment programs for children and young people who display sexually abusive behaviour but are not yet involved in the criminal justice system’. Ella-Duncan, M., et al. 2006. p. 11.
290 Ella-Duncan, M., et al. 2006. p. 8. Interviews conducted with New Street for this study also indicated that Indigenous clients comprise only 10 percent of referrals. This number is low in comparison with the fact that 25–30 percent of young people convicted of sexually abusive behaviour are Indigenous. In New Street’s OOH sub-program the referrals for Indigenous clients are higher. At present 31 percent n=4 of the young people in this program are Indigenous. Interview with Brenton Law and Simon Monk, dated 15 April 2009.
291 Interview with Brenton Law and Simon Monk, dated 15 April 2009.
292 Interview with Dale Tolliday, dated 12 April 2009.
The finding that few Indigenous clients engage with New Street\(^{293}\) prompted ACSAT’s recommendation that there be an increase in culturally appropriate services for adolescents with sexual offending behaviours. The taskforce identified that Aboriginal people (both adult and juvenile) require access to culturally effective sex offender treatment services, recommending the development of community-based treatment programs for Aboriginal young people aged 10–17 who are displaying sexually abusive behaviours. Identifying the need for programs for non-adjudicated clients, ACSAT stipulated that these programs were to be independent of the criminal justice system, and clients should be able to self-refer. Following these recommendations, Hunter New England Health were funded to develop a rurally located service for non-adjudicated young people aged 10–17. Established in 2009, Rural New Street is based in Tamworth and offers outreach to clients in other parts of the state.\(^{294}\) Rural New Street have an identified position for an Aboriginal worker and the funding agreement stipulates that 50 per cent of Rural New Street’s activity must be with Aboriginal clients.\(^{295}\) Although the formation of Rural New Street has provided a much needed rural service base, clinical managers at both New Street and Rural New Street agree that further services are required to service the state adequately.\(^{296}\)

Whilst Rural New Street is a much needed addition to the services in NSW, clinicians have indicated that additional resources are required to ensure that the state’s referral demand can be met.\(^{297}\) In NSW, there are few alternate referral options for young people with PSBs or SABs unless they are youth justice clients. For young people over the age of 10, New Street and Rural New Street are the only available options, and there is substantial demand on both services. Indeed, in November 2008, the Wood Inquiry found services to young people with sexually abusive behaviours to still be an area of need in NSW. This Inquiry recommended that non-government and government services be funded to provide services for 10–17 year-olds who display sexually abusive behaviours.\(^{298}\) The NSW Government has responded to this recommendation by allocating additional funding to expand services to children and adolescents with sexualised or sexually abusive behaviours.\(^{299}\) Keep Them Safe is the NSW Government’s five year plan in response to the recommendations of the Wood Inquiry.\(^{300}\)

\(^{293}\) New Street Adolescent Service works actively to make the service accessible to Indigenous clients. All staff complete cultural competence training with NSW ECAV, and New Street management have appropriated existing staffing allocations to create a dedicated position at New Street for an Indigenous counsellor. The creation of this position coincided with a NSW Health freeze on recruitment for New Street and the adult sex-offender diversion scheme Cedar Cottage. Accordingly, the Indigenous counsellor positions at each service remain unfilled. The intention is that the Indigenous counsellors for New Street, Rural New Street and Cedar Cottage work closely with the Aboriginal team from ECAV to constitute a team of Indigenous workers in this sector for NSW. Despite the freeze on recruitment for the Indigenous counsellor positions, Dale Tolliday, New Street Manager, is working closely with the Aboriginal team at ECAV to deliver community education to selected NSW Indigenous communities around issues of sexual assault and sexualised behaviours. This has been facilitated via ECAV’s ‘Weaving the Net’ program, in which Indigenous communities invite ECAV and relevant services to provide community and family-based solutions to child abuse and family violence. Interview with Dale Tolliday, dated 22 April 2009. For further information on Weaving the Net see http://www.ecav.health.nsw.gov.au/ecav/index.asp?pg=z&st=C&cNo=123.

\(^{294}\) This service was established in close partnership with the long running New Street, based in Parramatta.

\(^{295}\) This does not mean that 50 percent of the clients must be Aboriginal. Staff from Rural New Street indicated that whilst the service is being established there has been much work in engaging with Indigenous communities, in building relationships and creating awareness of the services offered by Rural New Street. Interview with staff from Rural New Street Adolescent Service, dated 21 April 2009.

\(^{296}\) Interview with Dale Tolliday, dated 22 April 2009; Interview with staff from Rural New Street Adolescent Service, dated 21 April 2009.

\(^{297}\) Interviews with clinicians from other services in NSW revealed several cases whereby young people had been referred to Rural New Street, and they were not accepted. Clinicians reported their perception that Rural New Street is ‘overwhelmed’. Interview with Tom Pepe and Linda Rawlins, dated 10 Jul, 2009; Interview with Ian Nisbet and Jeannette Liva, dated 23 April 2009. Staff from Rural New Street also expressed concern that their current necessity to decline some referrals might result in a reduction in referrals. Interview with staff from Rural New Street Adolescent Service, dated 21 April 2009.


\(^{299}\) $6.7 million has been allocated to expand services to young people aged 10-17 who display sexually abusive behaviours, including Aboriginal people, and $904,000 has been allocated to expand services for children aged less than 10 years who display inappropriate sexualised behaviours, including Aboriginal children. http://www.health.nsw.gov.au/resources/initiatives/kts/pdf/kts_200907_newsletter.pdf accessed 16 March 2010.

Amongst a suite of reforms for health and child protection services across the state, Keep Them Safe has allocated additional funding to Rural New Street to offer services from Newcastle and Dubbo.\(^{301}\) In addition, funding has been provide for a clinical coordinator to oversee the services offered by New Street (Parramatta), Rural New Street, and Cedar Cottage.

In NSW there is a substantial network of counselling services for children under ten, however, none of these services are established with the primary aim of responding to children with sexualised behaviours. There are three separate referral pathways for children of this age. Children who have been subjected to physical abuse or neglect are likely to be referred to one of the Child Protection Teams (Physical and Emotional Abuse and Neglect of Children - PANOC). For those who have experienced sexual assault counselling is available via the state-wide network of sexual assault services. For children to be eligible for counselling they must have been sexually abused. In the absence of a disclosure, children under ten who display PSBs may be referred to one of the Child and Family teams across the state. The degree to which these services provide specialised responses to PSBs varies. Some Area Health services do employ specialised staff to provide counselling to children under 10 who have displayed PSBs. In Newcastle, for example, children under the age of 10 may access counselling for PSBs from highly experienced counsellors at the Child and Family Health Team (Hunter New England Health). This service reports challenges in responding to the demand for services for children with PSBs.\(^{302}\)

NSW is the only Australian jurisdiction that has a residential treatment facility for young people who have displayed SABs. New Pathways (Youth Off the Streets) offers specialised and CSOCAS accredited counselling to males aged 13–17 years. Located in the NSW highlands, the facility has the capacity to accommodate only six clients. Referral criteria stipulate that sexual acts must be substantiated and the service is reserved for clients with high and complex needs. The practicalities of a residential unit determine that referrals for girls cannot be accepted, and clinicians from New Pathways identify services for girls to be an area of need within the state.\(^{303}\)

\(^{301}\) At the time that Rural New Street was established in Tamworth there was some suggestion that Newcastle was the area of greatest need in regional NSW. Interview with staff from Rural New Street Adolescent Service, dated 21 April 2009.

\(^{302}\) Interview with Tom Pepe and Linda Rawlins, dated 10 July 2009. Under Keep Them Safe this service has received funding for two additional positions (one clinical).

