

FINAL REPORT

Children with harmful
sexual behaviours



Royal Commission
into Institutional Responses
to Child Sexual Abuse

VOLUME 10

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Volume 10

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Content warning

This volume contains information about child sexual abuse that may be distressing. We also wish to advise Aboriginal and Torres Strait Islander readers that information in this volume may have been provided by or refer to Aboriginal and Torres Strait Islander people who have died.

Table of contents

Preface	1
The Royal Commission	1
Public hearings	1
Private sessions	2
Policy and research	3
Community engagement	3
Diversity and vulnerability	3
Our interim and other reports	4
Definition of terms	4
Naming conventions	5
Structure of the Final Report	5
Summary	9
The nature and extent of the problem	10
Current responses to children with harmful sexual behaviours	11
Improving responses to children with harmful sexual behaviours	13
Recommendations	18
1 Introduction	20
1.1 Overview	20
1.2 Terms of Reference	21
1.3 Links with other volumes	22
1.4 Key terms	23
1.5 Structure of this volume	25
2 Nature and extent of the problem	27
2.1 Overview	27
2.2 The extent of sexual abuse by children	28
2.3 Terminology	30
2.4 Developmentally appropriate sexual behaviours in children	34
2.5 The nature of children’s harmful sexual behaviours	37
2.6 What we learned about victims of children’s harmful sexual behaviours	47
2.7 Impacts on victims and survivors	50
2.8 What we learned about children who sexually abuse other children	52
2.9 Factors that may contribute to children exhibiting harmful sexual behaviours	56
2.10 Children’s capacity for rehabilitation	78

3	Current responses to children with harmful sexual behaviours	97
3.1	Overview	97
3.2	Institutional responses to children with harmful sexual behaviours	97
3.3	Government policies related to children with harmful sexual behaviours	104
3.4	Current systems that can respond to children with harmful sexual behaviours	109
4	Improving responses to children with harmful sexual behaviours	133
4.1	Overview	133
4.2	Framing a range of interventions	134
4.3	Primary prevention	139
4.4	Secondary prevention	144
4.5	Improving institutional policies and systems	147
5	Tertiary interventions for children's harmful sexual behaviours	165
5.1	Overview	165
5.2	Assessment and planning	165
5.3	Therapeutic interventions	175
5.4	Best practice principles for therapeutic intervention	192
5.5	Developing the therapeutic workforce	200
5.6	Improving evaluation of therapeutic interventions	202
	Appendix A Relevant terminology	220
	Appendix B Examples of existing guidance on children's sexual behaviours	221

Preface

The Royal Commission

The Letters Patent provided to the Royal Commission required that it ‘inquire into institutional responses to allegations and incidents of child sexual abuse and related matters’. In carrying out this task, the Royal Commission was directed to focus on systemic issues, be informed by an understanding of individual cases, and make findings and recommendations to better protect children against sexual abuse and alleviate the impact of abuse on children when it occurs. The Royal Commission did this by conducting public hearings, private sessions and a policy and research program.

Public hearings

A Royal Commission commonly does its work through public hearings. We were aware that sexual abuse of children has occurred in many institutions, all of which could be investigated in a public hearing. However, if the Royal Commission was to attempt that task, a great many resources would need to be applied over an indeterminate, but lengthy, period of time. For this reason the Commissioners accepted criteria by which Senior Counsel Assisting would identify appropriate matters for a public hearing and bring them forward as individual ‘case studies’.

The decision to conduct a case study was informed by whether or not the hearing would advance an understanding of systemic issues and provide an opportunity to learn from previous mistakes so that any findings and recommendations for future change the Royal Commission made would have a secure foundation. In some cases the relevance of the lessons to be learned will be confined to the institution the subject of the hearing. In other cases they will have relevance to many similar institutions in different parts of Australia.

Public hearings were also held to assist in understanding the extent of abuse that may have occurred in particular institutions or types of institutions. This enabled the Royal Commission to understand the ways in which various institutions were managed and how they responded to allegations of child sexual abuse. Where our investigations identified a significant concentration of abuse in one institution, the matter could be brought forward to a public hearing.

Public hearings were also held to tell the stories of some individuals, which assisted in a public understanding of the nature of sexual abuse, the circumstances in which it may occur and, most importantly, the devastating impact that it can have on people’s lives. Public hearings were open to the media and the public, and were live streamed on the Royal Commission’s website.

The Commissioners' findings from each hearing were generally set out in a case study report. Each report was submitted to the Governor-General and the governors and administrators of each state and territory and, where appropriate, tabled in the Australian Parliament and made publicly available. The Commissioners recommended some case study reports not be tabled at the time because of current or prospective criminal proceedings.

We also conducted some private hearings, which aided the Royal Commission's investigative processes.

Private sessions

When the Royal Commission was appointed, it was apparent to the Australian Government that many people (possibly thousands) would wish to tell us about their personal history of sexual abuse as a child in an institutional setting. As a result, the Australian Parliament amended the *Royal Commissions Act 1902* (Cth) to create a process called a 'private session'.

Each private session was conducted by one or two Commissioners and was an opportunity for a person to tell their story of abuse in a protected and supportive environment. Many accounts from these sessions are told in a de-identified form in this Final Report.

Written accounts allowed individuals who did not attend private sessions to share their experiences with Commissioners. The experiences of survivors described to us in written accounts have informed this Final Report in the same manner as those shared with us in private sessions.

We also decided to publish, with their consent, as many individual survivors' experiences as possible, as de-identified narratives drawn from private sessions and written accounts. These narratives are presented as accounts of events as told by survivors of child sexual abuse in institutions. We hope that by sharing them with the public they will contribute to a better understanding of the profound impact of child sexual abuse and may help to make our institutions as safe as possible for children in the future. The narratives are available as an online appendix to Volume 5, *Private sessions*.

We recognise that the information gathered in private sessions and from written accounts captures the accounts of survivors of child sexual abuse who were able to share their experiences in these ways. We do not know how well the experiences of these survivors reflect those of other victims and survivors of child sexual abuse who could not or did not attend a private session or provide a written account.

Policy and research

The Royal Commission had an extensive policy and research program that drew upon the findings made in public hearings and upon survivors' private sessions and written accounts, as well as generating new research evidence.

The Royal Commission used issues papers, roundtables and consultation papers to consult with government and non-government representatives, survivors, institutions, regulators, policy and other experts, academics, and survivor advocacy and support groups. The broader community had an opportunity to contribute to our consideration of systemic issues and our responses through our public consultation processes.

Community engagement

The community engagement component of the Royal Commission's inquiry ensured that people in all parts of Australia were offered the opportunity to articulate their experiences and views. It raised awareness of our work and allowed a broad range of people to engage with us.

We involved the general community in our work in several ways. We held public forums and private meetings with survivor groups, institutions, community organisations and service providers. We met with children and young people, people with disability and their advocates, and people from culturally and linguistically diverse communities. We also engaged with Aboriginal and Torres Strait Islander peoples in many parts of Australia, and with regional and remote communities.

Diversity and vulnerability

We heard from a wide range of people throughout the inquiry. The victims and survivors who came forward were from diverse backgrounds and had many different experiences. Factors such as gender, age, education, culture, sexuality or disability had affected their vulnerability and the institutional responses to the abuse. Certain types of institutional cultures and settings created heightened risks, and some children's lives brought them into contact with these institutions more than others.

While not inevitably more vulnerable to child sexual abuse, we heard that Aboriginal and Torres Strait Islander children, children with disability and children from culturally and linguistically diverse backgrounds were more likely to encounter circumstances that increased their risk of abuse in institutions, reduced their ability to disclose or report abuse and, if they did disclose or report, reduced their chances of receiving an adequate response.

We examined key concerns related to disability, cultural diversity and the unique context of Aboriginal and Torres Strait Islander experience, as part of our broader effort to understand what informs best practice institutional responses. We included discussion about these and other issues of heightened vulnerability in every volume. Volume 5, *Private sessions* outlines what we heard in private sessions from these specific populations.

Our interim and other reports

On 30 June 2014, in line with our Terms of Reference, we submitted a two-volume interim report of the results of the inquiry. Volume 1 described the work we had done, the issues we were examining and the work we still needed to do. Volume 2 contained a representative sample of 150 de-identified personal stories from people who had shared their experiences at a private session.

Early in the inquiry it became apparent that some issues should be reported on before the inquiry was complete to give survivors and institutions more certainty on these issues and enable governments and institutions to implement our recommendations as soon as possible. Consequently, we submitted the following reports:

- *Working With Children Checks* (August 2015)
- *Redress and civil litigation* (September 2015)
- *Criminal justice* (August 2017)

Definition of terms

The inappropriate use of words to describe child sexual abuse and the people who experience the abuse can have silencing, stigmatising and other harmful effects. Conversely, the appropriate use of words can empower and educate.

For these reasons, we have taken care with the words used in this report. Some key terms used in this volume are set out in Chapter 1, 'Introduction' and in the Final Report Glossary, in Volume 1, *Our inquiry*.

Naming conventions

To protect the identity of victims and survivors and their supporters who participated in private sessions, pseudonyms are used. These pseudonyms are indicated by the use of single inverted commas, for example, 'Roy'.

As in our case study reports, the identities of some witnesses before public hearings and other persons referred to in the proceedings are protected through the use of assigned initials, for example, BZW.

Structure of the Final Report

The Final Report of the Royal Commission into Institutional Responses to Child Sexual Abuse consists of 17 volumes and an executive summary. To meet the needs of readers with specific interests, each volume can be read in isolation. The volumes contain cross references to enable readers to understand individual volumes in the context of the whole report.

In the Final Report:

The **Executive Summary** summarises the entire report and provides a full list of recommendations.

Volume 1, *Our inquiry* introduces the Final Report, describing the establishment, scope and operations of the Royal Commission.

Volume 2, *Nature and cause* details the nature and cause of child sexual abuse in institutional contexts. It also describes what is known about the extent of child sexual abuse and the limitations of existing studies. The volume discusses factors that affect the risk of child sexual abuse in institutions and the legal and political changes that have influenced how children have interacted with institutions over time.

Volume 3, *Impacts* details the impacts of child sexual abuse in institutional contexts. The volume discusses how impacts can extend beyond survivors, to family members, friends, and whole communities. The volume also outlines the impacts of institutional responses to child sexual abuse.

Volume 4, *Identifying and disclosing child sexual abuse* describes what we have learned about survivors' experiences of disclosing child sexual abuse and about the factors that affect a victim's decision whether to disclose, when to disclose and who to tell.

Volume 5, *Private sessions* provides an analysis of survivors' experiences of child sexual abuse as told to Commissioners during private sessions, structured around four key themes: experiences of abuse; circumstances at the time of the abuse; experiences of disclosure; and impact on wellbeing. It also describes the private sessions model, including how we adapted it to meet the needs of diverse and vulnerable groups.

Volume 6, *Making institutions child safe* looks at the role community prevention could play in making communities and institutions child safe, the child safe standards that will make institutions safer for children, and how regulatory oversight and practice could be improved to facilitate the implementation of these standards in institutions. It also examines how to prevent and respond to online sexual abuse in institutions in order to create child safe online environments.

Volume 7, *Improving institutional responding and reporting* examines the reporting of child sexual abuse to external government authorities by institutions and their staff and volunteers, and how institutions have responded to complaints of child sexual abuse. It outlines guidance for how institutions should handle complaints, and the need for independent oversight of complaint handling by institutions.

Volume 8, *Recordkeeping and information sharing* examines records and recordkeeping by institutions that care for or provide services to children; and information sharing between institutions with responsibilities for children's safety and wellbeing and between those institutions and relevant professionals. It makes recommendations to improve records and recordkeeping practices within institutions and information sharing between key agencies and institutions.

Volume 9, *Advocacy, support and therapeutic treatment services* examines what we learned about the advocacy and support and therapeutic treatment service needs of victims and survivors of child sexual abuse in institutional contexts, and outlines recommendations for improving service systems to better respond to those needs and assist survivors towards recovery.

Volume 10, *Children with harmful sexual behaviours* examines what we learned about institutional responses to children with harmful sexual behaviours. It discusses the nature and extent of these behaviours and the factors that may contribute to children sexually abusing other children. The volume then outlines how governments and institutions should improve their responses and makes recommendations about improving prevention and increasing the range of interventions available for children with harmful sexual behaviours.

Volume 11, *Historical residential institutions* examines what we learned about survivors' experiences of, and institutional responses to, child sexual abuse in residential institutions such as children's homes, missions, reformatories and hospitals during the period spanning post-World War II to 1990.

Volume 12, *Contemporary out-of-home care* examines what we learned about institutional responses to child sexual abuse in contemporary out-of-home care. The volume examines the nature and adequacy of institutional responses and draws out common failings. It makes recommendations to prevent child sexual abuse from occurring in out-of-home care and, where it does occur, to help ensure effective responses.

Volume 13, *Schools* examines what we learned about institutional responses to child sexual abuse in schools. The volume examines the nature and adequacy of institutional responses and draws out the contributing factors to child sexual abuse in schools. It makes recommendations to prevent child sexual abuse from occurring in schools and, where it does occur, to help ensure effective responses to that abuse.

Volume 14, *Sport, recreation, arts, culture, community and hobby groups* examines what we learned about institutional responses to child sexual abuse in sport and recreation contexts. The volume examines the nature and adequacy of institutional responses and draws out common failings. It makes recommendations to prevent child sexual abuse from occurring in sport and recreation and, where it does occur, to help ensure effective responses.

Volume 15, *Contemporary detention environments* examines what we learned about institutional responses to child sexual abuse in contemporary detention environments, focusing on youth detention and immigration detention. It recognises that children are generally safer in community settings than in closed detention. It also makes recommendations to prevent child sexual abuse from occurring in detention environments and, where it does occur, to help ensure effective responses.

Volume 16, *Religious institutions* examines what we learned about institutional responses to child sexual abuse in religious institutions. The volume discusses the nature and extent of child sexual abuse in religious institutions, the impacts of this abuse, and survivors' experiences of disclosing it. The volume examines the nature and adequacy of institutional responses to child sexual abuse in religious institutions, and draws out common factors contributing to the abuse and common failings in institutional responses. It makes recommendations to prevent child sexual abuse from occurring in religious institutions and, where it does occur, to help ensure effective responses.

Volume 17, *Beyond the Royal Commission* describes the impacts and legacy of the Royal Commission and discusses monitoring and reporting on the implementation of our recommendations.

Unless otherwise indicated, this Final Report is based on laws, policies and information current as at 30 June 2017. Private sessions quantitative information is current as at 31 May 2017.

Summary

In the course of our inquiry we learned that the sexual abuse of children by adults does not represent all child sexual abuse that occurs within institutions. Children have also been sexually abused by other children. In this volume, we examine child sexual abuse in institutions by children with harmful sexual behaviours. We look at the nature and extent of the problem, how institutions and governments currently address it, and what can be done to improve responses to children with harmful sexual behaviours, particularly therapeutic interventions.

In public hearings and private sessions we heard from many survivors about sexual abuse by children. We learned that harmful sexual behaviour by children is an ongoing problem. We were told that many of the impacts of harmful sexual behaviour by children resemble the impacts of sexual abuse perpetrated by adults. These include immediate and long-term adverse effects for victims that can be serious, and detrimental to physical and psychological health, neurobiological development, interpersonal relationships, connection to culture and sexual identity.

We heard from experts, practitioners and survivors about institutions that did not protect children from sexual abuse by other children, did not respond effectively to complaints from children and their families about sexual abuse by a child, and did not provide appropriate support and intervention to either the children harmed or the children who exhibited harmful sexual behaviours.

The term ‘harmful sexual behaviours’ covers a broad spectrum of behaviours. They can range from those that are developmentally inappropriate and harm only the child exhibiting the behaviours, such as compulsive masturbation or inappropriate nudity, to criminal behaviours such as sexual assault.

The spectrum of harmful sexual behaviours and the diversity of children’s backgrounds and circumstances mean that no one response or intervention is suitable for all children with harmful sexual behaviours. A range of interventions is needed, from prevention and early identification through to assessment and therapeutic intervention. For a small group of children, a child protection or criminal justice response may be necessary.

Australia’s overarching policy for protecting children is set out in *Protecting Children is Everyone’s Business: National Framework for Protecting Australia’s Children 2009–2020* (the National Framework). However, we learned that no state or territory has a comprehensive and coordinated policy approach for preventing, identifying or responding to children with harmful sexual behaviours. We suggest governments should build on the public health approach embodied in the National Framework to develop a framework for preventing harmful sexual behaviours occurring, intervening early when problematic or harmful sexual behaviours first emerge, and enabling children with harmful sexual behaviours to access assessment and therapeutic intervention.

