



Children with problem sexual behaviours and their families

Best interests case practice model
Specialist practice resource

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About specialist practice resources

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

The Specialist Practice Resources are a valuable tool for practitioners, but do not replace the *Child Protection Practice Manual*, which is a step-by-step operational tool to help with day-to-day procedures. They have been designed as a useful guide to help practitioners deal with the particularly sensitive issues and situations when working with vulnerable children and families.

This resource consists of two parts: an overview of issues for children under 10 with problem sexual behaviours, and a practice tool to guide you when working with these children and their families.

Overview

What is problem sexual behaviour?

'For children with concerning sexualised behaviour, the terms 'problem sexual behaviours' (PSBs) or 'inappropriate sexual behaviours' are used. Behaviours in this spectrum vary from excessive self-stimulation, sexual approaches to adults, obsessive interests in pornography, and sexual overtures to other children that are excessive to developmental bounds. For some children, these PSBs are highly coercive and involve force; acts that would be described as 'abusive' were it not for the child's age.'

O'Brien 2010, pp. 13

When all the children involved are under 10, the behaviour is referred to as 'sexualised behaviour' or 'problem sexual behaviours' rather than 'sexually abusive behaviour'. Children under 10 are deemed by Victorian law to be unable to consent to any form of sexual activity. In addition, children under 10 cannot be held criminally responsible for their behaviour.

Problem sexual behaviours and the Children Youth and Families Act

The grounds for statutory intervention when a child is in need of protection are set out in the *Children, Youth and Families Act 2005* (CYFA). Section 162 (1) (c)–(f) apply to children aged under 10 years with problem sexual behaviours. Your role is to determine if family services or child protection services are warranted, and to locate an appropriate therapeutic service where required (see Appendix for the list of treatment services pp. 51).

Supporting the child and family is a vital role that will enhance their recovery. The knowledge contained in this resource is intended to equip you to be able to confidently support the child and family, and to bring more understanding to intervening with problem sexual behaviours.

To promote children's best interests, family services, child protection and placement and support services need to take account of a child's age and stage of life, and their culture and gender. Together, these considerations provide a lens through which to view children's safety, stability and development and we need to understand the unique circumstances and experiences of a child. For children with problem sexual behaviours, an added factor must also be borne in mind: the potential risks they might pose to others.

There are several reasons why you might have a role in a case in which a child under 10 years is presenting with problem sexual behaviours:

- the child is in need of protection or the family requires assistance due to continuing abuse or neglect (such as sexual abuse or family violence)
- the child's siblings are reported as being in need of protection because the parents require assistance to secure their safety from the child with sexualised behaviours
- a parental reaction to discovering the child's sexualised behaviours has resulted in them rejecting or posing a risk to the child (such as cases of sibling abuse).

In cases of children with sexualised behaviours, the families themselves may contact child protection seeking assistance. Where this occurs, it is important to acknowledge that the family has initiated contact and to engage with them respectfully and without blame. Some families may only require a referral to a specialist treatment provider for children with sexualised behaviours. However, sexualised behaviours may manifest in the context of family violence or because the child is experiencing abuse or neglect. Equally, it should be noted that children from nurturing and protective families can develop sexualised behaviours and this may be an indicator of sexual abuse experiences the child has not yet been able to disclose.

Where the cause of the child's sexualised behaviours is unknown, and protective concerns have been reported, child protection services are required to investigate to assess the child's safety before making a referral to a specialist treatment provider. Some children may be clients of several agencies and so child protection can provide important coordination of the systems around the child.

Differentiating problem sexual behaviour from age-appropriate behaviours

How can we tell if sexual behaviour in a child is concerning? Analyses by researchers and clinicians in the UK, US and Australia have produced consistent guidelines as to what specific childhood sexual behaviours are within the normal or age-appropriate range, are concerning behaviours or are very concerning problem sexual behaviours (Araji 1997; Cavanagh Johnson 1999; Cunningham & MacFarlane 1991; Gil 1993; NSW Department of Health 2005; Ryan et al 1993; 2000).

It is important to be mindful that children with these behaviours are children first and foremost and that with appropriate treatment and targeted intervention, they have a good prospect of returning to a healthy developmental track. Every case has unique circumstances and must be responded to in the best interests of the child. While it is important not to minimise or ignore the problem sexual behaviours and to seek specialist advice and treatment, it is also important that the child is not defined by these behaviours and inappropriately labelled.

Children with sexual behaviour problems are not miniature adult or adolescent sexual offenders... Not only is children's sexuality different than adults and adolescents, their emotional, social, and cognitive awareness and relationship to the world is different. It is dangerous to children that we do not recognize the differences and treat the child, not our projections onto the child.

Johnson & Doonan 2006, pp. 113

The following tables were developed by Barnett, Giaquinto, Hunter & Worth (2007) in the publication produced by SECASA and the Gatehouse Centre. They provide an excellent summary and synthesis to guide your assessment.

Age-appropriate sexual behaviours, as categorised in the tables, do not require intervention by professionals. Children readily take redirection of these behaviours and their accompanying emotions and expressions of age-appropriate sexual play include laughter, spontaneity, curiosity and experimentation.

Concerning sexual behaviours as categorised in the tables below, signal the need to notice the frequency and persistence of these behaviours and intervene. If a child exhibits these types of behaviours, or these behaviours continue, despite clear requests to stop, seek specialist advice. A proactive response is required and they should not be ignored or minimised. The details and context of the behaviours should be recorded accurately.

The very concerning behaviours listed are indicative of very problematic sexual behaviours and they require immediate specialist advice and a proactive, purposeful response. If the sexual behaviour is accompanied by secrecy, anxiety, tension, coercion, force, compulsion or threats this is particularly concerning and the details and context should be accurately recorded. These coercive behaviours require immediate intervention by parents and carers as well as professional assistance.

Table 1: Sexual behaviours of children aged 0–4 years: infant, toddler and preschool

Age-appropriate sexual behaviours

- Touching or rubbing their own genitals
- Enjoying being nude
- Showing others their genitals
- Playing doctors and nurses
- Playing mummies and daddies
- Touching or looking at the private parts of other children or familiar adults
- Using slang words/dirty language for bathroom and sexual functions, talking about 'sexing'

Concerning sexual behaviours

- Persistent masturbation that does not cease when told to stop
- Forcing another child to engage in sexual play
- Sexualising play with dolls such as 'humping' a teddy bear
- Touching the private parts of adults not known to the child
- Chronic peeping behaviour

Very concerning sexual behaviours

- Persistently touching or rubbing themselves to the exclusion of normal childhood activities; hurting their own genitals by rubbing or touching
- Simulating sex with other children, with or without clothes on
- Oral sex
- Sexual play involving forceful anal or vaginal penetration with objects

(Ref: Gil 1993; Cavanagh Johnson 1999, in Barnett et al. 2007)

Table 2: Sexual behaviours of children aged 5–7 years: early school years

<p>Age-appropriate sexual behaviours</p> <ul style="list-style-type: none"> • Self-touching including masturbating • ‘Show me yours/I’ll show you mine’ with same-age children • Hearing and telling age-appropriate dirty jokes • Playing mummies and daddies • Kissing/holding hands • Mimicking or practicing observed behaviours such as pinching a bottom
<p>Concerning sexual behaviours</p> <ul style="list-style-type: none"> • Continually rubbing/touching their own genitals in public • Persistent use of dirty words • Wanting to play sex games with much older or younger children • Continually wanting to touch the private parts of other children • Chronic peeping behaviour
<p>Very concerning sexual behaviours</p> <ul style="list-style-type: none"> • Touching or rubbing themselves persistently in private or public to the exclusion of normal childhood activities • Rubbing their genitals on other people • Forcing other children to play sexual games • Sexual knowledge too advanced for their age • Talking about sex and sexual acts habitually

(Ref: Gill 1993; Cavanagh Johnson 1999, in Barnett et al. 2007)

Table 3: Sexual behaviours of children aged 8–12 years: pre-adolescent

<p>Age-appropriate sexual behaviours</p> <ul style="list-style-type: none"> • Occasional masturbation • ‘Show me yours/I’ll show you mine’ with peers • Kissing and flirting • Genital or reproduction conversations with peers • Dirty words or jokes with their peer group
<p>Concerning sexual behaviours</p> <ul style="list-style-type: none"> • Attempting to expose others’ genitals • Sexual knowledge too advanced for their age once context is considered • Preoccupation with masturbation • Mutual masturbation/group masturbation • Single occurrence of peeping, exposing, obscenities, pornographic interest (sources include the internet, pay TV, videos, DVDs and magazines) • Stimulating foreplay or intercourse with peers with their clothes on
<p>Very concerning sexual behaviours</p> <ul style="list-style-type: none"> • Compulsive masturbation, including task interruption to masturbate • Repeated or chronic peeping, exposing or using obscenities • Chronic pornographic interest including child pornography* (sources include the internet, pay TV, videos, DVDs and magazines) • Degradation/humiliation of themselves using sexual themes • Degradation/humiliation of others using sexual themes • Touching the genitals of others without permission* • Sexually explicit threats – written or verbal* • Forced exposure of others’ genitals* • Simulating intercourse with peers with clothes off • Penetration of dolls, children or animals*

* For children aged 10–12, these behaviours may constitute criminal offences such as indecent assault, indecent act, or sexual assault (common law).

