Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

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Acronyms and abbreviations

ANROWS	Australia's National Research Organisation for Women's Safety
ANZATSA	Australian and New Zealand Association for the Treatment of Sexual Abuse
CALD	Culturally and linguistically diverse
ERASOR	Estimate of Risk of Adolescent Sexual Offence Recidivism
GYFS	Griffith Youth Forensic Service
HSB	Harmful sexual behaviours
J-SOAP-II	Juvenile Sex Offender Assessment Protocol-II
NGO	Non-government organisation
OOHC	Out-of-home care
RCFV	Royal Commission into Family Violence (Victoria)
RCIRCSA	Royal Commission into Institutional Responses to Child Sexual Abuse
SAB	Sexually abusive behaviours
SABTS	Sexually Abusive Behaviours Treatment Service
TTO	Therapeutic treatment order

Key terms

Doli incapax	Common law presumption that a child between the ages of 10–14 years does not possess the necessary knowledge to have a criminal intention. It is a rebuttable presumption. The prosecution must provide evidence that suggests that the child knew that their behaviour was criminally wrong.
Harmful sexual behaviours	Sexual behaviours expressed by children and young people under the age of 18 years that are developmentally inappropriate, may be harmful to self or others, or may be abusive to another child, young person or adult (Hackett, 2014).
Therapeutic treatment order	An order of the Family Division of the Children's Court of Victoria, which requires a child who has exhibited sexually abusive behaviours to participate in an appropriate therapeutic treatment program.
Multisystemic approach; eco-systemic	An approach which views young people as living in a network or ecology of interconnected spheres of individual, family, peer, school and neighbourhood systems.
Multisystemic Therapy®	A trademarked program, Multisystemic Therapy® (MST) is an intensive family- and community-based intervention for children and young people aged 11–17 years who are at risk of out-of-home placement in either care or custody due to their offending or are having severe behaviour problems (MST Services, 2017).
Young people; young person	Individuals between 10–17 years of age (inclusive).

Executive summary

Introduction

Harmful sexual behaviours (HSB) refer to a continuum of sexual behaviours engaged in "by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful to self or others, or that may be abusive to another child, young person or adult" (Hackett, Holmes, & Branigan, 2016, p. 12). Young people comprise a significant proportion of individuals engaging in unwanted or harmful sexual behaviours against children. Studies conducted in the United Kingdom and Europe have estimated that adolescents account for between 30–50 percent of all perpetrators of childhood sexual abuse (Erooga & Masson, 2006; Jaffé, 2010; McCartan, Law, Murphy, & Bailey, 2011; Vizard, 2006).

Multiple factors underpin why children and young people engage in HSB. These include, for example, the impact of adverse childhood experiences (e.g. experiences of abuse and maltreatment, neglect, and domestic and family violence [DFV]), the family environment, and the pyschosocial development of children and young people. Where the young person is over the age of 10 (the age of criminal responsibility in Australia) (Australian Institute of Criminology, 2005), the potential for criminal justice involvement adds additional complexity. Reflecting this complexity, a range of actors and services are involved in responding to young people engaging in HSB: teachers and educators; child protection workers; police; youth justice workers; family support services; sexual assault services; family violence services; and, of course, the specialist services that provide therapeutic interventions.

In the last 15 years, a maturing body of clinical, empirical and evaluative research has developed regarding how to work therapeutically with young people aged 10–17 years who engage in HSB as well as what constitutes good practice (O'Brien, 2010; Royal Commission into Institutional Responses to Child Sexual Abuse [RCIRCSA], 2017c; Shlonsky et al., 2017). Inquiries and Royal Commissions have lent an increased impetus to the need to improve service responses. However, compared to the developing consensus on the principles of good *therapeutic* practice, relatively little focus has been given to understanding:
- the factors that help or hinder practitioners and services

implement good practice principles
- what good practice looks like for different cohorts of young people
- interactions between therapeutic responses and broader systems responses such as child protection, criminal justice and education
- how these interactions impact on specialist therapeutic responses for young people engaging in HSB.

There is thus is a gap in the research and policy landscape, one that potentially hinders effective service development in at least two ways. Firstly, there is a lack of knowledge about what makes therapeutic interventions effective, and whether and in what ways this might be different for different groups of young people. Secondly, there is a lack of documented understanding about what features and conditions in the broader service delivery environment are needed for program effectiveness.

Project purpose

The key purpose of this project was to develop an in-depth understanding of the interplay between program design, delivery and outcomes and the contextual factors influencing these, with the aim of informing future therapeutic service development and evaluation for therapeutic responses to young people, aged 10–17 years (inclusive), engaging in HSB. The project grew out of a recognition that service responses for young people engaging in HSB have developed unevenly across Australia, with differences in, for example:
- philosophies about where HSB should sit as a policy issue (i.e. within health, community services, or youth justice)
- how specialist services are designed and delivered
- who is eligible for these services.

How HSB are framed in the policy context (e.g. as a child welfare or justice issue), as well as legislative requirements, approaches to service commissioning and funding, and the imperatives, philosophies, and practices of other service

systems (e.g. criminal justice or education), can work to amplify or constrain good practice.

This project joins a small but important body of research that examines the service and policy contexts in which therapeutic services for HSB are delivered (Clements, Ryder, Mortimer, & Holmes, 2017; Hackett, Carpenter, Patsios, & Szilassy, 2013; Hackett, Masson, & Phillips, 2006; Smith et al., 2014).

Project methodology

Project design and components

This project had three main research components: a state of knowledge review, a national mapping of the service landscape for young people (10–17 years inclusive) engaging in HSB, and an in-depth service model investigation of three services that work with young people engaging in HSB. These components are briefly described below.

State of knowledge review

This review aimed to synthesise the relevant literature in relation to key aspects of HSB: definitions and concepts, the extent of HSB occurring, why young people engage in HSB, and what is known about current therapeutic responses. A date range of 2006–17 was selected to provide an update on a literature review undertaken by one of the researchers and published in 2008 (O'Brien, 2008). A scoping review was undertaken to focus on peer-reviewed and grey literature[1] regarding:

- how HSB and their causes are understood (conceptual understandings)
- what we know about the extent of HSB, the circumstances in which they occur and why (empirical understandings)
- how best to work with young people engaging in HSB

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1 Grey literature has been defined in a range of ways. A commonly used definition, approved in 1997 at the Third International Conference on Grey Literature, is material that "is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers" (Farace, 1997). Examples include: annual reports, government documents, lectures, policy statements and documents, conference papers and research evaluations, and reports by NGOs.

and what is considered effective intervention (therapeutic understandings).

National service mapping

In the Australian Crime Commission's service mapping undertaken in 2010, O'Brien identified a range of issues affecting the provision of accessible specialist services to young people engaging in HSB, including geographic and demographic gaps, and differences in therapeutic philosophies, referral criteria, staffing expertise and funding arrangements (O'Brien, 2010). The aim of this component was to provide a broad understanding of the service landscape for these young people across Australia and how practitioners are working with them. This mapping aimed to provide an updated picture of the current service landscape across the states and territories mapped in O'Brien's study. This is important for understanding the service gaps that still exist, and to situate the research into the three service models. Two data collection strategies were used for this component of the study:

- a desktop review of information available on specialist service responses for young people between 10–17 years engaging in HSB in each state and territory. This involved collecting available online material (government and service sector websites) and recent grey literature
- an online survey (developed as a request for information tool) used to obtain information from specialist practitioners. This was distributed via several targeted email subscription and stakeholder lists.

Investigation of three service models

The aim of this component was to develop a detailed understanding of the interactions between therapeutic service provision and the context/s in which this work occurs. Three different services currently working with young people engaging in HSB were investigated in order to understand how good practice in specialised service provision for young people engaging in HSB is understood by those working with young people; the key "ingredients" or mechanisms that underpin good practice; and the factors in the broader service delivery context that facilitate—or hinder—good practice in specialised therapeutic interventions.

The services were Griffith Youth Forensic Service in Queensland (GYFS); New Street Adolescent Service in New South Wales (New Street); and Sexually Abusive Behaviours Treatment Service in Victoria (SABTS). These models have been in operation for almost two decades. They demonstrate important distinctions as service models: for instance, they vary along a spectrum from highly youth justice-oriented (e.g. GYFS) to a complete diversion away from a justice response (e.g. SABTS); and from a single outreach service (e.g. GYFS) to a networked service in local health districts (e.g. New Street). Their respective service contexts also differ in terms of who funds them, their policy history, and geographic location and coverage. As such, they were appropriate candidates for what constitutes good practice and what helps or hinders it.

For each of the three service models, we undertook in-depth interviews with:

- practitioners and clinicians working therapeutically with young people with HSB (n=44)
- policy and statutory professionals (n=19) who were part of the services' operating context (i.e. as funding agencies, as the main referring agencies, or as agencies involved in case and safety planning for individual clients).

We also collected relevant program documentation such as procedures, standards, training packages, intake forms and so on to develop an overall understanding of the service model.

Theoretical foundations

Two key theoretical approaches informed the overall purpose and design of the project: realist evaluation and systems thinking.

Developed by Ray Pawson and Nick Tilley (1997), realist or realistic evaluation aims to understand not so much *whether* a program works in general, but *why* a program works, who it works for and in what circumstances. Realist evaluation focuses on *what* it is about programs and interventions that bring about change (i.e. the mechanisms), and on the contexts or circumstances that enable (or constrain) these changes to take effect. Program outcomes are the result of interactions between mechanisms and context.

While this study was not an evaluation, it was a form of *evaluative inquiry* (Holtrop, 2018). That is, we used the questions typical of program evaluations to examine what constitutes and enables good practice and how factors in the broader service delivery context facilitate—or hinder—this. These questions focused on who services typically work with; how therapeutic interventions are implemented; what principles and concepts underpin interventions and how these are translated into practice; how success or effectiveness is defined; and what factors helped or acted as barriers to effective implementation.

Systems thinking is a conceptual orientation towards better understandings of:

- the dynamics of complex and intersecting service systems
- the levers at a systems level that can better align the mechanisms of good practice with their delivery contexts.

The insights from realist evaluation and systems thinking were used to orient the study's focus, analysis and conclusions in relation to:

- how interventions or programs are designed and delivered
- the influence of factors within the service delivery and broader systems landscape
- interactions between the programmatic and broader delivery contexts.

The aim was to inform both specialist service design and policy development.

Key findings

State of knowledge review

Research with different populations of young people (i.e. those in the general community, those within the child protection system, and those within the juvenile justice population) finds no single set of characteristics or circumstances that "cause" or predict a young person's engagement in HSB (Chaffin, 2008; O'Brien, 2008). Young people who engage in HSB are a diverse group, and a range of factors—individual

and environmental—contribute to these behaviours under different circumstances (Andrade, Vincent, & Saleh, 2006; Elkovitch, Latzman, Hansen, & Flood, 2009; Grant et al., 2009; Hackett, 2010; Jaffé, 2010; Withington, Ogilvie, & Watt, 2013). The research has identified risk factors across individual, familial, peer, school, and community-level domains (i.e. a socio-ecological framework) and emphasises the importance of taking an ecological approach for both risk and protective factors (Elkovitch et al., 2009; Smallbone, Rayment-McHugh, & Smith, 2013; Smith, Bradbury-Jones, Lazenbatt, & Taylor, 2013).

Reflecting the evidence on the diversity of young people engaging in HSB, and the importance of taking an ecological approach, researchers and clinicians have transitioned away from using individual behavioural modification models (such as individual counselling/psychotherapy) to incorporating more holistic frameworks that encompass both social and environmental elements (Pratt, 2014; Shlonsky et al., 2017).

National service mapping

Variations in service availability

The mapping, which was undertaken in 2017, indicates considerable variation in service availability. Key variations include:

- Different age eligibility thresholds and ranges: some services only work with young people up to the age of 12, or under 10, or between the ages of 13–16 years or 12–17 years.

- Different referral requirements: some services only accept referrals from nominated referrers such as Child Protection, while other services accept any source of referral.

- Different restrictions on the type of behaviours services work with: some services are only able to work with young people where HSB have been substantiated; others will not see clients who have been formally charged with an offence.

- Gaps in geographic coverage: some jurisdictions have limited services (e.g. Tasmania and the Australian Capital Territory), and within jurisdictions regional and remote areas are likely underserved.

In combination, these variations create a patchwork of services, access to which is determined by seemingly arbitrary restrictions rather than by the therapeutic requirements of the young person.

Lack of accessible, quality information

The quality of public information about service availability is an issue, for families in particular as well as for general practitioners (GPs), school counsellors, teachers and other key contact points with young people who may be seeking information about services.

Possible reasons for this lack of accessible information include:

- The relative newness of service responses to HSB: it is really only in the last decade or so that awareness and understanding of young people and HSB have extended beyond specialist practitioners to be part of child and youth service provision generally. While child and youth government agencies have endeavoured to keep abreast of these developments in therapeutic service provision, this has yet to translate into public-facing information.

- Lack of ownership for information provision: while many services are funded by a central government department, there is often a lack of clarity about who the central and authoritative source of information is. This can mean information published on multiple pages is inconsistent or contradictory.

- Absence of a user-experience perspective: services—large or small—may not have an orientation towards the user experience of attempting to locate information or what information they are actually after. This compromises the discoverability of information (i.e. how accessible, recent and relevant it is).

- Lack of resourcing and/or capability to publish information online: many providers are non-government, community-based organisations. This can mean they have limited resources to update information or fix broken or circuitous links.

Service and practitioner characteristics: Responses to the request for information

We developed a request for information survey tool that asked about the characteristics of practitioners, services, and clients. A total of 131 practitioners commenced the survey, with 59 completing it. Our analysis is based on this final sample of 59. As this was an opt-in survey circulated via stakeholder and subscriber lists (e.g. Child Family Community Australia–News), the results are not generalisable and are limited to this sample of respondents. Despite this, the results largely echo the broader literature on therapeutic interventions with young people engaging in HSB.

Eighty-five percent of respondents identified as female. The majority were also mature workers, with 42 percent over the age of 45, and 37 percent between the ages of 35–44 years. All respondents had some level of tertiary education. Ninety percent possessed a bachelor degree or higher, with one third holding a postgraduate qualification.

Service and client characteristics

Almost one third (31%) of respondents reported that their service was based in New South Wales; just over one fifth (22%) were based in Queensland. Service coverage was predominantly major cities and inner regional areas (55% of responses). Almost three quarters (73%) of clients that practitioners worked with were between 10–14 years of age. There were multiple sources of referral to services, with departments of human services/child protection being the main source (78% of responses), followed by schools (64%) and the justice system (63%).

A little over one third of respondents (37%) said that the funding their service received was ongoing; 41 percent described the funding as being a mixture of ongoing and timeline-limited funding arrangements. State and territory governments are the main source of funding (81% of responses).

In terms of factors these young people presented with in addition to the HSB themselves, a history of their own abuse (sexual, physical or emotional) was extremely common (80% of responses indicated this history being present among their clients). Half of respondents (51%) cited exposure to family violence as a common risk factor and 41 percent thought that exposure to pornography was a common risk factor. The frequency of these results suggests considerable co-occurrence of risk factors among the young people respondents see. Poor social skills, educational and learning difficulties, unstable living situations and exposure to parental or guardian substance abuse were also identified, but at much lower frequencies (between 15–17%).

Therapeutic approaches and practices

Practitioners work with young people intensively to address HSB. Over half of respondents (53%) said that they worked with young people for between 1–2 years; 60 percent said the treatment frequency was weekly, and another 29 percent saw clients fortnightly. The top three elements of effective intervention nominated were:

- tailoring the intervention to the needs of the individual (54% of respondents)
- working with the family system (44% of respondents)
- working eco-systemically, i.e. working with the young person in their familial, interpersonal and community systems (36%).

All respondents said that they assessed the presence of trauma in the history of the young person either always (86%) or most of the time (14%).

Barriers to service access and engagement

Responses to questions about service barriers indicated that in terms of accessing services in the first instance, geographic disadvantage was a commonly cited factor (46%) followed by insufficient places available at services (39%), family or guardian's reluctance or inability to participate (39%), and lack of awareness about services (38%). However, barriers to completing treatment differed; respondents saw family reluctance or inability to participate as the key barrier (66%).

Investigation of three service models

Understandings of good practice

A key insight arising from the in-depth investigation of the GYFS, New Street and SABTS service models was the identification of different categories or types of principles. The thematic analysis suggested three key types:

1. Principles that described *the conceptual underpinnings* of the work—specifically, having an understanding of:

- the developmental trajectories and capacities of young people (i.e. that cognitive, psychological, and relational capacities are still in formation, and that they rely on the adults around them as key supports)

- the HSB in young people's developmental and eco-systemic context (i.e. young people's behaviour is largely a product of what they have experienced at home and in their significant attachment relationships).

2. Principles that guided *the direct therapeutic work or intervention*:

- working systemically with the young person, their family and social ecology

- being trauma-informed

- tailoring therapeutic responses to the young person, in terms of cultural safety, gender, developmental stages and capacities.

3. *Enabling principles*, in particular:

- engagement of family/carers

- comprehensive assessment and case planning

- engaging broader systems agencies.

Factors in services' operating contexts that impact on good practice

Three categories of contextual factors influenced the provision of treatment for HSB. These factors were grouped into three main domains:

1. Service design and delivery, which related to:

- challenges to recruitment and retention, particularly of skilled workers in regional and rural areas, and perceptions that the work was highly specialised or was about "perpetrators"

- service demand, which generally outstripped the ability of services to provide services

- funding—short-term (i.e. yearly) funding cycles could make the work unattractive, particularly in terms of recruiting workers to regional and rural locations.

2. Service access and engagement, specifically:

- geography and location: challenges of providing face to face, discrete services to young people and families located in regional and rural areas, and challenges for families to attend weekly sessions

- knowledge, awareness and stigma: families often lack knowledge about HSB, or about the services available, and stigma about HSB can act as a barrier to accessing services

- maintaining engagement: a range of factors impacted on families' and carers' abilities to maintain engagement over the long term, including geographic location, family conflict, and family dysfunction.

3. Service systems, intersections and interactions, specifically:

- criminal justice: tensions and contradictions between therapeutic vs criminal justice paradigms that could render a young person ineligible for service or delay access to services

- child protection: different thresholds, assessments and prioritisation of risk; differing levels of comfort and specialisation regarding HSB between specialist services and child protection workers; different expectations about capacity of child protection as a key partner agency in safety plans; care placement instability and breakdown

- education: knowledge of and comfort with HSB varies between school communities, and there is a challenge in balancing duty of care for the harmed child and the young person engaging in HSB.

Implications

Following the Royal Commission into Institutional Responses to Child Sexual Abuse (RCIRCSA), as well as other inquiries into vulnerable children and family violence, a significant number of recommendations have been made to strengthen responses to HSB. Many of these are specific to responsible portfolio agencies and community sectors. Rather than add additional recommendations, we have identified a number of

implications or overall conclusions arising from this research for the research, practice and policy communities to consider.

Research implications

The state of knowledge review suggests a consolidation of the evidence base regarding the characteristics of young people who engage in HSB, and a deeper understanding of the co-occurring adverse experiences these young people have experienced. However, there are gaps in the research that should be attended to, including:

- Our knowledge about the extent of HSB: currently, recorded crime and administrative data act as proxies for extent; however, these types of data rely on children and young people disclosing, carers and guardians reporting to relevant agencies, and those agencies recording incidents in ways that allow them to be identified as HSB. Consideration could be given to developing additional programs of research, more qualitative in nature, to provide greater depth of understanding about the dynamics of HSB and the contexts in which they occur.

- Program effectiveness, particularly in the Australian context: there is limited research that evaluates the effectiveness of therapeutic interventions of the kind that reflect good practice principles identified in the literature. Consideration could be given to developing evaluation frameworks and evaluation projects that investigate Australian program design, delivery and outcomes across diverse cohorts and settings.

- How HSB present and are understood within culturally and linguistically diverse (CALD)[2] communities: to our knowledge, no published research exists on this in the Australian context. This gap signals the need for a new round of inquiry, working with diverse communities to develop an understanding of how HSB are understood and what types of interventions are needed.

- How developments in therapeutic approaches are being tailored to Aboriginal and Torres Strait Islander young people and their communities: consideration needs to be given to documenting current practice in working with Aboriginal and Torres Strait Islander young people and

how this articulates with, augments and differs from the current evidence base.

Practice and service implications

The national service mapping undertaken in 2010 identified:
- differences in therapeutic philosophies, treatment models, referral pathways, staff profile, eligibility criteria, and funding arrangements
- geographic gaps, particularly in regional and remote areas
- demographic gaps, with particular populations ineligible for intervention
- an absence of culturally appropriate therapeutic services
- the need for workforce development, including for Indigenous and CALD practitioners (O'Brien, 2010).

In the intervening years, differences in therapeutic philosophies and models have diminished. The findings from the request for information and the in-depth investigation into GYFS, New Street and SABTS service models indicate a high level of consensus about what the principles of good therapeutic practice involve. These are largely in line with the broader evidence base. However, differences and inconsistencies in service provision remain.

Currently, there is a focus on increasing the number of therapeutic services available (as recommended by the RCIRCSA). More and adequately funded services are essential. However, a key implication arising from this project is that this is not sufficient, and that focusing on the service delivery level alone is unlikely to address the variations identified above or the factors in the broader service delivery context that influence good practice (as explored in Chapter 4: Insights into good practice from three service models). In tandem with efforts to improve availability of and access to therapeutic responses, it is also necessary to look at the broader system in which services are provided.

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2   CALD young people in this report are defined as those who are born either overseas or in Australia and who do not use English as their main language (Sawrikar, 2011).

Policy and systems implications

There are a range of tools available that can be used to better align the principles of good practice with their service delivery context, namely:

- paradigm and policy frameworks: understanding and mapping the philosophies, imperatives, and drivers behind the different service systems that intersect with the young person in HSB services as well as where these roles and rules work against the principles of good practice

- funding structures: looking at how commissioning and funding approaches can be better aligned to amplify good practice, for example, the duration of funding, degree of autonomy on what funds are available for what activities, interrogating what is funded and with what assumptions, and the degree to which funding structure reflects the nature of work

- governance structures: governance, monitoring and reporting structures between services and government/commissioning agencies that reinforce or support the principles of good practice

- interagency governance and collaboration: mechanisms for collaboration and information sharing between services that support holistic interventions

- workforce development, recruitment and retention: the community and human services sector is one of the largest industry sectors in Australia and it continues to expand. At the service level, consideration is needed for how to support long-term retention of highly skilled workers. At the workforce level, long-term planning for the capacity and skills required to support more services is needed.

Introduction

The issue of young people engaging in harmful sexual behaviours (HSB) is complex. This is because multiple factors underpin the occurrence of HSB, their connection to other adverse experiences, the impact they have on young people and families, and what helps young people engaging in HSB to desist. The last two decades have seen significant development in understandings of, and responses to, children and adolescents who have engaged in unwanted, harmful or abusive sexual behaviours against other children and young people, internationally (Hackett, 2010; Hackett et al., 2016; Ryan, 1999) and in Australia (Flanagan, 2003; Nisbet, Rombouts, & Smallbone, 2005; O'Brien, 2008; Pratt, Miller, & Boyd, 2012).

Research on the characteristics of young people (as defined in this project) who engage in HSB shows on the one hand a heterogeneous population in terms of backgrounds, age, living circumstances and the types of HSB engaged in. On the other hand, this research also shows that this population generally presents with multiple difficulties, particularly experiences of trauma, family dysfunction and instability, and cognitive and learning impairments (Fortune, 2013; Hackett, Phillips, Masson, & Balfe, 2013).

This understanding of the characteristics of young people who engage in HSB has resulted in a shift away from criminal justice and correctional responses as the dominant framework towards holistic and broad-based therapeutic interventions that work with young people in their familial and community contexts (Rasmussen, 2013; Ryan 1999). In the last 15 years, a maturing body of clinical, empirical and evaluative research has evolved, describing good practice principles for working therapeutically with young people aged 10–17 who have engaged in HSB (O'Brien, 2010; Royal Commission into Institutional Responses to Child Sexual Abuse [RCIRCSA], 2017c; Shlonsky et al., 2017). While an emerging consensus has developed around the principles of good *therapeutic* practice, relatively little focus has been given to:

- the factors that help or hinder practitioners and services to implement these principles
- the interactions between therapeutic responses, the service delivery context, and broader systems responses such as child protection, criminal justice and education

- how these interactions impact on specialist therapeutic responses for young people engaging in HSB.

Understanding these issues and the impacts they have on therapeutic service provision are the central focus of this project.

Terminology used in this report

Young people

The term "young people" refers to individuals between 10–17 years of age. The rationale for this age range is based on legislative and service design factors. First, the project focuses on services provision for young people who meet the minimum age of criminal responsibility, which in Australia is 10 years (O'Brien & Fitz-Gibbon, 2017; Urbas, 2000). While services may also work with children under the age of 10 years, the interface with criminal justice significantly changes how interventions are delivered, who can access them, and the potential consequences for clients where criminal charges are a possibility. Second, the three main services we investigate are funded to provide treatment to young people up to the age of 17 inclusive (i.e. under the age of majority).

Harmful sexual behaviours

How to best conceptualise and describe young people engaging in inappropriate and/or unwanted sexual behaviours with another child or young person is complex. Although it has been generally accepted that the terms "juvenile sex offender" or "adolescent sex offender" are problematic in that they reflect a knowledge base of *adult* sex offending and can be highly stigmatising, a common nomenclature has not yet been settled upon, across either jurisdictions or service disciplines. In part, this is because overly simplistic, "imprecise or vague terminology can lead to misclassifying children and young people, or labelling them inappropriately" (Hackett et al., 2016, p. 12). As noted by O'Brien (2010, p. 14), "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".

Until recently, "sexually abusive behaviours" was the predominant terminology used in reference to children over the age of 10 years (the age of criminal responsibility) and "problem sexual behaviours" was the term used for children under the age of 10 years. However, a cogent argument has been presented that chronological age on its own is a somewhat arbitrary delineator between problem and abusive sexual behaviours. Other factors such as differences in cognitive development and intellectual ability also influence the extent to which behaviours are coercive or abusive. "Harmful sexual behaviours" has been increasingly adopted as an overall term to signal a continuum of behaviours from abnormal to violent.[1]

In this report, we use the term "harmful sexual behaviours" to refer to

> sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful to self or others, or may be abusive to another child, young person or adult. (Hackett et al., 2016, p. 12)

We use the term "sexually abusive behaviours" where relevant to refer more specifically to sexual behaviour towards another child or young person that is characterised by the use of coercion, force or threat; the misuse of power (e.g. due to disparities in age, physical size, or level of psychosocial development); and/or the absence of consent. The State of knowledge review discusses issues around terminology in greater detail.

Service, service model, and therapeutic program

Throughout this report we use a range of terms to describe services for young people who engage in HSB. We use "service" to refer to the actual organisation that is providing the treatment, for example the Griffith Youth Forensic Service or Australian Childhood Foundation. "Service model" refers to the design and delivery of a therapeutic program, for example whether it only provides treatment for HSB, its client eligibility (i.e. who they are funded to see), and whether it

includes outreach work. "Therapeutic or treatment program" refers to specific interventions provided to the young person.

Good practice

Good practice is a combination of practice knowledge (i.e. tested skills, knowledge and experience), the best available evidence (noting that this is always in development), and the circumstances, insights and preferences of clients (Drisko & Grady, 2015). In this project we have focused on practitioners' perspectives on what constitutes good practice for working with young people engaging in HSB, and their insights into what helps and hinders the elements of good practice. These insights are then situated among the broader research on therapeutic interventions for HSB.

Background to the Good Practice project

In 2010, O'Brien undertook a national review of specialised service responses to children and young people engaging in sexualised and sexually abusive behaviours.[2] O'Brien (2010) observed that "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" (p. 5). The review identified a range of issues affecting the provision of accessible specialist services to these young people, including geographic and demographic gaps, and differences in therapeutic philosophies, referral criteria, staffing expertise and funding arrangements. These observations echo those from the United Kingdom, where the issue of young people engaging in HSB had come onto the policy agenda in the early 1990s (Myles-Wright & Nee, 2017). A review of policy and practice in the United Kingdom[3] found inconsistent service approaches to assessment, investigation and treatment; a lack of agency coordination; clashes of agency philosophies about how young people engaging in

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2   "Sexualised and sexually abusive behaviours" was the terminology in use at the time.

3   In 1992, a Committee of Enquiry reviewed the status of professional responses to young people engaging in HSB. Its findings were published as the *Report of the Committee of Enquiry into Children and Young People who Sexually Abuse Other Children* (National Children's Home, 1992).

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1   This continuum recognises that there are developmentally appropriate behaviours for children and young people—that is, there is a range of behaviours that are appropriate for children and young people to engage in based on age and developmental capacities.

Figure 1: The location of good practice

- How work with young person occurs
- Principles/philosophy that underpin this
- What effectiveness/success looks like

Therapeutic
program

GOOD
PRACTICE

Broader
systems context

- Legislation
- Philosophies of intersecting agencies
- Approaches to collaboration
- Approaches to commissioning
- Governance

Service issues

- Service model design (e.g. referral criterias, staff profile, skills)
- Professional development
- Location
- Client characteristics
- Funding

Source: Based on O'Brien (2010)

HSB should be managed; and a paucity of training (Masson & Hackett, 2003; Myles-Wright & Nee, 2017). A decade later, follow-up research into the United Kingdom service landscape was undertaken (Hackett, Masson, & Phillips, 2005). This research found that there had been significant progress in how the issue of young people engaging in HSB was understood and that "considerable clarity was evident about the appropriate principles upon which assessment and intervention work with children and young people who have sexually abused should be based" (Masson & Hackett, 2003, p. 117). However, interagency and systemic issues remained. These included:

- challenges in reconciling child welfare and youth justice response systems
- high variability in the degree of co-ordinated, consistent approaches to the management of young people engaging in HSB
- challenges in service accessibility
- limited opportunities for training and skills building (Masson & Hackett, 2003).

In sum, a significant evolution has occurred over the last 15–20 years in the recognition of young people engaging in HSB as a policy and practice issue, how these young people and behaviours are understood, and the principles that should underpin therapeutic interventions. At the same time, the broader service delivery context presents challenges in the provision of therapeutic responses.

In this project, and as shown in Figure 1, we locate good practice in responding to young people engaging in HSB at the intersection of the therapeutic program itself, service level issues and the broader systems context. Given the multifaceted nature of HSB, therapeutic programs require the involvement of multiple partner agencies to work. Choices and decisions around, for example, client eligibility, referral mechanisms, location, funding agreements, juvenile and criminal justice legislation, and the differential responsibilities of agencies such as statutory child protection, police and children's courts shape how principles translate into practice and how they are experienced by clients.

Project description

The key purpose of this project was to develop an understanding of the interplay between program design, delivery and outcomes and the contextual factors influencing these, with the aim of informing future therapeutic service development and evaluation. This project joins a small but important body of research that examines the service and policy contexts in which therapeutic services for HSB are delivered (Clements et al., 2017; Hackett et al., 2006; Hackett, Carpenter, et al., 2013; Smith et al., 2014).

We had two objectives. The first was to provide a current snapshot of what services are available across the states and territories. We did this via desktop review, circulating a

national request for information survey, and direct approaches to states and territories for additional information.

The second objective was to develop an in-depth understanding of good practice, and specifically to better understand the complex interplay between program design and outcomes, and the contextual factors that shape therapeutic responses. We focused on three different service models to do this. The key research areas were:

- what might constitute good practice in specialised service provision for young people engaging in HSB

- the key "ingredients" or mechanisms that underpin good practice

- the factors in the broader service delivery context that facilitate—or hinder—good practice in specialised therapeutic interventions.

The three service models were Griffith Youth Forensic Service (GYFS) in Queensland, New Street in New South Wales, and Sexual Abuse Behaviour Treatment Service (SABTS) in Victoria. We conducted in-depth interviews with practitioners and service managers providing therapeutic services to young people, police and the departmental funding agencies. We also collected program and guidance documentation.

The rationale for the selection of service models was two-fold. First, these are relatively mature services; each service model has been in operation for near on 20 years, meaning each is a tested and refined service model. A second reason is that the services differ quite considerably in design:

- GYFS (Queensland) sees young people who have been convicted of a sexual offence, and is a field-based outreach model that works statewide.

- New Street (New South Wales) sees young people who have engaged in HSB that have been reported to and confirmed by the Joint Child Protection Response Program[4] or the Department of Families and Community Services (FACS).[5] New Street services are stand-alone services serving specific local health districts. Currently four specific local health districts are being served.[6]

- SABTS (Victoria) sees young people who have engaged in SAB. Referrals can come from family, schools, police, child protection and other community organisations. Currently 11 organisations deliver SABTS, nine of which are sexual assault services.

These variations allowed for investigation of how different service contexts inform good practice as well as what themes are shared across the services.

Research design

The project's overall research design draws on two approaches that we see as well suited to the above key questions: realist evaluation and systems thinking.

Insights from realist evaluation

While our study is not an evaluation, it is a form of evaluative inquiry (Holtrop, 2018) into what constitutes and enables good practice and how factors in the broader service delivery context facilitate—or hinder—this, with the aim of informing both specialist service design and policy development. The rationale for not undertaking evaluations per se of three service models was that assessing the "effectiveness" of one therapeutic model over others is fraught. The diversity in approaches and client profiles complicates assessments of effectiveness. There is variation in how services have been designed, who they cater for (e.g. any young person in the community, age ranges or adjudicated youth), and the extent to which they are primarily located within a criminal justice, community welfare or forensic mental health paradigm. Not attending to these contextual factors and how they influence service provision runs the risk of comparing apples with oranges. In practical terms, this can affect the design and implementation of therapeutic responses, both from a service perspective and from the perspective of policy and government.

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4   The Joint Child Protection Response Program was previously called the Joint Investigation Response Team. The program underwent a name change following a review by the NSW Ombudsman released in October 2018.

5   The Department of Family and Community Services (FACS) is now called the Department of Communities and Justice.

6   In 2019–20, New Street is expanding to provide statewide coverage, with additional full services being established in the following local health districts: Murrumbidgee (Wagga Wagga), Lismore (Northern NSW), Mid-North Coast, Southern NSW, and South Western Sydney. Additional "spoke services" will be established in the Central Coast and Far West local health districts.

In short, although this project was not an evaluation in the traditional sense, we were nevertheless interested in what makes for good practice in responding to young people who engage in HSB. Given our understanding that good practice sits at the intersection of the programs, service design, and systems organisation and dynamics, we felt that the insights gained from realist evaluation were particularly useful.

Developed by Ray Pawson and Nick Tilley (1997), realist or realistic evaluation aims to understand not so much *whether* a program works in general, but *why* a program works, who it works for and in what circumstances. From a realist evaluation perspective, programs and interventions are not discrete phenomena to be implemented and then tested. Rather, programs are firstly "theories" about the reasons or causes that have given rise to particular behaviours or social problems. These programs are then embedded in complex and dynamic social systems made up of individuals, organisations, relationships and stakeholders, policy frameworks and settings, and so on. How these levels interact and how people make sense of these interactions are part of—rather than a contaminant to—understanding effectiveness. Finally, programs are open systems:

> They cannot be fully isolated or kept constant. Unanticipated events, political change, personnel moves, physical and technological shifts, inter-programme and intra-programme interactions, practitioner learning, media coverage, organizational imperatives, performance management innovations and so on make programmes permeable and plastic. (Pawson & Tilley, 2004, p. 5)

This open dynamism is not an obstruction to understanding and implementing effective programs, but is necessarily part of inquiry and analysis.[7] Realist evaluation focuses on *what* it is about programs and interventions that bring about change (i.e. the mechanisms) and on the contexts or circumstances that enable (or constrain) these changes to take effect. Program outcomes are the result of interactions between mechanisms and context.

Systems thinking

The second approach we draw on is "systems thinking". Systems thinking is less a methodological approach than it is a conceptual orientation towards better understandings of:

- the dynamics of complex and intersecting service systems
- the levers at a systems level that can better align the mechanisms of good practice with their delivery contexts.

Systems thinking has several origin stories, beginning in the early 20th century in the social sciences before being taken up in engineering, computing and cybernetics and ecology in the 1950s and 1960s and, in the late 1980s, in the study of "complex adaptive systems" (Arnold & Wade, 2015). It is thus an interdisciplinary concept that has at its core a focus on understanding how a system's constituent parts interrelate with and influence each other. The key concepts in systems thinking include nested systems; feedback loops; resonance, amplification and dampening; non-linearity; adaptation; and organising structures (Midgley, 2003). In the last decade, systems thinking has been increasingly applied to the design, reform and evaluation of complex human service systems such as health systems, child and family welfare services and child protection (Arnold & Wade, 2015; de Savigny & Adam, 2009; Foster-Fishman, Nowell, & Yang, 2007; Lane, Munro, & Husemann, 2016; Peters, 2014).

In tandem, the insights from realist evaluation and from systems thinking were used to orient the study's focus, analysis and conclusions. As shown in Figure 2, the two approaches help to sensitise research to:

- programmatic factors (i.e. how interventions or programs are designed and delivered)
- contextual factors (i.e. within the service delivery and broader systems landscape)
- interactions between the programmatic and the broader delivery contexts.

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7   In developing their theory of realist evaluation, Pawson and Tilley (2004) critiqued and wanted to move past a medical–experimental approach to understanding program effectiveness in which human volition, change, unpredictability and values are "noise" to be excised from inquiry. For complex social interventions delivered to diverse populations in diverse settings, these elements are fundamental to understanding not only what makes an intervention effective, but what will make it effective in another setting, at another time, for another community.

Figure 2: Role of realist evaluation and systems thinking in project
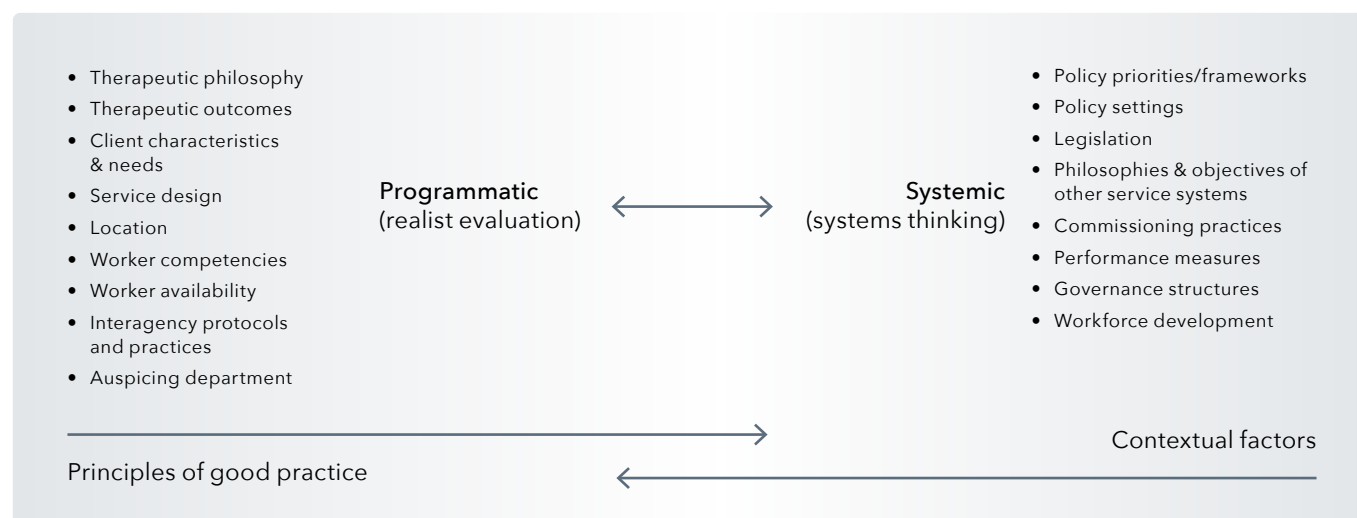
These theoretical approaches were a good fit in terms of the project objectives (as described above) and the context in which the project was implemented.

Project context

The project commenced in March 2017. Data collection, coding and analysis were completed by December 2018, and the project report finalised for peer review in mid-2019. This time frame coincides with several significant inquiries and reform agendas that have resulted in—and will continue to result in—changes to the service and policy contexts in which services for young people with HSB operate. Developments of particular relevance for this project are outlined below.

The Royal Commission into
Institutional Responses to Child Sexual Abuse

Between January 2013 and November 2017, the Royal Commission into Institutional Responses to Child Sexual Abuse (RCIRCSA) inquired into people's experiences of child sexual abuse in institutional contexts. Part of its inquiry focused specifically on children and young people who engaged in HSB in institutional settings. Key issues were examined through public hearings, issues papers, case studies, reports and roundtables. This heightened focus on HSB arguably catalysed developments across child protection, police, education, policy and the services sector to better respond to the cohort of children and young people who have displayed these behaviours.[8] Further, Volume 10 of the RCIRCSA's final report focused only on children and young people exhibiting HSB, and made seven recommendations to improve responses, assessment and therapeutic interventions; strengthen the workforce; and improve evaluation. The Commonwealth established a taskforce to consider and coordinate action on the recommendations, which ran to June 2018. State and territory governments were required to release formal responses to the RCIRCSA's recommendations and many also established taskforces to work through the recommendations, which had implications across education, policing and justice, child protection, and community service systems.

Reform agendas to address family violence

The 2015 Victorian Royal Commission into Family Violence (RCFV) resulted in 227 recommendations (State of Victoria, 2016). In March 2016, the Andrews Government committed to actioning all of the recommendations. A $1.9 billion reform strategy was confirmed in 2017 to implement the recommendations with material changes to services and police responses underway while this project was in train. In 2015, Queensland Premier Annastacia Palaszczuk announced her government would implement all 140 recommendations from the *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* report prepared by the Special Taskforce on Domestic and Family Violence in Queensland and chaired by the Honourable Quentin Bryce AD CVO (Special Taskforce on Domestic and Family Violence in Queensland & Bryce, 2015).

Reform agendas to address
child safety and child protection

A number of inquiries into the child protection and out-of-home care systems have occurred in the states and territories.

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8   The *Criminal Justice Report* (RCIRCSA, 2017a), the *Consultation Paper on Institutional Responses to Child Sexual Abuse in Out of Home Care* (RCIRCSA, 2016), and Case Study 45: Responses to children with problematic or harmful sexual behaviours in schools were particularly relevant to the issue of systems and service responses to young people engaging in HSB (RCIRCSA, 2017b) .

Again, these have resulted in changes being made to service systems design, policy and practice.[9] In some cases, these changes are significant, system-wide programs of reform, such as the Roadmap for Reform (Victoria. Department of Health and Human Services, 2018), the Roadmap for Queensland Child Protection (Queensland Child Protection Commission of Inquiry, 2013), and the Their Futures Matter reform in New South Wales (NSW Government, 2018).

An important element of the reform agendas relating to family violence and child protection in particular is a shift away from attempting to address these issues separately. Instead, there is a concerted effort to align reform across family violence, child protection, child and family welfare, policing, education and universal support services. For instance, responding to the noted service gap, the Victorian RCFV (State of Victoria, 2016) recommended that the age range for young people eligible for HSB therapeutic intervention be extended up to 17 years. The consequences of implementing this for SABTS' service model and therapeutic practice was likely to come up in interviews. In Queensland, Youth Justice, previously in the Department of Justice and Attorney-General, recently shifted to sit within the Department of Child Safety, Youth and Women. In Victoria, the converse happened, with Youth Justice shifting from the Department of Health and Human Services to the Department of Justice and Community Safety. In New South Wales, the Department of Education is developing protocols for responding to children and young people with HSB. In Western Australia, the Department of Justice is exploring therapeutic interventions for young people engaging in HSB.

Clearly, these and other developments make for a highly dynamic service delivery context and this has affected the project in several ways:

- Logistically: machinery of government changes to where departments sit altered the identification of key personnel and approval processes to undertake the research.

- Operationally: reforms to the broader systems of, for example, child protection and family violence were changing how therapeutic services and interfacing systems operated.
- Discursively: how the issue of HSB was understood and responded to was being actively reframed while we were undertaking the project. The RCIRCSA in particular triggered considerable dialogue and shifts in thinking across government departments that we needed to stay abreast of.

Realist evaluation and systems thinking enabled a degree of flexibility in identifying the most appropriate mix of participants and allowed us to follow threads of inquiry as they emerged.

Structure of report

This report has five substantive chapters:

1. State of knowledge review: this chapter reviews the recent peer and grey literature regarding the nature and extent of HSB among young people, circumstances in which these behaviours occur, and the risk and protective factors and current approaches being used.
2. Methodology: this chapter describes the project design, core methodological principles, research methods and ethical considerations.
3. National mapping of the current service landscape: this chapter describes the national context of service responses for young people engaging in HSB.
4. Insights into good practice from three service models: this chapter draws on qualitative research with GYFS, New Street and SABTS. It describes the elements of good practice, the enablers of good practice, and the contextual factors influencing practice.
5. Conclusion: the final chapter considers the implications of the research findings for future service design and implementation.

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9   These include *Queensland: Taking Responsibility: A Roadmap for Queensland Child Protection* (Queensland Child Protection Commission of Inquiry, 2013); *Betrayal of Trust: Inquiry into the Handling of Child Abuse by Religious and Other Non-Government Organisations* (Victoria. Family and Community Development Committee, 2013); and the Protecting Victoria's Vulnerable Children Inquiry (Cummins, Scott, & Scales, 2012).

CHAPTER 1:

State of knowledge review

Overview

The purpose of this state of knowledge review was to synthesise the current knowledge and evidence base in relation to HSB and to update the literature review undertaken by the Australian Crime Commission (O'Brien, 2008) in terms of current:

- conceptual understandings, specifically how HSB are defined and conceptualised
- empirical understandings, that is, what is known about the prevalence and incidence of HSB, the circumstances in which they occur, and associated risk factors
- therapeutic understandings, in terms of what constitutes effective therapeutic interventions, and how effectiveness is measured and evaluated.

The discussion below is organised into these three categories. The state of knowledge review was undertaken in 2017, however the research team conducted further limited searches while revising the report to ensure any new research that added insights to the evidence base was included in our discussion. Important new research published in 2018 and 2019 is referenced where relevant.

Review strategy

The review and synthesis strategy used was that of a scoping review (Arksey & O'Malley, 2005). The aim of a scoping review is to outline the nature and extent of research in a given field, provide an informed conclusion about the characteristics of the evidence base for a particular topic, and summarise what the evidence says about that topic. Scoping reviews help to set the scene of a given piece of research and are generally undertaken before the research commences. Given the relative newness of HSB as a social policy issue, a scoping review that synthesised how HSB are understood, what is known about reasons why HSB occur and current therapeutic responses aids readers' overall understanding of the phenomenon under inquiry.

Our search strategy focused on two types of literature: peer-reviewed academic publications and grey literature. Peer review literature generally incorporates scholarly articles published in journals that have been double-blind reviewed (i.e. the identities of both authors and reviewers are concealed at the time of reviewing) by expert academics and scholars in the relevant field.

Grey literature has been defined in a range of ways. A commonly used definition is material "produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers" (Farace, 1997). Examples include annual reports, government documents, lectures, policy statements and documents, conference papers and research evaluations, and reports by non-government organisations (NGOs).

Peer review and grey literature each bring benefits and limitations. Peer-reviewed literature is generally regarded as the most robust independent source of evidence. However, the review and publication process can be lengthy, making research potentially out of date, particularly from a practice perspective. Grey literature is generally published more rapidly, and while extremely useful, is often context- and sector-specific. It can also be of varying methodological quality.

Several strategies were used to search the current academic and grey literature. For academic peer-reviewed publications, we searched key social science databases using a combination of search terms and search strings. The databases searched, the search terms used and inclusion/exclusion criteria are presented in Figure 3. To locate relevant grey literature, we used the following strategies:

- Google Advanced Search for exact words and phrases reflecting the search strings used for academic peer-reviewed material, a publication range of 2006–17, and follow-up of targeted queries for Australia
- targeted searching of specific sites/organisations, such as the RCIRCSA and Commissions for Children and Young People in the states and territories.

Figure 3: Databases and search terms used for academic research literature

DATABASES | FOCUS | | SUBJECT (SU) AND KEYWORD (KW) SEARCH STRINGS

PsychInfo

PubMed

MedLine

Scopus

Google Scholar

AIFS Calalog Plus

CONCEPTUAL
- Terminology and aetiology

EMPIRICAL
- Nature/extent
- Characteristics of young people
- Risk/protective factors

THERAPEUTIC
- Types of programs or interventions
- Program effectiveness
- Risk assessment

AGE

SU: Youth

SU: Children

SU: Adolescents

SU: Juveniles

SU: Teenagers

SU: Harmful sexual behaviour/sexually abusive behaviour/problem sexual behaviours/adolescent sexual offender/juvenile sexual offender/young people who sexually harm

SU: Harmful sexual behaviour/sexually abusive behaviour/problem sexual behaviour AND
- KW: Prevalence; incidence
- KW: Risk factors
- KW: Protective factors

SU: Harmful sexual behaviour/sexually abusive behaviour/problem sexual behaviour AND
- KW: Therapeutic interventions/treatment programs
- KW: Risk assessment tools/risk assessment instruments
- KW: Effectiveness/outcomes/evaluation

+

TAILORING TO SPECIFIC GROUPS
SU/KW or abstract:
- Aboriginal/Indigenous/Aboriginal and Torres Strait Islander/Koori
- CALD, CaLD, culturally and lingustically diverse
- Diverse culture
- Ethnicity/ethinic
- Minority

Inclusion criteria:
- English language publications
- Publications between 2006 and 2017 (with the exception of hallmark studies)
- Preference given to Australian, New Zealand, United States, British and Canadian research

Excluded:
X Age: < 10 years and > 18 years

After conducting search runs, citations, abstracts and articles/documents were exported into an EndNote library. The research team then reviewed these references, and coded and filed them into themes, which were used to help organise the structure of this chapter. These themes were:

- definitions and contexts: how HSB are explained, terminology, nature and extent, historical perspectives
- characteristics: young people engaging in HSB, risk factors, protective factors
- therapeutic responses: how to best work with HSB, specific interventions
- effectiveness: how effectiveness is defined and evaluated
- tailoring to specific cohorts: Aboriginal and Torres Strait Islander people, people from a CALD background
- defining good practice: practice principles, current policies and guidelines, international approaches.

Issues and limitations in undertaking the review

While this is a relatively comprehensive synthesis of the available literature across the above domains, there are a number of limitations impacting our discussion that readers should be aware of, namely:

- Differing definitions and cohorts of young people included in studies: the studies reviewed use a range of terms aside from HSB, such as "sexually abusive youth", "juvenile sex offenders" and "adolescents who sexually abuse". In addition, the particular cohorts of young people vary; studies are based on community, child welfare, criminal justice or adjudicated populations. The result of this is that there are inconsistencies both in the types of behaviours captured by studies and the populations upon whom findings are based. It also means that at times, we need to use the terminology used by the particular studies.
- The preponderance of Northern Hemisphere and particularly United States-based literature: there is

generally a lack of Australian literature to draw on, and while the international published peer review literature is insightful, findings are not always transferrable to the Australian context.

