QCPCI Tendered in Chambers

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

Date: 17.12.2012

Exhibit number: 133

STATEMENT OF JANET MARTIN

I, **Janet Patricia Martin**, c/- 15 Butterfield Street, Herston in the State of Queensland, solemnly and sincerely affirm and declare:

1. I am the Manager, Clinical Governance, Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch in Queensland Health.

2. I was appointed to this AO8 level position on 15 October 2012.

3. When planning and reviewing my work and seeking approval for decisions, when required, I report to the Chief Psychiatrist who is based at 15 Butterfield Street, Herston. My position is within the Office of the Chief Psychiatrist. The Chief Psychiatrist reports to the Executive Director, Mental Health Alcohol and Other Drugs Branch.

4. Prior to this appointment, commencing in October 2007, I was the Manager of the Integrated Care Team, Strategic Policy Unit, Mental Health Alcohol and Other Drugs Branch. Prior to being appointed to the Manager's position, I was the Principal Project Officer (Mental Health Therapeutic Services) in the Child Safety Unit, Queensland Health, from January 2005 to October 2007. For the five years prior to this position, I held two mental health project officer roles (five months in the then Mental Health Unit and three and a half years in the then Central Zone Management Unit) which included almost 12 months of higher duties in two Team Leader roles. Prior to these roles in Queensland Health Corporate Office, I worked for 10 years as an Occupational Therapist in mental health including three and half years as Senior Occupational Therapist and two and a half years as Team Leader, Mental Health.

5. I hold a Bachelor of Occupational Therapy and Masters in Business Administration (Professional).

ROLE

6. The purpose of my role, as Manager of the Integrated Care Team, Mental Health Alcohol and Other Drugs Branch was to manage a team of six full time equivalent staff to develop mental health policy and implement programs that contribute to integrating and improving the continuum of clinical mental health treatment and care.

7. My duties and activities included:

    a. Provision of high level advice in relation to the mental health service system and clinical service delivery through departmental briefing notes and Ministerials, secretariat and policy support for various statewide advisory groups and networks, and the development of clinical policies, guidelines and service frameworks.
    b. The establishment of effective partnerships with private and public service providers in both the government and non government sectors.
    c. Engagement and collaboration with mental health consumers, carers and their families.
    d. Financial accountability for three cost centres.

8. As part of my role as Manager of the Integrated Care Team, Mental Health Alcohol and Other Drugs Branch, I:

- Supported the implementation of the Evolve Therapeutic Services program. This program was funded to implement recommendation 7.5 of the 2004 Crime and Misconduct Commission Inquiry report *Protecting children: an inquiry into abuse of children in foster care.* Queensland Health was initially allocated approximately $11 million to respond to the recommendation 'that more therapeutic treatment programs be made available for children with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated'. The budget has subsequently increased to $18.9 million in 2012/13.

  Implementation of the program included service planning, implementation support and ongoing review. I currently chair the Evolve Therapeutic Services Statewide Steering Committee, approve annual outcomes reports and interagency performance reports, advise the Queensland Health Child Safety Director on matters relating to child and youth mental health service provision, and undertake negotiations with the Department of Communities, Child Safety and Disability Services.

- Developed the *Meeting the needs of children for whom a person with a mental illness has care responsibilities* policy and *Working with parents with mental illness* guidelines for mental health clinicians. This project required extended and sensitive negotiations across multiple stakeholders, including mental health clinicians, consumers and carers, child protection staff across Queensland Health and the then Department of Child Safety, and representatives of the Royal Australian and New Zealand College of Psychiatrists. The policy and guidelines have subsequently been acknowledged by the Health Quality and Complaints Commission, Commissioner for Children and Young People and Child Guardian and State Coroner.

- Coordinated implementation of the National Perinatal Depression Initiative (NPDI) in Queensland. This has included planning the allocation of the $5.933 million over five years budget; supporting the Queensland Centre for Perinatal and Infant Mental Health to provide implementation support for the 12 perinatal mental health nurses employed across the state; chairing the Queensland NPDI Steering Committee; representing Queensland on the NPDI State and Territory Reference Group; negotiating with the Commonwealth Department of Health and Ageing, Queensland Treasury, and the QH Maternity Unit; and developing Queensland biannual progress reports against performance indicators. This initiative has significantly enhanced the provision of mental health care for women in the perinatal period, their infants and families, across Queensland's primary care, maternity and mental health sectors (including public, private and non-government service providers).

STATEMENT ADDRESSING KEY QUESTIONS OF THE QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

Introduction

This statement draws heavily from the results of a project conducted over a six month period from September 2008 to February 2009. The *Scoping Project: Responding to the needs of children and young people with identified sexually abusive behaviours* (Scoping Project) was sponsored by the Child Safety Directors Network (CSDN), and managed by the Evolve Interagency Services (EIS) State-wide Steering Committee. The government departments then involved in the project were Queensland Health (QH), Department of Child Safety (DChS), Department of Communities (DoCs), Department of Education, Training and the Arts (DETA), and Disability Services Queensland (DSQ).

The Scoping Project arose due to reports of increasing concern across multiple contexts (e.g. child safety services, education) of the numbers of children and young people with sexually abusive behaviours and the service system's apparent inability to fully respond to the needs of this group.

The Scoping Project was undertaken by Ms Tania Withington, Team Leader, North Brisbane Evolve Therapeutic Services (ETS) team, who was taken off line from her substantive position for the duration of the project.

The Scoping Project aims were to:

- Identify and outline the manner in which the needs of children and young people with identified sexually abusive behaviours were being addressed across QH ETS, DChS, DETA, DoCs, and DSQ Child Safety Behaviour Support Teams.
- Identify and outline existing gaps in current service provision, highlighting opportunities within the service system for future development.
- Increase the knowledge of current staff of QH ETS, DChS (Child Safety Officers), DoCs (Youth Justice), DETA (Guidance Officers and Behaviour Support staff), and DSQ Child Safety Behaviour Support Services, through training.

The project included all children and young people receiving services from the service system described, including those children and young people involved in the child protection system. Project plan – Attachment 1.

My role in this project was as a member of the EIS State-wide Steering Committee and line manager of the ETS Principal Project Officer who provided direct support to the project coordinator.

Service delivery to children and young people in, or are at risk of entering, the child protection system who –

- **Have experienced sexual abuse;**
- **Display problem sexual behaviours; and / or**
- **Have sexually offended.**

QH Child and Youth Mental Health Services (CYMHS) provide specialist mental health assessment, treatment and support for infants, children and adolescents up to the age of 18 years who are experiencing psychological distress and/or mental illness. Consumers engaged with CYMHS present with a range of mental health problems and/or disorders, but predominantly they have diagnoses such as depression, anxiety disorders and/or behavioural disorders. Behavioural disorders may include problem sexual behaviours.

CYMHS target children and young people known to be at higher risk of developing serious mental health problems and disorders, including those who are experiencing or have experienced abuse (including sexual abuse), neglect or other traumas, children and young people in care and/or those in contact with the juvenile justice system.

Specialist forensic mental health services provide consultation, assessment and intervention services for children and adolescents up to the age of 18 years who are consumers of CYMHS and/or youth justice services and who present with mental health problems and who are involved with or at risk of becoming involved with the juvenile justice system. Offences include those that are of a sexual nature. These forensic services operate in community CYMHS clinics and detention centres across the state.

EIS is a cross-government initiative involving Department of Communities, Child Safety and Disability Services (DCCSDS), QH, and the Department of Education, Training and

Employment (DETE). Therapeutic and behaviour support services are provided to children and adolescents up to 18 years who are on child protection orders and who present with severe or complex psychological and behavioural problems. Referrals are made from DCCSDS to an interagency group – the EIS Panel. ETS is the QH component of the program and provides specialist mental health and therapeutic services to children, adolescents, their carers and other key stakeholders. Evolve Behaviour Support Services is the disability services (DCCSDS) component of the program that provides specialist disability assessments and positive behaviour support to children and adolescents with a disability. DCCSDS provide child protection case planning and intervention, and DETE provide educational support and other intensive educational input. All three agencies collaborate to provide co-ordination of care and combined assessment of the child/adolescent and care system needs.

Data regarding the numbers of children and young people receiving any QH mental health service who have experienced sexual abuse, display problem sexual behaviours and/or have sexually offended is not available. The Scoping Project attempted to access data related to the nature and extent of the problem in Queensland. (See section three of the Scoping Project review report – Attachment 2).

The 2008 ETS Evaluation Report stated that based on the 241 EIS referral forms reviewed, almost half (44%) of the children and young people referred to ETS since the commencement of the service in early 2006 displayed inappropriate sexualised behaviours at the time of initial referral as identified by their Child Safety Officer.

With the development of the EIS program performance framework and ETS reporting requirements focusing on program outcomes, EIS Referral Form data is no longer collated on a statewide basis.

The Scoping Project review report (Attachment 2) includes brief information regarding other Queensland services for children and adolescents with identified sexually abusive behaviours across the government and non-government sectors.

The Griffith Youth Forensic Service based at Griffith University accepts referrals for young people throughout Queensland who have been found guilty in court in relation to sexual (or sexually motivated) offences. Referrals can only be made by Youth Justice Services, Department of Justice and Attorney General, and priority is given to referrals for pre-sentence assessments; cases assessed as high-risk / high-need; and clients from rural and remote locations. www.griffith.edu.au/criminology-law/griffith-youth-forensic-service

Key persons able to speak to the initiatives

- Ms Tania Withington, Director of Social Work, Child and Youth Mental Health Service, Children's Health Queensland Hospital and Health Service (HHS).
- Dr Stephen Stathis, Consultant Psychiatrist, Child and Youth Forensic Outreach Service, Children's Health Queensland HHS.
- Dr David Hartman, Consultant Psychiatrist, North Queensland Forensic Adolescent Mental Health Service, Townsville HHS.

Agencies that partner with the service provider to deliver these services

- Department of Communities, Child Safety and Disability Services, including Child Safety Services, Evolve Behaviour Support Services, and the Sexual Assault Counselling Service
- Youth Justice Services, Department of Justice and Attorney General
- Department of Education, Training and Employment
- Family Planning Queensland

- There are a range of non-government organisations funded to provide counselling for children and young people who have experienced sexual abuse. These include:
    - ACT For Kids Sexual Abuse Counselling Service is described on their website as 'designed to help kids and parents cope with the aftermath of sexual abuse. Trained counsellors work with kids to overcome trauma, and help parents create a safe environment so abuse doesn't happen again. Our counsellors act as trusted advisers and problem solvers to sexual abuse survivors. They engage the family in counselling which allows kids to understand what has happened and equip carers with skills to help with the healing process. This program is currently available to families in Townsville and on the Gold Coast'. (www.actforkids.com.au/work_counselling.php)
    - Phoenix House described on their website as 'a charitable community based organisation committed to the provision of a safe, supportive service which assists those members of our community who have been harmed, are at risk of harm, and/or are willing to address their own harmful behaviours, using a public health approach to the prevention of sexual violence'. (www.phoenixhouse.com.au)
    - Sunshine Cooloola Services Against Sexual Violence including Laurel House at Maroochydore and Laurel Place at Gympie provides sexual assault counselling for children and adults and counselling for children up to 12 years of age who display sexualised behaviours.

Current challenges

The Scoping Project consultation process identified a number of strengths and gaps in the service system. Whilst these service system issues were identified almost four years ago, the issues are still relevant.

Identified strengths include the capacity of specialist services (as described in the service delivery and partner agency sections above) to work in collaboration with local service providers across Queensland for joint care planning, consultation and provision of specialist assessment and treatment, and the delivery of training to enhance the service system's capacity to respond to the needs of children and young people. For example, in 2011 ETS staff provided training regarding sexual behaviour problems to over 100 people including carers (foster and kinship), Child Safety Services staff, non-government service providers, and others.

Identified service system challenges and gaps include issues relating to legislation (information sharing and enabling involuntary intervention), limited capacity of specialist services, equitable service availability across the state, the availability of specialist training, and quality assurance of training offered.

The Scoping Project review report (Attachment 2) and *Training and Supervision: The Queensland Context Discussion Paper* (Attachment 3) contains a more comprehensive description of gaps within the service system and challenges relating to quality, accessible training.

Suggestions for improvement

The Scoping Project made a number of recommendations outlined in the:

- Scoping Project review report (Attachment 2)
- *Training and Supervision: The Queensland Context Discussion Paper* (Attachment 3)
- Interagency Practice Paper: *Issues in building an interagency response to the needs of children and young people with identified sexually abusive behaviours* (Attachment 4).

As recommended by the outcomes of the Scoping Project, it is my opinion that the current Queensland government response to children and young people in, or are at risk of entering, the child protection system who have experienced sexual abuse, display problem sexual behaviours, and / or have sexually offended, could be improved by:

- The establishment of a high level cross-government forum, or ownership by a pre-existing forum, to provide leadership for the discussion and development of enhanced response to the needs of children and young people in the target groups, including:
    - Endorsement and implementation of common language concepts to facilitate communication and access to existing services.
    - A thorough cross-government review of the current distribution, accessibility and nature of available services relevant to the target groups.
    - Review of service responses and training requirements of service providers in the areas of accommodation, lifestyle support, carers etc, to enhance the service system's ability to meet the needs of children and young people in the target groups.
    - Development and implementation of a planned collaborative approach to addressing service delivery gaps, including the establishment of interdepartmental agreements to enhance collaborative practice.
- Education to staff about the application of legislation and policy regarding information sharing about children and young people in order to facilitate interagency collaboration.
- Reinforcement of the expectation that local leaders/managers are to invest in established networking activities in local areas to build relationships and thus enhance interagency collaboration.
- Each key agency to ensure internal data collection systems have the capacity to identify children and young people in the target groups.
- Review current departmental policy, practices and protocols to ensure appropriate and consistent responses to children and young peoples' sexuality, sexual development and sexual behaviours (including sexual behaviour problems, sexually abusive behaviours and sexual offending).
- Establish standardisation and accreditation of services including training, case management and therapy for the identified target groups in Queensland.

Declared before me at 15 Butterfield St, Herston this 16 day of October 2012.

Jennifer Mathews

JUSTICE OF THE PEACE
ATTORNEY-GENERALS DEPARTMENT
Reg. No. 69339
QUALIFIED

Signature of officer Janet Martin Witness Signature

Evolve Therapeutic Services
Child and Youth Mental Health Service
Royal Children's Hospital and Health Service

Project Plan

Responding to the needs of children and young people with identified sexually abusive behaviours.

Project statement

The scoping project aims:

- To identify and outline the manner in which the needs of children and young people with identified sexually abusive behaviours are currently addressed across Queensland Health Evolve Therapeutic Services, Department of Child Safety, Department of Education, Training and the Arts, Department of Communities, and Disability Services Queensland Child Safety Behaviour Support Teams.
- To identify and outline existing gaps in current service provision, highlighting opportunities within the service system for future development.
- To increase the knowledge of current staff of Queensland Health Evolve Therapeutic Services, Department of Child Safety (Child Safety Officers), Department of Communities (Youth Justice), Department of Education, Training and the Arts (Guidance Officers and Behaviour Support staff), and Disability Services Queensland Child Safety Behaviour Support Services, in the stated area through training.

This project will include all children and young people across the service system described including but not exclusively children and young people involved in the child protection system.

Relevant outcome/ partnership area/s
The following partners will be referred to as the key agencies for the remainder of this document:

- Queensland Health Evolve Therapeutic Services,
- Department of Child Safety
- Department of Communities
- Department of Education, Training and the Arts , and
- Disability Services Queensland Child Safety Behaviour Support Teams

Document revision history

Version	Date	Prepared by	Comments
One	September 2008	Tania Withington	Initial Project Plan for approval
Two	October 2008	Tania Withington	Final Project Plan (Endorsed Child Safety Directors Network November 4, 2008)

Part A: Business Case

Project scope

Purpose
To contribute to the key agencies understanding of existing service responses and service gaps, and to enhance the current service system capacity, when responding to the needs of children and young people with identified sexually abusive behaviours.

Potential Benefits

Achievement of the project purpose should contribute to the following benefits:

- Current status report which can be used interdepartmentally for future planning of service responses
- Improved communication about the issue between the key agencies
- Documenting current service system responses to the needs of children and young people with identified sexually abusive behaviours.
- Identification of opportunities to improve current service system responses to the needs of children and young people with identified sexually abusive behaviours.
- Increased knowledge based on the most recent evidence of current staff within the Department of Child Safety (Child Protection Officers), Department of Education, Training and The Arts (Guidance Officers and Behaviour Support staff) Disability Services Queensland Child Safety Behaviour Support Services, and Queensland Health Evolve Therapeutic Services.

Rationale
The Evolve Interagency Services State-wide Steering Committee have received numerous anecdotal reports from Evolve Interagency Service Panel's that a high number of children and young people are being referred to the service with identified sexually abusive behaviour. A review in September 2007 revealed 26.5% of young people referred to Evolve Interagency Services reportedly exhibited sexually abusive behaviours. These behaviours reportedly affect placement, educational engagement and access to services. Department of Education, Training and the Arts, Child and Youth Mental Health Services, and the broader community as highlighted by multiple media reports, have also identified concerns regarding children and young people with sexually abusive behaviour. The Evolve Interagency Services State-wide Steering Committee have noted that a multifaceted approach to enhancing the capacity of services to respond to this issue across the broader service system is required.

A literature review published by Family Planning Queensland commissioned by the Department of Child Safety noted the shortage of clear information in the literature regarding children and young people in care with identified sexual behaviour problems (Brennan 2008). There are limited specialised therapeutic services available to respond to this complex issue.

Strategies

- Develop Project Plan
- Consult with Child Safety Directors regarding draft project plan
- Plan endorsed by Evolve Interagency Services State-wide Steering Committee
- Plan endorsed by Child Safety Directors Network
- Form Advisory Committee
- Consult and review literature
- Consult and collaborate with key agencies and identified training partners
- Consult and review existing key agency documentation
- Complete Practice Paper
- Complete Project Report including options for future directions

Aim/Objectives	TASK	TIMELINE
To increase the knowledge of current staff of key agencies	*Coordination and facilitation of training* Consultation regarding training needs with: • Evolve Therapeutic Services • Department of Child Safety • Department of Education, Training and the Arts • Disability Services Queensland Child Safety Behaviour Support Services • Non-Government Organisation's (NGO) identified by Department of Child Safety and Evolve Therapeutic Services Consultation and collaboration regarding training options with identified training partners: • Child and Youth Forensic Outreach Service • Sexual Abuse Counselling Service (SACS) • Family Planning Queensland (FPQ) • Other relevant training providers as identified Facilitate links between services to provide training and services to be in receipt of training. Provide training to Evolve Therapeutic Services. Proposal for ongoing training opportunities for Evolve Therapeutic Services Proposal for future training opportunities and strategies for the key agencies including initial exploration of training opportunities for NGO's, residential carers and foster carers	Report on progress at 2 and 4 months Complete at 6 months
To increase the knowledge of current staff of key agencies	*Practice Paper* Conduct a literature review identifying key principals in best practice approaches to responding to the needs of children and young people with identified sexually abusive behaviours from an interagency framework.	Report on Progress at 3 months Complete at 6 months
To increase the knowledge of current staff of key agencies And To identify and outline existing gaps in current service provision, highlighting opportunities within the service system for future development.	*Development of common language to be used across key agencies* Review Literature Review each key stakeholder current documentation including, policies practice papers, guidelines and the like.	Report on Progress at 2 and 4 months Complete at 6 months
To identify and outline existing gaps in current service provision, highlighting opportunities within the service system	*Mapping Exercise* Identify the nature and extent of the problem across the key agencies including the current methods of addressing the needs of children and	Report on progress at 2 and 4 months Complete at 6 months

for future development.	young people with sexually abusive behaviours. Identify services funded to work with identified population across state and current responses to identified need Identify existing linkages between services i.e. MOU, informal practice links reported etc Identify existing related projects across key stakeholders Broadly map current service system and identify opportunities for service system development	

Assumptions

- The project will remain a priority for the Child Safety Directors Network.
- The project will remain a priority for the key agencies.
- Required resources to support the project will be available for the life of the project from Queensland Health Evolve Therapeutic Services.
- Required resources to participate in project will be available for the key agencies, for example release of staff for training purposes, release for consultation, release of relevant documentation by all key agencies including de-identified data, policies, guidelines and the like.

Constraints

- The project incorporates multiple and possibly competing goals that may result in a lack of clarity regarding project direction and achievable outcomes.
- As the project goals are broad, the project may be subject to an expanding scope that may impact upon the ability to achieve original and developing outcomes within the project timeframe.
- Resources required from agencies other than that hosting the project may not be available within the project timeframe i.e. time to attend meetings, time and practical resources to provide training
- Multiple partners may experience competing priorities that may result in a lack of clarity regarding project direction and achievable outcomes.
- The time consumed in routine organisational administrative tasks may impact upon the project timeline.
- Timely completion of the training component of the project is dependent upon the training partners/ providers and the training recipient/s taking responsibility to undertake the training.
- Data clearly identifying children and young people with sexually abusive behaviours problems is not readily available across the key partners thus describing the extent and nature of the current problem will be significantly limited.

Exclusions

The project will not include:

- Project Coordinator will not be providing direct clinical services.
- Training for biological family members or foster carers
- Culturally specific literature review
- Culturally specific training
- Specific search for data relating to specific cultural groups
- Provision of information and/or training specifically relating to the broad field of sexual abuse of children
- Development of policy, protocol or procedures

Other issues may arise that are not identified as part of this project. These issues will be noted, and they will be reported to Project Advisory Group and as part of the feedback at the conclusion of the project, including as recommendations for future directions as appropriate.

Related activity/projects

The Child and Youth Forensic Outreach Service (CYFOS), Sexual Assault Counselling Service (SACS) and Family Planning Queensland (FPQ) currently provide training to a range of stakeholders. These three services have been identified by the Evolve Interagency Services State-wide Steering Committee as training partners for this project.

Project partners/clients/stakeholders

Partners

- Queensland Health specifically Child and Youth Mental Health, Evolve Therapeutic Services, and Child and Youth Forensic Mental Health Services
- Department of Child Safety
- Department of Communities specifically Youth Justice and Non-Government Organisations as negotiated
- Department of Education, Training and the Arts
- Disability Services Queensland specifically Child Safety Behaviour Support Services

Other key stakeholders working with children and young people with identified sexually abusive behaviours

- Relevant Non-Government Organisations
- Residential Service Providers
- Foster Carer Agencies
- Family Planning Queensland (FPQ)
- Sexual Abuse Counselling Service (SACS)
- Griffith Adolescent Forensic Assessment and Treatment Centre (GAFATC)
- Face-Up (Mater)

Project timeframe

September 2008 – February 2009

Costs

Project costs

Labour Costing	* Costing at HP6 is dependent upon Stage 2 evaluations of the HP reclassification process Sept	Oct	Nov	Dec	Jan	Feb	Total
HP4	$6,448.40	$6,448.40	$6,448.40	$6,448.40	$6,448.40	$6,448.40	**$38,690.40**
PD Allow	$125.00	$125.00	$125.00	$125.00	$125.00	$125.00	**$750.00**
RL	$1,128.47	$1,128.47	$1,128.47	$1,128.47	$1,128.47	$1,128.47	**$6,770.82**
LSL	$112.85	$112.85	$112.85	$112.85	$112.85	$112.85	**$677.08**
SL	$193.45	$193.45	$193.45	$193.45	$193.45	$193.45	**$1,160.71**
Super	$609.02	$609.02	$609.02	$609.02	$609.02	$609.02	**$3,654.10**
							$51,703.11

	Sept	Oct	Nov	Dec	Jan	Feb	Total
HP6*	$7,553.20	$7,553.20	$7,553.20	$7,553.20	$7,553.20	$7,553.20	**$45,319.20**
PD Allow	$125.00	$125.00	$125.00	$125.00	$125.00	$125.00	**$750.00**
RL	$1,321.81	$1,321.81	$1,321.81	$1,321.81	$1,321.81	$1,321.81	**$7,930.86**
LSL	$132.18	$132.18	$132.18	$132.18	$132.18	$132.18	**$793.09**
SL	$226.60	$226.60	$226.60	$226.60	$226.60	$226.60	**$1,359.58**
Super	$711.43	$711.43	$711.43	$711.43	$711.43	$711.43	**$4,268.59**
							$60,421.31

Non - Labour Costing

Administrative		
Stationary	$ 1,200	
Photocopying	$ 3,000	
Publication	$ 1,000	
sub total	***$ 5,200***	
Travel		
Airfares	$ 400	(1 xReturn Airfare to North Qld)
Accommodation	$ 345	(based on 3 nights accomm)
Meals & Incidentals	$ 240	(based on 3 nights accomm)
Fuel	$ 2,500	
sub total	***$ 3,485***	
Telecommunications		
Mobile Phone charges	$ 500	
RAS Rental	$ 200	
sub total	***$ 700***	
total	***$ 9,385***	

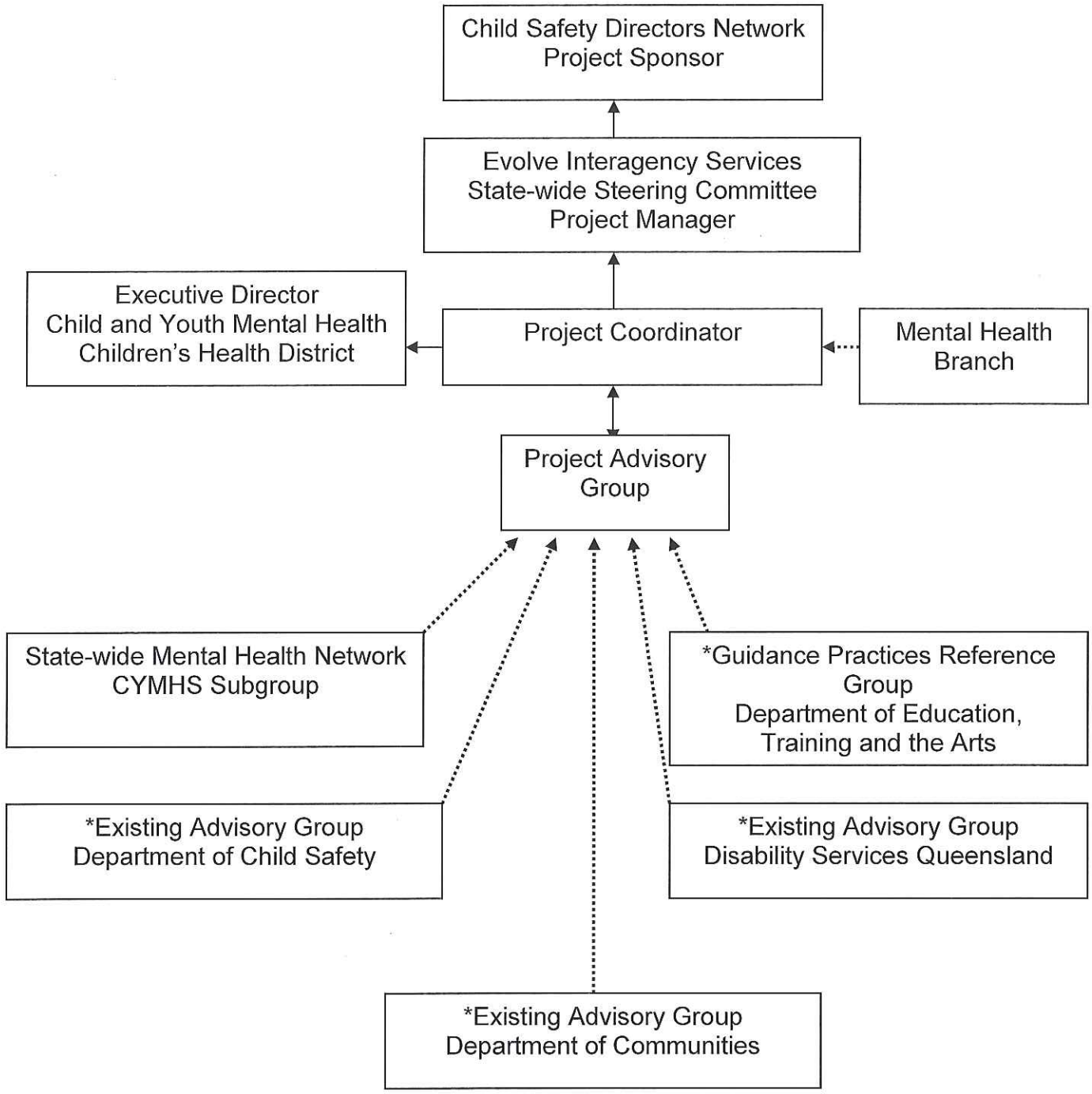
Resource contribution from stakeholders

- Key agencies release of staff to attend Advisory Group, participate in consultation, and attend training. There will be no funds available from the project to pay for staff release.
- Training provided by a training partner, within scope of project may attract a fee. Any fees will be negotiated between the training provider and the training recipient/s.