(Ref: Ryan 2000, in Barnett et al. 2007)

Determining when the behaviours are of concern

Case examples

Below are case examples. Reflect on the different presentations, and the analysis that we have provided about the behaviours.

Example 1

Aaron, aged four, had shown some problem behaviours at kinder. Hiding in the cubby or behind the chook pen, he had pulled other little boys' pants down as well as his own. He had told them to lick his penis and 'not to tell'. Several attempts at redirection had not seemed to slow down the occurrence of these behaviours. He seemed angry and defensive whenever the issue was raised.

This type of presentation is very concerning because:

- the level of sexual knowledge exhibited by Aaron is a gross mismatch to his age
- Aaron's behaviours are highly intrusive upon other small children
- Aaron is not responding to redirection
- he shows problematic emotions when spoken to, indicating feelings of disturbance around this issue.

Example 2

Libby, Flora and Terence were on Grade 5 school camp. Teachers were concerned to discover that they had removed some of their clothing and were engaged in 'show and tell'. They were running around laughing and splashing each other with water. When taken aside and spoken to, they were rather embarrassed but laughed. They were effectively redirected and did not persist in the behaviours.

This type of presentation appears to be more normative and most likely does not require therapeutic involvement because:

- the behaviour is not a mismatch with their age or development level (developmentally appropriate)
- nobody was hurt or upset (equality)
- nobody was coerced (forced, fearful, tricked or mistreated)
- they did not show negative emotions, indicating a lower likelihood that they felt disturbed (healthy emotions)
- they were easily redirected.

Example 3

Rollo (aged nine) was very angry when his father discovered that he had shut his cousin Nicos (aged five) in a cupboard for half an hour. This was after taking Nicos's pants down and handling his genitals roughly. He had warned Nicos not to tell anyone, or his older brother would 'get them both'. Nicos said that he had been afraid of Rollo for some time.

This type of presentation is very concerning and would require intervention. Consider:

- there is a significant age gap between the two children (inequality of power)
- Nicos was threatened and restrained (threat/force)
- Nicos could not have been consenting in a situation like this (non-consensual)

- Rollo showed anger rather than remorse or empathy (inappropriate emotion)
- this situation has been brewing for some time (pattern and history).

For detailed guidance on how parents, carers and practitioners can helpfully respond when they observe children engaged in problem sexual behaviours, see pages 40–41 in the Action section.

Why problem sexual behaviours are significant

During the late 1980s and 1990s studies began to show that problem sexual behaviours may turn into a long-term pattern if they are not addressed. Between 20 and 30 per cent of adult sexual offenders appear to begin their behaviours in childhood (Davis & Leitenberg 1987; Salter 1988). Previously, there had been a dangerous tendency to ignore, minimise or discount the serious impact of problem sexual behaviours of children who had been victimised. It was also a surprise to find that children assaulted by similarly aged children experienced harm very similar to those assaulted by adults, with few differences in levels of anxiety, depression or post traumatic stress (Brown 2004; Shaw et al. 2000). They can also experience intrusive flashbacks, nightmares and learning and behavioural difficulties.

Problem sexual behaviours therefore need to be recognised as developmentally inappropriate and viewed by you as highly concerning and as requiring a proactive and purposeful systemic intervention. Early and prompt intervention can be very successful but needs to be inclusive of the parents and significant others, and to address the underlying issues that have triggered the behaviours in the child

Siblings with problem sexual behaviours

Limited research on sibling sexual abuse indicates that it may be the most common type of intra-familial abuse. It involves greater degrees of coercion and violence and is more likely to involve sexual penetration than other types of intra-familial abuse. (Welfare 2008 pp. 139).

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

Child victims of sibling sexual abuse are much less likely to disclose than those sexually assaulted by an adult. In Lamb and Coakley's study, only 14% of sibling sexual abuse victims disclosed when they were a child, compared to more than 50% of those abused by an adult (Lamb & Coakley, 1993). In Carlson et al's study (2006) only 19.5% of sibling sexual abuse victims disclosed at the time (Carlson, Maciol & Schneider, 2006).

Children who have been victimised by a sibling with problem sexual behaviours can experience confused loyalty to their sibling; guilt/relief at seeing their sibling 'in trouble', fear of/distress at not being believed, fear of retaliation, and fear of breaking up the family. Professionals and parents are crucial in helping the child deal with confusion and guilt about the boundaries that have been violated.

The beginning point is always the establishment of safety and ensuring that no further abuse occurs. Where there are siblings involved, engaging the parents' emotional support for the child who has been victimised is crucial, along with supporting their response to the child who is acting out. Divided loyalties can pull parents into either minimising the problem sexual behaviour, or into rejecting the child with the problem sexual behaviour, neither of which is appropriate. Professionals need to support parents and carers in responding to each of their children's needs and engaging each of them in specific treatment programs. The child with the problem sexual behaviour needs to be supported to accept that the behaviour is harmful to others and that new rules of behaviour have to be put into place. At the same time, the child's underlying issues need to be addressed.

Why problem sexual behaviours may arise

Children who show problem sexual behaviours often experience multiple or cumulative types of harm to their development (Chaffin 2008; Tarren-Sweeney 2008). Between 35 and 50 per cent have experienced sexual abuse, and around the same proportion have experienced physical or emotional abuse or neglect or have witnessed parental violence (Kambouropoulos 2006; Merrick et al. 2008; Silovsky & Niec 2002). This underlines the importance of early intervention by practitioners and an understanding of family violence frameworks in addition to sexual abuse/problem sexual behaviours. The critical importance of understanding the family context in any intervention and thinking systemically is informed by this research-based evidence.

Since the children's difficulties may be complex, it is inappropriate to expect that the sexual behaviour elements will have evolved in the same way in all clients (Chaffin 2008). As in other protective assessments where the background factors are complicated, a detailed and individualised approach to understanding each child's needs is warranted (Parton, Thorpe & Wattam 1997). There is no single 'why' and each child and their family needs to be understood in their unique context.

Children with problem sexual behaviours typically have complex factors which are disrupting their wellbeing. Most often, specialist assistance will be needed. They are more likely than the general population to have experienced sexual abuse or significant sexualising impacts such as exposure to pornography or inappropriate adult sexual interactions. The younger the child is, the greater the likelihood that they have experienced sexual abuse. Consult with, and refer to the Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Service agencies (listed on pp.51) in your region.

The dynamics of abuse and patterns of disclosure

Children are more likely to *not* disclose sexual abuse, rather than to disclose incorrectly, as there are often overt or covert threats made by adult perpetrators to silence children. Disclosure is not normative in childhood; rather, keeping the secret is the norm (Salter 1995).

Only a minority of children who have experienced child sexual abuse report it to their parents, and only a minority of these parents report the abuse to the authorities. It is estimated that fewer than 30 per cent of all sexual assaults on children are reported (Stanley et al. 2003).

Furthermore, unreliable recall represents a threat to the validity of research results which retrospectively document rates and patterns of disclosure. However, follow-up studies show that a false-negative rather than a false-positive bias is the rule (Fergusson, Horwood & Woodward 2000). That is, it is more likely that a child wrongly says 'No it didn't happen' rather than to falsely disclose that someone has sexually abused them.

Retraction of a disclosure

Secrecy, entrapment, helplessness, accommodation and the pattern of delayed, partial and unconvincing disclosure, followed by retraction of the disclosure, was described as the '*child sexual abuse accommodation syndrome*' by Roland Summit in 1983. Even after children have disclosed it is common for them to retract their original disclosure as they can become frightened and easily overwhelmed by 'all the fuss' and the consequences of the disclosure on their parents and family. Many children have later reported that they 'just wanted it to stop' and that they could not cope with the distress and what followed. 'Taking it back' for some children can seem the only way they can manage.

Some children can also miss the positive aspects of the relationship with the offender. It is important not to assume that issues of abuse are "black and white" for children. For example, in some cases children may value 70% of the time that they spend with the abuser, but hate the 30% of the time that is abusive. When they disclose abuse, they lose the "70%" of positive time. Thus they may retract the disclosure to regain the positive parts of the relationship.

Some offenders do not make overt threats; however, the child can feel frightened and intimidated and therefore be less likely to disclose or to maintain their disclosure, if they have perceived the offender's power over others, particularly if they have witnessed his violence or aggression to other members of the family or to family pets. These behaviours by adult offenders are so powerful and frightening, there is no need for words.