- The time lag between research being conducted and publication, particularly for peer-reviewed journals: in the social sciences field, it can take up to 18 months for an article to be reviewed and published (Björk & Solomon, 2013, p. 20). Issues in the practice and policy sphere can develop rapidly over the same period.

Conceptual understandings of young people and harmful sexual behaviours

Until the 1990s, there was limited awareness across criminal justice agencies, child protection, child and family welfare services, and education settings of:

- the nature and extent of harmful or abusive sexual behaviours by one young person to another
- the underlying circumstances and factors that gave rise to these behaviours
- how these behaviours—and indeed the young person engaging in them themselves—should be understood (Grant, 2000; O'Brien, 2008).

In the absence of empirical research and data, understandings of young people and these behaviours have tended to vacillate between notions that harmful or abusive sexual behaviours were rare and pathological or, conversely, were simply demonstrations of youthful and benign sexual exploration (Boyd & Bromfield, 2006; Stathopoulos, 2012).

Contrary to these notions, a growing body of scholarship from the mid-1990s onwards was instead showing that young people engaging in harmful or abusive sexual behaviours against other children represented a significant proportion of sexual offending against children, and that these behaviours resulted in harm and distress for the other child. The initial response of communities, media, governments and the criminal law system to this growing awareness was largely to view—and treat—adolescents engaging in HSB and SAB as "mini sex offenders" who would continue to offend into adulthood

without rehabilitation. Further research, however, on the characteristics of adolescents charged with sexual offences and the risk factors that gave rise to their behaviours revealed a more complex picture of young people than simply mini sex offenders (Ryan, 1999).

The young people coming to the attention of criminal justice and child protection agencies were heterogeneous (i.e. came from diverse communities and contexts), reported high levels of child maltreatment (including physical and sexual abuse), and often reported other adversities, such as educational difficulties and difficulty forming social attachments (Epps & Fisher, 2004; Masson & Erooga, 2002; Nisbet et al., 2005; Nisbet & Seidler, 2001; Righthand & Welch, 2004).

These insights, combined with the existing evidence base on complex and developmental trauma[10] and their expressions (e.g. impacts on affect, impulse and emotional regulation; cognition; attachment styles), and the emerging evidence from developmental psychology, cognitive science, and neuroscience on continuing brain growth and change in adolescence (particularly in relation to executive functioning) (Johnson, Blum, & Giedd, 2009, p. 1), significantly changed interventions with young people. Therapeutic interventions shifted focus from offence-specific, relapse-prevention approaches (which mirrored adult offender rehabilitation) to understanding the features of the young person's personal history and their familial and social ecology (e.g. family dynamics); working with adolescents' developmental stage, capacities and strengths; and, relatedly, focusing on their capacity for positive change and healthy relationships.

Shifting terminology

Reflecting this deepening clinical understanding, consensus grew among researchers and clinicians that "to refer to

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10   "Complex trauma" is used to describe the experience of multiple and/or chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g. sexual or physical abuse, war, community violence) and often occurring early in life and perpetrated by caregiving figures in a child's life (van der Kolk, 2005, as cited in Wall & Quadara, 2014). Developmental trauma or developmental trauma disorder is used more specifically to refer to interpersonal trauma experienced at an early age that has had an impact on individuals' developmental trajectories (Briere & Jordan, 2009; Herman, 1992; Kezelman & Stavropoulos, 2012; van der Kolk, 2005 as cited in Wall & Quadara, 2014).

Table 1: Terminology used in O'Brien (2010)

Terminology	Applied to
Problem sexual behaviours (PSB)	· Children under the age of criminal responsibility (i.e. under 10 years) · Behaviours may 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 · Some PSB are highly coercive and involve force (acts that would be described as "abusive" were it not for the child's age)

Sexually abusive behaviours (SAB)	· "Young people" i.e. those aged 10–17 years
	· Behaviours generally involve the following contextual elements:
	  · absence of consent
	  · use of physical force or threats
	  · coercion
	  · disparity of age, level of development or physical size (CEASE, 2016, p. 6)

Source: Adapted from O'Brien (2010, p. 13)

juveniles as 'sex offenders', 'perpetrators', or 'abusers' is stigmatising and likely to inhibit the young person's impetus to change" (O'Brien, 2010, p. 12). Choice of terminology has been a key consideration in the research and practice literature. Clinicians and practitioners have instead opted to use terminology that describes the *behaviours* the young person has engaged in, and which doesn't label the young person or make their behaviours central to their identity in the way "juvenile sex offender" does, for example. Although there has not been definitive consensus or consistency in terminology, practitioners in Australia have, until recently, generally used the terms "problem sexual behaviours" and "sexually abusive behaviours" for children and young people respectively (see Table 1).

While these terms have been useful in providing alternatives to earlier, more stigmatising terms, they are not without issue themselves. In the service mapping, O'Brien (2010) argued for a more nuanced terminology that does not distinguish between "problematic" and "abusive" behaviours based solely on age. She reasoned that children under 10 *are* capable of using coercion against other children, and that the term "problematic" minimises both the potential impact of the behaviour on the victimised child and the urgent need for specialist care for the child responsible (O'Brien, 2010, p. 13). Further, the reliance on the age of criminal responsibility to differentiate between problem or harmful behaviours risks conflating all sexualised behaviours among those over 10 as being harmful, when the behaviours exhibited by some young people in this age range may be more appropriately described as problem behaviours.

In the United Kingdom, Hackett and colleagues have published research and guidance literature describing a conceptual framework for children and young people displaying HSB (Hackett, 2010; Hackett et al., 2016). Hackett defined HSB as

> sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult. (Hackett et al., 2016, p. 12)

In Australia, "harmful sexual behaviours" is emerging as the preferred terminology (Meiksans, Bromfield, & Ey, 2017), and has been adopted by the RCIRCSA and the Western Australia Commissioner for Children and Young People.[11] While this general shift is happening, a range of other terms are also in use, with sexually harmful behaviour, sexualised behaviours, and reactive sexual behaviours among them. It is unclear whether these are interchangeable, refer to different behaviours, or are different dimensions of a broader harmful sexual behaviours continuum. In addition, the term has also been contested, with some practitioners concerned that it minimises or obfuscates abusive behaviour and the existence of a victim.

In reviewing the original work by Hackett and colleagues (2016), it seems that something has been lost in translation in its uptake in Australia. The term harmful sexual behaviours, as Hackett developed it, was to be used as the basis of a

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11 The Western Australia Commissioner for Children and Young People (WACCYP) commenced a program of work relating to children and young people with HSB in 2017, resulting in several publications (see Western Australia Commissioner for Children and Young People, 2019).

conceptual framework to integrate two different dimensions—problematic and abusive sexual behaviours:

> "Sexually abusive" is mainly used to indicate sexual behaviours that are initiated by a child or young person where there is an element of manipulation or coercion (Burton et al., 1998), or where the subject of the behaviour is unable to give informed consent. By contrast, the term "sexually problematic" is more often used to refer to sexual activities that do not include an element of victimisation, but that may interfere with the development of the child demonstrating the behaviour or which might provoke rejection, cause distress or increase the risk of victimisation of the child. *The important distinction here is that whilst abusive behaviour is by definition also problematic, problematic behaviours may not necessarily be abusive* (Hackett, 2004). As both "abusive" and "problematic" sexual behaviours are developmentally inappropriate and may cause developmental damage, a useful umbrella term is "harmful sexual behaviours". (Hackett, 2014, p. 1, emphasis added)

This paragraph suggests that although the aim of the term harmful sexual behaviours is to provide an umbrella concept, it is also important to maintain behavioural distinctions and "a shared and meaningful *range of terms* … to enable clear communication between professionals" (Hackett et al., 2016, p. 12, emphasis added). In other words, harmful sexual behaviours is not intended to replace other terms; rather it is a conceptual framework that integrates a continuum of behaviours, from developmentally appropriate sexual behaviours at one end, to abusive and violent behaviours at the other. This conceptual framework is informed by the research evidence and is described in more detail below.

That it *is* a framework, and not a standalone behavioural definition to replace all other terms, seems inadequately emphasised in recent reports and resources. These publications often note that there is a range of behaviours that fall under HSB, but the sense of a behavioural continuum may not be well conveyed, as with this description:

> Harmful sexual behaviours can include problematic, coercive, violent and/or controlling behaviour patterns reflected in, for example, excessive or public self-stimulation; spying on others; unwanted sexual approaches to others;

sharing indecent images of persons under 18; coercive sexual assault and coercive sexual intercourse and/or oral sex. (RCIRCSA, 2017c, p. 32)

Alternatively, there can be a sort of slippage from harmful sexual behaviours as an integrated framework to describe a range of behaviours to becoming a single categorical definition encompassing all of them:

> In line with current evidence, this paper therefore uses the term "harmful sexual behaviour" to describe *any* problematic, harmful or sexually abusive behaviours by children and young people under the age of 18. (Hackett et al., 2016; Shlonsky et al., 2017 as cited in Meiksans et al., 2017, p. 3, emphasis added)

As Hackett and colleagues (2016) note, the key points about harmful sexual behaviours as a term are that it:

- aims to foster an integrated understanding of HSB that is shared across sectors and practitioners
- is designed to identify a continuum of responses from early intervention to intensive and specialist work with highest risk and needs populations
- doesn't replace terminology such as PSB and SAB; rather it removes *age* as the underlying organising principle, replacing it with a continuum as the organising principle.

Losing context and purpose of terms and definitions flattens nuances and differences and, rather than encouraging shared understanding, can create a situation where people are using the same term but meaning quite different things by it.[12]

In this project, we use HSB as an overall term to refer to a range of behaviours, but where relevant we refer to more specific behaviours as described in the continuum below.

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12 Similar observations have been made in relation to the adoption, diffusion and application of "trauma-informed care" (see Quadara & Hunter, 2016 for a discussion).

The continuum model and harmful sexual behaviours

Children and young people display sexual behaviours as a normal part of development. However, it is important for both professionals and members of the community to be able to distinguish between developmentally appropriate behaviours and abnormal/potentially harmful sexual behaviours (Hackett et al., 2016). The range of sexual behaviours exhibited by children and young people can be conceptualised along a continuum (see Table 2) and can also be classified by developmental stages (see Table 3).

The extent and nature of harmful sexual behaviours among young people: What the data tell us

Extent

The extent of HSB in Australia is difficult to establish accurately. There are limitations to what administratively held data can tell us, due to the following factors:

- The "dark figure" of crime and the attrition of recorded offences from the justice system: it is well established that recorded crime statistics represent a minority of actual offending in the community, particularly in the case of sexual offences (Lievore, 2003; Skogan, 1977). There is also the process of attrition, where incidents recorded by police are filtered out of the justice system, meaning that court and sentencing data represent a very small slice of the already small proportion of what is recorded by police. Again, this is particularly the case in sexual offences (Lievore, 2005; Tarczon & Quadara, 2012).[13]

- A lack of shared, consistent definitions: to date, there is no shared definition of either "young person" or the relevant behaviours to guide data collection in surveys or administrative data. While HSB as an umbrella concept or continuum of behaviour is useful from a policy and practice perspective, it is difficult to operationalise from a data collection perspective.

- Diverse administrative data holders: recent research by Bromfield and colleagues (2017) highlighted that there are many different data holders across police, health services, victim services, child protection, and education departments, making aggregation and comparability difficult.

- General lack of information collected about perpetration in police and other administrative data: the scoping by Bromfield and colleagues (2017) also noted that information about perpetrators, such as age, was often not recorded.

There are also inherent challenges in trying to establish the extent of an issue, such as HSB, that remains stigmatised, misunderstood, under-reported, or mischaracterised.

Noting these limitations, what the available data suggest is that young people engaging in harmful, unwanted or abusive sexual behaviour against other children and young people comprise a not insignificant proportion of individuals engaging in unwanted or sexually abusive behaviours against children. The Recorded Crime–Offenders data (Australian Bureau of Statistics [ABS], 2019a) for 2017–18[14] show that offenders in two youth cohorts (10–14 years; 15–19 years) whose principal offence was a sexual assault or related offence comprised approximately 23 percent of all offenders with a principal offence of sexual assault or related offence. However, sexual assault and related offences represent only a small proportion of youth offending overall (comprising 2.2% of all youth offences). This echoes Warner and Bartels' observation (based on 2012–13 ABS data) that "although sexual offending comprises only a small proportion of youth offending … juveniles account for a relatively high proportion of sex offences committed" (2015, p. 52).

Trend analysis of Recorded Crime data over the period 2008–09 to 2017–18 shows an increase of 35 percent in youth sexual assault and related offences (see Figure 4). This increase can be largely attributed to a rise in non-assaultive offences,

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13 Although there has been a shift away from conceiving of young people who are engaging in HSB as offenders, criminal justice data can provide at least some baseline around juveniles that have been charged with a sexual offence.

14 ABS Recorded Crime data for 2017–18 have been released (see ABS, 2019a), however there were a number of revisions made by Western Australia police to their offence coding, including recoding of offences relating to "aggravated sexual assault" and "non-assaultive sexual offences against a child". As such, data for offenders against these principal offences are not comparable to previous time points.

Table 2: Hackett's (2010) continuum model—The range of sexual behaviours presented by children and young people

Normal	Inappropriate	Problematic	Abusive	Violent
Developmentally expected	Single instances of inappropriate sexual behaviour	Problematic and concerning behaviours	Victimising intent or outcome	Physically violent sexual abuse
Socially acceptable	Socially acceptable behaviour within peer group	Developmentally unusual and socially unexpected	Includes misuse of power	Highly intrusive
Consensual, mutual, reciprocal	Context for behaviour may be inappropriate	No overt elements of victimisation	Coercion and force to ensure victim compliance	Instrumental violence which is physiologically and/or sexually arousing to the perpetrator
Shared decision-making	Generally consensual and reciprocal	Consent issues may be unclear	Intrusive	Sadism
		May lack reciprocity or equal power	Informed consent lacking, or not able to be freely given by victim	
		May include levels of compulsivity	May include elements of expressive violence	

Source: Adapted from Hackett (2010)

Table 3: Expected sexual development in children, by age group

Development stages	Age-appropriate sexual behaviours	Concerning sexual behaviours	Very concerning sexual behaviours
0–4 years	· exploratory behaviours (e.g. touching and looking at bodies) · comfort in being nude · asking about/wanting to touch genitals of familiar adults/children · un-self-conscious masturbation	· explicit sexual talk, art or play · curiosity about sexual behaviour becomes obsessive · pulling others' pants down or skirts up against their will · touching the genitals of animals after redirection	· compulsive masturbation · persistent sexual themes in talk, art or play · behaviour involves coercion, threats, secrecy, violence and/or aggression · disclosure of sexual abuse · persistently touching the genitals of others
5–9 years	· asking questions about bodies/comparing bodies with peers · desire for privacy · using sexual language · curiosity about sexuality	· masturbation in preference to other activities · persistent nudity/exposing self in public places · mimicking advanced sexual flirting behaviour	· compulsive masturbation · sexual penetration · genital kissing · disclosure of sexual abuse · simulated intercourse · persistent sexual activity with animals

Table continues overleaf

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

Development stages	Age-appropriate sexual behaviours	Concerning sexual behaviours	Very concerning sexual behaviours
10–13 years	· growing desire for privacy · masturbation in private · curiosity and seeking information about sexuality · boyfriend/girlfriend relationships · kissing, hugging and flirting	· attempting to expose others' genitals · sexual knowledge too advanced (considering context) · preoccupation with masturbation · simulating intercourse with peers (clothes on) · irregular viewing of pornography	· compulsive masturbation · chronic pornographic interest · simulating intercourse with peers (clothes off) · oral sex and/or intercourse with a person of a different age or developmental ability · touching others' genitals without permission · force or coercion of others into sexual activity
14–18 years	· need for privacy · consensual sexual activity with a partner of a similar age and developmental ability · masturbation in private · sexually explicit conversations with peers · viewing pornography	· sexual preoccupation interfering with daily function · spying on others engaged in sexual activity or nudity · repeated exposure of private parts in public places (e.g. flashing) · verbal sexually aggressive themes or obscenities	· compulsive masturbation · exposing others' genitals · sexual contact with animals · sexual activity in exchange for money, goods, etc. · forcing or manipulating others into sexual activity · possessing, accessing or sending child exploitation materials

Sources: Table compiled using information from Child at Risk Assessment Unit (2000); Pratt et al. (2012); Stathopoulos (2012)

Figure 4: Number of youth offenders with sexual assault and related offences as a principal offence—2008–09 to 2017–18
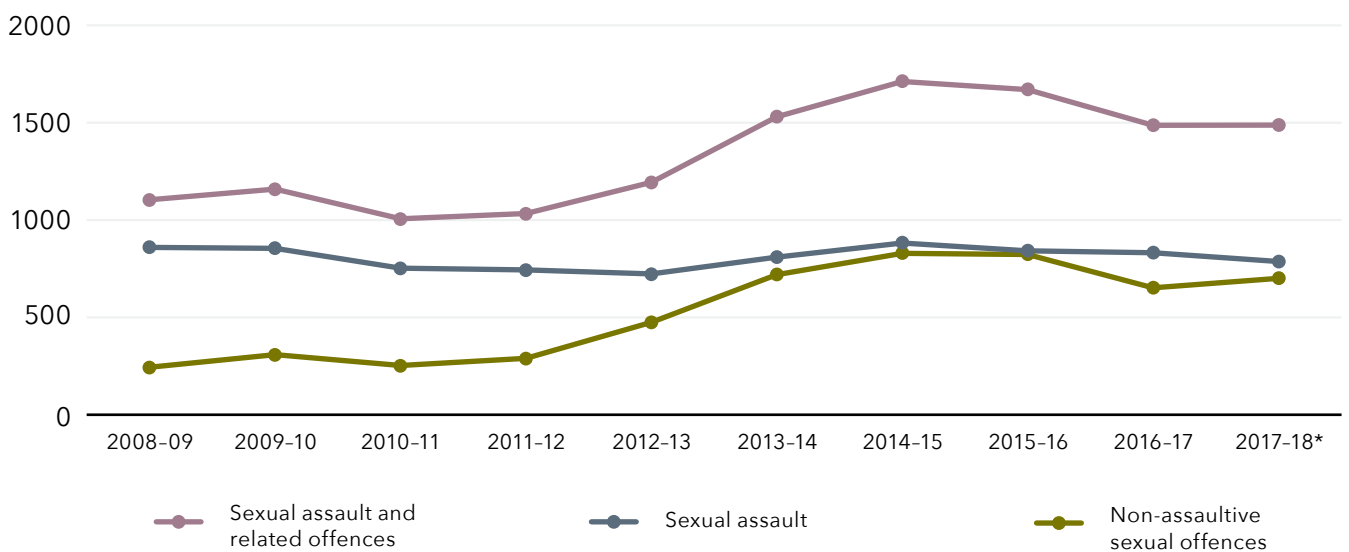
Source: Recorded Crime—Offenders, Australia 2017–18 (ABS, 2019a)

Note: *Data for this principal offence in 2017–18 are not comparable to previous reference periods due to offence coding changes in Western Australia

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

which increased from 243 to 702 during this period. The number of youth offenders with sexual assault and related offences as a principal offence peaked in 2014–15, but has since decreased by 13 percent between 2014–15 and 2017–18. During the 2017–18 period, youths aged 10–17 accounted for 17 percent of recorded sexual assault and related offences (1488 of a total 8528 offences). Overall, the offender rate per 100,000 people was higher in youths (63.0) than in the general population (39.5).

It is important to note that increases in recorded crime do not automatically signal an increase in the actual occurrence of HSB. Increases in recorded crime data can stem from increased reporting (e.g. more people are opting to report to police) and changes in police recording practices (e.g. greater awareness about HSB, greater consistency in how behaviours are categorised, and consistency in actually recording reports).[15]

In research conducted for the RCIRCSA, Bromfield et al. (2017) analysed a range of administrative data recording allegations of child sexual abuse in institutional settings between 2008–13. They found that

> where the perpetrator was recorded, a substantial proportion were themselves children or young people (ranging from 32% in the Australian Capital Territory to 93% in Queensland). Adult perpetrators accounted for less than a third of allegations in six states and territories, and represented the minority in six of the seven jurisdictions where this data was available. (Bromfield et al., 2017, p. 15)

This analysis also found that "the majority of recent allegations of sexual abuse reported to police occurred between children/ young people" (p. 208).

Community-based studies tend to find higher proportions again of young people as the perpetrator in allegations of child sexual abuse. Studies conducted in the United Kingdom and Europe have estimated that adolescents account for between 30–50 percent of all perpetrators of childhood sexual abuse

(Masson & Erooga, 2006; Jaffé, 2010; McCartan et al., 2011; Vizard, 2006). Further studies and the continuing collection of national data are required in order to gain a more accurate representation of the extent of the problem in Australia.

Factors contributing to under-reporting

Lack of understanding about and stigma surrounding harmful sexual behaviours

A general lack of understanding about young people with HSB has led to inappropriate responses, and continues to contribute to the largely hidden and under-reported nature of HSB. Beliefs that such behaviour is the result of "normal experimentation" or "developmental curiosity" remain evident in society's responses to HSB in young people (O'Brien, 2008). Hackett (2010) notes that misunderstandings regarding HSB have the propensity to increase the likelihood of either under- or over-reaction in response to young people's sexual behaviours. Parents may be able to identify that their child is exhibiting (or is a victim of) HSB, but may not be aware of what can be done about it (Grant et al., 2009). Further, it is commonplace for parents to experience feelings of denial and shame in response to their children's HSB, leading to minimisation of the harmful behaviours (National Institute for Health and Care Excellence [NICE], 2016; Smith et al., 2013).

Stigma and pathologisation is also likely to act as a barrier to the disclosure or identification of HSB. As noted earlier, it was generally understood that such behaviours only existed in young people coming from extreme circumstances (Chaffin, 2008; O'Brien, 2008; Pourliakas et al., 2016) and that HSB were the result of a "compulsive and incurable" behaviour pattern (Chaffin, 2008; Jaffé, 2010; Lane, 1997; Rasmussen, 2013). These beliefs have led to an "impoverished conceptualisation" (Grant et al., 2009, p. 63) of young people with HSB, which has contributed to both the hidden nature and minimisation of HSB. Longo and Prescott (2006) commented that imposing adult models on young people tends to "keep youth in treatment longer than necessary and … youth are often considered untreatable and as predators" (p. 46). This could explain why professionals, parents and guardians are often reluctant to report cases to authorities. Grant and colleagues (2009) noted that media sensationalism of this issue also reduces the likelihood of young people seeking

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15 See the following for information about crime measurement in Australia: Crime Statistics Agency (2020); ABS' declaration of the quality of recorded crime data (ABS, 2019b); and an ABS information paper on measuring crime victimisation (ABS, 2002).

treatment, due to fears of being "labelled as sex offenders at a time in their lives when they are most vulnerable" (p. 64). Sensationalism can also result in HSB being dismissed as "normal sexual exploration" due to preconceived notions that HSB only occur in extremely hostile environments (Chaffin, 2008; Grant et al., 2009; Krienert & Walsh, 2011; Stathopoulos, 2012).

Complex responses to harmful sexual behaviours

Research consistently shows that disclosure of HSB is a complex process and is influenced by a range of factors (Allnock & Miller, 2013; Esposito, 2013; Malloy, Brubacher, & Lamb, 2013; Schaeffer, Leventhal, & Asnes, 2011). In a synthesis of studies on disclosure, Esposito (2013) outlined three main reasons a victim may not disclose their abuse: fear of consequences (for themselves or family), feeling responsible for abuse, and/or fear of not being believed (Crisma, Bascelli, Paci, & Romito, 2004; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Hershkowitz, Lanes, & Lamb, 2007; Schaeffer et al., 2011). There are also a number of individual and contextual factors that can interact to either promote or inhibit disclosure of abuse, for example:

- Age of victim: younger children are less likely to disclose than older children (Esposito, 2013; Schönbucher, Maier, Mohler-Kuo, Schnyder, & Landolt, 2012).

- Gender of victim: boys are less likely to disclose and more likely to delay disclosure than girls (Tang, Freyd, & Wang, 2008).

- Severity and duration of abuse: severe/ongoing abuse can promote or inhibit disclosure under different circumstances (Esposito, 2013).[16]

- Cultural issues: "taboos and modesty, virginity, women's status, honour, respect and patriarchy may silence disclosure" (Fontes & Plummer, 2010 as cited in Esposito, 2013, p. 23), for example.

- Family and environmental dynamics:[17] patriarchal

gender roles in families, the presence/history of family violence, closed or indirect family communication, and social isolation can all inhibit disclosure (Alaggia & Kirshenbaum, 2005; Esposito, 2013).

- Sibling sexual abuse: victims of sibling sexual abuse are often reluctant to disclose abuse (reasons for this are discussed below).

Intrafamilial and sibling sexual abuse

Sibling sexual abuse (SSA) has been identified as the most common form of intrafamilial sexual abuse (Boyd & Bromfield, 2006; Grant et al., 2009; Krienert & Walsh, 2011; Rowntree, 2007; Stathopoulos, 2012; Welfare, 2010). Many children who have been victims of SSA are reluctant to report or disclose their abuse at the time it occurs (O'Brien, 2010; Stathopoulos, 2012; Welfare, 2010). The barriers to disclosure are similar to those identified for victims of HSB and include fears of upsetting parents or not being believed (Ballantine, 2012; O'Brien, 2010; Rowntree, 2007; Stathopoulos, 2012). Recent commentaries of SSA postulate that when a victimised sibling does disclose the abuse, their families may be reluctant to report the abuse due to shame associated with the abuse, minimisation of the behaviour, disbelief or victim blaming (Rowntree, 2007; Stathopoulos, 2012; Thornton et al., 2008). SSA may also be concealed due to past or existing abusive relationships within the family, either experienced or witnessed, that can affect how parents and/or guardians respond to the abuse (Grant et al., 2009; Stathopoulos, 2012). It is also believed that parents' dual role in supporting both the offender and victim of SSA can lead to divided loyalties, making parents reluctant to formally report abuse (Daly & Wade, 2014; Grant et al., 2009).

Panagakis' (2011) critical literature review emphasised the need for empirical research studies in this area, as the current literature is predominantly comprised of commentaries. Two exploratory studies of SSA have made valuable contributions to the literature (Carlson, Maciol, & Schneider, 2006; Welfare, 2010). Welfare's (2010) study involved interviews with 17 sisters who had been abused by their brothers, and found that the victim would often minimise or not reveal the true extent of their traumatic experiences to other family members. In

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16   As noted in Esposito (2013, p. 25), there is "no consistent evidence of the relationship between severity of abuse and disclosure. Several studies find increased likelihood of disclosure with greater severity of abuse […] other studies find that the severity of abuse was associated with delays in or non-disclosure (Hershkowitz et al., 2005; Ullman, 1996; Hanson, Resnick, Saunders, Kilpatrick, & Best, 1999)".

17   Alaggia and Kirshenbaum's (2005) qualitative study involving a long interview method with 20 male and female survivors of child sexual

abuse found that disclosure of abuse can be significantly compromised where patriarchal family structures are present.

particular, sisters who had secure and connected relationships to their parent(s) were less likely to disclose abuse, in order to emotionally protect their parent(s). Family knowledge and understanding of the extent of the abuse contributed to family patterns around management following disclosure (Welfare, 2010). Carlson and colleagues' (2006) study involved semi-structured interviews with 41 victims/survivors of SSA, and found that only 19.5 percent of victims disclosed their abuse at the time it occurred. Victims also reported experiencing confused loyalty towards their sibling; feelings of guilt or responsibility for some aspect of the abuse; and fears of not being believed, retaliation or breaking up the family.

Accessibility of services

Lack of accessibility to therapeutic services is a key issue contributing to the unreported nature of HSB (Barbour, 2012; Gatehouse Centre, 2015; O'Brien, 2010; Shlonsky et al., 2017). Complex program eligibility requirements such as contact with the criminal justice system and being within a specified age range have excluded a significant number of young people from receiving treatment (O'Brien, 2010; RCIRCSA, 2017c). In a submission from the Victorian CASA Forum (2015, pp. 10–11) to the RCIRCSA, the following barriers to therapeutic service access for young people were identified:

- no counselling offered in the person's first language
- no provision of face-to-face interpreting service
- potential clients living in rural/remote areas with inadequate means of transport
- perceived or actual associations with institutions in which abuse occurred (e.g. church-related or government departments)
- perceived or actual "women only" services (or heterosexual, Anglo or English-speaking, or able-bodied services)
- conversely, services that do not actively attend to safety and risk management for women
- barriers to physical access (e.g. wheelchair access or discrete entry).

The lack of accessibility can be attributed, in part, to the scarcity of therapeutic programs for young people and their families. This cluster of challenges compromises the

effectiveness and scope of specialised therapeutic programs (Sexual Assault Support Service [SASS], 2014).

Characteristics of and correlating risk factors for young people engaging in harmful sexual behaviours

Young people who engage in HSB are a heterogeneous group (Andrade et al., 2006; Elkovitch et al., 2009; Grant et al., 2009; Hackett, 2010; Jaffé, 2010; Withington et al., 2013). There is no universal set of characteristics or profile of the young person who engages in HSB. However, the literature does provide insight into factors in young people's backgrounds—shared across both community-based and criminal justice populations—that tend to be associated with HSB. As we describe below, key characteristics associated with engagement in HSB are:

- Gender: the vast majority of young people receiving treatment for HSB are male.
- Histories of trauma: regardless of the type of population (e.g. community, statutory, criminal justice or correctional), histories of abuse and neglect are common.
- Learning, cognitive and intellectual disabilities: while the proportion of young people with such disability is low in the general population, they are over-represented in community and criminal justice populations of young people engaging in HSB.

Other relevant factors include family conflict and dysfunction, parental alcohol and substance misuse, and placement and care instability. These factors or characteristics should not be regarded as causal. Indeed, as Pratt and colleagues (2012) observe, "despite there being numerous studies and books investigating why young people undertake [HSB] … no causal factors have been identified" (p. 12). Rather, the documented characteristics should be regarded as part of the overall circumstances in which HSB occur.

Gender

The literature reviewed indicates that the majority of young people engaging in HSB are male. Vizard, Hickey, French,

and McCrory (2007) reviewed 280 case files of young people referred to a national treatment service in the United Kingdom, 91.5 percent of whom were male. Hackett and colleagues (2013) found that in the United Kingdom, 97 percent of cases across nine services were male. This proportion of male to female clients engaging in HSB demonstrates the overrepresentation of male cases (e.g. Ryan, 1999). There is likely to be some degree of under-reporting of young women engaging in HSB and also a lack of specialist treatment that might underestimate the proportions of females somewhat (Hackett et al., 2013), however the highly gendered nature of HSB is well established.

Exposure to trauma

Regardless of whether studies are based on young people in voluntary community-based services, statutory child protection services, or juvenile justice/correctional services, significant proportions of these young people have their own experiences of victimisation and trauma (Dillard & Beaujolais, 2019).[18] These experiences often include sexual, physical and emotional abuse; exposure to domestic violence; and family breakdown, conflict or dysfunction (Mallie, Viljoen, Mordell, Spice, & Roesch, 2011).

Childhood abuse

In their study, Hackett and colleagues (2013) found that in 66 percent of the case files that recorded trauma histories (n=627), the young person had experienced at least one form of abuse or trauma. Child sexual abuse was recorded in 50 percent of case files; 31 percent of the young men had experienced child sexual abuse, while in another 19 percent strong professional suspicions of sexual abuse were recorded.

Recent research undertaken in Queensland (McKillop, Rayment-McHugh, Smallbone, & Bromham, 2018) found that almost three quarters of the adolescent sample (n=215) had a history of child maltreatment:

- 33.3 percent had experienced non-sexual abuse

- 7.5 percent had experienced sexual abuse
- 31.3 percent had experienced both sexual and non-sexual abuse.

Research conducted in New Zealand that reviewed the case files (n=702) of children and young people who had received treatment for SABs (Fortune, 2007) found that:

- 38 percent had experienced child sexual abuse, over half of whom (57%) were between the ages of 1 and 9 when first abused
- 38.7 percent had experienced physical abuse, with over half these young people having been victims for more than 5 years
- 12.4 percent had experienced neglect, 10.3 percent had experienced emotional/verbal abuse and 16 percent had experienced both neglect and emotional/verbal abuse.

In short, young people who engage in HSB often have hostile and traumatic childhood experiences (Allan, 2006; Creeden, 2013; Elkovitch et al., 2009; Grimshaw, Downes, & Smith, 2008; Hutton & Whyte, 2006; O'Brien, 2011; Seto & Lalumière, 2010; Withington et al., 2013).

A history of child sexual abuse appears to be particularly correlated with engaging in HSB. A meta-analysis of 59 studies comparing criminal justice populations of adolescent male sex offenders with non-sexual offenders on a range of characteristics found that a history of sexual abuse was more frequent among adolescent sexual offenders compared to non-sexual offenders (Seto & Lalumière, 2010). Taking the average of studies that reported proportions, the researchers found that 46 percent of adolescent sexual offenders had a history of child sexual abuse compared to 16 percent of non-sexual offenders. A history of physical abuse was also more common among adolescent sexual offenders, however the difference between sexual and non-sexual offenders was not as stark. Adolescent sexual offenders were 5.54 times more likely to have experienced sexual abuse than non-sexual offenders, compared to 1.6 times more likely to have a physical abuse history (Seto & Lalumière, 2010).

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18 This article reviewed 13 relevant studies published between 2002–17 which examined the extent of trauma histories of community, criminal justice and adjudicated populations of young people who engage in sexually abusive behaviour. It included many of the same studies reviewed for the Good Practice project.

Exposure to family and domestic violence

Exposure to family violence refers to witnessing inter-parental violence through direct observation, overhearing or observations of the aftermath (Holt, Buckley, & Whelan, 2008). Previous literature suggests that family dysfunction and domestic and family violence (DFV) have strong correlations with the development of HSB by young people (Boyd & Bromfield, 2006; Withington et al., 2013). The New Zealand study found exposure to family violence noted on 38 percent of case files (Fortune, 2013). In Australia, Withington and colleagues (2013) investigated the individual, family and environmental characteristics of a cohort of young people who were referred to a child and youth forensic mental health service in Queensland because they had exhibited HSB. This study found that 79.3 percent of participants were victims of family violence, 89.7 percent were subjected to familial emotional abuse, and 72.4 percent had witnessed intra-familial violence. In Seto and Lalumière's (2010) meta-analysis, eight studies contained information about adolescents' exposure to DFV. Six of these studies indicated that adolescent sexual offenders had higher rates of exposure to spousal, family, or domestic violence, however the differences in rates between sexual and non-sexual offenders were not statistically significant.

Instability

The majority of those who witnessed or experienced DFV (both violent physical and sexual assaults) and sexual abuse within the home went on to be removed from the family home and placed into out-of-home care (Shlonsky et al., 2017). Elkovitch et al.'s (2009) research found that frequent exposure to volatile environments and constant disruptions in placement can place a young person at higher risk of internalising and externalising behaviours (Elkovitch et al., 2009).

The severity[19] of violence can have a significant influence on how traumatic the experience is for a young individual (Holt et al., 2008). The growing body of research raises great

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19 In the fields of what could broadly be called "relational violence" (e.g. child abuse, DFV or sexual violence), "severity" is difficult to define simply. It can refer to the duration of the violence, its frequency, its physical severity, the nature of the relationship between victim and perpetrator (such as the perpetrator as a guardian/caregiver), and the co-occurrence of multiple forms of violence. Our use of it here should be read as encompassing these different dimensions.

concerns in regards to the detrimental effects of witnessing family violence on a young person's cognitive, emotional and psychological developmental trajectory (O'Brien, 2008; Shlonsky et al., 2017).

Other factors related to harmful sexual behaviours

Learning, cognitive and intellectual disabilities

Young people who have deficits in cognitive ability may display a difficulty in learning or have poor educational attainment. This is often referred to as a "cognitive impairment" or an "intellectual disability" (Grimshaw et al., 2008). Previous research has found that individuals with intellectual disabilities who have experienced sexual abuse are more likely to engage in HSB as they grow older (Martinello, 2015). This may be because the young person is unable to process and understand the behaviours that surround them, and compensates for the deficit in coping skills through HSB as a coping mechanism (Martinello, 2015; Pratt et al., 2012). Hence, "individuals with intellectual and developmental disabilities commit sexually inappropriate acts because they are making crude or imitative attempts at what they perceive as normal sexual interests" (Walters et al., 2013, p. 74). Without the ability to effectively distinguish between appropriate and inappropriate behaviours, those with intellectual disabilities often internalise actions and mimic and model behaviours as a learning mechanism (Elkovitch et al., 2009; Martinello, 2015; Walters et al., 2013). Subsequently, many incidents of HSB involving a young person with an intellectual disability have been found to be of a non-contact nature, such as exhibitionism (Lindsay, Steptoe, & Haut, 2012). These behaviours can be largely attributed to a deficit in social skills, where there is limited understanding of what constitutes private behaviour, and a lack of understanding as to the wants and needs of others (Martinello, 2015).

Furthermore, those with intellectual disabilities may display low levels of social competence and present difficulties in establishing strong, age-appropriate peer relationships (Fortune, 2013). Difficulty in maintaining appropriate friendships and relationships can put young people with an intellectual disability at higher risk of developing HSB, as

this may often result in the individual becoming isolated. Thus, this can account for why young people with HSB seek comfort by befriending younger age groups and select inappropriate partners who are in this respect considered to be victims (Fortune, 2013; Martinello, 2015). Although young people with intellectual disabilities may exhibit more visible HSB when compared to other young people who sexually abuse (Hackett, Phillips, Masson, & Balfe, 2013), this does not mean that those with learning disabilities are more likely to engage in HSB than non-learning-disabled young people (Grimshaw et al., 2008).

Exposure to pornography

It is only relatively recently that the relationship between young people and exposure to sexualised or violent material has become a focus area in HSB research (Pratt & Fernandes, 2015). At present, there is limited understanding and a lack of research on the association between the engagement with pornographic materials and the development of HSB in young people. However, previous work carried out by Burton, Leibowitz, and Howard (2010) posited that viewing pornographic material does not necessarily lead to engagement with HSB. Rather, it was found that young people who engaged in HSB or who were deemed "at risk" often reported having more exposure to pornography, compared to those who do not engage in HSB.

Previous work recognises that young people often hold complex and multifaceted beliefs about sexual behaviours. As a consequence, frequent exposure to pornographic material can have negative influences on the individual's beliefs and expectations about certain gender stereotypes (e.g. rigid stereotypes about the roles and capabilities of men and women, beliefs in male sexual entitlement, beliefs about the nature of sex between men and women), and may further contribute to the development of sexual aggression in young people (Elkovitch et al., 2009; Quadara, El-Murr, & Latham, 2017). Research findings indicate that frequent exposure to pornography is largely associated with coercive behaviours among young people (Horvath, 2013). A longitudinal study conducted in the United States by Brown and L'Engle (2009) found that young people who were often exposed to pornography in early adolescence were more likely to engage in sexually aggressive behaviours by middle adolescence.

Similarly, Ybarra, Mitchell, Hamburger, Diener-West, and Leaf (2011) established that young people who viewed violent, sexually explicit material were more likely to display sexually aggressive behaviours compared to those who were not exposed to such materials.

As such, early exposure to pornographic material among young people can exacerbate violent behaviours that are deemed not socially normal (Flood, 2009). The majority of cross-sectional and correlational studies have established that young people who view pornographic materials are more likely to have:

- unrealistic attitudes towards sex and more sexually permissive attitudes towards the concept of sex
- beliefs about relationship norms that are unclear
- sexual activity from an early age
- riskier sexual behaviours (such as unprotected intercourse, including anal and oral sex)
- greater acceptance of casual sex
- attitudes that objectify women as sex entities
- more frequent thoughts about sex
- attitudes of sexual uncertainty—the ambiguity of one's sexual values and beliefs
- non-equal gender role attitudes—male dominance and female submission (Horvath, 2013; Kraus & Russell, 2008; Mitchell, Patrick, Heywood, Blackman, & Pitts, 2014; Skau, 2007).

Broader family context

Furthermore, the majority of those who witnessed or experienced DFV (both violent physical and sexual assaults) and sexual abuse within the home went on to be removed from the family home and placed into out-of-home care (Shlonsky et al., 2017). Elkovitch and colleagues' (2009) research found that frequent exposure to volatile environments and constant disruptions in placement can place a young person at higher risk of internalising and externalising behaviours (Elkovitch et al., 2009).

Situational and community-level factors

Compared to research on the individual characteristics of young people who engage in HSB, there is relatively little research examining situational and community factors that may be relevant to understanding the occurrence of HSB.

Situational and institutional contexts

In their research on the onset of adolescent and adult sexual offending, McKillop and colleagues (2018) analysed information about the situation in which the behaviours had occurred. In relation to the adolescent sample, they found that HSB most often occurred against another child known to the young person (43.5% familial, 51.4% non-familial) and in a domestic setting (79.4%). The HSB predominantly occurred while playing a game (29%) or not doing any particular activity (31.4%). Of note, another person was present in 82.1 percent of circumstances (compared to 59% in the adult sample). This was most commonly an adult (76.9%), and was attributed to the higher likelihood of young people being in the presence of adult supervision.

This research concluded that "offending is differentially influenced by situational factors within the routine activities and social ecologies" that comprise the two developmental stages of adolescents compared to adults, with adolescents tending to abuse non-familial children, and adults familial children (McKillop et al., 2018, p. 37). As the researchers noted:

> In adolescence, independence from family is a dominant factor. More time is spent engaging with peers, in and outside the home environment, and supervision may be relaxed somewhat. (McKillop et al., 2018, p. 38)

The RCIRCSA provides detailed insight into the broader institutional factors that contribute to young people engaging in HSB, such as:

- physical and emotional abuse and neglect occurring within institutions
- bullying and initiation rituals
- hierarchical structures where children hold power over other children

- lack of supervision of children
- lack of understanding of children's sexual development and of HSB
- inadequate provision of sex education to support healthy behaviours. (RCIRCSA, 2017c, p. 11)

Research commissioned by the RCIRCSA to inform its inquiry suggested that "institutions where children live full-time—especially the large, residential care facilities that used to exist in Australia—were particularly risky environments for children" (RCIRCSA, 2017c, p. 43).

Community-level factors

There is very little examination of factors within community and social environments that might be relevant to the occurrence of HSB. In part, this may be related to the concept of risk factors itself, and how they are identified and tested through empirical research. This research is often of a quantitative and experimental nature, and aims to isolate factors that increase the likelihood of something occurring from factors that do not. The effects of features at the community and collective levels are difficult to demonstrate through such methods.

Moreover, it is problematic to isolate community-level features as somehow causal or predictive; this risks "exceptionalising" or "othering" particular social segments as more prone to social problems. At the same time, we do live in nested structures, and, from a public health prevention approach, it is essential to understand how features of where people work, live and raise families differentially affect a range of outcomes. As O'Brien (2011) notes:

> Experiences of childhood trauma, compromised educational outcomes, adverse socio-economic conditions, homelessness or an unstable home-life, intellectual impairment and exposure to caregiver drug or alcohol misuse are just some of the conditions of disadvantage that characterise the lives of children who come to attention for problem sexual behaviours. (p. 699)

That is, the contexts of risk for children and young people engaging in HSB align "with particular indicators of social

exclusion: geographic disadvantage, compromised family functioning and poverty" (O'Brien, 2011, p. 697).

The RCIRCSA heard via submissions that children and young people from particular communities such as Aboriginal and Torres Strait Islander children, children with disability and children from CALD backgrounds were "more likely to encounter circumstances that increased their risk of abuse in institutions [and] reduced their ability to disclose or report abuse" (RCIRCSA, 2017c, p. 3). Reasons for this related to experiences of prior trauma and intergenerational trauma.

Protective factors

Protective factors are characteristics that can act as a buffer against the development of problem behaviour when a person has been exposed to particular stressors (Rennie & Dolan, 2010). It is difficult to ascertain what protective factors are particularly relevant in relation to the occurrence of HSB. There is comparatively less research on protective factors than there is on risk factors, and very little work on validating the protective factors; thus, much less activity has occurred in terms of integrating protective factors into risk assessment instruments and practices (Hall, Simon, Lee, & Mercy, 2012; Rennie & Dolan, 2010). Further, the limited empirical and clinical research on protective factors is generally based on young people who have engaged in HSB (and predominantly on adjudicated young people offenders). Thus the research interest is on what protective factors buffer against reoffending, not against the behaviour occurring in the first instance. Finally, this research has been criticised on the basis of "definitional inconsistency" (Spice, Vilojen, Latzman, Scalora, & Ullman, 2013, p. 6) in terms of whether protective factors are mirror images of risk factors (e.g. the *absence* of an identified risk factor) or separate concepts altogether (Lussier, McCuish, Mathesius, Corrado, & Nadeau, 2018).

The available research suggests that secure, enduring attachments to family and prosocial networks can mitigate against further engaging in HSB, in particular:

- attachments to family (Carpentier, Leclerc, & Proulx, 2011; Spice et al., 2013)

- attachments to school (Carpentier et al., 2011; Prentky & Righthand, 2003; Spice et al., 2013)
- stability in current living situation (Prentky & Righthand, 2003)
- positive support networks (Prentky & Righthand, 2003).

Certain characteristics within the family environment can have a buffering effect against the development of HSB (Elkovitch et al., 2009; Holt et al., 2008).

There is consensus among international and Australian scholars that parental engagement and strong relationships between parents and children are key factors that aid in the developmental foundations for prosocial functioning in young individuals (Creeden, 2013; Holt et al., 2008; O'Brien, 2008). Secure relationships across all domains (at the individual, family, school, peers and community levels) foster honest and respectful attitudes and care and concern for others (de Vries Robbé, Mann, Maruna, & Thornton, 2015). Where there are strong relationships and attachment bonds between the young person and those around them, individuals are more likely to seek out advice and guidance about the world, their relationships and sexual development from their parents or caregivers first (O'Brien, 2008). These studies indicate the importance of strong familial relationships in prosocial adolescent sexual development.

Summary of factors associated with HSB

There is no single factor that can be said to cause a young person to engage in HSB. Rather, there are multiple factors across the individual, interpersonal/familial, peer group, settings/institutions (e.g. school settings) and community domains that increase the risk of HSB developing. Having said this, it is important to note that risk factors are not determinative. That is, not all young people experiencing the risk factors will go on to engage in HSB. Both risk and protective factors are indicators, not causes for the development of HSB (Rich, 2009).

Figure 5 provides a diagrammatic representation of these factors across the social ecology.

Figure 5: Factors associated with HSB across socio-ecological domains

Growing understanding of complex factors associated with harmful sexual behaviours

- Developmental delays
- Intellectual disabilities
- Deficits in self-regularity and inhibitory control
- Mental health and medical diagnosis

- Family dysfunction
- Family abandonment
- Highly sexualised home environment
- Parental/care giver mental health, alcohol/drug issues
- Controlling behaviours by caregivers
- Pervasive neglect
- Social isolation
- Exposure to abuse and violence, including domestic and family violence

- Poor peer relationships

- Poor attitude towards school
- Low performance in school
- Limited educational opportunities

- Sexualised environments
- Early exposure to sexualised content
- Socio-economic disadvantage

INDIVIDUAL   FAMILIAL   PEER GROUP   SETTINGS   COMMUNITY LEVEL

Sources: Creeden (2013); Elkovitch et al. (2009); Horvath (2013); Quadara, El-Murr, & Latham (2017); Rennie & Dolan (2010); Rich (2009)

Therapeutic responses to young people engaging in harmful sexual behaviours

Understandings about young people who engage in HSB have become more sophisticated and multi-factored. The research makes very clear that young people who engage in HSB need to be distinguished from adult sex offenders. There are fundamental differences in the age of onset, the types of behaviours engaged in, the circumstances in which the behaviours occur and the duration of behaviours (Hall et al., 2012; Jaffé, 2010; McKillop et al., 2018; Seto & Lalumière, 2010; Vizard et al., 2007; Worling, 2012). In short, adolescents are an etiologically different group to adult sex offenders. The strategy of adapting standard adult approaches to young

people engaging in HSB is now seen as a clear error in early efforts to work with this cohort (Miner & Newstrom, 2018).

In this section of the chapter, we outline the nature of the overall shift in therapeutic responses, and what the literature suggests about effectiveness.

Developments in therapeutic responses

In the last decade and a half, treatment approaches have generally transitioned away from using individual behavioural modification models to more holistic, ecological frameworks that encompass the complex lived environments in which HSB occur (Miner & Newstrom, 2018; Pratt, 2014; Shlonsky et al., 2017).

Two key developments in the broader research fields helped to drive this shift. The first was the recognition of the fundamental developmental differences between adolescents and adults in terms of cognitive processing, decision-making, impulsivity, self-regulation and risk-taking, with young people in a highly formative stage on these dimensions (Steinberg, 2009). As Rich (2015, p. 1) notes, "The emotions, attitudes and ideas, cognitive capacities and behaviors of adolescents at every level, are driven and motivated by very different experiences, forces and factors than those of adults." (p. 1) The second development was the significant evidence base that had amassed since the 1990s on the negative impacts of trauma, disrupted care relationships, and other vulnerabilities on precisely these domains of child and adolescent development.[20]

Interventions with young people engaging in HSB have thus increasingly integrated:

- their neuro-psychosocial developmental capacities
- the experiences of trauma and their impacts on these young people
- their lived social ecology (e.g. their familial, kinship and care contexts; peer relationships; school attachments; organisational affiliations; community contexts)
- the influence and role of these social ecologies in therapeutic responses (Creeden, 2013; Hackett et al., 2016; Hall et al., 2012, 2013; Pratt & Fernandes, 2015; Ward & Beech, 2006; Worling, 2012; Worling & Langton, 2016).

On this shift, Rich (2015, p. 2) observes:

Perhaps more than ever, we recognize not just the problem of sexually abusive behavior, but also the nature of the sexually abusive youth as a person-in-development, a moving target very much influenced by his or her social environment, and not just thoughts and behaviors that are somehow intrinsically embedded inside of the young person.

Honouring this notion of the adolescent as a "person-in-development" requires a change of focus in the therapeutic relationship between young people and clinicians, risk

assessment, and the goals of treatment (Rich, 2015; Worling & Langton, 2016):

Treatment programs have historically focused on therapeutic procedures (e.g. assessment checklists or relapse-prevention strategies) that are "applied *to* clients—at the expense of therapeutic process [that] works *with* clients". (Marshall et al., 2003 as cited in Worling & Langton, 2016, p. 1247, emphasis in original)

Risk assessment needs to take into account the developmental aspects of adolescence, and in this light, risk assessment tools and processes need to be dynamic, factor in young people's social contexts, and be understood as one aspect of case-planning management (Rich, 2015). The heterogeneity of the experiences, contexts and needs of young people engaging in HSB means that treatment goals need to include not only accountability for the behaviour and prevention plans, but also enabling recovery from traumatic distress, enhancing healthy sexual attitudes, and strengthening young people's ability to form healthy social attachments (Worling & Langton, 2016).