Part B: Project Management

Human resource management

Governance Structure



*Directors of Child Safety will provide relevant contact persons to enable identification and engagement with these advisory groups

Roles and responsibilities

Project role	Name/s	Responsibilities
Project Coordinator	Tania Withington	Complete Project. Produce Report
Executive Director CYMHS RCH CHSD	Denisse Best	Line Manager of Project Coordinator
Project sponsor: Child Safety Directors Network	Corelle Davies Senior Director	Maintain project as a priority and communicate priority status to key agencies Identify and enable access to key agency representatives and staff Problem solve blockages that put project at risk Identify capacities and options for future collaboration and service enhancement
Project Manager Evolve Interagency Services State-wide Steering Committee	Corelle Davies Senior Director	Report project progress to Child Safety Directors Network regularly Problem solve blockages that put project at risk Identify and enable access to key agency representatives and staff Identify capacities and options for future collaboration and service enhancement
	Project Advisory Group	Assist in reaching the completion of the Project Provide sounding board Assist with problem solving Provide feedback on documentation as requested

a) **Key decision points**

Key project decision points	Higher authority for approval/sign-off
Approval of project plan	Child Safety Directors Network
Release of project funds	Executive Director CYMHS RCH & HSD
Status reports	Child Safety Directors Network through Evolve Interagency Services State-wide Steering Committee
Exception reports	Child Safety Directors Network through Evolve Interagency Services State-wide Steering Committee
Significant variations to project plan	Child Safety Directors Network through Evolve Interagency Services State-wide Steering Committee
Approval to progress to finalisation phase (final status report)	Child Safety Directors Network through Evolve Interagency Services State-wide Steering Committee
Project completion report	Child Safety Directors Network through Evolve Interagency Services State-wide Steering Committee

Project Schedule

Strategy/Activity	Accountable Officer/s	Duration	Months											
			Sept	Oct	Nov	Dec	Jan	Feb						
Final Draft Project Plan tabled at Evolve Interagency Services Steering Committee	Project Coordinator													
Establish Project Advisory Group														
Coordination and facilitation of Training														
Literature Reviews														
Documentation Reviews														
Mapping														
Draft Practice Paper														
Draft Final Report														
Consult with Project Advisory Group on Draft Final report and Draft Practice Paper														
Table Draft Final Report and Draft Practice Paper at Evolve Interagency Services Steering Committee														

Risk management

Risk	Risk Management Activities	
	Preventive	**Contingent**
The project incorporates multiple and possibly competing goals that may result in a lack of clarity regarding project direction and achievable outcomes or scope creep.	Development of a clear project plan identifying parameters of the project and signed of by the Child Safety Directors Network prior to implementation. Development of a Project Advisory Group incorporating representation from key agencies. Key decisions to be signed off by Evolve Interagency Services State-wide Steering Committee and/or Child Safety Directors Network for the life of the project.	
Resources required from agencies other than that hosting the project may not be available within the project timeframe i.e. time to attend meetings, time and practical resources to provide training	Ongoing consultation with Project Advisory Group . Regular reporting to Project Manager and Project Sponsor	
Multiple partners may experience competing priorities and political agendas which may impact upon expectations of the project.	Ongoing consultation with Project Advisory Group. Regular reporting to Project Manager and Project Sponsor	
Quantitative data clearly identifying children and young people with sexual behaviours problems is not readily available across the key partners thus describing the extent and nature of the current problem will be significantly limited.	Acceptance that quantitative data will be limited. Alternative information sources such as published research, qualitative data etc will be utilized for project.	
Timely completion of the training component of the project is dependent upon the training partners/ providers and the training recipient/s taking responsibility to undertake the training.	Ongoing consultation with Project Advisory Group. Regular reporting to Project Manager and Project Sponsor	

Quality management

Quality standards/benchmarks/guidelines

The project will be undertaken within a continuous quality improvement framework.

Project evaluation

Achievement of objectives will result in

- Final Report tabled
- Practice Paper tabled
- Status reports provided
- Meeting Minutes and notes
- Training Evaluation Summary

Communication management

Communication

What	How	With/To Whom	When/how often
Project planning and implementation	Email Meetings	Project Advisory Group	To be negotiated
Status Reports	Email Meeting attendance	Evolve Interagency Services State-wide Steering Committee / Child Safety Directors Network	As negotiated / as invited
Project promotion	Attend Meetings/Forums	Key agencies and stakeholders	As negotiated

Information management

Document Type/Name	Electronic Location	Hard copy location
Project Plan		
Practice Paper (Draft)		
Final Project Report (Draft)		
Training Materials (Draft)		

Procurement and cost management

Queensland Health Evolve Therapeutic Services funding will cover the cost of the six month project from within the 2008-2009 budget allocation. The Project Coordinator will be managed by Child and Youth Mental Health Services, Royal Children's Hospital and Health Service District.

References

Brennan, H., (2008) ***Settings and Solutions: Supporting access to sexuality and relationships information for children in care***. Family Planning Queensland www.fpq.com.au

Scoping Project:

Responding to the needs of children and young people with identified sexually abusive behaviours

A Review

September 2008 – February 2009

Executive Summary

EXECUTIVE SUMMARY

The following paper is a review of the *Scoping Project: Responding to the needs of children and young people with identified sexually abusive behaviours.* The review aims to provide understanding of the issues relating to supporting children and young people with sexually abusive behaviours in Queensland and draws upon extensive consultation with relevant Queensland service providers as well as national and international evidenced based practice.

A review of the literature indicated that:

- Sexual development is a lifelong task that is multi-dimensional incorporating biological, psychological and socio-cultural factors.
- Knowledge about the sexual development and sexual behaviour of children and young people is limited.
- Research cannot identify clear pathways or specific predictors and risk factors for the development of sexual behaviour problems, sexually abusive behaviours or sexual offending in children and young people.
- Children and young people with sexual behaviour problems are frequently exposed to a multitude of familial, social, cultural, economic, material and educational disadvantage, to which they display negative behavioural responses.
- The resulting problems faced by the client group/s are varied and complex and impact across multiple support systems.
- Multi-systemic interventions customised to individual and contextual factors are the most effective in addressing and reducing sexual behaviour problems, sexually abusive behaviours and sexual offending in children and adolescents.
- Best practice incorporates collaborative intervention options across families, schools, child protection, juvenile justice and therapeutic treatment services, and that these interventions are not necessarily long term or intrusive.

In an attempt to understand the nature and extent of the problem in Queensland a small study was completed with data provided by a small number of government and non-government services. Overall, the resulting data is comparable to national and international data. What is most noteworthy is that there does appear to be a significant number of children and young people with sexually abusive behaviours in Queensland and that these client groups are particularly present in intensive support services.

A broad mapping of existing funded organisations was undertaken and revealed a concentration of specialist services for children and young people in the Brisbane area, limited access to services in larger regional and rural areas, and an absence of services in Far North Queensland. The two state-wide services reported limited capacity to meet the need across the state due to eligibility and resource limitations.

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

- Service availability.
- Service knowledge, skill and access to training.
- Service availability and knowledge with regards to special needs groups such as disability and mental health.
- Indigenous issues.

- Carer issues.
- Legislation and policy issues.

In many respects, the outcomes of the Scoping Project are not unexpected. The Project arose due to reports of increasing concern in multiple contexts of the numbers of children and young people with sexually abusive behaviours and the service systems' apparent inability to fully respond to the needs of these groups. This report provides a benchmark against which the nature and extent of the problem over time, and the performance of the service system in responding to the relevant needs can be measured.

In order to facilitate immediate to long term change in the service system in Queensland a number of recommendations have been made. These include:

- The establishment of a high level cross-government forum or ownership by a current forum, to provide leadership for the discussion and development of the Queensland response to the problem.
- Endorsement and implementation of the common language concepts developed through the Scoping Project.
- Endorsement and implementation of the *Training and Supervision: The Queensland Context* Discussion Paper options.
- Endorsement and circulation of appendices including service mapping and core language concepts to facilitate access to existing services and communication.
- Education to staff about applying legislation and policy regarding information sharing about clients in order to facilitate interagency collaboration.
- Advocating for legislative change to provide the legal framework to improve information exchange and collaborative work with the child/young person and their family.
- Reinforcement of the expectation that local leaders/managers are to invest in established networking activities in local areas to build relationships and thus enhance interagency collaboration.
- Influence internal research/scholarship programs to enhance a focus on prioritisation of this population.
- Review current departmental policy, practices and protocols to ensure appropriate and consistent responses to children and young peoples' sexuality, sexual development and sexual behaviours (including sexual behaviour problems, sexually abusive behaviours and sexual offending).
- Establish standardisation and accreditation of services including training, case management and therapy for the identified client groups in Queensland.
- A standard data set be developed, collected and shared across Key Agencies to assist in monitoring and managing the problem in Queensland.
- A cross-government review of the current distribution, accessibility and nature of available services relevant to the client groups be undertaken and a planned collaborative approach to addressing the gaps be developed and implemented.
- Establish interdepartmental agreements to enhance collaborative practice.
- Review service responses in areas of accommodation, lifestyle support, carers etc, to facilitate adequate service responses, appropriate training and supervision, and collaborative practice with all other aspects of the relevant service system.

1. INTRODUCTION

This review aims to:

- Identify the nature and extent of the problem of children and adolescents with sexual behaviour problems, sexually abusive behaviours and sexual offending in Queensland.
- Identify and outline the manner in which the needs of the client group/s (children and adolescents) are currently addressed in Queensland.
- Identify and outline existing gaps in current service provision, highlighting opportunities within the service system for future development.

A number of strategies were utilised to identify the nature and extent of the problem and the current service response in Queensland. These strategies included:

- A broad consultation across government and non-government agencies.
- A brief review of the literature.
- A service mapping exercise.
- Data collection.

The Key Agencies involved in the Scoping Project included:

- Queensland Health (QH), specifically Child and Youth Mental Health, Evolve Therapeutic Services and Child and Youth Forensic Mental Health Services.
- Department of Child Safety (DChS), including the Sexual Abuse Counselling Service.
- Department of Communities (DoCs), specifically Youth Justice and funded Non-Government Organisations as negotiated.
- Department of Education, Training and the Arts (DETA).
- Disability Services Queensland (DSQ), specifically Evolve Behaviour Support Services.

Key Stakeholders identified for the purposes of this Scoping Project are organisations that currently provide a range of services in the relevant field/s. These included:

- Family Planning Queensland (FPQ).
- Mater Family and Youth Counselling Services (FYCS).
- Griffith Youth Forensic Services (GYFS).

Other Stakeholders identified for the purposes of this Scoping Project included organisations that provide services directly or indirectly to the client group such as non-government agencies.

The terms Key Agencies, Key Stakeholders and Other Stakeholders will be used throughout this document to refer to these services.

2. THE NATURE AND EXTENT OF THE PROBLEM – A BRIEF SUMMARY OF THE LITERATURE

There are a number of challenges presented in gathering data both nationally and internationally on childhood and adolescent sexuality and sexual behaviours. Restrictions include ethical considerations regarding research and analysis of children and adolescents, ideological and historical belief systems that children

cannot be perpetrators of sexually abusive behaviours, community reluctance to report sexual abuse and sexual assault and reluctance on behalf of service providers to label or record data on children presenting with sexually abusive behaviours. One Australian study found that agencies providing services to victims of sexual assault were unwilling to become involved with young sexual offenders despite the fact that many of these young people were also victims of sexual abuse themselves [1]. A further example of data recording problems is found in relation to interfamilial sexual abuse, specifically sibling sexual abuse, which is highlighted in developing research as twice as common as adult-child sexual abuse, yet it appears to be under-reported, under-prosecuted and under-recorded in Australia and internationally [2].

Research is further hampered by national and international debate regarding what constitutes 'normal' and deviant sexual behaviour in children and adolescents. Definitions of 'normal' and deviance' are subjective, socially and culturally specific and often contingent on the context of the sexual behaviour. In addition to disparities in definition, challenges in research in this field to date include methodological difficulties such as insufficient empirical data and difficulties with data set comparability. Researchers do agree however, that the groups of children and adolescents who engage in sexually abusive behaviours are heterogenous and a response to this problem must be multi-systemic and customised to individual and contextual factors [3].

2.1 Sexual Development and Sexual Behaviours Of Children and Adolescents

Sexual development is a gradual process that begins before birth and continues across the lifespan [4-6]. Sexual development including sexual knowledge and sexually explorative play is a part of healthy childhood development [7-10]. A child's interest in sexuality is generally balanced by curiosity about other aspects of life [7]. Childhood sexual play is motivated primarily by curiosity, thus the qualities of each individual child's temperament, personality and cognitive potential plays a role in childhood sexual behaviours, as does the context in which the behaviour develops and occurs [11].

Despite strong societal beliefs about what constitutes healthy sexual development in adolescents, there is very little data available [11]. Beliefs about healthy sexual behaviours are typically defined by the community culture, moral standards and socially defined gender roles. Research investigating adolescent sexuality typically focuses on behaviours such as age at first intercourse, contraception and sexually transmitted diseases. While the research exploring healthy sexual development in adolescence is limited, it does demonstrate that psychosexual development is multidimensional, incorporating biologic, psychologic, and socio-cultural factors [5].

Unusual sexual behaviours are typically understood as those that fall outside an expected range of sexual behaviour for a specific age group or gender role norm. The challenge for all observers of sexual behaviour is that unusual behaviours are evaluated on the presumption that usual behaviours are known. Whether a sexual behaviour is illegal or not depends on the law governing the community in which a person lives [11].

Although studies of children and adolescents with sexual behaviour problems, sexually abusive behaviours and sexual offending cannot identify clear pathways or specific predictive or risk factors, research does indicate a number of commonalities present in these client groups.

A literature review of 14 published studies summarised the current evidence and found that children who engage in problem sexual behaviours are frequently exposed to a multitude of familial, social, cultural, economic, material and educational disadvantages and that these children frequently display negative behavioural responses to this disadvantage [12]. The factors consistently found in the backgrounds of children with sexual behaviour problems include:

- An over representation of males.
- High rates of sexual, physical and emotional abuse by caregivers
- Exposure to domestic violence.
- High levels of anger, anxiety, sexual and substance abuse, and parent-child relationship problems in adult caregivers.
- Very low income families frequently living below the poverty line and large biological family groups.
- High levels of other maladaptive behaviours including high rates of disobedience, physical fights and property damage, commonly diagnosed with Attention Deficit Hyperactivity Disorder, Conduct Disorder and/or Oppositional Defiant Disorder.
- High levels of externalising and internalising problems, low levels of empathy, restricted affective experience and higher incidence of depressive symptoms.

Studies of adolescents convicted of sex offences reveal a similar set of complex contextual and individual factors that may indicate possible risk pathways [9,13-22]: These include;

- Over representation of males.
- Low socio-economic status of biological family.
- Lack of parental involvement, poor parental supervision, poor parent-child relationship, harsh and or inconsistent/lax parenting styles.
- Parents with anti-social personality types, including criminality, sexual deviance, and substance misuse.
- Abuse (particularly physical) and neglect by parents.
- Multiple out of home placements.
- Academic under achievement and learning difficulties (particularly verbal skills deficits, planning skills and impulse control).
- Diagnosis of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, Depression, Anxiety and Post Traumatic Stress Disorder.
- Anti-social attitudes and behaviours and involvement in anti-social peer groups.
- Poor emotional and behavioural regulation.
- Social isolation of biological family and/or adolescent.

While there are no empirical studies regarding sexual behaviour problems in Australian indigenous children (or indigenous adolescents specifically), the above factors are reportedly highly prevalent in Australian indigenous communities [23, 24]. A recent Australian review of sexual behaviour problems in indigenous children theorised that these factors may be significant contributors to the anecdotally reported high prevalence of sexual abuse and childhood/adolescence sexual behaviour problems [25].

A recent longitudinal study of Queensland children found that childhood abuse and neglect had the most detrimental effect and thus was the most likely risk factor to developing offending behaviours [26]. It must be noted however, and the study clearly indicates this, that not all children exposed to abuse and neglect go on to offend. Correlating factors play a strong role in the occurrence of sexually offending

behaviour and whether it is limited to adolescence or goes on to be a lifelong problem.

Available evidence suggests that the developmental adversities associated with the onset of problematic sexual behaviours in youth generally (i.e. trauma, attachment disruption and family dysfunction) also occur in the lives of youth with disabilities. Particular issues that may adversely effect the sexual development of youth with disabilities include limited opportunity for social development, social isolation, limited sexual education, lack of privacy, lack of opportunity to experience normative and appropriate sexual interactions, specific difficulties in communication and the impact of genetic and medical factors [27].

Research suggests that the children and young people with sexual behaviour problems, sexually abusive behaviours or sexual offending, face varied and complex problems over time. These problems include disrupted developmental pathways, co-morbid mental health problems (e.g. depression, anxiety, trauma and attachment symptoms, conduct disorder), social isolation, poor self concept and low self esteem, and learning problems [17, 28-30]. This frequently results in multiple accommodation and school placement breakdowns, educational underachievement, association with anti-social peer groups, vulnerability to the abusive behaviour of others and an escalation of general delinquent behaviours including sexually abusive behaviours.

In summary, the literature indicated that children and adolescents who present with sexual behaviour problems, sexually abusive behaviours and sexual offending are a heterogenous group with diverse characteristics and treatment needs. Researchers and scholars are moving to place an emphasis on situational and contextual factors contributing to sexual behaviour problems in children and young people, and moving away from 'blaming the individual' [31, 32]. The establishment of theoretical models and conceptual frameworks for understanding are still developmental, particularly for children under 12 years where research is still in its infancy.

2.2 Prevalence

It is very difficult to estimate the prevalence of the problem of children with identified sexually abusive behaviours either nationally and internationally, as there have been no published attempts to gauge the rates of children under 10/12 years of age who engage in sexually abusive behaviours [12]. Research investigating the problem is hampered by an absence of clear definitions about how to define children's sexual behaviour, and under-reporting and/or under-recording of the problem by adult caregivers and professionals. The Crime and Misconduct Commission Enquiry reported that 11% of children in care in Queensland had problem sexual behaviours with less than 2% identified as 'sexual offenders' [33].

There are reportedly no studies upon which to base population estimates of the prevalence of sexually abusive behaviours during adolescence. There is very little information available regarding adolescents engaging in problem sexual behaviours who have not been identified in the justice system [34], and it must be noted that sexual abuse generally is under-reported.

The majority of young people reportedly committing sexual offences are male however there is a growing recognition in the literature that adolescent girls also engage in sexually abusive behaviours. International research indicates between 2% and 9% of all juvenile arrests for sexual offences, excluding prostitution, are

female [35-39]. These studies argue that there are some distinct differences in the presentation and intervention needs of female adolescent sexual offenders, however the studies are small and diverse and further research is required.

The 'peak' ages for male sexual offending is thought to be at 14 years and mid to late 30's [40]. Some international researchers argue that adolescent males commit up to 50% of all sexual offences against children and up to 30% of all rapes against adolescent girls and adult women. Queensland Police data for 2005, reports the percentage of young people committing sexual assaults in Australia is between 9% and 16% (14.9% of all sexual abuse cases prompting police involvement in Queensland) [13]. Factors such as low conviction rates for juvenile sex offending, and under-reporting associated with all sexual assaults, may result in data under-representing the prevalence of the problem nationally and internationally.

Young people who engage in sexually abusive behaviours and/or who sexually offend tend to undertake the behaviours with young children or peers, although adults can also be the recipients of these behaviours. The limited Australian research available indicates that peer-aged victims of adolescent sex offences tend to be female, and that child victims are equally male and female [41]. Victims are believed to be individuals who are available and accessible, rather than related to an arousal interest [42].

Research suggests that sibling sexual abuse is more common than sexual abuse perpetrated by a parent or step-parent [42, 43], and that younger siblings with developmental or intellectual delays are at higher risk of sexual victimisation. Sibling sexual abuse is reportedly more intrusive, extends over longer periods and often involves multiple perpetrators [2, 3, 42].

2.3 Risk and Recidivism

Current evidence supports the fact that adolescent sex offenders are low risk for committing future sexual crime, and that children with sexual behaviour problems appear to pose an even lower risk, particularly where intervention occurs.

The single study available indicates that as a group, children with sexual behaviour problems pose a low long term risk for future child sexual abuse perpetration and sex crimes, approximately 2-10% at 10 year follow up depending upon the type of treatment received [44]. This randomised treatment intervention study also compared children with sexual behaviour problems and children with general behaviour problems (i.e. Attention Deficit Hyperactivity Disorder or learning problems) and found that the long-term sex crime risk of children treated for sexual behaviour problems was no different to the risk of children with no history of sexual behaviour problems.

It is well established in the research that for adolescent sex offenders, sexual offending recidivism rates are relatively low, between 5% and 20% [3, 45-48]. However, this group is more likely to re-offend with non-sex related crime (primarily property crime and drug crime) [9]. A large study of incarcerated adolescent sex offenders that compared re-offending rates to that of incarcerated general non-sexual offenders found that at 5 year follow up the two groups had the same rate of sexual offending (6-7%) [46].

Review of individual actuarial risk assessment tools such as the Juvenile Sex Offender Assessment Protocol II (J-SOAPII) ([49]), indicate that it is the generalist risk factors (i.e. those tapping general delinquency or antisocial behaviour or

environmental instability) that are most predicative of re-offending rather than those focused on sexual deviancy [50]. These studies also reinforce the fact that risk is dynamic particularly with regard to family and environmental stability, treatment completion and other factors [51]. There are no comparable risk assessment tools for preteen children with sexual behaviour problems, with it being likely that once a child has completed treatment the long-term risk is so low that risk assessment is not required (exceptions include where a child has been exposed to long term repetitive abuse including intrusive sexual abuse).

2.4 Evidenced-Based Practice Approaches to Intervention

There is a paucity of research investigating the effectiveness of intervention with children under 12 years with sexual behaviour problems. However, the small number of available studies indicates children with sexual behaviour problems respond well to a variety of treatment modalities, all of which are relatively short-term [52, 53]. Treatment models tested to date include cognitive behavioural therapy, psychodynamic play therapy and expressive therapy. Researchers and professionals agree that the most effective interventions incorporate individual and family based treatments, and that care-giver involvement may be the essential component to effective intervention [53-56].

It is difficult to determine the treatment modality most effective in working with adolescents with sexually abusive behaviours or sexual offending due to limitations in the comparability of current research. However, meta-analysis investigating treatment effectiveness in reducing sexual offending recidivism indicated that all tested treatments are effective [57, 58]. The treatment modalities with the greatest effectiveness were cognitive behavioural therapy and multi-systemic therapy. Earlier studies indicate that increased rates of positive outcomes are achieved in adolescent sex offender treatment where services employ multiple treatment techniques i.e. individual focused intervention, group-work, family interventions, educational input and expressive therapies [59, 60]. This is consistent with the view that interventions addressing high risk and problematic behaviours, including but not isolated to sexual offending, are likely to be most effective in reducing sexual and non-sexual recidivism [49, 50, 61, 62] (note: adolescents who have sexually offended are more likely to re-offend non-sexually than sexually [48, 63]). A recent Australian review of treatment options for adolescent sexual offenders found that best practice incorporates collaborative intervention options across families, schools, child protection, juvenile justice and therapeutic treatment providers and that these interventions are not necessarily lengthy or intrusive [40].

Research of treatment effectiveness for children and adolescents with sexual behaviour problems, sexually abusive behaviours and sexual offending is in its infancy. A lack of research does not necessarily equate to treatment ineffectiveness but rather it highlights that additional research is required in this field. To date, effective treatments appear to be those that are multi-systemic and customized to individual and contextual factors.

2.5 Interagency Collaboration and Partnership

All children and young people who engage in sexual behaviour that may cause harm to others need access to a range of intervention and treatment options in order to address complex issues across a variety of settings. A multi-service response to the complex needs of the client group requires the availability of a varying array of services. These services are likely to include family support and therapy, individual support and therapy, residential, foster care and community

placement options, recreational and other activities to promote community connectedness and pro-social peer socialisation and education options. Ideally, access to the full array of services would be available regardless of potentially discriminatory factors such as age, gender, race, socioeconomic status, disability, education, religion, sexual identity and geographical location. A continuum of care service delivery model is essential as it offers multiple options in the least restrictive treatment settings, consistent with the needs of individual children, young people, families and communities [64, 65].

Collaboration in the context of legislation, organisational polices and ethical guidelines is essential across all services working with a child or young person with sexual behaviour that may result in harm to self or others [66, 67]. Collaboration enables planned and coordinated service delivery to address complex needs and enables service evaluation across multiple domains, and helps avoid duplication or incompatible interventions. The Scoping Project consultation process identified individual organisational practices and government legislation (child protection and youth justice) as barriers to collaboration in Queensland. The Project highlighted the need for legislative change, and the development of policy and protocol to facilitate and enable cross sector collaboration.

Successful treatment outcomes depend upon informed and knowledgeable collaborative community efforts [66]. Ideally those working with children and young people should be educated to recognise indicators of sexual harm and how best to respond. Educating families and the wider community regarding current evidenced-based knowledge in this field should also be part of the role of specialists in the field.

An option to assist in the development of knowledge and skill in non-specialist services is the use of collaborative partnerships. Griffith Youth Forensic Service (GYFS) conducted a study of the effectiveness of collaborative partnerships in enhancing knowledge, skills and confidence in working with adolescent sex offenders in Queensland [68]. This study focused on the collaborative partnerships of GYFS with professionals and paraprofessionals, developed on a case-by-case basis. Results indicated that collaborative partnerships were effective in enhancing knowledge, skill and confidence to work with young people who have committed sexual offences and that these improvements were maintained up to one year following the collaboration.

Research indicates that most youth who have committed sexual crimes can be safely managed in the community [66, 69]. However, some individuals require supervision to remain in community settings. Typically, supervision and management strategies require multiple formal and informal supports that are identified in collaborative safety plans [65, 47]. Supervision is utilised to facilitate client accountability and compliance with treatment as well as a means to prevent future sexually abusive behaviours. Policies and protocols are required to enable cross-government and non-government participation in this essential intervention process.

3. THE NATURE AND EXTENT OF THE PROBLEM: THE QUEENSLAND CONTEXT

The Scoping Project was unable to access data related to the nature and extent of the problem in Queensland. Key Agencies in Queensland typically do not collect data related to the sexual behaviours of children and young people. Although

some Key Stakeholders and Other Stakeholders do collect the kind of data required for the Scoping Project, they do not typically provide data to a centralised office for collation. Some services that did have relevant data available were unable to share the data at the instruction of the funding organisation (usually a Key Agency).

Queensland Police data in 2006/2007 identified youth aged 10-19 years as the perpetrators of 27% of sexual offences [70]. Griffith Youth Forensic Service (GYFS) estimate that approximately 90-100 male adolescents 10-17 years appear in Queensland courts each year charged with sexual offences [68].

The Scoping Project tasks were extended in late 2008 to include a data collection exercise with the aim of providing a brief 'snapshot' of the nature and extent of the problem of children and young people with sexual behaviour problems, sexually abusive behaviours and sexual offending in Queensland.

3.1 Methodology of Data Collection

A survey (Appendix 7) and a database (Appendix 8) were developed based on current knowledge of the field and in consultation with the Project Advisory Group. Services were given the opportunity to complete either. Strategies regarding confidential management of Project data were discussed with services at the time of initial data request. The survey requested summarised information of the total numbers of clients meeting the project definition plus a detailed de-identified case study, whereas services that elected to complete the database provided detailed de-identified information on individual clients within the scope of the project. In addition to the data collection tools developed for the Scoping Project, data was sourced from existing databases i.e. DChS Transitional Placement data, Child and Youth Mental Health Services Queensland Health Outcomes data, Evolve Therapeutic Services State-wide Referral data.

Potential data sources across government and non-government services (state-wide and localised) were identified, followed by multiple requests for data within the Scoping Project time-frame. Each participating service was asked to provide data on the total number of children and young people (0-18 years) who were referred and/or accessing and/or receiving a service in the month of October 2008. Services were then asked to identify the number of children and young people with sexually abusive behaviours in either their current presentation or history. A number of demographic and other psychosocial factors were included in the data request that have been previously identified in the research literature (section 2 of this report) as present in the stories of the client group and that are believed to contribute to a vulnerability to developing sexually abusive behaviours.

For the purpose of data collection a very broad definition of sexually abusive behaviours was employed. This step was taken in order to allow for the wide variety of terms and language used in Queensland to describe children and young people with sexually abusive behaviours and to be as inclusive as possible in the data collection exercise. The definition employed was as follows:

> *Identified sexually abusive behaviours (SAB) broadly includes non-age appropriate sexual behaviours, high risk sexual behaviours, sexual behaviour problems, sexual behaviours placing self or others at risk, sexual behaviours that cause problems for self or others in the context in which they occur.*

Sexual offending is included, but the definition is not limited to sexual offending.