The nature and extent of the problem

There is no universally accepted terminology to describe children with harmful sexual behaviours. As noted, in this volume we use the term ‘harmful sexual behaviours’ to cover the full spectrum of sexual behaviour problems in children. We also use ‘problematic sexual behaviours’ to refer to behaviours that fall outside the normal or age-appropriate range for younger children, and which may only harm the child exhibiting the behaviours. We use ‘juvenile sexual offending’ to refer to behaviour that falls within the legal definition of a sexual offence, where the child could be held criminally responsible for their conduct. For fuller definitions of these terms, see ‘Key terms’ in Chapter 1.

As at 31 May 2017 the Royal Commission had spoken with 6,875 survivors in private sessions. About one in six of them told us about sexual abuse by children in institutions. Contemporary data from the criminal justice system points to an ongoing problem of child sexual abuse by children with harmful sexual behaviours within institutions and in the wider community. We believe that there may be thousands of children harmed by other children’s sexual behaviours in Australia each year.

Of the survivors who spoke to us in private sessions and told us they had been sexually abused by another child or children, 61.8 per cent were male and 38.1 per cent female. Of this group of survivors, 86.3 per cent said they were abused by a boy. This is consistent with research that shows that children with harmful sexual behaviours are overwhelmingly male.

In private sessions, the duration of sexual abuse described to us by survivors who told us they were sexually abused by a child was similar to that described by survivors who told us they were sexually abused by adult perpetrators.

A number of adverse experiences in childhood have been identified in cohorts of children displaying harmful sexual behaviours. These include trauma, prior sexual and physical abuse and exposure to family violence and pornography. We also believe exposure to violent or harmful practices in an institutional context is a risk factor for exhibiting harmful sexual behaviours. Institutions may have played a role in enabling harmful sexual behaviours by allowing a culture of violence and intimidation to prevail so that abuse was ‘normalised’.

We learned that adults in institutions have struggled to recognise, react and respond appropriately to incidents of children displaying harmful sexual behaviours. We believe future responses to the problem must be informed by a better understanding of children’s sexual and psychological development and increased knowledge about harmful sexual behaviours exhibited by children.

Institutional leadership and culture are overarching factors that provide strong situational influences on children's behaviour in institutions. Leaders influence the culture within an institution, which may be protective of children and facilitate appropriate responses when children are harmed or threatened with harm, or may enable abuse of children by endorsing harmful attitudes and behaviours. We heard about aspects of institutional cultures that may have contributed to children exhibiting harmful sexual behaviours, including aspects of cultures in institutions that are effectively 'closed' to outside influences. These include:

- encouragement of sexualised behaviours
- physical and emotional abuse and neglect
- bullying and initiation rituals
- hierarchical structures where children held power over other children
- lack of supervision of children
- lack of understanding of children's sexual development and of harmful sexual behaviours
- inadequate provision of sex education to support healthy behaviours.

Research about children with harmful sexual behaviours indicates a low rate of recurrence of the behaviours. Studies show average recidivism rates for harmful sexual behaviours that reach a criminal threshold range from 3 per cent to 14 per cent. This challenges a common assumption that children who commit sexual offences will inevitably become adult sex offenders. In addition, we heard of therapeutic interventions that can reduce recidivism.

It is important that children's harmful sexual behaviours are identified early. If children are provided with an appropriate assessment and a therapeutic response that is tailored to their particular needs, background and situation, then the behaviours are more likely to cease and less likely to escalate. In turn, children are less likely to require a criminal justice intervention.

Current responses to children with harmful sexual behaviours

There are significant inconsistencies and gaps in Australia's approach to harmful sexual behaviours in children. We have found there is a general lack of knowledge and limited education about the issue within the community, and this is reflected in the inadequate institutional responses we learned about.

We have identified some of the key problems with institutions' reactions and responses to incidents of harmful sexual behaviours by children, including:

- not identifying that harmful sexual behaviours were occurring
- minimising the harmfulness of the sexual behaviours rather than recognising them as serious matters requiring intervention
- inadequate institutional policies and procedures for handling complaints about children engaging in harmful sexual behaviours
- not communicating with affected parties, including parents of the child engaging in the harmful sexual behaviours and the parents of the victim/s
- excluding the victim/s from the institution.

Institutional responses are connected to broader government responses to this issue. Australia's overarching policy for protecting children is set out in the National Framework. Children with harmful sexual behaviours are explicitly referenced in Strategy 6.2 of the National Framework. However, apart from a 2010 report mapping therapeutic intervention services across the country for children with harmful sexual behaviours, we are not aware of any coordinated progress on this issue.

In January 2017, we asked states and territories for information about their current policies applicable to children with harmful sexual behaviours. Despite the National Framework, state and territory governments have not yet adopted a nationally consistent approach to preventing, identifying and responding to children with harmful sexual behaviours. Policy responses have been incorporated into education policy, child protection guidelines or mandatory reporting rules with nature and scope of these policies varying widely across the jurisdictions. There is currently minimal evidence regarding the effectiveness of these policies.

We acknowledge the research regarding harmful sexual behaviours in children is emerging and current policies are developing. We are encouraged by information provided by some jurisdictions that suggests the issue is starting to be addressed in a more comprehensive and holistic way.

Child protection responses to children displaying harmful sexual behaviours may be necessary and appropriate, but we believe child protection should not be the sole focus of government and community efforts in addressing this issue. The statutory child protection system is typically reactive and overstretched and has some inherent limitations. Instead, we believe expertise and resources should be directed towards prevention and early intervention to address children's harmful sexual behaviours. It is also our view that governments should ensure children exhibiting these behaviours have access to specialist assessment and a range of therapeutic interventions that can address their varying levels of need and be tailored to the child's particular background and situation.

A small proportion of children with harmful sexual behaviours enter the criminal justice system. Where abuse of a child by another child has been severe, a custodial sentence may well be appropriate to protect the community and take account of the serious harm done to victims. Nevertheless, support and therapeutic intervention services are important for children with harmful sexual behaviours, both during detention and upon release.

Improving responses to children with harmful sexual behaviours

The public health approach is an established model that has been applied in Australia and internationally and there is support for using this approach to address child protection issues. We believe a public health model can be applied to preventing problematic and harmful sexual behaviours by children.

The public health model encompasses three tiers of interventions – primary, secondary and tertiary. We believe this model can be applied as an overarching framework that will improve prevention as well as allow a range of interventions to be implemented so that children with harmful sexual behaviours receive a response that is tailored to their unique situation and context.

Multi-agency collaboration should be at the heart of a public health approach to children with harmful sexual behaviours. Child protection, police, health, therapeutic treatment services, juvenile justice and institutions where a child has exhibited harmful sexual behaviours will all have expertise and particular insight that can inform interventions for the child. Information sharing is key to achieving the best possible outcomes.

Primary interventions for harmful sexual behaviours

Primary prevention initiatives are directed to the whole community and aim to educate adults and children to help prevent children from engaging in harmful sexual behaviours. There has been a lack of understanding of children's harmful sexual behaviours in the general community and within institutions. We have heard that harmful sexual behaviours are often not recognised and adults in institutions can struggle to know how to react when these behaviours become apparent. Consequently, we believe primary prevention should:

- outline the difference between developmentally appropriate and harmful sexual behaviours by children in a non-stigmatising way
- give children clear guidance on what sexual behaviours are acceptable, what peer and adult behaviours are wrong, and where they can seek help if they feel unsafe
- take into account gender, age, cultural context and disability.

Secondary interventions for harmful sexual behaviours

Secondary prevention focuses on early intervention to prevent children's problematic sexual behaviour from escalating to the point where they might harm other children. Secondary intervention should be directed to children who are at higher risk of displaying harmful sexual behaviours than other children and towards institutions with higher situational risk. We acknowledge that the presence of risk factors does not guarantee abuse will occur, but can serve as a guide for the allocation of resources. Risk factors for children displaying harmful sexual behaviours include adverse childhood experiences, intellectual impairment and learning difficulties, being in out-of-home care and institutional cultures that are hierarchical and hyper-masculine (such as those existing in some elite sporting clubs, male boarding schools, or defence force settings).

Institutions should have clear policies on how to deal with harmful sexual behaviours in children. These policies should support adults within institutions to react to these behaviours when they occur and respond to incidents in an appropriate, informed and calm manner, while prioritising the safety of all children involved. An institutional response to an incident where a child displays harmful sexual behaviour should include:

- monitoring the wellbeing of all children involved – the victim, the child who caused the harm, and any witnesses or other children who have been impacted
- communicating with the children involved, their parents or carers and relevant agencies, including police and child protection where relevant
- documenting events and sharing relevant information with relevant agencies, where necessary and appropriate.

These practices should be outlined in the institution's complaint handling policy. We discuss complaint handling in detail in Volume 7, *Improving institutional responding and reporting*. An effective complaint handling procedure should clearly outline roles and responsibilities, approaches to dealing with different types of complaints, including complaints about children with harmful sexual behaviours, and reporting obligations.

Tertiary interventions for harmful sexual behaviours

Tertiary interventions for harmful sexual behaviours displayed by children include child protection and criminal justice responses as well as therapeutic assessment and interventions. Referring a child with harmful sexual behaviours for specialist assessment is necessary to determine the most appropriate therapeutic intervention for that child. Interventions to address the behaviours cannot take a 'one-size-fits-all' approach. Each child who exhibits harmful sexual behaviours does so within the context of their current family situation and against the

background of their unique upbringing and life circumstances, which may have contributed to the development of those behaviours. In institutional settings, the institution provides part of this context. Therapeutic interventions should be tailored to the child's behaviours as well as their particular situation.

Research suggests therapeutic interventions can reduce or eliminate children's harmful sexual behaviours. It is important to note that much of the research regarding children with harmful sexual behaviours is based on children who have attended some form of therapeutic intervention. Consequently, there is very little known about outcomes for children with problematic and harmful sexual behaviours who did not access treatment. Regardless, we believe it is critical for children with harmful sexual behaviours to have access to quality assessment and therapeutic intervention. These children should be assessed by specialist practitioners who can consider the context in which the harmful sexual behaviours occurred as well the child's background, the broader contexts they operate in and the nature of the behaviours. Effective assessment is necessary to determine the most appropriate therapeutic intervention for the child.

Different sectors and jurisdictions currently assess children with harmful sexual behaviours via different processes. We were told of some assessments conducted by professionals with insufficient training in harmful sexual behaviours. Some assessment tools do not take enough account of variables such as age, gender, disability and cultural context, often leading to a choice of therapeutic intervention that is ineffective for a child. There is a need for well-developed and contextually appropriate assessment tools that are supported by informed clinical judgement.

A research review we commissioned suggests that Multisystemic Therapy (MST) can be effective for children with harmful sexual behaviours. The review found that MST can help reduce a number of negative social outcomes for the child receiving therapy, including sexual aggression, violence and recidivism in the short- and medium-term. MST practitioners draw on a range of approaches including cognitive and behavioural therapies and family therapy. The interventions chosen are tailored to the child's individual, family, friendship, school and community environments. MST has a strong focus on developing the capacities of the child's caregivers. There were some limitations with this research and more work is necessary to determine if MST is effective in the Australian context. We also heard about a range of approaches, models and therapeutic techniques that show promise for children with problematic and harmful sexual behaviours that have not yet been subject to rigorous evaluation.

In Australia, therapeutic intervention for children with harmful sexual behaviours varies across states and territories. Therapeutic services use different theoretical models and modes of delivery. We were told that many therapeutic services have inadequate resources and demand outstrips capacity. Therapeutic services receive little funding for primary prevention and early intervention initiatives.

We were also told there are services gaps for some specific populations. These include:

- inconsistent treatment options for children under the age of 10
- limited or non-existent services for children in out-of-home care in some jurisdictions
- lack of training for staff to work effectively with children with an intellectual impairment, learning difficulties or emotional or behavioural disorders (including conduct disorders), who are over-represented in therapeutic services
- lack of specialist services in regional and remote communities
- lack of expertise in culturally safe services for Aboriginal and Torres Strait Islander children.

We are of the view that governments should make assessment available for children with harmful sexual behaviours, fund a network of therapeutic services for these children, and ensure there are clear referral pathways so children are able to access the services they require. We also believe these therapeutic services should apply a principles-based approach to delivering therapeutic interventions. We have developed best practice principles, which are based on research, existing overseas and domestic frameworks, and consultations with experts as well as what we have been told during our public hearings and private sessions. Our best practice principles for therapeutic interventions are:

- A contextual and systemic approach should be used. For interventions to be effective they should take account of a child's whole environment and include family, neighbourhood and community supports.
- Family and carers should be involved. Practitioners should equip the child's family and carers with techniques and strategies so they can play a continuing role in behaviour management and promoting positive change for the child.
- Safety should be established. An overarching safety plan must be agreed on between services, home and school that provides safe and appropriate ways of managing the child's behaviour.
- There should be accountability and responsibility for the harmful sexual behaviours. Therapeutic interventions should assist the child with the harmful sexual behaviours to acknowledge and take responsibility for their behaviours.

- There should be a focus on behaviour change. The aim should be to guide the child towards understanding appropriate and safe ways to behave, through education which takes account of the child's entire circumstances, including at home and at school.
- Developmentally and cognitively appropriate interventions should be used. They should be tailored to the child's age and developmental stage and accommodate learning and language difficulties, developmental delays, cognitive impairment and other needs resulting from disability.
- The care provided should be trauma-informed. A trauma-informed approach recognises that many children with harmful sexual behaviours have trauma in their background and therefore have complex needs that require a holistic response.
- Therapeutic services and interventions should be culturally safe. In particular, Aboriginal and Torres Strait Islander children and their families may require culturally tailored approaches. Practitioners should consult with cultural experts to ensure interventions are effective.
- Therapeutic interventions should be accessible to all children with harmful sexual behaviours.

In addition, we believe ongoing evaluation is necessary to improve the implementation and delivery of interventions, to inform practice, and to demonstrate the impact of an intervention. Evaluation is particularly important for emerging fields such as working with children with harmful sexual behaviours, because it advances the limited evidence base and provides a positive direction for the development of new interventions.

Recommendations

The following is a list of the recommendations made in this volume.

A framework for improving responses (Chapter 4)

Recommendation 10.1

The Australian Government and state and territory governments should ensure the issue of children's harmful sexual behaviours is included in the national strategy to prevent child sexual abuse that we have recommended (see Recommendations 6.1 to 6.3).

Harmful sexual behaviours by children should be addressed through each of the following:

- a. primary prevention strategies to educate family, community members, carers and professionals (including mandatory reporters) about preventing harmful sexual behaviours
- b. secondary prevention strategies to ensure early intervention when harmful sexual behaviours are developing
- c. tertiary intervention strategies to address harmful sexual behaviours.

Improving assessment and therapeutic intervention (Chapter 5)

Recommendation 10.2

The Australian Government and state and territory governments should ensure timely expert assessment is available for individual children with problematic and harmful sexual behaviours, so they receive appropriate responses, including therapeutic interventions, which match their particular circumstances.

Recommendation 10.3

The Australian Government and state and territory governments should adequately fund therapeutic interventions to meet the needs of all children with harmful sexual behaviours. These should be delivered through a network of specialist and generalist therapeutic services. Specialist services should also be adequately resourced to provide expert support to generalist services.

Recommendation 10.4

State and territory governments should ensure that there are clear referral pathways for children with harmful sexual behaviours to access expert assessment and therapeutic intervention, regardless of whether the child is engaging voluntarily, on the advice of an institution or through their involvement with the child protection or criminal justice systems.

Recommendation 10.5

Therapeutic intervention for children with harmful sexual behaviours should be based on the following principles:

- a. a contextual and systemic approach should be used
- b. family and carers should be involved
- c. safety should be established
- d. there should be accountability and responsibility for the harmful sexual behaviours
- e. there should be a focus on behaviour change
- f. developmentally and cognitively appropriate interventions should be used
- g. the care provided should be trauma-informed
- h. therapeutic services and interventions should be culturally safe
- i. therapeutic interventions should be accessible to all children with harmful sexual behaviours.

Strengthening the workforce (Chapter 5)

Recommendation 10.6

The Australian Government and state and territory governments should ensure that all services funded to provide therapeutic intervention for children with harmful sexual behaviours provide professional training and clinical supervision for their staff.

Improving evaluation (Chapter 5)

Recommendation 10.7

The Australian Government and state and territory governments should fund and support evaluation of services providing therapeutic interventions for problematic and harmful sexual behaviours by children.

1 Introduction

1.1 Overview

Public perceptions and media depictions of institutional child sexual abuse centre on abuse committed by adult perpetrators. This does not represent all child sexual abuse that occurs within institutions. During our inquiry we were told of children sexually abusing other children in institutional contexts and that this has been an ongoing problem. In this volume, we examine the sexual abuse of children by children with harmful sexual behaviours, how institutions and governments respond when this occurs, and how these responses could be improved.

Throughout the course of our inquiry, a large number of survivors told us that they were sexually abused by another child or children in an institution. Survivors in our public hearings gave evidence that children had sexually abused them in an institutional context.¹ As at May 2017, 1,129 of the 6,875 people who attended a private session with the Royal Commission told us about child sexual abuse by another child. This equates to 16.4 per cent of those who attended a private session. Survivors also gave written accounts of being sexually abused as children by other children.