A developmental, ecological and trauma-informed approach to working with young people engaging in HSB has increasingly formed the basis of therapeutic practice. In the United Kingdom, this is demonstrated in the *Operational Framework for Children and Young People Displaying Harmful Sexual Behaviours* (Hackett et al., 2016; see also NICE, 2016). Nationally, there are numerous guidance documents that outline what principles should underpin therapeutic interventions.[21] In addition, the RCIRCSA drew on its

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20 See Wall and Quadara (2014) for a review of this literature.

21 New South Wales: *New Street Policies and Procedures* (NSW Health, 2018a); *Working with Children who Display Harmful Sexual Behaviours* (for child protection workers) (New South Wales. Department of Families and Communities, 2016). South Australia: *Responding to Problem Sexual Behaviour In Children and Young People: Guidelines For Staff in Education And Care Settings* (South Australia. Department for Education and Child Development, Catholic Education South Australia, Association of Independent Schools of South Australia, 2013). Tasmania: *Tasmanian Standards of Practice for Problem Sexual Behaviour and Sexually Abusive Behaviour Intervention and Treatment Programs* (Sexual Assault Support Service, 2012). Victoria: *CEASE Standards Of Practice For Problem Sexual Behaviours And Sexually Abusive Behaviour Treatment Programs* (CEASE, 2016); *Adolescents with Sexually Abusive Behaviours and Their Families: Best Interests Case Practice Model–Specialist Practice Resource* (Pratt et al., 2012). Western Australia: *Information Sheet 10: Children's Sexual Behaviour Can be a Child Protection Issue* (Western Australia. Department of Health, n.d.); *Standards For The Delivery Of Child Sexual Abuse Therapeutic Services* (Western Australia. Department for Child Protection and Family Support, 2014).

commissioned research and submissions to identify the following best practice principles for therapeutic interventions (RSIRCSA, 2017c, p. 193):

- a contextual and systemic approach should be used
- family and caregivers should be involved
- safety should be established
- accountability and responsibility for the harmful sexual behaviours should be established
- behaviour change should be a focus
- developmentally and cognitively appropriate interventions should be used
- care provided should be trauma-informed
- therapeutic services and interventions should be culturally safe
- therapeutic interventions should be accessible to all children with harmful sexual behaviours.

On balance, the literature signals a definitive shift both in how young people engaging in HSB are understood, and in the foundational principles informing therapeutic practice. However, this shift is not consistently demonstrated across the evidence base. Indeed, there is something of a schism between grey, practice-informed literature and recent peer-reviewed academic studies in which researchers seem to suggest that the practice principles above are not yet evidenced in interventions (e.g. Kettrey & Lipsey, 2018; Miner & Newstrom, 2018; Worling & Langton, 2016; Yoder, 2014). The reason for this schism is unclear, but may be related to the publication delay in peer-reviewed research, the North American bias of published research which reflects that particular policy context, or a combination of the two.

Assessing risk

A number of comprehensive structured instruments have been designed to assess risk of further engagement in HSB by young people.[22] The majority of these instruments aim to measure the potential risk of reoffending and the probability of both static and dynamic risk factors (Powers-Sawyer & Miner, 2009). These measures are empirically based checklists devised to assist—not replace—clinical decision-making. The

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22 See Gotch & Hanson (2016) for a summary of the risk/need assessment tools used with young people who have engaged in HSB.

research and practice literature emphasise the importance of using risk assessment tools as one aspect of a comprehensive risk assessment process (NSW Health, 2018a; Rich, 2017). There is a significant and highly technical scholarship around risk assessment that is beyond the scope of this state of knowledge review. The following briefly describes those commonly in use in the Australian context.

The Juvenile Sex Offender Assessment Protocol-II

The Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) is a revised version of the pioneering risk assessment tool, consisting of an evaluator-completed checklist intended to gauge the likelihood of both sexual and non-sexual offending in young people aged 12–18 years (Prentky & Righthand, 2003). J-SOAP-II consists of four scales, organised into *static* and *dynamic* risk factors, as below:

- Static risk factors:
    - Scale 1: sexual drive/sexual preoccupation
    - Scale 2: impulsive, antisocial behaviour
- Dynamic risk factors:
    - Scale 3: clinical/treatment
    - Scale 4: community adjustment.

A total of 28 risk factors (12 static, 16 dynamic) make up the checklist, and were identified through a systematic review of professional literature regarding sexual and criminal offending (Prentky & Righthand, 2003). The creators of the J-SOAP-II tool caution evaluators that "decisions about reoffense risk should not be based exclusively on the results from J-SOAP-II" and that it "should be used as part of a comprehensive risk assessment" (Prentky & Righthand, 2003, p. 1). They also acknowledge that the tool will require ongoing validation and potential revision as knowledge about young people with HSB continues to expand (Prentky & Righthand, 2003, p. 1).

The J-SOAP-II's ability to assess the risk of young people exhibiting HSB has been examined extensively in the literature (Fanniff & Letourneau, 2012; Prentky et al., 2010; Viljoen, Mordell, & Beneteau, 2012). There are variations in the studies' findings on the instrument's predictive validity (i.e. its ability to accurately predict re-offending). For example, an evaluation of 667 male and 155 female young people found

a high predictive validity for the J-SOAP-II (Prentky et al., 2010). However, meta-evaluations have produced more varied results. For example, a review by Fanniff and Letourneau (2012) found "significant limitations" in all but one (impulsive/antisocial behaviour) scales of the J-SOAP-II (Fanniff & Letourneau, 2012, p. 400). In contrast, a meta-analysis of 15 studies that employed the J-SOAP or J-SOAP-II found that overall they were able to predict sexual re-offending (Viljoen et al., 2012). The overall conclusion of these and other meta-analyses (Hempel, Buck, Cima, & Van Marle, 2013), is that the instrument has some predictive validity, but that it should not be used as a substitute for clinical or practitioner decision-making.

Estimate of Risk of Adolescent Sexual Offence Recidivism

The Estimate of Risk of Adolescent Sexual Offence Recidivism, Version 2.0 (ERASOR) was developed by Worling and Curwen (2001). It is an empirically based checklist instrument specifically designed for clinicians to use during real-time clinical assessments (Worling, 2004). The ERASOR is a single-scale tool that aims to only predict adolescents' sexual reoffending, and comprises 25 risk factors (9 static and 16 dynamic) that are categorised into five sections: 1) sexual interests, attitudes, and behaviours; 2) historical sexual assaults; 3) psychosocial functioning; 4) family/environmental functioning; and 5) treatment. The majority of the items on the risk assessment tool aim to identify dynamic risk factors, thus measuring variables that are potentially amenable to deliberate interventions for both the young person and their families (Worling, 2004). In assessing the ERASOR's reliability and validity, a meta-analysis reviewing 11 studies using the ERASOR found that clinical judgement ratings were moderately predictive of future offending (Rasmussen, 2013). While Worling and Curwen (2001) have posited that the ERASOR can be used to assess female youths as well, to date no studies have been conducted to evaluate predictive validity for females (Rasmussen, 2013).

The Protective + Risk Observations for Eliminating Sexual Offense Recidivism

The Protective + Risk Observations for Eliminating Sexual Offense Recidivism (PROFESOR) was developed by Worling (2017) to address the lack of structured tools that assess both protective and risk factors. There are 20 protective factors corresponding to domains such as healthy and respectful attitudes/beliefs about sexual relationships and interests; prosocial values and attitudes; strong attachments to parents/caregivers; and commitment to and engagement with school.

Effectiveness of therapeutic interventions

While there is a considerable body of literature describing the shift in how to best work with young people engaging in HSB, there is comparatively little research evaluating the effectiveness of therapeutic interventions modelled on the principles outlined above. The evaluation studies themselves have tended to evaluate effectiveness primarily as a reduction in sexual reoffending and in general offending (Reitzel & Carbonell, 2006). However, the goals and objectives of therapeutic interventions for HSB are typically broader than this and include:

- establishing safety, for example:
  - connections with family or carers that are secure and safe
  - ensuring safety for others, including the harmed child
  - reducing the young person's risk of victimisation
  - recognising and addressing the impacts of trauma for the young person (within their developmental stage and ability)
- domains of wellbeing, for example:
  - developing healthy relationships with peers and others
  - educational engagement and process
  - identity development, including gendered elements of belief, experience, behaviour and identity
- acknowledgment and restitution, for example:
  - acknowledgment of the HSB and their impacts on self and others
  - appropriate restitution to the other child offered
  - demonstration of responsibility for decision to sexually harm and commitment to not do so in the future (slightly adapted from NSW Health, 2018a; see also Pratt et al., 2012; Worling & Langton, 2016).

In recent years multisystemic therapy (MST) has emerged as a potentially effective program for young people engaging

in HSB. However, there is a lack of clarity about what MST actually refers to and, connected to this, a lack of consensus about its suitability as a specific intervention. First, the issue of clarity: MST refers on the one hand to a specific, registered program (denoted by MSTÒ), developed in the United States by Henggeler and colleagues in the 1990s.[23] MSTÒ is an intensive family-focused and community-based treatment program for juveniles with serious criminal offences. It has been adapted to work with a range of antisocial behaviours, child abuse and neglect, and HSB (Borduin, Schaeffer, & Heiblum, 2009; Tan & Fajardo, 2017).

MST® focuses on addressing the underlying, contextual and/or related factors associated with HSBs, and that "family, neighbourhood, and community environment supports and maintains behavioural change" (Shlonsky et al., 2017, p. 10). The elements of MST® include an individualised approach taken to the young person, the involvement of parent/caregiver, and a systems approach that enables the involvement of key institutions and organisations that have relationships with the family. As Shlonsky and colleagues (2017) write: "In essence MST represents a constellation of all the things that programs must do to be effective." (pp. 63–64)

Multisystemic therapy (without the registered trademark) is often used to refer to a general treatment/therapeutic approach signalling the aim of working with a young person across the multiple interpersonal and social systems in which they are located and ensuring that key stakeholders in those systems are part of treatment. In many cases, where "multisystemic therapy" is identified as a therapeutic approach (e.g. in program documentation or in recommendations for good practice), it is unlikely to be referring to the registered program but rather to a general approach of working across intersecting systems in the young person's life.

The second issue of MST's effectiveness for young people engaging in HSB is confounded by these differing meanings of MST. MST® is a heavily evaluated program, possibly aided by the fact that there are at least 250 licensed MST® teams in North America and Europe, treating some 10,000 young people (Littell, Campbell, Green, & Toews, 2005). Research

23 See Littell et al.'s (2005) review for the Cochrane Collaboration for background and a systematic review of studies relating to MST®.

suggests that MST® is promising when compared with individual counselling or treatment as usual (Shlonsky et al., 2017; see also Borduin & Schaeffer, 2001; Letourneau et al., 2009, 2013). However, most of the evaluation studies have been conducted by the developers of the program themselves and there are questions about the effect this may have had on findings (Fonagy et al., 2017). The systematic review for Cochrane Collaboration found that MST® is *not* consistently more effective than other alternatives for young people with social, emotional or behavioural problems (Littell et al., 2005). Further, the implementation of MST® requires significant levels of intensive training, high levels of fidelity to the model and weekly monitoring by an MST® expert (Tan & Fajardo, 2017), raising the issue of cost effectiveness.

In terms of modification and application of MST® to HSB, recent research and practice expertise is also equivocal (Fonagy et al., 2017; personal communication, Pratt, 2019). Fonagy and colleagues' (2017) feasibility evaluation identified limitations in the MST® model including:

- the degree to which the stringent fidelity to the model required was a good fit given the heterogeneity of young people engaging in HSB
- whether young people and families/carers where trauma was part of the clinical picture would be adequately served within the general 5–7 months' time frame
- the extent to which therapists had the requisite skills for working with trauma. (p. 7)

In short, while there is some evidence that MST® is effective in reducing negative social outcomes such as sexual aggression (RCIRCSA, 2017c, p. 176), the applicability of this evidence to the Australian context is unclear. As Fonagy and colleagues (2017, p. 10) concluded:

> The pattern of results found in transportability RCT [randomised control trial] evaluations of standard MST in Canada and Europe suggest that the effectiveness of MST-PSB [problem sexual behaviours] needs to be demonstrated outside the USA … in studies where the therapists delivering MST are independent of those who were involved in the development of MST-PSB (as involvement in the development may have an effect on therapist motivation); [and] where the comparison services

or management as usual (MAU) are consistent with the options currently available for young people showing problem sexual behaviour in that region.

Another common therapeutic intervention used with young people engaging in HSB is cognitive behaviour therapy (CBT). However, this method of intervention has been criticised for failing to address the multiple determinants of juvenile sexual offending (Letourneau & Borduin, 2008). CBT aims to modify individual thought processes, and includes major components such as "cognitive restructuring, victim empathy, decreasing deviant sexual arousal, social skills training and relapse prevention" (Grant et al., 2009, p. 17). Despite the broader empirical evidence demonstrating the effectiveness of CBT (Carpentier, Silovsky, & Chaffin, 2006; NICE, 2016), various studies posit that CBT is not the most appropriate method of treatment (Grant et al., 2009; Letourneau & Borduin, 2008).

Other treatment approaches include the Good Lives Model (Collie, Ward, Ayland & West, 2007; Fortune, 2018); Mode Deactivation Therapy (MDT) (Apsche et al., 2005); and Functional Family Therapy (Lambie & Seymour, 2006). A rapid evidence assessment reviewed the available evaluation studies for these programs, but found that few were rigorous enough to be included in the review (Shlonsky et al., 2017). The one Australian evaluation included was for New Street Services (Laing, Tolliday, Kelk, & Law, 2014). This evaluation found that young people who had completed treatment showed statistically significant changes in relation to recidivism measures compared to those who did not complete.

Tailoring therapeutic interventions for different populations

Aboriginal and Torres Strait Islander young people

At present, there is limited research that identifies intervention programs currently being run for Aboriginal and Torres Strait Islander young people who engage in HSB. Combining "contemporary and traditional healing approaches (e.g. smudging, sacred circle and sweat lodge ceremonies)" can support treatment completion and reduce recidivism (Rojas & Gretton, 2007, p. 278; see also Funston, 2013; Hovane, 2012).

An evaluation of New Zealand's community treatment programs for young people engaging in HSB by Ian Lambie and colleagues (2007) established that the integration of Māori health models, such as the Te Whare Tapa Whā,[24] showed positive outcomes for Māori clients. Results indicated that the overall sexual reoffending rate was 2 percent for Māori young people who had successfully completed treatment programs that combined culturally appropriate treatment components for Māori clients (Lambie et al., 2007). However, no empirical evidence currently exists to confirm whether culturally specific frameworks increase the effectiveness of HSB treatment interventions for Aboriginal and Torres Strait Islander youth, although tailored approaches may be effective (Allard, Rayment-McHugh, Adams, Smallbone, & MacKillop, 2016).

A recent study conducted by Allard et al. (2016) at GYFS employed individualised multi-systemic therapy to treat 104 adjudicated youths from both Aboriginal and Torres Strait Islander and non-Indigenous backgrounds. Results showed success in reducing sexual recidivism rates for Aboriginal and Torres Strait Islander young people with HSB; however, analysis found that clinicians were required to spend more time consulting with community members and other professionals when treating Aboriginal and Torres Strait Islander participants (Allard et al., 2016). The outcomes of Allard and colleagues' (2016) study contradict previous work completed by Allan, Allan, Marshal, and Kraszlan (2003) and Rojas and Gretton (2007) in which findings reported Aboriginal youth were more likely to re-engage in HSB than non-Indigenous youth. Thus, while there are mixed findings in the present literature, "there is a need for theoretically informed, evidence-based clinical practice models, with demonstrated effectiveness to serve as exemplars to reduce [HSB in] Indigenous youth" (Allard, et al., 2016, p. 84).

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24 A Māori philosophy for health, the Te Whare Tapa Whā model is based on a holistic health framework that understands health as a four-sided concept, signifying the four basic beliefs of life: Te Taha Hinegaro (psychological health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health), and Te Taha Whānau (family health). The Te Whare Tapa Whā can be used as a clinical assessment tool to treat health issues ranging from psychological to physical wellbeing (New Zealand. Ministry of Health, 2017).

Culturally and linguistically diverse young people

A significant gap in the literature exists in relation to young people from CALD backgrounds. The empirical evidence base regarding therapeutic interventions for young people engaging in HSB from CALD communities is limited in both the Australian and international contexts; we found no research that looked specifically at interventions with this cohort of young people. Possible reasons for this relate to:

- cultural barriers to identifying or disclosing HSB, from the young person engaging in them, family and community members or the victimised young person themselves
- the lack of services tailored to CALD communities
- a reluctance among CALD community members to seek out mainstream services.[25]

There is, thus, a need for targeted and community-appropriate research with CALD communities and their young people to develop an understanding of the extent and dynamics of HSB, the needs of the community and the nature of the support that would best meet their needs.

Summary of the current evidence

The last decade of research has seen significant consolidation and growing sophistication in the following areas:

- understandings of the characteristics of young people who engage in HSB and the key risk factors associated with their occurrence
- understandings of therapeutic responses to this population, coalescing into a broadly shared approach that prioritises child and adolescent bio-pyschosocial development, a holistic, multi-systemic approach to treatment, and multi-agency involvement
- development and testing of adolescent-specific risk assessment tools.

However, significant gaps remain in terms of data on the prevalence of young people engaging in HSB, detailed knowledge of risk and protective factors, HSB within CALD communities, program evaluation, and tailoring good practice principles for particular communities. These issues are assessed in turn below.

While the conceptual understandings of HSB and the young people that engage in them have deepened, and empirical research on the young people themselves has grown, our knowledge about the extent of HSB remains limited. This is largely the consequence of the challenges in feasibly defining a continuum of behaviours such that they can be measured at a community or whole-of-population level. Currently, recorded crime and administrative data act as proxies for extent; however, as noted earlier these are problematic. Consideration should be given to developing ways of measuring HSB outside of these two mechanisms.

As conceptual understandings have deepened, so too have understandings about the characteristics of young people who engage in HSB and the risk factors that are associated with this behaviour. Prior experiences of trauma, exposure to family violence, neglect and exposure to pornography are key factors. Intellectual, cognitive and developmental disability are also relevant. However, this research has tended to focus on individual and interpersonal factors. Gaps and challenges remain in identifying and making sense of factors at the community and socio-cultural levels that might be relevant. For some communities, risk factors accumulate intergenerationally and are simultaneously individual, relational, and collective. What gives rise to these factors is historical, structural, and cultural. There is a dearth of published literature exploring these issues in relation to HSB, which makes it difficult to address appropriately within the realm of "risk factors". This is particularly relevant for Aboriginal and Torres Strait Islander young people.

There are significant gaps in our understanding of how HSB present and are understood within CALD communities. To our knowledge, no published research exists on this in the Australian context. This gap signals the need for a new round of inquiry, working with diverse communities to develop an understanding of how HSB are understood and what types of interventions are needed. There is also limited research on how the developments in therapeutic approaches are being tailored to Aboriginal and Torres Strait Islander

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25 These barriers are drawn from the broader—but still limited—research on barriers to accessing services for sexual violence against girls and women (see Allimant & Ostapiej-Piatkowski, 2011).

young people and their communities. While some research has been conducted in the Queensland context, it is difficult to extrapolate these findings out to other Aboriginal and Torres Strait Islander populations. Again, this signals a need for dedicated, collaborative research in partnership with different Aboriginal and Torres Strait Islander communities to develop a more detailed understanding of how therapeutic responses should be designed, delivered and evaluated.

Finally, there are gaps in program evaluation. In Australia, a limited number of program evaluations have been published. International studies have evaluated programs such as MST-PBS, however the applicability of findings to the Australian context is unclear. This signals a need for a more fulsome research and evaluation agenda that encompasses formative, process and outcomes evaluation.

CHAPTER 2:
Methodology

Research design

The key components of this project were:

- a state of knowledge review of the current literature that synthesised the conceptual and empirical understanding of HSB and current therapeutic approaches to working with young people who engaged in HSB
- a mapping of the national service landscape in each state and territory in terms of availability of HSB services, their operation, referral and service pathways, and evaluation processes
- an investigation into three service models in order to understand the "key ingredients" that enable good practice in HSB interventions, and the role contextual factors in services' operating environments play in facilitating or hindering practice.

Figure 6 provides a summary of each component's focus and purpose.

Theoretical approach

Realist evaluation and systems thinking were the two key theoretical approaches that informed the overall purpose and design of the project.

Realist evaluation

The realist approach seeks to understand "how things change", which makes this theoretical approach particularly suitable for our aim of wanting to identify the key ingredients of complex interventions that are designed to achieve behavioural change (Pawson & Tilley, 1997, p. 56). According to a realist evaluation approach, programs are "theories" about what effects change; "embedded" in a range of intersecting contexts and social systems; taken up by active, volitional subjects; and parts of "open systems" where change, feedback and adaptation are the norm (Pawson & Tilley, 2004, p. 4).

Figure 6: Summary of research components

FOCUS	PURPOSE	METHOD	ANALYSIS	RELEVANCE
State of knowledge review	To synthesise the research base regarding understandings of and responses to harmful sexual behaviours to situate components 2 and 3	Search of peer-review and grey literature published 2016–17 regarding: aetiology; risk/protective factors; therapeutic approaches; policy responses	Scoping and synthesis review of the current evidence regarding: • conceptual understandings • empirical research • therapeutic developments	**Benchmark state of knowledge re: HSBs and therapeutic responses**
National service mapping	To describe the nature and extent of specialist services in each state and territory	Desktop review of service availability in each state and territory Online request for information circulated to services and practitioners	Service coverage; client eligibility; referral sources; worker profiles; therapeutic ethos; funding source	**Indication of national:** • service coverage • therapeutic approaches
Investigation of 3 service models	To develop an in-depth understanding of: • principles of good practice • factors in the broader service delivery context that influence implementation of principles	Pre-interview questionnaires to obtain operational information Collection of program and practice documentation In-depth interviews with specialist practitioners and relevant policy professionals	Descriptive review of data provided re: operations and therapeutic models Thematic analysis of good practice principles and factors that influence this	**Detailed understanding of:** • good practice enablers of good practice • influence of delivery context

While we have drawn on the insights and concepts of realist evaluation, the project was *not* an evaluation itself. That is, we did not undertake an evaluation of the implementation and effectiveness of the three service models. Rather, we are using a realist evaluation orientation to understand and distil the mechanisms that enable good practice in therapeutic HSB interventions, and the role of contextual factors in services' operating environments in facilitating or hindering practice. The aim of this is not so much to improve or inform those particular service models, but to inform future service design and implementation in other settings and contexts.

Realist evaluation relies on the following formula for identifying, and explaining, causation in the social world: *mechanism + context = outcome*. The terms of the equation are understood as:

- Mechanism: the various means by which aspects of a program might work (contingent on the context).

- Context: a set of circumstances that allow for particular actions (mechanisms) to be triggered (or not).

- Outcome: the result of the particular mechanism/s that is enabled within particular contexts. (Pawson & Tilley, 1997, p. 57)

These concepts are particularly appropriate for this study. In seeking to understand the conditions that give rise to successful therapeutic outcomes, we need to acknowledge that complex social problems such as HSB are rarely successfully addressed with singular solutions. Consistent with the theoretical framework for realist evaluation, this study recognises that therapeutic outcomes are contingent on a range of variables, some of which cannot be controlled by program staff (i.e. the client's context, their individual response to the program, the responses of other services systems, etc.) or even by the design of the intervention itself.

The realist evaluation theoretical approach was used in the formulation of our project objectives and our areas of inquiry regarding:

- what constitutes good practice in specialised service provision for young people engaging in HSB

- the key "ingredients" or mechanisms that underpin good practice

- the factors in the broader service delivery context that facilitate—or hinder—good practice in specialised therapeutic interventions.

Systems thinking

Therapeutic responses for young people engaging in HSB take place within—and rely on—relationships between multiple agencies and systems, most often child protection, police and the broader justice system. Until relatively recently, the concept of human or community service *systems* has been underdeveloped in public and social policy research and evaluation. As policy problems have become increasingly complex, entwined and interdependent—for example, mental health and homelessness (Cook & Tonurist, 2016)—and as inquiries continue to point to systems or systemic failures in areas such as child safety, child abuse and maltreatment, and family violence,[26] taking a "systems perspective" on service provision and service reform has come to the fore. Consequently, and as noted in the Introduction, systems thinking has become of significant interest to policymakers and to the public sector more broadly (Cook & Tonurist, 2016). Systems thinking is an interdisciplinary concept that helps to shift focus from the programmatic and service level to look at the relationships, behaviours and dynamics within and between systems and how these influence a particular program or intervention (Arnold & Wade, 2015; Peters, 2014).

In defining a system, Foster-Fishman and colleagues (2007, p. 198) write that, "at their most basic level, systems are generally considered to be a collection of parts that, through their interactions, function as a whole". This definition captures a whole range of phenomena from the human body through to families, organisations, and service sectors. What are important are the properties or characteristics of systems, such as being:

- Self-organising: there is no single internal structure that determines the nature or behaviours of a system; how a

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26 Recent examples include Betrayal of Trust: Inquiry into the Handling of Child Abuse by Religious and Other Non-Government Organisations (Victoria. Family and Community Development Committee, 2013); Taking Responsibility: A Roadmap for Queensland Child Protection (Queensland. Child Protection Commission of Inquiry, 2013); Victorian RCFV (State of Victoria, 2016). See also Swain, 2014 for a review of Australian inquiries into services providing out-of-home care to children and young people.

system is organised arises through the interactions of the system's constituent parts, including subsystems.

- Dynamic: systems are adaptive and adjust and re-adjust in response to changes in other parts of the system.
- Tightly linked: the constituent parts of a system are linked. Interventions targeting one part of the system will have effects—positive or negative—on other parts of the system.
- Non-linear: few complex systems operate on a straightforward input/output dynamic. Interventions within systems are non-linear and unpredictable.
- Counter-intuitive: relatedly, the relationship between cause and effect (or intervention and desired outcome) is not linear. That is, interventions to address a particular social issue or problem may not be effective due to a range of other issues surrounding the problem that undermine or work against what the intervention aims to achieve. (Cook & Tonurist, 2016, p. 42)

Systems, in other words, are inherently open, dynamic and in flux as they respond to "feedback" from behaviours, outcomes and practices from other systems.

Systems thinking has been used to inform our analysis of the contextual factors influencing good practice and in our analysis of implications for designing and implementing therapeutic responses for young people who engage in HSB. In particular, we have used systems thinking to help identify the levers in policy context and in the design of service delivery that could augment good practice in therapeutic interventions.

Practice sector engagement

Both realist evaluation and systems thinking invite a more collaborative or dialogic engagement between researchers and those that traditionally have been the "subjects" of research. Practitioners often possess a depth of expertise, insight and tacit knowledge about the realities and complexities of service delivery from which researchers are often too far removed, or are not sensitised to. Thus, it was important to harness the expertise of practitioners who have been working in the

HSB treatment field at different stages of the project. We used the following mechanisms to do this.

A "facilitating partners" team was established comprising the senior practitioners who lead or who helped design the service models in New South Wales, Queensland and Victoria. The group included Dale Tolliday (New Street), Jodie Barton (GYFS), Carolyn Worth (SABTS) and Russell Pratt (previously SABTS).[27] The facilitating partners and the research team held three workshops over the course of the project to refine its design, implementation and analysis stages. We also liaised with them individually where required. Facilitating partners:

- helped refine the focus of project components and the data collection instruments
- provided guidance about the operational context in their jurisdiction (e.g. developments at the policy, jurisdictional and service sector levels)
- facilitated entry into the three study sites and engagement with other key stakeholders.

In addition, a project advisory group was established comprising stakeholders from other jurisdictions and services including Western Australia, Tasmania and South Australia, which met three times over the course of the project. Members were:

- Dr Howard Bath (Consultant, Allambi Care, NSW)
- Professor Leah Bromfield (Co-Director, Australian Centre for Child Protection, University of South Australia)
- Natalie Hall (Principal Policy Officer, Commissioner for Children and Young People, Western Australia)
- Mabor Chadhoul (Community Engagement and Project Officer, Refugee and Migrant Communities at Centre for Culture, Ethnicity & Health, Victoria)
- Jill Maxwell (CEO, Sexual Assault Support Services, Tasmania)
- Holly Mason-White (Social Policy Adviser, Sexual Assault Support Services, Tasmania)
- Dr Gemma McKibbin (Research Fellow, Department of

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27 Members of the group also have leadership roles within the broader community of practice for HSB practitioners as executive members of ANZATSA (Dale Tolliday and Russell Pratt) and as convener of SABTS's professional development training (Carolyn Worth).

Social Work, University of Melbourne)

- Lisa Rodda (Office of Professional Practice, Department of Health and Human Services, Victoria).

The main purpose of this group was to provide high-level advice and guidance on aims, purpose and findings of the project; how HSB intersected with other issues (e.g. family violence); and current policy and service developments or priorities regarding these other issues.

We also used an Australian and New Zealand Association for the Treatment of Sexual Abuse's (ANZATSA) Adolescent Roundtable[28] as an opportunity to introduce the research's main aims and test their relevance with practitioners (June, 2016) and promote the request for information survey.

Component methodology

State of knowledge review

The purpose of the state of knowledge review was to synthesise recent research regarding understandings of the nature of HSB among young people in Australia, the circumstances that lead to young people engaging in HSB, and the various intervention approaches that are being employed to prevent HSB from occurring or reoccurring. The methodology for the state of knowledge review is described in Chapter 1.

Mapping of services for young people with HSB

The national mapping component of the project aimed to provide a description of the therapeutic services currently available for young people with HSB in each state and territory, and the characteristics of these therapeutic services. It provides an update on the previous service mapping, which was undertaken almost a decade ago. For continuity, we used

O'Brien's (2010) mapping of community-based services as a guide, which considered:

- service reach in terms of geography, population, accessibility
- characteristics of the client populations
- client eligibility
- referral sources
- therapeutic principles
- practice evaluation.

While we used O'Brien's (2010) mapping as a guide for inquiry areas, there are differences in execution—namely, we did not have the same imprimatur as the Australian Crime Commission to request submissions from government departments, nor did we undertake direct consultations as did O'Brien. This means that while there is continuity in the areas of inquiry, the way we collected this information may have altered the results.

The main purpose of service mapping is to describe what services are provided to whom, and covering what geographic or service area, and to identify service gaps (e.g. in relation to particular populations or communities). Two data collection strategies were used for this component:

1. Desktop review of services available in each state and territory for young people with HSB, including published reports (e.g. Volume 10 of the RCIRCSA final report). This was done using Google Advanced search, and followed up with direct requests for information from relevant departments and services in each state and territory.

2. An online survey (developed as a request for information tool [see Appendix A]), which was circulated to services and practitioners using the following channels:

   ○ AIFS's Child Family Community Australia eNewsletter, which goes to some 10,000 subscribers, many of whom are social work practitioners

   ○ targeted email lists (created by the research team) of individual practitioners, including the facilitating partners and advisory group members

   ○ use of other e-newsletters, such as those of the Australian Psychological Society and ANZATSA.

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28 The Adolescent Roundtable is a sub-group of ANZATSA. Held at minimum annually, the Roundtable brings practitioners working with adolescents engaging in harmful, abusive and/or sexually violent behaviours together to share experiences and research and for professional development.

Table 4: Key inquiry areas in the service mapping

Desktop review of services in each state and territory	Request for information
· Service name/provider · Location and coverage · Client eligibility · Referral sources · Exclusions	· Workforce characteristics (age, gender, qualifications, experience) · Characteristics of the client populations · Referral pathways · Therapeutic principles · View of good practice · Funding arrangements · Practice evaluation

These data collection strategies focused on somewhat different areas, as outlined in Table 4.

This information—a state/territory description of what therapeutic services are available (location, geographic coverage, client eligibility such as age, referral sources), and analysis of the survey responses from the request for information—is analysed separately. The request for information was an opt-in invitation circulated via a range of distribution channels. This means that we do not know what proportion of specialist workers did not respond (as there was no sampling framework). As such, the request is limited in its generalisability; the responses reflect only the views of the participants themselves. Analysis involved extraction of responses from LimeSurvey into Excel and basic descriptive analysis of response frequencies. Five-point Likert scales were used to determine how important respondents deemed each element of good practice to be.

Investigation of three service models

This phase constituted the major fieldwork component of the project. We focused on three different service models to understand:

- the internal features of these therapeutic programs—including the treatment philosophy, staffing profile, client eligibility criteria, practice guidelines adopted, and the profile of the client base within each program

- the extent to which contextual factors impact on the operation of programs—including attention to factors that assist with, or impede, both
  - effective program delivery/implementation
  - effective service access by young people, and the families or caregivers of young people displaying HSB.

The three service models were GYFS, New Street and SABTS. We conducted in-depth interviews with practitioners and service managers providing therapeutic services to young people, police, and departmental funding agencies, and collected program and guidance documentation.

The rationale underpinning this selection of service models is two-fold:

- their maturity—as service models, they have each been in operation for, on average, 20 years

- the variations in the service models in terms of who is eligible to receive treatment and how therapeutic treatment is provided.

The service models' maturity means each has an articulated model of delivery and therapeutic philosophy, procedures and guidance material. Evaluations and other research have been undertaken on each model,[29] the findings of which have been taken up by service managers, senior clinicians and funding bodies to improve service provision. This means that issues, challenges, gaps and other insights are unlikely to stem from "teething problems" in implementing a new service, for example. The variations in features of the service models mean that themes and findings common to all three are likely to be particularly salient in helping to determine what facilitates and hinders good practice. A brief description of each service is provided below. More detailed descriptions are provided in Chapters 3 and 4.

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29 New Street Services has been evaluated by Laing, Mikulsky, and Kennaugh (2006), Laing et al. (2014), and KPMG (2014). GYFS has undertaken a number of studies looking at outcomes for their clients on a range of measures (e.g. Allard et al., 2016) and testing the collaborative approach with other services (Smallbone, Rayment-McHugh, Crissman, & Shumack, 2008). The SABTS model was evaluated in 2011 by Success Works as part of the evaluation of Victoria's Sexual Assault Reform Strategy.

Queensland–Griffith Youth Forensic Service

GYFS is a statewide assessment and treatment service for young people who are convicted of sexual offences. It operates out of Griffith University in Brisbane, where it is closely aligned with academic research into the effectiveness of its therapeutic interventions. Services are delivered through outreach: staff travel to where their clients are, giving priority to the most geographically remote children. Founded in 2001, GYFS is funded by the Queensland Department of Child Safety, Youth and Women (Youth Justice), with in-kind support from Griffith University (GYFS, 2019).

New South Wales–New Street Services

New Street is a therapeutic counselling and prevention program that encourages behavioural change among young people aged 10–17 years who have engaged in HSB. Founded in 1998, the original New Street services in Sydney and Newcastle have since been complemented by services in Western New South Wales (Dubbo, Orange and Bathurst), Illawarra Shoalhaven (Wollongong and Nowra) and Hunter New England (Tamworth), with additional services soon to open in another six local health districts. All sites were included in this study. The services are funded by NSW Health and administered through New South Wales's local health districts. Each service has an identified Aboriginal counsellor position and each provides outreach services within the bounds of their district (NSW Health, 2018b).

Victoria–Sexual Abuse Behaviour Treatment Services

The Victorian Department of Health and Human Services funds 11 community-based services to provide SABTS. SABTS providers are existing services (i.e. no new service was set up). The majority of these services are sexual assault services (e.g. Centres Against Sexual Assault); two are child welfare agencies. A small number of these services started providing SABTS at the beginning of the 2000s; this number has since expanded to service all health regions in the state. SABTS clients are young people aged 10–17.[30] Referrals can come from families themselves, schools, police, child protection or any other service. The majority of clients are voluntary

and a small number are clients mandated to treatment via a therapeutic treatment order (TTO).[31]

Method

We sought information from two key groups:

- specialist practitioners and clinicians working therapeutically with young people with HSB in each of the three program sites (i.e. practitioners with experience, training and current focus on working with these behaviours)
- policy and statutory professionals who are part of the services' operating context (i.e. as funding agencies, as the main referring agencies, or as agencies involved in case management and safety planning for individual clients).

Data collection included the following methods:

- Pre-interview questionnaires from practitioners were used to gather more programmatic information about the characteristics of the service model such as length of operation, client characteristics, and staffing profile. This information helped the research team to better understand the shared and different programmatic features across the three service models and has been used to provide an overall description of each service.
- Semi-structured interviews were used to gain in-depth qualitative insights about elements of good practice and the contextual factors that affect program delivery and access (see Appendices D & E).
- Relevant program documentation such as procedures, standards, training packages, intake forms and so on was collected. This information was also used to develop an overall understanding of the service model.

Key areas of inquiry in pre-interview questionnaire for practitioners

For clinician and practitioner interviews, we separated quantitative questions from the qualitative interview.

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30 Until recently, SABTS were funded to work with young people aged 10–15 years. The Victorian RCFV recommended that the age threshold be increased to 17 years.

31 A therapeutic treatment order (TTO) provides an alternative pathway into treatment for children aged 10–17 years (inclusive) when a child does not voluntarily seek treatment, and without the need to rely on a successful criminal prosecution or a protection order. The order is made where it is seen as necessary to ensure the child's access to, or attendance at, an appropriate therapeutic treatment program.

Quantitative questions relating to, for example, number of clients seen, average caseload, number of staff, their qualifications, length and frequency of interventions were asked through a pre-interview questionnaire (see Appendix C). This approach has been called a "mixed methods interview" (Frels & Onwuegbuzie, 2013, p. 184). Using a pre-interview questionnaire enables:

- the two types of questions to potentially be answered by different staff: sometimes the manager or research officer is the best placed to provide quantitative data about the service, while a counsellor is chosen to discuss their therapeutic work in the interview
- respondents to look up the quantitative data we seek: they may not have it to hand in an interview, and this allows us to gather more complete and accurate quantitative data
- interview time-management, as well as allowing adequate time in the interview to explore interviewees' professional experience, observations and views.

Key areas of inquiry in interviews

For specialist practitioners and managers working with young people, we asked about:

- operational information about the program (time of operation, purpose of service, staffing profile including qualifications and workforce development issues)
- characteristics of the client base (age, background, apparent risk factors)
- therapeutic approach (treatment philosophy, program fidelity, young person involvement, group/individual, key stakeholders including family, duration and intensity)
- contextual factors (funding, eligibility, referral pathways, demand, issues relevant to adjudication)
- effectiveness and evaluation (prior evaluations, views on evaluation, obstacles and alternatives to evaluation).

For policy professionals/police we asked about:

- their role in relation to young people with HSB (assessment of the state of knowledge among professionals in the organisation or in relevant roles in state or region, broader policy context in region, investment in professional development and research into best practice)
- insights into therapeutic approaches and service responses

(point of contact and referral pathway, views on perceived risk factors for HSB, characteristics of successful services, barriers to successful program delivery, broader challenges or positive factors, criminal law)

- effectiveness and evaluation (prior evaluation experiences, views on evaluation, obstacles and alternatives to evaluation).

The interview schedules were structured around these main inquiry areas, with sub-questions as prompts for the interviewer. The interviews were conducted in a semi-structured mode, using the interview schedules as a guide. Although questions are listed in a particular order, semi-structured interviews allow for topical lines of inquiry to be pursued as they arise (David & Sutton, 2004). Structured interviews, on the other hand, ensure that each interviewee is presented with exactly the same set of questions in the same order and may draw more heavily on closed questions (Lindlof & Taylor, 2002).

Sampling and recruitment

Purposeful sampling is widely used in qualitative research. Purposeful sampling is non-random and involves searching out what Patton (2002) calls "information rich cases"—individuals, texts, et cetera—that are related to the topic of interest. Specifically, we used a combination of two types of purposeful sampling. Criterion sampling involves selecting participants who demonstrate criteria of predetermined importance. In our case, we wanted to obtain perspectives from managers and practitioners, metropolitan and regional professionals, those that fund the services, and agencies that interact with the three service models. Within this we also used snowball sampling (sourcing research participants through the professional networks of other participants or expert informants). This approach has the advantage of flexibility in being able to interview a previously unknown key informant, and can also ensure that the most relevant and knowledgeable participants are located.

The facilitating partners and the project advisory group were used to help identify key participants in both the treatment services and in the broader context. During recruitment

Table 5: Total number of participants in each state and profession

	Therapeutic practitioners			Policy and criminal justice system[a] professionals		
	Principal service model	NGO providers	Private practitioners	Policy & CJS professionals	Police	Total
Queensland	7	8	4	5	2	26
NSW	7	0	3	8	0	18
Victoria	12	1	2	2	2	19
Total	26	9	9	15	4	63

Note: [a] Criminal justice system practitioners include police and corrective services professionals.

for interviews, participants also nominated other potential interviewees. We also drew on expert collaborators and professional networks in each state to establish who else is active in the field—whether government providers, non-governmental organisations or private practitioners—to ensure comprehensive coverage of the service field. For example, researchers attended professional gatherings of HSB workers to inform them about the project, answer questions about the study and encourage their participation.

Recruitment was via direct approaches following discussions with the facilitating partners (who were themselves interviewed). Facilitating partners provided contact details to the key individuals at the relevant service or agency—typically a senior manager—who were followed up with by a member of the research team via email or phone if that was the preferred mode of contact. Following this initial contact, provision of a plain language statement (see Appendix B) and an invitation to participate, an interview would be arranged. Ahead of the interview, a pre-interview questionnaire was sent to the interviewee.

Participant sample

A total of 63 interviews were completed. Table 5 provides a breakdown of the sample. Despite invitations to participate in interviews, we were unable to secure interviews with NSW Police and the Victorian Department of Education and Training. Therefore, there are gaps in perspectives.

Additional interviews with NGO providers and private practitioners provided further insight into developments in good practice in working with young people and the history of the field in Australia. While the focus of the in-depth component of the study was on the three service models, these additional insights helped the research team to understand the broader context in which these services operate.

The majority of interviews were conducted face-to-face. The average time for interviews was 1.5 hours; however, group interviews would run longer than this. All interviews were audio-recorded and transcribed verbatim for the purpose of analysis. NVivo (Version 11) was used to systemise coding.

Data analysis

We used thematic analysis for the interview data. Thematic analysis is one of the most common approaches to analysing qualitative data (Braun & Clarke, 2006; Guest, MacQueen, & Namey, 2012). It ultimately aims to identify shared or common patterns (themes) in the data collected. It involves becoming familiar with the data itself (i.e. reading and reviewing transcripts), generating initial codes to reduce and organise the data, analysing for themes, and reviewing and aggregating themes (Braun & Clarke, 2006).

To do this, we first developed codes based on the areas of inquiry (described above) and the insights and concepts from the realist evaluation and systems thinking perspectives. Thus, in line with these theoretical orientations, we coded for:

- how participants described good practice in working with young people engaging in HSB
- what they identified as barriers to and enablers for this
- the factors, characteristics, practices and policies in the broader service delivery environment that affected therapeutic responses.

Members of the research team first analysed a sample of interview transcripts to develop a shared set of codes, which were then reviewed by the chief investigators and used as the coding frame for subsequent coding. Interviews were coded vertically (i.e. identifying themes within each transcript). This was done firstly with the practitioner interviews to obtain a detailed understanding of what constituted good

practice from the perspective of specialist practitioners in the three service models, and subsequently with policy and other professionals' interviews in order to understand the broader systemic issues at play. NVivo was used to code and manage the data.

Preliminary analysis of key themes was presented and explored with the facilitating partners in a half-day workshop in November 2018. Discussion and insights arising from this workshop were fed into subsequent analysis. We then aggregated the codes into more meaningful patterns. This was done through a horizontal analysis of the coded transcripts (i.e. identifying themes across transcripts) to identify overarching themes or patterns in relation to the following questions:

- What are the key elements of good practice?
- What are the conditions for good practice?
- What factors influence this?
- What does this tell us about service and program design and delivery?

Program documentation was used as background material to provide additional descriptive information about the service models.

Ethical considerations

Ethics approval was secured from the AIFS Human Research Ethics Committee (Ethics number 17/11) and mutually recognised by Deakin University (DUHREC 2017-294). A number of departments and agencies required separate ethics applications, including:

- Northern Sydney Local Health District Human Research Ethics Committee
- Victorian Department of Justice Human Research Ethics Committee
- Queensland Department of Child Safety and, specifically, Youth Justice.

While this was a low-risk project seeking practitioner views on their areas of expertise and not seeking data from or about client populations, there were still a number of ethical considerations. The main ethical considerations in this project related to confidentiality, participant distress, researcher distress and ensuring participant consent.

Confidentiality

There were specific concerns around balancing the assurances of confidentiality and anonymity with the possibility that some participants could potentially be identifiable to other people by virtue of their role or service. For example, there may be a situation in which there is only one clinician that works with a particular cohort in regional New South Wales, or where there is no comparable role in the other case study sites. While we took possible steps to remove personal and other identifying information, the possibility of being identifiable to others remains.

Our strategy for managing this was to explain this possibility clearly to participants as part of the consent process, so that they could make an informed assessment about whether they wished to proceed and, if they did, what they may need to consider in sharing their views. As part of this strategy, we gave participants the options of a) alerting us to when something was to be considered off the record; and b) contacting us post-interview to request certain statements be categorised as off the record. In some cases where the likelihood of identification was very high due to the singularity of the service we have further obscured details of participants.

Participant distress

All participants were professionals trained to work, if not specifically with HSB, then at a minimum with vulnerable young people. Their working environments generally included clinical supervision and debriefing. Further, interviews were limited to seeking their professional opinions rather than personal experiences or views. Nonetheless there was still the potential for interviews to cause distress. Our strategy to manage this should it arise was to ensure that:

- participants did in fact have debriefing avenues including Employee Assistance Program options
- contact information for referral to support (1800 RESPECT) was available.

Researcher distress

There was the possibility that members of the research team could become distressed by the content of interviews. Strategies in place to manage this included managers checking in with researchers after interviews, weekly team meetings to discuss issues arising, and the availability of the AIFS Employee Assistance Program system.

Participant consent

Participants were provided with a plain language statement (see Appendix B) describing the research and how data and identifying information are treated, along with a written invitation describing what to expect in an interview, and evidence of relevant ethics approval(s). Participants were offered individual interviews, or joint interviews with a colleague(s), at a time and place of their choosing.

While verbal consent was secured in advance of the interview, participants were sent a written consent form and were given the opportunity to seek clarification on any aspect of the project. The consent form has two versions, for individual and group interviews respectively (see Appendices F & G).

The interviewer discussed the consent form at the beginning of each interview. The research and confidentiality provisions were described once again, with particular attention paid to the clause regarding participant involvement in the treatment of any information that, while de-identified, may nonetheless be potentially identifying. These discussions were not recorded. Once the participant was ready to commence recording, the recorder was switched on and participants were asked to give verbal consent to proceed with the interview. Participants' verbal consent was thereby recorded and subsequently transcribed as a formal record of consent.

National service mapping

This chapter describes the service responses available for young people displaying HSB in Australia. The purpose of this component was to provide a national picture of the current therapeutic service landscape and, in doing so, provide an update to O'Brien's (2010) service mapping.

We begin with a description of service availability by state and territory. An overview of the services available for young people 10–17 years with HSB by jurisdiction is presented (see Table 6). Following this, the results of the request for information are described.

Mapping national service availability

Service mapping can be challenging. Often, public sources of information are:
- irregularly updated
- located in diverse sites (e.g. the services themselves or the government departments funding them)
- described differently by these different sources
- insufficiently detailed about client eligibility, referral mechanisms, geographic coverage, or therapeutic approach.

In short, public online information can be fragmented and lack detail. To address these issues, we directly approached relevant services and departmental agencies for further information. This too has challenges, relying on busy and often time-poor professionals to respond with the required information. With these limitations in mind, the following sections describe the national service landscape as at July 2018. Where updated information is available, we have noted this.

We provide a narrative description for each jurisdiction followed by a tabulated summary of all jurisdictions. It is important to note that service mapping is primarily descriptive in nature. In the absence of detailed information about how particular services operate, we have not made assessments as to whether they are actually specialist HSB services or doing this work alongside other child and family service provision.

Australian Capital Territory

There is limited information available regarding services for young people aged 10–17 years old exhibiting HSB in the Australian Capital Territory. A lack of specialised services available to this cohort in the Australian Capital Territory was noted in O'Brien's (2010) paper, which highlighted issues of workforce development such as training, accreditation and supervision as contributing factors to this gap in the service landscape (p. 65).[32]

The Child at Risk Health Unit (CARHU) provides services for children under 10 years of age with problematic sexualised behaviours. This service is based at the Canberra Hospital and funded by Canberra Health Services. CARHU requires the involvement of Child and Youth Protection Services (CYPS) or the NSW Department of Communities and Justice (DCJ) in order to undertake PSB intervention work. In addition, they require a safe home environment and a stable parent/caregiver to provide support and containment during and between sessions. These safety assessments are made on a case-by-case basis. CARHU have also started offering "concern interviews" to parents/caregivers who are worried about their child following exposure to trauma. These interviews may cover a range of areas, including sexual assault, PSB, domestic violence, and children in out-of-home care.

Between 1999–2013 the Thomas Wright Institute was sponsored by Marymead Child and Family Centre to provide intervention services to children and adolescents with sexualised behaviours. After the Institute closed in 2013, Therapeutic Welfare Interventions was established to provide a structure for the continuation of specialised services formerly offered by the Thomas Wright Institute. The new Therapeutic Welfare Interventions does not work

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32 Funding was allocated in the 2019-20 Australian Capital Territory Budget to enable the Health Directorate to focus specifically on children who are exhibiting sexually concerning behaviours, many of whom have a family history of DFV. The Health Directorate will engage a specialist consultant to assist with mapping therapeutic services in the Australian Capital Territory for children who are exhibiting sexually concerning behaviours. This mapping, together with the definitional work and mapping undertaken by the Community Services Directorate in relation to therapeutic services, will inform the review, development and implementation of health-specific and system-wide responses to children exhibiting sexually concerning behaviours (ACT. Community Services Directorate, p. 20).

independently with clients, but instead refers work to a professionally accredited (Child Sex Offender Counsellors Accreditation Scheme) clinician in New South Wales. Therapeutic Welfare Interventions maintains professional development through membership with ANZATSA and peer supervision.

New South Wales

NSW Health funds New Street Services to provide treatment and intervention for young people with HSB. In addition to the funding distributed by the NSW Ministry of Health, the NSW Government, under the reforms recommended by Justice Wood's 2008 Special Commission of Inquiry into Child Protection Services, have issued the Keep Them Safe initiative—a new funding commitment for services in New South Wales (Wood, 2008).

New Street Services are part of NSW Health's child protection services and provide a specialised, early intervention, community-based service to address HSB displayed by young people aged 10–17 years who have not been criminally prosecuted. New Street Service is currently operational in four local health districts with new full services as well as hub and spoke models being rolled out across the state in 2019–20.

The New Street Services program is supported by a clinical advisor and associate clinical advisor located in the Sydney Children's Hospitals Network. Clinical support includes coordination of the New Street network of services, specialist training, supervision of clinical coordinators, complex case consultation across agencies and facilitating development of New Street Aboriginal counsellors.