For the purposes of this report, data in the first instance will be summarised separately for each organisation, attempting to estimate the prevalence of the problem (Table 4 in Appendix 6 provides a summary of the raw data). Psychosocial factors data will then be summarised together to further define the extent of the problem and to characterise this population (see Section 3.7).

3.2 Data Limitations

There are multiple limitations in the data collected for the Scoping Project. The following list highlights some of those issues.

- A small number of services identified as potential data sources were able to provide data within the Scoping Project time-frame. The majority of services approached were not able to provide data.
- The Department of Communities work extensively with the client group/s of the Scoping Project, particularly the Youth Justice Service and Youth Justice Conferencing. Data was requested from this Key Agency for the purposes of the Scoping Project however, it was not made available within the time-frame of the Project.
- Evolve state-wide referral data is drawn from those referrals to Evolve Interagency Services Panels that were allocated to QH Evolve Therapeutic Services only. Data was not available for referrals allocated to DSQ Evolve Behaviour Support Services. This data is limited further as specific behavioural difficulties are frequently identified after referrals are accepted to Evolve Therapeutic Services, rather than being reported on the referral forms. Consequently, data presented in this report may under-represent Evolve Interagency Services referrals where clients display sexually abusive behaviours.
- The DChS Transitional Placement Services data is limited as it was drawn only from material contained in applications for Transitional Placement funding.
- The DChS Transitional Placement data is reflective only of the children and young people in the care of DChS with severe and complex needs, and does not reflect the prevalence or nature of the problem across the DChS service system.
- Evolve Therapeutic Services and Evolve Behaviour Support Services completed either the data survey or the database. The method of gathering data across the state varied significantly i.e. file reviews, a clinician's immediate knowledge of own their clients, one staff member's knowledge of all clients etc, thus accuracy can not be guaranteed.
- In the state-wide CYMHS data collection, data was obtained from two QH stand alone data collection systems, Client Event Service Application (CESA) and Outcomes Information System (OIS). There are inherit complexities in integrating and ensuring the integrity of data provided from this search.
- In the state-wide CYMHS data collection, data was limited to specific items of the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and the Factors Influencing Health Status (FIHS). The data presented does not report on the additional items of either of these scales.
- The state-wide CYMHS data must be read with caution as there is variability in completing data entry across the state, and the quality of the

data is understood to be inconsistent particularly in the early years of establishing the data collection system.

- Data requests for the Scoping Project coincided with the launch of the new Mental Health Information System in CYMHS. This impacted upon CYMHS services' ability to provide data from existing databases.
- The CYMHS (Royal Children's Hospital and Logan) who completed the database, utilised a variety of data collection methods i.e. electronic database, file reviews, a clinician's immediate knowledge of their own clients etc.
- There is significant variation in eligibility criteria and available services across the organisations who contributed to the data collection i.e. mental health, sexual assault and child protection.
- There are difficulties comparing the database and the survey information as the database is more detailed.
- It is possible that there is duplication in the data collected. A single child with sexual behaviour problems could be reported by two agencies i.e. a sexual assault service and a mental health service.
- Data does not reflect those children and young people referred to private practitioners i.e. psychologists, psychiatrists, social workers.

3.3 Child and Youth Mental Health Services (CYMHS)

CYMHS provide mental health assessment and intervention for children and young people 0-18 years and their families in community clinic and inpatient facilities across Queensland.

CYMHS data was accessed in two ways. Firstly, state-wide CYMHS data was obtained from two stand alone data collection systems, CESA and OIS, in an attempt to identify those CYMHS clients potentially vulnerable to developing sexually abusive behaviours, as defined below. Secondly, a number of CYMHS community clinics were approached to identify children and young people currently accessing the service with identified sexually abusive behaviours.

3.3.1 State-wide collection

CYMHS do not collect data specifically with regard to the client group. However, all CYMHS clinicians (including Evolve Therapeutic Services) collect data as part of measuring client outcomes on a three monthly cycle. Two of these measures are particularly relevant to the Scoping Project data collection exercise, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and the Factors Influencing Health Status (FIHS). The HoNOSCA is a 15-item clinician rated measure used in the assessment of children and adolescents consumer outcomes in child and youth mental health services. Individual items are scored on a 1-4 scale, with scores 2 and above indicating clinical significance. The FIHS measure is a clinician rated checklist that identifies the degree to which a child or adolescent has complicating psychosocial factors that require additional clinical input during a mental health service admission. The FIHS comprises of seven items, which are scored as either being present or not present. The HoNOSCA is collected at the beginning of a episode of care in a mental health service and every three months afterwards. The FIHS is not collected at first point of contact but rather every three months afterwards. HoNOSCA and FIHS are both collected at discharge from mental health services.

The items selected from these measures for data collection reflect some of the key vulnerabilities to developing sexual behaviour problems reflected in the brief literature review earlier in this report. The Items included:

- HoNOSCA Item 1 - Problems with disruptive, antisocial or aggressive behaviours.
- FIHS Item 1 – Maltreatment Syndromes.
- FIHS Item 2 – Problems related to negative life events in childhood.
- FIHS Item 3 – Problems related to upbringing.
- FIHS Item 5 – Problems related to social environment.
- FIHS Item 7 – Problems related to other psychosocial circumstances.

A state-wide data search was undertaken by the Queensland Mental Health Clinical Improvement Team for all outcomes data entered into OIS from its inception in 2003 through to November 2008, meeting the below criteria;

- a child or adolescent (0-18years) with a HoNOSCA Item 1 scoring in the clinical range (i.e. 2 or above); and
- a child or adolescent (0-18years) with FIHS items 1,2,3,5, or 7 being marked as present.

OIS data includes CYMHS community teams, Evolve Therapeutic Services, Mental Health Forensic Services, and mental health in-patient facilities across Queensland providing a service for children and adolescents aged 0-18years. A total of 30 008 clients had a three month review or discharge outcomes completed within the above time period, of which 18.1% (n=5,436) were identified in the clinical range for problems with disruptive, antisocial or aggressive behaviours and had one or more of the following events present at the three month case review; maltreatment syndromes, problems related to negative life events in childhood, problems related to upbringing, problems related to social environment, or problems related to other psychosocial circumstances. This result indicates that 18.1% of those who had outcomes completed, fall in the 'vulnerable/at risk' group of developing sexually abusive behaviours. However, average completion rates for outcomes range from 60% to 85% across the state, therefore this data may under-represent the number of identified clients as vulnerable or at risk.

It must be noted that as a number of protective factors are likely to exist across this group, it is unlikely that every child and young person identified in this data collection will develop sexual behaviour problems.

3.3.2 Summary of Child and Youth Mental Health Services

This data was provided by RCH CYMHS and Logan CYMHS community clinics for the reporting period October 2008 via completion of the Scoping Project database.

Of the 798 clients opened to CYMHS, 4% (n=32) were identified as having a history of, or were exhibiting current, sexually abusive behaviours, with a mean age of 13 years (age range 6-18yrs). 47% were male and 6% identified as Aboriginal and/or Torres Strait Islander.

This low percentage of children and adolescents with sexually abusive behaviours may replicate the significant under reporting and under recording of the issues by services as identified in the earlier literature review (section 2). Compounding this problem is that CYMHS data systems do not require recording of information about the sexual behaviours of clients.

3.3.3 Child and Youth Forensic Mental Health Services

CYMHS forensic services provide consultation, assessment and intervention services for children and adolescents aged 0-18 years who are clients of mental health services and/or youth justice services and who present with mental health problems and offending type behaviours. These forensic services operate in community clinics and detention centres across the state.

RCH Child and Youth Forensic Mental Health Service and Northern Area Adolescent Forensic Mental Health Service provided data for the reporting period of October 2008 via completion of the Scoping Project database and/or survey.

Of the 251 clients opened to Forensic Mental Health Services, 19% (n=48) were identified with sexually abusive behaviours in their current and or past history, with a mean age of 15 years (age range 8-18yrs). 38% identified as Aboriginal and/or Torres Strait Islander, and 95% were male.

As noted in the earlier literature review, adolescents convicted of sex offences tend to be male, and approximately 14 years of age. The client group described here appears to be comparable to the current research. It must be noted however, that the client group of these services may be engaging in sexually abusive behaviours but not yet engaged in the justice system and therefore may represent a unique cohort. Further analysis of this data is required.

3.4 Evolve Interagency Services

Evolve Interagency Services is a cross-government initiative involving DChS, QH, DSQ and DETA. Therapeutic and behaviour support services are provided to children and adolescents 0-18 years who are on child protection orders and who present with severe and complex psychological and behavioural needs. Referrals are made from DChS to an interagency group – the Evolve Interagency Services Panel. Evolve Therapeutic Services is the QH component of the program and provides specialist mental health and therapeutic services to children, adolescents and their carers. Evolve Behaviour Support Services is the DSQ component of the program that provides specialist disability assessments and positive behaviour support to children and adolescents with a disability. DChS provide child protection case planning and intervention, and DETA provide educational support and other intensive educational input. All four agencies collaborate to provide co-ordination of care and combined assessment of the child/adolescent and care system needs.

Evolve Interagency Services (EIS) data was collected from three sources; Evolve Therapeutic Services state-wide referral data, and specific data collections from Evolve Therapeutic Services and DSQ Evolve Behaviour Support Services.

3.4.1 Evolve Therapeutic Services State-wide Referral Data

State-wide EIS referral data was drawn from referrals to EIS Panels by DChS and reviewed for referral to Evolve Therapeutic Services from the inception of the services in 2006 until mid 2008. The EIS referral form asks the referrer to detail the presence and frequency of sexual behaviour problems for each client referred. The presented data reported upon the presence of sexual behaviour problems for each referred child.

Available EIS state-wide referral data indicates that of the 436 referrals, 26.8% (n=117) were identified to have some level of inappropriate sexualised behaviour, with a mean age of 12.6 years (SD = 3.68yrs). 59% were male and 31% identified as Aboriginal and/or Torres Strait Islander.

Children and adolescents with sexually abusive behaviours tend to present with a range of anti-social behaviours and highly disadvantaged backgrounds as noted in the earlier literature review (section 2). It was expected that a service client group presenting with severe and complex needs and a history of extensive child protection service involvement would include a high percentage of clients with sexually abusive behaviours. It must be noted that it is likely that this data under reports the problem as anecdotal evidence suggests that the comprehensive assessments undertaken by Evolve Therapeutic Services frequently reveal sexual behavioural problems not reported at the point of referral.

3.4.2 QH Evolve Therapeutic Services

Seven Evolve Therapeutic Services teams across Queensland provided data. Data revealed that of the 164 clients opened to Evolve Therapeutic Services, 58% (n=95) were identified with sexually abusive behaviours in their current and/or past history, with a mean age of 11.6 years (age range 3-17yrs). 30% identified as Aboriginal and/or Torres Strait Islander and 60% were male.

Of particular significance in this data set is the number of females reported to present with sexually abusive behaviours and a lower mean age. This would appear to be a different client group than that typically identified in the research and further analysis is required of this data.

3.4.3 DSQ Evolve Behaviour Support Services

Eight DSQ Evolve Behaviour Support Services (DSQ Evolve BSS) teams across Queensland provided data. Data indicated that of the 95 clients opened to DSQ Evolve BSS, 36% (n=34) were identified with sexually abusive behaviours in their current and/or past history, with a mean age of 14.3 years (age range 10-17yrs). 74% were male and 35% identified as Aboriginal and/or Torres Strait Islander.

This data appears comparable to the current research particularly in regard to adolescents, with a high percentage of males and a mean age of 14 years (Section 2 in this report). As the eligibility criteria for EIS is children and young people on Child Protection Orders who have severe and complex psychological and behavioural needs, it was expected that the percentage of clients with sexually abusive behaviours would be high.

Of note is that approximately 30% of EIS clients identified as Aboriginal and/or Torres Strait Islander. Further analysis of this data is required.

3.5 Department of Child Safety (DCHS)

DChS do not typically collect statistical data on children and young people's sexual behaviour. Information that is collected by DChS about sexual behaviour is typically used in case planning and is recorded in individual case files. This information was not easily retrievable for the purpose of the Scoping Project. DChS data cited in this document was obtained from two sources, Transitional Placement data and SACS.

3.5.1 Transitional Placement Data

Transitional Placements are utilised for children or young people with complex to extreme needs and funded on an individual basis to enable a time limited individual response, while preparing children and young people for less intensive and more sustainable placements. Transitional Placement data was provided by DChS and reports upon the number of children and young people in October/November 2008 who were living in Transitional Placements and who reportedly presented with sexual behaviour problems. Sexual behaviour problems were defined broadly as per the Scoping Project survey and database.

Overall, of the 370 children and young people in a transitional placement 30% (n=117) were identified with sexually abusive behaviours in their current and/or past history, with a mean age of 14 years (age range 4-18yrs). 65% were male and 32% identified as Aboriginal and/or Torres Strait Islander.

It is important to note that there is likely to be a high incidence of duplication across the DChS Transitional Placement data and other service data i.e. of the 117 children and adolescents in transitional placements who have identified sexually abusive behaviours, 24% have involvement with Evolve Therapeutic Services, 7% have involvement with DSQ Behaviour Support Services and a further 14% have involvement with both. This population may also be duplicated in general CYMHS data and/or forensic mental health data.

3.5.2 Sexual Abuse Counselling Service (SACS)

The SACS funded by DChS provides individual counselling with children and adolescents 5-18 years who are clients of DChS, and who have experienced substantiated sexual abuse. In addition, SACS provide services to children between the ages of 0-10 years displaying sexual behaviour problems.

SACS completed the survey and identified that of the 25 children and young people accessing the service in October 2008, 28% (n=7) were identified with sexually abusive behaviours in their current and/or past history, with a mean age of 11 years (age range 7-16yrs). 57% were male and 0% identified as Aboriginal and/or Torres Strait Islander.

The cohort represented in the SACS data is primarily children under 10 years of age. Contrary to the research regarding children 6-12 years of age, the client group of SACS is largely male [12]. This may represent a unique cohort and requires further analysis.

3.6 Other

A number of other services were approached with a request for data for the purposes of the Scoping Project. Family Planning Queensland and Phoenix House were able to meet this request within the Project time-frame.

3.6.1 Family Planning Queensland

Family Planning Queensland (FPQ) provides an educational service for children and adolescents with disabilities and their families with regards to sex and sexuality. While FPQ is a state-wide service, data for the Scoping Project was provided from the Brisbane based service.

Data provided by FPQ indicated that of the 21 clients accessing the Brisbane based service in October 2008. 38.1% (n=8) were identified with sexually abusive behaviours in their current and/or past history, with a mean age of 13 years (age range 7-17years). 88% were males and 0% were identified as Aboriginal or Torres Strait Islander.

3.6.2 Phoenix House Association Inc.

Phoenix House is a sexual assault service for children, young people and adults. Phoenix House also provides intervention services for children and adolescents with sexually abusive behaviours. Further information about Phoenix House is located in the document *'Training And Supervision: The Queensland Context. Discussion Paper'.*

Phoenix House completed the survey and identified that all 48 children and young people accessing the service in October 2008 had a current and/or past history of sexually abusive behaviours. Mean age was 8.8 years (age range 3-16yrs), 50% were male and 31% identified as Aboriginal and/or Torres Strait Islander.

This data set included primarily children under 12 years of age. 50% of the identified client group were female which is comparable with the research regarding younger children with sexually abusive behaviours (Section 2 of this report). Of note is that 30% of the identified client group is Aboriginal or Torres Strait Islander which is comparable to the Evolve Interagency Services and Transitional Placement data. Given that this service is provided specifically for young people who do have problematic sexual behaviours it represents a unique perspective.

3.7 Characteristics of the client group/s identified during the project period

In summary, services participating in the Scoping Project data collection reported on a total of 2,202 children and adolescents. Of these 28.7% (n=496) were identified with sexually abusive behaviours. The data presented in sections 3.7.1 to 3.7.7 is based upon these 496 identified clients.

Psychosocial factor data and demographic data was collected via the Project Scoping survey and database in order to provide a description of the client group/s, specifically the living situation, current educational level, disability and mental health diagnosis of children and young people with sexually abusive behaviours. Where this data was available in existing databases i.e. DChS Transitional Placement data, QH Child and Youth Mental Health Services, it was also included in the following data collation.

3.7.1 Living Situation

Of the 496 children and adolescents identified with sexually abusive behaviours, 8% (n=38) of data was unknown or missing. Of the 458 with data, 30% of young people identified with sexually abusive behaviour resided in foster care, 23% were living in 24hr youth worker supported accommodation, 20% resided with their biological family and a further 10% were living independently. The remaining 17% reside in a variety of accommodation options as per the figure below.

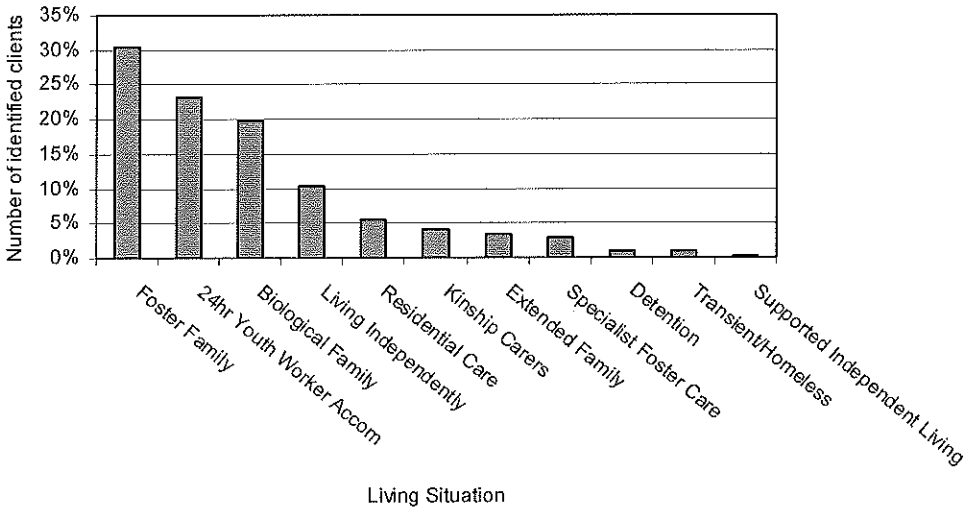


Figure 1. Living situations of children and adolescents with identified sexually abusive behaviour.

Current research outlines the multiple difficulties faced by children and young people with sexually abusive behaviours including chaotic and abusive family environments and multiple out of home placements (Section 2 of this report). Figure 1 highlights firstly that the majority of children and adolescents with sexually abusive behaviours in this data set live away from biological family, and secondly that a significant percentage reside in some form of supported intensive accommodation. These figure may appear higher than expected due to the likelihood that data for one child has been reported by more that one participating service.

3.7.2 Education Level

Of the 496 children and adolescents identified with sexually abusive behaviours, 29% (n=142) of data was unknown or missing. Of the 354 with data, 32% were in primary school, 25% were in secondary school, a further 15% were identified in special education and 11% were not attending school. See below figure for further educational level classification.

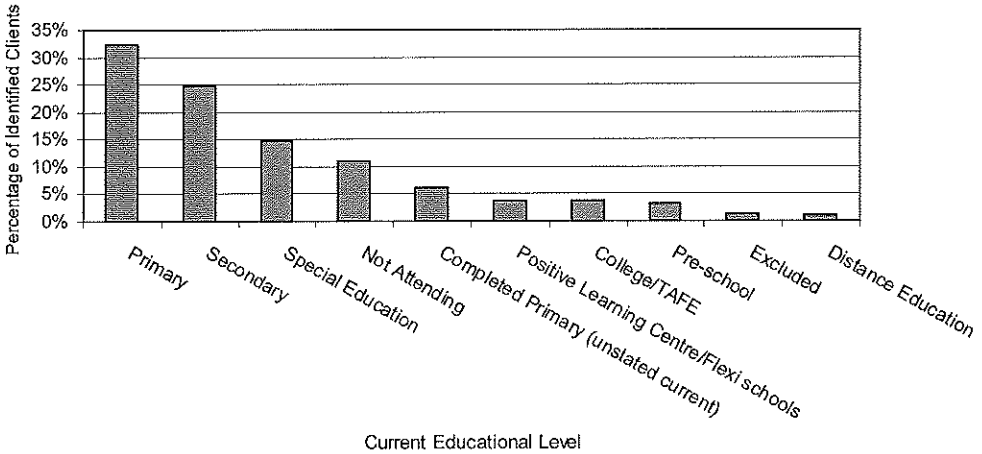


Figure 2. Current educational level of children and adolescents with identified sexually abusive behaviour.

Approximately one third of the identified client group attend primary school and approximately one quarter attend secondary school, providing evidence that the problem of children and adolescents with sexually abusive behaviours exists across school grades and across age groups. This data reveals a surprising small number of the identified client group as accessing special education options; however, it is possible that some of the identified client group access special education support from mainstream class groups. Current research summarised in Section 2 of this report notes that many children and adolescents with sexually abusive behaviours have learning difficulties; this may not automatically translate to diagnosed disabilities and thus special education options. Finally, one in ten identified clients were not attending school, which is of concern as all identified clients were under 18 years of age with the overall mean age of 12 years (Appendix 7). The data set did not identify reasons for non attendance at school such as employment, homelessness and truancy.

3.7.3 Disability

Disability was defined as per the *Queensland Disability Services Act 2005*, however for the purpose of this report mental health disability was excluded as mental health diagnosis is reported on separately.

Of the 496 children and adolescents identified with sexually abusive behaviours, 52% (n=257) of data was unknown or missing. Of the 239 with data, 36% were identified with no disability, 39% with an intellectual disability, 12% Autism and a further 9% with a developmental disability. See below figure for further disability classification.

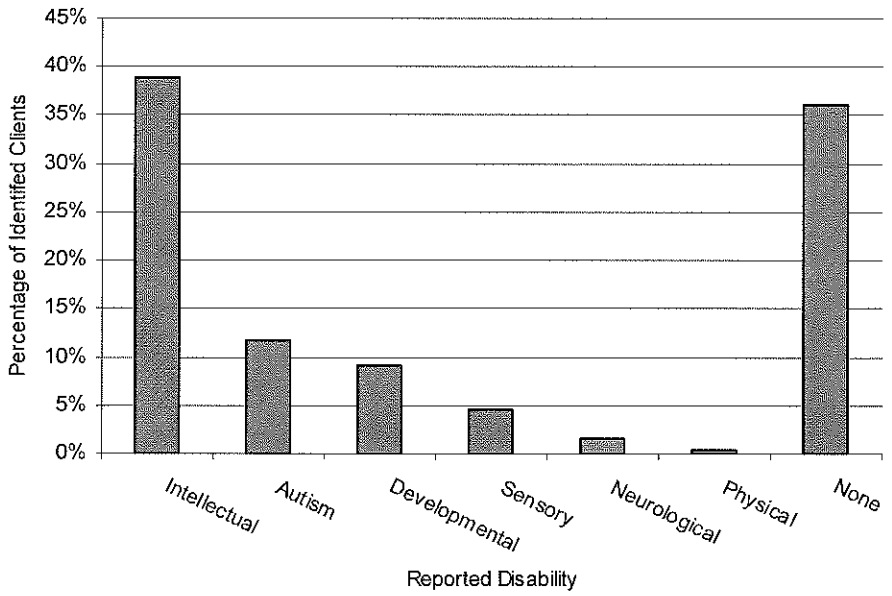


Figure 3: Percentage of identified clients with a reported disability.

There are gaps in the current research concerning healthy sexual development and sexuality for children and adolescents with disabilities. However, a multitude of psychosocial factors are believed to adversely effect sexual development pathways for this group (Section 2 of this report). The participating services in this data collection provide services to children and adolescents with complex problems including disabilities, therefore an over representation of children and adolescents who exhibit sexually abusive behaviours with co-morbid disabilities would be expected.

3.7.4 Mental Health Diagnosis

Mental health diagnosis was provided by the participating services and cannot be confirmed as adhering to a formal classification system (e.g. International Statistical Classification of Diseases and Related Health Problems 10th Revision). Additionally, only the primary diagnosis was recorded for the purposes of this study so co-morbid presentations are not reported.

Of the 496 children and adolescents identified with sexually abusive behaviours, 47% (n=245) of data was unknown or missing. Of the 251 with data, 27% of children and adolescents had a primary diagnosis of attachment disorder, 14% had a diagnosis of attention deficit hyperactivity disorder, 10% had a diagnosis of post traumatic stress disorder, and a further 9% were diagnosed with mixed disorders of conduct and emotion. See below figure for further mental health diagnosis classification.

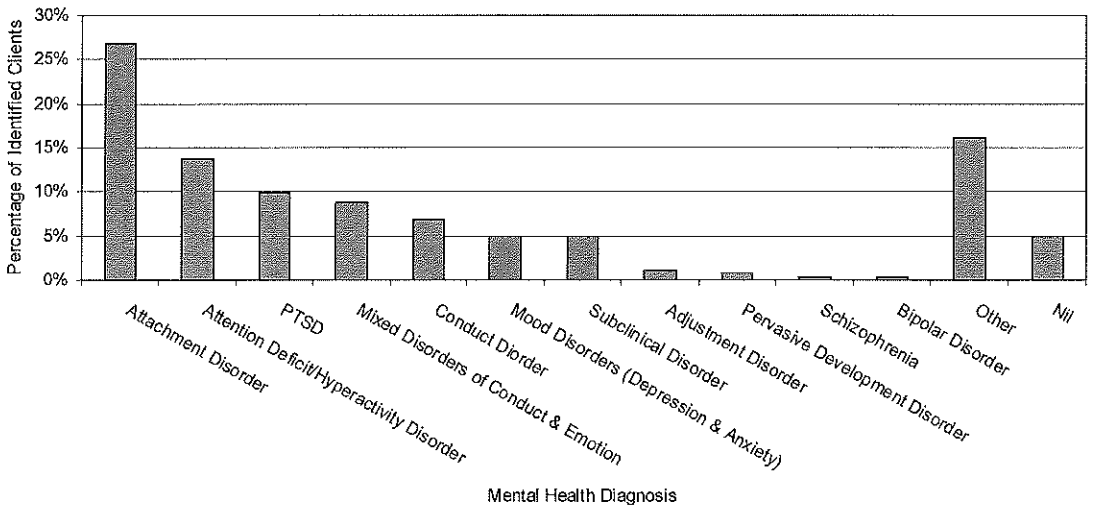


Figure 4. Percentage of mental health diagnosis of identified clients.

Current research identifies common mental health diagnoses in children and adolescents with sexually abusive behaviours as Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, Depression, Anxiety and Post Traumatic Stress Disorder (Section 2 of this report). Overall, this data set is comparable to current research findings, however the high prevalence of

Attachment Disorders in this identified population is to be expected given the sub sample analysed i.e. children and adolescents in the care of DChS.

3.7.5 Child Protection History

Of the 496 children and adolescents with identified sexually abusive behaviours 72% (n=367) have a child protection history. Exploring this data further, in terms of current and past history and type of abuse was not possible as the majority of participating services did not provide this information.

3.7.6 Youth Justice History

Of the 496 children and adolescents identified with sexually abusive behaviours, 36% (n=180) of data was unavailable. Of the 316 with data available, 28% (n=90) were identified to have a youth justice order, of which 17% had a youth justice order specific to sexual offending.

3.7.7 Context and Type of Sexually Abusive Behaviour

Acknowledging that the below data represents less than half the population identified with sexually abusive behaviours, it was considered important to explore this data as the context of the behaviour relates directly to its impact upon others.

Information gathered through the Scoping Project survey and database was available for 39% (n=192) of the total children and adolescents identified with sexually abusive behaviour in relation to the context and type of sexually abusive behaviour.

Figure 5 highlights the percentage of children and adolescents displaying sexually abusive behaviours in various contexts.

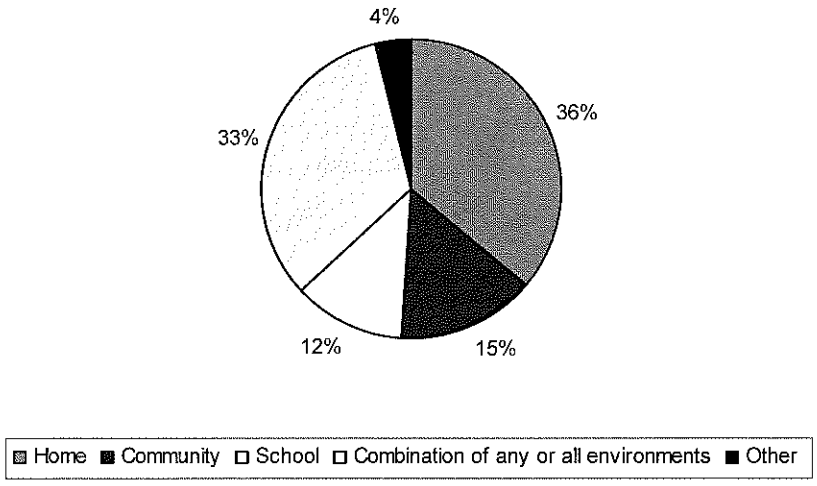


Figure 5. Context of sexually abusive behaviour.