We learned throughout our inquiry that child sexual abuse by other children can have serious and detrimental impacts on victims, which can resemble the impacts of adult-perpetrated abuse detailed in research we commissioned.² These include adverse effects on psychological and physical health, neurobiological development and interpersonal relationships.³ There is some evidence that some children who have been sexually abused by another child may begin to re-enact the abuse they experienced and cause harm to other children.⁴

Children who exhibit harmful sexual behaviours are a diverse group.⁵ They vary in their age and the extent to which they understand, and intend to engage in, harmful sexual behaviours. Their social and economic backgrounds vary. Many, but not all, children who engage in harmful sexual behaviours have experienced prior trauma or abuse, which may have contributed to the development of their behaviours.⁶ We heard from some survivors who attended private sessions about being sexually abused as children by adults and that they then, as children, sexually abused other children.

The nature of children's harmful sexual behaviours covers a broad spectrum, from behaviours that are lower-risk to other children, such as compulsive masturbation, to those that cause severe harm to another child, such as raping another child.⁷

In our public hearings and private sessions, survivors, experts and practitioners told us of institutions not protecting children from sexual abuse by other children; failing to respond effectively to the complaints of children or their families of sexual abuse by children; and not providing appropriate support and intervention to either the children harmed or the children who exhibited harmful sexual behaviours. These institutions were often environments where other forms of abuse, including bullying and bastardisation (routine humiliation as part of initiation, also known as 'hazing'), frequently occurred, and were often characterised by strict and hierarchical structures, a lack of supervision and oversight, and a tendency to ignore or minimise the harmful nature of certain behaviours.

The broad spectrum of harmful sexual behaviours displayed by children, as well as the diversity of children's backgrounds and circumstances, means that no one response or intervention is suitable for all children exhibiting harmful sexual behaviours.⁸ However, all instances of children exhibiting harmful sexual behaviours, especially towards another child, should be recognised and taken seriously. Adults and institutions should neither under- or over-react to these behaviours; rather, the reaction and response should be proportionate to the behaviours and the circumstances in which they occurred.

Children who have exhibited harmful sexual behaviours require access to a range of interventions, from early identification, education and support for lower-risk behaviours, to assessment and therapeutic intervention for children with higher-risk behaviours.⁹ For a small group of children, a child protection or criminal justice response may also be necessary, including support and treatment available in detention and on release. In each case, the child's individual circumstances and the factors contributing to their harmful sexual behaviours should be considered when selecting an appropriate response.

Overall, Australia lacks a comprehensive overarching framework to guide formal systems, individual institutions and practitioners on how to provide effective, consistent responses to harmful sexual behaviours by children. We heard that there are insufficient therapeutic services for children with harmful sexual behaviours, particularly for children under 10 years old, in out-of-home care, with intellectual disability or cognitive impairment, and in rural or remote areas. The public health approach to prevention provides a framework that can be applied to help prevent harmful sexual behaviours occurring, intervene early when harmful sexual behaviours first emerge and provide appropriate therapeutic intervention to prevent recurrence and minimise harm. We suggest that governments should ensure children with harmful sexual behaviours have access to a range of interventions. These interventions should include strategies to better prevent, identify and assess children's harmful sexual behaviours, as well as therapeutic interventions that are effective in addressing these behaviours so no further harm is caused to other children.

1.2 Terms of Reference

The Letters Patent establishing the Royal Commission required that it 'inquire into institutional responses to allegations and incidents of child sexual abuse and related matters' and set out the Terms of Reference of the inquiry.

In carrying out this task, we were directed to focus on systemic issues, informed by an understanding of individual cases. We were required to make findings and recommendations to better protect children against sexual abuse and alleviate the impact of abuse on children when it occurs.

This volume particularly addresses the future focus of our Terms of Reference. Under paragraph (a), we were directed to inquire into ‘what institutions and governments should do to better protect children against child sexual abuse and related matters in institutional contexts in the future’. Paragraphs (b) and (c) of the Letters Patent also directed us to consider what institutions and governments need to do to improve their responses to child sexual abuse in institutional contexts and reduce the impact on survivors.

1.3 Links with other volumes

This volume has close links with other volumes in our Final Report, in particular:

- Volume 2, *Nature and cause*, which considers the nature and causes of all forms of child sexual abuse, including sexual abuse by another child
- Volume 3, *Impacts*, which addresses the impacts of child sexual abuse on victims and other affected parties
- Volume 6, *Making institutions child safe*, which outlines why a nationwide approach is needed to address child sexual abuse in institutions and explains our recommended approach to child sexual abuse prevention, based on the public health model
- Volume 7, *Improving institutional responding and reporting*, which deals with problems with past institutional responses to complaints of child sexual abuse, including inadequate reporting to external agencies. These failings are closely connected to institutional failings in handling complaints about children with harmful sexual behaviours that we outline in Chapter 3 of this volume. The best practice principles for responding to complaints of child sexual abuse set out in Volume 7 should also apply to complaints regarding children with harmful sexual behaviours
- Volume 8, *Recordkeeping and information sharing*, which covers information sharing obligations. As discussed in Chapter 4 of this volume, institutions should have policies to facilitate the appropriate sharing of information about children with harmful sexual behaviours
- Volume 9, *Advocacy, support and therapeutic treatment services*, which discusses therapeutic interventions for victims of child sexual abuse to enable them to cope with the abuse and its impacts
- Volume 12, *Contemporary out-of-home care*, Volume 13, *Schools* and Volume 14, *Sport, recreation, arts, culture, community and hobby groups*, which discuss in detail those institutional contexts in which child sexual abuse occurred, which are particularly relevant to the issue of children displaying harmful sexual behaviours
- Our *Criminal justice* report, which examines how the police and justice system respond to juvenile sexual offending.¹⁰

1.4 Key terms

The inappropriate use of words to describe child sexual abuse and the people who experience the abuse can have silencing, stigmatising and other harmful effects. Conversely, the appropriate use of words can empower and educate.

For these reasons, we have taken care with the words used in this report. Some key terms used in this volume are set out below. A complete glossary is contained in Volume 1, *Our inquiry*.

Children with harmful sexual behaviours

We use the term ‘children with harmful sexual behaviours’ to refer to children under 18 years who have behaviours that fall across a spectrum of sexual behaviour problems, including those that are problematic to the child’s own development, as well as those that are coercive, sexually aggressive and predatory towards others. The term ‘harmful sexual behaviours’ recognises the seriousness of these behaviours and the significant impact they have on victims, but is not contingent on the age or capacity of a child.

The term ‘children with harmful sexual behaviours’ is used when referring to the general group of children with sexual behaviour problems. At times, we use more specific terms:

- ‘Problematic sexual behaviours’ refers to sexual behaviours that fall outside the normal or age-appropriate range for younger children. These may or may not result in harm to another person. Problematic sexual behaviours by young children may be an indicator of them having been harmed themselves and may place the child displaying such behaviours at risk of sexual exploitation.
- ‘Sexual offending’ refers to sexual behaviours that fall within the definition of a sexual offence, where the child could be held criminally responsible for their conduct. In Australia, children aged 10 and over can potentially be charged with a sexual offence.

The significance of this terminology is discussed in more detail in Chapter 2.

Child sexual abuse

‘Child sexual abuse’ refers to any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. Sexually abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism, and exposing the child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child’s inhibitions in preparation for sexual activity with the child.

Victim and survivor

We use the terms ‘victim’ and ‘survivor’ to refer to someone who has been sexually abused as a child in an institutional context.

We use the term ‘victim’ when referring to a person who has experienced child sexual abuse at the time the abuse occurred. We use the term ‘survivor’ when referring to a person who has experienced child sexual abuse after the abuse occurred, such as when they are sharing their story or accessing support. Where the context is unclear, we have used the term ‘victim’.

We recognise that some people prefer ‘survivor’ because of the resilience and empowerment associated with the term.

We recognise that some people who have experienced abuse do not feel that they ‘survived’ the abuse, and that ‘victim’ is more appropriate. We also recognise that some people may have taken their lives as a consequence of the abuse they experienced. We acknowledge that ‘victim’ is more appropriate in these circumstances. We also recognise that some people do not identify with either of these terms.

When we discuss quantitative information from private sessions in this volume, we use the term ‘survivor’ to refer both to survivors and victims who attended a private session and those (including deceased victims) whose experiences were described to us by family, friends, whistleblowers and others. This quantitative information is drawn from the experiences of 6,875 victims and survivors of child sexual abuse in institutions, as told to us in private sessions to 31 May 2017.

1.5 Structure of this volume

Chapter 2 outlines the nature and extent of the problem of children displaying harmful sexual behaviours. We describe what children’s harmful sexual behaviours are and how these differ from healthy sexual behaviours. We address the scale of the problem of children displaying harmful sexual behaviours, and its serious impacts on victims. Chapter 2 presents what we have learned about the victims who have been sexually abused by other children and the children who have caused harm, within an institutional context. It considers the institutional settings where children have most often been sexually abused by other children and the institutional risk factors that contribute to this abuse occurring.

Chapter 3 examines current responses by institutions and governments in Australia to the issue of children displaying harmful sexual behaviours. We outline what we have heard, in our public hearings and private sessions, about institutions failing to respond appropriately and allowing children to continue to sexually harm other children. Inadequate institutional responses to children with harmful sexual behaviours are connected to problems with the broader, societal response to this issue. Chapter 3 describes government policy and formal systems for responding to children with harmful sexual behaviours, through therapeutic intervention and the criminal justice and child protection systems.

Chapter 4 outlines how institutions and governments should improve their responses to children with harmful sexual behaviours. We describe how a public health approach to prevention can be applied to prevent harmful sexual behaviours occurring, intervene early when harmful sexual behaviours first emerge and provide appropriate therapeutic intervention to prevent recurrence and minimise harm.

Chapter 5 provides a detailed discussion of tertiary interventions for children with harmful sexual behaviours. Tertiary interventions include therapeutic assessment and intervention, as well as child protection and criminal justice system responses. We focus our discussion on the benefits of responding to children with harmful sexual behaviours with therapeutic intervention. We outline how to improve access to and the quality of assessment and therapeutic interventions for children with harmful sexual behaviours. We outline that sometimes the identification of harmful sexual behaviours will trigger a child protection or criminal justice response, which we believe may be necessary for a small proportion of children with harmful sexual behaviours.

Endnotes

- 1 See for example, Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 3: Anglican Diocese of Grafton's response to child sexual abuse at the North Coast Children's Home*, Sydney, 2014, pp 13–14; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 5: Response of The Salvation Army to child sexual abuse at its boys homes in New South Wales and Queensland*, Sydney, 2015, pp 20–4; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 7: Child sexual abuse at the Parramatta Training School for Girls and the Institution for Girls in Hay*, Sydney, 2014, pp 17, 19; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 11: Congregation of Christian Brothers in Western Australia response to child sexual abuse at Castledare Junior Orphanage, St Vincent's Orphanage Clontarf, St Mary's Agricultural School Tardun and Bindoon Farm School*, Sydney, 2014, p 25; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 17: The response of the Australian Indigenous Ministries, the Australian and Northern Territory governments and the Northern Territory police force and prosecuting authorities to allegations of child sexual abuse which occurred at the Retta Dixon Home*, Sydney, 2015, pp 22, 27; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 30: The response of Turana, Winlaton and Baltara, and the Victoria Police and the Department of Health and Human Services Victoria to allegations of child sexual abuse*, Sydney, 2016, pp 30–5; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 33: The response of The Salvation Army (Southern Territory) to allegations of child sexual abuse at children's homes that it operated*, Sydney, 2016, pp 45, 54, 65; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 32: The response of Geelong Grammar School to allegations of child sexual abuse of former students*, Sydney, 2017, p 29; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 41: Institutional responses to allegations of the sexual abuse of children with disability*, Sydney, 2017, pp 36–7; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 40: The response of the Australian Defence Force to allegations of child sexual abuse*, Sydney, 2017, pp 29–31, 53–4; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and harmful sexual behaviours of children in schools*, Sydney, 2017, pp 12–13, 32–33, 59–64.
- 2 See, for example, T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017.
- 3 See, for example, T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017; W O'Brien, *Australia's response to sexualised or sexually abusive behaviours in children and young people*, Australian Crime Commission, Canberra, 2010, p 23.
- 4 T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 58.
- 5 W O'Brien, *Australia's response to sexualised or sexually abusive behaviours in children and young people*, Australian Crime Commission, Canberra, 2010, p 14; S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, UK, 2014, p 11; S Hackett, J Phillips, H Masson & M Balfe, 'Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers', *Child Abuse Review*, vol 22, no 4, 2013, pp 232–45, note that children and young people who display harmful sexual behaviours are a diverse group who display a wide range of behaviours; Transcript of D Tolliday, Case Study 45, 3 November 2016, 22819:5–22820:8.
- 6 See, for example, Transcript of D Tolliday, Case Study 45, 3 November 2016, 22818:41–22820:22 and Transcript of M Watson, Case Study 45, 3 November 2016 at 22820:28–45. See also S Hackett, J Phillips, H Masson & M Balfe, 'Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers', *Child Abuse Review*, vol 22, no 4, 2013, pp 232–45.
- 7 See, for example, S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, UK, 2014, p 18: Hackett presents a continuum of children's sexual behaviours, ranging from those considered normal, to those categorised as abusive and violent.
- 8 See, for example, I Lambie & F Seymour, 'One size does not fit all: Future directions for the treatment of sexually abusive youth in New Zealand', *Journal of Sexual Aggression*, vol 12, no 2, 2006, pp 180–83. See also S Hackett, J Phillips, H Masson & M Balfe, 'Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers', *Child Abuse Review*, vol 22, no 4, 2013, pp 232–45.
- 9 S Hackett, D Holmes & P Branigan, *Operational framework for children and young people displaying harmful sexual behaviours*, NSPCC, London, 2016, p 7.
- 10 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017.

2 Nature and extent of the problem

2.1 Overview

During the course of our inquiry the sexual abuse of children in institutions by other children emerged as a significant issue. In our public hearings we heard survivors give evidence about being sexually abused by other children. We heard similar accounts from survivors in private sessions. As at May 2017, 1,129 (nearly one in six, or 16.4 per cent) of 6,875 private sessions attendees spoke to us about sexual abuse by another child. Of these, 86.3 per cent told us they were abused by a boy. Overall, in our public hearings and private sessions, we heard about the experiences of hundreds of survivors and numerous secondary victims, including parents and carers, whose lives have been adversely affected by this kind of abuse. We became aware that children with harmful sexual behaviours harming other children is a kind of abuse that has occurred across all levels of society and in many different settings, in historical and contemporary times.

We learned that few people understand how to identify, react and respond to children's harmful sexual behaviours or fully appreciate the damage the behaviours can cause. We heard that children themselves were sometimes unaware another child could sexually abuse them, or that another child's sexual behaviour was harmful.¹ For example, during her private session 'Helena' told us that she questioned whether she had been sexually abused: 'Can you be molested by somebody who's the same age as you? I'd only ever heard about it in the context of an adult'.²

In this chapter we present what we have learned about this problem. We begin by discussing the extent of the problem of harmful sexual behaviours exhibited by children. We also describe harmful sexual behaviours and distinguish them from children's healthy sexual behaviours. Children's harmful sexual behaviours cover a broad spectrum, ranging from problematic sexual behaviours that are potentially harmful only to that child's own development, to children who have displayed violent and abusive sexual behaviours that victimise another child, adult or animal.³ We discuss the impacts of these behaviours on victims and explain the language we use to describe children's harmful sexual behaviours, which differs from the terminology we use to discuss child sexual abuse perpetrated by adults.

We then discuss the types and features of child sexual abuse by children with harmful sexual behaviours. We explain what we have learned about the children (mostly boys) who have sexually abused others. We outline what we learned about the victims of this abuse, such as their gender, age and relationship to the child with harmful sexual behaviours. We explain the risk factors – including social, environmental and institutional risk factors – that may contribute to these behaviours.

Finally, we outline why children with harmful sexual behaviours should be treated differently to adult perpetrators of child sexual abuse, due to their developmental stage and capacity for rehabilitation. Studies into recidivism indicate that most children with harmful sexual behaviours will not continue offending.⁴ This is underscored by evidence that appropriate support, education or therapeutic interventions can help to stop children's problematic or harmful sexual behaviours.⁵ Therefore, timely access to early intervention, assessment and therapeutic treatment services is essential.

This chapter provides the background for our recommendations in Chapters 4 and 5 regarding a range of interventions required to improve identification, early intervention and responses to children's harmful sexual behaviours.