The NSW Child Sex Offender Counsellor Accreditation Scheme provides a list of private practitioners in New South Wales who have demonstrated the necessary skills, experience, education and expertise to provide treatment to young people with HSB (Office of the Children's Guardian, n.d.).

Northern Territory

There is limited information available regarding services for young people aged 10–17 years exhibiting HSB in the Northern Territory. There is currently no main body or organisation that provides services across the territory.

Sexual Assault Referral Centres (SARC) provide counselling services, information and support for non-offending parents, family members and partners; education for community and professional groups; education of protective behaviour for young people; and prevention work with other government agencies. While SARC predominantly offer services for men, women and young people who have experienced sexual abuse, young people who display HSB may have a past history of being victimised and have experienced sexual assault in some way. Therefore, on these grounds, young people with HSB are eligible for counselling at SARC; however, therapeutic treatment is not provided for young people over the age of 10. Special circumstances may see SARC offering services on a case-by-case basis to young people up to the ages of 14; however, it is clear that the young person's HSB would need to be classified as inappropriate and not coercive. Territory Families Youth Justice Clinical Services team runs a fly-in, fly-out service for children and young people with HSB in detention.

Very few community-based services in the Northern Territory have been established to specifically provide therapeutic work for young people with HSB. This lack of services may be due to a shortage of funding for work in this area, and other barriers such as:

- limited expressions of interest from psychologists, social workers and caseworkers for rural locations
- limited Aboriginal and Torres Strait Islander or CALD practitioners
- limited Aboriginal and Torres Strait Islander community involvement
- inherent limitations in provision of accessible, timely and specialist services in regional, remote and very remote areas.[33]

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33 Advice from the Northern Territory is that between 2009–15 there was a Mobile Outreach Service (MOS) and then an MOS Plus that operated in the Northern Territory, which provided services to young people

Queensland

In Queensland, therapeutic work for young people who exhibit HSB used to be funded by the Queensland Government Department of Communities, Child Safety and Disability Services. However, changes in policy structural systems in 2017 mean that now most, if not all, services offering work with young people who have HSB are primarily funded by the Youth Justice section of the Department of Child Safety, Youth and Women. There are several leading bodies providing therapeutic services for young people, although all operate independently.

The two specialist services conducting therapeutic treatment interventions for young people with HSB in Queensland are GYFS and the Mater Family and Youth Counselling Service. Both only offer treatment services for young people who have been convicted of a sexual offence. GYFS is a specialist forensic psychological assessment and intervention service that is offered at a statewide[34] provision level funded through Youth Justice. It offers treatment intervention specifically for young people who have been subject to a youth justice intervention order (assessment and supervised orders).

The Mater Family and Youth Counselling Service was previously funded by the Department of Justice and Attorney General; however, that has since changed and funding comes from the Department of Children, Youth and Women following Youth Justice's move. The service sits within the Mater hospitals and is part of the Mater Young Adult Health Centres. With their service agreement, the centres are funded to only work with young people who have committed sexual offences, and who are having their matters dealt with through a restorative justice conference. As such, there are no limitations in regards to the type of sexual offences that are referred to the service.

Aside from the two specialist services, Bravehearts, Laurel Place, Phoenix House, ACT for Kids, Evolve Therapeutic Services, Tablelands Sexual Assault Service (TSAS), Mercy Community Services, Wide Bay Sexual Assault Services (WBSAS) and True: Child and Family Service are funded to provide generalist services. The majority of these services are located in the corridor along the east coast of Queensland, with limited service provision to regions further inland. As such, the west and far north of the state have been identified as significant geographical gaps in the provision of services for young people with HSB.

South Australia

In South Australia, the Women's and Children's Health Network (WCHN) provides the majority of services to children and adolescents with PSB or HSB. Located in metropolitan Adelaide, the WCHN overlooks a number of health services that provide therapeutic treatment to young people with HSB. Of the eight services in the network, two administer programs for this population of young people.

The first service that facilitates counselling for young people with HSB—under the WCHN—is the Child and Adolescent Mental Health Services (CAMHS), with locations in metropolitan Adelaide and non-metropolitan areas in the state. There are currently 16 community-based, country, inpatient and specialist CAMHS in South Australia. The majority of CAHMS work is largely tailored towards children and adolescents between the ages of 0–18 years. Funded by the Department of Health, young people with HSB and their families are referred to CAMHS where CAMHS duty workers are the initial point of contact for the particular area. CAMHS do not generally do HSB work; however, where appropriate, CAMHS will decide the order of treatment using the PSB checklists and will refer the young person to a CAMHS-funded service. CAMHS-funded services include Enfield Behavioural Intervention Service (BIS)—based in Enfield and previously known as Adolescent Services Enfield Campus (ASEC)—and Adolescent Sexual Abuse Prevention Program (ASAPP). Services provided through CAMHS include community visits, clinics, counselling, psychological therapy and staff

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with HSB. The objective for MOS Plus is to provide equitable access to timely, culturally safe and valued responses to Aboriginal and Torres Strait Islander children, adolescents and their families living in remote communities of the Northern Territory affected by trauma associated with any form of child abuse and neglect, including sexual assault. However, we were unable to find any details of a specific HSB service attached to the MOS during our review.

34 Although GYFS operates as a "statewide" service, our stakeholder consultations revealed that clients in remote areas only have access to treatment once every month, because "it's just not logistically possible to get there every fortnight" (NGO, Queensland, Practitioner 6).

training in child and adolescent mental health issues.

The Enfield BIS responds to children and young people aged 5–17 years who have mental health issues and persistent, pervasive and challenging behaviours. Services at BIS include incident management, intervention planning and positive behaviour support. Eligibility criteria for the service specify that the young person must have a mental health concern and have persistent, pervasive and challenging behaviours.

Similarly, the ASAPP is another CAMHS-funded service located in the eastern region of South Australia, based at Eastern CAMHS in Paradise, and part of the Forensic CAMHS team. The service provides both metropolitan and outreach services statewide. ASAPP uses the Traffic Lights framework[35] to make an assessment of whether clients are suitable for their service (Family Planning Queensland, 2012). Clients who are assessed to be between orange and red (or worse) are then referred to ASAPP. Eligibility criteria for the service stipulate that the young person must be aged between the ages of 10–18 years, have engaged in inappropriate or offensive behaviour, have sexually harassed others, or have committed a sexual offence. Increased consideration is shown towards clients who have demonstrated indicators of more serious risk of ongoing offending, such as recurrent offending, significant index offending, offences which include physical violence, female offenders, escalating patterns of sexual violence, abuse against boys or strangers, intellectual disability (e.g. autism), and families where siblings are at risk of continuing sexual abuse. Referrals are accepted and processed through CAMHS from various sources such as family, police, courts, schools or self-referrals.

Child Protection Services (CPS) is the second service under

the WCHN that provides specialised counselling to young people with HSB from families residing within the northern metropolitan and non-metropolitan areas of Adelaide. CPS offers specialist assessment and treatment services to children and young people from the ages of 0–18 years and their families, particularly in circumstances where there is a suspicion of child abuse, psychological maltreatment and/or neglect. There are a number of programs within CPS that cover individual, group and family interventions, and the most appropriate program for young people with HSB is therapy for children and young people under the age of 18. This specific program works not only with children and young people, but also family members where abuse, neglect or psychological maltreatment has been recognised and there is proof of resulting harm that needs to be addressed to restore and enhance health. Referrals for CPS therapy are accepted from the Department for Child Protection, South Australia Police (SAPOL), other professionals, and parents and carers. Other therapeutic treatment services offered at CPS are primarily aimed towards children under 12 years of age (Women's and Children's Hospital, 2019).

The final therapeutic service offered through CPS is the Keeping Them Safe (KTS) program, which offers long-term therapy for children who are under the guardianship of the Minister, or of Aboriginal or Torres Strait Islander descent, or aged 12 years and under. Referrals to the KTS program are only accepted from the Department for Child Protection and the eligibility criteria for this service specify that children must be mandated. No voluntary referrals are permitted.

In addition to the two services under the WCHN discussed above, several other specialist services exist in South Australia. The Sexualised Behaviour Treatment Service provides therapy to children aged 2–12 years and their families or carers where the key concerns are problematic sexual behaviours and where there is a suspicion of unconfirmed recent sexual abuse to the child. Referrals for the Sexualised Behaviour Treatment Service are accepted from the Department for Child Protection, SAPOL, other professionals, parents and carers. Referrals for treatment are also accepted from the eastern and western CAMHS catchment areas (Women's and Children's Hospital, 2019).

Youth Justice Psychology Services (YJPS) provides interventions

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35 The Traffic Lights system is a framework, developed by Family Planning Queensland, that guides people working with children to identify, understand and respond to child and adolescent sexual behaviours. Green represents sexual behaviours that are normal, age appropriate, spontaneous, curious, mutual and easily diverted experimentation and provides opportunities to talk, explain and support. Orange identifies sexual behaviours that are considered outside the "normal" range of behaviour, concerning persistence, frequency and inequality in age. Exhibiting power signals the need for supervision and the provision of extra support. Red signifies sexual behaviours that are problematic, harmful, forceful, secretive and compulsive. Portraying coercive and degrading behaviours signals the need to provide immediate intervention and protection and to follow up with additional support.

and assessments for young people with HSB who are subject to a sentenced order. YJPS also provides psychological assessments and behaviour support strategies for high-risk young people, as ordered by the Youth Court (South Australia. Department of Human Services, 2019b).

Independent services established with the primary purpose of providing therapeutic responses to children with PSB or young people with HSB include ACT for Kids, Shine SA and the Childhood Sexual Abuse Counselling Service (Uniting Communities).

ACT for Kids is a non-government organisation based in Marden, in the northeast of Adelaide. It provides services tailored towards preventing and treating child abuse and neglect and is funded by the Department of Communities, Child Safety and Disability Services. There are a number of specialist programs within ACT for Kids that cover individual, group and family interventions, although the most appropriate program for young people with HSB is the Sexual Abuse Counselling Service (SACS). Children 12 years and under who display early problematic or reactive sexual behaviours and young people under 18 years of age who have experienced unwanted sexual contact are eligible for SACS. The SACS program is intended to provide individual, centre-based and outreach counselling to children and young people.

At the time of writing, no HSB-specific service tailored towards working with people from Aboriginal and Torres Strait Islander or CALD backgrounds has yet existed. The Metropolitan Aboriginal Youth and Family Services (MAYFS) provides culturally sensitive, family-centered generalist programs that promote pathways for positive change for Aboriginal children, young people and their families. Referrals to MAYFS come from youth justice case managers, the Department for Child Protection case managers and service providers to youth at risk (South Australia. Department of Human Services, 2019a).

Although MAYFS does not offer specialised counselling or therapeutic treatment services for children and young people with either PSB or HSB, there are a number of programs delivered by MAYFS that are appropriate for this population of young people with HSB. The first is the Warpulaiendi Program (Programs Team), a co-ed program delivered within the metropolitan community for at-risk Aboriginal young people between the ages of 10–18 years. Other appropriate programs include the Panyappi Program (Mentoring Team), which provides mentoring services for Aboriginal young people aged 10–19 years, focusing on early intervention and prevention for young people who are experiencing complex issues that may place them at risk of offending or becoming victims of crime. At present, it seems that MAYFS will often refer young people who exhibit PSB or HSB to more specialised services.

As in other jurisdictions, the major challenges to a comprehensive service delivery in South Australia is ensuring that individuals residing outside of metropolitan zones, in regional and rural areas, can have access to services (O'Brien 2010, p. 91). Shine SA, Childhood Sexual Abuse Counselling Service, BIS, ASAPP and CPS are all based in the metropolitan area, and there are little to no permanent outreach services catering for young people engaging in HSB. CAMHS and ACT for Kids are just two of the services that offer outreach services in country areas to ensure that mental health support services are being provided to children and young people statewide. The major constraints to these services are often presented when these country services refer clients on to more specialised services that are based within a metropolitan area. Currently, there are issues around the difficulties for families in rural and regional areas in commuting to services.

Tasmania

In Tasmania, there is no primary, publicly funded, designated service for responding to young people with HSB.

The Sexual Assault Support Service (SASS) is the only community-based organisation servicing the needs of victims/survivors of HSB in the state. Located in the south of Tasmania, SASS offers trauma-informed counselling and support services to survivors of sexual violence, family members, carers, friends of victims/survivors and professionals working with people affected by sexual harm.

SASS is funded by the Tasmanian Government (through the Department of Communities Tasmania) to deliver a therapeutic behavioural change program to children aged up

to and including 11 years. Eligibility criteria for the service stipulate that the young person is aged 11 years or under, must display PSB or HSB, is not deemed to be a safety risk to SASS or other clients, and is willing to engage (along with their family members) with SASS. The service program adheres to the *SASS Practice Handbook for Responding to Children and Young People with Problem Sexual Behaviour* and the *Tasmanian Standards of Practice for Problem Sexual Behaviour and Sexually Abusive Behaviour Intervention and Treatment Programs* (SASS, 2012), which are based on the Victorian *CEASE Standards of Practice for Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Programs* (CEASE, 2016).

SASS also works with adolescents aged 12–17 years who are displaying PSB or HSB on a fee-paying basis.

Victoria

The Department of Health and Human Services funds 12 SABTS to provide services across the state. At present, Centres Against Sexual Assault (CASA) are the primary therapeutic provider of the SABTS. This is inclusive of the Centre Against Violence and the Gatehouse Centre (part of CASA). Treatment centres are located in metropolitan and rural regions. The Australian Childhood Foundation and Children's Protection Society also deliver the SABTS model.

SABTS are funded to provide therapeutic treatment for children under the age of 18 and their families for up to 24 months, either in a voluntary capacity or subject to treatment made via a therapeutic treatment order (TTO). New South Wales initiated TTOs in the Australian context; Victoria followed and has implemented TTOs more substantially as part of a single-service system that enables voluntary referral and engagement, a statutory mechanism to mandate treatment, and a criminal justice response.

A TTO (and its legislative and practice provisions) enables a young person to be mandated to SABTS. Prior to their introduction, if the young person and/or their family were unable to engage in treatment and if there was no finding of guilt, there was no avenue to engage the young person in treatment. TTOs are mandated court orders, often ordering

for a maximum period of 12 months of therapy, whereby the young person is required to participate in an appropriate therapeutic treatment program.

Western Australia

There are considerable challenges in providing statewide services in Western Australia, given the size of the state and the heterogeneous nature of the population. The primary services available for young people with HSB in Western Australia are provided through the Department of Justice and the Department of Communities (formerly the Department of Child Protection and Family Support). The Child Protection Unit at Perth Children's Hospital also provides limited services to children and young people with HSB.

Department of Justice

The Department of Justice funds Youth Justice Psychological Services (YJPS) for adjudicated young people. YJPS provides largely individual psychological interventions for young people with sexual offences. Treatments are targeted at addressing evidence-based risk factors for general and sexual offences. These include motivation for change; sexual interests; sexual drive/pre-occupation; social skills; personal maltreatment history; attitudes, beliefs and/or cognitive distortions; emotional management; self-image; family relationships; peer relationships; and community supports.[36]

The YJPS psychology team is comprised of 13 full-time employees, two part-time employees, two team leaders, one principal psychologist manager, and three full-time senior project officers. All psychologists hold a masters or doctoral degree in clinical/counselling or forensic psychology and have attended regular professional development sessions pertaining to young people with HSB.

Department of Communities

The Department of Communities[37] funds the community services sector to provide therapeutic responses to young

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36 Submission from the Department of Justice, Western Australia.

37 In 2017 there was an amalgamation of several government departments in Western Australia. As a result, the Department of Communities now comprises a number of pre-existing departments, including the Department of Child Protection and Family Support.

people and families who have experienced sexual abuse. There are currently 10 not-for-profit organisations that provide 13 Child Sexual Abuse Therapy Service (CSATS) programs in Western Australia. There are also two not-for-profit organisations providing Indigenous Healing Services (IHS).

CSATS programs provide healing, support, counselling and therapeutic responses to children, 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, sexually abusing other children. The service requirements are as follows:

- Services assist children and young people to recover from harmful impacts of child sexual abuse, and assist families and communities to support children and young people in the healing process.
- The safety of children and young people is enhanced when families and communities learn how child sexual abuse harms their children, families, kinship relations and community, and how to prevent future child sexual abuse. This includes the development of safety plans with family and significant others to keep children and young people safe.

Children and young people who are responsible for, or at risk of, sexually abusing other children are assisted to accept responsibility for their behaviour and develop knowledge and skills to stop abuse occurring. The *Standards for the Delivery of Child Sexual Abuse Therapeutic Services* (Western Australia. Department for Child Protection and Family Support, 2014) do not provide specific therapeutic guidelines for working with young people and HSB. Instead, the document contains a set of practice goals that services should have achieved or be working towards. For example, Standard 2: Professional service provision requires that:

- service providers have mechanisms in place to guide professional conduct in the workplace
- service provision is planned, purposeful, reflective and client-focused
- evidence-based theoretical and practical models inform and guide interventions.

The service descriptions outlined in *Metropolitan and Regional*

Child Sexual Abuse Therapeutic Services (Western Australia. Department of Child Protection, 2010) show that CSATS providers have taken different approaches in developing their treatment models (i.e. eligibility criteria, referral pathways, priority areas and therapeutic approaches vary depending on the service provider). Differences in therapeutic models may be indicative of a number of factors such as service location, client demographic, demand for services, service philosophy, and the clinical training of service providers.

The extent to which services are able to respond to children and young people with HSB "depends on the service model for the individual agency, and the clinical skills of the service providers" (O'Brien, 2010, p. 95). To our knowledge, there has been no external evaluation of services for young people with HSB in Western Australia, however they are reviewed internally over the life of the contract and have regular reporting requirements.

In addition to CSATS programs, the Department of Communities contracts private practitioners who work with children with HSB.

Child Protection Unit

The Child Protection Unit (CPU) is based at the Perth Children's Hospital and provides some outpatient services for children with HSB. This service, funded by Western Australia Health, provides medical, forensic, social work and therapy services for children up to the age of 16 who have experienced some form of child abuse and their families. Some of these cases are for children with HSB; however, this therapy service is only available to children up to 12 years of age.

The CPU conducts an extensive assessment of clients with HSB, to discern whether the harmful behaviours being displayed are the result of the child's own experience of abuse (i.e. re-enactment of trauma) or some other cause. Following this initial assessment, individual treatment programs are designed for each client.

Table 6: Services available for young people 10–17 years

with HSB by jurisdiction

Program/service provider	Location	Specialist HSB	Age of clients	Referral sources	Restrictions
Australian Capital Territory					
Program for sexualised and sexually harmful behaviours Child at Risk Health Unit (CARHU) ACT Health	Canberra Hospital	Yes	<10 years	Any source	Child and Youth Protection Services or NSW Department of Community and Justice must be involved
Therapeutic Welfare Interventions (TWI)	Canberra	Unclear	<18 years	Any source; mostly from schools, family and self-referral	Do not provide treatment services but refer clients to an accredited (Child Sex Offender Counsellor Accreditation Scheme [CSOCAS]) clinician in NSW
New South Wales					
New Street Adolescent Services	Four local health districts, including: · Illawarra, Shoalhaven, Sydney and Central Coast · Western Sydney · Hunter New England · Rural Western NSW	Yes	10-17 years	Any source, but report of HSB must be confirmed by Joint Investigation Response Team or FACS	Young person cannot have been charged with a sexual offence associated with the referring report
Queensland					
GYFS	Statewide	Yes	10-17 years	Youth Justice, Department of Child Safety, Youth and Women	Young person must have been adjudicated for a sexual offence and referred for a pre-sentence assessment or treatment services

Table continues overleaf

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

Program/service provider	Location	Specialist HSB	Age of clients	Referral sources	Restrictions
Bravehearts	Strathpine	Yes	12-17 years	General public, Youth Justice, Child Safety Services, Queensland Police, schools, general practitioners, and other agencies	
Laurel Place	Maroochydore, Gympi, Murgon and Moreton Bay		13-16 years	Department of Child Safety, Youth and Women; Queensland Police Service or other government department	Have sexually abused
Phoenix House	Bundaberg		>10 years		
ACT for Kids	Townsville (provides centre-based and outreach support); Wynnum, Beenleigh and Redlands Bay regions (outreach service available to children and families)		<12 years who exhibit early sexually reactive behaviour	Only accepts referrals from Department of Child Safety, Youth and Women	
Mater Family and Youth Counselling Service	Brisbane			Department of Child Safety, Youth and Women	Young person convicted of a sexual offence
Evolve Therapeutic Services (ETS)	Kirwan			Referrals only accepted from the Department of Child Safety, Youth and Women	
Tablelands Sexual Assault Service (TSAS)	Atherton		>15 years	Any sources.	

Table continues overleaf

Program/service provider	Location	Specialist HSB	Age of clients	Referral sources	Restrictions
Mercy Community Services	Goodna, Toowoomba		0-12 years who are subject to child protection statutory intervention	Referrals only accepted from the Department of Child Safety, Youth and Women	
Wide Bay Sexual Assault Services (WBSAS)	Hervey Bay				
True: Child and Family Service	Cairns				
South Australia					
ACT for Kids	Marden	Yes	<12 years who exhibit early sexually reactive behaviour	Unknown	
Enfield	Enfield Behavioural Intervention Service (BIS)		5-18 years	Any source and referrals processed through CAMHS	
Shine SA	Metropolitan Adelaide and regional services			Any source	Only see voluntary clients; do not provide counselling or therapy to those who have been formally accused of "sexual offending"
Adolescent Sexual Abuse Prevention Program (ASAPP), CAMHS	Paradise	Yes	12-18 years		
Youth Justice Psychology Services	Adelaide	Yes	10-17 years	Youth Justice (clients convicted of violent, sexual or high frequency repeat offending)	Prioritises young people who have been convicted of serious offences and/or are at high risk of re-offending

Table continues overleaf

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

Program/service provider	Location	Specialist HSB	Age of clients	Referral sources	Restrictions
Tasmania					
Sexual Assault Support Service (SASS)	Hobart	Yes	0–11 years	Any source	Only see voluntary clients; service exercises discretion in accepting referrals where child displays behaviour deemed to be a risk to others
Sexual Assault Support Service (SASS)	Statewide	Yes	12–17 years	Any source	Fee-paying basis as program is not Government-funded; only see voluntary clients; service exercises discretion in accepting referrals where adolescent displays behaviour deemed to be a risk to others
Victoria					
Sexually Abusive Behaviours Treatment Services (SABTS) Victoria Centres Against Sexual Assault (CASA) Children's Protection Society (now Kids First) Australian Childhood Foundation	CASA Metropolitan (Gatehouse) Ballarat Barwon Centre Against Violence (previously Upper Murray CASA) Gippsland Goulburn Valley Loddon Campaspe Mallee Sexual Assault Unit South Eastern South Western Australian Childhood Foundation Heidelberg West Children's Protection Society Thomastown	Yes	10–17 years	Department of Human Services (Child Protection), Youth Justice, Schools, Community Organisations, Police, TTO referrals, voluntary or mandatory referrals	

Table continues overleaf

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

Program/service provider	Location	Specialist HSB	Age of clients	Referral sources	Restrictions
Transformers Program	Australian Childhood Foundation (ACF)	Yes	<14 years	Department of Human Services (Child Protection)	Access to service is only limited to young people residing in the 6 local government areas: Boroondara, Manningham, Maroondah, Monash, Whitehorse, Yarra Ranges
Berry Street	Melbourne region Gippsland region Hume region Northern region South Eastern region Western region	0–17 years	Any sources	Referral is required for young people 0–14 years; no eligibility exclusions for young people 15–17 years	
Bravehearts	Geelong		12–17 years	Youth Justice, Child Safety, Headspace, psychologists, families	
Australian Community Support Organisation (ACSO) Problematic Sexual Behaviour Service (PSBS)			12+ years	Referrals are only accepted from Disability Service (DS) or DS-funded clients services (e.g. Anglicare)	Clients must have an intellectual disability; other eligibility criteria exist and are determined according to a compulsory developmental psychological assessment or a test of socio-sexual knowledge
Male Adolescent Program for Positive Sexuality (MAPPS) Caraniche	Youth Detention services	Yes	10–21 years		

Table continues overleaf

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

Program/service provider	Location	Specialist HSB	Age of clients	Referral sources	Restrictions
Western Australia					
Goldfields Child Sexual Abuse Therapeutic Service (Centrecare Inc.)	Goldfields (Kalgoorlie)		4–18 years	Department of Communities, self-referrals, general practitioners, schools	Clients must be between 4–18 years
Anglicare Great Southern Child Sexual Abuse Therapeutic Service (Anglicare WA Inc.)	Great Southern (Albany, Manjimup and Katanning)		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
Child Sexual Abuse Therapy Service—Perth (Anglicare WA Inc.)	Metropolitan (Gosnells, Midland, Joondalup, Rockingham)		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
Perth Children's Hospital—Child Protection Unit (CPU)	Metropolitan (Nedlands)		<12 years	CPU receive calls and referrals regarding inappropriate sexual behaviours from private sources	Only provide intervention services for children up to 12 years; treatment is only available following initial assessment of risk
Child Sexual Abuse Treatment Service—Perth Metropolitan Area (Phoenix Support & Advocacy Service)	Metropolitan (Coolbinia)		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
UnitingCare West Child and Family Therapeutic Service (UnitingCare West)	Metropolitan (Fremantle) and Merriwa		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
Yorgum Healing Service (Yorgum Aboriginal Corporation)	Metropolitan (East Perth)		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children

Table continues overleaf

Program/service provider	Location	Specialist HSB	Age of clients	Referral sources	Restrictions
Parent's and Children's Therapeutic Service (Parkerville Children and Youth Care Inc.)	Mirrabooka		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
Carnarvon Sexual Assault Response Service (Carnarvon Family Support Service Inc.)	Murchison		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
Child Sexual Assault Counselling Service (Desert Blue Connect Inc.)	Murchison		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
Peel Child Sexual Abuse Therapeutic Service (Allambee Counselling Inc.)	Peel		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
Yaandina Child and Family Counselling Service (Yaandina Family Centre Inc.)	Pilbara		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
Waratah Child Sexual Abuse Therapeutic Service (Waratah Support Centre Inc.)	South West		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
Indigenous Child Sexual Abuse Response Service –Marooloo (Anglicare WA Inc.)	West Kimberley		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children

Table continues overleaf

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

Program/service provider	Location	Specialist HSB	Age of clients	Referral sources	Restrictions
Therapeutic Family Service–Wheatbelt Region (Parkerville Children and YouthCare Incorporated)	Wheatbelt		<18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children
Indigenous Healing Service–Hedland (MacKillop Family Services Ltd)	Pilbara		0–18 years	Any source	Children and young people who are responsible for or who are at risk of sexually abusing other children

Note: Blank cells indicate we were unable to obtain this information.

Responses to the request for information

Where the desktop review focused on service availability, the request for information sought insight from practitioners working with young people (aged 10–17 years) with HSB in relation to current intervention strategies, workers' perspectives regarding their efficacy, challenges faced in delivering services, and ideas about effective evaluation processes. Practitioners may be located in specialist services, as part of more general child welfare services or within private practice.

We received a total of 131 responses to the request for information, with 59 complete and 72 incomplete attempts overall. The majority of incomplete attempts (~60%) did not progress further than the preliminary questions relating to the worker's background, experience and relevant qualifications. While the request for information complements the desktop review by providing more granular, practitioner level information, the data generated are limited—specifically:

- The request for information instrument was an *information gathering* tool, not a validated, cognitively tested survey instrument. As such, it is possible that respondents brought their own interpretations to questions and responded accordingly.
- The request for information was an opt-in invitation circulated via a range of distribution channels. This means that we do not know what proportion of specialist workers did not respond (as there was no sampling framework). The results therefore are not generalisable beyond the 59 completed responses.

The analysis below draws from the 59 completed responses and reports on:

- worker profile
- characteristics of service
- client characteristics
- systems context
- service review.

Respondent profile

Of the 59 respondents, 50 were female (84.75%). All respondents had some level of tertiary education. Fifty-four respondents possessed a bachelor degree or higher, with 20 holding at least one postgraduate qualification (see Figure 7). The most commonly held bachelor degrees were in social work (n=28) and psychology (n=21).

Figure 8 shows that 19 respondents had been working with young people with HSB for over a decade. A further 15 respondents reported having between 6–10 years of experience.

In sum, clinical and therapeutic practitioners working in the area of HSB responding to this request for information were predominantly female; relatively mature workers, with 25 (~42%) of respondents reporting their age as 45 or older (see Figure 9); highly qualified, with 20 holding at least one post-graduate qualification; and highly experienced. These characteristics are similar to those reported in findings from a recent national survey of workers in the domestic, family and sexual violence sectors (Cortis et al., 2018, pp. 30–34). Of the 1134 respondents in this study:

- 83 percent identified as female
- almost 50 percent were between the ages of 35 and 54 (with a quarter over the age of 55)
- more than one third held a bachelor-level qualification, with almost a third holding a postgraduate degree.

Service and client characteristics

Service characteristics

The following section reports on responses regarding how long services have been in operation, their location, and who was eligible to access the service.

Thirty-one services had been in operation for at least 20 years. Only a few respondents indicated that the service had been in operation for less than 5 years (see Figure 10). The number of practitioners engaged in HSB therapeutic work varies, with the majority of services employing 1–5 practitioners who worked directly with HSB (see Figure 11).

Figure 7: Practitioner qualifications

- Postgraduate degree
- Graduate diploma or graduate certificate
- Bachelors degree
- Diploma or advanced diploma
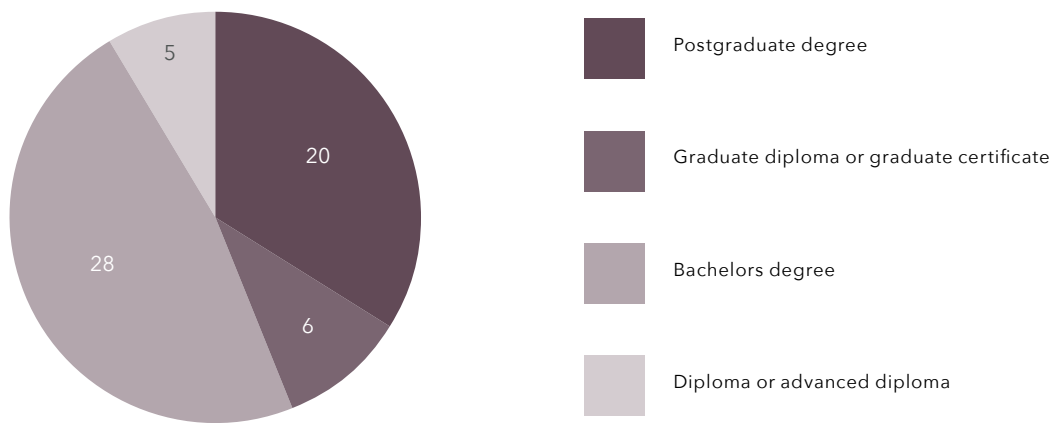
Figure 8: Practitioner experience

Years of experience
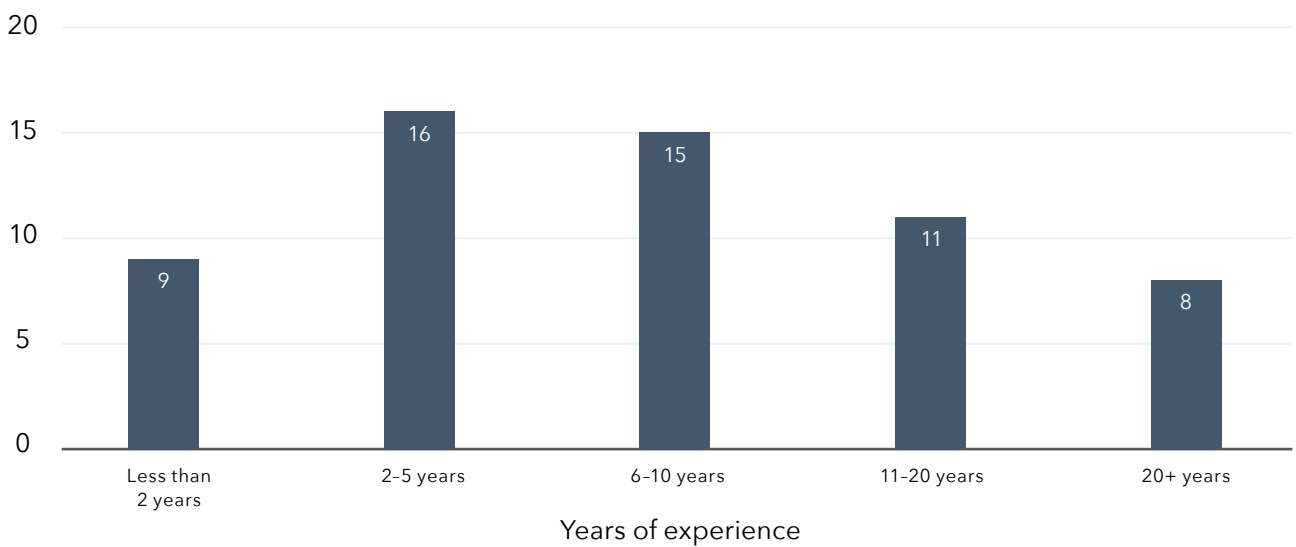
Figure 9: Practitioner age

Age in years

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours
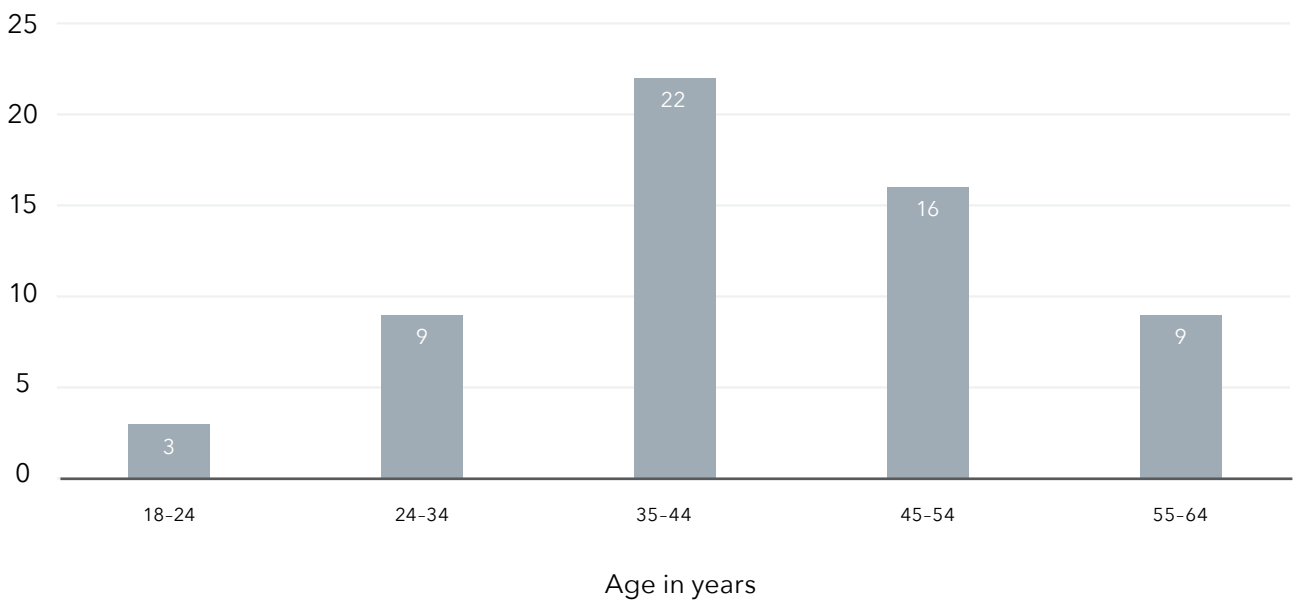
Figure 10: Years of service operation

| 3 | 2 | 13 | 2 | 3 | 31 | 5 |

- < 1 year
- 1–5 years
- 6–10 years
- 11–15 years
- 16–19 years
- 20+ years
- Unknown
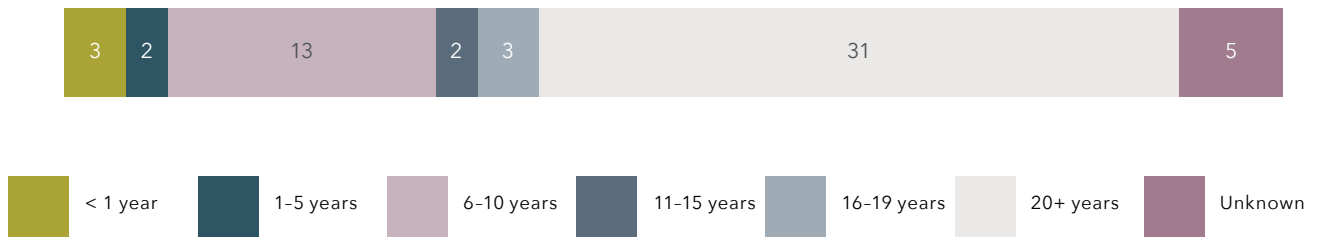
Figure 11: Number of practitioners engaged in HSB work in a service
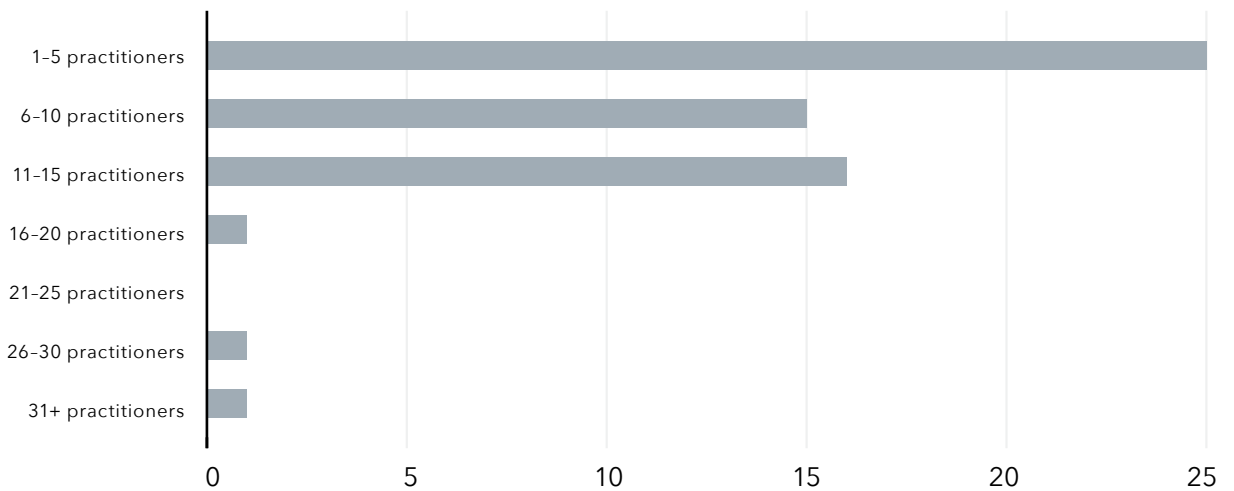
Note: Data for the category of 31+ practitioners may be an outlier, as respondent works in Department of Child Protection and included entire staff.

As shown in Figure 12, respondents were unevenly distributed across the country, with the majority coming from New South Wales and Queensland. Given the statewide service system in place in Victoria for HSB, the lower engagement in the request for information from this state was somewhat surprising.[38]

Client eligibility criteria vary among HSB and SAB services. Figure 14 shows that clients' age, reports made to a relevant government department, and other clientele characteristics—such as if the client has identified as any gender/non-gender specific/gender fluid—are the top three criteria used by services to filter which young people can access the service.

While there were specific eligibility requirements, respondents indicated that their services are targeted towards the general population. Those who stipulated a specific target population for their service most commonly selected Aboriginal and Torres Strait Islander peoples or clients who were of low socio-economic status (see Figure 15).

Referrals come from a range of sources but are most commonly made through the state or territory's Department of Human Services/Child Protection, schools, police, or the families themselves (i.e. self-referral). From the obtained responses, the priority criteria for new referrals appears to vary between services (see Figure 16). Clients were prioritised if they fit the service's age criteria, indicated signs of complex trauma, and/or were from an Aboriginal and/or Torres Strait Islander background. Respondents who nominated "other" criteria provided examples such as prioritising clients who demonstrate a high level of risk, possess limited protective factors, have a high level of complexity, or have a court order (see Figure 17).

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38 There are several possible reasons for this. At the time the request for information was being circulated and the project team was meeting with services to promote the project, Victorian service providers were also being consulted about the increase in age to 17 for SABTS clients. It is possible practitioners understood these to be the same project, and assumed they had already provided information. There is also only a small private practice or other NGO sector doing this work in Victoria, meaning that if the SABTS providers were less inclined to respond to the request for information, there is not really another group of clinicians to reach. Finally, the program of reform following the Royal Commission into Family Violence recommendations is extensive and involves considerable engagement from the community services, family violence and sexual assault sectors. There may simply have been limited capacity to engage with the survey.

Figure 12: Location of service by state/territory

Figure 13: Geographic coverage of services
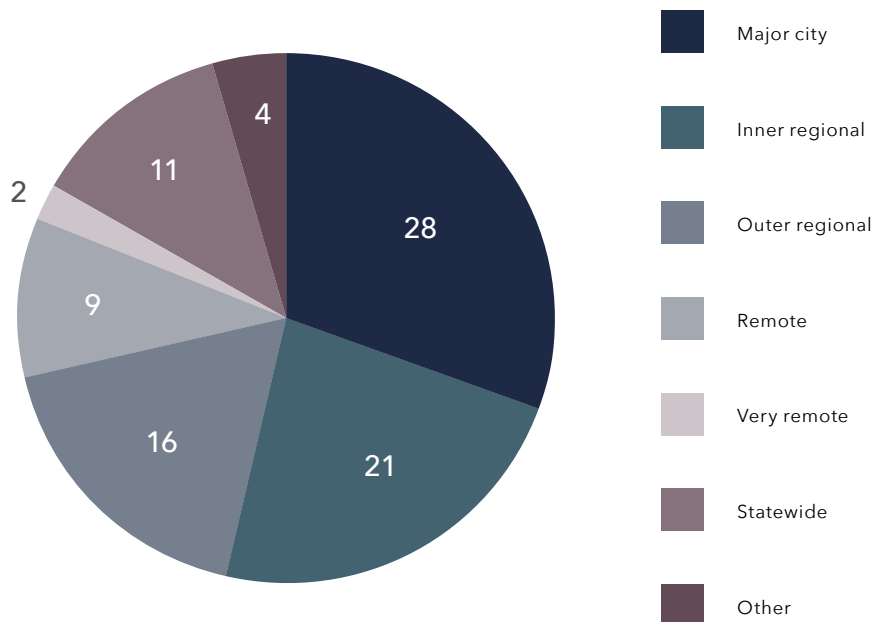
Note: Multiple responses were allowed.

Figure 14: Eligibility criteria for services

Category	Value
Age	46
Report made to relevant government department	28
Other	21
Disclosure of abuse by victim	11
Conviction or guilty plea for sexual offences	10
Acknowledgement of responsibility for behaviour (within the treatment setting)	6
Gender	4
Don't know	1
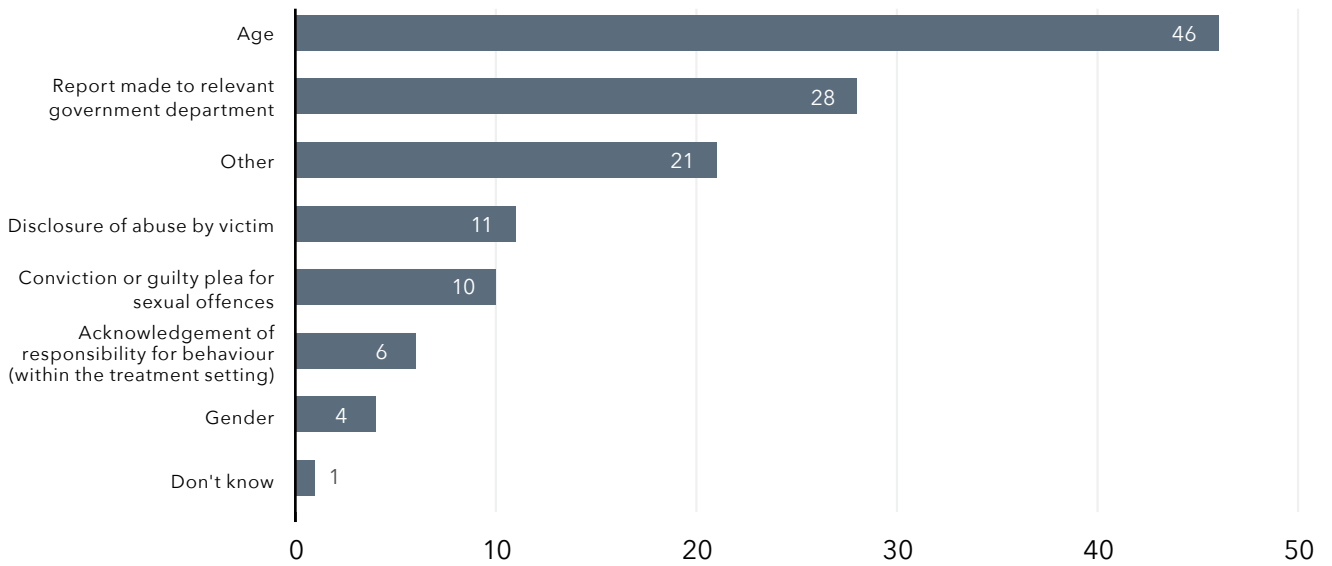
Figure 15: Client population

Category	Value
Culturally and linguistically diverse (CALD)	21
Indigenous/Aboriginal and Torres Strait Islander	31
Low socio-economic status	30
General population	43
Other	16
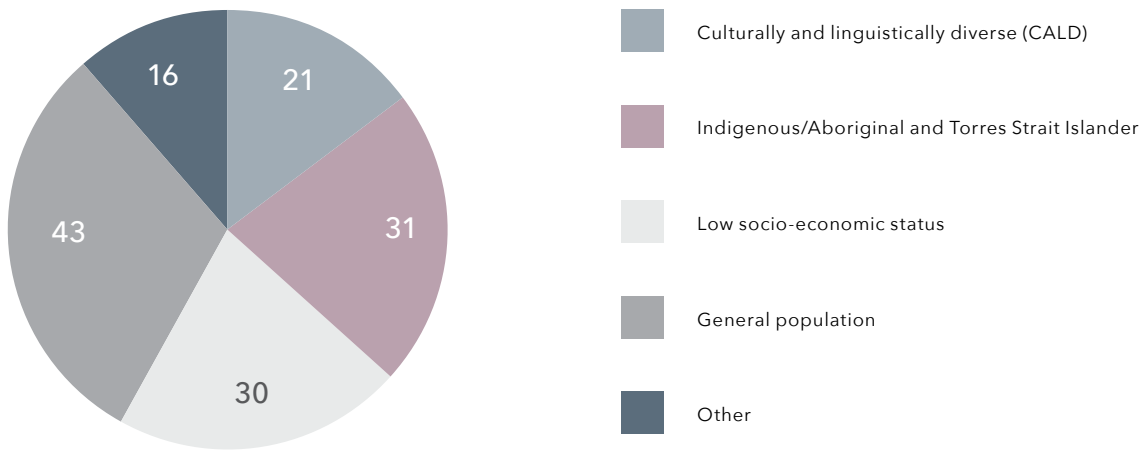
Note: Multiple responses were allowed.

Figure 16: Most common client referral sources

Category	Value
Departments of Human Services & Child Protection	46
Schools	38
Justice system (police, courts and Juvenile Justice)	37
Self-referral	33
Public health professionals	27
Private health professionals	21
Other	18
Therapeutic treatment order (Victoria only)	7

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

Figure 17: Priority criteria for services
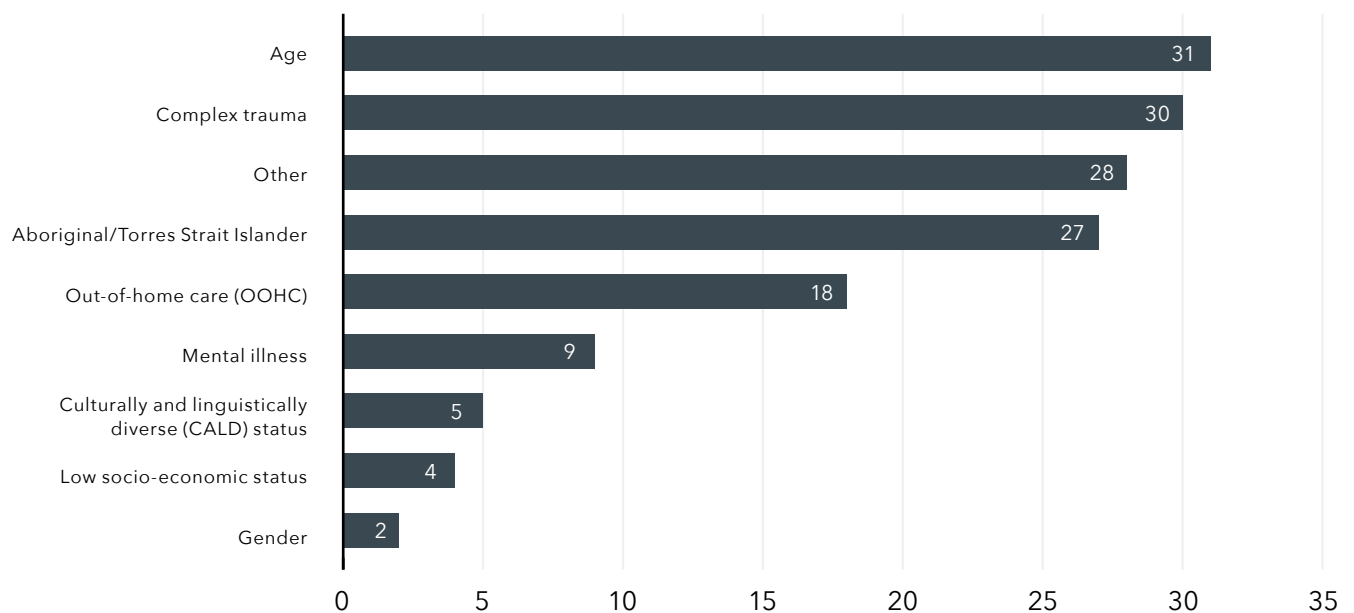
Client characteristics

Respondents were asked to provide information about the nature of their client base. The results indicate that intervention services are most commonly provided to young people between the ages of 10–14 years (see Figure 18), and that there were three key factors that practitioners saw correlating with HSB. Forty-seven respondents (~80%) indicated "history of child abuse" as a key correlative factor, followed by 30 (~50%) who indicated "exposure to family violence" and 24 (~40%) who indicated "exposure to pornography" (see Figure 19). These results suggest a degree of co-occurrence, which would be in line with the extant empirical literature. Following these three major factors, similar numbers of respondents identified issues such as poor social skills, educational difficulties, and instability at home as additional correlating factors.