Participating services also provided brief descriptions of the types of sexually abusive behaviours displayed by the client group/s. The most commonly reported sexually abusive behaviours included inappropriate sexual touching, language, exhibitionism and penetration (including oral and anal).

Consistent with existing research, the types of behaviours displayed by the identified client group were varied and not dependent upon age or gender.

The context of the reported sexually abusive behaviours is highlighted here as firstly, it provides a picture of the potential environments that may experience the negative impact of a child or adolescent's sexual behaviour, and secondly as it represents the environments in which a child or young person may experience negative consequences because of their behaviour. Current thinking in the field nationally and internationally is that a multi-systemic and contextually relevant response to the problem is the most effective intervention (section 2). This data highlights the home, school and community as relevant contexts for intervention.

3.8 Case Examples

As part of the survey services were invited to provide case studies of children and young people with sexually abusive behaviours as part of the Scoping Project data collection exercise. In discussion with the Project Advisory Group, it was acknowledged that identification of these children and families would be difficult to disguise in Queensland. As a result the following examples are brief case compilations rather than individual cases.

The case examples demonstrate the range of behaviours that are potentially harmful to the child/adolescent or others, the complexity of the problems across environments, and the impact upon the child/adolescent e.g. isolation from age appropriate support systems such as education and pro-social developmentally matched peers and family. This is particularly relevant as each of these factors (educational achievement, pro-social peer connectedness, family acceptance and support) are protective factors against repeated harmful sexual behaviour.

- 14 year old indigenous male with diagnosed disability excluded from all school systems, living in youth worker model of accommodation, unable to access therapeutic services, no peer contact, no family contact and no community access without high levels of supervision. Behaviours both present and past include sexually abusive behaviours towards multiple siblings and non-familial typically younger children of both genders, violence towards adults, peers and property, high risk and self-harming behaviours in multiple environments.

- 7 year old female, living in youth worker model of accommodation, limited school hours, all contact with others highly supervised, no family contact, no access to therapeutic services. Behaviours include high levels of violence towards self and others, intrusive and aggressive sexual behaviours towards adults and peers, high risk behaviours in multiple environments.

- 11 year old female living with foster family, limited school hours, highly supervised with peers and adults, behaviours include frequent absconding, public masturbation, sexual behaviours towards adult females, high risk sexual behaviours i.e. intercourse with adults, under influence of substances, and without contraception.

- 17 year old male, diagnosis of Autistic Spectrum Disorder, foster family placement, regular school attendance (special education), supervised peer group, unsupervised family contact. Behaviours include frequent public

masturbation, stealing female carer's underwear, watching female carer in bathroom and bedroom, frequent drawing of sex organs and sex acts in public settings, accessing internet role play sites and engaging in violent cybersex with adult males.

4. CURRENT RESPONSES OF KEY AGENCIES

4.1 Department of Education, Training and the Arts (DETA)

DETA does not currently have a data collection system that enables the determination of the nature and extent of the problem, or the typical school response, to children and young people with sexual behaviour problems, sexually abusive behaviours or sexual offending. The current reporting process about behaviour in Education Queensland schools does not enable the author to determine whether reports of sexual behaviour are healthy sexual behaviours in the wrong context (school), behaviours related to sexual victimisation or sexually abusive behaviours.

Despite this impediment to collecting detailed information, anecdotal reports indicate that there appears to be a small percentage of the total number of state school students who exhibit sexual behaviours in the school environment. The ages of children and young people reported with sexual behaviours crosses all age-groups. The range of sexual behaviours reported includes:

- Sexually explicit language
- Sexually explicit drawings
- Public exposure
- Fondling themselves and/or others

Anecdotal reports indicate the response to children and young people with sexual behaviour problems, sexually abusive behaviour and sexual offending in the school context varies across the state. When police and youth justice services become involved, a child or young person is frequently understood to be of a high risk to other students and is deferred to other educational options such as Distance Education.

Schools are reportedly experiencing an increase in the numbers of young people enrolled with adjudicated sex offences. The lack of protocols or guidelines, including interagency protocols to guide DETA with regard to best practice responses, affects the ability of schools to support the client group/s in the school context.

DETA has recently clarified procedures for schools in relation to reporting to parents and supporting students who have been sexually harmed by other students, as well as students alleged to have sexually harmed others. Materials that have been provided to schools include:

- *Students' sexual behaviour – a guide for schools.*
- *Principals' Checklist: Managing Students' Sexual Behaviour.*
- *What happens when...* A series of parent information sheets outlining actions taken by schools when a student is harmed or at risk of harm.

DETA also has a number of documents that provide guidelines and management strategies where a student is engaging in behaviours that negatively impact upon

themselves, fellow students and/or the broader school community. These documents may apply to the Scoping Project client group/s (Appendix 1).

4.2 Department of Child Safety (DChS)

DChS direct service staff are frequently faced with children and young people exhibiting sexual behaviour problems, sexually abusive behaviours and sexual offending. The child protection legislation in the state provides some consistency in responding to the behaviour where it places another child at risk. Responses to sexual behaviour outside the legislative framework reportedly vary across the state.

DChS provide funding to a number of non-government sexual abuse counselling services across Queensland. Unfortunately, these services have not developed consistently or in collaboration with one another. Approximately three years ago DChS moved to standardise service delivery in sexual abuse counselling services through the development of a standardised funding agreement consistent with the SACS framework. This strategy has reportedly gone some way to standardising core business however local area variations still occur as the services work with Child Safety Service Centres and report to zonal office staff in relation to funding service delivery issues.

DChS provide support (including resources) to foster carers, foster care agencies and accommodation service providers. Anecdotally, the numbers of children and young people in these care settings with sexual behaviour problems are increasing. To date there is no consistent response to the client groups across this aspect of the support system.

DChS have a number of documents that refer to and/or are related to decision making about children with severe and complex needs. These documents may apply to children and young people with sexual behaviour problems, sexually abusive behaviour or sexually offending. DChS provides funding to a number of sexual abuse counselling services that also provide counselling services to children under 10 years who are exhibiting sexual behaviour problems, and these services are guided by a Funding Information Paper and Service Level Agreement. DChS has developed a number of training tools (primarily on-line) specifically aimed at increasing the knowledge of staff regarding the client group. A summary of relevant DChS documents is located in Appendix 2.

4.2.1 Sexual Abuse Counselling Service (SACS)

SACS is a service provided by DChS. SACS core business is to provide individual counselling to children and young people and their families across Queensland who are:

- 5-18 years old and requiring sexual abuse counselling (clients must be verbal).
- An open case within DChS.
- Have experienced substantiated sexual abuse.
- Non-offending family member/carers and siblings.
- 0-10 years old displaying sexualised or early sexual behaviour problems.

SACS is a state-wide service, providing consultation, training, mentoring and psycho-educational sessions on demand and within the limitations of capacity, for

areas outside the Greater Brisbane area. These services are primarily utilised by DChS staff however, DETA staff and the general public also request consultation services. SACS staffing includes a manager, 4.8 counselling staff and one administration support officer. Currently, one member of the counselling staff is indigenous. While SACS have trialled outreach services, this has been found to be impractical due to the service model of allocating a single counsellor to each family member, in addition to practical resource limitations.

Where a child under 10 years of age is engaging in sexualised or sexual behaviour problems, there does not need to be substantiated sexual abuse in order to access SACS services. SACS do not see children over the age of 10 years exhibiting sexually abusive behaviours towards others, as at this age a child can be charged with a sexual offence under Queensland law. Sexual behaviour problems range from those indicating sexuality development problems, to high risk sexual behaviours, exposure, compulsive masturbation and intrusive actions to see others genitalia. Children under 5 years of age are referred to a range of other services, including private practitioners where possible.

4.3 Disability Services Queensland (DSQ)

Disability Services Queensland (including Evolve Behaviour Support Services) do not currently have policy, procedures and systems in place regarding sexuality, sexual development and sexual behaviours of children, adolescents or adults. DSQ do not traditionally provide services to children and adolescents in Queensland. A small number of children and young people under 18 years access a variety of DSQ respite and family support services that may have service specific practices. There is reportedly significant variation across the state in how DSQ services respond to this broad issue.

4.4 Queensland Health (QH)

Queensland Health Child and Youth Mental Health Services (including Evolve Therapeutic Services) do not currently have policy, procedures and systems in place regarding sexuality, sexual development or sexual behaviours of clients. Individual Health Service Districts, and specific services within these districts may have policies or protocols in this area i.e. the Child and Family Therapy Unit in the Child and Youth Mental Health Services, Royal Children's Hospital, Children's Health Service District has a local policy related to managing children and young peoples' sexual behaviours in the inpatient setting. There is variation across the state as to how Child and Youth Mental Health Services view their roles in relation to the sexuality and sexual behaviour of children and young people.

Queensland Health does have current policy and guidelines with regard to child protection: *Protecting Queensland Children. Policy Statement and Guidelines on the management of abuse and neglect of children and young people (0-18 years)*. This document specifically addresses the identification, reporting and management of child abuse and neglect by all Queensland Health staff.

4.5 Department of Communities (DoCs)

Youth Justice and Youth Justice Conferencing provide case management and restorative justice mediation respectively for young people 10-17 years convicted of an offence, including sex offences. Youth Justice and Youth Justice Conferencing are currently completing projects that will result in clearer guidelines for departmental staff and the department funded services in responding to the

needs of young people who have sexually offended (a brief outline is located in Appendix 4). Youth Justice Conferencing current policy *Youth Justice Conferencing Sexual Offence Policy* outlines the expectations of young people referred to conferencing for a sexual offence.

5. SERVICE MAPPING – QUEENSLAND CONTEXT

Consultation reveals that services for children and adolescents with identified sexually abusive behaviours in Queensland appear to have developed in a relatively uncoordinated manner, with limited collaboration across the related sectors of health, disability, child protection, sexual assault and justice. This reactive program and service development approach appears consistent with the broader Australian and New Zealand context, where services for this population group have grown independently from one another [71]. Implications arising from this developmental history include:

- Access to services being dependant upon geographical location,
- A lack of standardisation of available services,
- Services are developing according to local need but there is no coordination of state-wide service need,
- The expertise in the field required to operate and implement specialist services is developing post service setup and in response to local area needs.

The range of services currently available in Queensland includes:

- Psycho-sexual education,
- Consultation,
- Case management,
- Counselling,
- Training for professionals.

However, this range of services is not equally available across the state, with availability predominantly limited to areas with significant population levels. The two state-wide service providers are: 1) a service limited to adjudicated youth (GYFS), and 2) a service limited to children under 10 years who are clients of DChS and/or who have experienced sexual abuse (SACS). These services are also not equally available to children and young people or indeed carers including families. Finally, existing services target children and young people with identified problems and do not address early intervention issues. The more generic services that may be in a position to address early intervention issues do not have access to trained staff, training or supervision, or resources to enable sexuality and sexual behaviours to be part of their intervention services.

Appendix 5 identifies services funded by Key Agencies to provide services to children and/or adolescents with sexual behaviours problems, sexually abusive behaviours and sexually offending behaviours. There are reportedly a small number of non-government organisations and private practitioners who provide services to this client group/s, and who do not receive funding from a Key Agency. These services were not included in the scope of the Project however, a small number of other service providers who are typically referred to by Key Agency staff are included in Appendix 5.

6. RELATED PROJECTS

Key Agencies, Key Stakeholders and Other Stakeholders are currently undertaking or concluding projects that relate to the subject of this report. The tables located in

Appendix 4 outline those projects reported to the author. Many of these projects are in developmental phases, relate indirectly to the Scoping Project, and/or are awaiting approval for release outside the relevant Key Agency.

Essentially these related projects are attempting to enhance the knowledge and skill of Key Agency staff, build capacity in the current service system relevant to the client group/s, enhance existing collaborative practices between Key Agencies, Key Stakeholders and Other Stakeholders, and clarify the role of Key Agencies in responding to the client group/s. These strategies will likely contribute positively to the development of the Queensland service system response to children and adolescents with sexual behaviour problems, sexually abusive behaviours and sexual offending.

7. SUMMARY OF CONSULTATION REGARDING QUEENSLAND SERVICE SYSTEM

All information contained in this summary is self-reported by service providers who engaged in the Scoping Project consultation process. The Scoping Project did not identify a reliable source of data regarding service system strengths and weaknesses so cannot attest to the veracity of the claims made by specific services.

7.1 Service System Strengths in the Queensland Context

A number of strengths in the current service system in Queensland were identified during the Scoping Project consultation process. These strengths represent areas that could be enhanced to assist in facilitating collaborative and coordinated responses to the client group/s state-wide.

Service system strengths included:

- Specialist services such as GYFS, SACS, FPQ and CYFOS were frequently reported as useful consultation services across the state. The availability of a specialist consultation service was frequently noted as important to a more generalist service's willingness to work with the client group/s.
- Positive reports concerning available co-working and mentoring opportunities with specialist services were often expressed. Key Agency staff reported that they experienced an increase in their knowledge, skill and confidence through these processes.
- Positive reports regarding the existing training from specialist services were frequently received.
- In local areas, cross-agency collaboration on a case-by-case basis reportedly works effectively in coordinating responses to the client group/s.
- The existence of cross-agency relationships (formal and informal) in local areas were often reported as effective facilitators of referrals of the client group/s to Key Agencies and Key Stakeholders.
- Evolve Interagency Services, particularly the model of stakeholder coordination and collaboration, was frequently noted as improving access to services for the client group/s. It was also reported that accommodation and education placements were often stabilised through this process, enabling the client the opportunity to develop appropriate supportive relationships and to engage in therapeutic interventions.
- The existing specialist services e.g. GYFS, SACS, Phoenix House, Laurel House and Laurel Place, tend to utilise models of intervention that are evidenced-based and that engage a child or adolescents support system.

7.2 Service System Gaps In The Queensland Context

Broad consultation with Key Agencies, Key Stakeholders, and Other Stakeholders in the context of this project identified a number of significant gaps in service provision for children and young people with identified sexual behaviour problems, sexual abusive behaviours and sexual offending behaviours in Queensland. These gaps appear to be consistent with the broader Australia and New Zealand context and include services for children, Aboriginal and Torres Strait Islander children and young people, females, and children and adolescents with disabilities [71].

The summary of reported issues presented below highlights service system gaps from legislation to direct service availability and service system standardisation to communication. Such a breadth of service system gaps indicates that children and adolescents in Queensland are at risk of experiencing inadequate access to appropriate community supports and services, inadequate coordination of services that are available, and inconsistent service standards. Geographical location also appears to significantly impact upon service availability and coordination. Of particular note is that services for children, adolescents and their families appear to be inadequate across healthy sexuality and sexual development through to sexual offending.

7.2.1 Legislation, Organisational Policy And Protocols

- Gaps exist across all human service organisations working with children, young people and families with regard to policy and formal practices recognising sexuality and sexual behaviours in the context of human development and human relationships, and that enable recognition and early intervention in situations where disruptions to healthy sexual development and sexual behaviour problems occur.
- There is no consistency in the language used, the assessment undertaken or the intervention model used across the state. This includes within the same Key Agency but over different geographical locations e.g. one school may respond quite differently to another school creating confusion and conflict with shared Child Safety Service Centres.
- Current child protection legislation in Queensland does not enable involuntary intervention by any service where a child is engaging in behaviours that place him/herself at risk. The experiences of other Australian states indicate legislation change can improve service utilisation for children and families in this circumstance.
- Current youth justice legislation places limits on the Key Agencies' ability to release information and thus work collaboratively with other services.

7.2.2 Service Availability/Referrals

- Limited referral options exist for children and young people with sexual behaviour problems, sexually abusive behaviours or sexual offending. This is evident state-wide but options are particularly limited in regional, rural and remote areas.
- There is overall a lack of early intervention services for children, adolescents and families where sexual behaviour problems occur.

- Where there are services available to provide assessment and intervention there are frequently limiting eligibility criteria and/or long waiting lists.
- The limited services that do exist across the public, private and non-government sector are concentrated in the Brisbane area.
- Areas directly outside Brisbane (urban fringe areas and regional areas) are disadvantaged with regard to access to services, training and supervision.
- Far North Queensland reports that there are no services for the client group/s, limited knowledge and skill amongst service providers willing to provide interventions, and limited access to knowledge and skill development opportunities.
- DChS experience difficulties when part of the region is covered by a specialist service and part is not – decisions about alternative care are complicated by attempts to locate young people where services are available.
- Rural and remote communities are significantly disadvantaged in terms of access to services, training and supervision. Generalist services attempt to respond to the needs of children, adolescents and families in these areas however, most do not have the experience, knowledge or specialist skills.

7.2.3 Service Relationships

- There is frequently poor communication between services, and/or poor understanding of what each service contributes to work with the population. Communication challenges are exacerbated by some legislation e.g. the Juvenile Justice Act 1992.
- There is reportedly often poor coordination, collaboration, networking and liaison between services in local areas and across the state working with children, young people and families with sexual behavioural problems and sexually abusive behaviours and sexual offending histories.
- There is no system for sharing information across Key Agencies or the broader service system working with the identified population. For example, a child/adolescent may be a client in multiple services but services are unaware of this, e.g. Youth Justice and CYMHS. Legislation can limit a service's ability to share information e.g. the release of information by Youth Justice Services to schools, some confusion with respect to the legislation regarding release of information between DChS and Youth Justice Services and other services.
- There are multiple service models across the state that are not aligned to one another, that are not integrated, that do not cover all aspects of services required to meet the population needs, and that are not consistent in most aspects of service with the other available service models.
- There is inconsistent access to consultation, support and supervision for generalist services from specialist services in the field.

7.2.4 Children And Adolescents With Disabilities

- Lack of knowledge and skill across the human service sector with regards to disability and healthy sexuality resulting in poor responses, labelling of healthy behaviour as problem behaviour, and lack of opportunities for individuals with disabilities to explore and experience healthy sexuality.
- Lack of knowledge and skill across generalist and specialist services with regard to assessment and intervention with children and adolescents with disabilities and sexual behaviour problems and/or sexually abusive behaviours and/or sexual offending behaviours.
- There is little education and support available for families, carers, respite carers, residential staff and youth workers to understand healthy sexuality and

behaviours, how to respond, and how to identify and respond to early sexual behaviour problems before sexual behaviour problems become reinforced.

- There is little availability of services (psycho-sexual education, therapeutic) for adolescents transitioning to adulthood and independence with regard to sexuality and sexual behaviours.
- In addition to the overall lack of knowledge, skill, training and services in this area, there is little available with regards to the impact of different forms of disability on sexual development, sexuality and sexual behaviours.
- Specialist services working with adjudicated sexual offenders in Queensland do not hold high levels of knowledge and skill in working with offenders with disabilities.
- Many therapeutic services do not accept children and young people with disabilities, as the common belief is that therapeutic input will have limited outcomes.
- Young people with disabilities, and particularly intellectual impairments, who allegedly offend are frequently not charged with an offence and thus cannot access specialist services. Conversely, if the alleged recipient of sexually abusive behaviour has an intellectual impairment and thus is deemed a poor witness, the young person allegedly engaging in the abusive behaviours is frequently not charged with the offence.

7.2.5 Mental Health

- Children and adolescents with sexual behaviour problems, sexually abusive behaviours and sexual offending histories are frequently not accepted to mental health services, particularly where presenting sexual behaviour problems are the primary reason for referral.
- Children and adolescents with sexual behaviour problems, sexually abusive behaviours and sexual offending histories are frequently unable to access inpatient mental health services due to concerns about risk to other patients.
- Access to mental health services for adolescents convicted of sexual offences is not consistent across the state.
- CYMHS do not consistently recognise sexual behaviour problems as a symptom of a major disruption to a core developmental task of childhood and adolescence. This impacts on early intervention options.
- CYMHS report that it can be difficult to identify co-morbid mental health problems in children and young people with sexual behaviour problems or sexually abusive behaviours.
- CYMHS forensic workers require higher level knowledge and skill in this area and access to expert supervision and mentoring in order to support CYMHS to work effectively in this field.
- Due to service eligibility criteria, CYMHS forensic teams are unable to work with a child or adolescent if they have not been accepted to CYMHS or Youth Justice.
- Evolve Therapeutic Services staff require higher level knowledge and skill in this area and access to expert supervision and mentoring.
- Many adolescents with sexual behaviour problems or sexually abusive behaviours have historically accessed DChS SACS service at the time of their own abuse. There are no services that provide medium to long term therapeutic options for this group of young people who report experiencing problems relating to previous sexual abuse over time and particularly at developmental transitional periods.
- General therapeutic services for children and adolescents frequently provide early to intermediate intervention where abuse (particularly family violence) and

neglect occur. These services do not commonly address sexual development issues.

7.2.6 Foster Care / Residential Care / Youth Worker Models

- Accommodation options that are able to cater for the specific needs of children and adolescents with identified sexual behaviour problems, sexually abusive behaviours or sexual offending histories are limited. This frequently results in multiple placement breakdowns, multiple school changes, disrupted relationships and general instability, all of which potentially contributes to an exacerbation in the problem behaviour.
- Service options across the continuum of care for the client group/s are not consistently available across the state. There are capacity issues where services do exist. There is often limited collaboration between services locally and state-wide.
- Carers are frequently not told of a child/adolescent's sexual behaviour problems, sexually abusive behaviours or sexual offending and the needs related to these behaviours prior to agreeing to placement so are unprepared and as result placements frequently break down in crisis. There appear to be a range of reasons why carers are not fully informed including respect for the child/adolescents privacy and fear that a child/ adolescent will be turned away from the foster family.
- Carers frequently do not have transparent or formally agreed safety rules for home and broader community environments for all children in care.
- There is limited availability of education, training, supervision and consultation for carers in relation to healthy sexual development, the impact of trauma and disrupted attachment on children's sexual development and behaviour, and strategies to respond to sexual behaviour.
- There is limited collaboration between carer support agencies reportedly leading to inconsistent practices across the sector with regards to the client group/s.
- Children and adolescents in care of DChS do not consistently access information and strategies to keep themselves safe in multiple environments and this contributes to vulnerability for further abuse and/or abusive behaviours.
- Where a child is in the care of DChS, interventions including education tend not to include biological family members even where reunification and contact is part of the case plan.
- Many children/ adolescents end up in youth worker models of care (including some very young children) as there are limited caring options when a child or adolescent has a sexual behaviour problem.
- Youth workers who are recipients of abusive behaviours (including sexual) often either resign, refuse to work with a single individual or any individual with sexual behaviour problems, or lower their expectations of the individual or all individuals with sexual behaviour problems. All of these outcomes potentially disadvantage a young person.

7.2.7 Adolescents Convicted Of Sexual Offences

- Accessing Department of Prosecutions information and releasing this information to services for assessment and intervention purposes is very difficult. Specialist therapeutic services advise Key Agency staff that the absence of this information can disadvantage an adolescent in treatment.

- These adolescents are frequently excluded from schools, which impacts negatively on prognosis. Reasons for exclusion are frequently unclear to other service providers.
- Adolescents are often not considered high risk offenders in the adult correctional system although they have been considered a high risk in the juvenile justice system.
- Adult corrections have a very different framework to youth justice generally, providing significantly less support and resources, including with regard to adjudicated sex offenders. Continuity of service during the transition between the two systems is challenging for many adolescents.
- Child protection legislation and justice legislation is not aligned in terms of the ages of children and adolescents that it supports. This can create a mismatch of service responsibilities and service interventions that create communication breakdowns and significant service gaps for adolescents.
- There are significant gaps in services for young people transitioning from detention to the community. Many adolescents go from intensive support to no support, which has an impact upon the monitoring and implementation of individual safety plans. Many adolescents decline follow up if it is not mandatory.
- Limited placement options for adolescents convicted of sexual offending often sees court forced to order an adolescent placed in the most available placement option, which may mean a detention centre or return to family, even where these environments may not best meet the adolescents needs.
- Some adolescents are not receiving specialist intervention services while in detention. This is particularly an issue where the adolescent is released from detention prior to receiving specialist intervention, and he/she returns to a remote community where specialist intervention and support services are non-existent.

7.2.8 Services for Children And Adolescents Not Engaged In The Justice System

- There are limited services for children over 10 years of age including psycho-sexual education, therapeutic intervention, accommodation, education etc.
- The current system in Queensland requires a child or adolescent over 10 years to be charged and/or convicted and/or deferred by police or courts in order to access specialist services. This does not allow for early identification or intervention (there are limited generalist services available for this population group i.e. private for profit services, private practitioners).
- The current service system for children under 10 years generally requires a child to be a client of DChS and/or subject to sexual abuse. This limits access to services across the broader Queensland population.
- Children and adolescents cautioned by the police but not charged or convicted or deferred to Youth Justice Conferencing are reportedly a large group who have no formal follow up. Data linking children and adolescents who have been cautioned by police with those who are later charged with further offences including sexual offences is not readily available, however all consultations identified this issue as a major concern.
- Therapeutic services frequently require an adolescent's consent to participate in therapy. Where an adolescent does not consent therapeutic services or other forms of intervention are not available. Some Key Agencies particularly struggle with this issue, as therapeutic intervention is reportedly a frequent condition of access to other services such as education and accommodation.

7.2.9 Indigenous Issues

- There is a lack of knowledge and skill with regards to working with indigenous children, adolescents and communities generally.
- There are significant gaps in knowledge about indigenous sexuality and sexual behaviours, and related gaps in skill across all human service organisations.
- There are limited indigenous positions located in services who work with children, adolescents and families with sexual behaviour problems, sexually abusive behaviours and sexual offending histories (where indigenous positions are part of sexual assault services there is a reportedly higher number of indigenous children seen for sexual behaviour problems).

7.2.10 Training

- Limited availability and accessibility for all human service organisations working with children, young people and families across the spectrum of knowledge and skills i.e. healthy sexuality and behaviours, identifying and responding to sexual behaviour problems and sexual offending.
- Limited availability of training for all Key Agency staff specifically with regard to healthy sexuality and behaviours, identifying and responding to sexually abusive behaviours, the role of family members and carers, the truth about risk and recidivism, how to collaborate across services, and understanding and implementing risk and safety planning.
- Extremely limited availability of training for family members, carers, youth workers, and residential workers despite the fact that this section of the service system work most intensely with the most vulnerable children and young people.
- Training not available for school staff or family day care providers (particularly relevant if they have a DChS client in their care).
- The lack of training across all human service providers increases the risk that services will focus on the sexual behaviour of a child or adolescents and not address the core issues that precede and contribute to the development and sustainability of the behaviours. This also frequently results in non-acceptance to a service.
- Of the limited training available in the state there is a gap between clinical expertise and training expertise.
- Youth Justice case workers tend to have training specific to working with adjudicated sexual offenders and their family members.
- University level courses do not routinely include components regarding sexuality and sexual behaviours including sexual abuse and sexual offending. Thus, voluntary post-graduate or professional development learning opportunities represent the most available training options.

7.2.11 Other Issues

- There is no method in Queensland of establishing whether or not a practitioner and/or service in this field is practicing with the required training, knowledge, skill and/or supervision to work with children and young people with sexual behaviour problems, sexually abusive behaviours or sexual offending.
- There are a number of homeless or transient youth across the state who do not have their basic needs met who are presenting with sexually abusive

behaviours and sexual behaviours that place themselves and others at risk of harm.

- Children and adolescents are generally not aware of the legal responsibilities and ramifications of sexual behaviours – this information is not generally incorporated in educational sessions about sexuality provided in school contexts.
- Children and adolescents in the care of DChS are most likely to receive inconsistent messages from multiple care givers about sexuality and sexual behaviours. They are also at risk of being labelled with sexual behaviour problems for behaviour that may be within the healthy spectrum because their private behaviours are more likely to be monitored and reported upon.
- Labels placed on children tend to follow them over their lifetime and across service systems, which can adversely affect access to services such as education, access to independent peer relationships, and all sexual behaviours being perceived as harmful by adult care providers.
- If a child or adolescent is suspected of being at risk of engaging in sexually abusive and/or sexual offending behaviours, most Key Agency, Key Stakeholder and Other Stakeholders refer to DChS as there are seen to be no other options available. Frequently, unless these children/adolescents are subject to abuse, these matters are outside the parameters of child protection. As such DChS can not respond to these reports and police later deal with the child/adolescent regarding alleged sexual offending.
- Services providing assessment and treatment, particularly for adolescents, frequently recommend supervision options for staff that far exceed available resources. This leaves the case management agency, often Youth Justice or DChS, to make decisions about supervision based primarily on resource availability.
- A young person returning to a remote community from a period in detention without access to appropriate support or intervention may be at risk of repeating sexual offending.
- Staff turnover in all services impacts upon ability to build knowledge and skill in the field and to respond consistently over time.
- Crisis responses do not facilitate best practice in this field however it is the most common approach undertaken across the state.
- Migrant and refugee children may present specific challenges as they have frequently been exposed to systemic inter-generational abuse, have different cultural knowledge of sexuality and sexual behaviours, and may be socially isolated.