A common constraint that prevents children from disclosing sexual abuse is that the offender has manipulated the child into thinking that the behaviour was their fault or choice, or normal – "this is what we do" or "you played the game", therefore the child carries the shame and feels guilty and responsible. Given most abuse of children is perpetrated by known and often trusted adults, the child is enmeshed in a complex relationship and the dynamics of that relationship are powerful determinants in restricting the child's freedom to speak out.

The adult offender often grooms the victim child to believe they participated in the abuse, that they 'enjoyed it' and 'did not tell him to stop', constructing a particular reality for the child and working to actively shift responsibility for the abuse onto the child. The offender will often provide messages to the child, for example, 'your mother knows' and 'it's alright' or 'if you tell you will be taken away and I will go to prison'. If sexual abuse occurs within the context of family violence, the offender does not always need to make verbal threats as the child can see what will happen if they speak out.

Sexual abuse is therefore often a process embedded in a relationship where the adult has enormous power to manipulate and distort the child's belief system. Children generally do not have the language or the cognitive capacity developmentally to name or understand what is happening to them. They are dependent on the offender's greater power and are vulnerable to internalising the offender's manipulative beliefs or cognitive distortions.

Commonly the child is made to feel 'special' by the offender and is entrapped in a relationship where they believe they have to look after the feelings of the offender. The abuse is a betrayal of the child's trust in the offender.

New information which challenges the reality created by the offender is often the start of the child being able to disclose; for example, sex education at school or conversations with friends that reveal that their parent/sibling/cousin 'does not do it to them.'

Understanding the child's behaviour

Practitioners need to stay calm and interact warmly with the child and ask non-leading questions about the child's life. This can be inclusive of gentle enquiries about the games that they play with the different adults in their lives.

Where some adult offenders have groomed the child and distorted their understanding of the sexual touch under the guise that it was a 'game', some children may re-enact the 'game' with other children, particularly if there are props or triggers indicative of the original abuse. The 'home corner' at kindergarten is one example where children who have experienced sexual abuse may be triggered to act this out with other children.

Internal emotional states can also trigger children to act out, such as feeling powerless or frightened. They may have developed a pattern where the problem sexual behaviours become the way they self-regulate or self-soothe when they experience anxiety. Parents, carers and teachers need to be mindful of the triggers and antecedents that are likely to precede the child acting out the problem sexual behaviours. The significant adults in the child's life need to understand the particular triggers for this child and at what times or circumstances they are likely to be dysregulated.

As a practitioner, you need to be aware of the particular triggers for the child and appropriate responses so that you can give relevant advice to parents, carers and teachers when required. Always consult with the treatment service to ensure that your advice is appropriate.

If the stressful circumstances are present there should be a clear plan so that the adults feel empowered to intervene with pre-planned strategies, and support the child so that the behaviours are prevented from being enacted.

Family stressors

Children with sexualised behaviours are more likely to come from families with stress factors such as family violence, poverty, substance abuse, mental illness or a history of abuse. Deprived environments lack important protective factors and are associated with attachment problems in children (Friedrich 2007; Pithers et al. 1998b; Staiger et al. 2005).

Stress levels in parents and ineffective parental responses can be both a contributing factor to problem sexual behaviours in the child and a result of the child's behaviours. This is particularly the case where there has been sibling problem sexual behaviour or where a close extended family member's child has been harmed which has resulted in conflict between the families. Parents can struggle with painful feelings of anger, fear, self-doubt, divided loyalties and shame. Where parents are acutely distressed by the child's problem sexual behaviours and they feel that they are ineffectual or inadequate in their response, their confidence and therefore their parenting practices can be compromised. The child will sense the parents' anxiety and this will impact and increase the child's anxiety, which frequently increases their behavioural difficulties. Families are dynamic and interactional and most communication is non-verbal. Children will sense and be affected by the emotional climate within the family, as well as what is being said or not said.

Some family environments may foster a lack of empathy for others, for instance, where cruelty to animals is enacted 'for fun' or where the scape-goating of a particular child is encouraged. The child may have experienced bullying or sexual assault at school, but this may not have been understood or responded to by the parents.

Where the parents are preoccupied or overwhelmed themselves, and there is a lack of supervision and parental support for the child, the child may be more vulnerable to sex offenders. Sex offenders frequently target vulnerable parents and groom the children in order to sexually abuse them. The child often accommodates to the sexual abuse and believes that such behaviours are the norm. Hence they are more likely to re-enact these sexual behaviours with other children.

Psychological problems

Psychological and emotional problems are common for children with problem sexual behaviours, with anxiety and withdrawal featuring alongside behavioural problems, often extending back over several years. Psychiatric diagnoses undertaken by a trained Child and Adolescent Mental Health clinician can include problems such as oppositional defiant disorder, conduct disorder and depression (Gray et al. 1999; Hall et al. 1998; Pithers et al. 1998). Many of these symptoms can typically present as a response to trauma.

Trauma

Trauma is also a strong possibility for many children with problem sexual behaviours. Experiences of unmanaged stress can lead to cognitive and emotional processing difficulties in children, as well as a lack of trust in their environment.

Whereas single traumatic incidents tend to produce isolated behavioural responses to reminders of trauma, chronic trauma can have long-term pervasive effects on a child's development (van der Kolk 2003). Exposure to chronic trauma may lead to serious developmental and psychological problems for children and later in their adult lives.

van der Kolk (2005) termed this complex set of emotional, cognitive, behavioural and neurobiological impacts as developmental trauma. He proposed that some children who attract a diagnosis of attention deficit/hyperactivity disorder (ADHD) are in fact responding to complex trauma phenomena.

van der Kolk identified several developmental effects of childhood trauma including:

- disturbances in memory and attention – dissociation, sleep disturbances and intrusive re-experiencing of trauma through flashbacks or nightmares
- disturbances in interpersonal relationships – lessened abilities to trust, re-victimisation, victimising others, lessened ability to cooperate and play and negotiate relationships with others such as caregivers, peers and marital partners
- increased anxiety disorders and personality disorders (van der Kolk 2003).

The child's subjective experience and the *meaning* attached by the *child* to traumatic events, is central to the analysis of the impact of cumulative harm. This includes the child's prolonged and sickening anticipation and fear of repeating traumatic events (Miller 2007).

(See also *Child development and trauma specialist practice resource* for the impact of trauma by age and stage of development.)

Attachment

Disruptions in their attachment relationships are common in children with problem sexual behaviours and the assessment and treatment plan needs to be informed by the history and current parenting pattern within the family or in the out-of-home care placement.

Attachment difficulties are likely to increase when maltreatment is prolonged. Children's responses will largely mimic their parents' and therefore the more disorganised and inconsistent the parent, the more disorganised the child (Streeck-Fischer & van der Kolk 2000). Without the security and support from a primary caregiver, children may find it difficult to trust others when in distress, which may lead to persistent experiences of anxiety and anger (Streeck-Fischer & van der Kolk 2000). Children with problem sexual behaviours are more likely to act out when they are in an anxious state, therefore the security and support of the primary caregiver is of central importance to the child's recovery.

If the source of the harm is also the young person's source of safety (an attachment figure) then the level of trauma is increased (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, DeRosa, Hubbard, Kagan, Liautaud, Mallah, Olafson, & van der Kolk, 2005).

Learning difficulties

Children with problem sexual behaviours are more likely to have either slightly lower IQs or 'specific learning difficulties', with studies finding between 28 and 88 per cent of clients experiencing these issues. Experiences of ongoing sexual abuse or violence often impact on a child's ability to concentrate and this can lead to learning difficulties. ADHD is also a common finding within this group (Pithers et al. 1998; Staiger et al. 2005). Problems with learning or impulse control make it more difficult for children to control their behaviours and emotions.

Children with intellectual disabilities

As distinct from those with specific learning issues or low average IQs, children with an intellectual disability are at much greater risk of abuse and neglect, which increases their risk of trauma and sexualisation.

It is estimated that fewer than 30 per cent of all sexual assaults on children are reported (Stanley et al. 2003). Furthermore, children with intellectual disabilities are less likely to have the ability to report and, when abuse is reported, they are more likely to be ignored (Evertsz & Kirsner 2003; Glaser & Bentovim 1979; Kvam & Braathers 2008; Sullivan & Knutson 2000). They have a heightened dependence upon family, and may also be more severely affected by abuse due to processing difficulties and social isolation.

Children with intellectual disabilities are also more likely to suffer from impulse-control problems. They may experience a lack of sex education, and caretakers attempt to modify their inappropriate behaviours less often (Cole 1986). This group of children spends more time in care settings, where they are likely to be exposed to other children who are also more likely to show disinhibited behaviours for the reasons outlined above. Hence, children with intellectual disabilities are more likely to present with problem sexual behaviours than average-ability children. Furthermore, if they do exhibit problem sexual behaviours, they are more vulnerable in terms of their own inner resources and adults' responses.