2.2 The extent of sexual abuse by children

Of the 1,129 private sessions attendees who spoke to us about sexual abuse by another child, 473 (41.9 per cent) told us they were abused by another child or children only, with the remainder telling us about abuse by both adults and other children. Some of these survivors also told us that, as children, they then sexually abused other children. In a number of our public hearings, survivors gave evidence about sexual abuse by other children, and experts provided advice on the topic.⁶ *Case Study 45: Problematic and harmful sexual behaviours of children in schools (Harmful sexual behaviours of children in schools)* examined in detail the issue of harmful sexual behaviours exhibited by children.⁷

Australia is one of few developed countries where a nationally representative prevalence study on child maltreatment and child sexual abuse has not been conducted.⁸ Consequently, there is no uniform data collection on children with harmful sexual behaviours. Varying methods of defining and counting occurrences of child sexual abuse has led to different conclusions, and most official figures probably underestimate the occurrence.⁹

Crime data in Australia provides one indication of the potential extent of sexual abuse by children. According to existing Australian police data, in the period from July 2015 to June 2016, 21 per cent of those persons against whom the police initiated legal action for a sexual offence were aged between 10 and 17 years.¹⁰ The Australian Bureau of Statistics reports that this amounted to 1,672 children.¹¹ This data was not limited to sexual offences against children, and there was no distinction made between institutional and non-institutional contexts in this data.

These figures are likely to underestimate the true extent of child sexual abuse and sexual offences by children in Australia. The data is drawn from statistics on recorded crimes by youth offenders aged between 10 and 17 years (10 being the age from which a child can

be held criminally responsible for their actions) and is limited to information about cases of sexual abuse reported to police.¹² Much less is known about the extent of children's harmful sexual behaviours that do not meet the criminal threshold or are not reported to police.¹³

Research from the United Kingdom and the United States indicates that children are responsible for a sizeable proportion of reported sexual offences in those countries. In 2004, in the United States, juveniles accounted for more than 25 per cent of all sex offenders and more than 35 per cent of sex offenders who had offended against children.¹⁴ In England and Wales in 2002, 20 per cent of those found guilty or cautioned for a sexual offence were children.¹⁵

We commissioned research to help us better understand the extent of child sexual abuse in Australia. The first piece of commissioned research explored contemporary incidents of child sexual abuse using various administrative datasets, such as police data, education department data and child protection data. This research looked specifically at child sexual abuse in institutional contexts in Australia from 2008 to 2013.¹⁶

This research showed that, where information was available about the subject of a report, children were the subject of most reports to police between 2008 and 2013 about child sexual abuse in institutional contexts.¹⁷ This was the case across most Australian jurisdictions. Of reports of child sexual abuse in institutional contexts between 2008 and 2013, children made up 67 per cent of those reported to police in Victoria; 76 per cent in New South Wales; and 93 per cent in Queensland.¹⁸ It is important to note that there was a significant amount of missing data in relation to the characteristics of the subject of the reports, and that recording practices varied across jurisdictions.¹⁹

The second piece of research we commissioned regarding the extent of child sexual abuse in Australia was concerned with how cases of child sexual abuse reported to police were finalised. This research also included a detailed statistical analysis of the 'extent and nature of child-to-child sexual abuse reported to police from 1 January 2010 to 31 December 2014'.²⁰ It should also be noted that this research was not limited to institutional contexts. This research found that, overall, children were the subject of 20 per cent of child sexual abuse reports to police between 2010 and 2014 (for which details of the subject of the report were known).²¹ It is important to note that the details of the subject were not recorded in 41 per cent of reports.²² The 1,642 reports involving children in institutional settings equated to 8 per cent of all reported occurrences of child sexual abuse by a child.²³ The researchers acknowledged that the number of reports involving child sexual abuse by a child in institutional settings was likely an underestimate.²⁴ Victims of child sexual abuse by children were predominately female (67 per cent), while children who sexually abuse other children were mostly male (87 per cent).²⁵

Due to a number of variations in recording practices across jurisdictions and the significant amount of missing data, cautious interpretation of these findings is required.

Researchers agree that most figures concerning sexual abuse where both parties are under the age of 18 are likely to be underestimates.²⁶ This may be due to different methods of counting and defining sexual abuse, resulting in different conclusions as to how often it occurs.²⁷ It has also been proposed that victims may feel ashamed or are scared of the consequences of disclosing sexual abuse, and that this contributes to the under-reporting of child sexual abuse by children.²⁸ A 2011 study in the United Kingdom indicated that 66 per cent of contact child sexual abuse is caused by persons aged under 18 years.²⁹

Together, the available information suggests there may be thousands of children harmed by other children's sexual behaviours in Australia each year, across both institutional and non-institutional settings. This is an ongoing problem that requires contemporary solutions.

However, due to the limitations of existing data, we believe comprehensive research into the prevalence of harmful sexual behaviours exhibited by children is required. While the focus of our inquiry is on child sexual abuse in institutional contexts, the prevalence of harmful sexual behaviours exhibited by children should be considered across all contexts. Research on prevalence should also track any changes attributable to government reforms.

In Volume 2, *Nature and cause* we recommend a nationally representative prevalence study be conducted to establish a baseline for the extent of child sexual abuse in Australia (see Recommendation 2.1). We are of the view that information about the extent to which children have sexually abused other children should be collected in this study.

2.3 Terminology

2.3.1 Existing terminology

There is currently no consistent terminology, nationally or internationally, to describe children with harmful sexual behaviours. Practitioners, policymakers and researchers use an array of terms to describe children who have exhibited sexual behaviours toward another child. These terms reflect the diverse disciplines of the practitioners and agencies that engage with these children.³⁰ Some practitioners and agencies, such as juvenile justice or child protection agencies, only engage with a subset of children with harmful sexual behaviours. Consequently, their terminology may not be suitable for all children with these behaviours. Adding to the complexity, even where the same term is used by multiple agencies, those agencies may define it differently.

In general, language used in this field has emerged from a criminal justice context and as a result has tended to be framed in criminal justice terms. Children with these behaviours have been labelled ‘perpetrators’, ‘juvenile sexual offenders’ or ‘child sexual abusers’.³¹ Such labels may be appropriate for some children who are old enough to be held criminally responsible and whose behaviours have resulted in convictions for sexual offences. However, these labels do not reflect the breadth of behaviours or circumstances across the entire group of these children. Such language equates the actions and intent of children to those of adult sexual offenders and fails to take into account differences between individual children, as well as the differences between adults and children. We have also been advised that such terms reflect an inappropriate binary understanding of justice, which dictates that where there is a victim, there must always be an offender.³²

In Australia, language used to describe children with harmful sexual behaviours has shifted in focus in more recent times from the child to the behaviours themselves, and descriptors such as ‘children with sexually abusive behaviours’ started to emerge.³³ This shift reflected a growing understanding that language which frames children in purely criminal terms does not acknowledge that children have a greater capacity for rehabilitation than adult offenders.³⁴ Such descriptors can also adversely affect the motivation of a child to change their harmful sexual behaviours and detrimentally affects their view of their identity, future, and ability to engage in healthy and positive behaviours.³⁵

A 2010 report, *Australia’s response to sexualised or sexually abusive behaviours in children and young people*, urged caution in the choice of words. It stated:

Careful use of terminology is required to ensure that systems can respond appropriately, and with sensitivity, to the broad spectrum of sexualised behaviours and the conditions that are likely to have contributed to them.³⁶

In Australia, across various jurisdictions, practitioners, policy makers and academics use a range of descriptors for the sexual abuse of children by other children. These include:

- ‘problematic’, ‘inappropriate’ or ‘concerning’ sexual behaviours
- ‘sexually reactive behaviours’
- ‘sexually abusive behaviours’
- ‘sexual offending’
- ‘sexually harmful behaviours’ or ‘harmful sexual behaviours’.

We have included a table of these commonly used terms, and their contexts and definitions, in Appendix A of this volume.

2.3.2 Terminology used by the Royal Commission

Taking the breadth of behaviours and complexity of issues into account, we have chosen to use the term ‘children with harmful sexual behaviours’. This term covers children who display the full spectrum of sexual behaviour problems, including behaviours that are problematic to the child’s own development, as well as those that are coercive, sexually aggressive and predatory towards others. Our use of the term, therefore, captures all child sexual abuse by children, including juvenile sexual offending.

Harmful sexual behaviours can include problematic, coercive, violent and/or controlling behaviour patterns reflected in, for example, excessive or public self-stimulation; spying on others; unwanted sexual approaches to others; sharing indecent images of persons under 18; coercive sexual assault and coercive sexual intercourse and/or oral sex. Depending on the type of behaviour, they may be displayed in person or online.

At times, we use more specific terms to identify particular types of harmful sexual behaviours exhibited by children:

- We use ‘problematic sexual behaviours’ to refer to sexual behaviours that fall outside the normal or age-appropriate range for younger children.³⁷ These are generally considered to be behaviours that do not involve overt victimisation of another child but can harm the child displaying the behaviours. Problematic sexual behaviours by young children may be an indicator of them having been harmed³⁸ and may place the child displaying such behaviours at risk of sexual exploitation.³⁹
- We use ‘child sexual abuse’ to refer to sexual behaviours of children when they are directed towards another child and are beyond the other child’s understanding or are contrary to accepted community standards. Behaviours that fall under the definition of child sexual abuse are described in detail in Volume 2, *Nature and cause*.
- We use ‘juvenile sexual offending’ to refer to sexual behaviours of children that fall within the definition of a sexual offence,⁴⁰ where the child could be held criminally responsible for their conduct. In Australia, provisions regarding the age of criminal responsibility and the age of consent vary between Australian jurisdictions, but only children aged 10 years or older may be charged with a sexual offence.⁴¹

In this report, we do not use the terms ‘perpetrator’ or ‘sex offender’ to describe children with harmful sexual behaviours. As outlined below, many practitioners argue that such labels are stigmatising, damaging and inaccurate for many children with lower-level sexual behaviour problems.⁴² Some children, particularly younger children, engage in inappropriate sexual interactions without intending to cause harm, or understanding the harm it causes others. In addition, children’s harmful sexual behaviours do not always reach the criminal threshold for offending.

As Dr Elizabeth Letourneau, Director of the Moore Center for the Prevention of Child Sexual Abuse, stated in *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts* (*Nature, cause and impact of child sexual abuse*):

We use different language for children than the ‘perpetrator’ or ‘offender’ language that we use for adults, not just to be protective of children against the stigmatising effects of the labels of ‘sex offender’ and ‘perpetrator’, but also because children are in fact different from adults.⁴³

We have illustrated the key terminology we use in this volume in Figure 10.1. This figure displays how we have used ‘harmful sexual behaviours’ as an umbrella term for problems with children’s sexual behaviour. As shown, this term includes the categories of behaviour that comprise ‘child sexual abuse’ and ‘juvenile sexual offending’, as well as the lower-risk behaviours that fall within the category of ‘problematic sexual behaviours’. The smallest category is ‘juvenile sexual offending’. It does not neatly overlap with child sexual abuse by children, because children are not the only victims of children’s harmful sexual behaviours; adults and animals may also be victimised. ‘Juvenile sexual offending’ is the smallest category because it only captures those behaviours that are reported to police and reach the criminal threshold, in children aged 10 years and older.

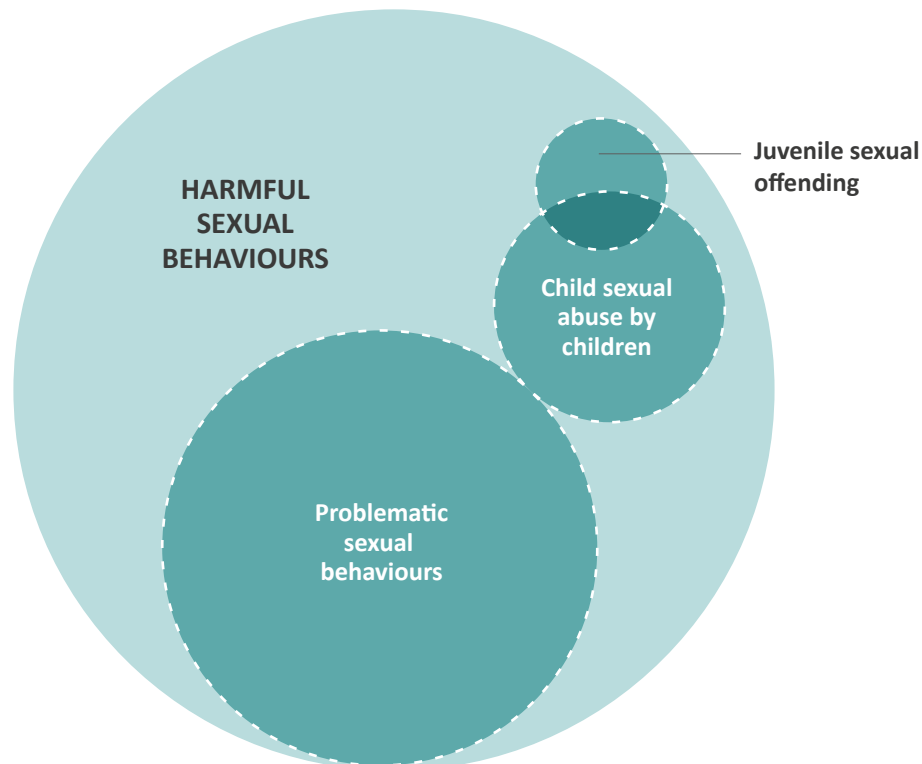


Figure 10.1 – Overlap between problematic and harmful sexual behaviours, juvenile sexual offending and child sexual abuse by a child

As children may potentially be held criminally responsible for some behaviours from the age of 10 onwards (see section 3.4.4), some experts use terminology that distinguishes between harmful sexual behaviours exhibited by children under 10 and those over 10 years old. We consider such age-based distinctions misleading because, in some instances, younger children may display sexual behaviour problems that are more severe than those of older children. Similarly, children over 10 may engage in lower-level 'problematic sexual behaviours' (such as excessive masturbation) without sexually touching another child. Practitioners told us that they consider that labelling these children's behaviours as 'abuse', simply because they are aged over 10 years, is unfair.⁴⁴

Age-based distinctions also present limitations for understanding the behaviour of those children aged over 10 years who have cognitive disability, intellectual impairment or are otherwise developmentally delayed. These children may struggle with interpersonal relationships and social skills in a way that makes it more difficult for them to understand the harmful impact of their behaviours on others.⁴⁵

We consulted with key subject matter experts who told us they supported the introduction of consistent terminology in Australia.⁴⁶ It is likely that applying more consistent terminology across sectors would assist meaningful and accurate communication between specialist practitioners and other professionals working with children.⁴⁷ We recognise that reaching consensus on these terms is a challenging process and that the language may remain contested. Notwithstanding ongoing debates, we have chosen to use these terms based on the best available evidence and endorse the adoption of a nationally consistent approach.

2.4 Developmentally appropriate sexual behaviours in children

Children develop sexually and display sexual behaviours throughout childhood as a normal part of growing up. Staff in institutions working with children should know how to distinguish between healthy and harmful sexual behaviours, and when to intervene.

A child's sexual development includes physical changes in the child's body as well as in their sexual knowledge and behaviours, and is a process that continues over the course of childhood.⁴⁸ A child's sexual development is influenced by biological, psychological, social and environmental factors – for example, gender, developmental stage, individual personality or temperament, parental attitudes, and the cultural context in which the child is raised.⁴⁹ What is considered appropriate consensual sexual behaviour for children of various ages and capacities in one community may be considered unacceptable in another.

It is common for infants and young children to be interested in body parts and functions and ask about, or want to touch, their own bodies and the bodies of other children.⁵⁰ They may demonstrate sexual behaviours in the presence of other children through engaging in games, such as 'playing doctor'. Developmentally appropriate sexual behaviours in young children are usually exploratory and spontaneous, by mutual agreement, and involve children of a similar developmental level.⁵¹ The behaviour is playful and curious, not aggressive, and does not cause physical or emotional harm to the child or others.⁵² Clinical experts and researchers suggest these behaviours may be unrelated to sexual gratification as it is understood by adults.⁵³

Puberty is an important landmark of sexual development for children. In puberty, children will begin to experience large increases and fluctuations in their hormonal levels, affecting their physical, emotional and psychological development.⁵⁴ The onset of puberty varies depending on a range of factors, including age and gender,⁵⁵ but usually begins around 10 to 11 years for girls and around 11 to 13 years for boys.⁵⁶

In the context of mutual, consensual activities involving children who are of similar ages and have similar abilities, children's sexual behaviours are part of healthy development.⁵⁷ The types of sexual activity that are developmentally appropriate for children vary by age group. Some consensual sexual activities, such as oral sex or sexual intercourse, may be considered developmentally appropriate for adolescents, but would be inappropriate for younger children.⁵⁸

Table 10.1 provides guidance compiled from a range of expert sources about expected sexual development in children across different age groups.⁵⁹ This is general guidance only.