8. DEVELOPMENT OF A COMMON LANGUAGE FOR QUEENSLAND

A task of this project was to develop a common language to assist communication across service providers in Queensland working with children and young people presenting with sexual behaviour that creates concern.

Broad consultation over the course of this project revealed a general commitment to developing a shared language to facilitate communication and address the issues arising from working with the stated population.

Consultation across Queensland revealed that the language used to describe children and adolescents sexual behaviour can have significant impact on the child or adolescents access to services including school and accommodation options. It can also create barriers in personal and professional relationships and as a result limit intervention responsiveness for children/adolescents and their families.

Alternatively, the language used can minimize the impact of the behaviour upon the child/ adolescent or others, it can draw attention away from the child/ adolescents' responsibility for the behaviours and it can positively reinforce the behaviour.

The following tasks were undertaken to achieve the goal of developing a common language:

- Reviewed existing documentation (policy, protocol, and training) across the Key Agencies.
- Review of a snapshot of current national and international literature (research, conference presentations, books, reports, program outlines).
- Development of a list of multiple terms used across Queensland Key Agency documentation and current literature.
- Discussion with the Training Consultation Group (a group of leading service providers in Queensland established for the purposes of this project).

Multiple challenges in developing a common language were identified. These included:

- Inconsistent language used within and across the Key Agencies.
- Inconsistent language used nationally and internationally.
- As understanding of healthy sexual behaviours in children and adolescents is in itself developmental, it is difficult to determine where and when some behaviours fall outside the healthy spectrum.
- Sexuality and sexual behaviours are culturally defined, culture itself is dynamic and changes over time.
- Multiple frameworks shape our understanding of the sexuality and sexual behaviour of children and adolescents and these frameworks do not necessarily align with one another. For example, our understanding of the stages of childhood development, including cognitive development and self-regulation, does not align with the legislative framework of Queensland that holds children from 10 years old criminally responsible.
- Multiple frameworks shape accessibility to services in Queensland, which in turn influences language i.e. sexual assault services do not work with sexual offenders and thus cannot work with children over 10 years who are engaging in sexual behaviours that may have legal ramifications. The language used may result in describing the behaviours of children over 10 years from a legal framework and the behaviour of children 9 years and under from a therapeutic framework.
- The field of working with children and adolescent's sexuality and sexual behaviours is relatively young, evokes high levels of emotion and is strongly associated with personal values.
- Initially language used to describe children and young people with sexual behaviours harmful to others was taken from the adult sexual offending field. It is now recognised internationally that this is not developmentally appropriate (issues across language, assessment, treatment, research).
- There is very little research available with regards to children adolescent's sexuality and sexual behaviours in the Australian context.

Drawing on practice experience and knowledge of evidenced-based practice and research, the Training Consultation Group outlined the following suggestions for developing a common language in Queensland:

- Should respect multiple frameworks and philosophical understandings of child and adolescent development, including sexual development.
- Should respect the Queensland legislative context.

- Must be mindful of the immediate, intermediate and long term implications for a child or young person and their family when behaviour is labelled negatively.
- The language used should not define the child or young person but rather describe the actual behaviour in a non-judgmental manner.
- The language used must acknowledge the dynamic nature of the problem.
- The language used must recognise that the behaviours may impact upon a child or young person and their family across multiple environments, and that the language will be used across multiple human service agencies.
- Language used should avoid terms not commonly used in practice or research literature or that are more typical of sensational media which result in negative labelling of a child or young person i.e. young sex offenders, early sexual offending, child perpetrator, sexual predator, victim perpetrator, or sexual deviant.
- Should avoid language that applies to the Adult Sexual Offending field i.e. avoid use of grooming, paedophilia, relapse prevention etc.
- Should avoid language that relates to typologies as these are developmental, often theoretical only, and not tested in the Australian context.

Those children and adolescents who engage in sexual behaviours that may place themselves at risk e.g. multiple partners, unprotected sex etc. were excluded from this discussion. While this behaviour may co-exist with sexual behaviour that is potentially harmful to others (as indicated in Queensland data collection for the purposes of this Scoping Project), it is outside the scope of this Project.

Core language concepts were agreed upon and have been suggested for use as common language to facilitate communication across the Key Agencies, Key Stakeholders and Other Stakeholders. These terms are located in Appendix 3.

9. RESPONSE IN OTHER JURISDICTIONS

A number of Australian states are attempting to address the issue of how to respond to the needs of children and young people with sexual behaviour problems, sexually abusive behaviours and sexual offending. Across Australia, responses have included changes to legislation, cross-government collaborative interventions and service development through resource allocation.

Table 1 highlights a selection of some of the responses undertaken in Australian states to date. These responses require further assessment as to their applicability to the Queensland context, the effectiveness of the response in the state in which it is undertaken, and the knowledge gained about ineffectual responses in the Australian context.

Table 1: Examples of Responses Across Australia

Name of Program	Primary Purpose
Australian and New Zealand Association for the Treatment of Sexual Abusers (ANZATSA)	• Provides an avenue for developing and maintaining professional standards, practices, and education in sex offender management, treatment, assessment and research in Australia and New Zealand.
New South Wales Child Protection Legislation	• Enables the Children's Court to make a care order and/or an order to attend therapeutic treatment

	programs for children under 14 years of age who have exhibited sexually abusive behaviours where an order is required to ensure access and attendance at an appropriate therapeutic service.
NSW Commission for Children and Young People, Child Sex Offender Counsellor Accreditation Scheme (CSOCAS)	• Has established an accreditation process for professionals working in a counselling capacity with sexual offenders against children (children, young people and adults). • Has established links with ANZATSA including adopting the ANZATSA Code of Ethics. • Has established a public register of Accredited counsellors with the necessary knowledge and skill to work with people who sexually offend against children.
Victorian *Children, Youth and Families Act 2005*	• Provides for an alternative pathway into treatment when a child (10-14 years inclusive) exhibits sexually abusive behaviours and does not voluntarily seek help. The Children's Court may make a *Therapeutic Treatment Order* where Child Protection assesses the child is in need of treatment, and the child or child's parent/carer is unable or unwilling to access treatment. Where such an order is granted, a *Therapeutic Treatment (placement) Order* may also be granted that allows a child to be placed away from home if this is necessary for treatment. Criminal prosecution is not required. • Also provides for the establishment of a multidisciplinary *Therapeutic Treatment Board,* made up of representatives from Child Protection, Victorian Police, Office for Public Prosecutions, and treatment providers. This board will provide advice to Child Protection regarding *Therapeutic Treatment Orders.*

9.1 Services in other Jurisdictions *

There are a number of services established across Australia currently working with children and adolescents with identified sexually abusive behaviours. The following table is not a comprehensive list, however it represents some services that require further investigation specifically with regard to the model of service applicability to the Queensland context.

It is noted that further examples of services specialising in working with the client group/s are found overseas, particularly in New Zealand, the United Kingdom and some states of America. These services were outside the scope of this Project, however should be considered in developing new service models for Queensland.

Table 2: Examples of Services Across Australia

Name of Service	Primary Services Offered
New Street Adolescent Service (NSAS) New South Wales	• Sits under NSW Department of Health as part of an interagency child protection initiative. • Interdepartmental Advisory Group with representatives from NSW Health, child protection, police, juvenile justice education and a community victims services

	representative. • Early intervention program for young people who have sexually abused. • Counselling intervention for children and young people 10-17 years who have sexually abused, and family/carers • Group work interventions.
Rural New Street Adolescent Service (RNSAS) New South Wales Commenced September 2008	• Regional and rural early intervention program for children and adolescents who have sexually abused. • Forms part of the NSW Government response to child sexual assault in Aboriginal communities. • Interagency child protection response (NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011). • Therapeutic intervention with children and young people 10-17 years who have sexually abused but have not been charged or convicted. • Program based on NSAS service model.
Support, Assessment and Intervention For Families (SAIFF) New South Wales	• Private practice. • Team of counsellors providing assessment and treatment services for families with children and adolescents who engage in problematic or abusive sexual behaviours. • Works with all family members in sibling incest cases. • Centre based, outreach and regional assessment and treatment services. • Consultation and supervision available. • Training across Australia and New Zealand available.
Male Adolescent Program for Positive Sexuality (MAPPS) Victoria	• Adolescent forensic health service providing services to young people 10-21 years who have been found guilty of one or more sexual offences. • Five stage individual and group treatment program over approximately 12 months incorporating family support.
Sexual Abuse Counselling and Prevention Program (SACPP) run by Children's Protection Society in Victoria	• Therapeutic counselling service for children and young people who have been sexually abused, children with sexualised behaviours and young people with sexually abusive behaviours. • Works with all family members and relevant professional support systems i.e. education, mental health, child protection. • Works with all family members in sibling incest cases. • Mandatory and voluntary clients.
Protective Behaviours: A personal Safety Program by Children's Protection Society in Victoria	• Training and professional development for professionals working with children and families. • Funding by Department of Education and Training. • Program is a practical empowerment and resilience program.
Sexual Offence Awareness Program (SOAP) South Australia	• School-based program presented by police with teacher support. • Aims to raise awareness and knowledge concerning sexual assault, encourage young people to take responsibility for their behaviours and safety, advise young people of their rights, and provide guidance regarding available supports.

Safecare Western Australia	• Independent community organisation providing counselling, treatment and support to families where sexual abuse is an issue. • The Young People's Program caters for adolescents 12-18 years who have behaved sexually inappropriately within the family. • Fee for service.

* This list highlights only some of the services currently established in Australia and is not comprehensive. In most cases the information presented has been sourced from the internet, publications or promotional materials.

9.2 Related Projects*

There are a number of projects currently being completed across Australia that relate to the Scoping Project. The resources under development by the National Child Protection Clearinghouse maybe of practical assistance particularly to DChS staff in Queensland. The South Australian project may provide guidance regarding the effectiveness of a model of therapeutic intervention in the Australian context.

Table 3: Examples Of Related Projects Across Australia

	Name of project
National Child Protection Clearinghouse	• Specialist Practice Guide: Children (under 10 years) with problematic sexualised behaviours. • Specialist Practice Guide: Young people (10-14 years) with problematic sexualised behaviours. Both Guides are being developed as part of contract with Department of Human Services, Victoria. Guides are directed towards child protection and related non-government service workers, particularly regarding children in out-of-home care. Guides will be completed early 2009 and available on website along with associated bibliographies and literature reviews.
Children, Youth and Women's Health Service South Australia	• Recommendations 21 and 22 of Government Response to Mullighan Enquiry. Mullighan Enquiry: Children in State Care Commission of Enquiry completed in 2008. A series of projects have been developed to address Enquiry recommendations. This particular 12 month project is focusing on the effectiveness of specific therapeutic services for children in care and their carers. The project includes one service working therapeutically with adolescents with sexually abusive behaviours.

*This list highlights some of the projects currently underway in Australia. This list is in no way a comprehensive list.

10 SUMMARY

There are a number of strengths in the current Queensland service system with regards to the client group/s. These include the existing specialist services and the range of options they provide, the formal and informal relationships and collaborative practices already in place, the existing guidelines regarding

information sharing about clients, the commitment of Key Agencies to developing practical cross-government partnerships, and the culture of government and non-government services to utilise evidenced-based practice.

There are also a number of limitations in the ability of the current service system to meet the needs of children and adolescents with sexual behaviour problems, sexually abusive behaviours and sexual offending, and their carers. Access to service is determined firstly by where a child adolescents person lives, with most services operating in Brisbane or large regional areas. Therapeutic services for children are essentially located within sexual assault services. Generic child counselling services address therapeutic needs resulting from other forms of abuse but do not specialise in working with children with sexual behaviour problems. These services require education and training in this field as supported by the developing evidence of the links particularly between physical abuse and neglect and sexual behaviour problems. Services for children generally stop at age 10 years due to the Queensland Legislative framework. Therapeutic services for adolescents not involved with the Youth Justice System are limited to general counselling services or private practitioners. For those formally diverted from court and police, services are largely limited to South Brisbane. There is one state-wide service addressing the therapeutic needs of young people convicted of a sex offence, while Youth Justice services provide case management services. Generic therapeutic and other services for children and young people are attempting to meet the needs of the client group/s in some areas with inadequate access to training, supervision or appropriate resources. Other non-government and private-for-profit services self-report that they do not usually work with these client groups.

In addition, factors related to the manner in which the Queensland service system operates impacts upon its responsiveness to the client group/s. Critical factors appear to be inconsistent communication between Key Agencies, limitations in the ability to share information including client information and data across Key Agencies, a lack of coordination and collaboration specifically with regard to developing services across Key Agencies, and a lack of standardisation and/or accreditation across all aspects of service delivery relevant to all levels of the service system. Finally, there is a distinct lack of clearly defined roles across the broader Queensland service system relevant to the client group/s.

While each Key Agency is committed to addressing the needs of the client group/s, all have deficits in current internal responses to the problem. Key Agencies do not currently have clear policies, practices or protocols with regard to sexuality, sexual development and sexual behaviours of children and adolescents. Key Agencies do not generally include these issues in the mandatory professional development of staff. Key Agencies do not typically have guidelines to assist senior staff and managers to provide leadership in these areas across their relevant agency. Nor are there guidelines regarding best practice responses of specific roles (internal and funded non-government agencies) in relation to the client group/s. Further, Key Agencies do not typically have guidelines with regard to appropriate referral pathways relevant to this client group/s. Finally, existing legislation prohibits some elements of collaborative practice in the field, and fails to enable pro-active early intervention in some instances.

The lack of standardisation and accreditation in Queensland for professionals and paraprofessionals working with the client group/s was consistently raised as a factor impacting negatively upon service development, service delivery and ultimately client outcomes. Some Australian states have moved to address this issue and there is much to be learnt from those experiences.

There are multiple gaps in research internationally and particularly concerning the needs of children and young people with sexual behaviour problems, sexually abusive behaviours and sexual offending in the Australian context. This means there are limits to the applicability of current evidenced-based practice in this field.

Finally, there are opportunities for development across the Queensland service system. While a significant increase in resources is required to address the multiple limitations, there are less resource intensive options that could be undertaken to enhance the current service systems responsiveness to the issue. These steps include utilising existing cross-agency networks to build relationships, clarifying and educating staff about the legislation and policies that allow for the sharing of information across all services, widely circulating information about the availability of existing services, and utilising the suggested language in this report to facilitate communication about the issues.

11 RECOMMENDATIONS

In many respects, the outcomes of the Scoping Project are not unexpected. The Project arose due to reports of increasing concern in multiple contexts of the numbers of children and adolescents with sexually abuse behaviours and the service systems apparent inability to fully respond to the needs of these groups.

This report provides a benchmark against which the nature and extent of the problem over time, and the performance of the service system in responding to the relevant needs can be measured.

To facilitate action the key recommendation is:

1. The establishment of a high level cross-government forum or the ownership undertaken by a current forum to provide leadership in discussion and development of the Queensland response to the problem including collaborative problem solving of interdepartmental issues and the sharing of innovation and best practice. Whilst taking a long term view this forum could also oversee or provide support to the many activities identified for action throughout this report that do not require large funding and resource injections and may assist in short-term solutions to the problem.

Further recommendations include:

2. Key Agencies endorse the common language concepts developed through the Scoping Project (Appendix 3) and implement the usage of these concepts in the service system including documentation

3. Key Agencies utilise the 'Training and Supervision: The Queensland Context Discussion Paper' options to commence training for staff. Specifically option one provides information to assist in the identification of possible training providers to meet Key Agency training needs in the short to intermediate term.

4. The Scoping Project Review Paper list of services found in Appendix 5 be circulated widely to promote easy access to existing services funded to work with the client group/s.

5. Key Agencies provide education to staff about applying legislation and policy regarding information sharing about clients in order to facilitate interagency collaboration.

6. Key Agencies work on legislative change to provide the legal framework to improve information exchange and collaborative work with the child/young person. Each Key Agency needs to examine legislation in its own context to ensure it is appropriate to meet the needs of this client group. Key Agencies needs to examine legislative implications across agencies to identify barriers to collaborative work and information sharing.

7. Key Agencies reinforce expectations that local leaders/managers are to invest in established networking activities in local areas to build relationships and thus enhance interagency collaboration. This may lead to local area formal agreements establishing agreed practices between agencies, specifically communication, role expectations and clear understanding of each agencies responsibility.

8. Key Agencies influence internal research/scholarship programs to enhance a focus on prioritisation of this population.

9. Key Agencies review current internal policies, practices and protocol to ensure appropriate and consistent responses to children and adolescents' sexuality, sexual development and sexual behaviours (including sexual behaviour problems, sexually abusive behaviours and sexual offending). Ideally, this would link with Key Agencies existing policies, practices and legislation regarding responding to children and young people with complex needs and behaviours. Preferably, this task would be undertaken with high levels of collaboration across Key Agencies, perhaps through the cross-government forum recommended previously. Ideally, this would incorporate a review of legislation and the interpretation of the same in relation to the client group/s.

10. Option three from the paper 'Training and Supervision: The Queensland Context. Discussion Paper (establishing standardisation and accreditation in Queensland)' be implemented.

11. A standard data set be developed to gather information about the nature, extent and impact of the problems, that can be collected by each Key Agency and ideally by funded non-government agencies. This would include the establishment of a formal mechanism that allows the collected data to be shared across the key agencies. While initially this process could be undertaken as a time-limited research project, the optimal goal would be that it would be established with a view to being maintained over time to assist in monitoring and managing the problem in Queensland.

12. A cross-government review of the current distribution, accessibility and nature of available services relevant to the client groups be undertaken and a planned collaborative approach to addressing the gaps be developed and implemented. An investigation of the applicability of interstate and international service options to the Queensland context may enhance these discussions.

13. It is recommended that interdepartmental agreements are negotiated between Key Agencies and with funded non-government services, to

establish communication channels, collaborative practices and coordination of the field in local areas initially, and across the state as a longer-term goal.

14. The Scoping Project has focused on therapeutic services for the client group/s, non-therapeutic services specialising in working with the client group/s were not identified through the consultation process. It is recommended that other service system areas, including accommodation, lifestyle support, carers etc, are reviewed to ensure adequate service responses, appropriate training and supervision, and collaborative practice with all other aspects of the relevant service system.

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APPENDIX 1: DETA DOCUMENTATION SUMMARY

Source	Key documents	Relevance
Policies and Procedure	SMS-PR-012: Student Protection	Policy applies to all educational employees, non-departmental employees working in school context, and school volunteers and regular visitors Policy includes processes for preventing and responding to harm caused by educational employees, other students, non-educational employees and self harm.
	SMS-PR-021:Safe, Supportive and Disciplined School Environment	Education Queensland system wise response aimed at facilitating high standards of responsible behaviour and positive learning environments throughout Queensland state schools.
	SMS-PR-018: Information Sharing under the Child Protection Act 1999	Policy details the information that can be shared, which DETA employees can share the information, and which government and non-government entities information can be shared with.
	The Code of School Behaviour. Better Behaviour Better Learning	Defines the responsibilities that all members of the school community are expected to uphold and recognises the significance of appropriate and meaningful relationships. The Code provides the basis to enable positive supports to promote high standard of achievement and clearly articulated responses and consequences for inappropriate behaviours.
	Education Support Plans	Identifies educational goals of child or young person in care of DChS, and identified strategies and resources needs to achieve goals.
Forms	SP-P: Report of Suspected Harm or Risk of Harm	Used to record and report situations where it is suspected that a student has been harmed or is at risk of being harmed to Queensland Police and/or DChS.
	Responsible Behaviour Plan for Students	Based on The Code of School Behaviour, this plan is particular to individual schools. The plan aims to promote appropriate behaviour as well as detail consequences for unacceptable behaviours.
	Education Queensland Sharing Information for Child Protection	Contains details of services with whom DETA may share information, and contains record of information given or received by DETA
Training material	Student Protection Fact Sheet: What Happens when...a student harms another student	www.education.qld.gov.au/studentservices
	Student Protection Fact Sheet: Key Terms	www.education.qld.gov.au/studentservices Includes definition of Sexual abuse, Sexual Harassment, Sexual conduct and Sexual misconduct
	Student Protection Fact Sheet: Students sexual behaviour – a guide for schools	www.education.qld.gov.au/studentservices
Legislation	Child Protection Act 1999	Collectively this legislation outlines the responsibilities of all DETA employees in relation to student protection including where one student harms another student
	Criminal Code Act 1899	
	Education (General Provisions) Act 2006	
	Code of Conduct	

APPENDIX 2: DCHS DOCUMENTATION SUMMARY

Information Paper	Funding Information Paper 2005/2006 Sexual Abuse Counselling Services	Assists non-government organisations to apply for funding to deliver specialist counselling and therapeutic services for children and young people subject to child protection statutory interventions who have been sexually abused or are engaging in sexualised or early sexual offending behaviour, and their non-offending family members and/or carers.
Tools	Child Health Passport	May assist in identifying sexual development need of a child or young person.
	Child Strengths and Needs Questionnaire	Used every 6 month in review of child's progress and may trigger issues with regard to sexual abuse and/or problem sexual behaviours.
	Carers Handbook	Includes referral sources such as Family Planning Queensland. Outlines decisions making responsibilities e.g. only the Guardian can make decisions about invasive contraception.
Practice standards	Child Safety Practice Manual 2007	Highlights the need to support children in care who engage in sexually abusive behaviours. Recommends support for foster carers and service providers. Makes four recommendations for the management of children who have sexual abuse histories and/or histories of problem sexual behaviours: - Supervision. - Adequate sexuality education. - Modification of inappropriate sexual behaviours. - Addressing child's underlying needs. Outlines steps to take where a child is both subject to a child protection process and is the perpetrator of the abuse of other children that may include sexually abusive behaviours. Highlights procedures with regard to Evolve Interagency Services including referral processes. Outlines transition from care procedures that may include sexual development issues.
Policy	Placement of children in out of home care as part of integrated child protection response	Outlines conditions under which out of home care is an appropriate response e.g. where a child or young person exhibits sexual behaviours that cannot be managed in a foster care environment.
	Therapeutic Residential Care	Outlines intended use of therapeutic residential as a placement option e.g. where a child or young person exhibits sexual behaviours that can not be managed in a foster care environment. Outlines target group for residential care and includes children and adolescents 12-17 years with sexual behaviour problems.
	Specific Response Care	Placement and support model where an approved foster or kinship carer is employed to provide a specific response in their own home. Used only for children in care who have extreme support needs and are subject to an interim child protection order, or a child protection order granting custody or guardianship to the Chief Executive.

	Positive Behaviour Support	Positive behaviour support responses promoted for all children and young people in out of home care. Positive behaviour support responses are those that assist a child to learn acceptable behaviours through positive strategies, and are based upon attachment, trauma and child developmental theories and research.
Legislation	Child Protection Act 1999	Collectively this legislation outlines the responsibilities of all DChS employees in relation to child protection. This legislation is also directly or indirectly relevant to other Departments i.e. Department of Justice manages the Children's Services Tribunal Act 2000
	Children's Services Tribunal Act 2000	
	Commission for Children and Young People and Child Guardian Act 2000	
	Child Protection Regulation 2000	

APPENDIX 3: COMMON LANGUAGE FOR QUEENSLAND

The following core language concepts are proposed to be adopted for use as common language concepts to facilitate communication across the Key Agencies, Key Stakeholders and Other Stakeholders.

9.1 Sexuality

Sexuality is an integral part of life and contributes to everyone's personalities and individuality. Sexuality influences how people understand themselves and how they relate to others. It includes physical, social, emotional and spiritual dimensions.

"Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors." [72]

"Sexuality...is the sum of a person's inherited make up, knowledge, experiences, attitudes and behaviour as they relate to being a man or a woman." [73]

"Our sexuality is a crucial part of who we are and how we see ourselves in relation to others."[74]

9.2 Sexual Health

"Sexual health is a state of physical, emotional, mental and social well being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.[72]"

9.3 Sexual Behaviour

"Sexual behaviour is what a person does in expressing their sexuality".[73].

"Sexual behaviour may be expressed in a variety of ways including language, touch, exploring one's own body or another's; sexual activity; games and interactions". [76].

9.4 Healthy Sexual Behaviour

Sexual behaviours that are considered healthy are characterised by spontaneous, curious, light hearted, easily distracted experimentation either by oneself or between those of equal age, size and ability levels [76].

9.5 Sexual Identity

Sexual identity is about how individuals see and present themselves to others. The development of sexual identity is a complex, lifelong process involving the interplay of sex, gender and sexual orientation. It will be influenced by social, emotional, economic, political, legal and cultural factors [73].

Sexual identity comprises three components:

- Sex is the biological component relating to being genetically male or female.
- Gender is what occurs through the socialisation process.
- Sexual orientation is what attracts someone sexually to another [73].

9.6 Sexual Behaviour Problems

To be used when referring to children and young people 0-18 years of age.

Refers to sexual behaviour that is:
- Developmentally inappropriate and/or may undermine developmental tasks.
- Undermines safety of self and/or others.
- Presents problems for child/adolescent and/or others in the context or environment or relationship in which it occurs.
- May involve threat, intimidation, manipulation and/or coercion.
- May cause harm and/or have a negative emotional impact upon the child/young person or others.

Examples of Sexual Behaviour Problems will vary according to the age and developmental status of the child or young person, and the context in which the behaviour occurs. Examples may include:. 0-5 years old sexual behaviour is obsessive preoccupation, sexual behaviour is re-enactment of adult sexual activity, behaviour involves injury to self, 6-10 years old sexual behaviour involves penetration, genital kissing, oral copulation, simulated intercourse, 10-12 years old sexual behaviour involves young children [77].

9.7 Sexually Abusive Behaviours

To be used when referring to children and young people 10 -18 years of age.

All sexually abusive behaviour is illegal however, not all children and young people with sexually abusive behaviours are engaged with the legal system.

Refers to behaviour that:
- May be developmentally inappropriate.
- May cause harm and/or have a negative emotional impact upon others.
- May involve threat, intimidation, manipulation and/or coercion.
- May be a significant difference of age, size, abilities, and/or developmental status between children/young people involved.
- May occur without consent.

Examples will vary according to age and developmental status of the young person, and the context in which the behaviour occurs. Examples may include: voyeurism, stalking, sadism, non-consensual touching including: kissing, coercive sexual intercourse including oral copulation, behaviour that isolated the young person and is destructive of relationships [13] .

9.8 Sexual Offending

Queensland Legislation defines sexual offending for all individuals from 10 years of age. Sexual offending generally includes:
- A victim or person/s harmed by the behaviours.
- Lack of consent or agreement on behalf of at least one party to participate in the sexual behaviours.

- A difference of power, age, size or developmental status including cognitive and physical disabilities.
- Other clear circumstances usually defined as a criminal act by legislation.

APPENDIX 4: KEY AGENCY, KEY STAKEHOLDER AND OTHER STAKEHOLDERS RELATED PROJECTS

Key Agencies

Branch	Name of related project
Queensland Health	• Ed-LinQ aims to build cross-sectoral capacity for the prevention of and early intervention in mental health problems and disorders affecting school-aged children and young people. • Review of Queensland Health responses to adult victims of sexual assault. • Proposal for a multi-agency response model to address child sexual assault in Cherbourg.
Department of Child Safety	• Introduction of a learning management system which will assist in the provision and/or monitoring of professional development services within DChS across Queensland including rural and remote areas. • Development and introduction of Therapeutic Residentials for children in out of home care. • External review of Sexual Abuse Counselling Service (SACS) • Practice Framework. • Development of new practice resource to assist in the identification of children displaying early at risk behaviour problems, includes questions about problem sexual behaviours and related risk factors. • Development of new policy– Specific Response Care – to target the needs of children who can't be safely placed with other children. • Ongoing review of Practice Manual (currently version 10). • Development of new policy - Positive Behaviour Support Policy – incorporates Transforming Care Program designed to assist carers and residential carers to understand trauma.
Department of Communities	• Working with young sexual offenders on youth justice orders – Training Framework. • Working with young sexual offenders on youth justice orders – Case Management Framework. • Working with young sexual offenders - Service Standards (for external practitioners and funded agencies). • Working with young sexual offenders – Literature Review. • Data analysis regarding young sexual offenders on youth justice orders. • Service agreement negotiations and review of current contracts, with externally funded services.
Department of Education, Training and the Arts	• Traffic Lights Model training. In negotiation with FPQ to develop a vodcast to be used for training of Guidance Officers. • Student's sexual behaviour – a guide for schools. Recently developed information sheet. • On-line Student Protection Training recently developed. • A new 'Guide to social and emotional learning in Queensland state schools' recently released.