Children with an intellectual disability exhibiting problem sexual behaviours need to gain help from dedicated treatment programs around limiting inappropriate behaviour.

Be alert to chronic neglect and cumulative harm

It is particularly relevant to be alert to the possibility of cumulative harm in cases of chronic neglect that are characterised by an unremitting low level of care.

The cumulative effects of chronic low-level neglect are easily missed because the term 'abuse' suggests a ring of urgency that 'neglect' does not and the effects of neglect are usually not as obvious. Frederico, Jackson and Jones (2006, pp. 18) caution:

It is critical that neglect is not considered a lesser problem than other forms of maltreatment given the evidence that its consequences can be damaging. It is also important that the presence of chronic neglect does not obscure other forms of maltreatment

Cumulative harm refers to the effects of multiple adverse circumstances and events in a child's life. The unremitting daily impact of these experiences on the child can be profound and exponential, and diminish a child's sense of safety, stability and wellbeing. The *Children, Youth and Families Act*, s. 10 (3) (e) requires practitioners to consider the effects of cumulative patterns of harm on a child's health, safety and development. Refer to the specialist practice resource on cumulative harm.

When you are working with a family where neglect or cumulative harm is the major concern but children are also presenting with problem sexual behaviours, it is imperative that they are not ignored or subsumed in the overwhelming family issues. Where there are multiple and entrenched family problems, and frequent emotionally draining crises (such as family violence or homelessness), it can be easy for the practitioner to be so focused on these issues that attention to the child's problem sexual behaviours becomes distracted and 'case drift' results. Responding to the basic needs of safety and shelter is always the priority; however, a concurrent response needs to occur to address the problem sexual behaviours because these will undermine the safety of other children and may indicate that sexual abuse is also being perpetrated against the child who is 'acting out'.

Aboriginal families

Cultural competence, sensitivity and respect are essential in any intervention with families. For Aboriginal and Torres Strait Islander children and families, the impact of historical and ongoing dispossession, marginalisation, racism, colonisation, poverty and the stolen generations have led to high levels of unresolved trauma, depression and grief (Human Rights and Equal Opportunity Commission 1997). However, it is critical that your practice is informed by cultural consultation and that you do not make ill-informed assumptions; many Aboriginal families in Victoria are resilient, thriving and strong within their culture.

Some of the key individual, family and community problems associated with unresolved trauma that have been associated with heightened rates of child abuse and neglect in Aboriginal and Torres Strait Islander communities include: alcohol and drug abuse; family violence; social isolation; and over-crowded and inadequate housing (Berlyn & Bromfield 2010). For example, the vast majority (78.6 per cent) of adults in Victorian Aboriginal families reported having themselves (or family or friends) experience one or more major life stresses (for example, death of a family member or close friend, serious illness or alcohol/drug-related problems). This is almost double the rate for non-Aboriginal Victorians (Department of Education and Early Childhood Development 2010, pp. 22).

Talking about past trauma, abuse and violence are culturally sensitive issues for many Aboriginal people. Involving an Aboriginal Child Specialist Advice and Support Service (ACSASS) practitioner is essential for planning a culturally competent assessment and

intervention. As with any child who presents with sexualised behaviours, it is important to assess the child's history for any trauma or abuse, particularly child sexual abuse, and to make every effort that the child is currently safe from abuse or neglect.

O'Brien (2010) notes that Aboriginal children engaged in problem sexual behaviours are more likely to have:

- experiences of trauma loss and alienation
- physical and or sexual abuse
- witnessing family violence

She notes that the proposed response to problem sexual behaviours amongst children in Aboriginal communities is less about focusing on the individual child's behaviour and more about addressing the contextual factors of systemic disadvantage that constitute risk pathways to these behaviours, e.g. care arrangements, overcrowding, homelessness.

Section 12(a) of the CYFA provides guidance on principles for engaging Aboriginal families (pp. 24–25). The *Best interests case practice model summary guide* lists and discusses these principles.

In practice with Aboriginal families give priority to:

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

Refer to the *Aboriginal cultural competence framework* and *Working with Aboriginal Children and Families: A guide for child protection and child and family welfare workers* VACCA, 2006 to guide you.

Culturally and linguistically diverse children and their families

Ethnic and cultural issues need to be understood from the intake phase and throughout your practice with families because reported sexual behaviour can vary widely; reporter characteristics and cultural variations will widen the differences in the way sexualised behaviours are viewed (Friedrich 2005; Mitchell 2005).

Refugee and migrant communities may have fled from war or oppression and been forced to flee to refugee camps and seek asylum. Children may have been exposed to trauma, violence and sexual abuse and adjusting to a new culture and way of life can also put further stress on families and increase children's vulnerability.

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

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

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

Consult with cultural experts and seek their advice.

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

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

Practice tool

Children with problem sexual behaviours and their families

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

Information gathering

In this resource, we provide specific tips and guidance for gathering information regarding children with problem sexual behaviours.

Information gathering is ongoing throughout the life of a case, and includes gathering information from existing case files, professionals involved with the family and, most importantly, from the children and families themselves. Information also needs to be gathered about *previous* attempts to resolve the problems within the family – by the family themselves, and by professionals and agencies involved with the child and the family. Refer to the *Best interests case practice model* (Miller 2010) for general tips and guidance on gathering information.

Key principles

To summarise, a comprehensive, early response to a child with problem sexual behaviours is reliant on an evidence-based approach by the practitioner.

By understanding the need for a thorough assessment of the family context, as outlined in this section, you are enabling effective planning and action:

- supporting the child and family in non-blaming ways and providing practical assistance
- establishing the history of behaviours
- understanding the child's family and environment
- actively coordinating referrals and sharing information with treatment agencies.

It is important to adopt an ecological perspective when gathering information about problem sexual behaviour and to be mindful of multiple possible contributing factors. Remember that children engaged in problem sexual behaviour and their families show great diversity. Information, which at first does not make sense, is often clarified in the process of information gathering.

You will need to develop a good developmental and health history of the child and a thorough family history including the child's siblings' histories.

Begin with a genogram to help you visually map the family system and significant transgenerational patterns.

Remember the importance of listening, paraphrasing and clarifying. Use empathy, warmth and transparency in your approach to maximise engagement through respectful practice.

Be alert to family violence

If there is a history of family violence you will need to refer to the practice guidelines for responding to family violence. There will be a heightened risk that an interview with a family around a child's problem sexual behaviours may precipitate violence toward the mother or child. In this instance, do not interview the couple about this together. Be very aware of immediate safety if there are disclosures, and seek advice in regard to police involvement and immediate planning.

Be strategic, aware of timing and mindful of not placing family members in further harm.

Seek multiple sources of information: Read the history

In gathering information, it is important to talk to multiple sources of information and to think systemically. Engage with parents, significant extended family members, siblings, schools, police, kindergartens, GPs, any other adult or family or child-focused services that are already active with the family.

It will be important to obtain summaries of any relevant cognitive, medical or neurological test results for the child. If the child has had previous involvement with child protection, it is fundamentally important that you read the file history and develop a chronology of critical events for the child and family. This is invaluable as you later analyse, hypothesise and plan your intervention, particularly as you critically reflect on potential cumulative harm. Ensure that you also read any files of the child's siblings and the parents' own child protection history.

Child protection should seek a criminal records check from Victoria Police on adults in the household and consultation should occur with police about any other pertinent information they have about the family, including information about family violence.

Initial information gathering

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

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

Once the caller has been reassured, ask about what has occurred. Take a detailed narrative history of the situation. This should include those areas listed below.

Challenges

Some issues can make the information gathering stage challenging. These include:

- disclosure is more often a process and not a one-off interview, so it often takes more time
- children and families might be reluctant to share information – they need to build trust
- cultural, attitudinal and stigma issues, promoting strong or distressed reactions in families, children and other parents – fear and grief can be prevalent
- fluctuating or buried protective concerns – secrets and deceptions are not uncommon particularly if there are intrafamilial sex offenders
- past negative experience with child protection, family support or counselling
- philosophical differences dividing professionals and/or carers, and members of the interagency team.

Attention needs to be given to the care team processes from the outset – this is a highly emotive issue and unless there is adequate information sharing and shared analysis and planning, professionals can polarise their views in unhelpful ways. Avoid the mistake of assessments that become biased by being overly pathologising and negative, or overly optimistic and superficial.

Engaging families

Be very aware of how you approach the parents and of your tone of voice and body language. They will be very sensitive to any blame or a patronising tone. While being clear about your role and purpose, remain warm and empathic. Combining a supportive tone with directness usually enables the parents to relax more and lessen their defences and begin to trust you with more detailed information (Miller 2009).

Acknowledge the strategies that parents have already used to manage the behaviour so far. Compliment the parents on the positive actions they have taken to support their child and acknowledge that some problems need ongoing strategies or extra help.