\(^{303}\) Interview with Leah Berry and colleague, dated 14 April 2009.
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<tr>
<td>Sydney (Parramatta)</td>
<td>New Street Adolescent Service</td>
<td>10–17 years (those aged 10–14 years are prioritised)</td>
<td>Any source. Most referrals are from the Joint Investigation Response Team (JIRT) and Human Services – Community Services (Child Protection). Others include: Teachers, Medical practitioners, Self-referrals.</td>
<td>New Street is a state-wide service, but there is limited capacity to provide outreach. Clients must visit New Street to participate in therapeutic counselling. Demand is consistently higher than the capacity to respond.</td>
</tr>
<tr>
<td>Sydney</td>
<td>New Street Adolescent Service – sub program for children in out-of-home care (OOHC).</td>
<td>8–12 years (children in OOHC with high and complex needs). 8–17 years (children in OOHC who have sexual behaviours that have caused difficulty in placements).</td>
<td>Human Services – Community Services (Child Protection).</td>
<td>Young people must be in OOHC, and eligibility is restricted to those aged 8–12 who have high and complex needs, and those aged 8–17 whose sexual behaviours have caused difficulties in their placement. Placement capacity is 12–18 young people—in staffed houses.</td>
</tr>
<tr>
<td>Tamworth</td>
<td>Funding provided under Keep Them Safe now allows for services to be offered from Newcastle and Dubbo.</td>
<td>Rural New Street 10–17 years (those aged 10–14 years are prioritised)</td>
<td>Any source. Referrals are predominately from JIRT as acts must be substantiated.</td>
<td>Acts must be substantiated. Rural New Street can only meet with clients fortnightly due to the demands of travel.</td>
</tr>
<tr>
<td>Sutton Forest</td>
<td>New Pathways (Youth Off the Streets)</td>
<td>Males only, aged 13–17 years.</td>
<td>Referrals from Human Services – Community Services via JIRT. The following criteria apply: acts must be substantiated, clients must have high and complex needs, clients must accept responsibility for the act.</td>
<td>The residential facility has the capacity to accept only six clients at any time. Referrals for girls cannot be accepted.</td>
</tr>
<tr>
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| Newcastle               | Child and Family Health Team     | Under 10 years, although existing clients may be able to continue with the service if their behaviours are self-directed rather than directed at others. | Any source. Most referrals come from schools, JIRT and Humain Services – Community Services. | The Child and Family Team are not established as a specialised services for children with PSBs, yet the Newcastle service employs two highly experienced counsellors to work with children with PSBs one day per week.*  
Children over 10 years are excluded from the service, even if they have a developmental age under 10 years. Clinicians identify this as an area of need.**  
The capacity to respond to demand is compromised by the service being funded for only one day per week.                                                                                                                                 |
| A state-wide network of 50 services. | Sexual Assault Services (NSW Health) | Under 10 years of age                                                                 |                                                                                 | These services are for counselling victims of sexual assault, although a proportion of these children also display sexualised behaviours.  
For children to be eligible for counselling they must have disclosed that they have experienced sexual assault. In the absence of a disclosure of sexual assault children can be referred to child and family health teams.                                                              |

As with other jurisdictions NSW has a network of services provided by CAMHS. Some young people may receive counselling, but CAMHS is not intended as a specialised provider of counselling services to children with sexualised behaviours (in any state or territory).

Child Protection Teams (PANOC) are located in each of the Area Health Services. These services provide counselling and support to children who have experienced physical or emotional abuse or neglect, a number of whom would present with PSBs. Although children with these behaviours would receive counselling for their abuse or neglect, PANOC is not a specialised service for PSBs.

In NSW there are a number of private practitioners that are accredited with CSOCAS. A list is available at http://www.kids.nsw.gov.au/kids/working/offendercounsellors.cfm the Department of Communities prioritise the services of accredited counsellors when making referrals.***

* Under Keep Them Safe this service has received funding for two additional positions (one clinical).
** Interview with Tom Pepe and Linda Rawlins, dated 10 July 2009.
*** Submission, NSW Department of Communities, dated 16 August 2009.
NORTHERN TERRITORY

The Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse published its findings in April 2007, stating that ‘sexual abuse of Aboriginal children is common, widespread and grossly under-reported,’ and that ‘everything that we have learned . . . convinces us that . . . [this is symptomatic of] a breakdown of Aboriginal culture and society.’ In the wake of Little Children are Sacred, the Howard Government implemented The Northern Territory Emergency Response (NTER). Commencing in June 2007, the immediate aims of the NTER were to protect children and make communities safe. The longer-term focus of the intervention was to ‘create a better future for Aboriginal communities in the Northern Territory’. Little Children are Sacred indicated that the challenges faced by Indigenous children were varied and many, and that a component of this risk was that ‘Aboriginal law had . . . deteriorated to such an extent that young children in the community were abusing one another’. The Inquiry was told of a range of juvenile offending, including:

A 12-year-old boy allegedly interfering with a three-year-old, a 13-year-old boy allegedly interfering with a five-year-old, a 15-year-old boy who had interfered with a three-year-old and an eight-year-old, a 15-year-old girl who allegedly interfered with a group of younger boys, and a 14-year-old girl who allegedly interfered with girls and boys . . . . The Inquiry was also told a story of a 17-year-old boy who would regularly show pornographic DVDs at a certain house and then get young children to act out the scenes from the films.

In considering the service provision available to youth justice clients in other states, primarily Victoria, the Inquiry concluded that the Northern Territory required ‘further investment in a range of correctional and community-based programs’. The Inquiry also stipulated that, ‘these programs will need to be culturally-appropriate and actively engage local communities in the post-release or post-program monitoring (and support) of offenders, particularly in rural and remote communities’.

In June 2008 the Australian Government appointed a Review Board to conduct an independent and transparent review of the first 12 months of the NTER. The Board reported that, ‘sexualised behaviour of children and young people was also widely expressed as a concern for Aboriginal communities’. Under the NTER measure ‘Improving child and family health’, a sub-measure of the Northern Territory Intervention was to ‘provide specialist counselling and support services for Aboriginal children and their families dealing with the affects of child abuse and trauma’. Against this sub-measure, funding was provided to scope a healing model for adolescent offenders. Some progress has been achieved against this sub-measure, with the NTER Review Board reporting, ‘It is understood that the development of an adolescent sex offender model is in its formative stages, and that it is likely a final operating model may take considerable time to implement. This is an area that will require particular expertise and extensive research and has the potential to contribute to a holistic therapeutic system.’

Following the publication of the *Little Children are Sacred*, funding was provided for a psychologist from Central Australian Aboriginal Congress to lead a series of community consultations with select remote Indigenous communities to ascertain whether there would be support for community-based therapeutic programs for adolescents with SABs.313 Malcolm Frost, the psychologist who led these consultations, reported that the community responded with enormous interest, indicating that they agreed that there was a problem with the sexualised behaviours amongst young boys, and that they would welcome an outreach program that would work with the community to address these challenges. Amongst the communities that Frost visited there had been a recent incident in which a group of young boys raped a very young child and, in another incident, several young boys had attempted rape. At the time of these incidents all five boys were under the age of criminal responsibility and there were no services available to counsel these boys regarding their behaviours. These cases indicate the context of need, yet there are also multiple challenges in delivering specialised services that work holistically and respectfully with remotely located communities. Frost reported that beyond the initial consultative exercise to ascertain the viability and need for services, he has been unsuccessful in securing funding to deliver the services that he identifies as urgently required.

The NT Inquiry revealed challenges in delivering counselling services for victims of sexual assault in communities outside major centres. In response to the recommendations of this report, the NT Department of Health and Families was funded by the Australian Government in 2007–08 to increase the capacity of its Sexual Assault Referral Centre (SARC) (based in Darwin, Tennant Creek and Alice Springs), through the new service delivery model of the NT Sexual Assault Mobile Outreach Service (MOS). Operational since 2008, this service received additional funding in 2009, with a mandate for a broadened therapeutic base.314 This service had previously been only for children who had experienced trauma as a result of sexual assault. The expanded MOS Plus now includes counselling for young people who have experienced trauma as a result of all forms of child abuse and neglect, including sexual assault.315 The original funding and focus for MOS meant that it sat within SARC, however the expanded scope and funding that has seen MOS turn into MOS Plus means that it is now a work unit in its own right and separate from SARC:

*MOS* Plus provides specialised and culturally safe counselling, support, education and community intervention. These are designed to deliver best practice preventative, therapeutic and protective services to clients in their local communities as voluntary clients, as part of a holistic circle of healing for the child. The focus of the service is on the child or young person, and enhancement of their social, emotional and psychological wellbeing, as well as a reduction of symptoms of trauma associated with [any form of child abuse, including] sexual assault.316

MOS Plus work closely with health and community service providers, law enforcement agencies and the NT Child Abuse Taskforce (CAT).317 MOS Plus teams comprise Aboriginal Therapeutic Resource Officers and qualified counsellors. MOS Plus is funded to provide services to children, families and communities in locations in all NT Health Service Delivery Areas, excluding Darwin Urban and Alice Springs Urban, and there are logistical challenges in providing comprehensive services to such a vast area.

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313 This work was funded by the Office of Aboriginal and Torres Strait Islander Health OATSIH.
314 The expansion of MOS is being implemented in the context of the Closing the Gap in the Northern Territory National Partnership Agreement and the Health Services National partnership Agreement between the Australian and Northern Territory Governments. Submission from DoHA, dated 3 September 2009.
315 Interview with representatives from SARC Darwin and MOS, dated 15 July 2009.
316 Submission from DoHA, dated 3 September 2009. The expanded MOS Plus responds to trauma associated with any form of child abuse, including sexual assault.
317 Submission from DoHA, dated 3 September 2009.
The work requires a great deal of community consultation and specific plans for each community are based on the needs that are articulated by the community. Amongst the therapeutic needs identified by communities, MOS Plus regularly receive enquiries and referrals regarding children with sexualised behaviours. Staff report that childcare centres and schools in remote communities will often call, seeking specialised assistance in responding to groups of children with sexualised behaviours. MOS Plus respond to these requests and also offer protective behaviour sessions for children, but they identify the need for greater attention to these issues; both in the school curriculum and in pre-service teacher training. The expanded MOS Plus staffing structure includes specialist PSB counsellors to support MOS Plus staff in the field.