Disability Services Queensland	• Paper under development to inform policy regarding restrictive practices for children and young people with regards to managing challenging behaviours. • Evolve Behavioural Support Services Manual in final revision. • Draft early intervention framework.

Key Stakeholders

	Name of project
Family Planning Queensland (FPQ)	• Traffic Lights Model. • Setting and Solutions: Supporting access to sexuality and relationships information for children in care – recent publication. • Participant in review of Queensland Health responses to adult victims of sexual assault. • Proposal to DChS to develop training and associated resource material for DChS staff and foster carers regarding healthy childhood sexual development to be delivered in 12 separate locations across Queensland. Proposal for non-recurrent funding.
Griffith Youth Forensic Services (GYFS)	• Service agreement negotiation and review of current contract with Department of Communities. • Invited participants in Australia and New Zealand Association for Treatment of Sexual Abuse (ANZATSA) Annual Round Table. • Establishing an office in Cairns.
Family and Youth Counselling Service (formerly Face-up)	• Service currently undergoing external review. • Service Agreement negotiation and review of current contract with Department of Communities. • Invited participants in ANZATSA Annual Round Table.

Other Stakeholders In Queensland

	Name of project
Sunshine Coast Cooloola Service Against Sexual Violence Inc. (Laurel House and Laurel Place)	• Development of therapeutic service for adolescents (adjudicated and non-adjudicated) with sexually abusive behaviours under negotiation with DChS.

APPENDIX 5: SERVICE MAPPING

Information in this table was provided by the Key Agency/s funding the individual service. Where a service is not funded by a Key Agency as defined by this Project, and/or a service was contacted directly for the purposes of gathering information for the Scoping Project, the service will be marked with a *.

This list is not comprehensive as it does not include private practitioners, nor does it include general counselling services who might accept children and adolescents with sexual behaviour problems, sexually abusive behaviours or who have sexually offended.

SERVICE	FUNDING SOURCE	SERVICE AREA	CORE BUSINESS	POPULATION SPECIFIC SERVICE	ELIGIBILITY FOR SERVICE	TRAINING PROVIDER
Wide Bay Sexual Assault Service Association – Kids Intervention and Prevention Program / KIPP-Family Support Contact: 4121 7983	DChS	DChS Central Zone	• Sexual abuse counselling • Counselling • Family therapy and mediation • Assessment and case management • Social and personal development		• 0-18 requiring sexual abuse counselling • Child protection statutory intervention • Non-offending family member/carer • **0-12 displaying sexualised or early sexual offending behaviours**	
* **Phoenix House Association Inc** Located in Bundaberg 9 staff including 4 counsellors, 1 indigenous support worker, 1 preschool teacher, 2 administration staff and 1 manager	DChS - Central Zone Queensland Health Department of Family and Community Services	Bundaberg and surrounds. Outreach limited by resources and distance.	• Public health response to prevention of sexual violence • General and prevention based educational programs for schools and broader community • Prevention programs for children at risk of developing problem sexual behaviours • Individual, and group	• Therapeutic preschool for children at risk of developing problematic sexual behaviours and children who have been sexually harmed • Individual and group intervention for children and young people with problem sexually behaviours	• Children, young people and adults • Sexual abuse history, **problem sexual behaviours**, **adolescent sexual offending**, witnessing domestic violence • Children and young people with child protection statutory intervention prioritised	Yes Local and across state

Contact: 4153 4299			therapeutic intervention			
*** Sunshine Cooloola Service Against Sexual Violence inc. Laurel House Maroochydore and Laurel Place Gympie** Contact: 54434711	DChS QH	Caloundra City, Noosa, Cooloola and Maroochydore Shires	• Therapeutic intervention for children, young people and their non-offending family members/supporters who have experienced sexual violence • Programs for adult women who have been sexually assaulted	• Therapeutic intervention for children up to 12 years of age who engage/have engaged in sexually abusive behaviours • Therapeutic program for young males (12-17 years) who sexually abuse is under development	• Children, young people and adults • Sexual abuse history, **problem sexual behaviours**	
Barambah Regional Medical Services (Aboriginal Corporation) – Sexual Abuse Counselling Service Contact: 4169 8600	DChS	DChS Brisbane North and Sunshine Coast Zone	• Sexual abuse counselling • Counselling • Family therapy and mediation • Assessment and case management • Social and personal development		• 0-18 requiring sexual abuse counselling • Child protection statutory intervention • Non-offending family member/carer • **0-12 displaying sexualised or early sexual offending behaviours**	
Abused Child Trust Inc – Family Assist Sexual Abuse Counselling Program Contact: 3857 8866	DChS	DChS Brisbane South and Gold Coast	• Sexual abuse counselling • Counselling • Family therapy and mediation • Assessment and case management • Social and personal		• 0-18 requiring sexual abuse counselling • Child protection statutory intervention • Non-offending family member/carer • **0-12 displaying sexualised or early sexual offending**	

			development		**behaviours**	
Lifeline – Gold Coast Child and Youth Sexual Abuse Counselling Service Contact: 5539 9922	DChS	DChS Brisbane South and Gold Coast	• Sexual abuse counselling • Counselling • Family therapy and mediation • Assessment and case management • Social and personal development		• 0-18 requiring sexual abuse counselling • Child protection statutory intervention • Non-offending family member/carer • **0-12 displaying sexualised or early sexual offending behaviours**	
Mercy Family Services Toowoomba Sexual Abuse Counselling Program Contact: 4635 8600	DChS	Ipswich and Western Zone	• Sexual abuse counselling • Counselling • Family therapy and mediation • Assessment and case management • Social and personal development		• 0-18 requiring sexual abuse counselling • Child protection statutory intervention • Non-offending family member/carer • **0-12 displaying sexualised or early sexual offending behaviours**	
Lifeline Community Care Healing, Opportunities, Prevention and Education Sexual Abuse Service Contact: 3209 3622	DChS	DChS Logan and Brisbane West Zone	• Sexual abuse counselling • Counselling • Family therapy and mediation • Assessment and case management • Social and personal development		• 0-18 requiring sexual abuse counselling • Child protection statutory intervention • Non-offending family member/carer • **0-12 displaying sexualised or early sexual offending behaviours**	
Abused Child Trust Inc – Family Assist Sexual Abuse	DChS	DChS Northern Zone	• Sexual abuse counselling		• 0-18 requiring sexual abuse counselling	

Counselling Program – Townsville Contact: 4779 0611			• Counselling • Family therapy and mediation • Assessment and case management • Social and personal development		• Child protection statutory intervention • Non-offending family member/carer • **0-12 displaying sexualised or early sexual offending behaviours**	
* **Mater Family and Youth Counselling Service (formerly Mater Face-up)** 3 counselling staff Counselling staff are accredited or associate members of ANZATSA Contact: 3393 2516	Department of Communities	Greater Brisbane, Sunshine Coast and West Morton All clients seen at rooms in South Brisbane	• Therapeutic Intervention for children and young people with identified sexually offending behaviours	• Individual and family counselling • Establishment of safety plans and protective strategies for individual and family • Assessment of readiness and preparation for Youth Justice Conferencing • Youth Justice conferencing support for young person, and/or family members.	• All referrals from Youth Justice Conferencing only. • Referrals are negotiated between Greater Brisbane Youth Justice Conferencing Coordinator and service Young people who have sexually offended and are between ages of 10 – 16 years at the time of the offence. Young people who have been harmed by the offending and who are under 18 years. • Young person must have an adult care giver available for support and participation	Yes – limited to Youth Justice
* **Bravehearts** 7 staff including 4 psychologists and 3 counsellors Contact: 32904474	DChS Self-managed fund raising	Springwood and surrounding areas Service undergoing development on Gold Coast with	• Therapeutic Intervention for children who have experienced sexual assault, or who are at risk of sexual assault.	• Psycho-educational and protective behaviours focused groups for: • Children between 5–8 years with sexual behaviour problems • Parents of children 5-8 years run	• Fee for service on sliding scale • Services for some DCHS referrals do not incur a fee • 0-18 years therapeutic service for children and young people who have experienced sexual assault • 0-12 years therapeutic services for children who	Yes – for DETA upon request and building up training capacity for 2009

		plans to increase service in early 2009		parallel to group for children • Parents of children younger than 5 years. • Individual therapy for children 9-12 years with sexual behaviour problems	have experienced or are at risk of sexual assault (includes children exhibiting sexual behaviour problems) • Groups : 5-8 years children who have experienced sexual assault by an adult or by a peer no more then 4 years older (not eligible for group if displaying behaviours that include coercion, force or threats)	
* **Griffith Youth Forensic Service** 4 professional staff and 1 part-time administration – staffing levels under negotiation currently Contact: 07 37356910	University-based program funded primarily by Department of Communities	State-wide	• Provides specialized services for youth who have appeared in Queensland courts in relation to sexual offence matters • Emphasis on the provision of specialized services to a geographically dispersed and culturally diverse client group	• Pre-sentencing assessment and court reports • Post-sentencing intervention services for young people and their families utilizing a collaborative multimodal model • Consultation and advice to staff of Department of Communities and others upon request	• Court ordered assessment and treatment services to 10-17 year olds convicted of sexual offending in Queensland	Yes – currently under review but to date 14 days a year for Department of Communities. Others as capacity allows

APPENDIX 6

Table 4: Data Summary

Services	Population	Identified Sexually Abusive Behaviour	% identified with Sexually Abusive Behaviour	Current Sexually Abusive Behaviour	Past History Sexually Abusive Behaviour	Both Current & Past History Sexually Abusive Behaviour	Mean Age	Age Range	% Male	Aboriginal and or Torres Strait Islander	Culturally and Linguistically Diverse
Health											
CYMHS – RCH/Logan	798	32	4.0%	5	17	10	13	6-18yrs	47%	6%	3%
Forensic	251	48	19.1%	19	19	10	15	8-18yrs	95%	38%	1%
Evolve											
Evolve State-wide Referral Data	436	117	26.8%				12.6	4-16yrs	59%	31%	NIL#
Evolve TS	164	95	57.9%	12*	39*	37*	11.6	3-17yrs	60%	30%	1%
DSQ Evolve BSS	95	34	35.8%	16	9	9	14.3	10-17yrs	74%	35%	0%
Child Safety											
Transitional Data	370	107	28.9%				14	3-17yrs	65%	32%	NIL#
SACS	25	7	28.0%	6	1	0	11	7-16yrs	57%	0%	14%
Other											
FPQ-Disability/Education	15	8	53.3%	1	3	4	13	7-17yrs	88%	0%	NIL#
1 Phoenix House	48	48	100%	37	1	10	8.8	3-16yrs	50%	31%	NIL#
Overall Total	**2202**	**496**	**22.5%**	**96**	**89**	**76**	**12.6**	**3-17yrs**	**66%**	**25%**	**4%**

* one of the Evolve Therapeutic Services did not provide detailed information about the clients identified with current or past history of sexually abusive behaviour and therefore the figures in these three columns do not add up to the total identified.
# Data not available.

APPENDIX 7. SURVEY

Children and Young People with Identified Sexually Abusive Behaviours
Brief Service Survey

The aim of the survey is to provide a snapshot of children and young people who have identified sexually abusive behaviours in their presentation and or history to your service. This information will be gathered across a number of agencies. Please complete **ALL** the following questions. If you require any further information, contact **Tania_Withington@health.qld.gov.au** or by mobile 0418 191 130.

DATA PROVIDED SHOULD BE BASED ON THE CALENDAR MONTH OCTOBER 2008

Name of your Service:

1. Number of children and young people (0-18 years) referred to your service in the month of October (i.e., number of referrals)
2. Number of children and young people (0-18 years) accessing your service in the month of October (i.e., Number of opened clients for all or part of October 2008)

DEFINITION OF SEXUALLY ABUSIVE BEHAVIOUR

Identified sexually abusive behaviours broadly includes non-age appropriate sexual behaviours, high risk sexual behaviours, sexual behaviour problems, sexual behaviours placing self or others at risk, sexual behaviours that cause problems for self or others in the context in which they occur. Sexual offending is included, but definition is not limited to sexual offending.

3. Number of children and young people with current identified sexually abusive behaviours (i.e., within last 12 months)
   Number of children and young people with a past history of identified sexually abusive behaviours (i.e., excluding last 12 months)
   Number of children and young people with both a current and past history of identified sexually abusive behaviours

The below questions relate **ONLY** to those children and young people with a current presentation and or past history of sexually abusive behaviours

4. Mean age of children and young people with identified sexually abusive behaviour
   (Please identify the number of children this is based on) N=
   Age range of children and young people with identified sexually abusive behaviour

5. Number of males who have identified sexually abusive behaviour
   Number of females who have identified sexually abusive behaviour

6. How many identify themselves as:
   Aboriginal
   Torres Strait Islander
   Both ATSI
   Neither
   Unknown

7. Number of children and young people from a Culturally and Linguistic Diverse Background

8. Current Educational Level
   Pre-school aged
   Primary school
   Secondary School
   Secondary colleges (e.g., TAFE)
   Positive Learning Centres / Flexi-schools
   Special Education
   Distance Education
   Excluded
   Not Attending School
   Unknown

9. Number of children and young people with an identified disability
   Intellectual
   Physical
   Autism

Developmental
Neurological
Sensory and Speech
Acquired Brain Injury

Remember these questions relate **ONLY** to children and young people accessing your service with a current presentation and or past history of sexually abusive behaviours

10. Number of children and young people with identified sexually abusive behaviour who live in
Metropolitan (e.g., Brisbane)
Regional (e.g., Townsville)
Rural (e.g., Gympie)
Remote (e.g., Longreach)

11. Number of children and young people living with
Biological Family
Kinship Carers
Extended Family
Adopted Family
Foster Family
Residential Care
24hr Youth Worker Accommodation
Independent
Detention
Transient / Homeless
Other
Unknown

12. Of the children and young people with identified sexually abusive behaviour, the number who have the below mental health diagnoses:
Post Traumatic Stress Disorder (PTSD)
Mood Disorders (Depression and Anxiety)
Schizophrenia
Bipolar Disorder
Conduct Disorder
Attention Deficit / Hyperactivity Disorder (ADHD, ADD)
Attachment Disorder
Adjustment Disorder
Mixed Disorders of Conduct and Emotion
Pervasive Developmental Disorder
Subclinical Disorder
Other
Nil
Not reported

13. Number of children and young people with a child protection order
Current Child Protection Order
Past History of Child Protection Order/s
Never had a Child Protection Order
Unknown

14. Number of children and young people with a Child Protection History
Physical Abuse
Sexual Abuse
Emotional Abuse
Neglect
Known History of Child Protection but reason unknown

15. Number of children and young people with a Youth Justice Order
Current
History
Neither
Unknown

15. Number of children and young people with a Youth Justice Order specific to sexual offending

16. Number of children and young people involved in Youth Justice Conferencing specific to sexual offending

Remember these questions relate **ONLY** to children and young people accessing your service with a current presentation and or past history of sexually abusive behaviours

17. Please identify the five most common types of sexual behaviour that is exhibited by children and young people accessing your service (e.g., oral, anal, penetration, verbal/inappropriate language, unusual, dangerous to self, dangerous to others, exhibitionism, involving animals, inappropriate touching, sexual behaviour with violence, sexual behaviour without violence, stalking, sexual harassment, sexual risk taking, group context, internet or texting)

18. Context in which the sexual behaviour is exhibited
    Home
    School
    Community
    More than one of the above
    Other

19. Who are these children and young people typically referred by (please identify the main five referrers)

20. Who does your service typically refer these children and young people to (identify the main five services / agencies)

---

21. Please provide ONE brief **case study** for your team.

Brief description of child, children's presentation and broad context (include age, gender, cultural background, living situation, education status, and social context)

Describe the nature of the sexually abusive behaviour

Describe the impact of behaviour on the child or young person

Describe the impact on the person/s harmed

Describe the impact on others in the context in which the behaviour occurred

Describe the challenges the behaviour presents for the context / system in which it occurred.

Thank you for taking the time to complete this survey, your assistance is greatly appreciated.
Please forward completed survey by email to Tania_Withington@health.qld.gov.au,
or 289 Wardell St Enoggera Q 4051 or by fax 07-3355-8928.

APPENDIX 8 DATABASE INSTRUCTIONS

Scoping Project Database (excel spreadsheet)

Instructions to entry data into database

Data required should be based on October 2008

1. Enter the name of your service
2. Enter the total number of children and young people (0-18years) referred to your service (i.e., total referral count for October 2008)
3. Enter the total number of children and young people (0-18years) accessing your service (i.e., total open count for October 2008)

The main part of the database requires you to identify your current clients (children and young people 0-18yrs) who have a current and or past history of sexually abusive behaviour.

DEFINITION OF SEXUALLY ABUSIVE BEHAVIOUR
Identified sexually abusive behaviours broadly includes non-age appropriate sexual behaviours, high risk sexual behaviours, sexual behaviour problems, sexual behaviours placing self or others at risk, sexual behaviours that cause problems for self or others in the context in which they occur. Sexual offending is included, but definition is not limited to sexual offending.

Enter each client on a separate row. Each client should only be listed once (if client has had more than one intake in the month, include client once).
Move to next cell and start to complete the required information. Below provides a brief description of the data that is required.
Note a number of cells have built in drop down lists. For drop-down list, select arrow tab to left of cell and a list will appear, select the most relevant / appropriate item from the list. Only one item can selected.

Item Description	
Client	Sequential number 1, 2, 3....
Sexually Abusive Behaviour	Select Current, History or Both current and past history of sexually abusive behaviour from drop-down list Current = within past 12 months History = history exceeding past 12 months
Age	Enter age in years of client
Gender	Select Male or Female from drop-down list
Indigenous Status	Select Neither, Aboriginal, Torres Strait Islander, Both, or Unknown from drop-down list
Country of Birth	Enter the Country of Birth of the client
Current Educational Level	Select Pre-school, Primary, Secondary School, Secondary College (e.g., TAFE), Positive Learning Centre/ Flexi-schools, Special Education, Distance Education, Excluded, Not Attending School from drop-down list

Geographical Location	Select Metropolitan, Regional, Rural or Remote from drop down list. (e.g., Metropolitan = Brisbane; Regional = Townsville; Rural = Gympie; Remote = Longreach)
Current Living Situation	Select Biological Family, Extended Family, Kinship Carer, Adopted Family, Foster Family, Residential Care, 24hr Youth Worker Accommodation, Independent, Detention Centre, Transient/ Homeless, Other, or Unknown from drop-down list
Disability	Select Intellectual, Acquired Brain Injury, Autism, Developmental, Physical, Neurological, or Sensory / Speech from drop-down list
Mental Health Diagnosis	Select the primary Mental Health Diagnosis: ADD/ADHD, Adjustment, Attachment, Mood, Bipolar, Conduct, Mixed disorders of conduct and emotion, Pervasive Developmental Disorder, Schizophrenia, Subclinical, Other, Nil, or Not reported from drop-down list
Child Protection Order	Select Current, History, Both, None, Unknown from drop down list
Child Protection History	Enter whether history of physical, sexual, emotional abuse, neglect or a combination of some or all, or unknown
Youth Justice Order	Select Current, History, Both, None, Unknown from drop down list
Youth Justice Order specific to Sexual Offending	Select Yes, No, Unknown from drop down list
Youth Justice Conference specific to Sexual Offending	Select Yes, No, Unknown drop down list
Type of Sexually Abusive Behaviour	Identify main type/s of sexually abusive behaviour (oral, anal, penetration, verbal/inappropriate language, unusual, dangerous to self, dangerous to others, exhibitionism, animals, inappropriate touching, with violence, without violence, stalking, sexual harassment, sexual risk taking, in group context, internet or texting)
Context of Sexually Abusive Behaviour	Select Home, School, Community, Any combination of the above, or Other from drop-down list
Referred to Service By	Identify the service / agency who referred the client
Referred by Service To	Identify the service / agency you have referred the client to

Please SAVE the database as your service name and return to Tania_Withington@health.qld.gov.au

Scoping Project: Responding to the needs of children and young people with identified sexually abusive behaviours

TRAINING AND SUPERVISION: THE QUEENSLAND CONTEXT DISCUSSION PAPER

Project Coordinator: Tania Withington, Evolve Therapeutic Services, Child and Youth Mental Health Services, Royal Children's Hospital, Children's Health Service District

1. INTRODUCTION

This brief review of training and supervision in the Queensland context was undertaken as a task of the Scoping Project: Responding to the needs of children and young people with identified sexually abusive behaviours. The Scoping Project was designed to contribute to the Key Agencies understanding of existing service responses and service gaps, and to enhance the current service system capacity, when responding to the needs of children and young people with identified sexually abusive behaviours.

An original aim of the Scoping Project was to determine the current and longer-term training needs, and training options for Key Agencies responsible for responding to the needs of children and young people with identified sexually abusive behaviours in Queensland. This Discussion Paper provides the following information:

- Training needs of Key Agency staff as outlined by senior staff of each agency,
- Information about current training providers in Queensland,
- Information about available training in Queensland to assist Key Agencies to identify the training provider/s most suitable to their agency training needs,
- The beginnings of a model for training and supervision in Queensland, and
- Immediate, intermediate and long-term options to address training and supervision needs of Key Agency staff in Queensland.

The Key Agencies in the Scoping Project included:

- Queensland Health Evolve Therapeutic Services (QH ETS),
- Department of Child Safety (DChS),
- Department of Communities Youth Justice Services (YJS),
- Department of Education, Training and the Arts (DETA), and
- Disability Services Queensland Child Safety Behaviour Support Teams (DSQ BST).

A number of strategies to identify the training needs and options where utilized and these included:

- Consultation with each Key Agency,
- Consultation with stakeholders regarding gaps in training and supervision services in Queensland,
- A broad mapping exercise of established training services in Queensland in the relevant field, and
- The establishment of a Training Consultation Group for the purposes of the project including the current leaders in the field in Queensland.

Details of individuals and services who participated in the consultation process are documented in the final report of the Scoping Project.

Although the consultation process recognized significant gaps in regards to current training and supervision of services in this field in Queensland, it also identified a number of strategies for service providers to enhance and access training and supervision in both the immediate and long-term future.

2. LIMITATIONS

- All information included in this report about specific services i.e. knowledge, skill, expertise, state-wide national and international recognition, training capacity and training expertise is self-reported by the relevant service. This project did not incorporate an evaluative component so cannot attest to the veracity of the claims made by specific services.

- The services represented in the Training Consultation Group, and others referred to in this report are not the only training services available in Queensland. For example, private practitioners were not included in this consultation process.
- Training is an important factor in assisting Key Agencies, Key Stakeholders and Other Stakeholders to respond to the needs of children and young people with Sexual Behaviour Problems, Abusive Sexual Behaviours and Sexual Offending however it is important to acknowledge that training alone cannot address the multiple and complex problems and concerns present in working with this client group.
- While it is likely critical that training regarding this client group be available to all stakeholders in the service system, the Scoping Project identified Key Agency staff as the target group with regards to training. This paper primarily relates to Key Agency staff.
- Evidence-based practice and research in the area of training and supervision concerning professionals and paraprofessionals working with this client group is limited.

3. KEY AGENCY IDENTIFIED TRAINING NEEDS

The Project Coordinator met with senior staff of DChS, DETA and DSQ BST. An email survey was undertaken with QH ETS Team Leaders. A meeting was held with YJS project staff working independently of this Scoping Project to address the issue of service development including training for YJS direct service staff about the client group.

A summary of the Key Agency identified training needs is located in Appendix A.

Senior staff from Key agencies identified the following limitations to current training approaches and availability in this field:

- Four of the five Key Agencies had previously accessed training in the field in an ad hoc manner, one Key Agency with a more planned approach to training in this area was not able to access training for all required staff.
- The Key Agencies had not conducted a recent or topic specific training needs analysis or similar process to establish the training needs of staff.
- One Key Agency has established some internal self-directed training options with limited consultation outside the agency. This Key Agency self-reported that it does not currently have a method establishing the frequency of access to, or effectiveness of the training.
- The Key Agencies each self-reported that they do not have a method of establishing the transfer of training knowledge to practice, although most are aware of this issue and are attempting to address it with regards to all training accessed by the services not limited to this field.
- (Youth Justice have draft documents outlining a new approach to staff training in this field that address some of these issues).

All Key Agencies identified that they required training that:

- Includes a range of knowledge incorporating content from a basic to advanced level,
- Relates directly to the context of the Key Agency, and the roles and responsibilities of staff,
- Incorporates ongoing professional development activities to support the transference of training knowledge into practice in a context appropriate to the Key Agency,
- Incorporates current evidence based practice and research, and includes a focus on collaborative practice ,and
- Is available to the broader network of support services including non-government agencies, residential staff and foster carers.

4. CURRENT QUEENSLAND TRAINING

There are a number of training providers in this field in Queensland, these include private practitioners, for-profit agencies, and government and non-government agencies. There is no

coordination across providers and as a result no standardization of training content, structure, or target audience requirements. Significantly, there is no manner in which to verify the credentials of training providers. Training amongst service providers is highly variable with some trainers providing infrequent training for-profit, others providing training upon demand whilst others participate in regular training forums with Key Agency staff coordinating the overall program. A small number of training providers are informally recognized as leaders in the practice field across the state, however most providers are known only to local geographically located service networks.

4.1 THE TRAINING CONSULATION GROUP

There are currently six services in Queensland that are established trainers in the field of working with children and/or young people with sexual behaviour problems, sexually abusive behaviours and/or sexual offending. These services include:

- Family Planning Queensland (FPQ)
- Sunshine Cooloola Service Against Sexual Violence Inc. Laurel House (LH) in Maroochydore and Laurel Place (LP) in Gympie
- Phoenix House (PH)
- Child and Youth Forensic Outreach Service, Child and Youth Mental Health, Royal Children's Hospital, Children's Health Service District (CYFOS)
- Sexual Abuse Counselling Service, Department of Child Safety (SACS)
- Griffith Youth Forensic Services (GYFS), Griffith University

Each of these services is recognized in Queensland by Key Agencies and Other Stakeholders as providers of training in this field over time, and they each have a connection to at least one of the Key Agencies, usually via service agreements and/or as a referral source and/or as a regular training provider. These services formed the basis of the Training Consultation Group for the purposes of the Scoping Project.

The primary audience for the Training Consultation Group services is currently very narrow, largely due to existing resource limitations. The primary audience includes staff from Key Agencies with limited opportunity for other services to access training, either by participating in cross-agency training upon invitation or by negotiating a fee for training arrangement. All but one of these training providers (FPQ) is also a clinical service provider in this field. As training is part of a broad service delivery model for each of these training providers, current resources limit the amount of training undertaken and the numbers of Key Agency staff who can attend.

FPQ has the broadest primary training audience, including mental health services, disability services, child protection workers, educational staff, foster carers and parents. FPQ also provides training to community and indigenous health staff, youth workers and early childhood workers. GYFS primary target audience is limited to Youth Justice workers, although they will also provide fee-based training and have historically trained child protection workers, disability services, non-government agencies, foster carers, youth workers, mental health workers, university students and practitioners in the field nationally and internationally. CYFOS primary audience is limited to mental health services and youth justice workers however others may access service in a cross-agency training context or for a fee. SACS primary audience is child protection workers and foster carers. SACS have historically provided training as part of the Interviewing Children and Recording Evidence (ICARE) program for police and DChS and can provide training to other services upon request. PH in Bundaberg take a whole of community approach to training and have both a targeted training program and program available upon request. Likewise, LH/LP adopts a whole of community approach training target populations such as professionals in human services, school staff and students, foster carers residential staff, family members and carers.

Appendix B outlines training content currently provided by members of the Training Consultation Group. Each training provider currently has the capacity to develop training to meet the needs of

the audience, to incorporate new Evidenced-based practice and research (critical in a developing field of practice and research), and to work collaboratively with Key Agency or other service providers to incorporate context related material and practice issues i.e. legislation, role responsibilities and policy.

Appendix C outlines the geographical availability of training in Queensland currently, and the structure of training i.e. lecture or workshop. Of note is that three training providers, FPQ, CFYFOS, GYFS, have or are either investigating or developing online training options.

4.2 OTHER TRAINING PROVIDERS IN QUEENSLAND

There are a number of other training providers in this field in Queensland. These include private practitioners, for-profit agencies and non-government agencies. Training providers not included in the Training Consultation Group include those who; are not recognized as established training providers in this field, only provide infrequent training, are not linked with a Key Agency, and those that are not accountable for the standard of training outside their own agency.

One example of a service developing training in this field is Bravehearts. This service currently provides training to DETA on an as needs basis. Bravehearts are also developing a fee-for-service one day training for therapeutic service providers that work with children who have disclosed sexual abuse. Bravehearts intend to build capacity to provide training across their expertise (including children with sexual behaviour problems) in 2009.