Several of the family factors noted above can combine to make family engagement initially difficult, and the fear of stigma regarding the nature of the child's behaviours can be an issue. However there is enormous variation in the way parents react to children displaying problem sexual behaviours. Some may be initially angry that you are involved; others may be relieved that help is available. Some may reject the child and, in some families where there are issues of violence, homelessness or a sense of chaos, there may be a lack of capacity to focus on the individual child's needs. Effective engagement will require you to build a trusting relationship with all family members, and your *persistence* is necessary to make sure that the children are helped.

These circumstances underline the importance of the relationship-building approach recommended in the *Best interests case practice model* (Miller 2010) and advised by the Dartington Social Research Unit (1998) and Thoburn, Lewis and Shemmings (1995).

Remain compassionate and use your authority wisely

Approach the family non-judgmentally and with respect at all times. Remain compassionate to their situation, but upfront about the need to respond to their children's behaviours. Reflect on how you approach the family; your warmth, consistency and practical assistance can make a powerful difference to the families' engagement with services and the lives of their children. However, you need to act assertively if children are at risk and use your authority wisely.

Miller, 2010

Many families will be more easily engaged if the practitioner is willing to listen to the parents' experiences but with an upfront agenda to help them to find a way to help the child to 'get back on track'.

Be mindful of the *parents'* need for self-care and your role in helping them understand the importance of *their* wellbeing to assist and facilitate the child's recovery. Parents often need individual and couple support and counselling to manage their own distress as well as parenting advice and support.

If evidence exists to suggest that the child's problem sexual behaviours may be caused by intrafamilial abuse, refer to the *Working with families where an adult is violent or sexually abusive specialist practice resource*. Consult with local treatment services.

As a practitioner, your self-care is important. Seek regular supervision where you can reflect on these issues and the emotional impact the work may be having on you. Remain committed to your own professional development and reflective practice.

Build relationships and engage with children families and other professionals

Talk to the child and family members separately and together, and observe the family dynamics.

Home visit, observe and interact with the children, their parents and siblings. You may need several visits to develop relationships and engage with immediate and extended family members. Also talk to other relevant people in the child's life, such as child carers, teachers, general practitioners (GPs), other support or counselling services and family friends.

Observe and remain curious

An important aspect of the children's presentation is their emotional profile. Emotions associated immediately with discovery of the behaviours, such as guilt, anxiety, confusion, shame, hostility or aggression (NSW Department of Health 2005), are significant and practitioners should record these aspects as well as their own observations of the child's emotional state when their problem sexual behaviours were disclosed or discovered.

Look for factors that produce stress and sexualisation in the child across different areas of the child's life.

Many children who present with sexualised behaviours experience cumulative harm from factors such as transience, family violence, repeated conflict, parental substance abuse, parental mental health issues, criminality, poor parenting practices, or disorganised or disrupted attachment relationships. The home environment may feature poor boundaries for sexual activity, or show active sexualisation processes (for example, making pornography available, engaging children in the production of pornography and promoting sexually abusive attitudes or actions). The level of parental and other support available to help the child to deal with these stressors makes a child more or less susceptible to problem sexual behaviours.

History of the behaviours

Take time to gather a comprehensive history, and not just in regard to the alleged event that precipitated the contact with child protection. (Merrick et al, 2008). For example, in talking to different adults in the child's life, it may transpire that there have been prior episodes of inappropriate behaviour. These may have been dismissed as unimportant at the time. It may also be that the child has often been the 'centre' of apparently consensual sexual behaviours between children but that this has occurred several times, and with critical reflection a concerning pattern can be detected.

The following information is highly relevant to obtain:

In what setting were the child's problem sexual behaviours observed?

- who were the target children?
- what behaviours were observed and between whom?
- has the behaviour been ongoing?
- how often does the behaviour occur?
- is the behaviour engaged in secret or accompanied by coercion/aggression?
- do the behaviours appear to be increasing over time?
- does the child show the behaviour in different settings or with differing types of children?
- is the child able to acknowledge the behaviours? How does the child react when confronted with the behaviours?

Does the family environment encourage sexualised behaviour and include easy unsupervised access to the internet?

- is there a web cam on the computer
- what is the degree of difficulty experienced by the adults in containing the behaviours?
- what strategies have they tried in the past and with what degree of success?
- is there a pattern around the behaviours?
- what are the triggers? (antecedents)
- how have parents, carers, school teachers, siblings and friends responded in the past?
- what effect did this have on the child?
- what support have they provided to support their child in dealing with problems e.g. with peers?
- how have they made sense of the behaviours? How come these behaviours have emerged at this point in time? Why now?
- what professional help have the parents/carers sought before this time?

Careful consideration of the above factors will help to build a comprehensive and accurate analysis of the situation. Refer to tables 1–3 of Age-appropriate sexual behaviours (pp. 8–10) to assist discussion with parents.

Presume that as your relationship with the child and non-offending family members develops more trust over time, and you become more immersed in the complexity and detail of the child and family's experience, more information will be revealed. This emerging information may shed light on problematic or perplexing behaviours displayed by the child, currently and historically.

- What has been the previous involvement of your service with the child, their siblings and their parents? Was it effective? If not, why not?
- Incorporate the history you are able to collect from other services and professionals who have been involved with the family.
- Summarise the file according to type, frequency, severity, source of harm and duration. Refer to the *Cumulative harm resource* and the *Child development and trauma resource*.

Stress or mental health issues in the child

Childhood problems such as stress or isolation, anxiety, anger, peer difficulties, learning difficulties or impulse control problems (such as those found in children suffering from ADHD) render children more susceptible to sexualising influences in their environments. Hence, children experiencing these stress factors are more likely to 'externalise' and exhibit sexualised behaviours. Under these circumstances, children will be overwhelmed and this needs skilled intervention that is mindful of the breadth of the child's needs. As you engage with the family, gather information about the following:

- do adults observe sadness, resentment or anger in the child?
- are problems with peers regularly experienced?
- is the child agitated or showing poor concentration?
- are difficulties with particular aspects of learning a feature of school life?
- is the child becoming demoralised?
- have there been events or influences in the child's life that have been traumatic?
- are there signs of attachment problems that may need further assessment?

What meaning do the parents/carers/teachers make of the child's behaviours? What do they hypothesise is driving the child's behaviours? Does the child show impulsive or attention-seeking behaviours?

If the child has an intellectual disability or developmental delay:

- what is the nature of the child's delay?
- does it affect the child's ability to control impulsive behaviour?
- is the child exposed to other children who show poor behavioural boundaries?
- what is the environment's capacity to respond to children's poorly self-regulated behaviours?
- does the child's delay put them at increased risk, given their environment?
- is the parent/carer engaging with services?

Remember – you are building up a comprehensive 'picture' of this child and family. The better the information gathering, the better the picture and the more helpful we can be as a service system. This information should be included in the referral to the Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Service agency.

Stress level in the parents; capacity to parent

Don't forget to ask yourself and/or the parents:

- do they need interpreters?
- have you consulted ACSASS or other relevant cultural consultants?
- have you consulted with family violence, mental health, drug and alcohol experts?

Be aware of potential family violence or domination that may inhibit disclosure or discussion. Consider who to interview where and when. Normalise that your process is one of interviewing parents separately and together and make sure that you interview the mother and each of the children on their own. Determine the order of the interviews according to the particular circumstances you encounter. Sometimes it is best to interview the father first to decrease his anxiety and potential intimidation; however, more often in practice, (to gain better quality information), it is prudent to interview the mother and children first. Also explore:

- the understanding that other siblings have of what has occurred and how they are coping
- the conflicting loyalties in the family and the general level of sibling violence within the family
- the incidence of other abuse between family members
- the availability of the parents both physically and emotionally (Kambouridis and Flanagan 2003 pp. 6)
- family strengths and informal and formal supports.