Since its formation in the early 1980s, SARC has been a counselling service for men, women and children who have experienced sexual assault, and this is still the primary objective of the service. In recent years however, the increased need for counselling services for children with PSBs has meant that SARC has commenced work in this specialised area. Although not always the case, children displaying sexualised behaviours may reasonably be thought to have been victimised in some way. It is on these grounds that children with sexualised behaviours are eligible for counselling with SARC staff, providing they are not older than 10 and their behaviours are not abusive. On a case-by-case basis, SARC might provide service to children up to the age of 14, but they are very clear that the sexual behaviours would need to be inappropriate rather than coercive.

None of the community-based services in the Northern Territory have been established with the primary function of offering counselling to young people with PSBs or SABs. In each case, the counselling has been introduced in response to the overwhelming demand. In some cases, there is little support and no allocated funding for this work to occur, and the therapeutic response is contingent on the commitment of a sole worker. This is the case for example, at Central Australian Aboriginal Congress. This service is not funded to provide counselling for SABs, however Malcolm Frost, the senior psychologist in the Male Health Program, has accepted referrals from SARC and the CAT for children over the age of 10 who have displayed sexually abusive behaviours. At present, Frost is the only psychologist at Congress undertaking this work, and he reports ongoing difficulty in securing external funding to extend this work into remote communities. Sam Lloyd, the psychologist at Headspace in Darwin, also reports that he will see young people who have PSBs or SABs, despite the fact that Headspace has been established to respond to the broad range of challenges faced by young people rather than sexualised behaviours specifically. Lisa Bennett, a counsellor and community education worker at Ruby Gaea (a service for victims of sexual assault), is also the only counsellor at that service who works with children with PSBs. All sole-workers in this area indicated that they are offering counselling in this field because of the shortage of available referral options for children and young people.

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318 Interview with representatives from SARC Darwin and MOS, dated 15 July 2009.
319 As with a number of services that have traditionally provided counselling to victims, SARC staff report that there has been the need for adjustment to accommodate the more recent provision of services to children who may cause harm. Interview with representatives from SARC Alice Springs, dated 14 July 2009. Lisa Bennett, from Ruby Gaea in Darwin, expressed the need for a similar adjustment when commencing work with children with PSBs. She indicated that working with victims would continue to take priority over working with children with PSBs, but she felt compelled to extend service to these children given the shortage of services. Interview with Lisa Bennett, dated, 17 July 2009.
320 Interview with representatives from SARC Darwin and MOS, dated 15 July 2009.
321 Interview with Lisa Bennett, dated 17 July 2009.
<table>
<thead>
<tr>
<th>Location</th>
<th>Service Name</th>
<th>Age of eligible clients</th>
<th>Referral Pathways</th>
<th>Eligibility exclusions and other challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice Springs</td>
<td>Headspace</td>
<td>12–25 years</td>
<td>Any source including self-referrals.</td>
<td>Headspace are not a specialised centre for young people with PSBs or SABs. Management report that they see young people who have a host of challenges, and that PSBs can be a part of this. Counselling will include attention to sexualised behaviours.</td>
</tr>
<tr>
<td>Alice Springs</td>
<td>Central Australian Aboriginal Congress</td>
<td>The service gap in Alice Springs is for children over 10 years, or those whose behaviour is seen as abusive (even if under 10 years). The service offered by Congress is out of necessity in response to this service gap.</td>
<td>Referrals for the other services offered by Congress can come from any source. Young people with PSBs or SABs are usually referred by the Sexual Assault Referral Centre or the Child Abuse Task Force (CAT).</td>
<td>Congress are not funded to provide services to young people with PSBs or SABs. Local referrals are taken on by one psychologist only where young people cannot receive counselling elsewhere. This is not seen to be sustainable, and this arrangement allows for no outreach to communities outside Alice Springs. Although Congress offers services to Indigenous clients, the SABs counselling offered by Malcolm Frost is also available to non-Indigenous children and young people who are ineligible for services elsewhere.</td>
</tr>
<tr>
<td>Four teams based in Darwin, Tennant Creek, Alice Springs, with the Darwin providing services to Katherine</td>
<td>Mobile Outreach Service (MOS) Plus</td>
<td>Aboriginal children and young people 0–17 years. Child’s family or community members also eligible for service.</td>
<td>Any source, including self-referrals.</td>
<td>Referrals accepted where sexualised behaviours likely to be symptomatic of abuse or related trauma. Remote workforce, infrastructure, and logistical challenges apply.</td>
</tr>
</tbody>
</table>
None of the community-based services in the Northern Territory have been established with the primary function of offering counselling to young people with PSBs or SABs. In each case, the counselling has been introduced in response to the overwhelming demand. In some cases, there is little support and no allocated funding for this work to occur, and the therapeutic response is contingent on the commitment of a sole worker.

* Children between 10 and 12 may be eligible on a case-by-case basis. Behaviours must not be abusive.

** Children between 10 and 14 may be eligible on a case-by-case basis. Behaviours must not be abusive.
SOUTH AUSTRALIA

In South Australia CAMHS provide the majority of services to children and adolescents with PSBs or SABs. Based in metropolitan Adelaide and with a number of country offices, CAMHS offer state-wide service to children and young people and their families. CAMHS provide specialised assessments and counselling for young people with sexualised behaviours and, where appropriate, CAMHS will refer the young person to a specialised CAMHS funded service. CAMHS funded services include the Adolescent Sexual Abuse Prevention Unit (Mary Street) a well-established service for those aged 12–18 who have committed a sexual offence or engaged in inappropriate or offensive sexual behaviour. Mary Street has an Indigenous counsellor and an Indigenous reference group. Mary Street provide therapeutic services to a number of Indigenous clients from the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands. Counselling staff have identified that the usual models of counselling are not always appropriate with Indigenous clients. These staff suggest that work with Indigenous clients must be respectful of cultural needs, including the reservations that Indigenous people may have about discussing sexual matters in direct terms and, in particular, with a member of the opposite sex. In South Australia, Mary Street is the most likely referral pathway for children or adolescents demonstrating PSBs or SABs.

Mary Street is the only service in South Australia established with the sole purpose of providing therapeutic response to children with either sexualised behaviours or young people with sexually abusive behaviours. There are however, several other CAMHS services for young people who have a range of high and complex needs that might also include sexualised behaviours. The Behavioural Intervention Service (BIS), based in Cambelltown, is a service for children between the ages of five and eight years who have acute needs and behavioural concerns. Eligibility is restricted to young people with mental health issues and persistent, pervasive challenging behaviours. Young people are accepted to BIS only after several other behaviour management interventions have failed. BIS Manager, Dy Smith-McCue, indicates that 77 per cent of clients to the service are under the Guardianship of the Minister, more often than not these are children in foster placement that are on the point of breakdown. 68 per cent of the client base has been diagnosed with Asbergers, and Smith-McCue identifies increased levels of inappropriate sexualised behaviours amongst this group. The service utilises a positive behaviour support framework and, given the high needs of the children, BIS works with a developmental approach, employing art therapy, music therapy and narrative therapy.

Adolescent Services Enfield Campus (ASEC) is another CAMHS service that provides specialised counselling to young people with sexualised behaviours. ASEC is a service for those aged 12–18 years who have complex mental health needs. There are a number of programs within ASEC that cover individual, group and family interventions, and the most appropriate program for those with sexualised behaviours is the Day Program. This service is primarily for those whose mental health issues impact on their ability to maintain engagement with school. Young people who are referred to the day program typically

322 Interview with Rob Hall and Shar Williams, dated 07 April 2009.
323 Interview with Rob Hall and Shar Williams, dated 07 April 2009.
324 Mary Street offer an invitational model of therapy in which young people twelve years and above are expected to acknowledge their behaviours and the harm these have caused, thus accepting the invitation to change their behaviours. To describe the behaviours of young people in this age range Mary Street use the term ‘sexually abusive behaviours’. For children younger than 12 years Mary Street utilise the term ‘sexualised behaviours’.
325 Interview with Dy Smith-McCue, dated 30 March 2009.
326 Interview with Dy Smith-McCue, dated 30 March 2009.
have a host of challenges, including high levels of anxiety and withdrawal, difficulties with emotional regulation, complex family issues and experiences of trauma. Aggressive and defiant behaviours are also common amongst children referred to the day program, and ASEC work intensively where young people display sexualised behaviours. Young people attend the day program two days per week and, in addition to group work, ASEC provide individual counselling and work closely with families and carers. ASEC Manager, Cynthia Lawson, indicates that whilst ASEC is a state-wide service, families located outside the metropolitan area experience great difficulties in accessing the service.327