Mater Family and Youth Counselling Service (FYCS), formerly Mater Face-up, were invited to participate in the Training Consultation Group for the purposes of the Scoping Project. FYCS participate in the training of Youth Justice Conference staff organized by the State-wide Quality Services Team in Youth Justice Training Unit on a regular planned basis. FYCS opted not to participate in this group as the service is not currently a frequent training provider, has very limited resources to commit to provide training and is not planning to develop this side of the service in the near future. However, FYCS have indicated in an interest in developing and providing mentoring services for other therapeutic services working with adolescents with sexual offending behaviours in the future, if an increase in resources is made available.

5. SUPERVISION AND MENTORING

The importance of supervision and mentoring to assist in the transfer of training knowledge to practice and to assist in maintaining currency in a rapidly developing field of practice was repetitively highlighted across the broader consultation of the Scoping Project. The Training Consultation Group identified access to this form of professional development and support as critical to individuals working in this field, to not only ensure sustainability of best practice but also for the well-being of the practitioner.

Currently, supervision and mentoring in this field are very limited resources in Queensland. GYFS provide supervision and mentoring to students and professionals working directly with GYFS, and or those service providers sharing clients with GYFS. PH may negotiate to provide supervision and mentoring upon request, PH also offer an internship program. SACS, CYFOS and FPQ provide informal mentoring within existing relationships, largely consisting of consultation and advice to CYMHS, QH ETS and to generalist counselling services in more rural and remote areas. LH/LP provides supervised student placements, and frequent consultation to human service agencies such as CYMHS, QH ETS, DSQBST, and education. All services represented in the Training Consultation Group provide internal clinical and/or educational supervision and mentoring for their own staff, and some purchase supervision from outside sources that are recognized leaders in the field nationally and/or internationally. All of these services, excluding FPQ, self-report that they are skilled and experienced to provide supervision externally however current resources place practical limitations on this aspect of service delivery.

It must be noted that the lack of standardization and accreditation in Queensland also has an impact on the supervision and mentoring, that is, there is no consistent manner in which to guarantee or evaluate the standard of service provided.

6. GAPS IN TRAINING IN QUEENSLAND– AN OVERVIEW

Consultation with Key Agency Staff, Key Stakeholders, Other Stakeholders and the Training Consultation Group identified multiple gaps in training and supervision across the state. These gaps are outlined below:

Broad Systems Issues:

- Limited availability and accessibility of training for all human service organizations working with children, young people and families across the spectrum of knowledge and skills i.e. healthy sexuality and behaviours, identifying and responding to sexual behaviour problems, and sexual offending.
- Training delivery currently tends to focus on direct service staff however training needs to also be delivered to senior staff including management to enhance system knowledge and responsiveness to population needs.
- Limited coverage in university courses to provide adequate skills and knowledge to equip people to work in the field.
- Some practitioners are working outside their professional training expertise (ethical concern). This issues has reportedly arisen for several reasons including pressure to respond to the client group/s needs as no other service is available, limited access to training and supervision, and the lack of standardization and accreditation in the state in this specialist field. This issue impacts equally across, training, supervision and mentoring.
- Training not readily available to appropriate audiences.
- Significant content gaps across developmental and risk continuums.
- Little coordination of training across state.
- Little collaboration between existing and potential trainers.
- There is no accreditation system for trainers or practitioners in the field in Queensland which potentially impacts on the quality of training and services available to children, young people and families.
- There is no systematic approach to evaluating training effectiveness, currency and transferability to practice.
- Of the limited training available in the state there is a gap between clinical expertise and training expertise i.e. a trainer may be very skilled clinically but not be a strong trainer.

Key Agency Issues :

- Access to training for Educational Staff i.e. Guidance Officers and Teachers.
- Access to training for YJC staff.
- Supervision and mentoring of YJS case workers when YP is not involved with GYFS.
- Training for residential staff i.e. youth workers.
- Training for frontline child safety staff particularly regarding sexually abusive behaviours and how to respond to and manage these behaviours, and how to support families to respond to and manage behaviours.
- Training and supervision for mental health staff including specialist and community services.

Issues for Specialist Services:

- Limited professional development opportunities for clinicians working in the field to up-skill and remain current in the field.
- Difficulty in accessing supervision specific to the field which increases as you move further away from Brisbane.

7. KEY LEARNINGS FROM THE LITERATURE

A brief review of the research literature investigating the relationship between training professional staff and positive intervention outcomes for children and young people with sexual behaviour problems, sexually abusive behaviours and sexual offending reveals a lack of evidence regarding links between training staff and positive outcomes for clients. A growing body of research literature does investigate the effectiveness of various therapeutic interventions; however, this was not reviewed as it was outside the scope of the current Project.

The research literature in the field of training for professionals and paraprofessionals working with adolescents and adults who have sexually offended, focuses on the impact of (primarily introductory) training on professionals/paraprofessionals confidence and willingness to work with the client group/s. The impact on individual service providers working with this client group i.e. burnout, are also touched upon. Only one study has been undertaken and reported from the Queensland context, this study specifically related to the effectiveness of the GYFS training [1].

The limited existing research literature indicates that:

- A key component of the successful treatment of young people includes the training and skill enhancement of all staff involved in intervention [1]
- Training is effective in improving awareness and confidence in working with sex offenders [2]
- Training results in attitude changes including challenging stereotypical negative views of sex offenders, and thus facilitating a willingness to work in the field [1, 3]
- Professionals working with sex offenders who complete training are at less risk of vicarious trauma, report an increase in confidence to provide intervention, and hold a stronger belief that intervention can be effective [3, 4]
- Best Practice in the field indicates that training providers need to have current practice experience i.e. The New South Wales accreditation scheme allows only the most experienced clinical practitioners to deliver training and supervision (www.kids.nsw.gov.au?kids/check/offendercounsellor.cfm)

Current research, while limited, appears to support links between training and the willingness and confidence of professionals and paraprofessionals to work with the client group/s. Training also appears linked to the sustainability of the workforce i.e. maintaining health and well-being of workers. These factors are seemingly influential in the availability and provision of treatment and intervention programs. As the completion of treatment programs appears to be a significant factor in reducing sexual behaviour problems in children [5, 6], and in reducing sexual offending recidivism in adolescents [7, 8], it appears that a commitment to training and supervision of service providers in this field in Queensland is essential.

8. A WAY FORWARD FOR QUEENSLAND

All consultation undertaken as part of the Scoping Project has highlighted the need for Queensland to develop a model of service provision (including training, case management therapy, specialist carers and others) that enables standardization and accreditation of all service providers working with children and young people with sexual behaviour problems, sexually abusive behaviours, and sexually offending. This model would best address the gaps by setting and monitoring standards for all aspects of the service system. Although the proposal below focuses on training it holds implications for all aspects of service delivery. The proposed model recognizes the critical roles played by case managers, therapists and trainers working directly with the client group, and the limitations of the current Queensland service system response to the needs of these children and young people. The proposed model also has the flexibility to incorporate other roles from within the current service system such as foster and residential carers.

Developing a model for Queensland is a challenging task. The physical size of Queensland, the widely spread population and the diversity of culture are issues not addressed in the proposed model but must be considered if the model is developed further. There are also multiple challenges in developing a training model across two diverse heterogeneous population groups, i.e. that is children with sexual behaviour problems and adolescents with sexually abusive behaviours or sexually offending. Additionally, when working with these populations it is critical to be mindful of the often delicate balance or even open conflict between the developmental tasks of childhood and adolescence and the risk continuum that exists when working with sexual abusive behaviours.

The proposed model is built on the following principles identified in the Training Consultation Group:

- Promoting healthy and positive childhood and adolescence sexuality is the responsibility of the whole community, including all service providers working with children, young people and families,
- The whole community of Queensland requires access to accurate information regarding the sexuality and sexual development tasks of childhood and adolescence,
- All human service workers require a basic level of knowledge in understanding childhood and adolescent sexuality and sexual development in order to assist in the identification and early intervention process where sexual behaviour problems emerge,
- There are multiple levels of responsiveness required to assist children and young people with sexual behaviour problems, sexually abusive behaviours and sexual offending including identification, early intervention, individual and systemic interventions and offense specific interventions,
- There are multiple roles played by service providers at each level of responsiveness and these roles require training and supervision on par with the responsibility of the role i.e. case management, therapy, trainer (this principle could be extended to other roles in the service system such as foster and residential carers).

While standardization and accreditation is not currently available in Queensland, this model was developed with the idea of prompting opportunities for building relationships, collaborative practices and consistency across the state. Each of the training providers represented in the Training Consultation Group has expressed a willingness to collaboratively develop and facilitate training with other training providers in the context of this model (or in the broader context) and with the support of the Key Agencies. The Training Consultation Group developed for the purposed of this project, has also identified that the membership of the group would likely need to be extended should this proposed model by supported for further development.

8.1 PROPOSED TRAINING MODEL

The proposed training model is presented in Table 1.

TABLE 1: THE PROPOSED MODEL

TRAINING LEVEL	CORE SKILLS	TARGET AUDIENCE	SUGGESTED AUDIENCE IN QUEENSLAND
Level Five: Established	Specialist therapeutic and/or training and/or case management skills and knowledge specific to working in this field including:	This group would work primarily with the identified population, most frequently in specialist services	*Ideally practitioners at this level would be accredited to provide therapeutic intervention, case management, training and/or supervision in relation to the*

	- Completion of complex risk assessments and safety planning - Supervision and mentoring - Systemic collaboration - Current Evidenced Based Practice and research - Contribution to Evidenced Based Practice and research May Include: - Peer supervision - Training by referred National and International trainers and practitioners - Annual forum/conference - Support for new services in field - Leadership of collaborative practice	as established practitioners. This group would hold expertise and skill, and responsibility, to train or source training including supervision and mentoring for own staff.	*specific population groups. Such an accreditation process would assist in establishing who the specialists in the field in Queensland are and who provides leadership in best practice in the Queensland context.* *The audience at this level would be active participants in professional development activities and leaders in the field for Queensland.* *May incorporate a train the trainer component.* For Example: - GYFS as specialists in the field of adolescent sexual offending with national and international recognized expertise in the field - FYCS - CYMHS Forensic Teams - Phoenix House - Laurel House/Laurel Place - Sexual Abuse Counselling Service - Individuals within broader services with specific expertise in the field i.e. Evolve Therapeutic Services, CYMHS, DSQBST, Youth Justice Caseworkers/Conferencing staff *It must be noted that many of the above examples are based on service self-reports of expertise and skill, or on an assumption that a service could develop the skill and expertise required to operate effectively at this level*
Level Four: Advanced	This group would require a high level of knowledge and skill particularly with	This group would work within more generalist services but hold a higher	*Ideally an accreditation system in Queensland would acknowledge the advanced knowledge and skills of this*

	regard to: - Current research - Best practice responses - Interpretation and implementation of risk assessment and safety planning - Collaborative practice	level of knowledge and skill with regard to the identified population and be able to provide leadership in the field within their relevant context.	*group* *This group may provide basic - intermediate training for levels 2 and 3.* *May incorporate a train the trainer component.* For example: - Senior Practitioners from DChS - Evolve Therapeutic Services - Evolve Disability Services Queensland Behavioural Support Teams - Youth Justice Conferencing - Youth Justice Caseworkers - Other services/individuals who have previous training and/or are practicing in the field - CYMHS
Level Three: Intermediate	This group would require an intermediary level of knowledge and skills specifically with regards to - Basic assessment - Referral pathways - Identifying when to consult or refer - Policy and procedures - Legislation - Safety planning - Working collaboratively	This group would work in generalist services with children and young people at risk, and be required to respond to the needs of the identified population.	*Ideally an accreditation system in Queensland would acknowledge and support developing expertise* For example: - DETA staff including Principals, Guidance Officers and Behavioural Support Staff - DChS - *Specialist / Specific Response Carers - *Therapeutic residential Case Staff * Further discussion regarding the placement of these groups is required.
Level Two: Basic	The group requires basic information with regards to: - Etiological theories - Healthy sexual development and sexuality	This group would work with children and young people at risk, or with identified problems.	All human service workers including but not exclusively pre-graduates, foster carers, kinship carers, parents with children and adolescents with identified problems, non-government agencies, indigenous services, migrant

	- Sexual Abuse generally – myth busting - Problem sexual behaviours - Abusive sexual behaviours - Sexual offending - Basic response and support strategies in relevant context - Referral pathways - Recognition of the complexity and influence of developmental context and social learning - Safety planning		and refugee services, private practitioners, medical practitioners, police, disability services, community visitors and general child health services. Educational staff such as teachers may be linked to this training level.
Level One: Community	Aims to educate the broader community to demystify childhood and young people's sexual development and sexual behaviours. Aims to promote the opportunity for all children and young people to experience healthy sexual development and remain safe.	Whole of Community	*Ideally, key agencies and other relevant government departments would work collaboratively to undertake this task.*

There are five levels of responsiveness required to meet the needs of children and young people across multiple service contexts. At each level there is core knowledge and skill required across all service contexts and a required focus on collaborative practice, the nature of which is defined by service specific knowledge and skills, roles and level of responsiveness. The proposed model advocates that cross-service and cross-sector training could occur at levels 2-5 with regard to core knowledge and that specific training could occur at the same level in addition to the core training i.e. day one cross-service core training, day two context/service/role specific training. At levels 4-5 more emphasis will need to be placed on context/service/role specific training and supervision. The model advocates training for a range of staff within each service organisation i.e. direct service staff, policy staff and management in order to facilitate consistency in response within and across services.

The provision of training may take several formats depending upon the training context and level. Training format may also take onto consideration the geographical spread of staff and the preferred format (or current professional development models) of the Key Agency/s or broader

audience. For example, DCHS and DETA may prefer on-line training options for basic training, and face-to-face or video-conferencing options for intermediate training, Evolve Therapeutic Services may access on-line training for basic training and intensive workshops for intermediate and higher level training.

The model is designed to be dynamic with training and practice experience at one level preceding advancement to the next level of responsiveness. Importantly the rapidly developing nature of this field of practice makes it imperative that contemporary knowledge and skills are incorporated into training and supervision. Providing annual training boosters, professional development activities and ongoing mentoring and supervision will be vital strategies to meet this requirement and will require a significant increase in current resources in Queensland

At this stage the model briefly outlines the core context likely to be required at each level of responsiveness. There is recognition that a continuum of knowledge and skill is required within each level to take account of developmental and risk factors present in the population group. Further development of the model would aim to clearly state the training goals, training content, and the expectations concerning knowledge and skill at the completion of training i.e. Participants completing level two training are not expected to provide a specialist service for adjudicated sexual offenders.

Ideally a whole of government governing body would be established that would provide support and facilitate collaboration across multiple service sectors working with all children, young people and families with sexual behaviour problems, sexually abusive behaviours and sexual offending. This body would develop, implement and monitor a process of accreditation for all parts of the service system working in this field and could potentially have a coordinating role for training, development and implementation of the proposed model. The training provided within this model should be competency based and relate to standardization and accreditation of therapists / trainers / case managers or others as negotiated i.e. specialist carers. This body would interact with the established overarching body already established to represent the field in Australia and New Zealand: The Australian and New Zealand Association for the Treatment of Sexual Abusers (ANZATSA)

Finally, all training provided in this field and in the context of this model would be evaluated by an agreed format with evaluation outcomes reported to Key Agencies, national and international peers. Ideally the evaluation process would become part of a collaborative commitment to research around training provision and effectiveness and contribute to the developing field of practice in the Queensland, nationally and internationally.

It is of note that each Key Agency could identify ways to work towards this model immediately. For example, Evolve Therapeutic Services may take steps to enhance the knowledge and skills of all therapeutic staff in this area, and a core group of therapeutic staff across the state may be identified to develop specialist skills through more specialist training and supervision. The ultimate aim would be for all ETS staff to hold a minimum of Level 3 knowledge and skill, with a smaller group of ETS therapeutic Staff working towards Levels 4 and 5 knowledge and skill.

8.2 CURRENT KNOWLEDGE AND SKILL TO PROVIDE TRAINING UNDER THIS MODEL IN QUEENSLAND

The members of the Training Consultation Group identified that they held the knowledge and skill to provide some of the training described under the proposed model as per Table 2. It is important to note here that this information is self-reported by each service as there is no consistent manner in which to evaluate training knowledge and skill or effectiveness in this field in Queensland. Each Training Consultation Group representative acknowledges this challenge.

TABLE 2: TRAINING CONSULTATION GROUP KNOWLEDGE AND SKILL

Training Provider	Age Range of clientele	Training Level Available	Supervision Availability
Griffith Youth Forensic Service	10-18 year olds	Levels 2 – 5	Levels 2-5 with additional resources
Child and Youth Forensic Outreach Service	0-18 year olds	Levels 2-5	Levels 2-5 with additional resources limited to CYMHS and YJS
Laurel House / Laurel Place	0-18 years, and adult women	All levels	All levels additional resources
Phoenix House *	0-18 years, and adults	All levels	All levels with additional resources
Family Planning Queensland	0-18 years or other levels in collaboration with other providers	Level 2	No
Sexual Abuse Counselling Service	Children under 10 years	Levels 2-5	For therapists working with children on a child protection order

* Phoenix House runs a number of courses, which can include supervision. Some Phoenix House courses include a Train the Trainer component for which Phoenix House staff are accredited by the author of the relevant course.

8.3 PROPOSED MODEL LIMITATIONS

A challenge for the future development of the proposed model is to map it against an existing system or systems relevant to all Key Agencies, Key Stakeholders, and other Stakeholders. This would include expanding the model from its current focus on content/knowledge, to incorporate adult learning principals, professional development models associated with specific roles i.e. university and professional associations, specific skill requirements associated with roles i.e. child safety caseworker and organizational structures, and mapping against existing Australian training systems i.e. AQTF

The model has focused on the needs of Key Agency staff as outlined in the Scoping Project Plan however other services and service system supports such as residential workers, youth workers and carers were considered. There was no agreement within the Training Consultation Group as to the expectations and responsibilities of these groups in providing specialist services to the client group and thus the requirements about access to higher levels of training and supervision were unclear. Part of the discussion appeared to be related to language i.e. the meaning of therapy, and partly it reflected the gaps between current expectations of these groups and the reality of educational and skill levels. All recognized the significant contribution of these groups to the successful engagement of children and young people, the implementation of safety and therapeutic goals, and the implementation of transition to independence from specialist services. This area requires further debate.

At this stage in its development the model outlines core skills required by the target audience at each training level but does not outline the expertise and experience that could be expected from training providers at each level. It is fair to assume that there would be different expectations of trainers depending upon the level of training to be provided i.e. at Level 5 training providers could be expected to be established specialists in the field with advanced clinical expertise. A standardization and accreditation processes for Queensland would assist in clarifying the expectations for training providers.

The model has identified a whole of community level for education, Level One. This level is outside the roles and capacities of the current training providers in Queensland but rather requires a whole of government approach for development and implementation.

This proposed model was developed in a half-day consultation with the Training Consultation Group and requires extensive further discussion and development. It also requires broader consultation with Key Agency, Key Stakeholders, and Other Stakeholders (defined in the Scoping Project Plan) and is particularly important if this model is to form the basis of discussion for a standardization and accreditation process in Queensland.

Finally, while there are aspects of the model that have the potential for implementation with Key Agency support and minor enhancement of current resources, the development and implementation of the model including a governing body requires whole of government support and significant resource enhancement.

9. OPTIONS

The following options have been identified to meet short, medium and longer-term training needs of Key Agency staff. The immediate options do not attempt to meet the needs of the broader human services sector including generalist counsellors, residential carers, or foster carers as resources are limited. However, options 1 and 2 have potential to be extended beyond Key Agency staff with appropriate resource allocation. Options 3 would ideally incorporate all providers within the service system working with the client group/s.

It must be noted that training is only one of a number of interventions required to address workforce development needs in relation to the Queensland service system and community response to children and young people with Sexual Behaviour Problems, Sexually Abusive Behaviours, and Sexual Offending. As such, moves to address gaps in training, supervision and other forms of professional development will ideally occur in the context of broader service system development in this field in Queensland. Some of the following options are offered within this context.

OPTION ONE: (IMMEDIATE / INTERMEDIATE OPTION)
This option is largely reflective of the current practices in Queensland.

Key Agencies to each approach training providers to negotiate training, supervision, mentoring needs and associated resource requirements.

The information presented in this document should provide a guide only to the training providers that may be best able to meet the Key Agencies identified needs. The Appendices of this paper provide an overview of self-reported relevant information about each member of the Training Consultation Group to assist in facilitating links between Key Agencies and training providers. To uses this document efficiently to identify possible training provides best able to meet the needs of a Key Agency the following steps are suggested:

1. Identify the training needs of your particular staff group/individual staff members.
2. Using Table 1, identify what level training is required.
3. Using Table 2, identify the training provider/s that self-report they are able to provide training at that level.
4. Using Appendix B review the content of training available (contact details are included in this Appendix).
5. Appendix C provides information about the training providers modes of training delivery and geographical areas covered.

It is suggested that Key Agencies consider the following factors when identifying potential trainers:

- What are the qualifications of the service and the individual training providers?

- What is the clinical and training experience of the service and individual training provider?
- What evidence does the training provider have of the effectiveness of training including the transference of training knowledge to practice?
- Does the training provider's qualifications and experience match the level of training your service requires, the client population of your service, and the role of your service?
- Does the training provider utilize current evidenced-based practice and research in training delivery and content?
- Does the training provider offer flexible training delivery options suitable to your agency context?
- Does the training provider offer clear training outcomes?
- Does the training provider offer post-training support in a form suitable to your service i.e. consultation, mentoring, supervision?
- Are the trainers members of ANZATSA?

OPTION TWO: (INTERMEDIATE OPTION)
The development and provision of basic and intermediate training (i.e. levels 2-3 of the proposed model) for Key Agency staff by the Training Consultation Group members. For example, a 2/3 day workshop for all Key Agency staff (cross-agency training) where each member of the Training Consultation Group provides an aspect of training, or potentially co-presents. Such a workshops could be held potentially twice a year with limited resource allocation required once established.

Key steps in the implementation of this option would include:
- Sponsorship of project by Child Safety Directors Network.
- A formal agreement across the Key Agencies responsible for funding members (Services) of the Training Consultation Group enabling resource allocation to this task.
- Appointment of a Project Coordinator.
- Supported collaboration (including resources) across the Training Consultation Group members to develop the training.
- Resources to support the practical elements of the training provision i.e. venues, flights, accommodations, training materials, trainer hours etc.

This option would be a step forward to building coordination and collaboration across services and to developing consistency in training content, while still enabling flexibility to meet Key Agency context requirements.

This option does not cater for the training needs of service providers outside Key Agency staff as a significant resource allocation would be required to enable this to occur.

This option could be combined with Option 1 in order to provide cross-sector introductory training, and service/agency specific training, as described in the proposed training model.

On-line and train-the trainer options could be incorporated into this option i.e. the development of on-line resources for all Level 2 service providers, the development train-the trainer models for Levels 2 and 3 Case Managers / Child Protection Workers. Ideally on-line and train-the-trainer resources would be developed and maintained by specialists in the field to ensure they remain reflective of current EBP. Additionally, these resources would be complemented by supervision or mentoring, particularly where the audience are direct service providers.

To enhance the sustainability of this option, and potentially to increase access to training and supervision across the state additional steps in the implementation of this option would be undertaken by Key Agencies responsible for service agreements and funding of relevant services. Steps would include:
- A review of resources allocated to training providers including training and supervision positions, or hours allocated for training and supervision.

- If required, an enhancement of resources to training providers in the form of training and supervision positions, particularly in geographical areas of the state where access to services is limited i.e. North Queensland.
- A review of resources allocated for purchasing training and supervision services to key groups identified as requiring greater access to training i.e. foster and residential carers.
- A review / development of on-line and train-the-trainer options.

OPTION THREE: (LONGER-TERM OPTION)
The development and introduction of a model of standardization and accreditation appropriate to the Queensland Context, would assist in addressing the multiple and complex issues that have arisen through the Scoping Project, including those related to training and supervision. Ideally, this model would not be limited to training but rather would be inclusive of training, supervision, therapeutic services, case management, and other specialist roles such as foster and residential carers. The proposed training model may form the basic structure of a model of standardization and accreditation.

The implementation of this option might incorporate the following steps:
- Sponsorship of the project by Child Safety Directors Network.
- Development of a cross-government collaborative group to oversee the process.
- Appointment of a Project Coordinator or cross-government Project Team .
- Consultation and Liaison with ANZATSA.
- Review of existing models in Australia i.e. New South Wales and overseas.
- Broader consultation and engagement of relevant government and non-government service providers.
- Review of relevant legislation etc.
- Development of model .
- Development of implementation plan including time-frame and required budget.
- Resource allocation – source to be determined.
- State-wide cross-government and non-government implementation of model.

This is a long-term option incorporating multiple complex tasks across the broad service system of Queensland. It is likely that this option would take a minimum of 5 years to complete.

Should this option result in an independent body overseeing standardization and accreditation in the field in Queensland, or indeed a service unit within an existing Key Agency, there may be a possibility to allocate the coordination of training delivery across the state to the same body. Such a task could assist to facilitate access to professional development activities for existing services in the field to up-skill and remain current with Evidenced Based Practice, it could also include developing relationships and coordinating training provision across the state from national and international leaders in the field.

10. SUMMARY

The consultation processes undertaken as part of the Scoping Project have revealed a number of gaps in training and supervision availability, accessibility, and appropriateness to the needs training recipients in Queensland. A number of limitations in the consultation process including the distinct lack of a training needs analysis or similar process across the Key Agencies and Stakeholders, and the lack of standardization across training providers, limit our ability to match training needs with training providers.

Research literature regarding the links between training for professionals and paraprofessionals and outcomes for clients is lacking. The limited research available investigates the relationship between training and professionals/paraprofessionals willingness and confidence to with adolescent and adults convicted of sex offending, and the sustainability of the workforce. These factors are presumably influential in the availability and provision of treatment services, and as treatment completion appears to have a positive impact upon reducing sexually abusive

behaviours in children and young people, a commitment to training in Queensland appears critical.

A consultation process with the leading training providers in the field in Queensland indicated a willingness to work collaboratively with one another, and Key Agencies, to establish standardized practices and accreditation across all levels of the service system. A draft model of training was proposed, and a commitment to its development made if the in principle and resource support of Key Agencies was forthcoming.

Three options for further development of training and supervision services in Queensland are outlined in the document. Option one is essentially an extension of the current practice in Queensland currently, with additional information found in the Appendices to assist in facilitating links between training providers and training audiences. Option two is a first step to collaborative practices across Queensland's' training providers, and could assist in the development of standardization across the field. This option requires Key Agency collaboration and resources. Option three represents a strong move towards standardization and accreditation of the field in Queensland. Other Australian states have made moves towards what is considered best practice in the field, New South Wales is one state where accreditation has moved ahead specifically in the area of clinical registration. Option one requires minimal resources – those related to purchasing training and releasing staff for training. Options two – three all require significant resources for further development and most likely for implementation.

The options presented are not necessarily exclusive of one another. They may be developed and implemented consecutively or simultaneously. Option one may be the most likely short-term solution as other options are considered and/or advanced. Option one can be undertaken within the framework of the proposed model.