Understand the family history and the parenting style

The parents' own family of origin experience is highly relevant to your assessment, i.e. their experience of being parented and their own life experience. Be curious about their couple relationship and their parenting style. Empathically enquire about:

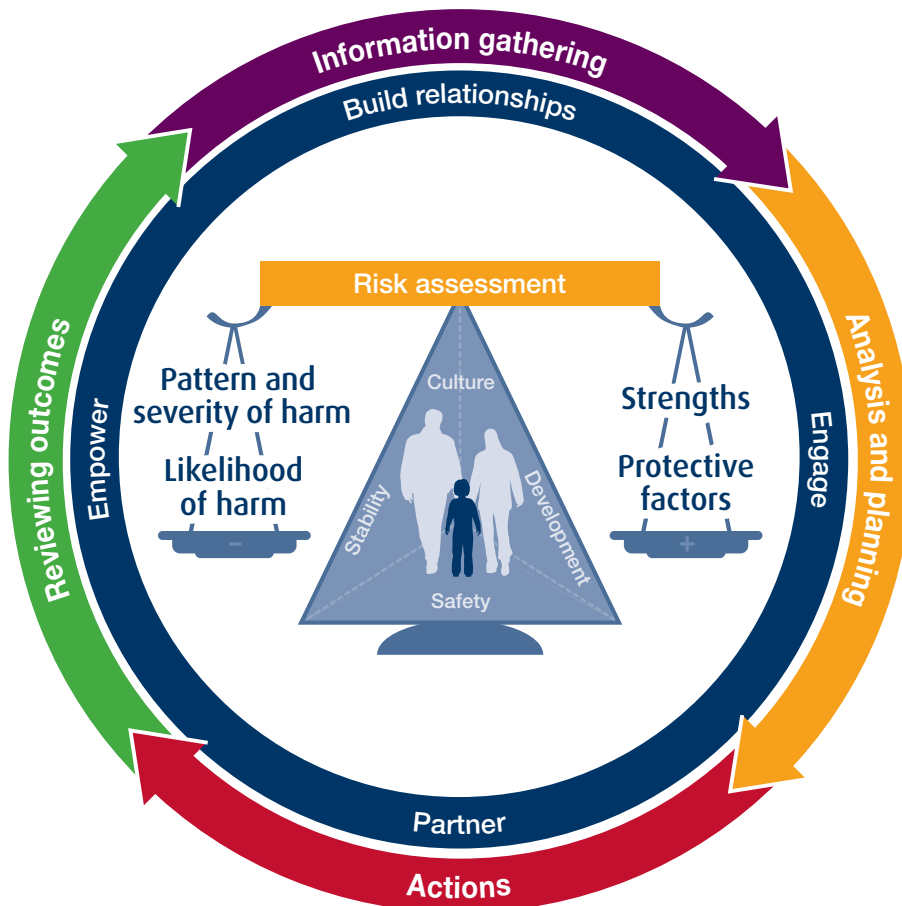
- the parents' own sibling relationships
- the parents' 'acceptance or otherwise of both the victim and the child with problem sexual behaviour' (Kambouridis and Flanagan 2003 pp. 6).

You need to convey that you are genuine about helping the child and the family, and to follow through with actions that show this intent. If the parents are dismissive and rejecting of the child and there is a need for out-of-home care, be extremely proactive in maintaining engagement with their parent/s. Be aware that the parents may be struggling with their own history of abuse and that they are often able to work through their initial reactions with your support and referral and linkage to expert help. The child's recovery is inextricably linked to their connection to their primary caregiver. The children need warmth, consistency and a secure base. Connection to their school, community and culture is healing and will help the child to be resilient. The response from the school, church, professionals and the community can also help or harm the parents' capacity to respond appropriately to the child. As you gather information, be aware of the need to respond immediately to the parents' distress.

- Are there obvious sources of stress for the parents and how have they been helped to manage this?
- What is their capacity to take an appropriate adult perspective?
- What is their capacity to put the needs of the child first?
- With siblings, what strategies have been suggested to help them balance the needs of each of their children without isolating them completely? Have they worked?
- How good is their ability to create boundaries and structure appropriate to each child?
- What sex education of the child has been undertaken so far?
- What do they do when they notice the child acting out sexually? How have they managed their emotional responses?
- Is the extended family supportive? Are they experiencing social exclusion or stigma because of their child's behaviours?
- Have they been able to take on board direction and advice as to how to manage the behaviours? What have they put in place? How effective has it been?
- What is the school's capacity to implement a safety plan around the child's behaviours? Can a clinician assist?
- Have disability services been involved?
- Are they open to being referred to a Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Service agency?
- What are the barriers to the family attending treatment? Can you assist?

This information is critical to informing us as to how the parents will safely manage the situation.

Analysis and planning



Risk assessment

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

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

Characteristics to consider when assessing risk

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

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

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

Attention to safety factors within the risk analysis recognises that:

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

(cf. Turnell and Edwards, 1999)

Current risk assessment

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

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

Principles of intervention

Critically reflect and synthesise the information you have gathered, and creatively focus on how you can facilitate the good outcomes this child and their family need right now. Intervening early in problem sexual behaviours is crucial.

Advocate, plan and organise necessary resources and activities around the child. Closely liaise and case conference with other agencies involved with the child. Avoid 'group think' and appoint a 'devil's advocate' at case conferences.

Safety

Successful intervention for children with problem sexual behaviours is based upon understanding that:

- safety is a prime consideration for both the subject child and those around them
- their behaviour is linked to multiple stressors – both external and internal to the child (the child and the environment)
- in children under 10, persistent sexualised behaviours are developmentally abnormal and are likely to indicate that harm has occurred to the child; the younger the child, the more likely this is
- once in a repeating pattern, the behaviours may be habitual and the child can no longer control them. Treatment should be sought from the Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Service agency.
- family and/or caregiver involvement is paramount and needs to be effective
- multiple factors need to be addressed, perhaps via different service providers, and you have a strong role in facilitating these services
- coordination and a well-functioning care team is critical to successful outcomes.

Safety planning should be based in a developmental context. The plan should meet the child's needs at the time and change as the child develops better self-control, understands the parameters around sexual contact, and is capable of more freedom. It is inappropriate to leave children completely isolated from other children with no chance to develop the social skills they need as they grow and develop. The children then feel as if they are dangerous and pariahs (Johnson & Doonan 2006). Safety planning needs to encourage social contact with other children who are well supervised by caring adults who are knowledgeable and aware of the issues, without stigmatising the child.

Outcomes for the children

For desired outcomes to be achieved, your planning of treatment/intervention should focus on:

- safety for all the children involved
- reducing the child's inappropriate behaviours – primary goal: contain (halt) the behaviour
- reducing the risk posed to the child
- reducing the risk posed by the child to others
- reducing psychopathology and emotional distress in the child
- increasing the child's coping mechanisms
- increasing the child's socialisation and engagement
- reducing trauma impacts
- improving attachment
- improving family functioning
- improving parenting responses.

Be mindful of the risk to other children

Children who evidence sexual behaviours at the concerning or very concerning level are generally not able to enact control over their actions until they have experienced safety and processed their issues (as much as the adults around them might wish otherwise). This is usually through a satisfactorily completed treatment process that has been inclusive of their parent/s or carers and has understood and addressed their experience of victimisation. Therefore, it is important to assess whether there are children at risk from exposure to further sexual behaviours from the child.

In what settings does the child appear to display problem sexual behaviours? Note that coercion, manipulating others into compliance, and being the leader in games that quickly become inappropriate, are key features of children's problem sexual behaviours.

Where behaviours are assessed as very concerning, a prompt and effective intervention is required and adults need to implement calm and consistent strategies to enforce simple limits and boundaries. The troubled child will need support and encouragement in the meantime, so as not to feel rejected. Children with risky behaviours towards others need line-of-sight supervision to protect themselves and others from potentially harmful situations, which can develop very quickly. These children often have difficulty in containing themselves and may need extra support at night time in order to settle and go to sleep, rather than wander. Supportive and containing actions by adults such as story reading, providing night lights and doors left ajar, can assist in night time safety and settling for younger children with problem behaviours. Seek advice and refer to the Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Service.

Refer to the *Child development and trauma specialist practice resource* for specific suggestions for each age and stage.

Other children at home

Younger siblings and same-age or vulnerable children in the home or placement setting may be at risk of further sexually intrusive behaviours from the identified child. It is vital that parents or caregivers be assisted to develop a safety plan that avoids stigma and balances restriction for the child with confidence that safety for others is being maintained. Therapists' recommendations may be needed to determine whether:

- the child can be safely maintained in the current environment
- line-of-sight supervision is needed at all times
- restrictions on venues and style of play are necessary
- sleeping arrangements need to be changed
- other children need support with developing protective behaviours
- other children have already been sexually enculturated
- restrictions need to be placed upon television viewing and the child's access to written and pictorial materials
- extra support is needed within the home
- ensure the child/ren who have been victimised have access to therapeutic assessment and treatment if this is recommended.

Out-of-home care

In home and care environments with several children, an assessment needs to be made of whether and how safety can be achieved. Adult carers need to be proactive in implementing clear boundaries and specific aspects of the safety plan. Schools usually also need to be part of the planning.

Children with problem sexual behaviours may be in out-of-home care due to their behaviour posing safety issues at home or they may have already been in the care system when the behaviours were noted.

Carers need to provide ongoing management of a potentially changing risk profile and it is critical that they are provided with adequate information about the child's problem sexual behaviours so that they can plan how to positively engage with the child whilst providing adequate boundaries, monitoring and supervision. At some point, concerns or crises may occur where the management of the child should be reviewed. Always consult with the treating therapist.

Some circumstances will warrant a change of placement and planning needs to support such a transition being as comfortable as possible for the child. Child protection practitioners are in a primary position to mobilise extra consultation and support resources and to assist in coordinating responses to risk issues for the child.

The following key points need to be addressed in planning a successful placement.