Therapeutic approaches and principles

Respondents were asked to provide information about how they worked with their clients and what they saw as the key elements of good practice.

This is high intensity work: 31 respondents (~60%) worked with young people for at least 1 year (see Figure 20), and 52 respondents (88%) indicated that they saw their clients on either a weekly or fortnightly basis (see Figure 21).

Respondents were asked to select the top three most important aspects of an effective intervention from a more extensive list of good practice principles. As demonstrated in Figure 22, having the intervention tailored to the individual client was nominated by more than half of participants (n=32),

followed by having a family focus and then having an eco-systemic focus.[39] The therapeutic relationship and family participation were seen as very important by the vast majority of respondents: 95 and 86 percent respectively (Figure 23).

Respondents were asked to provide an indication of how often their practice/organisation:

- tailors interventions to each client (i.e. provides interventions that differ according to clients' socio-ecological circumstances)
- assesses the presence of a trauma history in clients engaging in HSB.

Thirty-two respondents (~55%) indicated that their organisation "always" tailors interventions to the client's socio-ecological circumstances, with an additional 21 respondents stating that this occurs "most of the time" (Figure 22). Results indicate that it is commonplace to assess the presence of trauma histories in HSB clients, with 51 respondents indicating that this "always" occurs, and the remaining eight respondents stating that this occurs "most of the time" (Figure 24).

Barriers to accessing services and completing treatment

Respondents were asked to list the top three social barriers affecting access to treatment services for young people with HSB. The results indicate that geographic disadvantage,

39 "Tailored to the client" refers to working *with* the particular capacities, needs, contexts, developmental stages and family context that the client presents with. "Individually focused" is more about working *at* the level of individual issues rather than at the level of family, relationships, peers, etc.

Figure 18: Age of clients
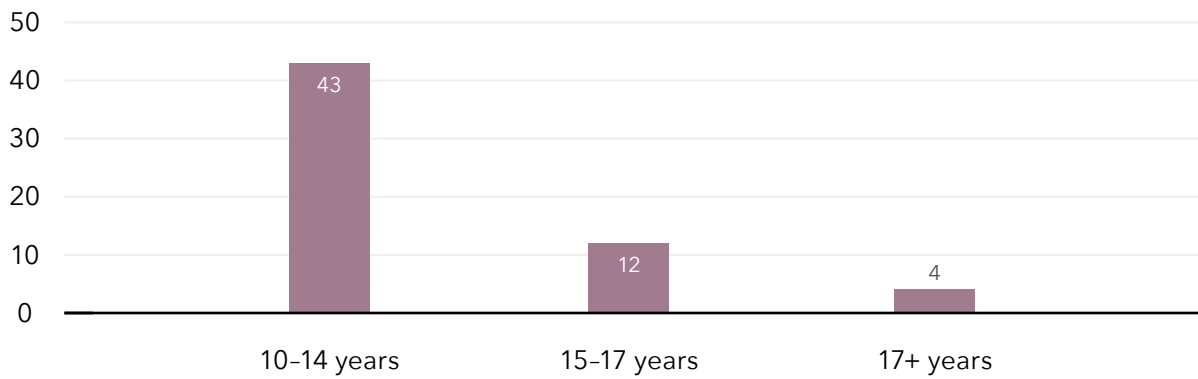
Figure 19: Common risk factors observed correlating with HSB
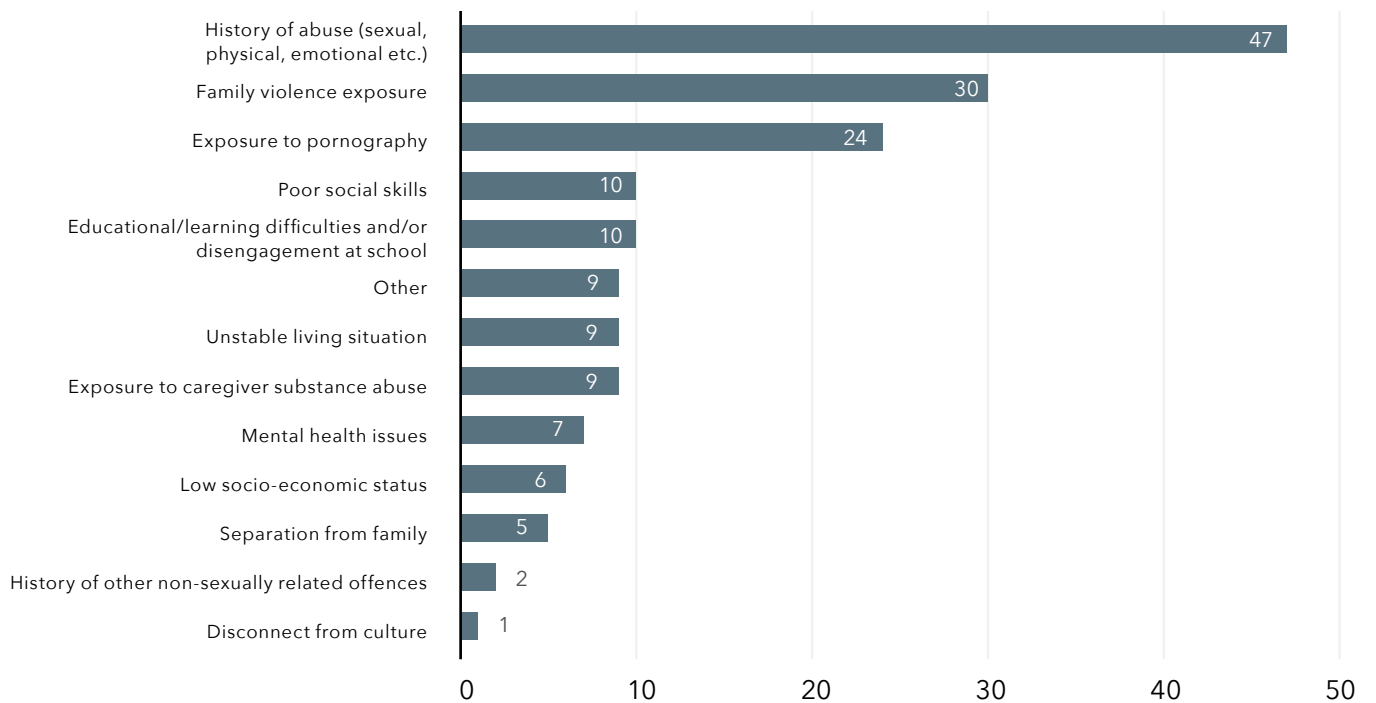
Note: Up to three responses were allowed.

Figure 20: Average duration of treatment for clients engaging in HSB

Less than 3 months	3–6 months	7–12 months	1–2 years	2+ years

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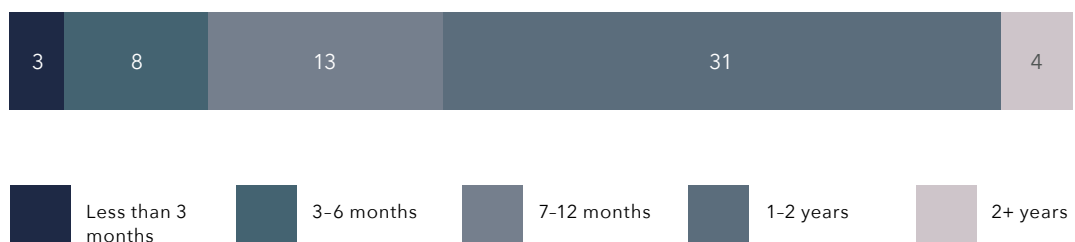
Figure 21: Average frequency of treatment for clients engaging in HSB

35	17	6	1

- Weekly
- Fortnightly
- Other
- Daily
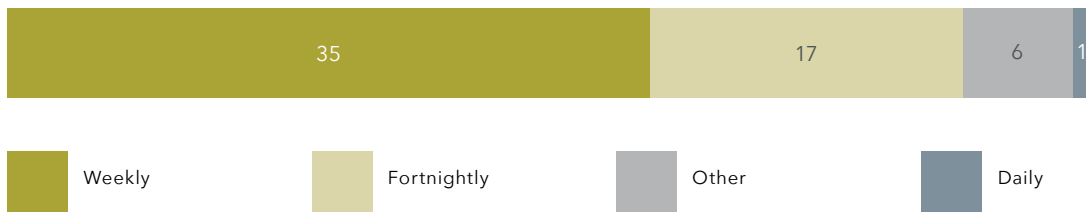
Figure 22: Most important aspects of effective intervention

Aspect	Value
Tailored to the individual	32
Family focused	26
Eco-systemically focused	21
Individually focused	20
Strengths focused	19
Culturally safe	16
Contextually sensitive	10
Goal/outcome focused	8
Other	6
Behaviourally focused	6
Focus on accountability for actions	5
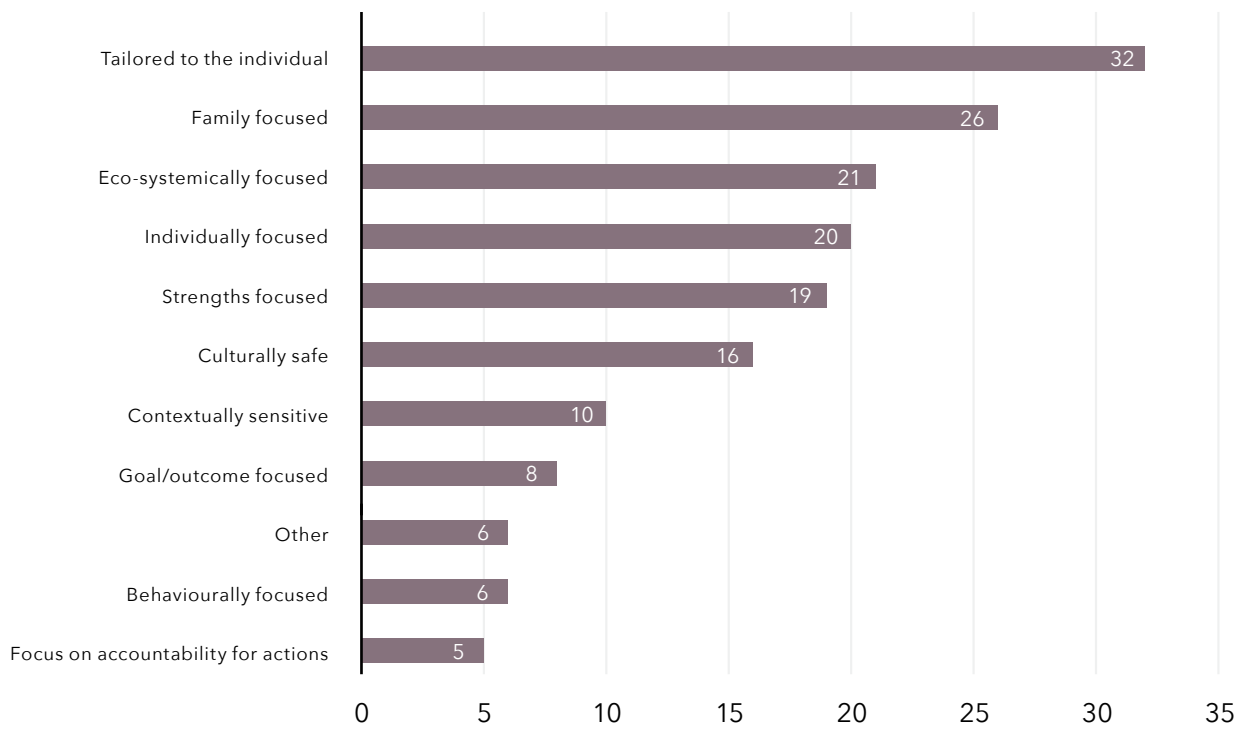
Figure 23: Key elements of good practice and their relative levels of importance

Element	Very important	Important	Moderately important
Family participation	51	6	2
Therapeutic relationship	56	3	0
Physical environment	37	21	1

- Very important
- Important
- Moderately important
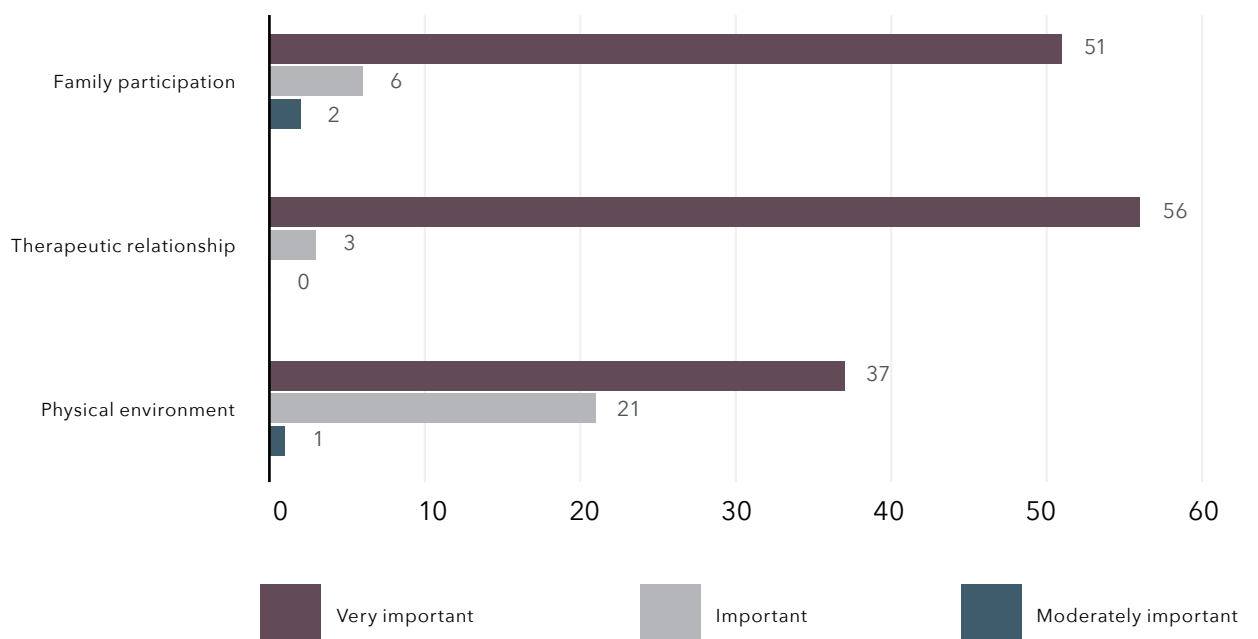
insufficient places available in services and family/guardian reluctance to participate in treatment programs were the primary barriers to accessing treatment (Figure 25). A lack of awareness of services was also a commonly cited barrier.

The major barriers affecting the completion of treatment for young people with HSB were family reluctance/inability to participate, client resistance due to other factors (e.g. behaviour disorder, substance abuse) and the geographic location of services (Figure 26).

Evaluating practice of service

Respondents were provided with a list of statements about the coordination and delivery of services within their organisation.

Respondents were asked to provide an indication of:

- how often their organisation incorporates new and relevant research findings into their practices
- whether the organisation evaluates (internally) the effectiveness of interventions for young people with HSB.

The majority (~90%) of respondents indicated that their organisation "always" or "most of the time" incorporates new research findings into their therapeutic practices. Forty respondents (72%) stated that their organisation "always" or "most of the time" evaluates the effectiveness of the interventions they are delivering (see Figure 27). Respondents indicated a range of mechanisms for evaluation including:

- formal independent evaluations
- periodic reviews
- stakeholder and client feedback.

Client treatment outcomes were also used as forms of treatment evaluation.

Service delivery context

Respondents were asked to describe their service in relation to demand, funding source(s), and extent of interaction with state justice/law enforcement and other related services. For questions regarding inter-service communication, respondents were asked to rate how regularly their service is in contact with other services (i.e. low, moderate or high level of interaction).

The results indicate a high demand for services, with the number of referrals often exceeding the resources that the service has available (see Figure 28).

Approximately 80 percent of respondents stated that their service receives funding from the state or territory government (see Figure 29), generally with ongoing or mixed contracts[40] (see Figure 30).

In free-text responses to the question of whether improvements could be made to the service system, respondents identified a range of areas for improvement. The most frequently identified were:

- Improvements to funding: ongoing and stable funding was a key issue, as was funding for services regardless of postcode/local government area/health region. The latter was viewed as an "equity of access" issue. Respondents also recommended sufficient funding to attract and retain qualified workers.
- Improvements to interagency collaboration, particularly in relation to human service agencies, child protection, out-of-home care workers, education and mental health services: shared principles and a shared understanding of therapeutic goals across these services and departments was important.
- Improvements to supporting family involvement were also key, in particular ensuring services are adequately funded to include family work as part of the intervention, including extended family members.

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40 Mixed contracts involve some level of state or territory government funding, with additional resources coming from other organisations.

Figure 24: Therapeutic practice
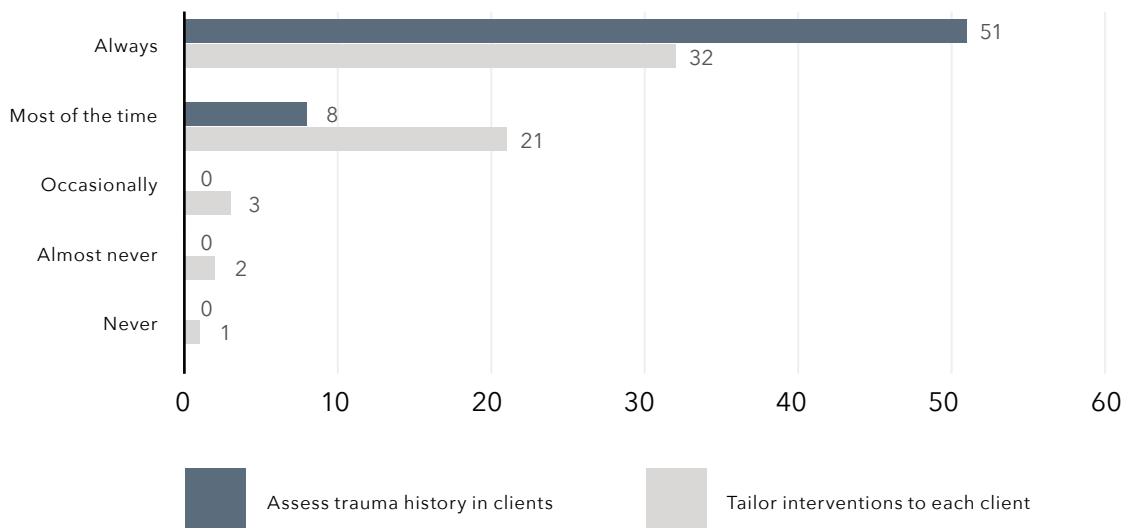
Figure 25: Barriers affecting access to treatment services
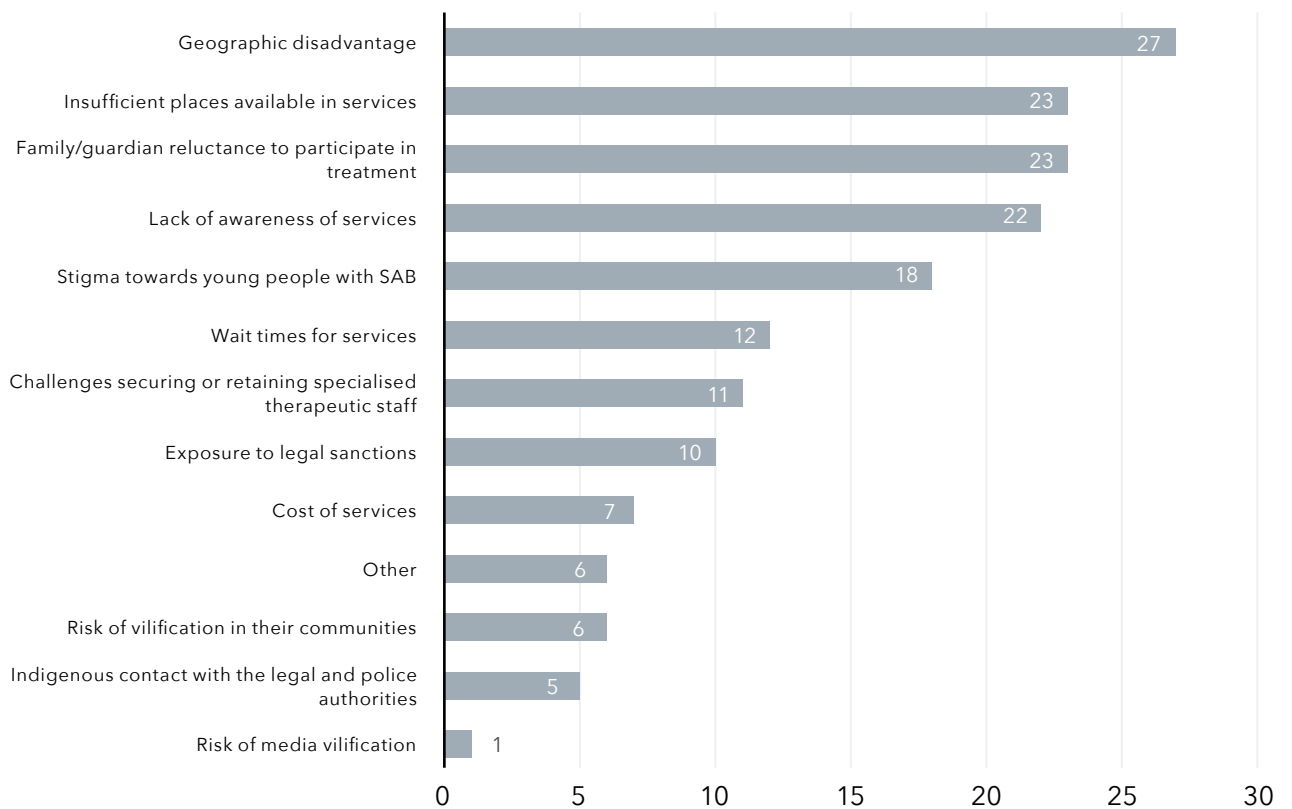
Figure 26: Barriers to completion of service treatment

Barrier	Value
Family reluctance or inability to participate	39
Client resistance due to other factors	21
Location of services	20
Other	19
Client reluctance to participate	16
Waiting times/inaccessibility of services	14
Conflicting demands with respect to OOHC	10
Cost of services	5
Conflicting demands with respect to school	4
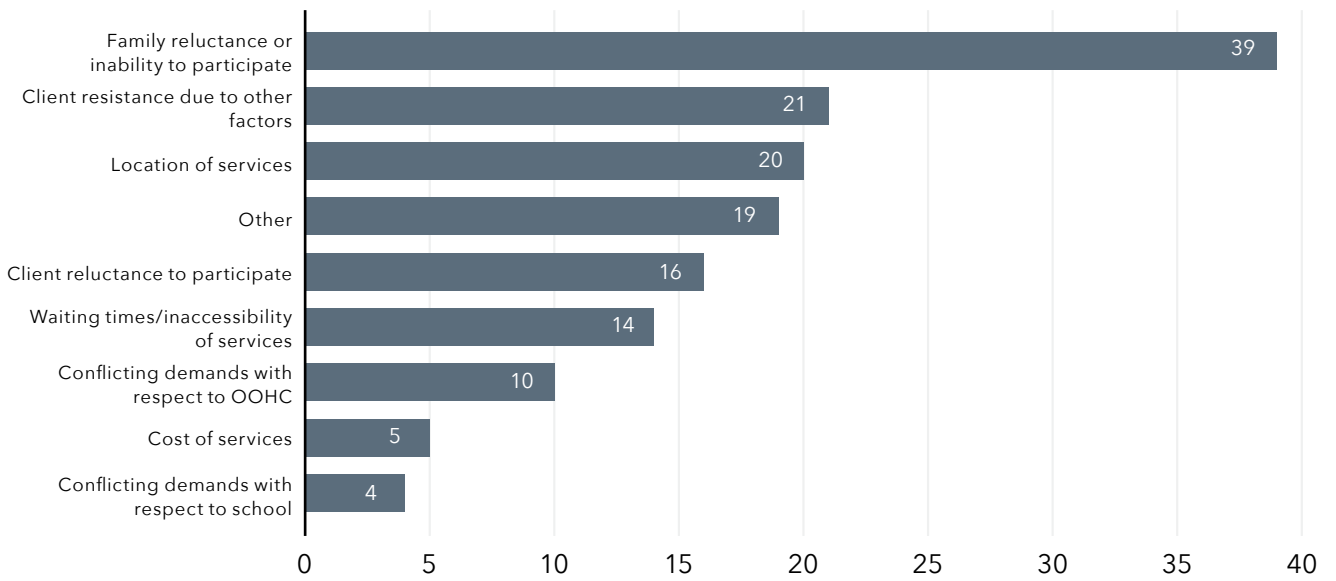
Figure 27: Evaluate the effectiveness of interventions

Category	Value
No answer	4
Never	2
Almost never	6
Occasionally	7
Most of the time	18
Always	22
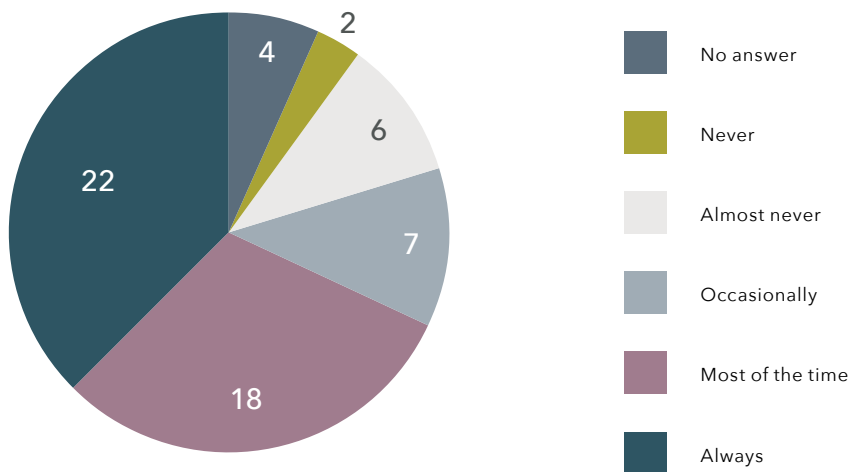
Figure 28: Referral numbers

Category	Value
Yes, sufficient	23
Yes, too many	33
No, not enough	3

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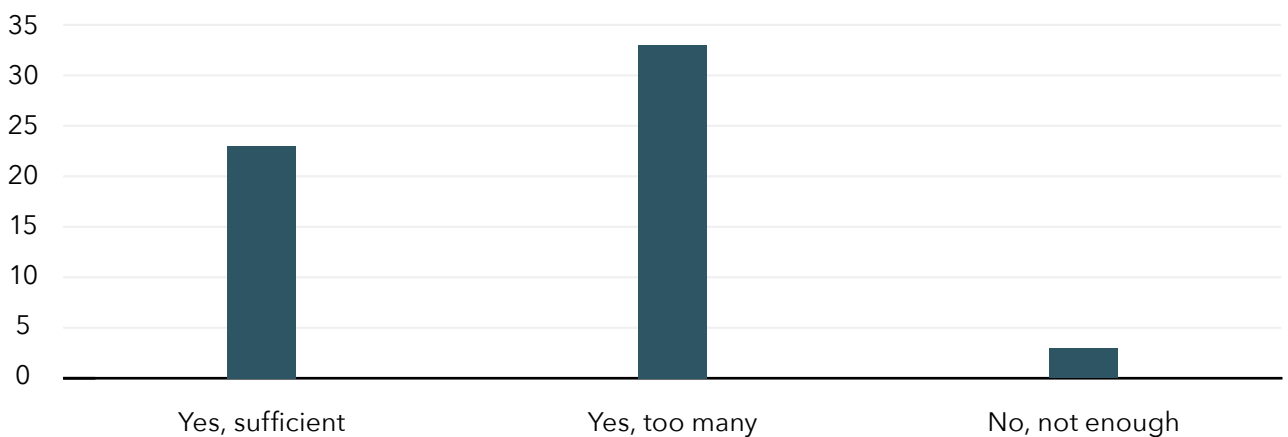
Figure 29: Funding sources

- State or territory government funding
- Mixed funding (combination of funding sources)
- Privately funded (e.g. philanthropic)
- Federal government funding
- Other
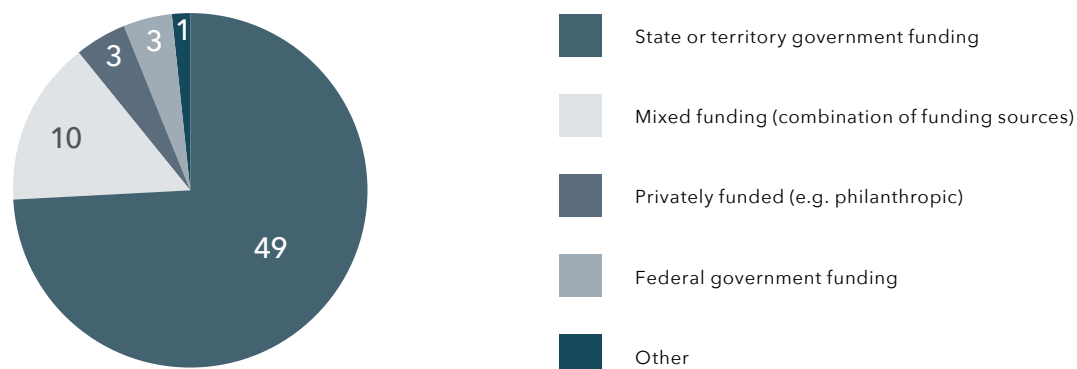
Note: Multiple responses were allowed.

Figure 30: Nature of funding received

- Ongoing
- Mixed contracts
- Intermittent (grants)
- Other
- No answer
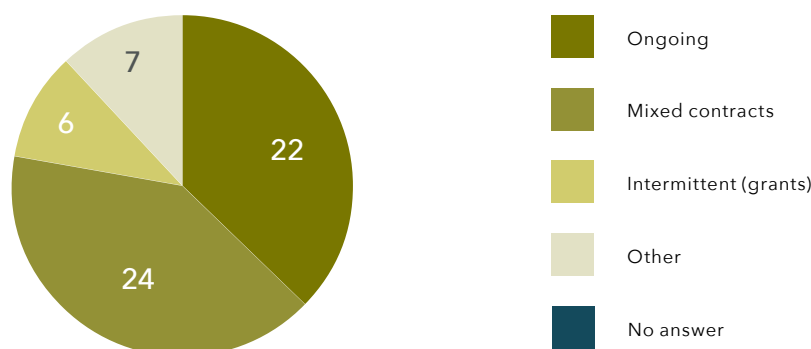
Summary

In 2010 the service landscape was characterised by:

- differences in therapeutic philosophies, treatment models, referral pathways, staff profile, eligibility criteria, funding arrangements
- geographic gaps, particularly in regional and remote areas
- demographic gaps, with particular populations ineligible for intervention
- an absence of culturally appropriate therapeutic services
- the need for workforce development, including for Indigenous and CALD practitioners. (O'Brien, 2010)

This more recent mapping of service responses suggests a shared and growing view among practitioners regarding therapeutic philosophies and treatment models. Practitioner responses to the request for information showed the following:

- The vast majority of practitioners saw traumatic experiences, particularly of child abuse and neglect and exposure to family violence, as correlated with young people's engagement in HSB. Assessing whether clients have their own trauma histories is the norm.

- The top three principles of effective intervention nominated were:
  1. tailoring the intervention to the needs of the individual
  2. working with the family system
  3. working eco-systemically (i.e. working with the young person in their familial, interpersonal and community systems).
- Practitioners are working with young people intensively to address HSB. The majority of respondents working with young people do so on a weekly basis for up to 2 years.

These responses reflect the empirical, clinical and therapeutic literature on the characteristics of young people engaging in HSB and what effective interventions involve.

However, service *availability* across Australia remains fragmented. Age appears to be the most common factor that fragments service responses in the states and territories. In many cases, the cut-off for services to accept a referral of a young person engaging in HSB is under the age of 10, or under the age of 12. In other cases, the eligible client age ranges vary from 12–17 years to 13–16 years.

Another key variation relates to who can refer young people into the therapeutic service. Variants in referral pathways include:

- any source of referral (i.e. the families themselves, schools, community service organisations, statutory child protection and police)
- referrals from several nominated agencies (e.g. child protection, police)
- referrals from only one agency.

In addition, some services have restrictions on:

- the degree of client complexity they can work with
- the severity of the behaviour (e.g. sexually reactive behaviours not SAB)
- whether the client has been formally charged with or convicted of a sexual offence.

These eligibility variations in age, referral sources and other restrictions can occur within a single jurisdiction. In practical terms, this means young people and their families or carers fall through the cracks of a fragmented and often complex service network. Further, geographical challenges (e.g. distance required to travel to attend available services) are a key barrier to families staying engaged in treatment.

O'Brien (2010, p. 16) wrote that the geographic and demographic service gaps identified in the earlier mapping were "in part a result of the ad hoc" and piecemeal evolution in service responses to children and young people with HSB. After almost a decade, one could argue that there has been sufficient time to "course correct" the ad hoc evolution of service responses by, for example, harmonising age eligibility across the service system.

However, this current service mapping indicates that there is a considerable way to go in minimising the gaps in service availability. The RCIRCSA also reported on service responses for HSB and similarly noted the service gaps that existed for particular groups of children and young people across states and territories. The RCIRCSA final report made a number of recommendations to improve service responses, namely:

- increase the number of therapeutic services
- improve referral pathways
- improve collaboration between generalist and specialist practitioners.

These are sensible recommendations. However, without an understanding of the context in which therapeutic services operate and how interactions between specialist and other relevant services influence decision-making around referrals, it is difficult to know, for example, whether there are better or worse *types* of referral pathways for young people; what *kind* of collaboration between generalist and specialist practitioners is important and why; or what this looks like in practice.

In the following chapter, we draw on the insights of specialist practitioners at GYFS, New Street and SABTS, and relevant policy and statutory professionals, to generate an in-depth understanding both of what constitutes "good practice" in this specialised area of work and how the services' operating context influences practice.

CHAPTER 4:

Insights into good practice from three service models

Overview

As described in the State of knowledge review, consensus is emerging in the extant clinical, evaluation and practice literature around principles of good practice in therapeutic responses for young people engaging in HSB (e.g. Hackett et al., 2006; Hackett et al., 2016; NSW Health, 2018a; O'Brien, 2010; RCIRCSA, 2017c; Shlonsky et al., 2017; Smith et al., 2013). Overall, this literature suggests that principles of good practice involve:

- working holistically and eco-systemically with the young person—that is, understanding the needs of the young person and working across individual, family, school and community domains of their life
- understanding and working with child and adolescent developmental processes
- understanding the bio-psychosocial impacts of trauma on children and young people
- taking a strengths-based, goal-focused approach with the young person
- tailoring approaches to the young person (including working in culturally safe ways)
- engaging family and/or carers.

These principles predominantly reflect good practice at the practitioner level. There is relatively little in the literature that explicitly considers what is required at the organisational, sectoral, or service system levels to enable and support good practice (cf. Smith et al., 2013). What features, principles and practices are needed to, for example, support working eco-systemically with the young person? Or to ensure that families and/or carers remain engaged in the therapeutic process? While specialist services and practitioners deliver the therapeutic intervention itself, a range of other service sectors and workers also have a role to play.

In this chapter we present the key findings that emerged from the investigation into three selected service models: Griffith Youth Forensic Service (GYFS) in Queensland, New Street Service (New Street) in New South Wales, and Sexually Abusive Behaviours Treatment Service (SABTS) in Victoria. This component of the research involved in-depth qualitative interviews with specialist practitioners that worked in these services (n=28), other specialist providers (n=16), and policy and criminal justice professionals that interacted with the services (n=19) about:

- what constituted good practice in specialised service provision for young people engaging in HSB
- the key "ingredients" or mechanisms that underpin good practice
- the factors in the broader service delivery context that facilitate—or hinder—good practice in specialised therapeutic interventions.

Note, when quoting directly from participants we have used the following convention of attribution: organisation/service, state, role and participant number. Where there is a risk of identifying participants, we do not name the organisation/service and refer only to the organisation/service type.

The three service models vary in their operation: they work with different cohorts of young people and receive referrals from sources and deliver interventions in different ways. There are also variations in their service delivery contexts. Understanding the features and enablers of good practice that are shared across the service models—and where they might diverge—assists in identifying salient issues about:

- the "mechanisms" (i.e. the various means by which aspects of a program might work) that underpin good practice
- the role that contextual factors (e.g. geographic location, workforce capabilities, interagency relationships, characteristics of other agencies, or legislation) have on good practice.

To elucidate the key principles of good practice, we draw specifically from the practitioners working within the three service models. In order to understand the broader contextual factors that help—or hinder—good practice we draw on the combined insights of the practitioners working in these services, the policy and statutory professionals that interface with specialist HSB service responses, and other specialist providers working outside of these services.

There are three sections to this chapter: the first section describes the characteristics of the three service models, the second section focuses on practitioner insights into good practice, and the third section explores the contextual factors that influence practice.

Service model characteristics

This section draws on responses to the pre-interview questionnaire and program information to provide an overall description of each service. The section following describes each model's service characteristics, the characteristics of the young people they see, and therapeutic philosophy and practice. Table 7 at the end of this section provides a summary of these features. The pre-interview questionnaire did not ask about the cultural appropriateness of the services.

Griffith Youth Forensic Service

Service characteristics

GYFS has been in operation for 17 years and works across Queensland, covering both metropolitan and regional areas. It is a partnership between Griffith University Criminology Institute and, originally, the Department of Justice and Attorney General (Youth Justice).[41] Although based at Griffith University, GYFS adopts a field-based assessment and treatment model. Clients do not attend sessions at the university; rather, the service operates within the young person's local context, often in collaboration with another partner (e.g. Youth Justice or another provider working with the young person such as a family member or someone from the community). In more remote locations, sessions are carried out within a school environment, the young person's home or in public meeting areas. Sessions may also be conducted at the Griffith University on-site clinic; however, these meetings are rare, and when they are carried out, this is due to special circumstances such as a parent interview or when there are safety concerns for GYFS clinicians.

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41 In 2017, Youth Justice moved from the Department of Justice and Attorney General to the Department of Child Safety, Youth and Women.

All HSB referrals at GYFS are legally mandated. All clients have proceeded through court processes and all referrals that are received come from Youth Justice. GYFS does not take referrals outside of that referral pathway and clients are all subject to Youth Justice intervention.

Waiting lists are not used. Referrals are often assessed based on cases with the highest risk and on the remoteness of location, along with where GYFS clinicians are currently located and their current caseload. If there is no capacity at GYFS to accept the case then the referral will be directed back to Youth Justice. Negotiations may then take place in regards to GYFS potentially only conducting an assessment but not administering treatment, or providing the young person with consultation in the interim while Youth Justice seeks other services or clinicians. For the cases that do not get treated by GYFS, recommendations of and referrals for private practitioners/psychologists working in the region may be made to Youth Justice to assist the young person.

There are 4.2 full-time equivalent workers who hold qualifications in clinical, forensic or general psychology. The average caseload per worker is 10 young people plus family and other stakeholders, with 40 young people on average seen per year.

Funding for the GYFS model comes exclusively from Youth Justice. GYFS is funded to provide pre-sentence assessment for court hearings and post-sentencing treatment for a fixed number of referrals for assessment and referrals for treatment within a given time period: 12 reports per year for court and 25 treatment clients per year.

Client characteristics

GYFS clients are young people who have been convicted and adjudicated and who have demonstrated a certain severity of offending. However, this alone does not qualify them to be eligible for GYFS treatment. Priority cases are assessed on a case-by-case basis, and considerations are made dependent on the young person's geographic location and level of indicated risk.

The majority of clients assessed are typically aged 14–17 years, with a significant proportion residing in out-of-home care (OOHC): placed within families or extended families via Child Safety, self-placed with friends, living in youth shelters, or living in private accommodation. As such, 11 percent of GYFS clients reside in formal OOHC placements, 24 percent are subject to child protection orders, 13 percent are from CALD backgrounds, and 30 percent are Aboriginal and Torres Strait Islander young people. GYFS sees on average 40 clients per year and 2.5 percent of this proportion are female.

Therapeutic philosophy and treatment practice

The GYFS clinical practice model has four dimensions:

1. It is field-based. Queensland has a heterogeneous, geographically dispersed population. A field-based model of travelling to the client provides equitable access to a specialist service regardless of location.

2. It is individualised—that is, designed for the individual client and informed by a risk–need–responsivity framework.[42]

3. It uses an ecological framework. This locates the young person's behaviour—and the therapeutic intervention— within the interconnecting individual, family, situational, peer, organisational, neighbourhood and socio-cultural domains.

4. It uses collaboration and partnering. Local professionals, paraprofessionals and non-professionals are recruited on a case-by-case basis as collaborative partners.

An added element in the ecological framework that GYFS uses is situational or place-based orientation (i.e. the setting and context in which HSB occur) to develop a deep understanding of the young person and the behaviours and the strategies needed to prevent the behaviours occurring again (Rayment-McHugh, Adams, Wortley, & Tilley, 2015).[43]

Typically, individual treatment would be delivered in a 1- to 2-hour, face-to-face session on a weekly, fortnightly or monthly basis, depending on the level of severity and remoteness of the particular case. Additionally, systemic partners are engaged in treatment through regular meetings and communication with all stakeholders. On average, a young person with HSB would typically spend 12 months in treatment at GYFS.

New Street Service

Service characteristics

The first New Street Service was established 20 years ago. Since then, three additional services have been established, with the newest service having been in operation for 6 months (at the time of fieldwork). These services cover four local health districts. New Street also provides outreach services to young people situated in regional locations and in surrounding Australian Capital Territory and New South Wales areas. Together, the services comprise a coordinated network of the New Street Service.

NSW Health funds New Street services. With different services located within various local health districts, allocation of funding and questions of how to best direct the funding are determined at the specific local health district level. New Street operates under a memorandum of understanding between NSW Health, NSW Family and Community Services, NSW Juvenile Justice, the NSW Police Force and the NSW Department of Education and Training.

Waitlists are not used in the New Street service model. The *New Street Service Policy and Procedures* explains that this is because:

- children/young people require a service at the time of referral

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42 Developed by James Bonta and D. A. Andrews, the risk–need–responsivity (RNR) model is the key model for the assessment and treatment of offenders. The risk principle asserts that criminal behaviour can be reliably predicted and that treatment should focus on the higher risk offenders; the need principle highlights the importance of identifying criminogenic needs in the design and delivery of treatment; and the responsivity principle describes how the treatment should be provided (see Andrews & Bonta, 2003; Bonta & Andrews, 2007).

43   Situational crime prevention sees crime as an opportunity that occurs

in everyday environments where particular circumstances combine to enable particular types of crime to occur (Morgan, Boxall, Lindeman, & Anderson, 2012). Prevention focuses on understanding the contexts and circumstances that give rise to these opportunities and then modifying these factors to make it more difficult for the offending to occur. Strategies can include increasing active surveillance such as police or supervisors, increasing natural surveillance (i.e. strategies that make the environment less favourable to offending) and other strategies to increase effort or risk for the offender (see Clarke, 1997; Clarke & Felson, 1993).

- uncertainty of when a place may become available is not helpful in addressing issues of immediate importance and may even exacerbate those issues

- it is difficult to predict when a place may become available due to the nature of the program and its duration. (NSW Health, 2018a, p. 26)

There are 38 full-time equivalent workers across the New Street Service network. These workers are social workers and psychologists (or equivalent). The average number of clients seen per service is 30, and the average caseload for a worker varies between 12–15 young people, plus family members. Two clinicians are allocated to each family so that different clinicians can work with children and carers. The ordinary case load is six families and six young people (12 primary clients in total). Clients aged between 10–14 years are given priority due to the effectiveness of early intervention models. Those who are deemed high risk, living in OOHC, or who are of an Aboriginal and/or Torres Strait Islander background are typically prioritised among the services as they present with more complex needs.

Client characteristics

Client characteristics across New Street services are consistent with the majority of young people coming in to seek therapeutic treatment services across Australia nationally. All clients coming through New Street are aged between 10–17 years at the time of referral. The majority of clients are male. A substantial minority are Aboriginal and/or Torres Strait Islander young people. The proportion of female clients is relatively low in comparison to their male counterparts, on average accounting for up to 10 percent of young people. Depending on the specific New Street Service, 30–75 percent of HSB clientele were in some form of OOHC.

Therapeutic philosophy and treatment practice

The New Street model is based on the belief that child sexual abuse is never acceptable and that every child has a right to be safe and free from harm. Many of the young people referred to New Street have complex trauma, developmental issues or struggles that have resulted in the occurrence of HSB. New Street's model works towards highlighting the message that the young person is not defined by their HSB, but rather that

the young person is located in a developmental context in terms of their age and maturity during pubescent years. The key dimensions to the New Street practice framework are:

- working with young person's family and context

- restorative practice, which involves a focus on the young person taking responsibility for their actions and recognising the impact on those they have harmed and on other people around them

- trauma-informed practice, which recognises that young people engaging in HSB often have their own trauma histories

- developmentally sensitive practice working with young people in the context of domestic violence to ensure safety. (NSW Health, 2018a; pp. 13–20)

Sexually Abusive Behaviours Treatment Service

Service characteristics

SABTSs are provided by ten Centres Against Sexual Assault (CASA) services and two community service organisations. SABTS is a statewide model that runs in accordance with the recommendations of the Department of Health and Human Services. Unlike New Street and GYFS, which only provide HSB intervention, SABTS is provided out of services that also deliver other therapeutic interventions: CASA provide counselling and support for child and adult victims of sexual assault, and the two community services provide trauma counselling and support for children and young people in relation to child abuse and neglect. While SABTS funding is a single stream provided by the Department of Health and Human Services, the services themselves—all NGOs—are independent from each other. The length of time that services have provided specialist HSB intervention varies; of the services we spoke with, five had been in operation between 19–25 years and five for 10–13 years.

There is considerable variation across the services in the number of HSB workers they have, the average caseload and the number of clients they see each year. Some services have a small number of workers, while others might have up to 20 HSB workers. The average number of clients seen annually is 118.

SABTS providers can take referrals from anyone. Around 80 percent of the referrals to SABTS providers are voluntary (these are often referred by child protection services and the Sexual Offences and Child Abuse Investigation Teams [SOCITs]). The rest of the referrals are young people on therapeutic treatment orders (TTOs). There has also been an increase in the amount of Youth Diversion referrals via the Criminal Court for Young People in the age range of 10–17 years—with many of the cases involving online HSB.

SABTS providers often give priority to referrals that have been made by child protection services or SOCIT, as young people referred through these agencies are deemed to be high risk. However, within the SABTS referrals, priority is often given to young people from Aboriginal and Torres Strait Islander backgrounds, and young people with intellectual disabilities present. Priority is also given in cases of a recent assault, whereby a young person has disclosed in the last 3–6 months, or recent risk—i.e., high-end behaviour or penetration. In addition, those who come in on a TTO are often taken on-board straight away and given priority.

The average client wait on the waitlist for treatment among SABTS providers varies between 2–6 months. Often, priority is given to certain kinds of cases on the waitlist; these may be recent cases of child assault and cases where the young person is at risk of re-engaging in HSB and is male. The clients who wait the longest are female. While clients are placed on the waitlist, the majority of SABTS providers make fortnightly contact with them to check if there are any changes to the information that they have provided and to monitor any ongoing risk or deterioration within the family. In addition, some SABTS providers liaise with the child protection manager and may attend a care team meeting or organise a consult meeting with the family while they are on the waitlist, so as to start planning the direction of treatment and intervention.

Client characteristics

Drawing from the pre-interview questionnaire, the majority of clients are typically male and aged between 10–17 years. Only a small proportion (approximately 5%) of SABTS clients are female and fewer are of Aboriginal and Torres Strait Islander or CALD backgrounds. Young people from Aboriginal and Torres Strait Islander and CALD backgrounds are found to be under-represented in the client groups, with approximately 5–15.7 percent of Aboriginal and Torres Strait Islander clients and a small number of young people from a CALD background accessing the service.

Occasionally, SABTS providers will have families accessing their service who will identify that the young person is Aboriginal and/or Torres Strait Islander through distant relational ties (i.e. their grandmother was Aboriginal) but without strong ties to the Aboriginal community and the family system. Therefore, therapeutic work does not look any different to the work that most SABTS providers do with other families. This work may include taking into consideration the young person's strengths in building up skills, confidence, self-esteem and connections with the community—such as the local sports club, Country Fire Authority or community groups that the young person may be interested in getting involved with.

Therapeutic philosophy and treatment practice

The SABTS model for working with young people with HSB follows the CEASE standards and adopts an ecological approach. There are four essential principles underpinning SABTS:

- community safety
- preventing further harm
- addressing harm caused
- promoting wellbeing. (CEASE, 2016, p. 18)

SABTS providers must work within the program principles:

- safety of children and young people is paramount, both for the child or young person harmed and for the young person engaging in HSB
- victims of sexual abuse engaged in by young people experience comparable harm to those abused by adults
- young people who have engaged with HSB must be assessed and considered within the context of their age, development, family, education and broader systems environment
- young people who have engaged in HSB are not identified by their behaviour

- all young people have the capacity to cease engagement with HSB and have the ability to develop healthy and respectful ways of communicating
- the young person's wellbeing should be taken into consideration when formulating methods of treatment and intervention
- family/carer participation should be encouraged, where appropriate, in treatment and intervention to develop and ensure open communication and improved family relationships
- clinicians need to be clear and inform the clients where necessary of their responsibilities for HSB and the implications of having police involved
- the involvement of and inter-service collaboration with other agencies and professionals involved with the client are essential. (CEASE, 2016, pp. 10–11)

Typically, treatment sessions among SABTS providers are delivered in weekly 1-hour, face-to-face sessions (with occasional phone contact or home visits) that may extend to fortnightly sessions depending on their levels of safety, for an average of 6–12 months spent in treatment (inclusive of an assessment period of approximately 3 months). Generally, there are no minimum or maximum lengths of treatment; however, funding for young people accessing SABTS via a TTO typically spans 12 months with a possible extension of a further 12 months.

Summary: Similarities and differences

Table 7 provides a summary of the key characteristics of these three service models. The service models share a number of similar features, including:

- Length of operation: these are mature service models that have delivered therapeutic responses to young people with HSB for around 20 years.
- Worker qualifications: social work and psychology are the main disciplines.
- The therapeutic philosophy underpinning treatment: an individualised, eco-systemic and trauma-informed approach characterises how these services work with clients.
- The gender composition of their clients: the vast majority of their clients are male.

- The length of engagement and its frequency: the length of engagement is a minimum of six months with a weekly treatment frequency.
- How clients are prioritised: complexity of need is the key prioritising factor (beyond eligibility requirements).

There are distinctions, however, in relation to:
- who they are funded to work with, the sources of referral and eligibility criteria, which is likely to influence the types of HSB they are addressing and the characteristics of clients
- how the therapeutic services are delivered, with GYFS working out in the field, while New Street and SABTS generally work from their premises
- size of the workforce, which limits the number of young people the service can work with at any one time
- whether the response is considered a single model (as is the case with New Street and GYFS) or a system of services that are funded to deliver a program (as with SABTS).