Table 10.1 – Expected sexual development in children, by age group

Development stages	Description of expected sexual development and behaviours
0–4 years	Children may display exploratory behaviours – touching and looking at bodies are common. Children in this age group often like to be naked, and games such as ‘mummies and daddies’ may be played. Some children will touch their genitals as a way of comforting themselves.
5–7 years	Children may engage in more exploratory behaviours, ask questions about bodies and compare their bodies to those of their peers. They may have a greater desire for privacy. Gender socialisation is beginning. The main influences on socialisation are parents, carers and the community.
8–12 years	Children in this age group are asking more informed questions. Their knowledge about bodies, sexual behaviours and procreation is growing, although myths about sex and babies flourish, often because the influence of peers and older siblings. Puberty has begun for some children.
13–15 years	Children have the beginnings of fully developed adult bodies. More advanced relationship behaviours are displayed – attachments are longer in duration and generally occur one at a time. Consensual sexual activity with a partner of a similar age and developmental ability may occur. Some children may be comfortable with their sexuality, while others may struggle not to be seen as different. The viewing of materials such as online pornography for sexual pleasure is not unusual.
16–18 years	Children will have adult sexual knowledge and language and may engage in sexual behaviours that include oral sex and intercourse. These older children are more likely to be settling into longer-term relationships that include intimacy and a need for emotional closeness along with sexual desire and pleasure.

We can determine whether a child’s sexual behaviours are harmful by considering how much they differ from these healthy developmental expectations, as well as by examining the context of the behaviours, their severity, and the impact on others.

A number of resources are freely available to assist staff in institutions to distinguish between developmentally appropriate and harmful sexual behaviours by children. We discuss these tools briefly in Chapter 4, ‘Improving responses to children with harmful sexual behaviours’.

2.5 The nature of children's harmful sexual behaviours

Throughout the course of this inquiry, we heard that children who sexually abuse other children are a diverse group who exhibit a variety of harmful behaviours. In public hearings, private sessions and written accounts, survivors told us about the nature of their experiences of sexual abuse by another child.

A small number of survivors also told us about their own harmful sexual behaviours. For example, in a written account provided to the Royal Commission, survivor 'Hilton' told us that he knew he had a 'sexual activity problem' when he went to a government school, after having been removed from his parents' care and living in a children's home. He described how he used to put his hand up his girlfriend's dress and 'play with her' when he was around 9 years old. 'Hilton' told us that he shouldn't have been sexually active with her at that time, but that it seemed normal to him after having been physically abused at the children's home and witnessing his mother and older siblings be violent and have multiple sexual partners when he was younger.⁶⁰ There is evidence that some children who have been sexually abused may re-enact the abuse they experienced or become hyper-sexualised, and that any harm caused to others by this behaviour is unlikely to be intentional.⁶¹

Some survivors told us they were forced by an adult to sexually abuse another child or that they were sexually abused by a child who was forced to do so by an adult. We do not consider this to be sexual abuse committed by a child, but rather by an adult perpetrator. For example, in *Case Study 5: Response of The Salvation Army to child sexual abuse at its boys' homes in New South Wales and Queensland (The Salvation Army boys' homes, Australia Eastern Territory)*, survivor Mr Raymond Carlile gave evidence that Salvation Army officer Lawrence Wilson made Mr Carlile have sex with another boy at Riverview Boys' Home. The officer watched the two boys and masturbated himself.⁶² For further discussions of this type of child sexual abuse, see Volume 2, *Nature and cause*.

2.5.1 Types of harmful sexual behaviours exhibited by children

In public hearings, private sessions and written accounts, we heard that the children who sexually abused other children exhibited a range of harmful behaviours. Researchers from Australia, the United Kingdom and the United States agree that children's harmful sexual behaviours may vary widely in the degree of severity and in the harm they cause to others.⁶³ This aligns with what we have heard from survivors who told us they had been sexually abused by another child.

Volume 2, *Nature and cause* sets out the common forms of child sexual abuse we heard about from survivors who attended a private session at the Royal Commission.

Table 10.2 outlines some of the forms of harmful sexual behaviours that we heard about from survivors who gave evidence at public hearings and attended private sessions. This table should not be considered an exhaustive list of the types of sexual harm a child can cause.

Table 10.2 – Common forms of child sexual abuse by a child, as we heard from by victims and survivors in public hearings and private sessions

Common forms of child sexual abuse by a child	Definition	Illustrative examples of the abuse
Non-penetrative contact abuse	A child with harmful sexual behaviours engaging in sexually touching another child's body, or forcing another child to sexually touch their body.	<p>FP gave evidence in the <i>The Salvation Army boys' homes, Australia Eastern Territory</i> case study that he was routinely sexually abused by two older boys at Riverview Boys' Home.⁶⁴ FP gave evidence that the abuse included fondling.⁶⁵</p> <p>Dr Robert Llewellyn-Jones, in <i>Case Study 32: The response of Geelong Grammar School to allegations of child sexual abuse of former students (Geelong Grammar School)</i>, gave evidence that on numerous occasions while he was a student at Geelong Grammar School, he witnessed several of his peers being indecently assaulted by another student.⁶⁶</p> <p>In our <i>Case Study 45: Problematic and harmful sexual behaviours of children in schools (Harmful sexual behaviours of children in schools)</i> study Mr John Williams and CLG gave separate evidence that older students forcibly applied black oil to their testicles.⁶⁷</p>

Common forms of child sexual abuse by a child	Definition	Illustrative examples of the abuse
Penetrative abuse	A child with harmful sexual behaviours penetrating another child's vagina, anus or mouth with their body part, including genitals, or a foreign object.	<p>In <i>Case Study 11: Congregation of Christian Brothers in Western Australia response to child sexual abuse at Castledare Junior Orphanage, St Vincent's Orphanage Clontarf, St Mary's Agricultural School Tardun and Bindoon Farm School (Christian Brothers)</i>, Mr John Hennessey gave evidence that another boy at Bindoon Farm School frequently raped him in the bushes after church. Although it 'started off as mutual masturbation', the boy would track down Mr Hennessey in the bush, hold him down and anally penetrate him.⁶⁸</p> <p>In <i>Case Study 7: Child sexual abuse at the Parramatta Training School for Girls and the Institution for Girls in Hay</i>, Mrs Fay Hillery gave evidence that she witnessed other girls forcing a bottle into the vagina of another resident.⁶⁹</p> <p>In <i>Case Study 30: The response of Turana, Winlaton and Baltara, and the Victoria Police and the Department of Health and Human Services Victoria to allegations of child sexual abuse (Youth detention centres, Victoria)</i>, we heard that BHU, then 15 years old, witnessed a young girl being taken to the toilets by three older girls who held her down and pushed the wooden handle of a toilet brush into her vagina. BDF gave evidence in this same case study that, at the age of 14, she was repeatedly abused by an older girl by fondling, penetrative and oral sex.⁷⁰</p>

Common forms of child sexual abuse by a child	Definition	Illustrative examples of the abuse
Violation of privacy	A child with harmful sexual behaviours forcing another child to undress or watching another child in a private space, such as a bedroom or bathroom.	‘Bertha’ was placed in a Presbyterian-run facility in the Northern Territory from age three until she was 15 years old. She shared a cottage with her younger siblings and about 10 other children. ⁷¹ She told us in a private session about one of the boys who lived in the same cottage. ‘Bertha’ said this boy hid under her bed at night and she would wake to find her hand on his penis, or his hand on her leg. She told us the molestation went on for years. ‘Bertha’ said the boy also took advantage of the lack of privacy at the cottage – no locks on the doors, no shower curtains and no curtains on the windows – to spy on her. She told us she would be showering or getting dressed in her room, and would look up to find him staring through the window at her. ‘All of a sudden you’d realise – that’s a face, out there in the bushes’, she said. ‘That’s lived with me. I don’t like plants close to the house.’
Exposure to sexual acts and materials	A child with harmful sexual behaviours forcibly showing pornography to another child and/or forcing another child to watch the child with harmful sexual behaviours engage in sexual acts, such as masturbation.	Mr John Williams gave evidence in our <i>Harmful sexual behaviours of children in schools</i> case study that, while boarding at The King’s School, an older boy, CLI, told Mr Williams to follow him to his room. Inside CLI’s room, CLI started masturbating. At the time, Mr Williams was in Year 7 and CLI was a Year 12 student. ⁷²

The Australian Bureau of Statistics reports that in the period from July 2015 to June 2016, where police initiated legal action against a person aged between 10 and 17 years for a sex offence against a person, slightly more children were charged with ‘sexual assault’⁷³ (843 persons) than ‘non-assaultive sexual offences’⁷⁴ (823 persons).⁷⁵ Sexual assault offences involve physical contact with a victim, and include offences such as rape or incest.⁷⁶ Non-assaultive sexual offences do not involve physical contact with the victim and include offences such as voyeurism, gross indecency and possession of child pornography.⁷⁷ This data represents offences reported to police, so it is likely to under-represent the true extent of these offences.

Online and image-based child sexual abuse, particularly self-produced content and image sharing, is an emerging complexity when addressing the issue of children with harmful sexual behaviours. Ensuring online safety of children is a growing area of concern for institutions and for communities. These, and other issues related to online child sexual abuse, are discussed in Volume 6, *Making institutions child safe*.

2.5.2 Severity of child sexual abuse by children

Research indicates that of the allegations of child sexual abuse that come to the attention of police, there is little difference in the type of criminal offence reported according to whether the allegation relates to a child exhibiting harmful sexual behaviours or an adult perpetrator. According to the available data:

- Of child sexual abuse reports to the police between 2010 and 2014, 60 per cent of the reports of adult-perpetrated abuse, 60 per cent of abuse by children, and 54 per cent of abuse by children in institutional settings were concerned with aggravated sexual assault.⁷⁸ Non-aggravated sexual assault was the subject of 17 per cent of reports of children sexually abusing other children and 22 per cent of adult-perpetrated child sexual abuse reports, but represented 39 per cent of reports of child sexual abuse by children in institutional settings.⁷⁹
- Between July 2015 and June 2016, the police launched sexual offence proceedings against 1,672 children aged 10 to 17 years.⁸⁰ Slightly more proceedings involved sexual assault (843 persons, or 50 per cent) compared to sexual offences that did not involve assault (823 persons, or 49 per cent), with the remaining 1 per cent unexplained.⁸¹ This data is sourced from recorded crime statistics published by the Australian Bureau of Statistics.

Relying on police reports for information on the severity of child sexual abuse by another child has some limitations. In institutional contexts, staff, as well as parents or carers, may not notice, recognise or understand the seriousness of a child’s harmful sexual behaviour. Consequently, only the most severe harmful sexual behaviours exhibited by children – that is, those recognisable as sexual offences – might be reported to the police. However, the existence of these police reports indicates that children in Australia in recent years have engaged in sexual behaviours that are so severe and harmful that they meet the threshold for criminal offending.

The severity of the harmful sexual behaviours exhibited by some children has implications for the type of response needed to ensure the behaviours cease, and to keep other children safe. We are of the view that some instances of children sexually abusing other children will require a criminal justice response because the child is 10 years or older and has engaged in behaviour that constitutes a criminal offence. The therapeutic intervention should often be delivered alongside this criminal justice response because, in comparison to adults, children are at a developmental stage where there may be more opportunity to change the behaviours and patterns that led to the abuse.⁸²

2.5.3 Duration of sexual abuse by children

From information gathered in our private sessions, the average duration of sexual abuse reported by survivors who said they were abused by another child or children was 1.6 years. Many survivors (68.3 per cent) who spoke to us in private sessions about child sexual abuse by another child and discussed the duration of abuse told us that the abuse lasted for up to a year. Table 10.3 shows the duration of sexual abuse from survivors in private sessions who told us they were abused by another child or children.

The average duration of child sexual abuse reported by all survivors in private sessions was 2.1 years.

Table 10.3 – Duration of child sexual abuse reported in private sessions by victims and survivors who said they were abused by another child^a, and who provided information about duration of abuse, May 2013 – May 2017

Duration of sexual abuse reported by survivors in private sessions	Number of survivors	Proportion of survivors (%; 319 survivors)
0–1 years	218	68.3
2–5 years	72	22.6
6–10 years	30	9.4
10+ years	3	0.9

^a Survivors included in this table told us they were sexually abused by another child/ren and did not mention sexual abuse by an adult.

There is limited research available in Australia about the duration of child sexual abuse for victims abused by children with harmful sexual behaviours. However, a meta-analysis of international studies (predominately from the United States) found that most children with harmful sexual behaviours do not continue to sexually abuse once they reach adulthood.⁸³ Given this, it is likely that for many children, their lower-level problematic and harmful sexual behaviours can be managed through lower-level interventions such as awareness and education programs. It is only a minority of children who will need therapeutic intervention, a child protection or a criminal justice response. In Section 2.10 of this volume we discuss children's capacity for rehabilitation.

2.5.4 Institutions where children sexually abused other children

In our public hearings, private sessions and commissioned research we heard accounts of child sexual abuse by a child or children occurring in a range of institution types. Our case studies have shown that the situational risk factors of certain institutions, particularly residential institutions, play a key role in enabling children to sexually abuse other children.⁸⁴

Research we commissioned suggests that institutions where children live full-time – especially the large, residential care facilities that used to exist in Australia – were particularly risky environments for children.⁸⁵ Reasons for this include that these institutions may have provided more opportunities for children to be alone together unsupervised, and that children in these institutions were less likely to have parents to turn to for protection.⁸⁶ We discuss such institutional risk factors in more detail in Section 2.9.2 of this volume.

In private sessions, survivors told us about the institutions where they said they were sexually abused by another child. These institutions provided a wide range of services or activities. Among the institution types survivors identified to us in private sessions, the most common were out-of-home care (63.2 per cent), schools (18.0 per cent) and youth detention (12.0 per cent).

We compared the institution types where survivors in private sessions told us they were sexually abused by another child to the institutions types identified by all survivors in private sessions (most of whom told us they were sexually abused by adult perpetrators). The largest difference between institution types related to some religious institutions. Institutions related to religious activities were identified as the location of sexual abuse by 3.5 per cent of survivors who told us they were sexually abused another child, but were identified as the location of child sexual abuse by 14.5 per cent of all survivors who attended a private session. For further information about the institutions where survivors commonly told us they were sexually abused, see Volume 2, *Nature and cause*.

Out-of-home care

During private sessions, many survivors told us they were sexually abused by a child or children while in out-of-home care.⁸⁷ From qualitative research we commissioned that involved a subset of private sessions attendees, most female survivors who told us they were sexually abused by another child told us the abuse occurred either when they were in foster care or in a group home setting. These survivors most commonly described being sexually abused by an older male child who resided in the same residence.⁸⁸ These survivors often told us that the child with harmful sexual behaviours had a higher status within the residence than they did, in many cases because the child with harmful sexual behaviours had been with the foster family for a longer period or was the birth child of the foster carer/s.⁸⁹

Most of the male survivors who told us in a private session they had been sexually abused by another child, said they were sexually abused in a residential setting, either an out-of-home care residential centre, youth detention facility or group home.⁹⁰

Experiences of sexual abuse by a child with harmful sexual behaviours in foster care

‘Myra’ was fostered by the ‘Dawson family’ in New South Wales in the mid-1960s, from the age of four. ‘Myra’ told us she was subjected to harmful sexual behaviours by ‘Aaron’, the 16-year-old biological son of her foster parents. We were also told that ‘Aaron’s’ brother-in-law ‘George’ abused ‘Myra’. ‘Myra’ suspects that ‘Aaron’ told ‘George’ about what he was doing to her, and ‘George’ thought he could get away with it too. ‘Myra’ said that both ‘Aaron’ and ‘George’ threatened her that if she resisted, they would start harming a younger girl, ‘Emma’, who had also been adopted into the family. ‘Myra’ told us that ‘Aaron’ and ‘George’ sexually abused her for approximately eight years.⁹¹

There is little empirical research about child sexual abuse by children in contemporary out-of-home care settings. In a study we commissioned that involved consultation with children who had been living in residential care facilities in recent years, children noted that bullying and intimidation by other children was a significant issue and often included, or escalated to, sexual intimidation.⁹² Children in these settings were exposed to sexual threats and assaults, with one participant stating, ‘other residents will try to pressure you into doing things you don’t want to do, whether that be go out, do drugs, have sex and it does happen, it does happen a hell of a lot in resi [residential care]’.⁹³

A 2002 study of child sexual abuse in residential care in the United Kingdom made similar findings, stating that sexual activity between children and young people in these environments was ‘rarely consensual, reciprocal or not exploitative’. It found that initiation rituals involved ‘unwanted sexual acts’ and/or ‘merged bullying and sexualised violence’, and that gendered attitudes led males to view females as ‘existing for their pleasure’.⁹⁴

Submissions to our consultation paper on out-of-home care, along with previous inquiries into child sexual abuse and out-of-home care, indicate that children's harmful sexual behaviours in contemporary out-of-home care have been increasingly recognised as an issue of concern by people working in the field.⁹⁵

We discuss the factors that may facilitate children exhibiting harmful sexual behaviours in out-of-home care settings in Section 2.9.2 of this volume, as well as in Volume 11, *Historical residential institutions*. Volume 12, *Contemporary out-of-home care*, provides a detailed discussion and our recommendations regarding identifying, assessing and supporting children with harmful sexual behaviours in out-of-home care (see Recommendation 12.12).