As in other jurisdictions, the major challenge to comprehensive service delivery in South Australia is ensuring that those in regional and rural areas can access services. Mary Street, BIS and ASEC are all based in the metropolitan area, and there are no permanent outreach capabilities for these services.328 CAMHS has several services based in country areas to ensure that there are mental health services for children and young people across the state. If these country services refer a client to a specialised or intensive needs service based in a metropolitan area, there may be difficulties for families in commuting. Access to specialist services is reported to be particularly challenging for Indigenous people from the APY lands. To redress this, and to address childhood trauma and increased levels of sexualised behaviours amongst children, CAMHS have established a small team of clinicians to travel to Indigenous communities to offer therapeutic work with young people. CAMHS acknowledge that there are challenges in terms of the investment in time for travel and the need for building relationships in communities, but delivering this service is identified as a priority.329

South Australian clinicians identified the major challenges in service delivery to include: ensuring equitable access to services for those residing outside the metropolitan area; and ensuring services for children under 12 who display PSBs, particularly those aged 7–10 years. Overwhelmingly, clinicians reported challenges in providing culturally appropriate and relevant services to young people from the APY lands, particularly where they have been relocated by youth justice or child protection.330 The Metropolitan Aboriginal Youth and Family Service (MAYFS) is a specialist team of Aboriginal service providers offering a number of programs for at-risk Aboriginal young people. In all programs, MAYFS is strengthening its focus on preventing the conditions for criminogenic behaviours.331 MAYFS do not offer specialised counselling for children and young people with either PSBs or SABs, although a number of young people that attend other programs display these behaviours. MAYFS staff indicated that they do refer young people to Mary Street and find these services are valuable, yet there are also reported to be cultural difficulties associated with this. The therapeutic model utilised by Mary Street requires young people to acknowledge responsibility for their behaviours. MAYFS staff indicated that this is more difficult for Aboriginal people because of shame.332

327 Interview with Cynthia Lawson, dated 30 March 2009.
328 Depending on worker availability, Mary Street may sometimes offer limited outreach to major regional centres such as Whyalla, Port Augusta and Port Lincoln. Interview with Rob Hall and Shar Williams, dated 07 April 2009.
329 Interview with Kathy Crossing and Pauline McEntee, dated 3 April 2009.
330 Interview with MAYFS staff, dated 03 April 2009. The need for culturally appropriate services is particularly evident in cases concerning Indigenous young people from the APY Lands who speak little English. Relocated to Adelaide by youth justice, these young people required comprehensive case management and access to both specialist counselling and services relevant to their culture. Interview with Rob Hall and Shar Williams, dated 07 April 2009.
331 Interview with MAYFS staff, dated 03 April 2009.
332 Interview with MAYFS staff, dated 03 April 2009.
MAYFS have indicated that anyone who comes to their service is provided with assistance, even if it is necessary to facilitate an outward referral. The majority of MAYFS programs are in great demand. The Social Inclusion program, an Aboriginal family-strengthening program, is funded to work with 20 families. MAYFS staff indicated that there are currently 45 families on the caseload, and there are 17 on the waiting list. MAYFS have a number of other strengths-based and early intervention programs designed to prevent young people from becoming disengaged at school or becoming youth justice clients. In an early intervention initiative, MAYFS’ street service, Panyappi, works with the Kumangka Aboriginal Youth Service to transport young people home if they are spending time on the streets at night. For children under 14 years, MAYFS will make an immediate notification and take the young person to the police, and for those over 14 years MAYFS will notify immediately and drive the young person home. Follow-up work is undertaken with these young people and their families. MAYFS staff explained that these services are in place to prevent a host of adverse outcomes for young Aboriginal people, including the risks associated with sexual exploitation. MAYFS also operate a school-based retention program at Warriappendi, an Indigenous secondary school in the inner western suburbs of Adelaide. This program, Tirkandi, works to encourage students’ engagement with schools, and works with families to provide links to services to strengthen the family. MAYFS report that with the introduction of this program in 2005, there has been a noticeable reduction in school suspensions and a reduction in school students engaging in offending behaviours.

**Table 1.6 Community-Based Services – South Australia**

<table>
<thead>
<tr>
<th>Location</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan Adelaide (Hindmarsh)</td>
<td>Adolescent Sexual Abuse Prevention Program (Mary Street)</td>
<td>12–18 years</td>
<td>Parents, care givers, self referrals, police, youth court, family conference team, Children Youth and Family Services (CYFS), health and welfare workers, schools, churches and other community groups</td>
<td>Mary Street don’t accept referrals for children under 12 years of age. Mary Street don’t routinely offer outreach, so in most cases only young people who can access the Hindmarsh service would receive service (refer to the left column for exceptions).</td>
</tr>
</tbody>
</table>

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333 Interview with MAYFS staff, dated 03 April 2009.
334 Interview with MAYFS staff, dated 03 April 2009.
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</thead>
<tbody>
<tr>
<td>Cambelltown, Adelaide</td>
<td>Behavioural Intervention Service</td>
<td>5–18 years</td>
<td>Via the local area interagency referral process (Department of Education, Training and Employment). Clients are then assessed by the BIS Intake Panel as to their eligibility. Only clients with the most extreme needs are accepted.</td>
<td>Eligibility is restricted to young people with acute needs - mental health issues and persistent, pervasive challenging behaviours. Young people are accepted to BIS only after several other behaviour management interventions have failed. BIS has the capacity for 14 children at any time.</td>
</tr>
<tr>
<td>Enfield, Adelaide</td>
<td>Adolescent Services Enfield Campus (Day Program)</td>
<td>12–18 years</td>
<td>Via the local area interagency referral process (Department of Education, Training and Employment, Child and Adolescent Mental Health Teams and Medical Practitioners).</td>
<td>The program is for young people who are experiencing significant mental health issues that are impacting on their capacity to maintain engagement with school. All referrals require the written consent of the parent or legal guardian. Although ASEC is a state-wide service there is no outreach capability for the Day Program, which is where young people with sexualised behaviours are most likely to receive therapeutic counselling. Young people and/or their guardians would need to make arrangement for transportation to Enfield. For metropolitan clients the commute may be an hour each way and these fares are likely to be funded. Many regionally located young people would find access to the service impossible.</td>
</tr>
<tr>
<td>Location</td>
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</tr>
<tr>
<td>Woodville, Adelaide</td>
<td>Shine SA</td>
<td>Over 12 years</td>
<td>A variety of disability services refer young people (and adults) with sexualised behaviour</td>
<td>Shine SA don’t provide therapeutic services to children with sexualised behaviours who are under 12 years of age.</td>
</tr>
</tbody>
</table>
| Metropolitan Adelaide, with Country Sites to provide state-wide service | Child and Adolescent Mental Health | Up to 18 years | - Child Protection  
- Medical practitioners  
- Parents / carers  
- Self-referrals from those aged over 16 years. | These services are not designed to be specialist PSBs or SABs counselling services. Children who demonstrate PSBs will be assessed by Uniting Care. Ordinarily those with sexualised behaviour will be referred to Mary Street. |
| Metropolitan Adelaide                        | Uniting Care Wesley | 10–25 years | Any source, but families and young people must be eligible for one of the programs.  
There are several programs in which young people often also display PSBs (Reconnect, Ruby’s and Streetlink.) |                                                                                           |

**WESTERN AUSTRALIA**

In Western Australia, the Department of Child Protection funds the community services sector to provide counselling and therapeutic response to young people and families who have experienced child sexual abuse. A total of 15 not-for-profit organisations are funded through the Child Sexual Abuse Therapeutic Services (CSATS) program.335

*Services in this program provide healing, support, counselling and therapeutic responses to children and young people and their families affected by child sexual abuse, people who have experienced childhood sexual abuse and children and/or young people who are responsible for, or at risk of, perpetrating child sexual abuse.*336

Recent changes to the service agreements for CSATS funding mean that services that were once exclusively for victims of abuse are now beginning to respond to children with SABs. A six-month snapshot of data since the commencement of therapeutic response for SABs indicates that 16 per cent of the client load is counselling for sexualised behaviours, including sexually abusive behaviours. This number (71 children of a total of state-wide total of 442 seeking counselling for sexual assault) indicates that state funded services are now responding to a need that was previously unmet. There are limitations to this service provision however. The Department of Child Protection indicates that

335 Services are located across the state, with 5 of the 15 located in the metropolitan area and approximately half of the CSATS funding allocated to services in regional WA.

336 Submission, Department of Child Protection, Western Australia, dated 11 August 2009.
the degree to which each of the 15 funded services are able to respond to children with sexualised
behaviours depends on the service model for the individual agency, and the clinical skills of service
providers. The Department of Child Protection recognises the importance of providing children and
young people with a broad range of services, including specialised services for PSBs and SABs. In their
submission to this study, they identify three major challenges in doing so:

**Service access** – there are often no or very limited services available in remote areas, and a high
level of need, especially in Indigenous communities.

**Workforce limitations** - poor assessment of a child or young person’s needs may occur by
caseworkers, and others, who lack specific training or knowledge in this area. There is a general
lack of knowledge on the part of carers, caseworkers and others, including clinicians about the
significance of these behaviours.