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APPENDIX A: KEY AGENCY IDENTIFIED TRAINING NEEDS

Key Agency	Current Training Provided to Staff	Past Training Provided to Staff	Training needs	Staffing numbers	Opportunities for future training include:
Evolve DSQ BST		• 2 day Griffith Youth Forensic Service training (general and case discussion) • Australian Childhood Foundation 2 days with Joe Tucci (sexuality and disability)	• case supervision and mentoring • training across introduction to advanced in ongoing manner • framework incorporating basic principals to complement BST Manual • shared framework across providers	Not provided	• Regular planned professional development for all state-wide staff • Regular planned meetings for all state-wide senior staff
DChS	• Specialist Skills Courses (On-line) designed to prompt reflection and development opportunities • Practice Paper: Child Sexual Abuse	• FPQ • SACS • Griffith Youth Forensic Service • DChS Research Forum: Relationship and Sexual Health Matters Feb 2008 • ICARE • CERT IV and	• Theoretical framework for understanding and responding to sexually abusive behaviours • Practical skills and strategies regarding assessment and case management within DChS context • What is sexually abusive behaviours and what should direct service staff be looking for? • Training required for all staff including indigenous staff regarding cultural issues and sexuality and sexually abusive	Approximately 2700 direct service staff across Queensland	• Research Conference (Bi-annual) • Research Forum (bi-monthly) • CSO Orientation Phase Three: Learning Guide (5 month process incorporating series of learning modules and supervision) • Practice Skills Development Workshops (Mandatory. Senior Practitioners undertake train the trainer process and then facilitate training units in DChS Service Centres. Could incorporate this issue within other units i.e. managing complex behaviours unit to be written in next 1-3 years)

		Diploma in Child Protection in connection with Sunshine Coast incorporates sexual abuse	behaviours • Determining risk to child and others and management strategies over time • Treatment responses • Additional tools i.e. checklist of steps to take		
Department of Communities Youth Justice and Youth Justice Conferencing staff **NOTE:** The State-wide Quality Service Tea, - Youth Justice Training Unit have developed a draft Training Framework. This information is drawn from draft document	• Level 1 – Basic Information Sessions • Level 2 – collaborative partner training including in-course examination of practice • Level 3 – Ongoing development for collaborative partners who have completed previous levels *NOTE: These levels refer to YJS draft training framework and not the model proposed in this document.*	• Griffith Youth Forensic Service • Child and Youth Forensic Outreach Service	• Evidenced-based • Requires prerequisite skills • Developmental program for staff • Collaborative treatment model for case managers • Includes ongoing supervision and access to a peer network • Adult learning principals to support transference of skills and knowledge to work place • Includes clear standards against which training can be measured	Approx 340 Youth Justice staff across approx 16 offices Approx 280 staff in detention facilities Approx 130 staff in Youth Justice Conferencing	

QHealth Evolve Therapeutic Services		• FPQ • SACS • Griffith Youth Forensic Service • DChS Research Forum: Relationship and Sexual Health Matters Feb 2008 • Internally	• Assessment • Health sexual behaviour and problem sexual behaviour • Standardized assessment tools • Practical tips for foster carers • Best practice intervention models including working with sexually reactive children, and young people with repetitive sexual behaviour problems • Risk assessment • Managing risk of offending behaviours and re-victimization in care environment and community settings • Strategies for youth workers/carers/parents/teachers/DChS workers/ETS clinicians to respond to behaviours • Relationship to trauma and attachment	7 Evolve TS teams Approx 80 staff	• Evolve TS Orientation • Evolve TS Professional Development Days • Evolve TS Professional Develop Advisory Group consultation
DETA **NOTE:** Guidance Officers and Behavioural Support Staff are predominately teachers. These roles are limited to non-clinical			• What are healthy sexual behaviours in children and young people • How to identify problem sexual behaviours • How to support child/young person in school setting • How to work with broader team i.e. therapist, police, youth justice, to support child or young person in school setting (liaison, monitoring,	Approx 690 Guidance Officers Approx 323 FTE Behaviour Support Staff	• Twilight Seminar Series – minimum 8 video link sessions per yr with potential to reach approx 600 staff

interventions and training must support the role requirements. While all schools have a Guidance Officer available the frequency of contact varies from full-time to on-call,			collaboration) • How to understand risk assessment and management as it applies to school settings • How to implement and monitor safety plans in school environment • When to make referrals and who to make referrals to • How to talk to parents/carers about sex, sexuality, sexual behavioural concerns presenting in school environment, and facilitate appropriate referrals		

APPENDIX B: CURRENT TRAINING CONTENT

The Training Consultation Group were asked to report on current training context and topics. In some instances, the training provider has given the title of a training package. All training providers have indicated a willingness to develop training suitable to the audience, keeping in mind the role of the Key Agency, and the job role of the participant in responding to the client group/s. This flexibility also enables training to incorporate current EBP in a developing field.

GYFS GYFS staff are members of ANZATZA **Contact:** Sue Rayment Manager 07 37356910	GYFS has provided various training programs to experienced as well as inexperienced practitioners in this field and across introductory to advanced levels. GYFS training programs have ranged from 2 hours to 2 days in length. Content included in some training programs has included: • Understanding adolescent sexual offending behaviour (etiological theory and current research) • Emerging trends in the field • Engagement • Assessment • Risk Assessment • Treatment Interventions (individual, family, ecosystemic) • Griffith Ecosystemic Model • Safety Planning • Risk Management • Sibling Incest • Reunification • Attachment • Measuring Progress • Denial and Minimisation • Managing high risk clients in the community • Psychiatric / psychological disorder in adolescent sex offenders • Adolescents • Counselling Skills • Prevention of Child Sexual Abuse • Collaboration • Working with Indigenous Clients • Sexual Deviance / paraphilic behaviour • Ethics • Impact of Work • Transference & Countertransference

CYFOS **Contact:** Team Leader Nicole Mikilich 07 3310 9444	• Healthy sexual development of children and adolescents, • Recognising appropriate and problematic sexual behaviours in children and adolescents, • Range of observable sexual behaviours in children and adolescents (normal and developmentally expected, requiring adult response, requiring correction, always problematic and requiring intervention), • Aspects of adolescent sexuality, influences on adolescent sexuality, defining abusive interactions, unusual sexual behaviours, • Parental responses, parental challenges, • Common characteristics of JSO's and general offenders; the juvenile sexual offender, female juvenile sexual offenders, • Sibling incest, sibling offenders compared to non-sibling sexual offenders, impact of sibling sexual abuse, Australian statistics, • Prevalence rates of juvenile sexual offending, • Differences between adult and adolescent sexual offenders, • Recidivism, • Risk and protective factors of sexual offending, • Family risk and protective factors, • Risk assessment, • Offence specific interventions, therapeutic approaches and management strategies
FPQ **Contact:** Holly Brennan Manager 3250 0244	• Understanding sexuality and sexual development • Identifying healthy, concerning, harmful, abusive sexual behaviours in children and adolescents • Strategies for responding to sexual behaviours FPQ is a registered training organisation. FPQ regularly delivers the following units of competency from the Community Services Training Package. Other packages are available on request. Teaching sexuality and self protection Unit of competency: CHCCD2B Provide community education projects Assessing and responding to sexualised behaviours to promote protection of young people Unit of competency: CHCYTH2C Provide care and protection to young people Promoting healthy sexual behaviours in children and adolescents Unit of competency: CHCCHILD1C Identify and respond to children and young people at risk of harm

	Provide sexualised behaviour support Unit of competency: CHCDIS15B Provide behaviour support Sexuality & Disability Unit of competency: CHCDIS2C Maintain an environment designed to empower a person with a disability HIV/AIDS, hepatitis C and sexual health promotion with young people Unit of competency: CHCCD13C Work within specific communities
SACS **Contact:** Sonia Thompson A/Manager 07 3391 6066	Training can run from hour long on a weekly/fortnightly basis, to daylong. Examples of topics include (but are not limited to): • Signs of child sexual abuse (CSA) or symptoms post CSA; • Issues to consider in planning safe contact and/or reunification; • Risk/protective factors; • Maternal support and impact on victims; • Children with sexual behaviour problems; • Sexual behaviour problems – healthy and unhealthy sexual behaviours; managing sexual behaviour problems; therapeutic intervention • Sexual offending behaviour, including male and female adults and juveniles; • Reunification and safety planning • Belief systems which increase/mitigate risk in families; • Adult grooming behaviour; • Sexual abuse in Indigenous communities; • Sexual abuse and disabilities; • Impact of sexual abuse in children exposed to multiple forms of maltreatment; • Substance use by victims - impact on victim safety or used as a coping strategy; • Disclosure in relation to interviewing/retraction; • Self-harm • Understanding Risk Assessments – implications for case work
Phoenix House **Contact:** Kathy Prentice Coordinator 07 41534299	Phoenix House provides a public health approach to the prevention of sexual violence, with training and education being a key component within this framework. Training provided: <u>For child care/school staff/foster carers</u> • Recognising and responding to the sexual behaviours of children • Stop it Now • Safety Planning

	• Therapeutic Care – for parents/carers Training re working with children and young people • Recognising and responding to the sexual behaviours of children • Stop it Now • Safety Planning • Therapeutic Care • What can I do? – for Indigenous Health Workers • Puppets, Sand and Gooey Staff • A Narrative Means to a Therapeutic End • Trauma Focused CBT • Working with children who have been sexually abused • Working with children with sexual behaviour problems • Working with young people who have been sexually abusive Training re working with adults • Working with People with an Intellectual/Learning Disability • Groupwork with Women • Working with adults who have been sexually abused in childhood • Childhood Sexual Abuse • Mother blame • Community supervision of adults who have committed sexual offences Courses run from 2 hours to 5 days in length
Laurel House and Laurel Place **Contact:** Jan Sweeton A/Manager 54434711 Marroochydore 54827911 Gympie	LH & LP have provided a number of trainings targeting various populations, knowledge levels and audience size encompassing school students, foster carers and human service professionals. In addition, LH & LP provided training to the staff of an Indigenous community school along with direction in the development of a culturally appropriate school curriculum targeting childhood sexual assault. Tailoring the specifics of the content to the audience, LH/LP training includes various combinations and degrees of the following areas: • Developmentally appropriate sexual behaviours • Defining, identifying what constitutes sexual assault; consent; and coercion • Legal implications/consequences • Myths about sexual assault • Importance of education and awareness • Sexualised behaviours

	• Sexual abusive behaviours • Impacts and indicators of childhood sexual assault (physiological, social, behavioural, emotional, psychological) • Responding to and managing sexualised and/or sexually abusive behaviours • Responding to and managing disclosures • Attachment • Specific issues/concerns (e.g., masturbation) • Working with young people (i.e., adolescents/pre-adolescents) who have experienced sexual assault • Prevalence and statistical information re: childhood sexual assault • Grooming process • Developing a plan to reduce sexualised behaviours • Creating and promoting a safe environment (e.g., family practices, beliefs, values, boundaries) • Barriers to safety (e.g., reasons children don't disclose) • Parent and carer concerns and issues • 'Looking after yourself' • Drink spiking, alcohol and sexual assault • Impact of substances (i.e., illicit drugs) and sexual assault • Personal rights • Support services: "What to do if you are sexually assaulted" Training Focusing on Sexual Assault Counselling • Principles and process of sexual assault clinical practice • Referral process • Process of prioritizing and evaluating acuity levels • Elements of assessment including risk assessment • Common presenting issues • Case planning and formulation • Best practice interventions • Process of evaluation • Process of service disengagement • Self-care Group work for women survivors and parents/carers of children who have been sexually assaulted also offered. Currently in process of developing educational puppet program

APPENDIX C: TRAINING AVAILABLITY AND STRUCTURE

	Griffith	CYFOS	FPQ	SACS	Phoenix House	Laurel House and Laurel Place
Geographical area	• State-wide including remote areas • National and International	Central and Southern Queensland	State-wide utilizing regional centers and staff	State-wide	State-wide but will travel interstate National and international conferences	Caloundra City, Noosa, Cooloola and Maroochy Shires. Can travel if additional costs paid.
Clinical Service	GYFS provides clinical intervention on a state-wide basis including remote communities. • Clinical intervention • Consultation	Consultation and offense specific therapeutic intervention	No	Therapeutic intervention	Therapeutic intervention	Therapeutic Intervention
Training Service	Yes	As part of broader clinical role (non-accredited)	Yes - AQTF	As part of framework of prevention. Some components are accredited by the author.	As part of broader clinical role (non-accredited)	As part of broader clinical role (non-accredited) as per funding agreements
Workshops: Skills Development	Yes	Yes	Yes – accredited through AQTF system includes workplace based assessments	Yes	Yes	Yes
Workshops: Knowledge Development	Yes	Yes	Yes	Yes	Yes	Yes

Lectures	Yes		Yes	Yes	Yes	Yes
On-line Training	Under development	Under development	On-line resources		Web-based conferences	No
Train the Trainer	Yes	Yes	Yes		Yes	Limited
Other: Specify	Conference Self-learning modules			Contributing to DChS resource development	Internships Placements for university students and medical staff Conferences	Conferences Student Placements
Training Costs	Fee for service for all non-Department of Communities requests	For training requests excluding CYMHS, Evolve TS and YJ	Yes	Charge to cover costs outside greater Brisbane area	Charge to cover costs when training outside immediate service region	Fee for training outside service regions and/or not approved by funding bodies.

APPENDIX D: FUTURE TRAINING CAPACITY

	Griffith	CYFOS	FPQ	SACS	Phoenix House	Laurel House
Capacity to develop training in partnership with key agency staff	Yes – has previously co-facilitated training with Departmental staff	Yes	Yes – map training to policy focusing on education and building capacity	Yes	Yes	Yes
Capacity to alter training content and structure	All training is individualized to target audience and to reflect current trends and research	Yes	Yes	Yes	Yes	Yes
Capacity to train large numbers of Key Agency staff	With appropriate resources including funding	Can currently provide package monthly to maximum 40 participants each session	Yes – negotiation required	Could currently do one-off large group training or a number of small group trainings across state if planned	Yes – if resources are increased	Negotiable - would require additional resources
Capacity to increase frequency of training with increased resources	With appropriate resources including funding	Yes although limited by broad range of training available through CYFOS Additional staff required	Have workforce development program with capacity to increase staff providing training	Additional resources would enable increased and planned training provision across the state	Yes – with additional resources	Yes

Scoping Project: Responding to the needs of children and young people with identified sexually abusive behaviours.

Interagency Practice Paper.
Issues in Building An Interagency Response To The Needs Of Children And Young People With Identified Sexually Abusive Behaviours.

Project Coordinator: Tania Withington, Evolve Therapeutic Services, Queensland Health

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1. Introduction

Factors influencing the development, initiation and maintenance of sexual behaviour problems, sexually abusive behaviours and sexual offending in children and young people are complex and multi-layered. They include vulnerabilities, and the interaction between these vulnerabilities in the community, the family and the individual [1-9]. The complex interplay that results in sexual behaviour that may be harmful to self or others requires a multi-layered, multi-provider response.

This Discussion Paper forms part of the Scoping Project: Responding to the needs of children and young people with identified sexually abusive behaviours. The Scoping Project was sponsored the Child Safety Directors Network to contribute to the Key Agencies understanding of existing service responses and service gaps, and to enhance the current service system capacity, when responding to the needs of children and young people with identified sexually abusive behaviours.

The Key Agencies in the Scoping Project included:

- Queensland Health Evolve Therapeutic Services (QH ETS),
- Department of Child Safety (DChS),
- Department of Communities Youth Justice Services (YJS),
- Department of Education, Training and the Arts (DETA), and
- Disability Services Queensland Child Safety Behaviour Support Teams (DSQ BST).

This Discussion Paper draws on current evidenced-based research and practice to highlight aspects of best practices approaches for consideration in the development of a cross-government response to the problem. As this is a developing area of study, the broad literature review undertaken included evidenced-based research and practice as defined below:

- Evidenced-based research obtained from empirical studies using experiment based research methods.
- Observational and qualitative research.
- Other literature reviews.
- Case studies.
- Expert opinion of clinicians and professionals in the field, based on observation and clinical experience, and on their own professional practice.

2. The Nature And Extent Of The Problem

There are a number of challenges presented in gathering data on childhood and adolescent sexuality and sexual behaviours, which are evident in the international and Australian contexts. Restrictions include ethical considerations regarding research and analysis of childhood and adolescence, ideological and historical belief systems that children cannot be perpetrators of abusive behaviours, a general community reluctance to report sexual abuse and sexual assault, and a reluctance on behalf of service providers to label or record data on children presenting with sexually abusive behaviours. In addition, an Australian study found that agencies providing services to victims of sexual assault were unwilling to become involved with young sexual offenders despite the fact that many of these young people were also victims of sexual abuse themselves [10]. A further example of data recording problems is found in relation to interfamilial sexual abuse, specifically sibling sexual abuse, which is highlighted in developing research as twice as common as adult-child sexual abuse, and yet it appears to be under-reported, under-prosecuted and under-recorded in Australia and internationally [11].

Research is further hampered by national and international debate regarding what constitutes 'normal' sexual behaviour in children and adolescence, and what is 'deviant' sexual behaviour. Definitions of 'normal' and deviance' are subjective, and socially and culturally specific, and thus contingent on the context of the sexual behaviour. In addition to definitional disparities, challenges in research in this field to date include methodological difficulties such as insufficient empirical data, and difficulties with data set comparability. Researchers do agree however, that the group of children and of adolescents who engage in abusive sexual behaviours are heterogeneous and a response to this problem must be multi-systemic and customised to individual and contextual factors [12].

Sexual development is a gradual process that begins before birth and continues across the lifespan [13-15].

Sexual development including sexual knowledge and sexually explorative play is a part of healthy childhood development [16-19]. A child's interest in sexuality is generally balanced by curiosity about other aspects of life [16]. Childhood sexual play is motivated

primarily by curiosity thus the qualities of each individual child's temperament, personality and cognitive potential plays a role in childhood sexual behaviours, as does the context in which the behaviour develops and occurs [20].

Despite strong beliefs about what constitutes healthy sexual development in adolescents, there is very little data available [20]. Beliefs about healthy sexual behaviours are typically defined by the community culture, moral standards and socially defined gender roles. Research investigating adolescent sexuality typically focuses on behaviours such as age of first intercourse, contraception or sexually transmitted diseases. While the research exploring healthy sexual development in adolescence is limited, it does demonstrate that psychosexual development is multidimensional, incorporating biologic, psychologic, and socio-cultural factors [14].

Unusual sexual behaviours are typically understood as those that fall outside an expected range of sexual behaviour for the specific age grouping or gender role norm. The challenge for all observers of sexual behaviour is that unusual behaviours are evaluated on the presumption that usual behaviours are known. Whether a sexual behaviour is illegal or not depends on the law governing the community, in which a person lives [20].

Studies of children and adolescents with sexual behaviour problems, sexually abusive behaviours and sexual offending cannot identify clear pathways, or specific predictive or risk factors. However, research does indicate a number of commonalities in the presentation of this client group/s.

A literature review of 14 published studies summarised the current evidence and found that children who engage in problem sexual behaviours are frequently exposed to a multitude of familial, social, cultural, economic, material and educational disadvantages, and that these children frequently display negative behavioural responses to this disadvantage [9]:

- An over-representation of males
- High rates of sexual, physical and emotional abuse by caregivers, and exposure to domestic violence
- High levels of anger, anxiety, sexual and substance abuse, psychological problems/disorders, and parent-child relationship problems in adult caregivers
- Very low income families frequently living below the poverty line, and large biological family groups
- High levels of other maladaptive behaviours including high rates of disobedience, physical fights and property damage and most commonly diagnosed with ADHD, Conduct Disorder, or ODD
- High levels of externalising and internalising problems, low levels of empathy, restricted affective experience and higher incidence of depressive symptoms

Studies of adolescents convicted of sex offences reveal a similar set of complex contextual and individual factors that may indicate possible risk pathways [1, 2, 6-8, 18, 21-25]:

- Over representation of males
- Low socio-economic status of biological family
- Lack of parental involvement, poor parental supervision, poor parent-child relationship, harsh/inconsistent/lax parenting styles
- Anti-social parents including criminality, sexual deviance, substance misuse

- Abuse (particularly physical) and neglect by parents
- Multiple out of home placements
- Academic underachievement, difficulties, learning difficulties (particularly verbal skills deficits, planning skills and impulse control)
- Commonly diagnosed with ADHD, ODD, Conduct Disorder, Depression, Anxiety, Post Traumatic Stress Disorder
- Anti-social attitudes and behaviours, anti-social peer group
- Poor emotional and behavioural regulation
- Social Isolation of biological family and/or adolescent

While there are no empirical studies regarding sexual behaviour problems in Australian Indigenous children (or indigenous adolescents specifically), the above factors are reportedly highly prevalent in Australian Indigenous communities [26, 27]. A recent Australian review theorized that these factors may be significant contributors to the anecdotally reported high prevalence of sexual abuse and childhood/adolescence sexual behaviour problems [28].

A recent longitudinal study of Queensland children found that childhood abuse and neglect had the most detrimental effect and thus was the most likely risk factor to offending behaviours [29]. It must be noted however, and the study clearly indicates this, that not all children exposed to abuse and neglect go on to offend, and that correlated factors play a role in whether offending behaviour occurs, whether it is lifelong or whether it only occurs in Adolescence.

Available evidence suggests that the developmental adversities associated with the onset of problematic sexual behaviours in youth generally (i.e. trauma, attachment disruption, and family dysfunction) occur in the lives of youth with disabilities. Particular issues that may adversely effect the sexual development of youth with disabilities include limited opportunity for social development, social isolation, limited sexual education, lack of privacy, lack of opportunity to experience normative and appropriate sexual interactions, specific difficulties in communication and the impact of genetic and medical factors [30].

The literature indicates that children and adolescents who present with sexual behaviour problems, sexually abusive behaviours and sexual offending are a heterogeneous group with diverse characteristics and treatment needs. Researchers and scholars are moving to place an emphasis on situational and contextual factors contributing to sexual behaviour problems in children and young people, moving away from 'blaming the individual' [31, 32]. The establishment of theoretical models of understanding or conceptual frameworks for understanding is still developmental, and particularly for children under 12 years where the field is very much in its infancy and further research is required.

3. Evidenced-Based Practice Approaches To Intervention

There is a paucity of research investigating the effectiveness of intervention with children under 12 years with sexual behaviour problems. However, the small number of available studies indicates children with sexual behaviour problems respond well to a variety of treatment modalities, all of which are relatively short-term [33, 34]. Treatment models tested to date include cognitive behavioural therapy, psychodynamic play

therapy, and expressive therapy. Researchers and professionals agree that the most effective interventions incorporate individual and family based treatments, and that care-giver involvement may be the essential component to effective intervention [5, 34-36]

It is difficult to determine the treatment modality most effective in working with adolescents with sexually abusive behaviours or sexual offending due to limitations in the comparability of current research. However, meta-analysis investigating treatment effectiveness in reducing sexual offending recidivism indicated that all treatments are effective [37, 38] (Walker 2004). The treatment modalities with the greater effectiveness were cognitive behavioural therapy and multi-systemic therapy. Earlier studies indicate that increased rates of positive outcomes are achieved in adolescent sex offender treatment where services employ multiple treatment techniques i.e. individual focused intervention, group-work, family interventions, educational input and expressive therapies [39, 40]. This is consistent with the view that interventions addressing high risk and problematic behaviours including but not isolated to sexual offending are likely to be most effective in reducing sexual and non-sexual recidivism [41-44](note: adolescents who have sexually offended are more likely to re-offend non-sexually than sexually [45, 46]). A recent Australian review of treatment options for adolescent sexual offenders found that best practice incorporates collaborative intervention options across families, schools, child protection, juvenile justice and therapeutic treatment providers and that these interventions are not necessarily lengthy or intrusive.[47].

Research of treatment effectiveness for children and adolescents with sexual behaviour problems, sexually abusive behaviours and sexual offending is in its infancy. A lack of research does not necessarily equate to treatment ineffectiveness but rather it highlights that additional research is required in this field. To date, effective treatments appear to be those that are multi-systemic and customized to individual and contextual factors.

4. Training, Professional Development And Supervision

Intervention and treatment of young people with sexual behaviour problems, sexually abusive behaviours, or sexually offending is a specialist field of practice. Interventions for youth who have caused sexual harm require a broad foundation of expertise [48]. Specialized training with evaluative supervision for responding to the needs of this client group/s is necessary for professionals and paraprofessionals at all levels of the service system in order to reduce the potentially harmful sexual behaviour [48, 49].

The field of children and young people with sexual behaviour problems, sexually abusive behaviours or sexual offending is only beginning to identify evidenced-based practice treatment approaches to inform intervention [50]. Developing research knowledge significantly influences change in our understanding of best practice service provision [51, 52]. As a result, to ensure service providers competence in the implementation of effective intervention practices, it is imperative that all staff across the service system have access to and participate in specialized continuing education [49].

Knowledge of child and adolescent development, and theories of attachment, trauma, and intervention models including cognitive behavioural approaches, expressive therapies, family interventions and collaborative practice models are thought to be essential in the tools kits of all professionals and paraprofessionals work with the client

groups [53]. For those working with adolescents, an understanding of the principles of restorative justice is also important.

Due to the intense nature of working with the client group/s, supervision is essential for all professionals and paraprofessionals in this field. In addition to providing support and guidance for staff, supervision assists in monitoring compliance to the evidenced-based approaches to treatment to support successful treatment outcomes [54]. Where services employ staff who do not have well developed knowledge and skill in this area, specialist training and supervision by qualified and experienced specialist in the filed will contribute positively to workforce stability and best outcomes for the client group/s.

An alternative or complementary option to assist in the development of knowledge and skill in non-specialist services is the use of collaborative partnerships. Griffith Youth Forensic Service (GYFS) have conducted a study of the effectiveness of collaborative partnerships in enhancing knowledge, skills and confidence in working with adolescent sex offenders in Queensland [55]. This study focused on the collaborative partnerships of GYFS with professionals and paraprofessionals, developed on a case by case basis. Results indicated that collaborative partnerships were effective in enhancing knowledge, skill and confidence to work with young people who have committed sexual offences, and that these improvements were maintained up to one year following the collaboration.

5. Interagency Collaboration And Partnership

All children and young people who engage in sexual behaviour that may cause harm to others need access to a range of intervention and treatment options in order to address complex issues across a variety of settings. A multi-service response to the complex needs of the client group/s requires the availability of a varying array of services. These services are likely to include family support and therapy, individual support and therapy, residential, foster care and community placement options, recreational and other activities to promote community connectedness and pro-social peer socialization, and education options. Ideally, access to the full array of services would be available to the client group/s regardless of potentially discriminatory factors such as age, gender, race, socioeconomic status, disability, education, religion, sexual identity and geographical location. A continuum of care model of service delivery is essential as it offers multiple options in the least restrictive treatment settings, consistent with the needs of individual children, young people, families and communities [48, 51].

Collaboration, in the context of legislation, organizational polices and ethical guidelines is essential across all services working with a child or young person with sexual behaviour that may result in harm to self or others [56, 57]. Collaboration enables planned and coordinated service delivery to address complex needs. Collaboration in this way can enable evaluation for effectiveness across multiple domains, and avoids duplication or incompatible interventions. Legislation change, policy and protocol is required to facilitate and promote collaboration across government and non-government services. The Scoping Project consultation process identified organizational practices and legislation as barriers to collaboration in Queensland.

Successful treatment outcomes depend upon informed and knowledgeable collaborative community efforts [56]. Ideally, all persons working with children and young people should be educated to recognize indicators of sexual harm and how best to respond.

Educating families and the wider community regarding current evidenced-based knowledge should also be part of the role of specialist in the field.

Research indicates that most youth who have committed sexual crimes can be safely managed in the community [56, 58]. However, some individuals in the client group/s require supervision to remain in community settings. Typically, supervision and management strategies require multiple formal and informal supports that are identified in collaborative safety plans [51 437]. Supervision is utilized to facilitate client accountability and compliance with treatment as well as a means to prevent future sexually abusive behaviours. Polices and protocols are required to enable cross-government and non-government participation in this essential intervention process.

6. Implications

- The problem of how to respond to children and young people with sexual behaviour problems, sexually abusive behaviours or who are sexually offending is complex.

- There are no nationally agreed standards for responding to the needs of children and young people with sexual behaviour problems, sexually abusive behaviours or sexual offending.

- Treatment effectiveness studies across both client groups (children and adolescents) indicate that multi-systemic approaches to intervention that incorporate individual and contextual factors lead to positive client outcomes.

- Cross-government and non-government collaborative partnerships are required to facilitate the development of a responsive state-wide service network for children and young people with sexual behaviour problems, sexually abusive behaviours and who are sexually offending. Such a network would aim to provide equal access to required services regardless of possible discriminatory factors such as geographical location, cultural background or socioeconomic status.

- Given the complexity of the problem and best practice interventions, services across child protection, therapeutic services including mental health, education, justice including police, disability, and family support services require a coordinated approach to addressing the broad systemic and individual issues.

- Cross-government and non-government legislative, policy and practice frameworks require review and development to facilitate collaborative and coordinated responses to the needs of the client group/s.

- An enhancement of existing specialist services in order to facilitate access to all children and young people in the client group/s, and to enable an enhancement of the knowledge and skill of more generalist intervention services through training, supervision and mentoring (or collaborative intervention partnerships) is required in Queensland.

- Contributions to evidenced-based practice across the field and specifically with regard to treatment effectiveness in the Queensland and broader Australian context, the impact of training and supervision, and collaborative practices on treatment outcomes, are required.

- In the current service system context, critical elements of collaborative work at an intervention level would ideally include:
  - A service (preferably a Key Agency i.e. DChS, Youth Justice) to take the lead role for an individual case,
  - The facilitation of a case specific interagency forum to build a shared understanding of the client and family intervention needs,
  - The development of agreed lines of communication and information sharing processes,
  - The development of a shared intervention plan with clear lines of responsibility and accountability,
  - A safety plan relevant to multiple environments with environment specific inclusions (i.e. home, school), and
  - The establishment of a regular review process to recognize achievements and monitor intervention effectiveness and relevance.

- In the current service system context, there are limited specialist services to work with the client group/s. Specialist services have specific eligibility criteria i.e. in some instances referrals can only be made through the court processes. Where a specialist service is not engaged with a child or young person, the service may still be able to provide consultation on a case-by-case basis. A specialist service may also be able to provide resources, supervision, mentoring or training if capacity allows and in some cases if financial compensation is available.

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