Appropriateness of current placement

- The placement may house other children, some of whom may have been subjected to the inappropriate behaviours. What is the capacity of this environment to provide daily comfort and safety for all the children? If the situation cannot be managed, which child will need to move to alternative care, and for how long?
- Decision makers should be mindful of not placing children with serious problem sexual behaviours with younger children or children who have an intellectual disability, or are otherwise disempowered. It is generally unwise to place them with older children with problem sexual behaviours or adolescents with sexually abusive behaviours.

Support, consultation and education for carers

- Carers may need extra training to orient and support them in assisting the child in their care interventions, because generally the behaviour is the symptom of an underlying, more complex issue.
- Carers are essential in providing useful feedback to therapists, and may need to be briefed by the therapists at key junctures, for instance, at times where emotional upset or behavioural outbursts may occur as a result of therapy.
- Carers need to be clearly aware of risks posed both to and from the child involved and they need to participate in planning the lines of consultation, communication and support, which they will find necessary.

In the case of multiple treatment intervention types, carers may need assistance in planning transport to ensure that appointment schedules are sustainable for them. Attend to the practical issues.

Carers need direct, regular ongoing access to therapists both for support around the child's problem sexual behaviour management and in order to provide or receive feedback. They should be viewed as an integral part of the care team.

The child exhibiting problem sexual behaviours

Consider whether there are factors within the child's life, people in their lives or characteristics of the child that place them at risk.

- The child may be at increased risk from opportunistic older children or adults because their behaviours signal poor sexual boundaries and little self-protection. Are there environments where this child is at risk?
- What are the access and contact arrangements?
- Is the child in contact with an adult sex offender?
- Do you need to vary the current court orders?

Key questions:

- Are there environments where this child is at risk?
- Do a parent's reactions mean that the child is at physical or emotional risk of harm?
- Is the child at risk of repeating the behaviours within a poorly supervised extended home or family setting?

Creating safe family and social environments

- Sometimes parents with large extended families, or blended families are reluctant to discuss issues or form safety plans with their relatives. Parents may need your support to have some difficult conversations within the family and with extended family and friends, especially if there are functions where children have free play and adults are socialising or distracted.
- Sleepovers are not advised until treatment is completed, but if an overnight stay is unavoidable, it is particularly important to have strict arrangements in place with line-of-sight supervision.
- There should not be unsupervised bath/bed times
- Children should not be sharing beds.
- Shared bedrooms are not advisable unless an adult is constantly present.

Discuss with caregivers so as to ensure they are adequately skilled to maintain safety. If a five year old child has been targeted by a 10 year old child, there is the potential to re-traumatise the younger child and in fact any contact at all may be contra-indicated until treatment has been completed.

Parents and carers need to:

- Establish routines for bath times (where privacy is respected) and bed times.
- At times of transitions and anniversaries be alert to the child's heightened emotional state and increase support and supervision. This will help to contain the child's anxieties and prevent the sexualised behaviours from being enacted.
- Providing warmth, consistency about boundaries, expectations and supervision is the key.
- Follow the treating therapist's advice about how to create opportunities for the child to learn and practise appropriate physical boundaries.
- Develop clear, simple rules with parents re appropriate and inappropriate sexual behaviour.
- Also follow the treating therapist's advice about how parents should provide developmentally appropriate sex education for the child and basic sexual abuse prevention strategies.
- Create opportunities for the child to have positive peer relationships in a supervised environment. Seek advice about appropriate sporting and recreational activities from the treating therapist.
- Plan to encourage and assist parents to follow the therapeutic plan for the child and to celebrate positive changes.

Parenting capacity

Apart from the level of stability achievable for the child, the capacity of the parents or caregivers to understand and respond to the child is one of the strongest outcome indicators for a child with problem sexual behaviours.

- Following the initial stress and crisis period, what level of capacity are the caregivers/parents showing in their ability to support and respond to the child? What type of support might they need in order to improve this?
- Do the caregivers/parents have appropriate support where they can safely identify their own feelings and responses to the child's behaviour?
- Have the parents been supported to manage where these events triggered responses to their own history that might have impacted upon their capacity to support the child?
- If a sibling has abused the child with problem sexual behaviours, parents may need additional assistance in supporting each of their children.

The parents need assistance in developing very practical strategies to manage different behavioural scenarios. They should understand the therapeutic goals and the safety plan for the child. Flexible support, that is responsive to their evolving and dynamic family life, is required by the family from the care team and should be led by the child protection practitioner if the program is involved.

Treatment may vary from separate sessions with the parents/extended family and siblings through to family and individual work with the child. Education and support for parents/carers is vital to build their confidence, competence and feelings of hope for the future. Ensure a comprehensive approach to the issue.

What help does the child and their family need?

As well as addressing protective concerns, an improvement to the child's environment is often necessary before treatment interventions can be effective.

- Does the family require a Family Support intervention or specialist resources?
- Where the child is in out-of-home care, could the carers access specialist supports to assist them?
- Does a parent need support from a drug/alcohol or mental health agency?
- Does a parent need access to their own counselling intervention?

Additionally, it may be apparent that the child needs assessment via medical checks or referral to a child and adolescent mental health team or specialist therapeutic service for particular needs.

Where a child experiences developmental delay or intellectual disability, additional resources, education or monitoring may benefit the child to prepare them for treatment.

At school

The child's school has significant opportunities for monitoring behaviour and changes in the child and also in helping to shape the child's responses. However, balancing this, combined with a duty of care towards all other students, can be difficult for the class teacher and others in key positions. Regular information updates and the ability to access consultation advice may be essential for the school.

Provide the school with access to resources such as the *Child development and trauma specialist practice resource*, and *Calmer classrooms* (Child Safety Commissioner).

At school it may be necessary to make a safety plan that addresses the protection and containment of the child, the protection of other children, and resources for teachers and after-school staff, as well as communication to caregivers or parents. This should be provided while provoking the least amount of stigma possible towards the child.

Sexualised behaviours are difficult to manage and teachers may be triggered into a stressed response. This may be more pronounced if they have experienced a similar type of trauma, which has remained unresolved. Teachers require sensitive support and it is essential that there is regular supervision and collaboration. The behaviours can provoke stronger reactions in staff who may need to process their fear, anger, disgust and frustration. They also may need help to recognise the positive progress which is being made with the child. A key staff member at the school should be identified to make every effort that the child is not stigmatised and that a strong shared approach is taken.

The therapeutic plan, with specific goals and strategies, needs to be understood by all staff involved in the child's care, including teachers at school and at sporting and swimming clubs etc. The privacy of the child and family needs to be respected; however, adequate supervision is of critical importance during the recovery phase. Liaise closely with the treating therapist.

Supporting effective therapy

Effective therapy for children with problem sexual behaviours is multimodal and needs to be systemic, that is, attending to the family dynamics and relationships between parents and children and siblings. Where the behaviours are entrenched or the underlying trauma is more complex, it may involve a long treatment track. This may tax parents or caregivers who are already showing signs of stress.

- Will the parents support the child's attendance at therapy and engage in the sessions themselves and in any homework tasks?
- Are there brokerage dollars to help with transport costs?
- Parents need to be adequately informed about what role they can play in the child's therapy?

Treatment for young children with sexualised behaviours and their families is sensitive and complex and needs the proper framework of training and experience in the field. When the family has been referred to a treatment provider who is not part of a recognised agency or clinical program that specialises in this treatment area, make assertive enquiries to assess the quality of service before committing to the referral.

Checks should be carried out to confirm the treatment provider will use empirically validated methods for assessment and treatment, such as those recommended in the CEASE Standards of Practice document at www.secasa.com.au.

Action

The child's home environment

Where the home environment has been a source of stress or distress for the child, regular monitoring is important to track the progress being made. Situations may change quickly, for example, where drugs or alcohol are an issue, or where the family relationships are volatile. What further supports may be necessary? Who is identified as needing most assistance? The child's behaviour at home or at school may be a mirror for their stress level and can be instrumental in understanding where a critical deterioration has occurred. Maintaining contact with the family and system around the child is critical.

Effectively engaging families

Research shows that practitioners who engage effectively with families:

- treat family members with respect and courtesy
- focus on building on the family's strengths
- promote positive relationships among parents and children
- develop trust through sensitive and inclusive enquiry about their circumstances
- take an active, caring, whole-of-family approach to their situation
- link up with other relevant services and work together to avoid conflicting requirements and processes
- focus on the children's needs
- maintain a continuous relationship with the family
- establish shared decision making
- provide crisis intervention prior to other intervention aims
- build the quality of the relationship between the parent and the service provider
- minimise the practical or structural barriers to accessing services
- choose non-stigmatising interventions and settings
- remain culturally aware and sensitive.

Sources: McArthur et al. 2009; Centre for Community Child Health Royal Children's Hospital 2010

Home visits and regular case conferencing that is inclusive of the family (where appropriate) should be happening consistently. Tasks and timelines, transport, respite and other arrangements need to be clear and documented for everyone involved. Stay involved, be in touch regularly and consistently with the care team.