**Establishing and maintaining interagency collaborative relationships for adequate case
management and good client outcomes.** It is often difficult to maintain on-going consultation
between the Department’s case managers and service providers, to ensure vulnerable children
in families are not placed at risk. . . . The Department needs to maintain their involvement if child
protection issues are evident. . . . Ensuring safety plans are in place (and actively monitored by the
Department and service providers) is critical, until sufficient treatment gains have been made.

These challenges echo those articulated by clinicians in every state and territory. The need for
workforce education is also identified by WA’s only tertiary Child Protection Unit (CPU). This service
provides medical, forensic, social work and therapeutic services for children and their families where
child abuse is a concern. The CPU report that where they perceive a child to be at ongoing risk
in the home, the statutory authority might not always agree. The CPU expressed their view that
organisations have differing levels of knowledge and differing assessment methods, and as a result
thresholds of safety are not uniform across the child protection sector. The CPU also indicated the
need for education for parents and community, both on ‘age appropriate sexual play, re-enactment
of trauma and entrenched patterns of molestation’. They added that where the behaviours are
concerning, parents may need education to realise the seriousness of the problem.

CPU provide state-wide consultation and advice as well as therapeutic care to regional and rural
children who are inpatients at Princess Margaret Hospital. Yet the service is not funded to provide
outreach, and there are challenges in finding appropriate referral options for clients who are ineligible
for CPU therapeutic services. Young people over the age of 16 are ineligible for service, as are those of
any age who demonstrate entrenched patterns of abuse to others. For these clients, CPU will refer to
a private psychologist or, prior to its closure in May 2009, to SafeCare.

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337 Submission, Department of Child Protection, Western Australia, dated 11 August 2009.
338 For WA there are approximately 10 clinical psychologists with specialist skills in responding to PSBs or SABs. ‘They consult with less experienced
colleagues, especially in country regions, to help them manage these clients.’ Submission, Department of Child Protection, Western Australia, dated
11 August 2009.
339 Information provided by Submission, Department of Child Protection, Western Australia, dated 11 August 2009.
340 Interview with Lee Henry and colleagues, dated 05 May 2009.
From 2001 to 2009, SafeCare offered the Young Person’s Program, the only program in Western Australia for adolescents with PSBs or SABs at that time.341 For the period of its operation, SafeCare was funded by the Department of Child Protection under the CSATS program. Prior to its closure, SafeCare was managed by a clinical psychologist with thirty years experience in sexual assault and sex offender counselling, and in 2006 the Young Person’s Program was rated positively in an independent evaluation.342 In 2008, when the Department of Child Protection changed the service specifications for CSATS funded agencies, the requirement was that all agencies receiving CSATS funding should provide counselling to adolescents with sexually abusive behaviours. With this decision, it was seen as no longer necessary to have a specialised service that responded to adolescents with sexually abusive behaviours. The client load for the adolescent program is to be taken on by Uniting Care West. The adult community-based clients from SafeCare’s adult sex offender service will, in time, be serviced by the justice system.343

341 For the period of its operation SafeCare provided services to approximately 70 adolescents with sexually abusive behaviours per annum. Cant, R., C. Penter. 2006. Unpublished Evaluation.
343 Interview with Christabel Chamarette, dated 6 May 2009.
### TABLE 1.7 COMMUNITY-BASED SERVICES – WESTERN AUSTRALIA

<table>
<thead>
<tr>
<th>Location</th>
<th>Service Name</th>
<th>Age of eligible clients</th>
<th>Referral Pathways</th>
<th>Eligibility exclusions and other challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perth metropolitan area</td>
<td>SafeCare</td>
<td>n/a</td>
<td>n/a</td>
<td>As this report was being drafted funding for this service was discontinued. Along with the 14 other CSATS funded services Uniting Care West is now funded to offer service to children with PSBs.</td>
</tr>
<tr>
<td>Perth metropolitan area (provides state-wide consultation and advice)</td>
<td>Child protection Unit, Princess Margaret Hospital</td>
<td>0–16 years</td>
<td>Any source, predominately parents or referrals from the forensic medical team.</td>
<td>Young people must have experienced sexual abuse or suspected sexual abuse. Those over 16 are ineligible. Those exhibiting a pattern of abuse towards others are ineligible, particularly if over 12 years of age.</td>
</tr>
<tr>
<td>Geraldton – Greenough, with an outreach service to Mullewa.</td>
<td>Chrysalis Support Services Inc.</td>
<td>0–18 years</td>
<td>Department of Child Protection, Police, Schools, the Geraldton Mental Health Service.</td>
<td>There are two counsellors for this program. There are reported difficulties in providing services to regional areas given limited staffing and funding.*</td>
</tr>
</tbody>
</table>

The Department of Child Protection currently funds 15 not-for-profit services to provide child sexual abuse therapeutic services. As of 2008, the service specifications for these 15 agencies have been extended to include children and young people with sexually abusive behaviours. The degree to which these services can respond to this client group depends on the level of staff expertise and the service model.** Given that until 2008 these services offered only victim counselling, there is great variance as to extent of PSB and SAB counselling offered.

The 15 funded services are: Carnarvon Sexual Assault Response Service (Gascoyne); Wirraka Maya Indigenous Health Service (Pilbara); Roebourne Indigenous Child Sexual Abuse Response Service (Pilbara); Indigenous Child Sexual Abuse Response Service (Derby); Child Sexual Assault Counselling Service (midwest); Therapeutic Family Service (Wheatbelt Region); Goldfields Child Sexual Abuse Therapeutic Service (Goldfields); Peel Child Sexual Abuse Treatment Service (Peel); Kids and Teens Waratah Child Sexual Abuse Treatment Service (south-west); Anglicare Great Southern Child Abuse Therapeutic Service (Great Southern); Child Sexual Abuse Treatment for Aboriginal People (metropolitan area); UnitingCare West Child and Family Counselling Service (metropolitan area); Parent’s and Children’s Therapeutic Service (metropolitan area); Child Sexual Abuse Treatment Service (metropolitan area); and Child Sexual Abuse Therapy Service (metropolitan area).

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* Submission, Chrysalis Support Services, dated 31 August 2009.
** Submission, Department of Child Protection, Western Australia, dated 11 August 2009.
TASMANIA

DHHS have indicated that whilst there are three major sexual assault services that provide counselling for children under 13 years of age in general, Tasmanian sexual assault services do not provide counselling to adolescents who have either sexualised behaviours or sexual offending behaviours.\(^{344}\) The two exceptions are that some young people aged 13 or over may receive individual counselling via the adult counselling service of Melaleuca House in Hobart (affiliated with the children’s service Galileo House), and those aged up to 15 may receive service at North West CASA, although there is only one children’s worker for this service. The lack of counselling for adolescents with PSBs or SABs is identified by DHHS to be an area of need. ‘The major gap, and hence potential risk, for Youth Justice clients is for those young people who are either not convicted or who are diverted away from the criminal justice system (that is, through Community Conferences), who do not receive treatment for their behaviour.’\(^{345}\)

This gap in service provision to adolescents is also of concern to those providing therapeutic counselling to children. Dianne Calderbank has had a longstanding commitment to working with children who display PSBs and she asserts that there is a lack of services for adolescents across the state. Calderbank indicated that whilst CAMHS may be a referral option for adolescents, they prioritise according to imminent risk and the waiting lists are lengthy.\(^{346}\) Moreover, Calderbank stressed that working with adolescents is an area requiring specific expertise, and this is currently lacking in Tasmania.\(^{347}\) In response to this need, CAMHS South and Galileo House are collaborating to offer training to teachers and community agencies in responding to sexualised behaviours.

In recent years, Galileo House has received a significant increase in referrals for children with PSBs, such that counsellors within this service cannot cope with the caseload. Counsellors from the adult program (Melaleuca House) are now counselling children. Galileo House report that in the last year they have seen approximately 70 children with sexualised behaviours, with the majority under 10 years of age. Galileo House have recently made the decision to run group programs, with concurrent programs for parents and siblings.

DHHS Tasmania identify under reporting to be a challenge. ‘There is some past anecdotal evidence that there are a number of young people, largely siblings, who have admitted to sexual offences but who have not been charged. There was some evidence that part of the reluctance to charge was because there was no treatment available.’\(^{348}\) Although the provision of services to adolescents remain a challenge, the Tasmanian Government has recently committed significant funding to introduce a therapeutic intervention service for children and young people involved with child protection services. This state-wide service commenced in 2009 and offers professional assessments and tailored therapeutic

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\(^{344}\) In Tasmania the client area for sexual assault services is demarcated according to the telephone area codes. North West CasA, based in Burnie, services the 03-64 region, Sexual Assault Support Service Inc. incorporating Galileo House and Melaleuca House is based in Hobart and services the 03-62 region, and Laurel House, based in Launceston, services the 03-63.

\(^{345}\) Interview with Jennifer Thain, and accompanying document, dated 20 March 2009.