Educational institutions

In our public hearings and private sessions we heard about child sexual abuse by children with harmful sexual behaviours occurring in educational settings, including day schools and boarding schools.

For example, in our *Harmful sexual behaviours of children in schools* case study CLC gave evidence of the child sexual abuse he experienced in a boarding school context. We heard that CLC was a student at The King's School in 2013 when, during a school camp, another student ejaculated onto his sleeping bag while CLC was inside it.⁹⁶ The story spread to all students at the school. CLC was regularly bullied about the incident and subjected to taunts that he was a 'cum rag' and a 'cum dumpster'. Some students renamed the school Wi-Fi networks to 'come wrack' and 'CLC's a cum rag'.⁹⁷ Following the abuse, CLC was withdrawn from the school.⁹⁸ We heard about this type of sexualised bullying from numerous survivors.

Of the survivors who attended a private session and told us they were sexually abused by another child in an educational setting, 64.0 per cent told us the abuse occurred in a day school, while 36.0 per cent told us they were abused at a boarding school. These figures do not include those who received education at a residential care institution, such as a mission or a farm school.

'Marsha' told us she was 10 years old when she was sexually abused by a 13-year-old boy at her school.⁹⁹ 'They say school's the best time of your life', she noted in her private session, but for 'Marsha', her early school years were maybe the worst time of her life. 'I just had it coming at me from all angles.'¹⁰⁰

The institutional risk factors that contribute to child sexual abuse in educational settings, including boarding schools, are discussed in Section 2.9.2. Further information about children exhibiting harmful sexual behaviours in schools in Volume 13, *Schools*.

Youth detention facilities

Youth detention facilities (also known as juvenile justice centres in some jurisdictions) were the third most common type of institution that we heard about during private sessions with survivors who told us they were sexually abused by another child. Of the survivors in private sessions who said they were sexually abused by another child, 12.0 per cent told us this abuse occurred in youth detention facilities.

Youth detention facilities were described by these survivors as violent places. In a private session, 'Matthias' told us that, having been sexually abused at home, things got worse when he was placed in a youth detention centre:

I looked at this as a safe haven. But the abuse was worse. I was made to do sexual acts, and at one stage I was made to put my penis on a table while the other boys stabbed it with a butter knife. I still bear the scars.¹⁰¹

'Matthias' told us he was also forced to masturbate staff members in the showers.¹⁰²

Similarly, in a private session 'Lochie' told us that in the week he was placed in youth detention, two other residents forced a toothbrush into his anus.¹⁰³ 'Lochie' told us he reported the abuse to an officer, who told him not to make a report because it might cause problems for him from the other boys.

For more information about what we learned about child sexual abuse in contemporary detention institutions, including youth detention centres, see Volume 15, *Contemporary detention environments*. The *Criminal justice* report contains our work on juvenile sex offenders.¹⁰⁴

2.6 What we learned about victims of children's harmful sexual behaviours

This section details what we heard about the age, gender and personal circumstances of victims at the time they were sexually abused by another child. The information in this section is drawn from the private sessions of 1,129 survivors who told us they were sexually abused by a child or children in an institutional context.

During private sessions, survivors were free to give an account of the child sexual abuse they experienced in their own way and were not asked to provide any specific information. We only have demographic information where survivors volunteered it, and it is important to note that this information is only from the group of survivors who chose to speak about experiences of child sexual abuse in a private session. As such, it may not be representative of other survivors in the wider community. For these reasons, the following cannot be considered a comprehensive statistical account.

Research we commissioned indicates that most children with harmful sexual behaviours were acquainted with or knew their victims. Children with harmful sexual behaviours who were known to the victim, but were not a family member or intimate partner of the victim, accounted for 43 per cent of all reports to Australian police about children with harmful sexual behaviours between 2010 and 2014.¹⁰⁵

This is consistent with what we heard from many of the victims and survivors in public hearings and private sessions. This is perhaps not surprising given that our inquiry focused on institutions, where children are often congregated together, which possibly minimised the accounts we heard from survivors about sexual abuse from a child who was unknown to them. Similarly, the fact that our inquiry focused on institutional settings would reduce the number of instances we were told about sexual abuse by a child who was a family member, such as a sibling. We also heard in a number of private sessions from survivors who told us that they were sexually abused by their biological siblings within an institutional context.¹⁰⁶

Table 10.4 gives a snapshot of key elements that we heard about in private sessions from survivors who told us they were sexually abused by another child. We discuss each of these elements in sections 2.6.1, 2.6.2 and 2.6.3.

Table 10.4 – Characteristics of survivors who told us in private sessions they experienced sexual abuse by another child

		Number of survivors	Proportion of survivors (%; 1,129 survivors)
Gender of survivors	Male	698	61.8
	Female	430	38.1
	Gender diverse or unknown	1	<1
Gender of children who sexually abused other children	Male	974	86.3
	Female	180	15.9
	Gender diverse or unknown	24	2.1
Institution types where children sexually abused other children	Out-of-home care (all periods)	713	63.2
	Historical out-of-home care (pre-1990)	521	46.1
	Contemporary out-of-home care (post-1990)	53	4.7
	Out-of-home care (unknown period)	153	13.6
	Education	203	18.0
	Youth detention	135	12.0
	Religious activities/personnel	40	3.5
Period of abuse	Pre-1990	764	67.7
	Post-1990	142	12.6
	Unknown	252	22.3

2.6.1 Gender

Of the survivors who came to private sessions and told us they were sexually abused by another child, 61.8 per cent were male and 38.1 per cent were female. Less than 1 per cent identified as gender diverse or were of unknown gender.

The gender demographics of our sample contrast with research that indicates girls are victims of child sexual abuse in higher numbers than boys. For example, we commissioned research to examine police data on reports relating to child sexual abuse, including juvenile sexual offending against a child. This indicated that, in Australian jurisdictions between 2010 and 2014, 67 per cent of victims of child sexual abuse by another child were female.¹⁰⁷ Similarly, a study of 157 juvenile male sex offenders aged between 12 and 18 years, and who had offended against a child under the age of 12 suggested 58.3 per cent of cases involved a female victim only, 23.8 per cent involved a male victim only, and 17.9 per cent involved harm against children of both genders.¹⁰⁸ It is possible the higher proportion of boys from our sample that spoke to us about sexual abuse by another child reflects the focus of our inquiry on institutional child sexual abuse and the tendency, particularly in historical residential and out-of-home care settings, for more boys to be institutionalised than girls.¹⁰⁹

2.6.2 Age

In private sessions, the survivors who told us they had been sexually abused by another child described being younger at the time of the first incident of abuse than survivors who told us they were sexually abused by adults.

Of survivors we heard from in private sessions who told us they were sexually abused by a child, and who provided information about their age at the time of the abuse, 44.9 per cent said they were aged between 10 and 14 years, and 39.6 per cent said they were aged between five and nine years when they were first abused. Small proportions of survivors told us they were first sexually abused between the ages of 15 and 17 years (8.1 per cent) or before they were five years of age (7.3 per cent).

In comparison, just over half (51.5 per cent) of all survivors in private sessions who provided information on their age at the time they were first sexually abused (including those who told us they were sexually abused by adults) said they were between the ages of 10 and 14 years. Another 31.1 per cent told us they were aged between five and nine when the abuse first started. A smaller proportion were aged between 15 and 17 years (11.5 per cent), and we least commonly heard about victims aged four years or younger (5.9 per cent). Female survivors in private sessions tended to identify as being a younger age at the time of the first incident of abuse than male survivors did.

Survivors we heard from in private sessions tended to indicate they were younger at the time they were first sexually abused by a child compared with victims whose age was recorded in reports to police of sexual abuse by a child. We commissioned research using police data that indicated that 41 per cent of victims of reported child sexual abuse by other children in Australian jurisdictions between 2010 and 2014 were aged between 10 and 14 years and 33 per cent were under 10 years of age at the time of the incident.¹¹⁰ The age of victims of child sexual abuse by an adult showed a similar pattern, with 39 per cent aged between 10 and 14 years and 32 per cent under the age of 10.¹¹¹

2.6.3 Victims with disability

During private sessions, 6.6 per cent of survivors who told us they were sexually abused by another child identified that they had disability¹¹² at the time of abuse. In comparison, 4.3 per cent of all victims who attended a private session told us they had disability at the time of the abuse.

It is difficult for us to accurately identify how many victims we heard about had disability at the time of the abuse. This is because a person's disability may change over time, may not have been identified when they were abused, or may not have been perceived as relevant or mentioned by the person who reported the abuse to us.

Some research has found that children with disability are at least 2.88 times more likely to be sexually abused than children without disability.¹¹³ This aligns with broader research that indicates children with disability report higher rates of maltreatment, including sexual abuse, across all settings.¹¹⁴ Children with disability have more engagement with institutions than other children as they commonly have a need for health services, education and employment support, and other assistance.¹¹⁵ This increased contact with institutions places children with disability at higher risk for child sexual abuse in institutional settings.¹¹⁶ Abuse of children with disability is also likely to be under-reported.¹¹⁷

2.7 Impacts on victims and survivors

The information we have received through public hearings, private sessions and written accounts suggests that the impacts of child sexual abuse by children are similar to that of adult-perpetrated child sexual abuse. This includes the impacts on secondary victims, such as family and friends of the victim. We provide a comprehensive discussion of the impacts of child sexual abuse on victims in Volume 3, *Impacts*. These include adverse effects on psychological and physical health, neurobiological development, interpersonal relationships, connection to culture, and sexual identity. What thousands of survivors told us in private sessions is largely consistent with the research evidence on the impacts of childhood trauma and abuse. Early onset trauma caused by adverse childhood events, including child sexual abuse, can have lasting and serious impacts on victims.¹¹⁸

There is limited research on the impacts of harmful sexual behaviours exhibited by children in institutional contexts. However, many survivors told us in public hearings and private sessions about the severe and complex effects the abuse has had on their lives.

Impacts for victims described to us in private sessions included suicidal thoughts, suicide attempts and deaths by suicide. In one private session, 'Asad' told us he was repeatedly sexually abused by a boy at his school.¹¹⁹ 'Asad' said the abuse lasted from when he was in Grade 3 into early high school, when the boy with the harmful sexual behaviours left the neighbourhood.

Later, seeing the boy again sent 'Asad' into a spiral of suicidal thoughts and self-hatred, which he tried to manage with marijuana. He switched to hard drugs, but said the sexual abuse still weighed heavily on him. 'Asad' explained, 'It's just on my back the whole time. I don't know how to get rid of it'. He told us the day he was sexually abused was a turning point. 'My life, from that day onwards, what happened to me, changed dramatically.'¹²⁰

In another private session, 'Dorothy' told us how, soon after her birth, she was placed in a Methodist children's home along with her brothers.¹²¹ She said that when she was 10 years old, one of her brothers started sexually abusing her and although she complained about the repeated abuse to staff, they did not believe her and took no action. 'Dorothy' told us she has attempted suicide numerous times since the abuse. She stated her last suicide attempt was three weeks before telling her story to the Royal Commission, when she broke a wine bottle and swallowed shards of glass. 'That's when I done this. I cut myself, cut my throat. I swallowed glass down my neck and everything. Tried to kill myself.'¹²²

The serious nature of the impacts detailed by survivors such as 'Asad' and 'Dorothy' demonstrates why the issue of harmful sexual behaviours exhibited by children must be recognised and addressed as a matter of urgency.

We heard that harmful sexual behaviours can also have ripple effects on families and communities. In public hearings and private sessions, survivors, victims and their immediate families told us about their shock, grief and distress. The families of a child who has sexually abused another child may also be affected by the abuse. In our private sessions, we heard about shame and stigma associated with children exhibiting harmful sexual behaviours.¹²³ In Section 3.4.1 we discuss how parents' or carers' shame regarding their child's harmful sexual behaviours can act as a barrier to that child being provided with responses or interventions that could help them develop healthy sexual behaviours and address any underlying trauma that has contributed to their harmful sexual behaviours.

For example, in our *Harmful sexual behaviours of children in schools* case study we heard about the impact this kind of sexual abuse can have on victims' and their families. EAA gave evidence about how the sexual abuse of his son CLA within the boarding house of Trinity Grammar School affected him and his family. EAA said that he worried that CLA would take his own life or turn to drugs. He said that the events also affected their daughter, who harboured a lot of anger about what had happened to CLA.¹²⁴ In the same case study we heard evidence from parents EAL and EAM, who described how the sexual abuse of their daughter CLF at Shalom Christian College changed their family.¹²⁵ EAL gave evidence that after CLF was sexually abused at Shalom Christian College, she began drinking and 'drugging', she self-harmed, attempted suicide and became well known to the police. EAL told the Royal Commission that she herself has also gone through 'bad patches' and 'got on the grog' after what happened to CLF at Shalom Christian College. EAL often feels helpless and frustrated that she cannot do anything to make CLF better.¹²⁶ CLF's father EAM gave evidence that he had a mental breakdown at one point because he 'just couldn't handle it all' and said that he lost his job, which he described as 'a really good job that I enjoyed'.¹²⁷

2.8 What we learned about children who sexually abuse other children

Information from our public hearings and private sessions indicates that children with harmful sexual behaviours are a diverse group. Research also shows this.¹²⁸ Experts regard children under 10 years of age who exhibit harmful sexual behaviours as different to adolescents with harmful sexual behaviours. Children under 10 years can vary in relation to the nature of their behaviours, their developmental histories, abuse or trauma they have experienced, and their legal status.¹²⁹ The range of behaviour exhibited by children with harmful sexual behaviours requires a range of interventions that cater to the variation within this group. Children with harmful sexual behaviours require a thorough assessment of their individual circumstances to guide the choice of appropriate interventions. We discuss assessment and interventions for children with harmful sexual behaviours based on best available evidence in Chapter 5.

While acknowledging that children with harmful sexual behaviours are a diverse group that may exhibit behaviours anywhere along a spectrum of harmful sexual behaviours, in this section we present information about what we were told about children who had sexually abused other children in institutional contexts. We also consider the type of institution where the sexual abuse occurred. As with our discussion of victims of sexual abuse by other children, the information we present here is largely drawn from the private sessions of 1,129 survivors who told us they were sexually abused by another child in an institutional context. We place this private sessions information in a broader context by drawing links with research as well as information on children with harmful sexual behaviours provided by state and territory governments.

Due to the limited empirical research available on this topic, we could not determine whether children who engage in harmful sexual behaviours in institutional contexts differ from those who engage in these behaviours in other settings.

2.8.1 Gender

By far the majority of survivors who told us in private sessions they were sexually abused by a child told us they were abused by boys. Of all survivors who told us in private sessions they were sexually abused by a child:

- 86.3 per cent indicated they were sexually abused by a boy
- 15.9 per cent indicated they were sexually abused by a girl.

These percentages add to more than 100 per cent, as some survivors of other children's harmful sexual behaviours told us they were abused by both boys and girls, and they have been included in both counts.

When we look separately at male and female survivors who spoke to us, the percentage of sexual abuse of boys by boys is even higher. Of survivors in private sessions who told us they were sexually abused by another child, 94.7 per cent of male survivors and 72.6 per cent of female survivors told us they were sexually abused by a boy.

Research we commissioned found boys were the subject of more reports to the police about exhibiting harmful sexual behaviours in institutions than girls. This research showed that between 2010 and 2014, in all Australian jurisdictions, 91 per cent of reports to the police about this type of abuse concerned abuse by boys.¹³⁰ This is consistent with international research. In the United States, 93 per cent of juvenile sexual offences against a child reported to police in 2004 were committed by boys.¹³¹ Similarly, in the United Kingdom, 97 per cent of children referred to therapeutic intervention for sexually abusive behaviours between 1992 and 2000 were boys.¹³²

It is possible girls who exhibit harmful sexual behaviours are less likely to come to the attention of authorities than boys with similar conduct. This could be due to an unwillingness to believe females are capable of causing sexual harm which would impact the rate of identifying, recording and reporting abuse by girls.¹³³ Nonetheless, most children with harmful sexual behaviours are male.