Practical responses to children engaged in problem sexual behaviours

Responding immediately to problem sexual behaviours engaged in by children is crucial. Individual values and attitudes about sexual behaviour may result in either minimising or over-reacting to the observed behaviours. The initial response to the behaviour by people around the child is important and can significantly impact on the child's ability or willingness to address the behaviours. As a professional, share the following useful information about how to respond 'in the moment' with parents and carers who are often looking for practical advice.

When you or others observe problem sexual behaviours:

- Remain calm.
- Externalise the behaviour, i.e. separate and comment on the behaviour – do not demonise the child.
- Clearly and calmly ask the child to stop the behaviour.
- Separate the children and prioritise the safety and emotional wellbeing of the child who has been victimised. Reassure the victim child and provide comfort as required.
- Then engage separately and remain calm and non punitive with the child who has enacted or initiated the problematic sexual behaviour. Be clear and firm that it is not okay, and note the child's explanation. Sometimes the child will be open and engage in conversation around the origins of the behaviour, e.g. 'Uncle Fred showed me this game and I was showing Terry'. The key is to remain low-key and conversational.
- Notice any unusual emotions in either of the children. Do they appear angry, agitated or upset? Make a note of this.
- Either child may become distressed and require nurture. If either child becomes angry and blaming of the other child, ensure that there is line-of-sight supervision and clear messages are given about boundaries and rules, particularly attending to any bullying or potential for retribution. Ensure safety and seek advice and expert assistance as soon as possible.
- Keep a record of the behaviour including the actions themselves, the context, date, times and frequency. (Note: this should be done discreetly and not used as a way of punishing children).

After noticing concerning or very concerning sexual behaviour, a carer or professional should seek professional consultation from their manager or supervisor to determine whether to contact one of the agencies in the Referrals section. If the child is already engaged in treatment, make sure that the therapist receives information about this recent concerning behaviour. Keep close communication with the parents.

Walking in on a seemingly abusive situation can be a shock for the adults involved. There are some common mistakes people make when they have witnessed/ discovered sexual behaviours between children. Try not to:

- appear shocked
- react in such a way that will make the child feel embarrassed or ashamed
- ignore the behaviour
- automatically assume that sexual abuse has occurred - some sexual behaviour between children is normal
- do not use language that labels a child as a “pervert” or “sex offender”
- do not try and conduct a formal disclosure interview unless you are formally assigned this role. However, if the child is wanting to talk, remain attuned and engaged, letting them know that you are listening and it is okay to talk. Note down the child’s disclosures as soon as possible as the details matter. Ensure that the appropriate professionals in the care team have access to this information, whilst respecting the privacy of the family.

(Adapted from Barnett, Giaquinto, Hunter and Worth 2007)

Safety plans

Children are on a developmental track and this may be reflected in changes in the profile of their behaviour or their approaches to other children. Additionally, changes may take place in the other children, which mean an alteration to the overall safety profile in these circumstances. What changes need to be made to the safety plan? Who should be consulted in its redevelopment?

Parents or carers can sometimes ‘burn out’ from the high level of vigilance required, or become less concerned as a result of the passage of time. Additional advice or extra meetings with the child’s treatment providers may be helpful in achieving clarity regarding safety issues.

Times of transition, such as parental separation, illness or death in the family, holiday times, moving schools, placements and terminations with key workers, often increase symptomatic behaviour in children and adults. Increase support in a planned, proactive way at times of predictable transitions. Anniversary times can also trigger traumatic memories and increase the likelihood of the sexually inappropriate behaviours: Christmas, Father’s Day, Mother’s Day, the time of the year that a child was sexually assaulted; anniversaries of deaths; separations, and any contact with police, courts or adult offenders, should all be planned for with a view to proactively increasing support.

Treatment: aims and progress

Following an assessment period, the goals for the child's treatment outcomes should have been indicated.

The Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Service agencies in Victoria are listed on page 51.

The CEASE Standards of Practice for treatment programs (2010) recommends that assessment by treatment services should include a review of the drivers of the behaviours and their risk profile, the context for the child, risks to the child, and the type of treatment elements recommended. Empirical tests can be incorporated if they are warranted for the child. Refer to the document for other relevant assessment tools at www.secasa.com.au/index.php/workers/24/424.

Successful intervention for the multiple components of the children's problem sexual behaviours may entail quite a long treatment track (often between six months and two years). Where there has been a secure attachment between the child and parent/s and there is a stable family base with sustained strengths and safety, the treatment phase may be shorter and still be very effective. This is often dependent on the sustained commitment of the parents in following through with strategies to assist the child.

Some components of the treatment may be streamed in for shorter periods, while others (for example, interventions for attachment, trauma or entrenched family difficulties) may carry on for longer. Since there is a tendency for fluctuation and change in this client group, the treatment plan may need to change direction to address this variability.

Feedback from therapy providers is essential in formulating responses to the child's needs and so regular feedback between the therapists, family, other counsellors, child protection practitioners and any out-of-home carers is vital to success.

Interagency collaborations

The quality of interagency collaborations is an important factor in achieving the best outcome for the child. Different agencies experience varying constraints, models of confidentiality and philosophical bases. Child protection practitioners are in a key position to facilitate regular communication between the interagency or care team, and to assist everyone in working towards the same overall goals.

Facilitate positive collaboration for the duration of treatment within the care team and between agencies and the family.

To ensure effective collaboration between the family and agencies involved, parents need to be informed that information exchange is essential to ensure the best therapeutic outcome for their child. This may mean having a conversation with the child's parents regarding the need for them to provide accurate information and why this information is needed and how it will be used so that there are no surprises for the family.

With this in mind, practitioners have a responsibility to ensure that the information they hold is accurate and up to date.

If you wish to find out more about information sharing refer to the information sharing guidelines on the Department of Human Services Children Youth and Families website.

Review Outcomes

The intervention track for children with problem sexual behaviours may be a complex one and, with any changes in practitioners, it is crucial that the narrative and experience of the child, family, carers and treatment team is not lost. Accurate recording that documents the outcomes of any interventions and placements is critical.

Therefore, reviewing progress as it pertains to any particular stage should be ongoing. During the early stages, for example, key points may indicate whether the intervention plan is working; these might be:

- how well the containment strategies and safety plans are operating in the school
- whether the parents are attending their own counselling appointments and participating in joint sessions with the child, and family sessions where appropriate
- whether the parents are regularly taking the child to counselling sessions
- whether the child is settled enough to benefit from therapy
- whether the child's home is able to provide safety for all of the children living and visiting
- the consistency and support provided by care team members.

During the entire intervention period, regular contact and meetings between the members of the care team will be essential.

Risks specified

In particular, carers need to be fully aware of a potentially unfolding pattern of risks, with the likelihood of new developments as the child matures. As an example they may have contact with their own extended family and plans should be made for safety in this environment too. Does the family share information in a way that maintains safety but does not stigmatise the child?

Consultation with the child's therapy provider, and therapy providers for the parents, and the child's school will be instrumental in advising whether the triggering stressors for the child have been adequately addressed, and whether the impacts upon the child's wellbeing and risk potential have been adequately moderated.

Key indicators for an outcome analysis will be:

- reduction in the range, severity and frequency of problem sexual behaviours
- an improvement in the level of the child's wellbeing
- improvements in the family environment
- treatment outcome indicators
- successful enactment of safety plans
- improvements in the child's adjustment at school
- stabilisation to the child's adjustment in out-of-home care
- the prospect of safety for other children in contact
- the ability of parents/carers to monitor and respond to future inappropriate behaviours.

If the child has been placed in out-of-home care in response to their problem sexual behaviours, a review of all of the above indicators will inform decisions regarding the appropriateness of a return home with support. Remember that assessment of the living situation should be ongoing and responsive to the needs of the child involved and the safety of those around them. This is a sensitive situation – we are dealing with young children who, while having the potential to cause harm, also require nurture and guidance from firm boundaries and attachment to family figures. Your care, consideration and expertise is crucial to a good outcome. Most importantly, celebrate positive changes and keep persisting. Don't label or give up on the child, and provide practical support and encouragement to the family.

Treatment of children with problem sexual behaviours and their families is very successful and can be life changing. Practitioner collaboration, ongoing training, supervision and a commitment to your own self-care and critical reflection are crucial.

Other relevant resources

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- CEASE 2010, *Standards Of Practice For Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Programs – February 2010* <www.secasa.com.au/index.php/workers/24/424>
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- CEASE 2010, *Standards of practice for problem sexual behaviours and sexually abusive behaviour treatment programs* – February 2010, <[www.secasa.com.au/Workers/Counselling Issues](http://www.secasa.com.au/Workers/Counselling%20Issues)>
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Appendix: Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Service Agencies in Victoria

The following agencies deliver therapeutic treatment services to children with problem sexual behaviours and young people with sexually abusive behaviours and their families in Victoria.

Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Service Agencies in Victoria

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