\(^{346}\) Whilst CAMHS South and CAMHS in Burnie do have clients with sexualised behaviours they are not established as a service for this client group specifically. PSBs is seen by CAMHS as a behavioural manifestation that often presents alongside mental health issues, but it is not a diagnostic category in either the DSM-IV or the ICD-10, so there is no data on the number of presentations, and there is not a targeted strategy to offer a specialised therapeutic response to young people with sexualised behaviours. If young people present with a diagnosable mental health disorder and sexualised behaviours, both CAMHS services will provide therapeutic counselling to the young person and their family.

\(^{347}\) Interview with Dianne Calderbank, dated 19 March 2009.

\(^{348}\) Submission from Department of Health and Human Services, Tasmania, dated 16 September 2009.
care for children. These assessment and therapeutic services are also available to children who are ‘acting out’, including those with sexualised behaviours. This service is operated by the ACF, a Victorian service that has significant expertise in responding to children with sexualised behaviours and experiences of early childhood trauma. Dr Joe Tucci, ACF Chief Executive Officer, identifies the new service as an important initiative for Tasmania. The establishment of Tasmania’s first ever dedicated service for children who have experienced abuse is a significant outcome achieved by the Tasmanian Government in its aim to strengthen responses to the state’s most vulnerable children.

Table 1.8 Community-based Services – Tasmania

<table>
<thead>
<tr>
<th>Location</th>
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<th>Age of eligible clients</th>
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</thead>
<tbody>
<tr>
<td>Hobart</td>
<td>Galileo House</td>
<td>0–12 years</td>
<td>Any source. Predominately Child Protection and the Department of Education.</td>
<td>The main counsellor for PSBs currently has a caseload of 35, with a total of 60-70 children accessing the service. Galileo House’s caseload currently exceeds their capacity to respond. Counsellors from the adult program at Melaleuca House are being used to provide services to children.* Children are not accepted if they’re known to be extremely violent or if they’ve had a criminal conviction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some children over 13 years may receive counselling services through the affiliated adult counselling service – Melaleuca House.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Launceston</td>
<td>Laurel House</td>
<td>No age restrictions. Those over the age of 12 who have abusive behaviours are referred to appropriate services.</td>
<td>Any source. Most referrals come from the Department of Education.</td>
<td>There is not a designated specialist counsellor for children with PSBs. The four counsellors at the service take on this work because of the need.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burnie</td>
<td>North West CASA</td>
<td>0–15 years</td>
<td>Any source.</td>
<td>There is only one children’s worker to provide this service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counselling is provided to those over the age of 15 if they have an intellectual disability.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


350 The ACF offer a comprehensive training program for professionals in most states and territories, and run the independently evaluated PSBs program, Transformers, in Victoria.
CONCLUSION

This study found multiple and complex impediments to the delivery of comprehensive services in this area. These challenges result in an overburdened sector that remains unregulated and, in some locations, lacking a much needed commitment to specialised training, supervision, accreditation, evaluation and ongoing research on best practice. The challenges felt by the sector also stem from a broader lack of awareness about the issue in professional contexts and Australian society more generally. Where this lack of knowledge or confidence results in non-disclosure, minimisation or stigmatisation there will always be ongoing risks for children. Comprehensive education strategies for parents and professionals in all related sectors would significantly improve children's pathways to specialised care.

Clinical research indicates that children with sexualised behaviours are more likely to also experience a host of adverse circumstances in their early years. Children who experience childhood trauma, removal from the home, violence, neglect, or profound social and economic disadvantage are in need of additional integrated and specialised supports. This study highlights the need for culturally sensitive services for Indigenous and culturally and linguistically diverse children, and the need for these services to work collaboratively with the communities in which children live. Therapeutic residential placements are also required for the many profoundly traumatised children who have been removed from family environments. Additional areas of specialised service need are for children with intellectual disabilities or developmental delays, and children from war torn countries who have settled in Australia.

Other major challenges to the comprehensive provision of specialised therapeutic services include the need for:

- therapeutic residential placements for young people with sexualised behaviours
- successful engagement and support for the family and community
- holistic and integrated care for all needs faced by the young person’s family
- specialised psychological services for the supervision of youth justice orders
- preventing the stigmatisation of children with sexualised behaviours.

The geographic and demographic gaps in the provision of tertiary services must be redressed in order to adequately respond to the current generation of children and young people with sexualised behaviours. This study highlights the challenges in delivering specialised services to all children in need, regardless of their geographic location or their demographic characteristics. A full understanding of a child’s context is crucial in both understanding their behaviour and in providing a therapeutic response that is both sensitive and likely to be effective. The importance of context, culture and community should form the cornerstone of any efforts to increase service provision. When coupled with Australia’s geographic vastness, the need for attention to such specificities of context presents particular challenges for the service sector.
Consistent with the public health model, this report emphasises the importance of prevention and early intervention initiatives for very young children. Yet preventing this therapeutic need in subsequent generations of children is not something that can be left to specialised counsellors. A whole of community approach is required so that parents, teachers, law enforcement officers, health professionals, child protection workers and children themselves all understand the importance of respectful relationships. A child demonstrating sexualised behaviours is likely to endure complex risks and challenges requiring a range of care and protection services. For the various sectors involved, this presents a challenging task in the provision of integrated case management and care.

Yet these same risks and adversities can also be considered in terms of prevention. Strategies to educate children and young people about the moral and ethical responsibilities of relationships would be likely to effect a reduction in the number of juveniles detained on charges of sexual assault. Any reduction in the estimated 40–90 per cent of sexual offences perpetrated by adolescents would make a significant impact on the intergenerational cycle of victimisation and abuse. This study is not only about the needs of children with sexualised behaviours; it highlights the need for integrated and holistic care for all Australian children who have experienced harm or adverse circumstances of any kind. A considered, committed and cross sectoral response is required to effect a reduction in the number of children experiencing childhood trauma and subsequently entering the criminal justice system.
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ABS, AIHW. 2008. The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples. Cat No 4704.0 Canberra, ABS.


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Kenny, D., Seidler, K. et al. 1999a. Profiling Australian Juvenile Sex Offenders: Offenders and Offence Characteristics. Sydney, Collaborative Research Unit, Department of Juvenile Justice.


Pugh, R. 2002. *ya pulingina kani – Good to see you talk*. Office of Aboriginal Affairs, Department of Premier and Cabinet, Hobart.


Withington, T. 2009b. ‘Scoping Project: Responding to the needs of children and young people with identified sexually abusive behaviours: A Review.’ (Project Coordinator) Evolve Therapeutic Services, Queensland Health. (Unpublished Paper)


## APPENDIX 1: LIST OF INTERVIEWS CONDUCTED

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Interviewees*</th>
<th>Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Department of Housing and Community Services (Turnaround Program)</td>
<td></td>
<td>ACT</td>
</tr>
<tr>
<td>2 Forensic Services Mental Health ACT</td>
<td></td>
<td>ACT</td>
</tr>
<tr>
<td>3 Thomas Wright Institute</td>
<td>Dr Diana Boswell</td>
<td>ACT</td>
</tr>
<tr>
<td>4 Winnunga Nimmityjah Aboriginal Health Service</td>
<td>Ann Baker</td>
<td>ACT</td>
</tr>
<tr>
<td>5 Child at Risk Health Unit, ACT Health</td>
<td>Josephine Alchin</td>
<td>ACT</td>
</tr>
<tr>
<td>6 Department of Communities</td>
<td>Erica Russ, Laura Hackett, Andrew Barr, Melita Harris</td>
<td>QLD</td>
</tr>
<tr>
<td>7 Program Managers, Evolve Interagency Services</td>
<td>Erica Russ and Melissa Yim</td>
<td>QLD</td>
</tr>
<tr>
<td>8 Evolve Therapeutic Services</td>
<td>Tania Withington</td>
<td>QLD</td>
</tr>
<tr>
<td>9 Remote Area Mental Health Service and University of Queensland, Cairns</td>
<td></td>
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</tr>
<tr>
<td>10 Queensland Health Integrated Child and Youth Mental Health Services</td>
<td></td>
<td>QLD</td>
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<tr>
<td>11 Child and Youth Forensic Outreach Service</td>
<td>Dr Scott Harden and Theresa Wood</td>
<td>QLD</td>
</tr>
<tr>
<td>12 Griffith Youth Forensic Service</td>
<td>Sue Rayment-McHugh</td>
<td>QLD</td>
</tr>
<tr>
<td>13 Phoenix House Bundaberg</td>
<td>Kathy Prentice</td>
<td>QLD</td>
</tr>
<tr>
<td>14 Sunshine Cooloola Services Against Sexual Violence Inc (Laurel House and</td>
<td>Karren Aspinall, Manager</td>
<td>QLD</td>
</tr>
<tr>
<td>Laurel Place)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 James Cook University</td>
<td>Laurel Downey</td>
<td>QLD</td>
</tr>
<tr>
<td>16 School of Justice Queensland University of Technology</td>
<td>Professor Kerry Carrington</td>
<td>QLD</td>
</tr>
<tr>
<td>17 Pathways to Peace Goodna State School</td>
<td>Dr Simon Petrie</td>
<td>QLD</td>
</tr>
<tr>
<td>18 Department of Human Services</td>
<td>Lisa Rodda and Madeleine Oakes</td>
<td>VIC</td>
</tr>
<tr>
<td>19 Sexual Assault Reform Unit Department of Justice, Victoria</td>
<td>Janice Watt and Natasha Habjan</td>
<td>VIC</td>
</tr>
<tr>
<td>20 Adolescent Forensic Health Service (MAPPs)</td>
<td>Dr Irene Panagopoulos and Lynne Evans</td>
<td>VIC</td>
</tr>
<tr>
<td>21 Australian Childhood Foundation</td>
<td>Cyra Fernandes and Angela Weller</td>
<td>VIC</td>
</tr>
<tr>
<td>22 Berry Street</td>
<td>Annette Jackson and Megan Pollard</td>
<td>VIC</td>
</tr>
<tr>
<td>23 South Eastern Centre Against Sexual Assault</td>
<td>Russell Pratt and Carolyn Worth</td>
<td>VIC</td>
</tr>
<tr>
<td>24 Gatehouse Centre Royal Children’s Hospital</td>
<td>Karen Hogan, Helen Kambouridis, Vicki Quinton, Margaret Heaton</td>
<td>VIC</td>
</tr>
</tbody>
</table>