Practitioner insights into good practice

This section of the chapter draws on the qualitative interviews with practitioners in these three services to explore:
- understandings of good practice principles
- what practitioners saw as the goals of therapeutic intervention
- how practitioners translated these principles into practice.

Realist evaluation theory (Pawson & Tilley, 1997, 2004) informed our thematic analysis of the interview data. As Pawson and Tilley (2004) explain, "realist evaluation has a distinctive account of the nature of programmes and how they work, of what is involved in explaining and understanding programmes" (p. 2). Programs, they argued, were theories or hypotheses about the nature and causes of the issue being addressed. Programs are also:
- embedded in social systems, and it is "the workings of entire systems of social relationships" that gives rise to changes in behaviours, events, and conditions (Pawson and Tilley, 2004, p. 4)

Table 7: Characteristics of the GYFS, New Street and SABTS service models

Characteristic	GYFS	New Street	SABTS
Service-related			
Funding agency	Department of Child Safety (Youth Justice) and attached to Griffith Criminology Institute, Griffith University	Ministry of Health	Department of Health and Human Services; network of 12 agencies funded to deliver SABTS
Length of service operation	17 years	20 years (newest has been in operation 6 months)	Between 10–25 years (5 services 19–20 years; 5 services 10–13)
Service model	Field-based	At service premises/ dedicated counselling space	At service premises
Average number of clients per year	Up to 40	30 per service	Approximately 118 but ranges from 10–400
Number of HSB workers (full-time equivalent)	4.2	38 across New Street network	9.8 but ranges from 3–20
Worker qualifications	Clinical, forensic and generalist psychologists or social workers	Social worker, psychologist or other relevant professional	Social worker, psychologist or other relevant professional
Average caseload per worker (treatment)	10 plus family and other stakeholders	12–15 plus family	Varies considerably from three up to 14 depending on whether caseloads are mixed (i.e. SABTS and sexual assault)
Geographic coverage	Statewide	Four local health districts; six further specific local health districts in 2019	Statewide through health regions
Client-related			
Referral source	Through a court order in relation to a young person found guilty of sexual offences as a: · pre-sentence assessment report · treatment condition of an order post-sentence · referral for intervention under a detention order for sexual offences (with a recommendation from the court) Referrals processed by Youth Justice Services Practice Support Unit	Any person connected with or involved in the care of the child or young person can refer them to New Street. Any source, and there is confirmation from Joint Investigation Response Team or FACS or the young person/their family that the HSB have occurred	Department of Human Services (Child Protection), Youth Justice, schools, community organisations, police, TTO referrals, and voluntary or mandatory referrals

Table continues overleaf

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

Characteristic	GYFS	New Street	SABTS
Client eligibility criteria	10–17 years who have pleaded to or been found guilty of a sexual offence	Any child or young person aged 10–17 years residing in NSW who has engaged in HSB (whether or not this occurred in NSW), where: · the HSB has been reported and there is confirmation from the Joint Investigative Response Team (JIRT)[44] or Family and Community Services (FACS) that the young person has sexually harmed another or the young person or family confirms the HSB (but they have not been charged) · the child or young person has sufficient capacity to participate in the program	10–17 years and resides in health region serviced by the SABTS agency. If convicted of sexual offences would generally be referred to Male Adolescent Program for Positive Sexuality (MAPPS) but not required
Priority clients	Highest risk/need and regional/remote	10–14 age group; Aboriginal and Torres Strait Islander children; children with complex needs	Therapeutic treatment order clients (in part due to time restrictions—orders last 12 months)
Gender	21 male; 3 female	Average is 90 percent male	Average 90–95 percent male
Age range	14–17 years	13.5 years average	10–14 years; 13–16 years
Proportion mandated	100 percent	0 percent	Approx. 20 percent
Treatment-related			
Therapeutic philosophy	Individualised, eco-systemic, and local knowledge partners	Family and social context, restorative practice, trauma-informed, and developmentally sensitive	Individual, family, eco-systemic, and the Four Pillars of Trauma[45]
Length of engagement	12 months on average but up to 3 years	12–24 months	12 months
Session frequency and duration	Weekly, fortnightly, monthly; 1–2 hours	Weekly, fortnightly; 1 hour	Weekly, fortnightly; 1 hour

Sources: Pre-interview questionnaires (n=21); CEASE (2016); GYFS Training Pack (GYFS, n.d.); NSW Health (2018a)

44 The Joint Investigative Response Team (JIRT) has been replaced by the Joint Child Protection Response Program (JCPRP).

45 The Four Pillars of Trauma are part of the Sanctuary Model, which is a whole-of-organisation way of working with people who have experienced trauma (Bloom & Farragher, 2010). The Four Pillars are shared knowledge about trauma and trauma theory; shared values and commitments; a shared language for recovery; and shared practice.

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

Table 8: Categories of principles and sub-themes

Category	Sub-themes
Conceptual	· Developmental: the developmental trajectories and capacities of young people (i.e. cognitive, psychological, and relational capacities) are still in formation, and young people rely on the adults around them as key supports · Eco-systemic: young people's behaviour is largely a product of what they have experienced at home and in their significant attachment relationships. The behaviours need to be situated within young people's developmental and familial, peer, and community contexts
Therapeutic	· Working systemically · Being trauma-informed · Tailoring therapeutic responses to the young person, taking into account cultural safety, gender, developmental stages and capacities
Enabling	· Engagement of family/carers · Comprehensive assessment and case planning · Engaging broader systems agencies

- active, that is, they require active participation and meaning-making by program participants to function. This introduces unpredictability and variation regarding how program elements are interpreted and engaged with

- open systems themselves. Programs "cannot be fully isolated or kept constant", and are affected by "political change, personnel moves, physical and technological shifts, inter-programme and intra-programme interactions, practitioner learning, media coverage, organizational imperatives, performance management innovations and so on". (Pawson & Tilley, 2004, pp. 4–5)

Programs and interventions, then, are "social interactions set amidst a complex social reality" (Pawson & Tilley, 2004, p. 6); good practice can be seen as the outcome of these interactions.

In this chapter, we draw on two key concepts of realist evaluation: *mechanisms* and *contexts*. Mechanism refers to what it is about a program or intervention that brings about change. From a realist perspective, it is not programs per se that work—i.e. their modules, or components, or modes of delivery—"but the resources they offer to enable their subjects to make them work" (Pawson & Tilley, 2004, p. 6). Context refers to the features or factors of the settings in which programs operate that variously support or constrain a program's underlying theory about the nature of the problem being addressed (e.g. young people who engage in HSB) and what works to address it.

In the section below, we discuss practitioner insights into what constitutes and enables good practice.

The principles of good practice

Understandings of good practice largely shared across GYFS, New Street and SABTS workers generally reflect those that have been identified in the broader literature. However, how participants described these principles working in practice and what they identified as key ingredients of good practice provided additional insight to current descriptions of good practice.

Focusing on the enablers and key "ingredients" of good practice generated a shift from "lists" of necessary elements to more nuanced descriptions of the function or role different principles had in the delivery of therapeutic interventions. We grouped these into three categories:

- conceptual principles: how young people/adolescents and HSB are understood

- therapeutic principles: how interventions should be designed and delivered; how the therapeutic work should be done

- enabling principles: what needs to be present make an intervention effective.

The sub-themes associated with these categories are summarised in Table 8.

These categories of principles have some—but do not exactly— overlap with work undertaken by Hackett et al. (2005, 2006). This work examined consensus on practice in therapeutic work with young people who engaged in HSB.[46] The similarities

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46 This study used a Delphi method to establish consensus in areas such as core beliefs about the area of practice; the most important principles that should inform practice; underlying aims/goals of

are seen in two dimensions in Hackett and colleagues' study (2005) that had high levels of consensus (greater than 85% agreement):

- fundamental and underpinning beliefs (aligns with conceptual principles): children and young people engaging in HSB are "first and foremost children"; there are multiple pathways to the behaviour
- intervention approaches (aligns with therapeutic principles): approaches need to be developmentally appropriate; need to balance holding young person to account and acknowledging their own trauma; need to focus also on young person's living environment.

Conceptual principles

Twenty years ago, there was a significant shift in how young people engaging in unwanted and abusive sexual behaviours against others were conceptualised (and subsequently responded to). The shift involved the insight that such young people needed to be understood in terms of young people's developmental trajectory. This understanding was the starting point for how participants in this study articulated the principles of good practice.

Young people and their behaviours

When practitioners were asked for their views on what constituted good practice and what their therapeutic philosophy was, responses frequently started with how they understood the young people they worked with, and how they understood the behaviours they had engaged in. A consistent view across the three services' models regarding the young people themselves was that they were not "predators":

> We're talking about children and young people who are not paedophiles, not monsters—they're not predators. They're kids whose lives, for lots of different reasons—in their lives, they're facing challenges, often family system past trauma, their own abuse, a whole range of issues that—leading them to engage in that behaviour and it can be corrected and is in almost all cases quite successfully. (SABTS, Victoria, Practitioner 1)

> One of the things that we're very quick to point out to people … is that young people who cause harm aren't monsters and that they're young people and we treat them as young people. And I like that. I like the idea that we can look at a young person and go, "You are much more than this sexual harmful behaviour. And that we will treat you respectfully, and we work with your family to treat you respectfully." So, I think that that's definitely a principle that underlines our stuff. (New Street, NSW, Practitioner 2)

As these quotes make clear, a key starting point is not just that young people that engaged in HSB were not predators but that they are young people first and foremost; the behaviours they have engaged in need to be situated within a broader context of trauma, family dysfunction or developmental challenges; and, finally, they are not their behaviour. Together, these views underpinned a belief in young people's potential for change:

> Every child has the capacity to live a respectful and responsible and happy life … the capacity to go to the place where the very concept of abusing or hurting another person is anathema to them as it is to anybody else. And we see that. We see that happen. (New Street, NSW, Practitioner 3)

Putting harmful sexual behaviours in context: Understanding correlating factors

A second conceptual principle that emerged from the interviews was that HSB rarely occurred in isolation. Practitioners in all three services consistently noted that young people who engaged in HSB often had multiple issues occurring in their family or care environment.

Experiences of trauma, exposure to family violence, and family dysfunction were most often identified. As noted by one practitioner:

> Most of these kids have some sort of attachment trauma in their background or there's some sort of intergenerational trauma that impacts the attachments. So, you've got to have that [trauma lens]. (SABTS, Victoria, Practitioner 4)

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treatment; core and essential components of treatment; the theoretical models used. Three levels of consensus were developed: overall consensus; approaching consensus; and overall divergence.

While there was overall agreement that some form of "attachment trauma" (i.e. violence, abuse, neglect, maltreatment by significant caregivers) was present in the lives of the young people they saw, there was a sense that the forms of trauma differed by gender, with sexual abuse a particular point of differentiation between young men and young women:[47]

> Every single girl we've ever worked with has a significant history of harm towards them. So, for a vast majority it's significant sexual harm, but also physical, and neglect. Boys, the pathways towards their own behaviour are varied. Although certainly their own abuse and harm is one of those pathways, but it's varied. (New Street, NSW, Practitioner 5)

> The risk factors for girls are very different to males … For girls, there's usually three global factors: trauma, mental health issues, or both. So, treatment for them is going to look a lot different from the boys that we work with. And for a lot of those girls, given the history of trauma, attachment difficulties, they do present with an attachment style that looks like early indicators of what would later be—[if they were] over 18—understood as borderline personality disorder. (NGO, Queensland, Practitioner 6)

Family violence was a common correlating factor present for both boys and girls. A number of practitioners spoke of the effect of family violence on young people's—particularly young men's—understandings of how relationships work:

> I think if a young fella has seen his mother being harmed, being hit, punched, kicked, humiliated, there's a significant message about how women can be treated … how needs can be met and frustrations expressed. (SABTS, Victoria, Practitioner 7)

In addition to the modelling of relationships learnt through the exposure to family violence, engagement in HSB could also be a coping mechanism for young people to manage their own feelings of anger, anxiety and confusion:

> Through their behaviour [they are] screaming out, "Pay attention to us. This isn't okay. We don't feel safe here."

They might be stepping in to try and protect mum. They might be feeling disempowered and fearful themselves and they want to feel a sense of being in control of their life … So, one easy way to feel powerful is to act out against your sibling or siblings or others. (SABTS, Victoria, Practitioner 8)

Having said that HSB rarely occurred in a vacuum, practitioners also stressed that it was rarely a case of singular linear causes, or a phenomenon where "one plus one equals two" (SABTS, Victoria, Practitioner 4):

> We can't say that there is any one thing that causes young people to demonstrate sexually harmful behaviour, but we can say that in a lot of families there are some consistencies, which is really poor supervision, perhaps an intellectual disability, mental health issues of either the young person or their parents, drug and alcohol issues, domestic violence and also a sexual assault history for one or two of the parents, or that they've been victimised by sexual assault themselves. (New Street, NSW, Practitioner 9)

As demonstrated in the following sections of this chapter, these conceptual principles inform both therapeutic principles and how these are translated into practice.

Therapeutic principles

When practitioners described their service model's therapeutic philosophy and what constituted good practice in their therapeutic work, the importance of the following three principles emerged across the three services:

- working eco-systemically with the young person
- being trauma-informed/working with a trauma lens
- tailoring interventions to the developmental stages, capabilities and characteristics of their client.

Working eco-systemically

Practitioners clearly saw working "eco-systemically" as foundational to good therapeutic practice. What an eco-systemic approach meant was consistent across participants, and included:

- understanding the whole young person and their family

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47 The more pronounced and significant histories of sexual abuse present among services' female clients is in line with the broader literature on the characteristics of adolescents' and adult women's criminal justice pathways (Stathopoulos & Quadara, 2014).

(family history; dynamics and relationships; past traumas and impacts; current pressures; and rules, patterns, and values)

- situating the young person and family system in their broader social ecology: peer relationships, school, services with which the young person and the family are engaged, the local environment and community
- understanding the HSB the young person has engaged in within these contexts.

Participants from across the three service models felt very strongly that working with the young person in isolation was not simply therapy:

> One of the greatest things that's happened in the last 20 years is a focus that you work with the family, you work with the context in which the child lives … Although you can't take away from direct work with the child—you got to—[but] I think there's broad recognition now that without working with the child's context, you're not really working with the child. (New Street, NSW, Practitioner 10)

> These children exist in a context. Their behaviour comes out of that context … So, what we try to do is understand where [this behaviour] has come from and what this actually means, what this behaviour means for this young person … what it means for their family. (SABTS, Victoria, Practitioner 11)

> At the core of our model, is that we operate from an eco-systemic perspective. So, when we're undertaking assessment and treatment services, it's looking at the whole young person and their family, their context, their community. So, the interventions that we're providing are delivered not just to the young person but to those levels of their ecosystem. (NGO, Queensland, Practitioner 6)

As the last quote indicates, working eco-systemically went beyond understanding the young person and the HSB in context, but also meant that the interventions involved needed to be targeted at the nested levels of the young person's ecosystem, which could include family, extended family networks, school and community settings, peer relationships, and other services.

Working with a trauma lens

Following the recognition that young people who engage in HSB often have their own experiences of trauma, being trauma-informed was another key principle guiding therapeutic practice:

> We're talking about relational interactions, relational trauma. If you don't have an attachment lens, it makes it very difficult to understand, to make sense of that: What is the impact of that trauma in this young person's history? How has it affected the way they relate to themselves, to the people around them, to the world they're living? And how is that gonna play out in the room when we're with them? Because it's gonna play out in the room with them and if we don't make sense of that, we can't help them. (SABTS, Victoria, Practitioner 12)

As this quote indicates, being trauma-informed or working with a trauma lens means, firstly, understanding the relationship between the history of trauma and the behaviours engaged in and, secondly, understanding how the impacts of trauma might affect the therapeutic work itself. Acknowledging the young person's trauma background is therefore a first order task in terms of the assessment.

The degree to which practitioners work with trauma as part of the treatment differs among the service models. SABTS is provided by services where trauma counselling with victims is central to the work. In the Queensland context, however, the main service providers working with adolescents are within a justice rather than a therapeutic domain, which shapes the extent to which they can incorporate a trauma lens into their work:

> We are working from a lens that understands trauma and inter-generational trauma. Particularly for the Indigenous young people that we work with. And that we apply that lens when we're doing assessment and when we're looking at treatment; that we're recognising what our limits are and our capacity … Looking at that on an individual basis, there might be times where we need to address specific issues with Child Safety, so we put what we're doing on hold to allow that process to happen, work with those agencies, and then continue our offence-focused treatment. (NGO, Queensland, Practitioner 6)

One practitioner reflected on the challenges of working with current and ongoing trauma and the type of skill required to engage families:

> We are more likely now than ever before to be working with kids who are experiencing ongoing and current trauma … historically, it was more likely to be viewing past trauma. We've developed a skills set which now allows us to engage better with families and young people who are in existing really, really difficult situations. In the past, I think we'd possibly lose them—I think the skills set is there so that we don't step back from families as quickly. We're a lot more creative and flexible in how we work with them. But I also think our engagement skills with family have improved … we're able to hold the families that I think in the past we would've lost. (New Street, NSW, Practitioner 10)

Individualised and tailored therapeutic responses

While there was considerable consistency among practitioners regarding working within a family and systems model, practitioners also emphasised the importance of tailoring therapy to the developmental and cognitive capacities of the young person, as well as their culture and their care situation.

Aboriginal and Torres Strait Islander young people

Practitioners working with Aboriginal and Torres Strait Islander young people and communities acknowledged that even attending a mainstream therapeutic service was a hurdle for this population:

> I find with the Koori clients, we need a lot more flexibility in our expectations because the whole appointment coming to a [service] thing can be more tricky. Often there's [cultural] family workers involved who then can make sure that the family is attending, but we're a very Anglo–Saxon service, really. So, for them to come here in itself can be a hurdle. Yeah, I find mostly that we require a lot of flexibility with regards to how we approach them. (SABTS, Victoria, Practitioner 13)

The practice of going out to Aboriginal and Torres Strait Islander clients rather than expecting them to go to the service was seen as signalling an important commitment:

> Our Aboriginal families, as much as we can, we try and go to them, because we think that's a strong statement to them about how important they are to us and, you know, the commitment that we made to them about coming regularly over quite a long period of time to them, rather than expecting that they can come to us … I just think that's a really important message. (New Street, NSW, Practitioner 14)

Depending on the nature of service delivery, services have taken different approaches to developing the necessary connections with community and to obtaining the necessary advice and guidance to formulate interventions. Some services—particularly in New South Wales—have Aboriginal workers on the team; however, there are not yet sufficient numbers for state coverage. Where Aboriginal and Torres Strait Islander young people are in care and off Country, services might seek out and develop links with local Aboriginal organisations or, in some cases, support OOHC workers to enable young people to go back to Country and link back to culture, or they might actively capacity-build residential care workers for cultural safety:

> So, what we find is there are lots of young Aboriginal children off Country who get sent to these residential care placements, which makes contact with family very difficult. One of the modifications we do—when it's not really our job—is to continue to bring cultural awareness to the out-of-home care agency about their responsibilities to include that in their own practices. (New Street, NSW, Practitioner 9)

Overall, there was variation in the extent to which the three service models worked with Aboriginal and Torres Strait Islander young people. For GYFS, it is a central component of the work. Their outreach model allows for clinicians to work with young people in community and to build the support coalition of key stakeholders—carers, extended family, and other services—who can help to sustain the intensive phase of treatment once GYFS workers go back to town. The support network can consist of up to 30 people beyond GYFS. In contrast, the services in Victoria appeared to engage in less therapeutic work with Aboriginal and Torres Strait Islander young people.

Young people with disability

Intellectual disability and autism spectrum disorder were the two main forms of disability that practitioners saw with clients. In practice, treatment and intervention plans are adapted and modified specifically for each young person. Individualisation often begins from the initial assessment phase and takes into consideration various factors that may influence client case formulation and the direction of treatment and proposed interventions used.

> There was an intellectually impaired young person that I worked with from a regional area, and safety planning for him involved driving around town and actually taking photos of situations or places that we might consider something where he has to enact a safety plan. For example, "Here's a picture of the pool. Here's a picture of my house. Here's a picture of the courthouse. Here's a picture of a playground, which [is a place] I know I shouldn't be." Things like that. (NGO, Queensland, Practitioner 6)

> With a young person on the spectrum … we have to be really mindful of our language and really concrete in the way that we describe things and explain things to them. [It's about] knowing that's going to take a little bit longer with that group with their intellectual delay, or on the spectrum, because they struggle to understand how their behaviour has affected another person. (New Street, NSW, Practitioner 5)

Overall, it did not appear that there were particular "modules" or a pre-prepared method for working with young people who had learning difficulties or other types of disability. Rather, an overall developmental framework oriented practitioners to the particular capacities and developmental stages (physical, cognitive, emotional) of the client, while comprehensive assessment (described in the section below) was used to tailor interventions to the particular young person.

Enabling principles

In line with a realist evaluation approach, we were interested in what factors enabled effective practice. What practitioners saw as the key mechanisms here fell into three domains:

- the engagement of families and/or carers

- comprehensive assessment and case planning
- engaging broader systems of care and agencies.

Family/carer engagement

The majority of clinicians across the service models saw family engagement as a key enabler to being able to work effectively with the young person. Indeed, families' willingness to acknowledge and not minimise the behaviour was viewed as critical. The importance of families' willingness to engage related in part to saving significant time trying to work through family barriers and minimisation. It also related to the extent to which therapeutic work with the young person could actually progress:

> One of the major contributors to successful treatment is family willingness, family involvement, support—it can be parents, carers, residential workers, that's a big one, so schools, but especially, I think, the family, the immediate family, whether it's carers or parents or whatever. If we have a referral and we have really resistant parents who minimise or say, "No, my child didn't do that. There's no way he or she did that" … then of course, the child will say, "No, I didn't do it." If we have an onboard family, it's like, "Yes!" because it's a really good start and probably saves about a good 2 or 3 months of work. (SABTS, Victoria, Practitioner 15)

> One [enabler] is having whoever is attending with the child, say, the family or the agency, for us to be able to work—a belief that the harm has actually occurred and that it is serious. It's very difficult and, usually the kids who don't get past assessment are the ones, quite often, where the family do the, "Oh, yeah, he did it, but" or, "We're not really sure he did it. I mean, it wasn't very much" or, "He did it, but only once", and that kind of not really believing. If we don't have the family or agency support, it's very difficult to hold the child in intervention. (New Street, NSW, Practitioner 16)

In some situations, parental disbelief and/or minimisation can be barriers to progressing beyond the assessment stage. In practice, this has meant discontinuing treatment at the end of assessment due to the lack of family engagement in supporting the young person to change, and referring the family back to child protection.

Practitioners also spoke of the need for family acknowledgement and understanding that they themselves need to be active participants in and, at times, recipients of the intervention, and that such engagement is long term:

> You're trying to make sure that all noses point in the right direction, that the parents, the child, the school, all sort of have a bit of a communal understanding on where we're going. That, in itself, is a body of work. (SABTS provider, Victoria, Practitioner 17)

In short, practitioners viewed family and/or carer engagement—that is, acknowledging the harmful behaviours and their impacts, facilitating the young person's engagement in treatment, and recognising that they themselves were also participants in the intervention—as central to progressing effectively in the intervention.

Finally, family engagement was essential for the role families have in being "knowledge holders" of the change process—not just at the time of therapy, but also for the future when life transitions and milestones (starting a relationship, beginning a family) can retrigger concerns:

> When it's time to finish, one of the things that we tell our families is that in the future, this thing will still crop up every now and again. Like, if the victim's in your family, as the victim gets older and faces their first sexual encounter, or they have a baby and what they think about uncle holding the baby and all of that kind of stuff, that comes back. And so parents are the gatekeepers. Parents are the knowledge holders. They're the ones that go, "No, we sat next to this kid for a year and a half while we went to therapy about this, so we definitely know that he's done it [the work], and that he's demonstrated since then, that he's safe." But inevitably, the victim will still struggle with this for some time. So, having the family be the keeper of all of that information, so that they can go on and repair that or deal with it when it happens is really important. (New Street, NSW, Practitioner 18)

Thus, the engagement of the family throughout the therapeutic process is a key enabler of the belief in a young person's capacity for change.

In the context of working with Aboriginal and Torres Strait Islander young people, practitioners emphasised the importance of maintaining the young person's connection to Culture, Country and community, particularly where they are in OOHC.

> How important it is for our young person to still feel connected to the family, not to feel completely isolated and alone … For Aboriginal young people who are in out-of-home care, they don't have any of that. They have some file somewhere in the Health Department that says that they did this and they were successful at completing our program, but none of their family know about that … So we have to modify that. At the end, we're having to help the young person themselves hold that information. But then later on, who's going to speak up for this young person who's been completely disenfranchised from their family? (New Street, NSW, Practitioner 10)

The point being made here is that working to maintain Aboriginal and Torres Strait Islander young people's ties to family and Culture is a way of ensuring that the story of change, of restitution and of healing is collectively held rather than something that only the young person themselves can attest to.

Assessment and case planning

Great emphasis was placed on having comprehensive assessment and case formulation processes. Having an individualised assessment phase identified the needs of the client, underpinned case formulation (i.e. how the client's background history and other internal and external factors from various system levels contributed to the HSB), and informed safety planning and goal setting. Successful treatment outcomes were heavily dependent on how well the assessment and client case formulation phases were conducted:

> After six sessions, I'll be asking my staff, "Where's your formulation? What's your gist of what's going on here?" in which we look at static and dynamic factors … the formulation is the most important part. The assessment and how you come to your formulation will inform how you do your treatment. So, it stands and falls with a good assessment actually. (SABTS, Victoria, Practitioner 12)

Locating the individual and the behaviour within the context of the individual, the family system and external environmental factors (such as school, community groups) was seen as crucial for the processes of assessment, case formulation and safety planning:

> We take an assessment lens that looks at that young person. We look at what their treatment needs are. We look at partnering with the ecosystem that the young person is within … [In] the field-based nature of what we do, where we're partnering with some of those key stakeholders to deliver treatment jointly. We might be identifying some offence-specific treatment needs that the young person has that we deliver one-on-one with the young person, but then there's a whole layer of other treatment needs that happen with those other key partners. (NGO, Queensland, Practitioner 6)

Some practitioners described how assessment and case formulation gave families a roadmap to work to, particularly in relation to developing a safety plan that could be shared with the family.

> [The assessment] is around identifying the different complexities for this young person and their family and what they need. So that will be formulated. And then they go into what we call a treatment—therapy, whichever way you like to describe it … the risk assessment and safety plan is part of that assessment. So, that's very clearly identified as well. So, that's very clear to the young person and the family, what we're actually dealing with. So, how to actually keep them safe and getting them to understand why they've done what they've done. (SABTS, Victoria, Practitioner 4)

However, practitioners also acknowledged that assessment, formulation and planning needed to take into account the realities of the young person's actual circumstances:

> … because sometimes the young people we work with got so much dysfunction that we're just trying to get some stability in their life. You mentioned homelessness before: it's very hard to sit there and really delve into the complexities of somebody's offending when they're—like Maslow's hierarchy—they're like, "Where the hell am I sleeping tonight?" So we're trying to focus on those sorts of issues with them. (NGO, Queensland, Practitioner 6)

Engagement by broader "systems of care" and agencies

A final key enabler was related to interagency engagement with the young person's broader systems of care and agencies. The main systems and agencies identified as critical partners were statutory child protection, the OOHC sector, police and schools (including specialist schools). This mechanism begins to signal the importance of understanding the particular contexts in which therapeutic responses operate.

Given the emphasis on taking a systemic approach to working with the young person and their behaviours, the importance of cross-agency engagement is perhaps unsurprising. Indeed, participants articulated several reasons why having the critical partners involved was so important to the effectiveness of therapy. One reason given was that for many of the young people, the HSB was often only one small part of a broader set of needs:

> [HSB are] not the biggest part. It's a small part of these kids' needs. It gets the most interest and attention because it's sexual, but it's only a small piece of very broad, broad needs. And I don't think we are doing our kids justice in proceeding with—I mean, this is my personal view—proceeding with a referral and intervention around sexually harmful behaviours when they've got all these other needs that aren't clearly identified. I think our intervention needs to sit inside a very, very solid case plan that is individualised and clearly meets that individual child's needs in terms of emotional, social, educational and vocational, as they get older. (New Street, NSW, Practitioner 18)

As indicated in this quote, "exceptionalising" the HSB over a broader set of needs perhaps did young people a disservice by highlighting only one area of need and potentially missing other areas requiring support. The point made here is that the therapeutic intervention for the HSB needed to be situated within a broader case plan that crosses agencies.

Related to this was the reality that in addition to the familial environment, implementing safety plans and monitoring and supervising the young person occurs in schools, after-hours school care, child and youth organisations, OOHC settings and in communities; that is, the places in which the young

person spends the majority of their time. Thus, specialist treatment services are reliant upon these agencies to be part of the care system both in terms of supporting the intersecting areas of need and in supporting safety planning.

Engagement between and across agencies was also a key element of coordination and communication where multiple workers and disciplines are working with the one family:

> Broadly speaking, when the systems work well, when there's good communication between us and Youth Justice and other collaborators for that young person, which can include family, that's when good outcomes happen. But when there's a breakdown in that communication or cohesiveness in the working of the team, that's when issues start to happen. (NGO, Queensland, Practitioner 6)

> We have care team meetings, case plan meetings, and say, "Okay, this is the work we're doing. That's the work you're doing" to make sure there's no crossover because there's nothing worse. We've got a family at the moment with four, five children, and this family's got about eight different agencies involved and it's just—it's way too much. It's way too much. So, we would talk to the other agency, "Can you just hold off for now until we do this work and make sure that the family is safe? Then you can come in and do that." (SABTS, Victoria, Practitioner 19)

Relatedly, the collectively held expertise across different parts of the care team was valued in that it enabled a more comprehensive and informed understanding to be created, which assisted with assessments of risk, progress and decision-making:

> In family situations, the family's saying, "Oh, he really misses his brother and he wants his brother to come home"—'cause the children are separated … the victim-child is younger and wants the family to be reunited and will often say that. That's because they haven't really processed what's happened to them. So, their response is usually, "I want my brother back or my sister back", right from the word go. And the families go, "Oh, but no, he's fine or she's fine. They want their brother or sister to come home and we all wanna be a family again." But we are checking in with sexual assault counselling, "How are they going? Where are you up to? Are they ready for

any kind of contact?" Until we get that okay from sexual assault, we won't be recommending that contact from our side. (New Street, NSW, Practitioner 18)

Thus, the engagement of other key agencies though good communication, information sharing and sequencing different service interventions so they are more in line with where the family is at (noting that this requires different services to have a shared understanding of each other's objectives) is fundamental to good therapeutic outcomes.

Summary

As noted earlier, the understandings of good practice suggested by this study are largely reflective of the broader research and practice evidence. In Table 9, we situate the current study within this literature. Differentiating among principles can help to better focus policy and service systems design in therapeutic responses for young people engaging in HSB.

Goals of therapeutic intervention

In this section, we shift to consideration of what the goals or aims of intervention are, how success is defined by practitioners, and how they measure successful outcomes. While responses often identified "preventing the behaviour from occurring again", there were multiple layers and stages to this:

> That behaviour has to cease, that's a really early goal, because that's really important for them and for any potential victims. That's something that's worked on all the time, but just also understanding their behaviour and how they can self-regulate, understanding their triggers and understanding why they're so angry, for example, and where that fits into their family system. (SABTS, Victoria, Practitioner 4)

Participants identified multiple goals in working with the young person and their families. For example, a key goal was getting clients to acknowledge the behaviour and to take responsibility for it:

Table 9: Principles of good practice in the literature

Current study	**Conceptual:** · understanding the developmental trajectories and capacities of young people (i.e. that cognitive, psychological, and relational capacities are still in formation; that they rely on the adults around them as key supports) · understanding HSB in their developmental and eco-systemic context **Therapeutic:** · working systemically · being trauma-informed · tailoring therapeutic responses to the young person **Enabling:** · engagement of family/carers · comprehensive assessment and case planning · engaging broader systems agencies
RCIRCSA (2017c)	· A contextual and systemic approach should be used · Family and caregivers should be involved · Safety should be established · There should be accountability and responsibility for the HSB · There should be a focus on behaviour change · Developmentally and cognitively appropriate interventions should be used · Care provided should be trauma-informed · Therapeutic services and interventions should be culturally safe · Therapeutic interventions should be accessible to all children with HSB (RCIRCSA, 2017c, p. 193)
Shlonsky et al. (2017)	· Based on specialised rather than non-specialised techniques · Delivered early, and therapeutic rather than punitive · Mediated by the parent or caregiver (i.e. The parent or caregiver is actively involved and delivers the treatment) · Based on behavioural and/or cognitive techniques · Based on a holistic and eco-systemic approach · Driven by outcomes, and includes reliable and valid wellbeing measures · Required to have minimal standards for treating PSB/HSB including use of continuous quality improvement processes (Shlonsky et al., 2017)
Smith et al. (2013)	**Individual-level principles:** · engaging the family · acknowledging the importance of context · ensuring child-centred approaches · taking account of individual needs · valuing the strengths of the child and family **Organisation-level principles:** · need for systematic assessments and interventions · adopting multi-agency approaches · ensuring a well-trained workforce (Smith et al., 2013)

We're facilitating the young person getting to a place where they can acknowledge that they did the behaviour, they can accept the responsibility that it was their choice to make the behaviour, and that they can be accountable for the behaviour and be able to report back to their families how it was before they started therapy, how it's been through therapy, what they've learnt, what they've changed, and how they now understand that that behaviour was wrong, and how they now understand that they've changed. (New Street, NSW, Practitioner 2)

Other judgements of "success" and "effectiveness" of treatment are made on whether or not there was discernible improvement in the young person's functioning, particularly in areas that appeared to be related to the problem behaviour. As noted in the earlier quote, working with young people to regulate their emotions and manage impulse control were key goals. Participants noted that many clients have some symptoms of traumatic stress such as high arousal states, emotional dysregulation or numbed affect, and that it was important to work with them psycho-educationally and give them skills that they could use in any situation. As such, for clients having awareness of their triggers; understanding what their general issues are in their life; understanding why the HSB happened; understanding consent; improving their emotional regulation; and demonstrating the ability to make better judgements of or reflections on behaviours before acting are forms of prosocial behaviours that are judged and recognised as other measures of success and effectiveness.

Parental capability was identified by some practitioners as a goal when working with the family to understand their role in the treatment process:

When you look at SABTS, it would be especially around parent engagement with the kids; for example, that sort of interaction between parents and kids, where the boundaries lie, how to reinforce those boundaries, what's the best way to go about that, how would a kid think about that. That's a short-term thing. That's a short body of work that could take four sessions sometimes, depending on the intensity of the behaviour or the interaction patterns that you're dealing with. (SABTS, Victoria, Practitioner 13)

Finally, a number of participants mentioned empathy as a goal—"developing empathy is probably one of the biggest things in looking at when you're working with children who have exhibited that behaviour" (SABTS, Victoria, Practitioner 15)—but they also acknowledged that this could be a considerable challenge or stretch for some young people.

The goals described here echo those identified by practitioners as essential in Hackett and colleagues' (2005, p. 14) study (with an agreement score of greater than 96%):

- the protection of other children
- stopping the sexually harmful behaviour
- developing controls and strategies to avoid risk situations/behaviour
- improving support within the systems in which young people live
- promoting healthy relationships and sexuality.

Goal setting

Goals and goal setting were very much an individualised process. Goals needed to match the issues raised in the assessment phase as well the actual lived context for the young person:

So again, from their comprehensive assessment, then we develop what we call a treatment plan and guide for that young person. Because their lives are often so chaotic, it will shape and change. So, we have individual, family [and] systemic goals and then we track them. And we do outcome rating scales of how the young people are meeting each of those goals. (NGO, Queensland, Practitioner 6)

When framing and setting goals, some practitioners reported that they preferred to focus on increasing safety (a strengths-based approach) versus decreasing risk, as safety was something families more readily understood:

I very much talk around levels of safety. So, when I'm sitting with a clinician in supervision, I might say to them something like, "What else do you need to be seeing? What else do the family need to be demonstrating for you to feel you can come to me and say that levels of safety are sufficient to close the case?" So, that might be things

around evidence of continuation of the safety planning being embedded—that maybe school have, if we're in contact with school, have been able to articulate that they've seen a shift in the young person's behaviour, they're behaving more respectfully, that within a session, that the young person can age-appropriately provide examples of how to engage in a respectful sexual relationship, that they understand around what consent might look like. (SABTS, Victoria, Practitioner 17)

While a number of key therapeutic goals were identified through the interviews, practitioners emphasised the importance of working to individual needs and contexts. Further, goal setting was seen as a process, with goals changing in line with points of therapeutic review:

We will set goals with the young person and/or the family, and it might be to look at schools and it might be helping them cope with even admitting that what they've done—why they've done it and how understanding the triggers for this behaviour … so, we set goals, and goals at 3 months and 6 months and then at 12 months of review. So, you would usually get those goals changing after 3 months because those have been achieved. (SABTS, Victoria, Practitioner 11)

A final point to make around the issue of therapeutic goals is that while acknowledgement and taking responsibility are central goals, young people were acutely aware of a double standard of being expected to take responsibility when adults in their lives were not held accountable for the harm they have caused:

We often say to young people, "You need to take responsibility for your actions", but often they've been victim to other behaviours and that adult hasn't taken responsibility for that, so then it leaves that young person in a dilemma in terms of—well, this has happened to me and nobody took responsibility for that, but then I'm being asked to be responsible for this behaviour. (SABTS provider, Victoria, Practitioner 17)

Young people's sense of injustice was a common theme in interviews with clinicians. Validating young people's victimisation experiences and acknowledging their hurt

was reported to be critical, and clinicians would do this with clients while also holding responsibility-taking as a key undertaking for the young person.

Measuring success

Although the main goal is to prevent the behaviour from occurring again, practitioners felt that using this as the main measure of success was probably not feasible or, perhaps, desirable: "I think a simple measure—are they harming [or] are they not—is not the correct measure" (New Street, NSW, Practitioner 10). In part this stemmed from the fact that it was too simple or blunt a measure, given the types of therapeutic goals intervention aimed for—that is, being able to recognise and manage triggers, accepting responsibility, developing empathy, and working towards healthy relationships. It also stemmed from the reality that measuring this in the long term was not something that was easily captured.

Nonetheless, practitioners did use a range of validated measurement tools such as the J-SOAP-II and the ERASOR (quantitative measures that identify the dynamic risk factors that inform practitioners on the areas that require concentration). These were used across the three service models as a method for assessing risks, needs, and protective factors to assist in measuring progress. Use of these assessment tools was fairly consistent, with the majority of practitioners administering the J-SOAP-II or ERASOR every 6 months, or more frequently depending on the nature of adolescent development, to evaluate changes and progress made.

Across the three service models, there appeared to be a shared agreement in regards to these assessment tools being useful for providing baseline measures on the assessments, and for use as a measure for court reporting (e.g. assessment reports). However, practitioners were aware of the limitations in that the instruments have not been validated on young women, Aboriginal and Torres Strait Islander young people, or those from CALD backgrounds. It was recommended that such forms of assessment should always be used in conjunction with a practitioner's clinical judgement, be embedded within a program protocol, and should not be used as stand-alone measures of success.

Although it was acknowledged that a simple measure of re-harming or not was perhaps too blunt, practitioners did want to know about the long-term outcomes:

> It would help our therapy if we had some way to measure "what happened after'. We have parents—we get cards, we have parents saying, "You saved our family. Thanks for all the work." We get hugs as they leave because they really don't want to leave, because we're being so supportive, but we've really got nothing else. How do the young people go after that? We've got really no idea. (New Street, NSW, Practitioner 2)

> We track in terms of: do they return? And do they re-harm? I mean we are involved when that happens. [And] how do we evaluate that? I think there's a lot more work that needs to go into how we evaluate that. (New Street, NSW, practitioner 10)

Translating principles into practice

The previous sections indicate considerable consistency in the principles underpinning providers' therapeutic philosophy across the three service models and settings. However, practitioners identified a range of approaches to translating these principles into practice settings and situations. The variations in what day to day, case-by-case practice looked like were in part associated with the service model itself, but also had to do precisely with the principles of comprehensive assessment and tailoring therapeutic responses to the young person's particular, lived systems context. For example, situations where clients are in OOHC call for particular approaches to enlist the engagement of child protection and care workers. Similarly, family dysfunction or family conflict required workers to think laterally about how they can work systemically in the absence of a family system per se. The following describes how practitioners actively translate principles into practice and the types of considerations that underpin this translation.

Working with the family context

Factors within the family context informed how practitioners worked within an eco-systemic model and how they engaged the family. Family conflict and relationship breakdown was one example given. For instance, complex family law matters and court orders could impact which family members could be present during therapeutic sessions. Difficult relationship dynamics could bleed into the therapeutic process, with practitioners recalling situations where parents going through separation could not be in the same room together, were not talking to each other, or could not focus on the child's therapy. There were also family situations where primary carers were unable to be the main supports for the young person due to their own needs such as mental health issues or alcohol and other substance misuse.

In such contexts, practitioners described how, in practice, working with the family meant making assessments about who, in the family system, was the most helpful person in the child's life:

> Sometimes we're making decisions [about] who is the most helpful; who is going to be competent in the kid's life and targeting our resources into that, whilst still updating [but not sharing with] the other party, because we recognise they're important. (New Street, NSW, Practitioner 10)

The aim was to ensure the young person was surrounded by a stable system of care, while not excluding ties with other, less able, family members because they are still part of that family system. Doing this in situations of family violence is particularly complex.

As demonstrated in the research literature and through practitioner insight, family violence is a significant co-occurring or correlating factor in the histories of young people engaging in HSB. Practitioners described somewhat different stances on how to work with families where family violence is a feature. For many providers this depended on whether the violence was a present concern, and its severity. The rationale for this was often that it was not possible to do therapeutic work in an environment where safety was lacking:

> It's very different whether it's historical or present, obviously. If it's present, it depends how significant that is … if there's significant family violence, it's likely that we will be saying, "This is an unsafe environment or an environment that's not at this point conducive to effective work with the young person" … if there's current violence, then the focus is gonna be initially on safety—creating

safety—emotionally—if not physical safety, then emotional and psychological safety. [This] normally involves other services than ours—it might be family support, might be child protection, depending on what the issues are. Our primary focus would be safety before we started. (SABTS, Victoria, Practitioner 20)

Other practitioners were more emphatic in their view that therapeutic work could not occur in the context of current family violence:

If there's current family violence—well, no, we would be mandatory reporting, we'd be reporting that, plus we'd be talking to [the family violence agency]—it goes back to Child Protection that they need to do something about getting him out of the home … because you can't really work therapeutically when that is happening. (SABTS, Victoria, Practitioner 15)

At the other end of the spectrum, some practitioners indicated increasing engagement in contexts of ongoing family violence, substance abuse issues and current child protection concerns. This practitioner described DFV as very present in their therapeutic work and noted that to a degree, working to engage the perpetrators of DFV—largely fathers—was a key part of restitution:

I think the key thing is to be working with the violent man and not shying away from that. So we will always try and engage with the person—with the adult in the family who is causing that harm and do so in a way that is separate and safe for the other family members. And very much with a child protection lens … (New Street, NSW, Practitioner 10)

While referring on to specialist family violence and men's behaviour change programs was considered optimal, it was also a case of "not letting the perfect get in the way of the good":

Engaging with them in the first instance is what may get them into that [men's behaviour change program]. But if we just said, "We're not gonna engage with you until you've done those things", chances are, that's not gonna happen. And chances are, there's things they might be able to do there and then. (New Street, NSW, Practitioner 10)

Keeping fathers who did perpetrate DFV in the frame was considered important at a number of levels. At its simplest, it related to the importance of keeping essential figures connected. At another level, it linked to the sense of injustice young people feel when they are expected to do therapeutic work and be accountable for the harm they have caused another person, yet the adult causing harm to *them* is not held to the same standard. Having fathers acknowledge the impact of their violent behaviour could be very powerful for the young person. At the same time, there is a degree of ambivalence about how this is done:

… the moment the father has been violent, we don't actually work with the father. As a family therapist, I would say, "Yes, I agree with that, but at the same time, I don't agree with that." Does that make sense? 'Cause there's an essential figure there that potentially should be in the loop somehow … (SABTS, Victoria, Practitioner 13)

The insights from practitioners, and this quote in particular, highlight the complexity and tensions that arise in realising good practice principles, where principles of being trauma-informed can seemingly work against the principle of family engagement.

The following section considers how services work with other settings in the young person's ecosystem.

Working with broader eco-systemic contexts

Each service model tended to have slightly different combinations of the types of services, agencies and settings that comprised the broader eco-systemic networks of their clients. This is likely influenced by who the services are designed to see and, therefore, the characteristics of their clients. For GYFS, Youth Justice, child protection workers, OOHC settings, youth detention settings, and the courts comprise the main ecology; for New Street Services, child protection workers, OOHC settings, other community service workers, and sexual assault workers appear as main contact points. With SABTS services, schools, child protection workers, OOHC settings, and the specialist sexual offences investigative teams (i.e. the SOCITs) appear to be the main agencies that practitioners work with.

School settings

For SABTS practitioners, schools were a key setting for their work with the young person and their family. How schools were enlisted in this depended on the behaviours themselves:

> It all depends on the behaviours that you're dealing with. A safety plan has to address the actual behaviours. So, if we find the behaviour is really specifically in the family home and there's not—no likelihood, whatsoever, [of it] going anywhere else, then of course, the safety planning is within the home more than anywhere else, but I still think that the conversation with the school is a really important thing to do. (SABTS, Victoria, Practitioner 13)

Individual school staff could have specific roles to play depending on families' needs:

> It might be organising meetings at the school with the, say, welfare department of the school and the person in the school system—whether it's the teacher or the welfare coordinator or whoever it might be who's got that relationship, inviting the parent in and saying, "Yep, J. from CASA is gonna come. We're gonna have a meeting about [the] young person", and it's on the school premises where the family feels comfortable … What I find happens in those scenarios is that the person at the school that has the relationship with the—usually mother—will often—not interpret, but explain—English skills might not be great, or their understanding of the service system [isn't]—so they'll often then explain in their own words that the mother's gonna understand what I've just said or what I'm explaining and whatever else gonna be. (SABTS, Victoria, Practitioner 1)

The extent to which schools are involved in the intervention depends both on the assessment of the HSB engaged in (against whom and in what circumstances), and on who has the relationship with the young person and the family to foster collaboration with the SABTS practitioner (who often will not have had a prior relationship with the young person). At the same time, practitioners were judicious about how extensively to involve schools. If the assessment, case formulation and safety planning indicated that the main focus was on the home setting and family environment, school involvement may be limited to talking to the school

about the anticipated absence of the young person on certain days and times to attend counselling.

Out-of-home care

Working systemically with young people in OOHC (particularly residential care) required considerable outreach and advocacy work to create the right care scaffolding around the young person. This could mean working to identify and work with decision-makers in the first instance to develop a safety plan before working more directly with staff:

> In out-of-home care, I won't be addressing the residential staff to start with. I would be engaging a key decision-maker and then coming out with a plan and it might mean that we then go into the unit and do a practical safety plan with all the staff, but I think you have to be really thoughtful about who the adults are that you're engaging right from the start … It's sort of going and targeting somebody that can influence the people underneath. (SABTS, Victoria, Practitioner 20)

While foster care placements were more akin to a family, carers still required additional support:

> If they're in foster care, clearly it's the foster carer who's the equivalent of the parent, so that's not sort of any different, but there'll also be support services around that foster care placement normally. So there'll be a case manager and a placement coordinator and sometimes a child protection case manager, sometimes maybe disability support person or whoever else might be involved will be all part of the intervention in the sense that we're at least consulting with—informing about the work that's being done, the safety planning that's put in place. (SABTS, Victoria, Practitioner 1)

For this worker, the additional support services were important to consult with as another "pair of professional eyes on the family system" and to share information with.

Juvenile detention

Juvenile detention presented a different context to which providers have had to adapt in order to create systems of support. In the example below, there are several levels of

complexity—detention, the young person's complex needs, coming from a remote location, and planning for their eventual transition back into the community—that all needed to be factored into the care system:

> We had a very complex young person in a detention centre. So we worked with the young person, their caseworker in the detention centre, their team leader in the detention centre, all of the youth workers within the section that he was in and we trained them in responding to that young person. He came from a remote location, so Youth Justice would fund the family to fly down regularly to see him. He would Skype with the family as well. So it looks a little bit different [but] we're going to follow the same process, though. (NGO, Queensland, Practitioner 6)

In the quote below, practitioners described how they brought family and community care systems into the justice domain when working with Aboriginal and Torres Strait Islander young people, and then worked closely with those care networks to understand how orders and intervention requirements were working back in the community:

> [Participant 1:] With the local Elders, local members who are brought in to, basically, who are involved in monitoring and maintaining safety, supervision within the community, those sorts of things.

> [Participant 2:] The Justice Groups might be involved in sentencing, within the court context with magistrates or judges. But they're also then seeing what's happening in their community beyond that and working in partnership with, say, Youth Justice. So they have a focus around offending and that context, but bringing a cultural lens to that. (NGO, Queensland, Practitioner 6)

The key point emerging from these reflections is that in order to give substance to the underlying therapeutic principles, the strategies, solutions and "workarounds" may look quite different from one client situation to the next, but the principle itself remains unchanged.

Contextual factors in the service environment and their influence on practice

In a realist evaluation framework, it is the interactions between mechanisms and context that influence program outcomes (Westhorp et al., 2011). Context refers to features in the service delivery environment from the characteristics of program participants and providers, to community characteristics, through to the characteristics of the policy environment (Pawson & Tilley, 1997, 2004).[48] This final section of the chapter describes the range of factors in services' operating contexts that affect the principles and the enablers of good practice described in the previous section. To obtain perspectives from diverse agencies and roles, we draw on the views of both practitioners in the three service models and policy and statutory professionals.

The contextual factors identified relate to:
- service delivery: factors that influence how the service operates or is delivered
- service access and engagement: factors that influence young people and families' ability to access and stay engaged in the therapeutic intervention
- Service systems intersections and interactions: factors that influence how different systems interact with each other and how this then influences the intervention for the young person.

Table 10 outlines the themes and sub-themes relating to these three levels.

A consistent theme both in the research literature and in the fieldwork is that effective therapeutic responses to HSB require a holistic, contextually informed, tailored, and eco-systemic understanding of both the young person and their behaviours, and that this, therefore, means family engagement and multi-agency, coordinated practice. Service delivery,

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48 There is no hard and fast rule about how micro or macro context should be defined. The resolution at which contextual factors become salient depends on the explanatory role context plays in the evaluation enquiry (Pawson & Manzano-Santaella, 2012 as cited in Jolly & Jolly, 2014).