Child sexual abuse by boys

We heard physical abuse often accompanied child sexual abuse by boys. For example, ‘Logan’ recounted being both physically and sexually abused by older boys at a boarding school he attended. ‘Logan’ told us that when he was 15 years old, in the late 2000s, he was sexually assaulted by some older boys. He said this sexual abuse continued over the course of a year and was accompanied by relentless physical abuse, including being locked inside cupboards, tied up and left outside, kicked in the testicles and stomped on.¹³⁴

We heard that boys also sometimes used sexually explicit material and pornography to sexually abuse other children. Survivors in private sessions gave us examples of this type of abuse from different eras. For instance, ‘Stew’ told us that in his first month at a boarding school in the 1960s he was sexually abused by older boys who showed him pornography. ‘Stew’ also walked in on a senior boy who was masturbating over a pornographic magazine in the dormitory. The boy made ‘Stew’ stay and watch ‘until he had finished’.¹³⁵ Similarly, ‘Trent’ told us that, in the 1990s, when he was five years old, he was forced to re-enact pornographic scenes from movies that ‘Xavier’, an older boy in his foster home, made him watch on the television.¹³⁶ ‘Tristan’ told us that when he was in his early teens, in 2013, older male members of his sporting team used pornography to sexually abuse him. ‘Tristan’ described being stripped to his underwear, tied to a chair and forced to watch pornography playing on the phone of a team member, while being told ‘you’re going to get raped’.¹³⁷

Child sexual abuse by girls

While survivors of child sexual abuse by girls often reported that violence was part of their experience, we also heard that some girls framed their sexual abuse as loving or romantic, telling their victims that ‘this is a love game’ and ‘this is how I show I love you’.¹³⁸ This may have been a way to ensure that contact with the victim was preserved.¹³⁹ Research suggests that some adult female perpetrators frame sexual abuse of victims in a similar way.¹⁴⁰

Research also suggests that some girls with harmful sexual behaviours engage in those behaviours due to a need to feel in control.¹⁴¹ Accounts we heard from survivors seem to support this. In some of our case studies, we heard evidence that girls displayed harmful sexual behaviours in the context of institutions where they lacked power over their day-to-day life. In our *Youth detention centres, Victoria* case study, for example, some former staff members gave evidence that the Winlaton Youth Training Centre fostered a culture of authority, command and control, rather than focusing on the care and welfare of residents.¹⁴² For example, we heard evidence that some staff members controlled and punished residents by forcing them to do menial tasks and made threats of punishment to ensure compliance and to exercise command and control.¹⁴³ Similarly, in our *Parramatta Training School for Girls* case study, past residents of the Institution for Girls in Hay told us they were forced to march around with their eyes to the ground, could only speak for 10 minutes each day and were only allowed to sleep on one side so that their faces were always visible to staff.¹⁴⁴ The girls were also forced to show officers their used sanitary pads before being given new ones.¹⁴⁵ We heard about girls sexually abusing other residents in the highly coercive institutions featured in both these case studies.¹⁴⁶

2.8.2 Age

Age of children with harmful sexual behaviours

Research conducted for the Royal Commission examined reports to Australian police between 2010 and 2014. Part of this research considered the age of children who were the subject of reports to police of about allegations of sexual offences against a child occurring in institutional settings within that period. It found, with respect to the age of the children who were the subjects of these reports:¹⁴⁷

- 55 per cent of the reports were about a child aged between 10 and 14 years
- 30 per cent of the reports were about a child or young person aged between 15 and 17 years
- 16 per cent of the reports about a child under the age of 10.

The Australian Bureau of Statistics reports that between July 2015 and July 2016, where police initiated legal action against a child for a sex offence, half of the children in the cohort were aged between 10 and 14 years (829 persons) and the other half were aged between 15 and 17 years (831 persons).¹⁴⁸ The most frequently occurring age for the cohort was 14 years, equating to 24 per cent of the cohort.¹⁴⁹

A retrospective study in the United Kingdom of 700 children referred for treatment for sexually abusive behaviours between 1992 and 2000 found the most common age at referral was 15 years, with one-third of all referrals for children aged 13 years or younger.¹⁵⁰ Data from the United States showed one in eight of more than 13,000 juveniles reported to the police for alleged sexual offences against children in 2004 were under 12 years old.¹⁵¹

We acknowledge that using administrative data, such as police reports and case files, provides only a partial picture of the age of children with harmful sexual behaviours. Children under the age of 10 cannot be held criminally responsible for their actions in any jurisdiction in Australia, meaning they cannot be charged or prosecuted for their conduct.¹⁵²

As we heard in our *Harmful sexual behaviours of children in schools* case study, some adults are reluctant to acknowledge that children can exhibit sexual behaviours that harm others.¹⁵³ This makes it likely that harmful sexual behaviours exhibited by children – particularly those behaviours exhibited by children aged under 10 years – are not always identified and not always reported to authorities.

Nonetheless, the information sources cited above indicate that most children coming to the attention of police and therapeutic intervention services for harmful sexual behaviours in Australia are aged between 10 and 14 years.

Age differences between children with harmful sexual behaviours and victims

Research suggests that children with harmful sexual behaviours often sexually abuse younger children.¹⁵⁴ This is reflected in reports to police in Australia between 2010 and 2014 about allegations against a child. An analysis of these reports indicates that children who were the subject of these reports were likely to be older than the children who were reported to have been abused (44 per cent of reports) or else to be adolescent peers of the children who were reported to have been abused (25 per cent of reports).¹⁵⁵ A 2003 study of 182 boys aged between 12 and 18 years who were convicted of a sexual offence in the United States showed that the age difference between the victim and the offender was five or more years in 87 per cent of cases.¹⁵⁶

2.9 Factors that may contribute to children exhibiting harmful sexual behaviours

We heard from many survivors who wanted to know why, as children, they were sexually abused by another child. We also heard from many family members of victims and survivors who are still searching for an explanation as to how and why the sexual abuse occurred.

The academic literature from both Australia and internationally suggests children's harmful sexual behaviours are more likely to result from their context or situation, as distinct from personal sexual motivations.¹⁵⁷ This is likely to be particularly the case for children exhibiting harmful sexual behaviours in institutions. This distinguishes these children from adult perpetrators of child sexual abuse in institutions. As set out in Volume 2, *Nature and cause*, a large body of research indicates that some adult perpetrators are motivated by innate characteristics, such as a pre-existing sexual predilection for children¹⁵⁸ or cognitive distortions that allow the perpetrator to rationalise their abusive behaviour.¹⁵⁹

In this section, we discuss various factors that may contribute to the risk that children will engage in harmful sexual behaviours. A number of adverse experiences in childhood have been identified as common to cohorts of children receiving interventions for harmful sexual behaviours. These common adverse experiences include prior sexual or physical abuse, exposure to family violence, interpersonal difficulties, and other influences, such as exposure to and consumption of pornography.¹⁶⁰ We are aware that the presence of any one or more of these risk factors in a child's life does not mean they will inevitably sexually abuse others. Personal risk factors relevant to an individual child and institutional risk factors in the child's environment combine to contribute to the risk that the child will exhibit harmful sexual behaviours. The more personal and institutional risk factors that are present, the more likely it is that a child will exhibit harmful sexual behaviours.

During the course of our inquiry it has become clear that exposure to violence in an institutional context may be another risk factor for children exhibiting harmful sexual behaviours. From the many instances of children sexually abusing other children we have heard about in public hearings and private sessions, we believe that institutions have at times played a key role in enabling this abuse. Some institutions may have allowed a culture of violence and humiliation to prevail, 'normalising' abusive practices and giving children with harmful sexual behaviours unsupervised access to other children. In addition, responsible adults within some institutions have not identified and put a stop to harmful sexual behaviours.

For example, in our *Harmful sexual behaviours of children in schools* case study, CLA gave evidence in his statement that violence between boys was ‘endemic’ and part of the ‘boarding house culture’ at Trinity Grammar School.¹⁶¹ He said that there was a lack of supervision in the boarding house, and that most of the assaults occurred during periods when no staff members supervised the boys. CLA stated that as a result, ‘toxic behaviours manifested themselves into serious criminal acts’.¹⁶²

The information in this section (Section 2.9) is based on children in a variety of institutions who have exhibited harmful sexual behaviours. It does not reflect information about children who have not yet, but may possibly, engage in these behaviours in the future. The information cannot be used to assess which children are more likely than others to exhibit harmful sexual behaviours.

2.9.1 Social and personal risk factors

In Volume 2, *Nature and cause* we set out the different types of adult perpetrators we have heard about during the Royal Commission. Although researchers have also developed typologies to better understand children who engage in harmful sexual behaviours, there is insufficient empirical evidence to support the use of these typologies to effectively guide practice.¹⁶³ While there are no reliable characteristics by which to differentiate types of children, it does appear that more severe harmful sexual behaviours are often associated with a background of multiple social issues and traumas. Research we commissioned found that children with ‘more severe problem sexual behaviour tend to have more comorbid social, family and mental health problems’.¹⁶⁴ This is supported by research from the United States, which found children with more severe or intense harmful sexual behaviours tend to have more social and family problems than those with inappropriate or problematic sexual behaviours.¹⁶⁵ Child neglect has been identified as one of the most significant pre-existing factors for juvenile involvement in all types of criminal activity.¹⁶⁶

Issues within a child’s broad social and environmental context may influence the likelihood of their exhibiting harmful sexual behaviours. This includes both their historical experiences and their current situation. In our consultations and in submissions to *Issues Paper 10: Advocacy, support and therapeutic treatment*, we were told that children with harmful sexual behaviours often had previous contact with child protection agencies and other authorities, as victims of neglect, abuse, family violence and/or child sexual abuse, and/or because of their own harmful sexual behaviours.¹⁶⁷

Research has also identified exposure to family violence,¹⁶⁸ physical abuse,¹⁶⁹ sexual abuse¹⁷⁰ and pornography¹⁷¹ as common experiences for children who have exhibited harmful sexual behaviours. This accords with evidence given by Dr Wendy O'Brien, expert on children with problematic or harmful sexual behaviours in our *Harmful sexual behaviours of children in schools* case study who stated that children who exhibit harmful sexual behaviours are likely to have experienced childhood adversity, including:

in no particular order, child sexual abuse, neglect, caregiver substance abuse, social isolation, cognitive delays and profound economic disadvantage ... when a child presents with one, they very often present with many of those issues.¹⁷²

Similarly, Dr Elizabeth Letourneau, Director of the Moore Center for the Prevention of Child Sexual Abuse, gave evidence during our *Nature, cause and impact of child sexual abuse* case study and stated:

Children who engage in harmful sexual behaviours are more likely to have been sexually abused than children who engage in non-sexual delinquent acts and those who have not engaged in criminal behaviour of any kind.

They're also more likely to have experienced other forms of physical abuse and neglect, and sexual behaviour may be something they learned as a self-soothing tool and they haven't figured out the rules of the road around applying those behaviours to others.

They may be modelling behaviours to which they were exposed at a developmentally inappropriate time – either pornography or the behaviours of others in their homes.

So there are many situational reasons that might explain these behaviours ...¹⁷³

Prior trauma

Research, supported by the views of practitioners, suggests that adverse childhood experiences, including childhood trauma, may be linked to harmful sexual behaviours.¹⁷⁴ Addressing prior trauma is likely to be an important aspect of responding to the needs of some children with harmful sexual behaviours to prevent future child sexual abuse.¹⁷⁵

Prior trauma has also been recognised by previous inquiries as a risk factor for children exhibiting harmful behaviours. For instance, the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse considered that the sexual abuse offences committed by juvenile offenders may be linked to their prior trauma, stating that:

this situation exists due to the combination of inter-generational trauma, the breakdown of cultural restraints and the fact that many of these children (if not all) have themselves been directly abused or exposed to inappropriate sexual activity (through pornography or observing others).¹⁷⁶

In research we commissioned, many children in residential care recognised that much of their peers' behaviour was driven by 'fear, distress and trauma'.¹⁷⁷ Several submissions to several of our issues papers expressed the need for responses to children with harmful sexual behaviours to take into account the trauma these children may have already experienced – and may continue to experience if there is no intervention.¹⁷⁸

In our *Harmful sexual behaviours of children in schools* case study we heard evidence from New Street Adolescent Services clinical advisor, Mr Dale Tolliday, who told us:

Most of the young people with trauma history have a multiple of different forms of trauma. At referral, something a little under a half of the young people coming to our services have an identified trauma. By the end of assessment that has grown to perhaps two-thirds of the young people.¹⁷⁹

Mr Tolliday qualified this view by pointing out there is a subgroup of children who display harmful sexual behaviours who do not appear to have trauma in their background.¹⁸⁰ There is nothing to suggest that a child without prior trauma will not exhibit harmful sexual behaviours, just as there is nothing to suggest that all children with prior trauma will inevitably sexually abuse others.

Specific types of prior trauma that children with harmful sexual behaviours may have experienced are discussed in more detail as follows.

Exposure to family violence

Exposure to family violence may be a risk factor for harmful sexual behaviours by children. It has been suggested by practitioners that being exposed to family violence provides children with 'dominant and gendered scripts for how they are expected to be in the world'.¹⁸¹

Family characteristics, including violence and instability, were identified as factors for children displaying harmful sexual behaviours in an evaluation of New Street Adolescent Services, a treatment provider in New South Wales.¹⁸² We were also advised by practitioners that violence was a common feature of families with children accessing therapeutic treatment for harmful sexual behaviours in Victoria.¹⁸³ Current family services, child protection and placement and support service practitioners in Victoria are advised to gather information on family violence when developing a child's case file.¹⁸⁴ The 2016 Victorian Royal Commission into Family Violence reported that providers of therapeutic intervention identified family violence as the prevalent co-occurring issue for children referred to Sexually Abusive Behaviours Treatment Services.¹⁸⁵

We heard similar evidence from Ms Karen Flanagan, Manager of Save the Children's Child Protection Technical Unit, in the *Nature, cause and impact of child sexual abuse* case study. Ms Flanagan stated that in her experience of working with young people and children with harmful sexual behaviours:

they came from families where there were high rates of violence – family violence, which was a stand out ... In the study I did there were 420 young people who had sexually abused another child. Almost 95 per cent had been victims of physical abuse or had witnessed family violence before.¹⁸⁶

Australian research on exposure to family violence and its connection to harmful sexual behaviours exhibited by children is limited. The following research is from two small-scale studies in New South Wales and Victoria:

- A 2005 evaluation of a program in Victoria that treated children with 'problem sexual behaviour' found almost one in five were living away from their parents due to an ongoing risk of abuse and family violence.¹⁸⁷
- In a 1999 study of children in New South Wales convicted of sexual offences, two-thirds experienced family risk factors during their early development and/or at the time of the study.¹⁸⁸ Of the children in this study, 36 per cent were identified as having been exposed to 'marital discord' in their family and 17 per cent to 'domestic violence'.¹⁸⁹

These findings about children with harmful sexual behaviours experiencing family violence are consistent with research from the United States and the United Kingdom:

- A study of a sample of boys aged under 10 years in the United Kingdom who were referred to a specialist treatment provider for 'sexually harmful behaviour' suggested that more than two-thirds were exposed to violence in their living situation before entering therapeutic intervention.¹⁹⁰
- In a 2003 study of 182 boys aged between 13 and 18 years who were convicted of a sexual offence in the United States, 54 per cent had witnessed a male relative physically assault a female.¹⁹¹
- In a study of 127 children who engaged in 'developmentally unexpected sexual behaviours' in the United States, 52 per cent of their caregivers acknowledged they had 'hit, slapped or shoved' their partner.¹⁹² A much higher proportion of children in the study (87 per cent) reported that they had seen their caregiver behave violently towards a partner.¹⁹³

While the precise nature of the link between family violence and harmful sexual behaviours exhibited by children is not yet known, there appears to be a close association. The Victorian Royal Commission into Family Violence concluded that children with harmful sexual behaviours need to be considered when designing family violence initiatives:

early intervention for adolescents displaying sexually abusive behaviours is a necessary part of any package of measures designed to combat family violence ... early intervention for these children is of paramount importance in the prevention of future family and sexual violence.¹⁹⁴

We discuss early intervention in Chapter 4 of this volume.

Prior sexual abuse

There is a widespread misconception that being sexually abused as a child will lead to a victim becoming an adult perpetrator of sexual abuse.¹⁹⁵ One survivor told us that he thinks the fear that a sexually abused person will become a sexual abuser still exists in the community:

I've worked really hard to conquer the demons that do come with that sort of stuff, but if I was public about it there is certainly people that would go, 'Oh, I better be careful with my children around him' and things like that. The point that I'd like to make is that more could be done socially, I think, to demonstrate or even prove ... that the majority of people who were victims don't become abusers.¹⁹⁶

The majority of children who are sexually abused do not go on to sexually abuse others.¹⁹⁷ In the *Nature, cause and impact of child sexual abuse* case study, Dr Margaret Cutajar, Senior Psychologist at the Victorian Institute of Forensic Mental Health, stated:

The research I've conducted on the largest population of known victims of child sexual abuse, with a cohort of 3,000 children followed up for 45 years, or up to 45 years, demonstrated that, by and large, the majority of them do not go on to sexually offend. So whilst public conception is around that a lot of sexual offenders have been sexually abused themselves, we can't say that for the reverse, in terms of children who have been victimised sexually, do they go on to commit sexual offences themselves. By and large, a minority do, the majority don't, in terms of committing sexual offences.¹⁹⁸

While the majority of victims of child sexual abuse do not go on to sexually abuse others, research indicates that many children with harmful sexual behaviours have themselves experienced prior trauma, which may have included child sexual abuse.