* Where names are not specified interviewees have requested their name remain confidential.
## APPENDIX 1: LIST OF INTERVIEWS CONDUCTED (CONT.)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Interviewees*</th>
<th>Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 Children's Protection Society</td>
<td>Jenny Wing</td>
<td>VIC</td>
</tr>
<tr>
<td>26 Child Wise</td>
<td>Karen Flanagan and Jacqui Morse</td>
<td>VIC</td>
</tr>
<tr>
<td>27 Australian Community Support Organisation</td>
<td></td>
<td>VIC</td>
</tr>
<tr>
<td>28 CASA House</td>
<td>Linette Harriott</td>
<td>VIC</td>
</tr>
<tr>
<td>29 Department of Juvenile Justice, NSW</td>
<td>Ian Nisbet and Jeannette Liva</td>
<td>NSW</td>
</tr>
<tr>
<td>30 Youth Off the Streets – New Pathways</td>
<td>Leah Berry and colleague</td>
<td>NSW</td>
</tr>
<tr>
<td>31 New Street Adolescent Service, NSW Health</td>
<td>Brenton Law and Simon Monk</td>
<td>NSW</td>
</tr>
<tr>
<td>32 Rural New Street Adolescent Service. Hunter New England Health</td>
<td></td>
<td>NSW</td>
</tr>
<tr>
<td>33 Cedar Cottage</td>
<td>Dale Tolliday</td>
<td>NSW</td>
</tr>
<tr>
<td>34 Psychologist in Private Practice</td>
<td>Gerard Webster</td>
<td>NSW</td>
</tr>
<tr>
<td>35 Child and Family Team, Hunter New England Health.</td>
<td>Tom Pepe and Linda Rawlins</td>
<td>NSW</td>
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<tr>
<td>36 NAPCAN National Association for the Prevention of Child Abuse and</td>
<td>Angela Walsh and Trudi Peters</td>
<td>NSW</td>
</tr>
<tr>
<td>Neglect (Love Bites)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37 Gnibi the College of Indigenous Australian Peoples, Southern Cross</td>
<td>Professor Judy Atkinson</td>
<td>NSW</td>
</tr>
<tr>
<td>University</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 Rekindling the Spirit</td>
<td>Greg Telford</td>
<td>NSW</td>
</tr>
<tr>
<td>39 The Whole Self / Ready to Learn</td>
<td>Sarah Ralston</td>
<td>NSW</td>
</tr>
<tr>
<td>40 NT Families and Children</td>
<td>Shelley Houtman</td>
<td>NT</td>
</tr>
<tr>
<td>41 Department of Health and Families, NT</td>
<td>Mary Culhane-Brown</td>
<td>NT</td>
</tr>
<tr>
<td>42 Department of Health and Families, NT</td>
<td>Sandra Anne McElligott</td>
<td>NT</td>
</tr>
<tr>
<td>43 NT Correctional Services</td>
<td>Dr Shirley Grace</td>
<td>NT</td>
</tr>
<tr>
<td>44 Sexual Assault Referral Centre Alice Springs</td>
<td></td>
<td>NT</td>
</tr>
<tr>
<td>45 Sexual Assault Referral Centre Darwin, and the Mobile Outreach Centre,</td>
<td>Barbara Kelly and Michelle Moss</td>
<td>NT</td>
</tr>
<tr>
<td>NT.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46 NAPCAN National Association for the Prevention of Child Abuse and</td>
<td>Lesley Taylor</td>
<td>NT</td>
</tr>
<tr>
<td>Neglect (Love Bites)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47 Ruby Gaea</td>
<td>Lisa Bennett</td>
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<tr>
<td>48 Central Australian Aboriginal Congress</td>
<td>Malcolm Frost</td>
<td>NT</td>
</tr>
<tr>
<td>49 Headspace Top End</td>
<td>Sam Lloyd</td>
<td>NT</td>
</tr>
<tr>
<td>50 Headspace Central Australia</td>
<td>Robbie Lloyd and Natalie Colmer</td>
<td>NT</td>
</tr>
</tbody>
</table>

* Where names are not specified interviewees have requested their name remain confidential.
## APPENDIX 1: LIST OF INTERVIEWS CONDUCTED (CONT.)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Interviewees*</th>
<th>Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>51 Children Youth and Women’s Health Service – Division of CAMHS</td>
<td>Pauline McEntee and Kathy Crossing</td>
<td>SA</td>
</tr>
<tr>
<td>52 Behavioural Intervention Service</td>
<td>Dy Smith-McCue</td>
<td>SA</td>
</tr>
<tr>
<td>53 Children Youth and Women’s Health Service – Division of CAMHS. Adolescent Services Enfield Campus</td>
<td>Cynthia Lawson</td>
<td>SA</td>
</tr>
<tr>
<td>54 Adolescent Sexual Abuse Prevention Unit (Mary Street)</td>
<td>Alan Jenkins</td>
<td>SA</td>
</tr>
<tr>
<td>55 Adolescent Sexual Abuse Prevention Unit (Mary Street)</td>
<td>Rob Hall and Shar Williams</td>
<td>SA</td>
</tr>
<tr>
<td>56 Families SA. Marni Wodli ‘Good House’</td>
<td>Angela Ricciotti</td>
<td>SA</td>
</tr>
<tr>
<td>57 Nunkuwarrin Yunti of SA, Inc.</td>
<td></td>
<td>SA</td>
</tr>
<tr>
<td>58 Metropolitan Aboriginal Youth and Family Services</td>
<td></td>
<td>SA</td>
</tr>
<tr>
<td>59 SHINE SA</td>
<td>Kaisu Värttö and Jane Flentje</td>
<td>SA</td>
</tr>
<tr>
<td>60 Uniting Care Wesley Adelaide, Inc.</td>
<td></td>
<td>SA</td>
</tr>
<tr>
<td>61 Family Court SA</td>
<td>The Honourable Justice Rod Burr AM</td>
<td>SA</td>
</tr>
<tr>
<td>62 Youth Legal Service Adelaide</td>
<td>Rob Croser</td>
<td>SA</td>
</tr>
<tr>
<td>63 Denise M. Rieniets and Associates, Pty. Ltd.</td>
<td>Denise M. Rieniets</td>
<td>SA</td>
</tr>
<tr>
<td>64 WA Country Health Service</td>
<td>Kate Gatti</td>
<td>WA</td>
</tr>
<tr>
<td>65 Dept of Health WA</td>
<td>Mark Crake</td>
<td>WA</td>
</tr>
<tr>
<td>66 Family Pathways - Child and Adolescent Health Services</td>
<td>Tony Fotios and Paula Chatfield</td>
<td>WA</td>
</tr>
<tr>
<td>67 Child protection Unit Princess Margaret Hospital</td>
<td>Lee Henry, Dr Peter Winterton and colleagues</td>
<td>WA</td>
</tr>
<tr>
<td>68 Department of Corrective Services - Juvenile Psychological Services</td>
<td>Louise Bromly and Sarah Dina</td>
<td>WA</td>
</tr>
<tr>
<td>69 SafeCare Inc.</td>
<td>Christabel Chamarette</td>
<td>WA</td>
</tr>
<tr>
<td>70 Youth Justice Services - Department of Health and Human Services</td>
<td>Jennifer Thain</td>
<td>TAS</td>
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<tr>
<td>71 Ashley Youth Detention Centre</td>
<td>William H. Doudle</td>
<td>TAS</td>
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<tr>
<td>72 Child and Adolescent Mental Health, Burnie</td>
<td>Suzanne Nesham and Julia Dixon</td>
<td>TAS</td>
</tr>
<tr>
<td>73 North West Centre Against Sexual Assault</td>
<td></td>
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</tr>
<tr>
<td>74 Laurel House</td>
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<tr>
<td>75 Sexual Assault Support Service - Galileo House</td>
<td>Dianne Calderbank</td>
<td>TAS</td>
</tr>
<tr>
<td>76 STOP, Adolescent and Children’s Program, Christchurch</td>
<td>Maureen Lorimer and Lyn Jansen</td>
<td>NZ</td>
</tr>
<tr>
<td>77 WellStop, Wellington, New Zealand</td>
<td>Lesley Ayland</td>
<td>NZ</td>
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</table>