Table 10: Outline of the three operating contexts and sub-themes

Service delivery	Accessibility	Systems interactions
· Workforce development: · recruiting and retaining workers · professional development · accreditation · Service demand · Service funding	· Geography and location of services · Knowledge, awareness and stigma · Maintaining engagement	· Child protection: · differences in safety and risk thresholds · varied capacity as a partner agency · placement stability and breakdowns · Policy and justice responses: · police decision-making · legal processes · Education: · competing assessments of risk · stigma/lack of awareness regarding HSB

service accessibility, and service systems are thus not three discrete domains; the complexity of both the issue itself and the service delivery landscape means considerable interplay between them. Such practice takes place within, and must negotiate, prevailing structures and ways of working that characterise these interfacing systems, particularly child protection, police and the justice system, and schools.

In the concluding chapter, we use the insights from systems change theory to identify ways forward for better aligning context with the principles (or mechanisms) of good practice.

Specialist service delivery

A range of factors influenced how services were designed and delivered. Key among these were issues relating to the workforce, namely recruitment, training and retention. Other key factors related to service demand and the extent to which funding was structured to reflect the nature of the work.

Workforce development

Recruiting and retaining workers

As the responses to the request for information indicated, the HSB sector is highly qualified and experienced. Interview participants identified a range of challenges in recruiting workers, including ability to find appropriately skilled staff, location, job stability, and perceptions of the work itself.

> Well, you'd be very, very lucky to get anybody who had direct experience. So quite often it's people who have

either worked with children, who have worked in sexual assault, or worked in [juvenile justice]. (New Street, NSW, Practitioner 18)

> We do have areas where there are no providers with the capacity to be undertaking a process, either within the restorative justice space or for kids on orders, and provide treatment for adolescents. It's a difficult area to find experience and expertise. (Justice, Queensland, Policy professional 1)

> Recruitment is tricky in our region—we definitely have a bit of a shortage of social workers. I would love a mix of—I mean, I'd love to be able to draw psychologists—we just couldn't match, I don't think, the wage, which is a shame. (SABTS, Victoria, Practitioner 20)

Policy developments and reforms were having an impact for some services in that an already limited pool of potential workers was also being engaged by other sectors, meaning that services were in competition with other agencies for staff:

> It is a difficult space to recruit in because even just what we hear nationally in terms of the growth with, maybe, just in the sector generally, community services, the funding in the family violence space, the NDIS, there's all this additional amounts of funding that are just making the whole sector really expand to the point where really it's very hard to recruit for the positions just across the SABTS. (SABTS, Victoria, Practitioner 12)

Some participants noted that perceptions about the work could act as a barrier:

> I think we struggle because I think people see—a lot of the people in the field—in the broader sort of welfare sector see this work—and sexual assault work generally as highly specialised, highly skilled, really niche work and probably beyond what they feel that they can do or are comfortable [doing]. So we get feedback from people saying, "Oh, that's beyond … That's really highly specialised, highly skilled work", and wouldn't even apply for it. And then SABTS work, again, that's even more specialised. (SABTS, Victoria, Practitioner 1)

In addition to the perception of the work being "niche work", this practitioner also noted that there was a perception it was "perpetrator work", which could also be a barrier to potential applicants.

> I think people see it as perpetrator work. [That] we're working with perpetrators, and not sort of really getting that we're talking about children and young people who are not paedophiles, not monsters—they're not predators … Some people aren't comfortable with the work, would rather work with the victim/survivor. (SABTS, Victoria, Practitioner 1)

While working with HSB was in large part seen as a specialist area, it was also acknowledged that few applicants simply "had expertise" in working with HSB; many have come from cognate disciplines and have been subsequently skilled up to work with young people. In the Victorian context, the strategy is often to start with sexual assault counselling within the service and to move onto SABTS work several years after that:

> If they put in an application, it will be looked at seriously and I think—and for us, we don't mind putting in a lot of time training people up with the skills. We know people aren't gonna come into this role with those skills already in most cases. So, we're looking for the right kind of people who we can train up, who've got the right values, got the engagement, got the warmth, got good assessment skills, got some counselling skills under their belt, and who have a passion for the work, for the issues, and then we can—we'll invest a lot of time in skilling them up. (SABTS, Victoria, Practitioner 1)

However, some participants were cautious about this approach in the absence of targeted training:

> If someone leaves the SABTS within that sexual assault centre, then someone else is kind of just drafted in. They don't give any training. They don't give any specific targeted training in terms of doing this work. So they have a very poor understanding of what's needed and it's almost like, "Look, this is just sexual assault work. You can do this. You can just do it", which is a problem given that there is a whole body of literature and research around the actual treatment model and what works with these kids and what doesn't. (Private practitioner, Victoria, Practitioner 21)

Short-term contracts also presented a challenge in being able to attract staff. Broader service-level funding agreements often limited the length of employment contracts, with 12 months being fairly common. While the demand for therapeutic services is unlikely to abate and, in practice, would mean contracts being renewed, job insecurity could be an issue. Short-term contract offers could make recruiting in regional areas particularly difficult, even where the likelihood of renewal is high:

> If we had someone leave tomorrow, the wheels turn slowly in regards to recruitment, as you can imagine, in health. I might be offering someone a contract 'til the end of June '19; that might mean 11 or 12 months absolute maximum of guaranteed work … that really does limit the pool of people. And, certainly, the great majority of people wouldn't leave the city to come out here for a 12-month contract. I mean, why would they? (New Street, NSW, Practitioner 5)

For some participants there was a sense that remuneration was not competitive enough to attract skilled and experienced workers from relevant disciplines.

Professional development

Each of the service models take somewhat different approaches to professional development and training. In Victoria, the Department of Health and Human Services funds a workforce development training calendar each year for both sexual assault and SABTS workers statewide. In addition, individual services have professional development budgets for staff. In

New South Wales, New Street Services has a significant period of staff induction. In addition, the Children's Guardian has a Child Sex Offender Counsellor Accreditation Scheme. GYFS clinicians are trained through the GYFS program at Griffith University. Student placements are used to begin this training.

The availability of professional development was often an issue of resources—both funding and staff time to attend—and thus dependent in part on how this was provided for within broader funding agreements and where the decision-making rested. In some cases, decision-making rested with the individual service manager:

> We've actually got a real generous professional development budget, so it's about $3000 annually for a full-time worker and they can use that to, like either go towards post-graduate study or for anything really. If they wanted to zoom in on a specific area and [brought in] a forensic psychologist for supervision, they can do that. (SABTS provider, Victoria, Practitioner 17)

In other contexts, such as New South Wales, the decision-making was more centralised, with decisions around how much funding should go to learning and development per person being formulated by the specific local health district. For some, this did not translate to the service level well:

> The last time the ANZATSA conference was on, we didn't send anyone because we were told that there were two or three people that the Health Department would pay for their registration for the conference. But we had to finance our own way to get there and our own accommodation for what essentially is four nights of accommodation and flights. So some of us have young families who can't afford that. So no-one went, in actual fact, because nobody was prepared. (New Street, NSW, Practitioner 9)

Clinical supervision was occasionally discussed, however it was not necessarily regarded as a factor that helped or hindered. This may be because clinical supervision is a relatively standard aspect of therapeutic work. That is, it is already factored into the structure of service operation and fairly normalised.

Accreditation

In terms of accreditation, only New South Wales had a specialised accreditation scheme (the NSW Child Sex Offender Counsellor Accreditation Scheme) for those working with young people, which is open to New Street workers, private practitioners and other providers. There were a variety of views as to its efficacy. Some specialist practitioners viewed accreditation and standardisation as essential. However, as indicated in the quote below, some practitioners thought the idea itself was sound, but were dubious as to its benefits both for themselves and for people seeking services:

> In theory, I think it's probably a good idea, the scheme. The reality for me is that it doesn't make any difference in terms of the work that I get. So I get a lot of work and I'm sufficiently well known within the system for people to feel confident referring people to me despite that I'm not currently on that particular list of accredited providers of services in this area … "Well, that's all very good, but now that you've fallen off the register, you need to jump through a whole bunch of more hoops" … I'm just not interested in filling out extra paperwork … (Private practitioner, NSW, Practitioner 22)

Others thought that more could be done to strengthen the scheme's purpose and to have more of a "community of practice" dynamism:

> Look, I think it's a great idea and I think it's very reassuring for people to see a name on there and think, "Yes, I'm looking for a service and here's this person and yes, they are accredited and they have to meet certain criteria involving predominantly clinical supervision and education and training in this specific area." So I think that it's good in that way. I mean, in many ways, to us, it's something that we put our name down for and it's nice to have—yes, you know, we've got that accreditation, but it doesn't really add or detract anything really, I think, in practice. So it could be more dynamic, I think. (New Street, NSW, Practitioner 5)

From an overall view, we have suggested through our interagency work in preparing our response for the Royal Commission [RCIRCSA] that there should be further work in looking at that scheme; that there's probably some strengths and weaknesses to it at present. And so

we're wanting to look at that further; how we could build on it. (Government policy, NSW, Policy professional 8)

Overall, specialist practitioners in New South Wales viewed accreditation as a fair expectation for service users to have, but suggested improvements such as updating readings and literature, and providing more dynamic ways of learning and discussion. General support for an accreditation mechanism for specialist practitioners was evident in interviews conducted in Queensland and Victoria, with some caveats—namely, sufficient resourcing for the accreditation agency to monitor and update their information on accredited workers, and ensuring the design of accreditation processes focuses on continuous improvement and professional development rather than acting as barrier for new workers.

Service demand

The view of many participants was that demand is exceeding supply and that this was unlikely to change in the future. Indeed, some participants anticipated an increase in demand as relevant sectors such as education sought to build capacity in identifying HSB:

> The New Street Services, the demand is way outstripping what [the Ministry of Health] could provide. And we know that demand is getting higher. And Education is planning to roll out a toolkit, which means there is going to be more identification. (Policy, NSW, Policy professional 2)

How this was dealt with in practice depended on whether services kept waiting lists or not. SABTS providers in Victoria, for example, commented on the challenges of increased referrals and waitlist management:

> There's still a waiting list 'cause we cannot meet the need. I mean, we get 20 or however many referrals a week … And if you're seeing these kids for 12 months, obviously, your caseload fills up fairly quickly … We spend a lot of time working on the waiting list and the duty intake senior clinician and the team leader are really aware of what's on the waiting list, what are the crisis areas. (SABTS, Victoria, Practitioner 4)

However, while this strategy was something that was employed by SABTS providers, it nevertheless raised questions about disengagement by families once the immediate sense of crisis has passed:

> You get a referral through and there's sort of [a] state of crisis … there's some harmful sexual behaviours going on in the playground or something or in class for older kids, secondary school-aged kids and even if it doesn't lead to any particular charges, that the parents were often—that they're encouraged by the school to quick get down to [SABTS], and then they come here and then we end up waitlisting them. [Parents] they're like, "Well, we want something now, we're in this state now, we're motivated because it's all in the front of our minds now" and then we waitlist them and often when you follow up with them, 6 months later when you say, "We're ready to work with you," you don't hear back from them or they say, "No, we don't want it now." (SABTS, Victoria, Practitioner 12)

In the New South Wales and Queensland contexts the main services do not keep waitlists. Where they could not accommodate the young person, the referral would go back to the referring agency or they provided the family with support to access other service providers:

> [There's] a lot of unmet demand. But we don't hold a waitlist, because we view—the behaviours are serious enough that they warrant some kind of immediate response. So if we can't respond, then we will 1) be telling FACS that we are unable to accept this particular referral; 2) we will be saying to the agency or to the families, "We can't. These are your options privately; this is what you can access." There's nothing else. (New Street, NSW, Practitioner 18)

> If we receive a referral, we will look at it in terms of two things: does it meet our threshold in terms of prioritising the highest risk and the location? We will look individually at where the clinicians are at in terms of their capacity, and if we can't accept it, then we would go straight back to Youth Justice and they will then say, "We'll go on and find another provider." We might say, "We'll provide you with some consultation in the meantime." There could be a whole range of outcomes, but ultimately, we might have to say, "No, we can't take it." (NGO, Queensland, Practitioner 6)

In short, while the three service models managed demand differently, it was generally agreed by therapeutic providers and policy and justice informants that demand certainly outstripped supply. It was also observed by some participants that events in the broader environment could increase awareness of and therefore demand for therapeutic services. Examples given included the RCIRCSA and high-profile media reporting.

One of the consequences of service demand outstripping the ability of services to accept referrals is that increasingly complex clients and behaviours are prioritised even if this was not the original intent of the service. This suggests a downward pressure on private practitioners to pick up unmet demand.

Service funding

Funding—not simply its quantum, but also the way it is designed—is an important influence in how services resource particular activities. How funding is structured also signals to both commissioners and services how the work is understood and what is valued.

Key issues regarding the funding of therapeutic services include the overall basis for payment, the problems associated with short-term funding agreements, and the mismatch between how funding is structured and the nature of the work. The bases upon which therapeutic services are funded are varied. One dimension is target- or output-based:

> Seven or eight years ago, they imposed an outputs model. So, "You will work with this many families and this many hours of output every year." But then they came up with this formula for how many hours you should be working, and it's actually ludicrous, because they deemed that the funding included the capacity to backfill, and so there was never any downtime. So, effectively, you were seeing clients every single day of the year, and so they just worked out how many hours in a year that you could see people, which is what I think they've done, although no one's ever really been able to tell me the algorithm. But if you work out the output hours for these funded therapy services, it's more hours than everybody works in the service, and so it's not achievable. (NGO, Queensland, Practitioner 24)

> Our targets are tiny. I think our annual target, so the turnover is like 11 annually or something like that, in terms of what the funding is … We do [exceed that]. We just take on referrals as we get them and then we'll just absorb that within the rest of our official program. (SABTS, Victoria, Practitioner 20)

As both comments make clear, the underlying assumptions for the calculation of the output measure can seem opaque, arbitrary and not reflective of the actual quantum involved. In the first comment, the practitioners thought the output measure was unachievable; in the latter comment, the anticipated target did not reflect demand, meaning that the service was finding other ways to resource the therapeutic work.

Another aspect that influenced the approach to funding services was more governance-based:

> It's meant to be tight–loose–tight. [The Ministry of Health] puts out the funding, the [Health] District says, "We're giving you the outcomes; you don't ask us how we spend it." But then [the Ministry of Health] monitors it. But the problem with this is, districts are always struggling around funding and so [there have been] a couple of problems with the fidelity of the model, so now [the] contract's pretty tight: that they have to spend the money on certain numbers of staff at certain levels to ensure it's safe. (Government policy, NSW, Policy professional 8).

The rationale here is that how government service funding is best used is something that should be devolved to a local—but not service—level. However, this resulted in issues in terms of how the devolved authority—in this case, the relevant local health district—actually passed on the funding to the specific service.[49] In response, the contracts were further tightened.

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49 NSW Health's local health districts are provided with funding from the Ministry of Health to deliver New Street Services. This funding originates from a range of sources, including the reprioritisation of existing program funds, specific government initiatives, and new investment following Justice Wood's Special Commission into Child Protection, the Aboriginal Child Sexual Assault Taskforce and the recent Royal Commission into Institutional Responses to Child Sexual Abuse. Some of this funding is recurrent and some time-limited. In addition to this, some local health districts also contribute funding and resources to enhance their ability to respond to local population and geographical needs.

What this could mean in practice is that the actual service has little authority on the use of funds.

> Because the way it's set up for New Street [is] there's a different New Street in different local health districts. So those different local health districts have different ideas about what they do with the funding and how much is available to the service and how much is used in other areas—it's a struggle because the money is given to the health district, and then the health district decides what—so they do follow the New Street model, but they get to decide, like, what the premises will be, who will be the practitioners, how many practitioners they will have and how much of the money that they get is filtered down into resources or whatever. So, the funding doesn't come directly to us. (New Street, NSW, Practitioner 10)

An issue that was regularly raised related to short-term funding cycles:

> There is always hope that there'll be a longer funding round. I think [leadership] was really hopeful we'd get 3 years this time. But they're not really looking, I don't think, at each program that's funded—and there are lots of them—in detail. They're just saying, "Oh well, everyone gets another 12 months." I think the way the funding's been approved, it's like everybody seems to get the same thing; the individual programs are not looked at in any great detail. That's my sense, anyway. So, you know, a program that's up and running and busy and doing a pretty good job gets 12 months, but something that perhaps not so much [also gets 12 months]. (New Street, NSW, Practitioner 5)

> So, the service over the last 4 years, I think, has been funded from year to year. Prior to that, it was running on a 3-yearly funding cycle, which is far more efficient [for] running a program. But there were decisions made within government to look at whether they were going to put the funding out to tender, and I don't think that they progressed to any decision. So then it's just gone into this year-to-year situation. Saying that, though, the next service agreement we have is for 2 years, which is good. (NGO, Queensland, Practitioner 6)

Many participants noted that all three of the main service models in our case study and several other services had been doing therapeutic work for 15 years or more and that 12-monthly funding seemed at odds with demonstrably effective services. This short cycle of funding has implications for recruitment, leasing premises, and renewing existing staff contracts.

Service funding also reflected a mismatch between the nature of the work and what the services were—and were not—funded for. In general, funding was for face-to-face, clinical service delivery:

> The funding is the face-to-face stuff. So, I think our particular reporting system identifies that the other case management stuff we do is important, but then the manager, at the end of the year, has to explain why, for every hour we sit in front of a client, there's 3 hours of case management stuff, why that's there. So it's explainable, but initially, there's the pressure that it's face-to-face [time that matters]. (New Street, NSW, Practitioner 10)

> We're only a little a service and we have to justify our funding with activity-based funding. So, the most important thing is that you're seeing the clients. So the idea that you would have time to read anything or go do anything else is—at our service level, that's promoted, but then we have the competing idea that we need to be seeing clients and we need to be ticking off boxes. (New Street, NSW, Practitioner 9)

The focus on hourly direct or individual service provision can "make invisible" all the other work that supports a multisystemic approach:

> The cases we get these days are so complex and we struggle sometimes to get Community Services, our local child protection, to be involved to manage the other things that need to be managed. So we're doing a lot of case management. We have to do a certain amount of case management, but we're doing a lot more case management than I really think we need to be doing. We're spending time chasing up schools and Community Services; and somebody can't drive, so they need to get to somewhere, and all of that kind of stuff. We have to book our own appointments within our own health system. And when

you get up there, one of the places we go for outreach, you get up there, you book the room, you've got the email that confirms you got the booking to the room, now you get out there, somebody else is in it. So you're doing all of that negotiation. So that makes your time run short on your session. (New Street, NSW, Practitioner 9)

This quote also highlights the possibility that other services and agencies that are part of a multisystemic model are themselves facing challenges and resourcing restrictions that can make it difficult for agencies to work together.

Accessibility of services for young people and their families

Four main types of factors influence clients' capacity to access therapeutic services and to remain engaged, namely geography and location of services; knowledge, awareness and stigma associated with accessing such services; affordability of services; and the challenges of remaining engaged in long-term treatment.

Geography and location of services

At the time of writing, of the three service settings, only SABTS in Victoria have statewide coverage. In the Queensland context, a number of geographic challenges exist to make accessing therapeutic services difficult. GYFS does provide treatment across the state for adjudicated young people. However, being based in Brisbane and providing outreach services to remote parts of the state presents significant challenges. Until recently, New Street Services has not been available in more than five locations across New South Wales (however the expansion of services will enable such coverage). As such, the lack of statewide service provision coupled with the size of these states has meant that geographic distance is a key factor influencing service access.

At the most practical level there are the challenges that clients faced in travelling to services they had already been connected to:

> We do have some families who are able to come us in [here] who live probably, maybe 90 [kilometres] away … public transport out here's pretty non-existent and

disadvantaged people often have cars that are not always reliable and the cost of petrol, as you know, is higher out here than it is in the city and you use more of it to get from A to B. (New Street, NSW, Practitioner 5)

Not having statewide coverage has also meant that young people might receive different responses depending on where they live:

> So, for example, gap: New Street Services are not available across the state. So, depending on where you live, you might get a really lovely therapeutic response, that supports you at school, assists us with risk management, works with the family and gets some really good outcomes. But that's just luck of the draw, depending on where you live. (Government policy, NSW, Policy professional 2)

> Anywhere outside of south-east Queensland is difficult. And there is a number of agencies scattered across the eastern coast, but the more rural and remote you get, the less likely that there'll be any opportunity for anything other than what's either ordered by through a Youth Justice response or through a Child Safety response… So it might potentially mean that if you live outside the south-east, you are far less likely to get an RJ [restorative justice] referral from the police if you sexually offend, because of the fact that there is a paucity of services in other parts of the state. (Government policy, Queensland, Policy professional 1)

Knowledge, awareness and stigma

The enduring stigma and taboo associated with sexual abuse compared to other social harms may also act as a barrier to service access. Some participants noted that families may not know that the service exists or what the service is actually for:

> Well, we don't advertise. We don't have a big sign out the front that says, "We work with young people who sexually harm." So they often have no idea where to go. Sometimes JIRT [Joint Investigation Response Team] or FACS might give them the number, but then they are cold-calling us and we have no information [about them]. So we are relying on very traumatised parents trying to refer their young person who's caused harm. (New Street, NSW, Practitioner 9)

For Aboriginal and Torres Strait Islander communities and CALD communities, it is possible that a sense of judgement from the community is a barrier to accessing a therapeutic service:

> I don't know but my hypothesis might be that there are some groups who may be less likely to access services because of what that will mean in their community in terms of shame. So, again, some of these community groups where everybody knows each other and everybody knows everybody's business—that where there are very strong ideas about privacy and stuff like that, see it would be very difficult. (Private practitioner, NSW, Practitioner 22)

> I think when you're talking about the CALD communities, there're different problems potentially associated with every different ethnic group, and every different religion [has] their own belief structures and reporting mechanisms. [Some communities] are very difficult to engage with because they don't want to share their problems with us, or the senior members of the community can ostracise and cast someone adrift if they report to police. (Police, Victoria, Policy professional 4)

Where there are service system gaps, services will often refer to private practitioners. However, the cost of private services can be a barrier to accessing therapeutic intervention:

> They can't afford it. That's another issue. People can't afford counselling. They see that as just outside of their family budget. And I understand that as well. (Private practitioner, NSW, Practitioner 23)

> The Medicare funding is up to a maximum of ten sessions. You get six sessions and the Medicare Better Access program is designed for people with simple Axis 1 disorders—depression, anxiety—and, of course, the kids meet that criteria 'cause their life has just been turned upside down 'cause they've been caught, and so there's no problem getting on that plan, but it's only about $85 a session. I charge the APS [Australian Psychological Society] rate, which is $246 a session. So the parents have to be fairly moneyed … (Private practitioner, NSW, Practitioner 22)

Maintaining engagement

In addition to factors that influence clients' access to services, there was also the challenge of keeping the young person and/or their families engaged in therapy. As the quote below indicates, dynamics within the family context can influence the capacity and willingness of parents to be part of the therapeutic intervention:

> We had another young person who maintained good participation and attendance during the assessment phase, but then when confronted with the more intensive work, just refused to do it. He would go missing at the time of his appointment so his parent couldn't bring him. Then just when his parent did manage to get hold of him and bring him, he just said, "I don't want to do this anymore" and disengaged. So we're a voluntary service. He wasn't under any kind of treatment orders, so we couldn't make that happen. (New Street, NSW, Practitioner 10)

It was not only the case that complex family dynamics influenced the capacity of families to engage in the treatment process; so too did the day to day pressures of parenting:

> With the safety planning that we're doing with families— it's a high level of supervision that's required by adults in the home … How can they make dinner when they're out in the backyard playing and, "I need to be out there with them, watching them. I can't be in the kitchen. My husband doesn't get home til six." And they're real problems. (New Street, NSW, Practitioner 5)

Intersecting service systems

Multiple service systems and institutions are involved in supporting the provision of therapeutic responses to young people engaging in HSB. The three service models examined in this project particularly intersect with child protection (both statutory child protection and the network of non-government service providers), police and the broader legal system, and school systems.

While there is a growing consensus across these service systems about how young people engaging in HSB are understood and what good practice in therapeutic responses entails, it is equally the case that these services have their own objectives,

imperatives, processes, and regulations that can work against these understandings, or complicate the ability of therapeutic providers to realise the principles described in the previous section. These issues are explored in the following sections.

Child protection

The child protection system intersects with specialist services in several keys ways. It is a main source of referral of young people into a therapeutic response and a key partner agency in the treatment plan, and it may have had a history of involvement with the young person and their family prior to the issue of HSB coming to light.

While participants agreed that child protection had a critical role to play in therapeutic responses to young people engaging in HSB, they also noted that child protection was an overwhelmed system, with its practitioners often managing significant caseloads, increased complexity of client need and competing priorities.[50] This, combined with the overall focus of child protection as intervening on behalf of vulnerable or at-risk children where there is an absence or inability of a protective parent or guardian, could mean:

- differences in safety and risk thresholds
- diminished capacity as a partner agency in the therapeutic process.

These issues and how they impact on therapeutic treatment are discussed below.

Differences in safety and risk thresholds

A common observation by participants was that child protection agencies often worked from different perspectives, or with different levels of risk. This was framed in different ways—for instance, reference to the crisis being over, or to securing safety for the child-victim as equating to safety overall. The point being made, however, was that child protection often operated from within a "crisis response" framework to prevent further significant harm from occurring, which was often shorter-term and targeted at high-risk situations

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50   Recent trend analyses by the Australian Institute of Health and Welfare (AIHW) bear this out. Between 2013–14 and 2017–18, there were increases in substantiations, care and protection orders and children in OOHC (AIHW, 2019).

such as ongoing physical abuse, significant neglect, or lack of attendance at school. As described in the earlier sections of this chapter, safety and risk management for therapeutic services is more long-term and is less a "safety from" orientation than it is a holistic and future-focused assessment of the young person's ability to restore their family relationships and to have healthy relationships:

> They [FACS] work from a different perspective … their role is to make children safe. When the referral comes to [FACS] after the JIRT investigation, they go, "Okay, victim child is with family and the [HSB] young person is living with some other extended family or in care or somewhere else", so the young victim child is safe. So they want to pull out at that stage because, for them, the crisis is over. They have secured the safety of both of these children, which is true, but there's no reunification. We can't reunify until, of course, the young person who's caused harm has done the work. (New Street, NSW, Practitioner 10)

Child protection agencies were also operating in a context of strained resources:

> It would be remiss to not note that Family and Community Services is unable to respond to the majority of contacts that they get that they have assessed to be at the "risk of significant harm" threshold. So there's many times that reports—and that will not be unique to New South Wales, that will be in every jurisdiction—but there's many times that we make a report to the statutory child protection agency and they say, "Yes, that is concerning, but no, we won't be able to respond, because we don't have the resources to be able to do that." (Government policy, NSW, Policy professional 2)

The complex dynamic between an overwhelmed child protection system and differing thresholds of risk and safety had practical implications for therapeutic services who were struggling to engage the young person and/or their family. Therapeutic practitioners often spoke of "doing the work"; that is, of engagement and assessment and of undertaking the intensive work individually and as a family to acknowledge harm, to implement safety plans, and to move on to restoring relationships. Each stage can present barriers and obstacles for the young person and their family. The statutory role of child protection was seen as a mechanism that could help hold

the family in the therapeutic process without compromising the therapeutic relationship:

> Sometimes, on more complex cases, we would really like Community Services to remain involved, because as we get into [the] intensive [phase], there are these other things that come up: that dad's domestically violent, or mum's got a secret drug and alcohol problem, or whatever, and so we need their assistance. Because we're a voluntary service, we can't make them [the clients] do anything. (New Street, NSW, Practitioner 9)

> Good cop, bad cop. I'd much prefer the good cop. Trying to establish a therapeutic working relationship, it's not particularly helpful if I'm having to wave a stick as well. So please, Child Protection, you're statutorily equipped to play that role, so can you please do it? Once you close your [Child Protection] case after 2 weeks, and they come for 2 weeks and then they'll [the clients] realise this is a bit tricky. "They're asking me questions I don't like, and we don't come anymore." We've got no leverage then. So Child Protection can be really helpful. (SABTS, Victoria, Practitioner 24)

From a systemic perspective, policy professionals in child protection emphasised that child protection workers needed to understand their role as statutory enablers, but also acknowledged the challenges of this role in practice.

Capacity as a partner agency

A final set of factors that influenced the delivery of therapeutic responses related to the nature of the child protection workforce compared to both specialist providers and the specialist police units that work with sexual offences. The two latter workforces are older and have seen considerable longevity in their roles. A number of participants noted that child protection workers were often recent graduates and may not have an in-depth understanding of harmful behaviours, or had yet to understand the role of child protection in responding:

> Of course, child protection workers should know about this stuff. It's their core business, vulnerable children, protective risk, et cetera. I think the reality is that a lot of child protection workers are incredibly overworked. I think that they're quite young and inexperienced, just out of uni, that these are very confronting issues for a lot of people. It's really, really complex stuff. Sexually abusive behaviours within the families is like, it's not something that people disclose straight away. It's a very complex issue and I think it takes a really skilled practitioner to work with families to get disclosures, to work effectively … I don't know how attuned their antenna is to sexually abusive behaviours, and it probably should be more. (Government policy, Victoria, Policy professional 3)

> I think it seems to be very kind of fragmented. And getting everybody together to understand this—because, again, to come back to agencies, a lot of the coal-face workers, the resi. [residential] staff: they don't have a lot of training. They have very basic training and they certainly don't have a lot of training in this area, an understanding in this area. Therefore, I don't think they appreciate the need for intervention around sexually harmful behaviours to sit in a broader foundation of adaptive skills. Because it is a maladaptive social behaviour, but these kids have a whole bunch of maladaptive behaviours. (New Street, NSW, Practitioner 18)

Over the last 10 years child protection departments have invested considerably in developing resources and practice guides and in having highly experienced practice leads support professional practice. However, the movement of new entrants to other parts of child protection or to other services can make it difficult to retain that knowledge in, for example, the intake teams:

> We try to educate our members in our unit, but with [Department of Human Services] in terms of their staff, I think are quite junior. They tend to have a lot of movement in their staff and some of them have a lack of knowledge. So, it's not from necessarily lack of wanting to do the right thing. It's that they have this knowledge gap and the team leaders really need to bring each new person up to speed as they become caseworkers. And so, in a lot of instances, the police would ring and make a referral and say, "We're referring and recommending a TTO", and the police as far as they were concerned would think that, "We've done our bit", and the caseworker not having an understanding of what their role now changed to, they would sometimes not even make a note of it on their database. And so, once I was meeting with

the team leader and the practice managers, they would be saying, "We didn't get a referral", and we're saying, "We've documented it. We've had these conversations", and it wasn't [documented] at their end. (Police, Victoria, Policy professional 4)

In the context of TTOs, which mandate SABTS treatment if engagement is absent, it is possible to see how child protection is used to both stave off a TTO and to apply for the order once this has been requested by police or the service themselves:

> I think there might be a reasonable amount of work involved in it [a TTO]—which I think is also why there's probably a reluctance to do them in the first place, because … they're managing their normal caseloads like any other practitioner or investigator is, and then they've got this extra work, which is something they don't always do, so it's probably a little bit different that takes a little bit of extra time or perhaps quite a bit of time and work and pulling together different reports and pieces of material that the board can look at and rely on. So, I suspect it's probably as much a resourcing situation for them as well as perhaps a knowledge thing because they're not an overly common sort of process that they would go through. (Police, Victoria, Policy professional 4)

Out-of-home care placement breakdowns

Stability of care and relationships has been identified by practitioners as central in their therapeutic work with young people with HSB. As such, the breakdown of OOHC placements presented significant challenges. This was particularly felt among New South Wales participants where a significant proportion of clients in New Street services were in OOHC:

> One of the frustrations we have is when placements break down in out-of-home care. And that can be for a whole range of reasons. It's not always because our young person has done something; sometimes it is, because of their behaviour. [But] we have a lot of kids with the ADD [attention deficit disorder], ADHD [attention deficit hyperactivity disorder]/ADD cluster—which you could argue that a lot of that is probably impact of trauma. So when placements break down and kids get moved around, that can be really difficult. Where we can, we continue to follow them. So if it's within our LHD [local health

district], and if that's at all possible, we will think, "Well, okay, we were seeing this family in [town], but guess what, they've moved to [another town], well, we'll go [there]." They've been coming for 6 months. And then it's about establishing a relationship with the new carers. (New Street, NSW, Practitioner 5)

Some participants saw placement breakdowns as endemic to the child protection system per se, and pointed to the work that needed to be done with kinship and foster carers to prevent removal into residential care:

> These kids' foster [placements] are breaking down, breaking down and end up in resi. care. Particularly these kids [with HSB]. Quite often, families that [have] these kids aren't told that the children have harmful behaviours. And then, when something goes really wrong, those families don't want them anymore. Because they're not properly prepared. (Government policy, NSW, Policy professional 8)

While there was recognition that effective place matching was a priority (i.e. ensuring the young person engaging in HSB was matched appropriately), to minimise placement breakdowns, there was also a call from some participants for specialist therapeutic services to work with the reality of this system—that living stability for young people in out-of-home care was relative and precarious. The focus on establishing safety could act as a barrier for some young people.

Police and justice responses

The last two decades have witnessed considerable change in how young people engaging in HSB are understood, with a shift away from an adult-based, criminogenic lens to viewing both the young person and their behaviours within their particular developmental and relational contexts. That is, and as elucidated in previous sections, young people engaging in HSB are not smaller versions of adult sex offenders, and the HSB themselves are often a response to adverse experiences in the young person's life, including their own sexual victimisation, child abuse and maltreatment, family violence, and dysfunctional home environments. This reconceptualisation has informed a shift to therapeutic rather than justice interventions; however, there are challenges in bridging the two paradigms.

Police decision-making

The extent to which therapeutic services are an actual diversion away from the criminal justice system or an alternative differs across jurisdictions:

> [Compared to Victoria,] if it [the case] is accepted by JIRT, it's got to be prosecuted through the usual channels. There is not a diversionary program. And that raises particular complexities for families around sibling sexual abuse and for investigation and prosecution of those matters. (Policy, NSW, Policy professional 2)

Police are often a—if not the—first point of contact for a young person who has engaged in HSB. Whether they respond by diversion and/or referral or charge can fundamentally influence the therapeutic options available. As participant statements make clear, these decisions themselves occur within a broader police framework in terms of how sexual violence and abuse is understood.

In the New South Wales context, and with particular reference to New Street Service, the eligibility criteria state that a young person can be referred to New Street subsequent to a substantiation by the JIRT, but is not eligible if they have been charged:

> If a young person is charged, then of course we can't see them. Part of the way it's been set up … If FACS are involved, they might pay someone to do it, so their own psychologist may do something. But at the moment, the way it stands, being charged is a barrier to coming to New Street … And if they're charged, they won't get a service—usually from Juvenile Justice—until they're convicted. And as we know, there's not a high correlation between being charged and being convicted in the area of child sexual assault. (New Street, NSW, Practitioner 5)

A number of practitioners noted that opting to charge a young person could lead to significant delays in accessing timely therapeutic intervention:

> So sometimes that lag in the court process [leaves] families and young people having no help—I mean, if you could afford a private psychologist or social worker and there's one in your town, maybe you might access that and get some help and support in that process. But if you live in

the remote area and you're disadvantaged, well, you know … (New Street, NSW, Practitioner 5)

Whether charges proceeded or not, delay was still an issue in that it closed the window of a timely therapeutic option. Once the investigation had ceased and charges were dropped, families were often not willing to continue therapeutically:

> So the kids that are charged—getting to court is quite a delayed process, so it might be 12 months before they get to court to either get convicted or not convicted. If they're not convicted, nothing happens [to/for them]. And we know that, often, just because people aren't convicted, it doesn't mean anything didn't happen. So that is a problem with our New South Wales system: that we don't have more of that diversionary kind of idea where there's the possibility of a charge, that New Street or a similar service could come in and offer help and support at that time when families are really willing. It's kind of like a window of opportunity. (New Street, NSW, Practitioner 5)

A possible key factor in police decision-making about whether to charge may be how they understand their role in responding to HSB by young people. There were considerable differences in the views of police members interviewed. Some police understood their role as being primarily focused on the victim; having a "therapeutic" orientation towards the young person with HSB was not part of that role:

> Most police would have this idea: that when the file comes in, your focus is the victim. And what you want from the offender is to solve the matter for the victim. Does that make sense? So, say if you've got someone 10–17 who's a sexual offender: to deal with them in some holistic way down the track is not your priority when you get your job in … It's not in our role. Our role is to get 'em to court. And we can refer, but really it isn't our role. We've also got to be protective. And that's how we see that. If we're going to the point where we're putting him before the court, we're saying we have to be protective because there's other kids in the community that need that protection from this person. And the only way is for a court-ordered program for this child. (Police, Queensland, Policy professional 5)

Further, these participants felt that they did not have the legislative flexibility to respond differently for young people who had disabilities such as being on the autism spectrum:

> Unfortunately, our legislative requirements are not that flexible for that. And that's not for us to decide. We're not professionals in term of where he fits on the spectrum, so we have to count them all the same. So unless there's remorse or some admissions made, he doesn't get the alternatives. And no matter how bad it is and how minor the offence is, if he's just going to close down and not talk to us, then he gets treated as: "Okay, if we've got enough evidence, you're going to court." (Police, Queensland, Policy professional 5)

Other police professionals we interviewed had a different understanding about the priorities informing their decision-making:

> Sending someone through the court system just with the outcome of getting them a finding of guilt or a conviction or whatever is next to useless, really—doesn't have a whole lot of deterrent, doesn't change the behaviour, doesn't educate the kid or anything like that … We just—overall, we see the value of the treatment, the therapeutic treatment. We see the value of getting it happening early and the value of keeping the kids engaged in it. At the end of the day, we just want the best thing for these kids. We're not looking to prosecute them, nail them to the cross or do anything like that. We just wanna see these kids get the right outcome. (Police, Victoria, Policy professional 4)

However, this view may not be shared across specialist police members, as this service provider reflected:

> I think the only thing I could say is that the SOCIT unit is still really seeing this age group through the eyes of the adult lens and because of that sometimes I think they're forgetting about the therapeutic options. So there's been a few times where they'll be just sort of proceeding with charges and it's been Child Protection that sort of said, "Hang on a minute, we've got the SABT program and could we get an assessment to see whether this young person would be suited to going through a community program like this." (SABTS, Victoria, Practitioner 20)

Legal processes

Where young people are charged by police, *doli incapax*[51] will invariably come into play. The overall principle of the presumption was seen as a protection for young people under the age of 14; however, there were questions about the very purpose of charging where the presumption appeared too difficult for the prosecution to rebut:

> *Doli incapax* is—it's not perfect, but I think it is a protection for those younger kids that are charged … We've had a number of kids where they've been charged. The DPP [Director of Public Prosecutions] hasn't been able to get over *doli incapax*—and everyone's convinced the young person did the behaviour, but [because] they're charged, they can't come to us. The charges are dropped. They then say, "Well, okay, New Street's the fall-back position." But as I said, sometimes that window of opportunity is shut. (New Street, NSW, Practitioner 5)

> We don't charge many of the kids because we know that we're going to have the *doli incapax* issue at court and so, we're doing all this paperwork and we're getting them to court and putting the child through, going through the court process, having to speak to solicitors, have the family drag through court when they're gonna get a probably—I don't know, I'm not an expert, but I'm thinking they're probably gonna get a better result if they get that counselling, which is why they get the TTO. (Police, Victoria, Policy professional 4)

There was also a sense that in order for solicitors to make the rebuttal too difficult, they would argue that the young person did not know what they were doing, which went against the aims of therapeutic intervention:

> The solicitors argue that they [the young person] didn't understand what they were doing was wrong—were wrong. They couldn't find the necessary criminal intent to commit the crime. So, again, they're so caught up on trying to defeat the court process or defeat the charge using a *doli incapax* argument that this kid didn't know what they were doing were wrong, rather than looking at

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51 This is a common law presumption that a child between the ages of 10–14 years does not possess the necessary knowledge to have a criminal intention. It is a rebuttable presumption. The prosecution must provide evidence that suggests that the child knew that their behaviour was criminally wrong.

the bigger picture to say whether the kid necessarily knew that this was a criminal offence or whatever, the bottom line is this kid has inappropriately sexually touched, abused a sibling or a friend or another resident in the resi. [residential] unit or whatever—that's not really in dispute, but we're trying to defeat it on a *doli incapax* argument here rather than just saying, "This kid needs to get some treatment. Let's just get it happening." (Police, Victoria, Policy professional 4)

In real terms for the young person, it often meant not taking up any therapeutic response because it would potentially signal to the court that they were aware that what they were doing was morally wrong.

Education and school sector

A third key system that affected therapeutic responses to HSB was the school and education sector. The ideal school response was described as follows:

We would ideally love to see a differentiated response based on developmental appropriateness, ages, cohort of student, individual background, et cetera …We would like to see a school tailor that response to the individual child, what their circumstances are and what they're moving through. We would want schools providing a sensitive, dignified response to all parties that are part of that. And we would want to ensure that they're meeting their legal obligations and getting the correct support and advice that is required for that response; that they are linking that family [and] child—both sets [i.e. the young person engaging in HSB and the harmed child]—into appropriate therapeutic responses if need be, supporting them through statutory processes as they may occur. (Government policy, NSW, Policy professional 2)

Many participants acknowledged that schools in general attempted to respond with a caring, non-punitive response to the young person; however, there were several factors that could sometimes work against this type of response.

One element was schools' duty of care to their whole school community and the need to balance risk, safety, and school

engagement for all students. However, this could sometimes mean isolating or excluding the young person from school engagement, even though this is a key protective factor:

It's great to have school settings who are prepared to give a little bit of leeway and not just have a child sit outside the principal's office for 12 months while they're in treatment. Who are open to understanding some of the dynamics and some of the issues around the safety and things like that, so that's helpful. It's understandable, particularly in school settings, that they're anxious about duty of care and other kids, et cetera, et cetera, but part of the whole point of our assessment is to understand why a young person might have engaged in this behaviour, and if school isn't a risk area, it's not a risk area. (SABTS, Victoria, Practitioner 24)

Therapeutic service providers described the importance of working with schools—principals, educators, and parents—to help them understand the nature of the behaviour, and what this meant for safety and risk management in the school setting. Some practitioners felt that if they did not actively engage school leadership, schools would tend towards isolating, suspending or expelling the young person, although this was not a common view:

When a school becomes aware that a young person has been placed on a charge, there is a capacity for the principal of that school to decide that the risk is too great to have that young person in the school, and they are therefore placed on a charge-related suspension, which means that they can only access their education by distance education until that situation is resolved somehow. Which could take a long time. Not all principals—and I would say probably the minority—do go down the path of a charge-related suspension. They are generally really responsible and do a thorough risk analysis first to determine what strategies can be put into place to enable that young person to remain at school. (Government policy, Queensland, Policy professional 6)

Participants noted that many school communities found HSB confronting and that despite developments in improving responses to young people engaging in them, the "taboo" nature of HSB and the lack of shared knowledge could negatively impact the types of decisions made:

At the moment, they're redeveloping their responses to kids with harmful sexual behaviours. So I think they've got a whole sort of protocol. But we just hear little bits and stories about kids who have been placed on a therapeutic treatment order and the schools just not knowing how to manage that—and isolating that kid away from their peers because they're scared that they're gonna be like a "sex fiend". And it's all caught up with just not knowing and being scared about the impact for their kids and their community. (Government policy, Victoria, Policy professional 7)

You might see in the newspaper a headline about bullying and the evil bullies who have driven a child to die by suicide. But that loses sight of the fact that people who're engaging in these behaviours are also children. And that's—I think that's one of the messages we could get through: treat it seriously, be respectful, be calm, tell people who need to know; and engage and work and with other agencies to support children where that's required. (Government policy, NSW, Policy professional 2)

As such, a number of participants thought that the area of focus going forward was not so much schools and teachers themselves (though this was still important) but improving parental and community understanding of HSB:

… I think people understanding that: that the language of the criminal law should not be used in the context with these children. They're not perpetrators, they're not offenders. They're certainly not rapists. But this is the sort of language that comes in when people become emotionally involved. It'd be helpful to have people actually understanding more about the underlying dysfunction or abuse or neglect that could be factoring in those kids' lives. You'd get a sympathetic—hopefully—a much more sympathetic response in these behaviours and exhibit an understanding of why we don't, for instance, immediately move to expel a child. I think that would be really helpful and I think that that's missing at the moment. (Government policy, NSW, Policy professional 2)

The role of education is likely to be an area of growing focus following the RCIRCSA. As this section suggests, schools' responses are variable, depending in part on the level of

understanding the school community—including parents—has about HSB. Without a shared understanding, high emotion can replace a fair assessment of risk and duty of care to both the young person engaging in HSB and the harmed child.

Summary

This chapter has sought to provide a detailed, in-depth description of:

- what constitutes good practice in therapeutic responses for young people who have engaged in HSB
- the goals of therapeutic interventions
- how these principles are translated into practice
- the factors in services' operating environments that facilitate or act as barriers to good practice.

There was a shared understanding among practitioners about the key principles that made for good practice. These principles can be grouped into principles that describe the conceptual underpinning of the work, principles that guide the direct therapeutic work or intervention, and those about what needs to be present to make the intervention work.

There were some differences, however, in how the specific service models translated these principles into practice. These differences are arguably a feature of holding the principles front and centre while working with different client cohorts (voluntary compared to court mandated), and include:

- different service setups (field-based outreach compared to a standalone dedicated service compared to a program within a broader service)
- different referral and eligibility requirements (harm confirmed by an investigation such as JIRT compared to no requirement for this)
- different characteristics of the jurisdictions (geographic as well as the broader policy approach to community service provision).

Finally, there were common themes in relation to factors in services' operating environments that helped or hindered in the provision of good practice. Factors that affected service

delivery were common across the service models, particularly in terms of workforce development and retention, and in terms of the demand for service outstripping the capacity to meet that demand. HSB work is highly specialised, and for those outside of the sector, stigma or a trepidation about that specialisation can act as a barrier to recruiting staff. Short-term contracts—often reflecting short-cycle service funding—made it difficult to retain staff and to attract new workers with the skills and experience to specialise in HSB treatment.

There were a range of factors that affected clients' (i.e. young people and their families) ability to access, and stay engaged in, treatment. A key issue related to the challenges of geography and the challenges of statewide service provision: depending on where young people lived, they may not receive a service at all. Where there was a service in the regions, travel distance could make it difficult for families to attend counselling sessions. When practitioners did go out to the families, challenges presented themselves in attempting to find suitable counselling rooms that were sufficiently private, particularly in small communities. In the New South Wales context, the accreditation scheme enables families to identify accredited private practitioners, which can help to address service coverage gaps. However, this could raise financial difficulties for families, particularly given the long-term nature of HSB intervention.

A third dimension of services' operating context that facilitated—or could act as a barrier to—good practice related to the broader service systems that intersect with or are in fact part of the intervention. Typically, these are the criminal justice system, child protection (both statutory child protection and the network of non-government service providers), and education. As much as there is a high-level, and somewhat abstract, understanding that responses to HSB are a multi-agency endeavour, in practice, differences in organisational imperatives and pressures, thresholds of risk, and other service systems' understanding of HSB can derail the intervention.

The following, concluding chapter synthesises the findings of this chapter with the national service picture more broadly, and considers the implications for future service design and implementation.

CHAPTER 5:

Conclusion

The key purpose of this project was to understand what constitutes good practice in therapeutic responses for young people engaging in HSB, and what factors in the broader service delivery context helped—or hindered—effective therapeutic work.

We begin with a summary of the key findings from the study components. The final section of the chapter firstly synthesises the main findings across the three components and then considers the implications of our findings for future service provision for young people engaging in HSB.

Summary of project findings

The state of knowledge relating to harmful sexual behaviours

The State of knowledge review suggests the need for a consolidation of the evidence base in relation to identifying the characteristics of young people who engage in HSB, and a deeper understanding of the co-occurring adverse experiences of these young people. There is no single set of characteristics or circumstances that "cause" or predict a young person's engagement in HSB (Chaffin, 2008; O'Brien, 2008). Young people who engage in HSB are a diverse group, and a range of factors—individual and environmental—contribute to these behaviours under different circumstances.

A second key area of research consolidation relates to deepening the knowledge base about therapeutic approaches to HSB. Researchers and clinicians have transitioned away from using individual behavioural modification models (such as individual counselling/psychotherapy) to incorporating more holistic frameworks that encompass both social and environmental elements (Pratt, 2014; Shlonsky et al., 2017). Interventions with young people engaging in HSB have thus increasingly integrated the below:

- their neuro-psychosocial developmental capacities
- the experiences and impacts of trauma on of these young people
- their lived social ecology (e.g. their familial, kinship and care contexts; peer relationships; school attachments;

organisational affiliations; community contexts)
- the influence and role of these social ecologies in therapeutic responses (Creeden, 2013; Hackett et al., 2016; Hall et al., 2012, 2013; Pratt & Fernandes, 2015; Ward & Beech, 2006; Worling, 2012; Worling & Langton, 2016).

However, there are gaps in the research, including the following:

- Our knowledge about the extent of HSB: currently, recorded crime and administrative data act as proxies for extent; however, these types of data rely on children and young people disclosing, carers and guardians reporting to relevant agencies, and those agencies recording incidents in ways that allow them to be identified as HSB. A lack of knowledge, fear, stigma and concerns about what will happen to family members are barriers to reporting.
- Program effectiveness, particularly in the Australian context: there is very limited research that evaluates the effectiveness of therapeutic interventions that reflect good practice principles identified in the literature.
- Understanding of how HSB present and are understood within CALD communities: to our knowledge, no published research exists on this in the Australian context. This gap signals the need for further inquiry, working with diverse communities to develop an understanding of how HSB are understood and what types of interventions are needed.
- Limited research on how developments in therapeutic approaches are being tailored to Aboriginal and Torres Strait Islander young people and their communities.

The national picture of service responses for young people with harmful sexual behaviours

Service mapping

The first observation we make is that, overall, the quality and usefulness of public information about what services are available in each jurisdiction, who they see, what they do, and who can refer is poor. Despite having a dedicated research team to obtain this information (including through follow-up requests), this was a challenging undertaking and there are still information gaps in our service mapping. For families who may be seeking information about what is

available through GPs, school counsellors, teachers and other key contact points with young people, this is a problem. It means that individuals (private and professional) need to have "inside knowledge" about where to go to find out what is available in their state or territory and how the service system works (i.e. who can make contact and what happens once contact is made). Possible reasons for this lack of accessible information include:

- The relative newness of service responses to HSB: it is really only in the last decade or so that awareness and understanding of young people and HSB has expanded beyond specialist practitioners to be part of child and youth service provision generally. While child and youth government agencies have endeavoured to keep abreast of these developments in therapeutic service provision, this has yet to translate into public-facing information.

- Lack of ownership for information provision: while many services are funded by a central government department, it is often unclear who is the main and authoritative source of information. This can mean inconsistent information about the same service on different webpages.

- Lack of resourcing and/or capability to publish information online: many providers are non-government, community-based organisations. Lack of resourcing may mean, for example, that they are unlikely to have the resources to dedicate to keeping websites up to date. This can mean limited or out-of-date information and broken or circuitous links.