* Where names are not specified interviewees have requested their name remain confidential.
## APPENDIX 2: LIST OF SUBMISSIONS RECEIVED

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<thead>
<tr>
<th>Organisation</th>
<th>Name*</th>
<th>Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1   Bendigo Psychology, Inc.</td>
<td>Shona Innes, Clinical Psychologist.</td>
<td>VIC</td>
</tr>
<tr>
<td>2   Child protection Unit, Princess Margaret Hospital</td>
<td>Lee Henry, Manager.</td>
<td>WA</td>
</tr>
<tr>
<td>3   Boystown</td>
<td>Tracy Adams, Chief Executive Officer.</td>
<td>QLD</td>
</tr>
<tr>
<td>4   Carnarvon Family Support Service Inc. Carnarvon</td>
<td>Julee Nelson, Executive Officer.</td>
<td>WA</td>
</tr>
<tr>
<td>5   Australian Institute of Family Studies</td>
<td>Professor Alan Hayes, Director</td>
<td>VIC</td>
</tr>
<tr>
<td>6   ACT Department of Education and Training</td>
<td>Dr Jim Watterson, Chief Executive.</td>
<td>ACT</td>
</tr>
<tr>
<td>7   Barnardos</td>
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<td>National Body</td>
</tr>
<tr>
<td>8   Griffith Youth Forensic Service</td>
<td>Professor Stephen Smallbone</td>
<td>QLD</td>
</tr>
<tr>
<td>9   Department for Child Protection Western Australia</td>
<td>Terry Murphy, Director General</td>
<td>WA</td>
</tr>
<tr>
<td>10  Australia and New Zealand Association for the treatment of sexual abuse</td>
<td>Gerard Webster, ANZATSA President</td>
<td>National Association</td>
</tr>
<tr>
<td>11  NSW Department of Communities</td>
<td>Annette Gallard, Chief Executive</td>
<td>NSW</td>
</tr>
<tr>
<td>12  Department of Human Services</td>
<td>Fran Thorn, Secretary</td>
<td>VIC</td>
</tr>
<tr>
<td>13  Chrysalis Support Services Inc.</td>
<td>Jan Fisher and Kirstie Martin</td>
<td>WA</td>
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<tr>
<td>14  Queensland Law Society</td>
<td>Ian Berry, President</td>
<td>QLD</td>
</tr>
<tr>
<td>15  Headspace</td>
<td>Chris Tanti, CEO and Verity Newnham, Project Coordinator.</td>
<td>National Body</td>
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<tr>
<td>16  Department of Families, Housing, Community Services and Indigenous Affairs</td>
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<td>Commonwealth</td>
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<tr>
<td>17  Department of Health and Human Services Tasmania</td>
<td>David Roberts, Secretary</td>
<td>TAS</td>
</tr>
<tr>
<td>18  Department of Health and Ageing</td>
<td>Jane Halton PSM, Secretary</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>19  Juvenile Justice, NSW</td>
<td>Richard Parker</td>
<td>NSW</td>
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</table>

* Names were not specified for all submissions.
## APPENDIX 3: LIST OF ACRONYMS USED

<table>
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<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AASW</td>
<td>Australian Association of Social Workers</td>
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<td>ACC</td>
<td>Australian Crime Commission</td>
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<tr>
<td>ACF</td>
<td>Australian Childhood Foundation</td>
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<tr>
<td>ACSAT</td>
<td>NSW Aboriginal Child Sexual Assault Taskforce</td>
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<tr>
<td>ACSO</td>
<td>Australian Community Support Organisation</td>
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<tr>
<td>ACSSA</td>
<td>Australian Centre for the Study of Sexual Assault (Part of the Australian Institute of Family Studies)</td>
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<tr>
<td>ACTCS</td>
<td>ACT Corrective Services</td>
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<tr>
<td>AIATSIS</td>
<td>Australian Institute of Aboriginal and Torres Strait Islander Studies</td>
</tr>
<tr>
<td>AIFS</td>
<td>Australian Institute of Family Studies</td>
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<tr>
<td>ANZATSA</td>
<td>Australia and New Zealand Association for the Treatment of Sexual Abuse</td>
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<tr>
<td>APY</td>
<td>Anangu Pitjantjatjara Yankunytjatjara</td>
</tr>
<tr>
<td>ARACY</td>
<td>Australian Research Alliance for Children and Youth</td>
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<tr>
<td>ASEC</td>
<td>Adolescent Services Enfield Campus (SA)</td>
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<tr>
<td>BIS</td>
<td>Behavioural Intervention Service (SA)</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CARHU</td>
<td>Child At Risk Health Unit (WA)</td>
</tr>
<tr>
<td>CASA</td>
<td>Centre Against Sexual Assault</td>
</tr>
<tr>
<td>CAT</td>
<td>Child Abuse Taskforce (NT)</td>
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<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy</td>
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<td>CPS</td>
<td>Children’s Protection Society</td>
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<td>CPU</td>
<td>Child Protection Unit (WA)</td>
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<td>CSATS</td>
<td>Child Sexual Abuse Therapeutic Services (WA)</td>
</tr>
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<td>CSOCAS</td>
<td>Child Sex Offender Counsellors Accreditation Scheme</td>
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<td>CYFS</td>
<td>Children Youth and Family Services (SA)</td>
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<tr>
<td>DEEWR</td>
<td>Department of Education, Employment and Workplace Relations</td>
</tr>
<tr>
<td>DHCS</td>
<td>Department of Housing and Community Services (ACT)</td>
</tr>
<tr>
<td>DHHS</td>
<td>The Department of Health and Human Services</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services (Victoria)</td>
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## Appendix 3: List of Acronyms Used (Cont.)

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>DS</td>
<td>Disability Services</td>
</tr>
<tr>
<td>ECAV</td>
<td>Education Centre Against Violence</td>
</tr>
<tr>
<td>FaHCSIA</td>
<td>Department of Families, Housing, Community Services and Indigenous Affairs</td>
</tr>
<tr>
<td>GYFS</td>
<td>Griffith Youth Forensic Service</td>
</tr>
<tr>
<td>JIRT</td>
<td>Joint Investigation Response Team (NSW)</td>
</tr>
<tr>
<td>MAPPS</td>
<td>The Male Adolescent Program for Positive Sexuality</td>
</tr>
<tr>
<td>MAYFS</td>
<td>The Metropolitan Aboriginal Youth and Family Service (SA)</td>
</tr>
<tr>
<td>MF&amp;YCS</td>
<td>Mater Family and Youth Counselling Service</td>
</tr>
<tr>
<td>MOS</td>
<td>NT Sexual Assault Mobile Outreach Service</td>
</tr>
<tr>
<td>NAPCAN</td>
<td>National Association for the Prevention of Child Abuse and Neglect</td>
</tr>
<tr>
<td>NIITF</td>
<td>National Indigenous Intelligence Taskforce</td>
</tr>
<tr>
<td>NTCS</td>
<td>Northern Territory Corrective Services</td>
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<td>NTER</td>
<td>Northern Territory Emergency Response</td>
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<tr>
<td>OOHC</td>
<td>Out of home care</td>
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<tr>
<td>PANOC</td>
<td>Physical Abuse and Neglect of Children Services (NSW)</td>
</tr>
<tr>
<td>PSBs</td>
<td>Problematic sexual behaviours</td>
</tr>
<tr>
<td>RRR</td>
<td>Responsible, Respectful Relationships (Program, WA Corrective Services)</td>
</tr>
<tr>
<td>SABs</td>
<td>Sexually abusive behaviours</td>
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<tr>
<td>SACPP</td>
<td>Sexual Abuse Counselling and Prevention Program</td>
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<tr>
<td>SARC</td>
<td>Sexual Assault Referral Centre (NT)</td>
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<tr>
<td>SECASA</td>
<td>South Eastern Centre Against Sexual Assault</td>
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<tr>
<td>SOP</td>
<td>Sex Offender Program (NSW Department of Juvenile Justice)</td>
</tr>
<tr>
<td>TTO</td>
<td>Therapeutic Treatment Order</td>
</tr>
<tr>
<td>TWI</td>
<td>Thomas Wright Institute</td>
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<tr>
<td>VAACA</td>
<td>Victorian Aboriginal Child Care Agency</td>
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<td>VOTA</td>
<td>Victorian Offender Treatment Association</td>
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<tr>
<td>YJC</td>
<td>Youth Justice Conferencing</td>
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</table>
Australia’s Response to Sexualised or Sexually Abusive Behaviours in Children and Young People

Dr Wendy O’Brien

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