- Absence of a user-experience perspective: services—large or small—may not have an orientation towards the user experience of attempting to locate information or what information they are actually after. This compromises the discoverability of information (how findable, recent and relevant it is).

A corrective to the situation would be to have a central, public repository of information that describes what services are available in each state and territory, who can access these services, how a young person is referred, how the services can be contacted and what the nature of the program is. This would need to be updated on a regular basis (e.g. every 6 months).

A second observation is that nationally there appear to be significant gaps in the provision of services for young people with HSB. Some jurisdictions appear to have no therapeutic service provision (e.g. Australian Capital Territory). Since O'Brien's (2010) service mapping, there has been an increase in specialist services in some jurisdictions (e.g. Western Australia, Queensland and Tasmania); however, eligibility criteria relating to age and the nature of the behaviours engaged in place exclusions on who can access treatment; those over the age of 12 and those whose behaviours are at the more serious end of the spectrum can be deemed ineligible.

The corrective for addressing these service gaps is fundamentally tied to the question of what kind of service systems response is desired for young people (i.e. under the age of majority) who engage in HSB.

Responses to the request for information

Practitioner characteristics

What we learned from these responses was very much in line with the existing evidence. Practitioners' responses indicated that:

- they were aware of the co-occurring issues that accompanied HSB
- clients' trauma histories were part of assessment the majority of the time
- family participation was considered to be very important.

Compared to practitioner views from the three service models, however, there were some differences in what the most important principles of effective practice were considered to be. Practitioners responding to the request for information indicated that tailoring interventions to the individual was most important, followed by being family focused. Being eco-systemically focused was the third most important principle. Why this ranking occurred is not clear. It may be a consequence of question ordering (i.e. the question came after questions about treatment duration and frequency). It may also be related to the fact that practitioners were responding as individual practitioners rather than as workers in a particular service.

In terms of worker characteristics, the responses reflect what is known about the broader community services sector that works with complex clients:

- the vast majority of respondents were female
- they are highly qualified (i.e. 90 percent of respondents had a bachelor degree and a third held a postgraduate qualification)
- almost two thirds had been working as HSB practitioners for more than 6 years
- of these, one third had over a decade of experience.

In short, the request for information responses reflected a highly qualified and experienced workforce.

Therapeutic approaches and practices

Practitioners work with young people intensively to address HSB. Over half of respondents (53%) said that they worked with young people for between 1–2 years; 60 percent said the treatment frequency was weekly and another 29 percent saw clients fortnightly. The top three elements of effective intervention nominated were:

- tailoring the intervention to the needs of the individual (54% of respondents)
- working with the family system (44% of respondents)
- working eco-systemically (i.e. working with the young person in their familial, interpersonal and community systems) (36% of respondents).

All respondents said that they assessed the presence of trauma in the history of the young person either always (86%) or most of the time (14%).

Barriers to service access and engagement

Responses to questions about service barriers indicated that in terms of accessing services in the first instance, geographic disadvantage was a commonly cited factor (46%) followed by insufficient places available at services (39%), family or guardian reluctance or inability to participate (39%), and lack of awareness about services (38%). However, barriers to completing treatment differed; respondents saw family reluctance or inability to participate as the key barrier (66%).

Insights from the review of three service models

Understandings of good practice

The review of three service models aimed to generate an in-depth understanding of the principles of good practice and the factors in the services' operating contexts that were enablers of and barriers to good practice.

As with the request for information responses, there is significant overlap in the principles of good practice identified by participants and those articulated in the broader research and guidance literature. How practitioners described these principles working in practice provided additional insight and nuance to the function different principles have within HSB responses. These functions were categorised as principles that:

- described the conceptual underpinnings of the work
- guided the direct therapeutic work or intervention
- enabled or supported the delivery of the intervention.

Table 11 summarises what these principles involve and what they look like in practice.

Distinguishing between types of principles is useful in three key ways. First, the distinctions provide additional guidance to the principles already described in the literature by making explicit how these principles function to underpin the work, characterise the therapeutic engagement, and sustain therapeutic work with young people. Second, such distinctions also make explicit how principles of good practice articulate and reinforce each other. Finally, from a systems perspective, they can be used to help align how intersecting agencies and systems interface with specialist responses to HSB. For instance, they can be used to help assess:

- the extent to which conceptual understandings about young people and HSB are shared across different service systems
- the extent to which intersecting service systems are able to respond in trauma-informed ways
- the respective roles of different agencies in, for example, supporting families and carers, providing information for case assessments and supporting safety plans.

Table 11 : Summary of the conceptual, therapeutic and enabling principles of good practice

Dimension	Principles	What this means
Conceptual	Understanding the developmental trajectories and capacities of young people (i.e. cognitive, psychological, and relational capacities are still in formation; they rely on the adults around them as key supports)	· A young person is not synonymous with their behaviour. Connected to a developmental understanding, the young person's potential to acknowledge the harm their choices caused and to change this for the future were also central components of what made for good practice · Effective therapeutic responses meant enlisting parents, carers and other relevant guardian figures as both possible elements that underpinned the reasons for the behaviour and key mechanisms of change
Conceptual	Understanding HSB in their developmental and eco-systemic context	· Evaluating not just the nature of the behaviour (e.g. penetration as a marker of severity; or the age of the harmed child) but also the developmental, cognitive and functional capacities of the young person, their own experiences of harm, victimisation and trauma, and their current lived context
Therapeutic	Working systemically	· Neither the young person nor their behaviour should be worked with in isolation from the familial context (dynamics, strengths, norms, practices, or history), their community or culture, the settings and activities in which they spend their time, and the interconnecting support services they are involved with
Therapeutic	Being trauma-informed	· Being aware of the nature and impacts of trauma the young person themselves had experienced, the impacts on attachment and schemas about relationships and the impact of the behaviour on the harmed child
Therapeutic	Tailoring therapeutic responses to the young person	· Therapeutic interventions need to be tailored and responsive to the young person's particular needs and lived contexts · Working in culturally safe ways means recognising the importance of being on Country, working with broader kinship and community systems, and helping Aboriginal and Torres Strait Islander young people to maintain connection to community · Flexibility is used in determining who the protective/supportive adults are, what broader systems of care need to be involved in the treatment plan, and strategies to ensure their engagement over the treatment period · Working at and with their developmental capacities, which means taking into account age; gender; pubertal development; and particular intellectual, cognitive and other factors that shaped the young person's understanding of themselves and their relations with others

Dimension	Principles	What this means
Enabling	Engagement of family/carers	· Families/carers need to acknowledge the occurrence and seriousness of the behaviour; minimising was seen as a significant inhibitor to successful treatment. The participation of the family in the therapeutic process—as protective guardians, but also in terms of addressing issues in the family system—was also critical. Practitioners used a range of strategies to create the most appropriate scaffolding around the young person, which included working with extended family, grandparents and others to create that network of care
	Comprehensive assessment and case planning	· Seen as central to understanding why the behaviours occurred and the foundation upon which case formulation, safety planning and therapeutic goals are based
	Engaging broader systems agencies	· Just as the young person cannot be understood in isolation from their social ecology, therapeutic responses could not be delivered as isolated, "standalone" interventions. Interagency relationships, cross-sector communication, and coordinated care teams were essential to implementing, monitoring, adjusting and evaluating treatment progress

Factors in services' operating context that impact on good practice

Therapeutic responses for HSB occur within a complex service environment, and several intersecting systems and agencies are involved in referring, investigating and monitoring situations involving HSB. Participants identified a range of factors in the broader service delivery context that adversely impacted on the provision of therapeutic interventions. These factors relate to:

- service design and delivery
- service accessibility and engagement
- the intersections and interactions between different service systems.

Service design and delivery

Key issues in relation to service design and delivery were:

- Difficulties in recruiting and retaining skilled workers: participants stated that recruiting skilled staff was particularly challenging due to:
  - a lack of sufficiently trained practitioners, particularly in regional and rural areas
  - limited ability to offer contracts beyond 12 months, which made it difficult to attract skilled practitioners
  - perceptions among potential workers that the work is too specialised/complex
  - stigma among potential workers that the work was about "perpetrators".

- Demand for services outstripped supply: it was acknowledged that services were unable to attend to all referrals that came in to the service.
- Short-term funding contracts: yearly funding cycles introduced uncertainty for existing staff. They could also make the work unattractive, particularly in terms of recruiting workers to regional and rural locations for positions with a 12-month term.

Service accessibility and engagement

There were several factors relating to service accessibility and engagement that presented challenges for young people and families. Key challenges were:

- geography and location:
  - challenges of providing face-to-face, discreet services to young people and families located in regional and rural areas
  - challenges for families to attend weekly sessions
- knowledge, awareness and stigma:
  - families often lack knowledge about HSB, or about the services available
  - stigma about HSB can act as a barrier to accessing services
- maintaining engagement: a range of factors impacted on families' and carers' ability to maintain engagement over the long term, including geographic location, family conflict and family dysfunction.

Intersections and interactions between different service systems

Finally, participants identified challenges in how different service systems intersected and interacted in responding to young people engaging in HSB, which could undermine the enabling principles of family/carer engagement, assessment, case planning, and supporting care and safety plans. For example:

- In criminal justice systems, tensions and contradictions between therapeutic and criminal justice paradigms that could render a young person ineligible for service or delay access to services were identified.

- As a system, child protection demonstrated:
  - different thresholds, assessments and prioritisation of risk
  - differing levels of knowledge and specialisation regarding HSB between specialist services and child protection workers
  - different expectations about capacity and role of child protection services as a key partner agency in safety plans
  - instability and breakdown in care placements, which directly impacted therapeutic work.

- In the education system, knowledge of HSB varied between school communities, affecting how schools responded to cases of young people engaging in HSB, and their preparedness to support care and safety plans. It was also acknowledged that schools could have to contend with the challenge of balancing a duty of care for both the harmed child and the young person engaging in HSB.

Project limitations

The main limitations of the research stem from:

- Incomplete data regarding the national mapping desk top review: as noted earlier, the desktop review of services is highly likely to contain information gaps.

- Lack of a sampling frame for the request for information: we did not have a known list (or frame) of providers. Respondents to the request for information self-selected on the basis of receiving an invitation. This means that the results cannot be taken to be representative generally of current practice.

- Lack of representation of key policy areas involved in the three service models: as noted in the Methodology chapter, not all policy/partner agency voices were captured in this study, as we were unable to obtain interviews with all key partner agencies. Moreover, the number of partner and policy agency voices is significantly fewer than those of practitioners. While this project has been able to provide detailed practitioner insight, it is possible that the views of intersecting agencies such as child protection, education, and police are not as well represented.

While the research design overall was sound, our methods drew primarily on qualitative insights from practitioners and professionals. In the absence of additional data (e.g. from clients),[52] it is an incomplete picture. Future research investigating clients' views of "good practice" would further extend findings from this research project. Service users in particular tend to be sensitive to key change mechanisms.

Implications of project findings

Focusing on service systems design

The last decade of research and practice literature has resulted in a relatively consistent set of good practice principles (which this study largely echoed); however, there has been little investigation into how factors in services' operating contexts influence their ability to realise these principles.

While it is essential to keep developing the evidence on what is good practice in therapeutic responses for HSB, and to keep investing in specialist services to undertake this work and building professional capabilities, on their own these efforts are not sufficient. Specialist therapeutic services necessarily operate within a complex landscape of other service systems, chief among them child protection and criminal justice; it is important to ensure that the operating contexts in which services are embedded support these principles and create favourable conditions for service operation (as distinct from therapeutic practice).

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52 The lack of client voices is a noted gap in the research; however, see research with young people as clients of HSB service by McKibbin, Humphreys, and Hamilton (2017).

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

There are three key reasons why taking a systems approach to service design is important:

1. Services and practitioners operate within and are constrained by factors that are often out of their control (funding approaches, pre-determined policy frameworks, legislation) but which directly influence services' day to day operation. These factors can sometimes operate in ways that are counter-productive for good practice (as described in Chapter 4: Insights into good practice from three service models).

2. The clients attending HSB services are likely to be involved in multiple services: the nature of HSB is complex, and the needs of the clients are complex and can include trauma histories, family and attachment issues, family instability, intellectual disability, and difficulty engaging at school. These needs mean that these young people and their families are likely to be receiving assistance from multiple services.

3. The therapeutic approach to HSB is eco-systemic; interagency working is a necessity.

These issues point to the potential for considerable clashing of different priorities, rules and procedures in the very delivery of therapeutic treatment, with the potential for the operations of other service systems to actually work against good therapeutic practice. These issues are not specific to specialist services for HSB, but are features in community, health and human service systems generally, especially for service users with complex and multiple needs. Complex, siloed services; cost; and the systemic barriers to creating coordinated, holistic service systems are regularly acknowledged as challenges to effective service provision.[53]

The findings of this project point to a gap, or mismatch, between the principles of good practice on the one hand, and the broader service delivery system on the other. This gap is visually represented in Figure 33. Between the principles of good practice and the challenges of the operating environment

is a space where questions about, and the levers for, better service systems design are located.

Levers and tools available to align systems contexts with good practice

In the areas of health and other complex service systems, policymakers and researchers have increasingly sought to identify what levers and influences exist within a systems "ecology" to better align the desired aims of particular interventions with the operating contexts in which they are embedded. These influences include "high points of leverage" such as government commissioning practices, but also the practices of individual implementers who often have little input into the overall intervention but may have a degree of discretion in how they interpret guidance in their day to day interactions (Cook & Tonurist, 2016). Understanding which factors matter, and how they matter, is essential to improving service systems design.

There are a range of tools and levers available that can help to better stitch practice and context together. Table 12 details key levers identified in the systems literature and what they influence.

Figure 34 demonstrates how these levers intersect and are articulated down the levels of service delivery.

Summary

Systems thinking and systems design has at times been criticised as being too complex or too abstract for the practicalities of service delivery (Cook & Tonurist, 2016). However, reviews of service systems suggest that it is not enough to implement a service here and a service there, or even a whole service delivery program. We also must look at how good systems *design* can be used to optimise the aims of service provision itself.

As the national service mapping showed, there are significant gaps across the country for young people engaging in HSB. The challenges of delivering human-centred, holistic and

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53 For reviews of service systems see, for example, *Service Sector Reform in Victoria* (Shergold, 2013), and the *Inquiry into Competition and Informed User Choice into Human Services* (Australia Productivity Commission, 2017). Research with those seeking trauma counselling and other services also finds complex and often contradictory systems of care (see Quadara, Stathopoulos, & Carson, 2017; Quadara, Stathopoulos, et al., 2017).

Figure 33: The influence of operating environments on enacting good practice

PRINCIPLES OF GOOD PRACTICE

CONCEPTUAL

Developmental view of YP and behaviours

HSB need to be understood in context

- YP is not synonymous with their behaviour
- YP has potential for change
- YP's systems of care are part of the solution

THERAPEUTIC

Working eco-systemically
- Holistic understanding of family/carer environment
- Understanding YP's broader social ecology
- Understanding HSB within this context

Working with a trauma lens
- Understanding YP's trauma history and connection to HSB
- Factoring impacts of trauma into therapeutic engagement

Tailoring interventions
- Tailoring to culture
- Tailoring to care situations
- Tailoring to cognitive and intellectual capacity

ENABLING

Family/carer engagement
- Acknowledgement of HSB
- Willingness and capacity to be part of the treatment
- Provide protective scaffolding around young person

Comprehensive assessment
- History, family context
- Circumstances of behaviours
- Needs and capabilities of YP—emotional, cognitive, developmental, social—i.e. more than HSB itself
- Baseline and follow themselves up
- Clinical judgment critical

Broader interagency engagement
- Treatment cannot be delivered in isolation of other services
- Interagency relationships, communication, and coordinated care teams essential in implementing treatment, and evaluating treatment progress

Referral pathways and practices

Client engagement

Collaboration and case management

Safety planning

Levers for better fit?

CHALLENGES IN OPERATING ENVIRONMENT

Service design and delivery
- Difficulty in recruiting for expertise needed
- Difficulty in recruiting and retraining especially in regional areas, or where short term contracts are used
- Demand exceeds capacity to deliver > unmet need
- Short-term funding cycles given nature
- Output vs outcome funding measures

Service accessibility and engagement
- Lack of statewide coverage
- Stigma around HSB/lack of knowledge
- Distance for families to attend sessions at services
- Challenges for families to maintain engagement during intensive period of treatment
- Affordability of private services

Systems' intersections
- Criminal justice vs therapeutic orientation
- Capacity of child protection to play the role required against other imperatives
- Different understandings of risk in CP/OOHC
- Misalignment of policies, procedures, legislation
- Different levels of knowledge and confidence about HSB among non-specialists
- Highly variable capacity of schools to engage

Good practice in delivering and evaluating interventions for young people with harmful sexual behaviours

Table 12: Key levers identified in the systems literature and their focus

Building blocks	Focus
Paradigms and policy frames	Roles, rules and priorities of the different service systems that intersect with HSB services
Funding structures	How commissioning and funding approaches can be better aligned to amplify good practice, for example, the duration of funding; degree of autonomy on use of funds interrogating what is funded, with what assumptions; and the degree to which funding structure reflects the nature of work
Governance structures	Governance, monitoring and reporting structures between services and government/ commissioning agencies that reinforce or support the principles of good practice
Interagency governance and collaboration	Mechanisms for collaboration and information sharing between services that support holistic interventions; cross-system training and capacity-building to increase knowledge and confidence of non-specialist workers; and support, rewards or incentives for this collaboration
Workforce development, recruitment and retention	Consideration is needed on how to support long-term retention of highly skilled workers. At the workforce level, long-term planning for the capacity and skills required to support more services is needed

co-ordinated services for individuals and families with multiple needs is well documented across reviews, Royal Commissions and other public inquiries.

While there is an imperative to address the unmet needs of young people engaging in HSB, a moment should be taken to properly consider the contexts in which these services operate and to understand how interactions between different parts of the system can reinforce, contradict or dampen the ability of specialist services to work effectively with young people and their systems of care. Consensus around good practice has evolved and deepened, and there is a significant degree of shared understanding among practitioners about what this looks like. There is much less consensus about the principles of what an effective service system would look like in order to support this practice. In the wake of the RCIRCSA, it is likely that there will be increased focus on implementing or expanding therapeutic services and timely opportunity to build this consensus.

That the findings about what factors in services' operating contexts impact on good practice are consistent with broader research and reviews suggests that it may be time to increase the focus on understanding what is required to design and implement human service systems, themselves, in ways that actually map onto good practice principles.

Figure 34: Suggestions for levers at the systemic, sectoral and service model levels

SYSTEMS FACTORS

Child protection

Education

HIGHER LEVEL

Policy frame
- View of YP and HSB
- Portfolio location
- Policy priority/visibility
- Policy outcomes desired
- Degree of interdepartmental support
- Funding measure

Commissioning
- How services are procured
- Duration of agreements
- Funding and unit cost formulations
- Performance measures and reporting

Governance
- Nature of relationship between government and services (centralised, devolved)
- Decision-making roles
- Degree of sector autonomy

Legislation
- Provisions in child welfare legislation for YP and HSB
- Provisions and powers for different providers and officers

SECTOR LEVEL

Policy frame
- View of YP and HSB

Workforce
- Development and planning
- Skills gaps
- Awards/renumeration

Collaboration mechanisms
- Who partner agencies are
- MoUs, cross-leadership
- Modes of collaboration
- Degree of information sharing

Policy and procedures
- Standards of practice
- Protocols
- Guidelines

SERVICE LEVEL

Service model
- Treatment philosophy
- Service characteristics
- Client characteristics
- Mode of service delivery
- Location

Workforce
- Development and planning
- Skills gaps
- Contracts offered
- Location

Collaboration mechanisms
- Who partner agencies are
- MoUs, cross-leadership
- Modes of collaboration
- Degree of information sharing

Policy and procedures
- Standards of practice
- Protocols
- Guidelines
- Organisational practice, values

SPECIALIST RESPONSES

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Request for information questionnaire

The Australian Institute of Family Studies (AIFS), together with Deakin University, has developed the following survey intended for professionals working with young people with sexually abusive behaviours (SAB). The aim of this survey is to gain an understanding of current intervention strategies, practitioners' perspectives regarding the efficacy of interventions, insight into the challenges faced when employing interventions, and ideas about effective evaluation processes.

The age range of clients in this survey refers to those 10–17 years of age.

The request for information is divided into three sections:

1. Background information
2. Systems and practices
3. Evaluation of services

The estimated completion time for this survey is **20 minutes.**

Respondent demographic questions

A. What gender do you identify most closely with?

☐ Female

☐ Male

☐ Trans male/trans man

☐ Trans female/trans woman

☐ Different identity (please state):_____

☐ Prefer not to say.

B. What is your current age?

☐ 18–24 years old

☐ 25–34 years old

☐ 35–44 years old

☐ 45–54 years old

☐ 55–64 years old

☐ 65–74 years old

☐ 75 years +

1. Background Information

Worker profile

1) In which state or territory is your service located?

A – Australian Capital Territory

B – New South Wales

C – Northern Territory

D – Queensland

E – South Australia

F – Tasmania

G – Victoria

H – Western Australia

2) As a service provider, what locations does your service cover?

A – Major city

B – Inner regional

C – Outer regional

D – Remote

E – Very remote

F – Statewide

G – Mixed category (e.g. major city and outreach to remote)

3) How many years of experience do you have working with young people exhibiting sexually abusive behaviours (SAB) and/or problematic sexual behaviours (PSB)?
A – 0–2 years
B – 2–5 years
C – 6–10 years
D – 11–20 years
E – 20+ years

4) Please list any relevant qualifications you hold (Text–100 words)
- List relevant qualifications (postgraduate/bachelor/ graduate certificate/diploma and advanced diploma/ certificate I-III)

5) What specific training do you have in providing interventions for young people with SAB? (Please specify the year in which this training was completed, if possible)
(Text–100 words)

6) What is the **target population(s)** of your practice?
A – Culturally and linguistically diverse (CALD)
B – Indigenous/Aboriginal and Torres Strait Islander
C – Low socio-economic status
D – General population
E – Other (please specify)

Client demographics

7) Where do the majority of your clients **primarily** reside?
A – Major city
B – Inner regional
C – Outer regional
D – Remote
E – Very remote

8) How many young people with SAB do you provide treatment to each year?
A – 1–5
B – 6–10
C – 11–20
D – 20+

9) What proportion of your client base is male?
A – 0–20%
B – 21–40%
C – 41–60%
D – 61–80%
E – 81–100%

10) What age are the majority of your SAB clients?
A – 10–14 years
B – 15–17 years
C – 17+ years

11) Where do your SAB referrals come from? (multiple selections allowed)
A – Justice system (police, courts and juvenile justice)
B – Departments of Human Services & Child Protection
C – Public health professionals
D – Private health professionals
E – Self-referral
F – Schools
G – Therapeutic treatment order (VICTORIA ONLY)
H – Other (please specify: text – 50 words)

12) What is the basis of the majority of SAB referrals to your service?
A – Voluntary
B – Legal obligation
C – Therapeutic treatment order (VICTORIA ONLY)

Free text box–for further description if applicable (there may be interesting data to gather here about the functioning of the TTO, i.e. many of the "voluntary clients" are likely to be "voluntary" because they would otherwise be put on a TTO)

13) What eligibility criteria are required in order for young people to access your services?

A – Age (please specify)

B – Gender

C – Conviction or guilty plea for sexual offences

D – Acknowledgement of responsibility for behaviours (within the treatment setting)

E – Disclosure of abuse by victim

F – Report made to relevant government department

G – Other (please specify)

H – No eligibility criteria required

I – Don't know

15) Which of the following risk factors are most common within your SAB client base?

(max. 3 selections):

A – Low socio-economic status

B – History of abuse (sexual, physical, emotional etc.)

C – Educational/learning difficulties and/or disengagement at school

D – Mental health issues

E – Poor social skills

F – History of other non-sexually related offences

G – Exposure to pornography

H – Exposure to caregiver substance abuse

I – Unstable living situation

J – Separation from family

K – Disconnect with culture

L – Family violence exposure

M – All of the above

17) What is the average frequency of treatment for a young person with SAB accessing your practice's services?

A – Daily

B – Weekly

C – Fortnightly

D – Monthly

E – Other (please specify)

14) What are the priority criteria for new referrals?

A – Age

B – Gender

C – Complex trauma

D – Culturally and linguistically diverse (CALD)

E – Indigenous

F – Low socio-economic status

G – Mental health issues

H – Out–of-home care (OOHC)

I– No priority criteria

J – Other (please specify)

16) What is the average duration of treatment for a young person with SAB accessing your practice's services?

A – Less than 3 months

B – 3–6 months

C – 7–12 months

D – 1–2 years

E – 2+ years

2. Systems and Practices

Practice overview

18) How long has your practice/organisation been operational?

        Drop-down boxes (numbers, months, years)

19) Is clinical supervision provided at your practice/organisation?

☐   Yes

☐   No

☐   Don't know

20) Is the person providing the clinical supervision qualified and experienced with young people and SAB?

☐   Yes

☐   No

☐   Don't know

21) How many clinicians are involved in the treatment programs for young people with SAB through your practice/organisation?

        Drop-down box (numbers)

22) Does your service/organisation receive sufficient referrals to fill the program?

☐   Yes

☐   Not enough

☐   Too many

23) What are the funding sources for your practice/organisation?

A – Privately funded (e.g. philanthropic)

B – Federal Government funding

C – State government funding

D – Mixed funding (combination of funding sources)

E – Other (please specify)

24) Is funding ongoing, mixed or intermittent?

A – Ongoing

B – Fixed contracts

C – Intermittent (grants)

D – Other (please specify)

25) What type of treatment is usually involved when working with young people with SAB within your practice/organisation?

A – Individual therapy

B – Family therapy

C – Parental therapy

D – Girls in relation to their victimisation history

E – Boys in relation to their victimisation history

F – Group therapy

G – A combination of the above

H – Other (please specify)

26) What approach is employed when designing interventions for young people with SAB within your practice/organisation?

A – Cognitive-behavioural therapy (CBT)

B – Multi-systemic approach

C – A combination of approaches (please specify)

D – Other (please specify)

27) How would you describe the level of interaction between your practice/organisation and the state justice and law enforcement systems?

A – High

B – Moderate

C – Low

D – Not applicable

28) How would you describe the level of inter-service communication between your practice/organisation and other related services (e.g. schools, out-of-home care, drug and alcohol agencies)?
A – High
B – Moderate
C – Low
D – Not applicable

Elements of "good practice"

29) How important do you believe the physical therapeutic environment is in the delivery of interventions for young people with SAB?

☐ Very important
☐ Important
☐ Moderately important
☐ Of little importance
☐ Unimportant

30) How important do you believe the therapeutic relationship is in the delivery of interventions to young people with SAB?

☐ Very important
☐ Important
☐ Moderately important
☐ Of little importance
☐ Unimportant

31) How important is family participation in the therapeutic process when delivering interventions to young people with SAB?

☐ Very important
☐ Important
☐ Moderately important
☐ Of little importance
☐ Unimportant

32) What are the most important elements required for an effective intervention? (max. 3 selections allowed)

☐ Individually focused
☐ Family focused
☐ Eco-systemically focused
☐ Contextually sensitive
☐ Tailored to the individual
☐ Behaviourally focused
☐ Strengths focused
☐ Focus on accountability for actions
☐ Culturally safe
☐ Goal/outcome focused
☐ Other (please specify) _____

33) In your professional experience, what is the optimal duration & intensity of treatment for a young person with SAB?
(Free text)

Service review

Service delivery

Below are a number of statements regarding the coordination and delivery of services for young people with SAB through your practice/organisation.

Please indicate to what extent does your organisation do the following:

34) Is it standard to assess the presence of trauma history with clients?

☐ Always

☐ Most of the time

☐ Occasionally

☐ Almost never

☐ Never

35) To what extent does your service provide interventions that incorporate a socio-ecological framework (personal, environmental and cultural status) of young people with SAB?

☐ Always

☐ Most of the time

☐ Occasionally

☐ Almost never

☐ Never

36) To what extent does your organisation attempt to incorporate new research findings into their practice model?

☐ Always

☐ Most of the time

☐ Occasionally

☐ Almost never

☐ Never

37) To what extent does your organisation evaluate the effectiveness of interventions for young people with SABs? (Provide examples as guidance)

☐ Always

☐ Most of the time

☐ Occasionally

☐ Almost never

☐ Never

☐ How does your organisation do this? (FREE TEXT BOX)

38) To what extent does your organisation support the justice system in providing an alternative pathway for young people with SAB?

☐ Always

☐ Most of the time

☐ Occasionally

☐ Almost never

☐ Never

☐ Not applicable

SABs clinical framework

Preamble – Think about the jurisdiction (state/territory) in which your organisation operates in answering the questions below.

39) Are there improvements that could be made to the system for delivering treatment services for young people with SAB?

☐   Yes

       Please specify _____

☐   No

☐   Don't know

40) What are the three major social barriers affecting access to treatment services for young people with SAB? (max. 3 selections)

A – Lack of awareness of services

B – Cost of services

C – Geographic disadvantage

D – Stigma towards young people with SAB

E – Family/guardians reluctance to participate in treatment

F – Exposure to legal sanctions

G – Risk of media vilification

H – Risk of vilification in their communities

I – Indigenous contact with the legal and police authorities

J – Wait times for services

K – Insufficient places available in services

L – Challenges in securing or retaining specialised therapeutic staff (including Indigenous/CALD, or male practitioners)

M – Other

N – All of the above

41) In your opinion, how well do you think service providers conform to their stated treatment approach? (For example, risk assessment tools)

(Free text)

42) What are the major barriers affecting the completion of treatment for young people with SAB?

A – Cost of services

B – Location of services

C – Family reluctance or inability to participate

D – Client reluctance to participate

E – Client resistance due to other factors (behaviour disorder, substance abuse etc.)

F – Conflicting demands with respect to school

G – Conflicting demands or impediments with respect to OOHC

H – Waiting times or inaccessibility of services at the appropriate time in the trajectory of behaviours

I– Other (please specify)

J – All of the above

43) Do you believe "sexually abusive behaviours (SAB)" is the terminology we should be using to describe this phenomenon in young people?

☐   Yes

☐   No

☐   Please explain and/or provide preferred terminology

Feedback

Thank you for taking the time to complete this survey. We value every opportunity to gain a greater understanding of SAB from the perspective of specialised practitioners. If you have any feedback regarding where you would like to see future research in this area being directed, please leave a comment below:

(Text–200 words)

**Would you be interested in being involved in future studies with AIFS?
Please provide your email address/contact details below …

APPENDIX B:

Plain language statement

Plain language statement for key professionals participating in the "Good practice in delivering and evaluating interventions for young people with sexually abusive behaviours" project.

The Australian Institute of Family Studies (AIFS) and Deakin University are conducting research in the field of sexually abusive behaviours (SAB) to inform the project team's understanding of the service landscape in various states and territories. We are conducting this study to develop a detailed understanding of the diverse factors that influence the design, implementation and provisions of current therapeutic services for future research and practice to advance on.

The chief investigators for the study are:

Dr Antonia Quadara (AIFS) email: antonia.quadara@aifs.gov.au

Dr Wendy O'Brien (Deakin University) email: wendy.obrien@deakin.edu.au

The current project aims to provide a state/territory and national picture of the current available services, and their operation, referral/service pathways, and evaluation processes. The project will focus on identifying the range of factors and conditions that enable or inhibit implementation both in a general sense, and also within each jurisdiction, as well as to facilitate a multi-sectoral dialogue between the range of professionals who work with young people who engage in SAB.

The research will harness the knowledge of the various strands of this service sector and will carefully document the "evolving consensus" around good practice and the impediments to its application. The study also aims to foster a shared understanding about the characteristics of the effective approaches in responding to adolescents with SAB, and to capture information about the range of services and service pathways available for young people who engage with these behaviours.

The findings of the study will ensure that future research, policy and funding decisions are informed by a comprehensive evidence base that aligns with the national outcome standards. The intended audience of this project will largely comprise specialist providers, agencies, and decisions-makers in policy and service development.

If you want to be involved

We are recruiting program managers and leading practitioners from service providers of therapeutic responses to young people to describe their therapeutic philosophy; explore how experiences of family and domestic violence (FDV) feature in client groups; and gather relevant data on program logics, evaluations, policy documentation, and data collection protocols.

Participants will be asked to explain how different contextual factors impact on their work (barriers and enablers of good practice) and to explain the intersection with other service systems (e.g. education, child welfare, child protection, police, FDV services, and sexual assault services).

Involvement will consist of participating in an interview which will run for approximately 60–90 minutes.

If you are interested in participating, please contact the "Young People and Sexually Abusive Behaviours" research team during to arrange an interview on (03) 9214 7865.

We know that talking about these issues can sometimes be upsetting. If you need extra support after the interview we can provide you with the contact details of services that can help.

Study results dissemination

In line with the principles of knowledge translation and exchange (KTE), communicating the research will include:

- follow-up reports and peer-reviewed publications
- conference and seminar publications
- a forum will be conducted by the research team to discuss their findings
- the production of an online resource that provides interested parties about relevant services in Australia
- a variety of "push mechanisms" (e.g. news alerts, social media) to disseminate information about the project.

Your privacy and data storage

Participation within this study is confidential and voluntary, and the information obtained will not be used for other purposes. If you are to give consent, we will record the interview in order to produce an accurate record of your experiences and views. The recordings and transcripts will be securely kept and only members of the research team will have access to the records. Your personal details, such as your name and address, will not be recorded on tape or appear on the written transcript or be used in any reports or presentations coming from the project. You are free to discontinue the interview at any point during the interview, if so, all your records and data collected from the interview will be discarded.

All voice recordings will be deleted from the recording device once they have been uploaded onto the AIFS server and/ or de-identified transcripts have been generated—as stipulated in the AIFS Records Authority–Class No. 21914 which states, "Destroy 24 hours after data is transferred from collection tool, de-identified and quality checked". This will be done via deletion and over-writing of the memory card on which interviews are recorded.

All de-identified transcripts or data files will be kept electronically under password protection and will be only be available to research staff or appropriately trained and experienced AIFS staff.

It is important to highlight that there is a limit to the confidentiality of the group interviews. If there is disclosure of unreported abuse or neglect, or a revelation of imminent threat of harm to a child, yourself or another person, AIFS has an obligation to report this information to the relevant prescribed child welfare authority and/or to the police.

Research data and materials will be stored securely to protect against theft, misuse, damage or loss, and stored in a key-pass secure building. Data will be stored on a password protected computer, in a lockable office. The data will be kept for a minimum of five years (after the final date of publication of research outcomes), after which these data will be securely destroyed.

About the Australian Institute of Family Studies

The project team comprises highly skilled researchers in the fields of child protection, sexual victimisation, family functioning and adolescent development, and practitioners with experience in developing, delivering, evaluating and training on specialist SAB therapeutic responses.

The Australian Institute of Family Studies is based in Melbourne and is an independent statutory agency, established by the Commonwealth Government in 1980 to promote the identification and understanding of factors affecting family relationships and family stability in Australia. The Institute aims to help in the development of better policies for the future of Australian families. More detailed information can be obtained from our website: http://www.aifs.gov.au/

Who to contact for support

We acknowledge that participation in this research may bring up memories and strong feelings. If at any time you wish to speak to someone about this, please contact 1800RESPECT, or Lifeline at 13 11 14.

Further information

If you have any queries or would like more information concerning the study please contact the "Young People and Sexually Abusive Behaviours" research team directly. Please phone (03) 9214 7865 to speak with David O'Keeffe, Project Manager.

This study has been reviewed by the AIFS Ethics Committee. If you have any concerns relating to the project ethics, please contact the AIFS Ethics Committee Secretariat via ethics-secretariat@aifs.gov.au or (03) 9214 7888.

This project has been approved by Sydney Children's Hospitals Network Human Research Ethics Committee. If you have any concerns about the conduct of this study, please do not hesitate to contact the Executive Officer of the Ethics Committee (02) 9845 3066 and quote approval number LNR/17/SCHN/392.

Pre-interview questionnaire for program managers and clinicians

Thank you very much for participating in this research. Please complete this short questionnaire before the interview if at all possible. There will be opportunity to elaborate on your responses in the interview. If more than one person from your service is participating in an interview, please nominate one person to complete the questionnaire.

This questionnaire has been designed to assist us in gaining detailed insights into the Victorian, NSW and Queensland service providers that have been identified as points of particular focus for our study. This questionnaire asks for quantitative information about your service, allowing us more time in the interview to discuss your views on the delivery of good practice.

Please refer to the plain language statement and informed consent form accompanying this questionnaire. If you have any questions, please phone Dr Olivia Ball on (03) 9246 8467 or email olivia.ball@aifs.gov.au

We appreciate some of this information may be of a sensitive nature. Your answers to this questionnaire are subject to the same conditions of confidentiality and anonymity as the interview.

Name: . . . .

Service: . . . .

Location: . . . .

Where exact answers are not possible or available, *please give your best approximation*.

Operational information about your program

1)   How long has your service been operating? . . . .

2)   How long has your service been treating young people with SAB? . . . .

3)   Does your service offer services apart from therapy for young people with SAB? Yes/no

4)   How many clinicians does your service employ? (FT equivalent) . . . .

5)   Do all staff at your service work with young people with SAB? Yes/no

6)   If not, how many do? . . . .

7)   What proportion of the clinicians at your service are:
        Male . . . . . . .female . . . . . . .gender unspecified/undisclosed . . . .

8)   What proportion of the clinicians at your service are Aboriginal or Torres Strait Islander?

9)   Can you describe the qualifications of clinicians at your service?
        Are they mostly psychologists, social workers, other? (Please specify, if possible) . . . .

10)   How many young people with SAB does your service treat each year? . . . .

11)   What is the average case load for an individual practitioner? . . . .

12)   What proportion of a typical case load is young people with SAB? . . . .

13) How often do you normally see an SAB client & what is the duration of a typical session?

14) How long would a young person with SAB typically spend in treatment at your service? (In weeks/months/years) . . . .

15) Is there a minimum or maximum length of treatment mandated or recommended by your program, by your funder(s) or by your therapeutic approach? . . . .

16) Do you deliver therapeutic treatment in a face-to-face setting only, or are there other modalities for supporting a young person with SAB? (E.g. online or by Skype) . . . .

Characteristics of your client base

17) What age (range) are most of your SAB clients? . . . .

18) What proportion of your clients are girls? . . . .

19) Does the age of girls attending your service for SAB treatment (if any) differ from the age of boys in treatment? . . . .

20) What proportion of your SAB referrals attend voluntarily vs by legal mandate? . . . .

21) What proportion of your SAB clients are in some form of out-of-home care? . . . .

22) What proportion of your SAB clients are Aboriginal or Torres Strait Islander? . . . .

23) To what extent, in your professional experience, do the following factors correlate with or contribute to SAB? (Please tick *weak or no* correlation or contribution, *moderate* or *high* degree of correlation or contribution)

Degree of correlation or contribution to SAB: weak/no   moderate   high

Low socio-economic status

History of exposure to family violence

History of sexual abuse

History of physical abuse

History of emotional abuse

History of neglect

Learning difficulties/educational disengagement

Mental health issues

Intellectual disability/acquired brain injury

Developmental delay/disorder

Poor social skills

History of non-sexually related offending

Exposure to pornography

Exposure to caregiver substance abuse

Unstable living situation

Separation from family

Disconnection from culture

Other? *(please specify)* . . . .

Client eligibility criteria

24) Is there formal geographic boundary for eligibility for your service? (I.e. young people outside a certain area are ineligible) . . . .

25) Is there an *informal* geographic boundary? (I.e. beyond a certain geographic point young people may be eligible but don't tend to access the service) . . . .

26) Are there demographic factors for eligibility? (E.g. age, gender, contact with the criminal justice system) . . . .

27) Are your eligibility criteria determined by the program or by funding body/ies? . . . . .

Request for relevant program information:

As part of the study, please consider sharing program documents that might assist the research team in gaining a full understanding of your service and the context in which it operates. Relevant documents may include (but are not limited to) program logics, position descriptions for relevant job roles, prior evaluations of the service, statements of program philosophy, and training materials for staff.

We appreciate that some of these documents may be considered sensitive. Any documents that you share will be protected by the same anonymity and security safeguards as the completed questionnaire and transcript of interview. Documents will not be published as part of the report, or as appendices, although excerpts may be cited.

Thank you.

APPENDIX D:

Script for semi-structured interviews with program managers and clinicians

Referring to our pre-interview questionnaire:

- Do you have additional comments on the profile of the clinicians at your service?
- Are there challenges in attracting and retaining suitably qualified and diverse staff?
- Can you comment on the case load expected of your staff? Is it too high, too low?
- Are there other factors relating to case load that you would like to discuss?
- The questionnaire asks about length of treatment; do you have other insights about the appropriate length of time for a young person's treatment?
- The questionnaire asked about eligibility criteria; are there particular benefits or limitations of the eligibility criteria at your service?
- The questionnaire asked about the age and gender of young people attending your service for SAB treatment; do you have comments about the age or gender of young people with SAB?

Therapeutic approach

1) Can you describe the **treatment philosophy** for your service?

- Does it have a specific theoretical or psychological approach? (referring to SAB interventions specifically)
- Do you adhere strictly to this approach, or are there ways in which you see it appropriate to modify treatment on a case-by-case basis? To what extent does the young person (or their circumstances) shape the intervention provided?
- Does the service offer individual treatment, group therapy, family therapy, or a combination of any or all of these? Reasons?

2) What do you think are the **conditions or criteria that contribute to success** in therapeutic treatment? Are there **factors that inhibit** successful interventions with young people with SAB? How do you manage/work with this?

3) Do you have a view as to whether specialised practitioners in Australia should be accredited, on either a state and territory or national basis?

- If you do support **accreditation**, what institution would be the suitable governing body?

Characteristics of the client base

4) What are the **characteristics** in the background and circumstances of the clients that you see?

- Role and impact of trauma
- How does the presence of family violence affect the provision of therapeutic treatment to young persons with SAB? Correlations with other forms of violence?
- Any other comments

5) What are your views about **prevention** initiatives? And on family violence prevention initiatives? Is there (or, in your view, should there be) a link between the two?

6) How do you tailor approaches for different cohorts of young people with SAB? (e.g. Indigenous, intellectual disability, cognitive delay, out-of-home care, substance abuse)

- Do any or all of these cohorts require specific or additional *therapeutic measures*? (Indigenous practitioners, for example)
- Do any or all of these cohorts require specific *practical supports* in addition to the therapeutic interventions you offer?
- How do you work with diverse cultures and communities?

Contextual factors

7) What is the **funding** structure for your service? (Government funded or other?)

- Is funding ongoing, intermittent or other?
- Do you have additional comments about the level/structure of funding, or other requirements that accompany this funding?

8) How are young people referred to your service?

- Are certain referral pathways prioritised?
- Are some referral pathways working particularly well?
- Are there challenges with particular referral pathways?
- Do you have suggestions for improving current referral processes?

9) Are you in a position to see all eligible clients? If not, how do you manage this?

- Do you have a **waiting list**?
- Can you quantify the number of young people unable to access the service?
- Are you aware of the treatment outcomes for these young people? Do they access treatment elsewhere?

10) How do you involve **stakeholders** in a young person's life in their therapy? (e.g. parents/caregivers, teachers, cultural mentors, drug and alcohol counsellors) If so, how?

- Is this work part of the treatment philosophy for your program?
- Is work with stakeholders funded?
- Are there challenges or disincentives to including these relevant stakeholders?

11) What are your thoughts about the **criminal justice system** in responding to young people with SAB? (this may include diversion, therapeutic orders, police, courts and/or corrections, or any other aspect of the criminal justice response)

12) The **minimum age of criminal responsibility** in all Australian states and territories is currently 10, with the rebuttable principle of *doli incapax* applying to children aged 10–13.

- Do you think that 10 is an appropriate age at which to criminalise children with SAB? If not, how would you like to see this reformed?
- How well does *doli incapax* safeguard children aged 10–13 from the full rigors of the criminal justice system?

Effectiveness and evaluation

13) What do you see as key **measures of success** of your program?

- Do you keep formal records to measure this success?
- If measurement is difficult, can you explain why?

14) What role does (or could) program evaluation play?

- Detail any involvement that you/your program has had with evaluation (i.e. formal external evaluation, internal evaluation, internal monitoring processes, encouragement from the funding body to engage in evaluation, etc.)
- Was it useful? Were you satisfied with the focus of the evaluation, the methodology used and the findings delivered?
- **What are the obstacles** to your service engaging in evaluation?

Close

15) Are there other issues that you would like to discuss with respect to the delivery and evaluation of good practice in interventions with young people with SAB?

Script for semi-structured interviews with policy professionals and police

Role in relation to young people with harmful sexual behaviours

1) Can you **describe your role**, and the role of your organisation, with respect to young people with HSB?

2) What is the level of awareness about HSB in your organisation?

3) Can you **comment on the broader policy context** in your region/city/state relating to the understanding of and support for therapeutic interventions with young people with HSB?

4) Does your organisation invest in research, and **ongoing professional development** to ensure that staff are aware of the best practices, nationally and internationally, in responding to young people with HSB?

Therapeutic approaches and service response

5) Do you have insight into the "**point of first contact**" for a young person with HSB, and the general reporting and referral pathways in your region or state?

For example if a young person comes to attention for HSB within a school setting—what is the likely reporting and referral pathway? Or OOHC?
- *For interviewees from police or criminal justice services*—Can you **provide data** on reports, cautions, and charges for young people with HSB? What role does *doli incapax* play when reports of HSB are made? Can you quantify the extent to which *doli incapax* diverts children aged 10–13 at the pre-charge stage?

6) Can you give us an idea of the **demand for HSB interventions** in your state?
- Are there gaps in these services or in referral mechanisms?
- For different cohorts of young people including within CJS

7) In your view, what are the **characteristics of a successful intervention** with young people with HSB?
- What do you think the main risk factors are for HSB? What role do you think FV might have?
- What are the barriers to successfully intervening with young people with HSB?
- Are there other factors that should be noted as risk pathways or contributing factors for HSB—or do you have other comments relevant to risk pathways for HSB?

8) Do you have insight as to whether young people with HSB who have been exposed to family violence **go on to act out with physical violence** in domestic settings themselves (against siblings, carers or parents, or against peers in out-of-home care settings)?

9) Do you have comments on HSB **prevention** initiatives? And on **family violence prevention** initiatives? Is there (or, in your view, should there be) a **link** between the two?

10) Do you have comments on the **role of the criminal justice system** in responding to young people with HSB? (this may include diversion, therapeutic orders, police, courts and/or corrections, or any other aspect of the criminal justice response)
- The minimum age of criminal responsibility in all Australian states and territories is currently 10, with the rebuttable principle of doli incapax applying to children aged 10–13 (inclusive). Do you think that 10 is an appropriate age at which to criminalise children with HSB? If not, how would you like to see this reformed?
- To what extent does the rebuttable presumption of doli incapax safeguard children aged 10–13 from the full rigors of the criminal justice system?

Effectiveness and evaluation

11) What do you see as key **measures of success** for programs that intervene with young people with HSB?

- Depending on your role, are you in a position to keep formal records to measure this success?
- If measurement is difficult, can you explain why?

12) What role could or has evaluation of HSB played for your organisation?

- If evaluation has been undertaken, was it useful? Were you satisfied with the focus of the evaluation, the methodology used, and the findings delivered?
- Did the evaluation (or, should evaluation) also consider contextual factors such as referral pathways, public perception or awareness of your service, and interagency cooperation (i.e. the means by which your service works with child protection, juvenile justice, housing, and other support services)?
- Are there any obstacles to your organisation engaging in evaluation of the role that you play with respect to responses to young people with HSB?
  - Are there alternatives to evaluation, or are there other quality assurance measures that should be of higher priority?

Close

13) Are there **other issues** that you would like to discuss, with respect to the delivery and evaluation of good practice in interventions with young people with HSB?

Verbal consent script for individual interview participants

I agree to participate in an interview for the research project "Good practice in delivering and evaluating interventions for young people with sexually abusive behaviours" conducted by researchers from the Australian Institute of Family Studies (AIFS) and Deakin University.

I have read the plain language statement for the study. I understand the research aims to develop an understanding about the characteristics of effective approaches in responding to adolescents with SAB and the contextual factors affecting implementation or delivery.

I understand that:

- My participation in this interview is voluntary.
- I am free to withdraw my consent at any time up to the writing up of the results of the study, in which event my participation in the research study will immediately cease and any information obtained from me will not be used. If I wish to withdraw from the project, I can do so by contacting Dr Olivia Ball by phone or email.
- I may ask Dr Olivia Ball questions about the study at any time.
- My participation in this interview is confidential, except as required by law.
- The interview will be audio-recorded.
- All data relating to this project will be stored securely and will only be available to members of the research team.
- Information gathered by interview may be published, but quotes and accounts will be attributed to me under a pseudonym (i.e. a false name) and any other potentially identifying information will be removed or modified to protect my anonymity.
- While every effort will be made to protect my anonymity, as above, if I am concerned that the nature of the information I provide will allow for me to be identified I can discuss this with Dr Olivia Ball at the time of the interview.
- I can, at the time of interview or in the week following, ask to view sections of the report containing information that derives from my interview before the report is published; if I perceive that the draft text will lead to me being identified I can, at that time, request modifications to the way the transcript of interview is cited, with a view to protecting my anonymity.

APPENDIX G:

Verbal consent script for group interviews

Thank you for agreeing to participate in this group interview. As you are aware, the Australian Institute of Family Studies, in conjunction with Deakin University, is conducting research called "Good practice in delivering and evaluating interventions for young people with sexually abusive behaviours", which has been commissioned by Australia's National Research Organisation for Women's Safety (ANROWS). As part of this study, we are undertaking interviews to collect the views of a range of professionals who work in therapeutic and support services for young people with sexually abusive behaviours. We wish to understand what you see as the most important elements of the service, what are the elements of good practice and how it has impacted on your clients.

Thank you for reading the plain language statement we provided. You are welcome to ask me any questions you might have in relation to that information.

Your participation in this group discussion is completely voluntary. It is an important condition of participating in this group interview that everyone present respects the confidentiality of all participants. This will include not disclosing the identity of other people here today and not discussing what other participants have said outside of this group discussion.

With your permission, the discussion will be recorded. Your personal details, such as your name and address, will not be recorded on the audio recording or transcript or used in any reports or presentations arising from the project.

The project team will also ensure that all your responses are anonymised—that is, any personal details or identifying information reported in the group discussion will be removed and the information that you provide will not be used by the project team in any way that could suggest that it came from you.

If you are concerned that, despite being anonymised, the information you provide could lead to you being identified—for example, where information shared in the interview relates to a position held by only one person within a state or territory—please discuss this with Dr Olivia Ball at the time of interview or in the week following. You may request—today or in the coming week—to view extracts of the report containing information that derives from your interview in draft form before the report is published. If you perceive that the draft sections could lead to you being identified, you can, at that time, request modifications to the way the information is cited, with a view to protecting your anonymity.

The interview should not take more than around 1–1.5 hours. You may choose not to answer some questions and you may choose to leave the group interview at any time.

Does anyone have any questions?

Do you each agree to participate and proceed with the group discussion on this basis?

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AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children