A broad review of research literature in 2014 found that high rates of sexual abuse are found among children who have displayed harmful sexual behaviours.¹⁹⁹ Similarly, a meta-analysis indicated that male adolescent sexual offenders were approximately five times more likely to have a history of being sexually abused, compared to male adolescent non-sexual offenders.²⁰⁰

Service providers also told us that some children with harmful sexual behaviours who participate in therapeutic intervention programs have experienced sexual abuse themselves:

- One-third of 152 children who engaged in ‘problem sexual behaviour’ in Victoria and were referred to a therapeutic intervention program between 1999 and 2001 were victims of sexual abuse.²⁰¹
- A 1999 study of the files of 70 children convicted of sexual offences in New South Wales found 20 per cent of these children had experienced sexual abuse.²⁰²

Findings from international research also indicate higher levels of child sexual abuse among children with harmful sexual behaviours than among children who do not exhibit these behaviours, though this research tends to be based on small numbers of children:

- A 2011 study in the United Kingdom of 27 boys aged under 10 years who were referred to a specialist treatment provider for ‘sexually harmful behaviour’ showed that all of these boys had experienced sexual abuse before entering treatment.²⁰³
- A study of 34 boys referred to a treatment provider in Scotland between 2001 and 2008, showed sexual abuse in the backgrounds of 50 per cent of the group who had harmed another child in the community (that is, not within the family) as a result of their harmful sexual behaviours.²⁰⁴ Prior sexual victimisation rose to 100 per cent for the boys who had harmed both a sibling and another child in the community.²⁰⁵

It is also important to keep in mind that survivors of child sexual abuse can often take many years to disclose, if they disclose at all.²⁰⁶ Volume 4, *Identifying and disclosing child sexual abuse* contains an in-depth discussion of this issue. Given the likely delay in victims disclosing, studies investigating the sexual abuse histories of children with harmful sexual behaviours may not capture all instances of prior child sexual abuse.

In our public hearings, we heard evidence that children with harmful sexual behaviours may replicate trauma they have themselves experienced. For example, Dr Joe Tucci, CEO of the Australian Childhood Foundation, gave evidence in *Case Study 24: Preventing and responding to allegations of child sexual abuse occurring in out-of-home care* about the impact of past sexual abuse on children’s behaviour:

These are kids who are vulnerable, traumatised, and their trauma specifically has them either looking to resolve it through their own behaviour, or replicating it over and over again, because that’s part of the way the trauma has had an impact on them.²⁰⁷

We heard accounts in some private sessions of children replicating what an adult has done to them, such as the example from ‘Alan Geoffrey’.

‘Alan Geoffrey’: replicating sexual abuse

‘Alan Geoffrey’ was a state ward in care at a children’s home in the 1970s. He told us that when he was 13, ‘Glen’, the superintendent of the home, took him to a paddock and asked him many questions about sex and masturbation. ‘Alan Geoffrey’ said ‘Glen’ asked him to expose his genitals and then ‘Glen’ fondled him.

‘Alan Geoffrey’ told us that a year later he acted out this same behaviour on a 10-year-old boy, ‘Terry’, who also resided at the home. ‘Alan Geoffrey’ said he did exactly what the superintendent had done to him. He took the boy to a paddock, then ‘pulled his trousers down to his feet. I then proceeded to play with his genitals just the way ‘Glen’ had taught me’. ‘Alan Geoffrey’ told us he did this to the boy on a few occasions and sometimes he invited other boys to join in: ‘We would laugh at ‘Terry’ as he stood there naked in the middle of the paddock, with no idea what to do’.

‘Alan Geoffrey’ stated that he was very remorseful about what he had done to ‘Terry’. This aspect of his life troubles ‘Alan Geoffrey’ deeply and he has never had any counselling about it. ‘Alan Geoffrey’ told us, ‘Even though I never sexually penetrated him, I feel now that I raped and humiliated that poor boy. I cannot imagine the pain that I must have caused for him and for the people that have been involved in his life since’.²⁰⁸

We also heard from some survivors of child sexual abuse and/or their parents that after the abuse, victims began to display sexualised behaviour – for example, behaving in a sexually aggressive manner with other children, including siblings.²⁰⁹ What we heard in private sessions about victims of child sexual abuse displaying sexualised behaviour is consistent with the findings of research reviews that consider the impacts on survivors of adult-perpetrated child sexual abuse.²¹⁰ The research suggests that adult-perpetrated abuse may be associated with sexualised and sexually reactive behaviours for children abused within a family setting and those abused outside of a family setting.²¹¹ This issue was also raised in submissions to our issues papers.²¹²

One researcher from the United Kingdom has suggested children may display harmful sexual behaviours at different points after being sexually abused. The child may exhibit sexually reactive behaviours that parallel the sexual abuse they experienced.²¹³ The behaviours may occur sometime after the sexual abuse, if the child is feeling anxious and finds that exhibiting harmful sexual behaviours is the only way they can deal with the anxiety.²¹⁴ Lastly, some harmful sexual behaviours may occur if a child associates them with a positive sexual feeling, and seeks to experience it again.²¹⁵

There is some consensus among practitioners that younger children who exhibit more extreme harmful sexual behaviours are more likely to have been sexually abused themselves and see their behaviours as 'normal' and their behaviours are likely to affect a greater number of children.²¹⁶ Assessment of these children is particularly important to ensure that interventions to protect other children from their behaviours also address their own victimisation. This is discussed further in Chapter 5 of this volume.

We acknowledge this is a complex and sensitive issue. There needs to be a balance between understanding that:

- many children who have displayed harmful sexual behaviours have previously experienced child sexual abuse
- some children who have displayed harmful sexual behaviours and have previously experienced child sexual abuse may continue the harmful sexual behaviours or go on to offend in adulthood, particularly if the behaviours are not identified early or if the child with harmful sexual behaviours does not receive appropriate support and intervention
- many children with harmful sexual behaviours who have previously experienced child sexual abuse will not continue these behaviours, either as children or in adulthood, and can benefit significantly from receiving understanding, support and an appropriate intervention.

The complex interplay between past trauma (including childhood sexual abuse), displaying harmful sexual behaviours as a child and the risk of recidivism requires further research, particularly in the Australian context. We discuss the need for further research and evaluation regarding children with harmful sexual behaviours in Chapter 5 (see also Recommendation 10.7).

Prior physical abuse

Research and practitioner literature indicates children who have exhibited harmful sexual behaviours have sometimes experienced physical abuse prior to exhibiting the behaviours. More than one in five children aged under 10 years who attended treatment for 'problem sexual behaviours' in Victoria had experienced physical abuse before entering therapeutic intervention.²¹⁷ The Victorian Department of Human Services case practice model notes that between 35 and 50 per cent of children with 'problem sexual behaviours' have experienced physical or emotional abuse, or neglect.²¹⁸

This is consistent with international research. A study published in 2003 noted that 63 per cent of a sample of 182 boys aged between 12 and 18 years who were convicted of a sexual offence in the United States said they had past experiences of physical abuse by a father or stepfather.²¹⁹ A review of the case files of 27 boys aged under 10 in the United Kingdom who were referred to a specialist treatment provider for harmful sexual behaviours showed more than three-quarters of them had experienced physical abuse before entering treatment.²²⁰

Studies suggest physical abuse or neglect – which commonly co-occurs with sexual abuse – may be stronger predictors that a victim will sexually abuse children later in life than the experience of child sexual abuse.²²¹

Exposure to pornography and other sexual activity

Research indicates that children and young people today are accessing pornography and sexually explicit material at increasing rates and that, with the proliferation of high-speed internet and smart phones, pornography is readily available.²²² Studies show children have considerable exposure and access to pornography and that this is true in many countries.²²³ There are indications that the proliferation of violent pornographic material is negatively affecting children's sexual attitudes and behaviours.²²⁴ While not all children exposed to pornography will react in sexually abusive ways, consumers of violent, sexually explicit material are almost six times more likely to display sexually aggressive behaviour than those who do not consume such material.²²⁵ A study that compared the pornography exposure of 283 male adolescent sexual abusers against that of 170 delinquent youths who were not sexual offenders found the adolescents who sexually abused reported more exposure to pornography than those who engaged in non-sexual crimes.²²⁶

Frequent viewing of pornography has also been linked to sexually coercive behaviour by boys in intimate relationships. A study of 4,564 children aged between 14 and 17 years in five European countries concluded that, for boys, regularly watching pornography and sending or receiving sexual images or messages was associated with an increased probability of them being sexually coercive.²²⁷ Dr Michael Flood, Associate Professor at Queensland University of Technology and an expert in gender, sexuality and interpersonal violence, gave evidence to the Victorian Royal Commission into Family Violence that supports this:

Young men, for example, who consume pornography, particularly violent pornography, are more likely to be tolerant of and indeed to perpetrate sexual violence to try to coerce or force a girl or woman into sex, than other young men.²²⁸

Research suggests that exposure to sexual or physical violence toward females is indirectly linked to sexual offences against prepubescent children for adolescent males.²²⁹

A media survey of exposure to pornography among children and adolescents from 1,588 households with members aged between 10 and 15 years over a three-year period suggested that the relationship between sexually explicit material and sexually aggressive behaviour may be due to the violent content of the sexually explicit material.²³⁰ Consumers of violent sexually explicit material were almost six times more likely than non-consumers of violent sexually explicit material to engage in sexually aggressive behaviour.²³¹

In contrast, consumers of non-violent sexually explicit material were equally likely to exhibit sexually aggressive behaviour compared to those who said they had not consumed any such material. In our *Harmful sexual behaviours of children in schools* case study, Mr Dale Tolliday, clinical advisor at New Street Adolescent Services, gave evidence that his service is treating children who have harmed another child by re-enacting sexual activities shown in pornography:

Significant for these young people, and probably all, is the availability of explicit sexual material now available electronically on mobile devices and over the internet. Some of these young people have exposure by being shown and led into the behaviour by peers; some have antisocial peers. Some young people have simply been curious and are in intact families, supportive, no sign of abuse; have engaged in viewing material online and in a very short period of time have then gone and acted the behaviour, clearly not recognising the impact on the child that they've enacted this behaviour towards or on.²³²

This view of the negative effect of pornography on children's sexual behaviours is consistent with evidence Australian treatment providers and academics have submitted to the Royal Commission and other government inquiries.²³³ One practitioner who treats children with harmful sexual behaviours told us at a private roundtable, 'I can't think of anything that is going to impact us or what is actually happening for our young kids as much as the easy access of quite hardcore pornography'.²³⁴

Some survivors told Commissioners about children with harmful sexual behaviours forcing them to watch pornography and, in some instances, re-enact the sexual activity that was represented in the pornographic material.²³⁵

'Trent': copying behaviours represented in pornography

'Trent' was raised in foster homes in Queensland. At the age of five, he was placed with a family with an adopted son, 'Xavier', who was a few years older than 'Trent'. When the foster parents went out, they would leave 'Xavier' to look after 'Trent'. 'Trent' told us that 'Xavier' would put pornographic movies on the television and made 'Trent' watch them with him. 'Trent' explained that after a while, 'Xavier' made him copy the behaviours in the movies. He said this included performing oral sex on 'Xavier'. 'Trent' told us 'Xavier' also instructed him to practise: 'I had a big fluffy bunny rabbit, and he told me to practise on the bunny rabbit. It had a carrot'. 'Trent' told the Royal Commission that he did not understand what he was doing at the time, and that 'Xavier' told him not to talk about it, or he would get into trouble. Sometime later, 'Trent's' foster mother found him 'practising' on the bunny rabbit. 'Trent' said his foster mother asked him why he was doing it, and he told her what 'Xavier' had made him do. 'Trent' is not sure what action his foster mother took, but 'Xavier' never touched him again.²³⁶

Intellectual impairment and learning difficulties

Research suggests that children with intellectual impairment and learning difficulties may be an emerging subgroup of the wider population of children with harmful sexual behaviours.²³⁷ Children with intellectual impairment and learning difficulties make up a high proportion of children presenting to specialist services for treatment for harmful sexual behaviours.²³⁸

While this is an emerging concern, the relationship between intellectual impairment and learning difficulties, and harmful sexual behaviours by children is an underdeveloped area of research. It is not clear from the available research why children with intellectual impairment and learning difficulties present in proportionally higher numbers to specialist services for treatment for harmful sexual behaviours. Some authors have cautioned against the assumption that this over-representation reflects a greater propensity for abuse.²³⁹

Some practitioners have argued that children with intellectual impairment and learning difficulties are more visible within the service system than other children,²⁴⁰ and that behaviours displayed by these children might be more readily construed as problematic.²⁴¹ The nature of behaviours also suggests that the harmful sexual behaviours of children with intellectual impairment are often less sophisticated, less planned and more impulsive than those of other children.²⁴² This may reflect the child's developmental stage and capacity in areas such as social skills, cognitive abilities and emotional regulation.²⁴³

Some children and young people with intellectual impairment and learning difficulties who display harmful sexual behaviours may be unaware of the impact their behaviour has on others, or of the social norms of appropriate and inappropriate sexual behaviours.²⁴⁴ In addition, we have learned that children with disability, including intellectual impairment, experience maltreatment (including sexual abuse) at higher rates than other children.²⁴⁵ As discussed earlier, prior trauma is associated with children exhibiting harmful sexual behaviours.

Research suggests children and young people with intellectual impairments and learning difficulties have until recently been generally seen as 'asexual', leading parents and carers to dismiss or fail to talk about the sorts of sexual behaviours that might be seen as coercive or abusive.²⁴⁶

We have also been informed that children with disability may be denied access to education about sex and sexuality, and about what are considered to be appropriate expressions of their sexual identity.²⁴⁷ A lack of appropriate sex education, and lack of appropriate opportunities for sexual relationships and sexual expression, are potentially significant factors in understanding the behaviours of this group of children and young people.²⁴⁸

2.9.2 Institutional risk factors for children exhibiting harmful sexual behaviours towards another child

Situational factors, including factors within the institutional context, can influence children's harmful sexual behaviours. Research from the United States suggests harmful sexual behaviours by children are more likely to be impulsive than compulsive.²⁴⁹ This may be attributed to children's shorter attention spans and more limited impulse control, which is linked to children's incomplete cognitive development and less complex cognitive processing.²⁵⁰ An Australian research review suggests that situational factors – including an institutional context – are more significant in shaping the decision-making processes leading to children engaging in harmful sexual behaviours than the individual attributes of the child concerned.²⁵¹

Taken together, these studies indicate that both situational and individual factors contribute to children exhibiting harmful sexual behaviours. This suggests that, when institutions enable opportunities for sexual abuse, a child – especially if they have an underlying motivation or a history of harmful sexual behaviours – may impulsively seize that opportunity.

In the *Nature, cause and impact of child sexual abuse* case study, Dr Letourneau stated that children who sexually abuse other children are 'much more likely to be influenced by their environment, by their parents and by their peers, more so than adults, and that's a developmentally normative way of being for kids'.²⁵² In our *Christian Brothers* case study, we were told about the Brothers watching boys in the homes while they were showering, taking boys into their rooms at night, and molesting boys in the dormitory in front of other residents.²⁵³ One survivor, Mr John Hennessey, gave evidence that he was sexually abused by Brother Keaney at Bindoon Farm School for five years and believes this led to him becoming a 'sexual target' for many others, including older boys at the institution.²⁵⁴ Another survivor, VI, gave evidence that older students made sexual advances towards him after he was transferred to St Vincent's Orphanage Clontarf. At the time, he thought it was because they knew that Brother Dick had sexually abused him at Castledare Junior Orphanage.²⁵⁵ In both of these instances, it appears that once the behaviour was modelled and permitted by adults, the victim was identified by some children as an acceptable target.

In Volume 2, *Nature and cause*, we identify institutional risk factors that enable all forms of child sexual abuse in institutional contexts. In Volume 6, *Making institutions child safe*, we identify 10 standards of a child safe institution that are necessary to address these risks. In this section, we focus specifically on the institutional risk factors we consider may make it more likely that a child will direct harmful sexual behaviours towards another child. These risk factors all relate to failings in one or more of the child safe elements. We have drawn the information in this section from the best available research and expert opinion, and also from the large number of private sessions in which we heard about the settings in which this type of sexual abuse occurred. These included residential homes,²⁵⁶ foster care,²⁵⁷ youth detention centres,²⁵⁸ schools,²⁵⁹ defence institutions,²⁶⁰ hospitals,²⁶¹ sporting clubs²⁶² and many other settings.

Physical and emotional abuse and neglect in institutions

We heard in public hearings and in private sessions that in many institutions where children were sexually abused, children also experienced other forms of abuse, including physical and emotional abuse as well as neglect. This is consistent with research that suggests sexual abuse frequently occurs alongside other forms of abuse and neglect.²⁶³

The sexual abuse we heard about most commonly occurred in historical institutions where violence and abuse were a standard part of children's lives. In *The Salvation Army boys' homes, Australian Eastern Territory* case study, we were told that residents of Riverview Boys' Home experienced physical and sexual abuse by officers of The Salvation Army and older boys who also lived there. Multiple survivors recalled a weekly punishment line-up where Salvation Army officers flogged or caned boys for minor infractions, such as wetting the bed.²⁶⁴ For example, FP told us he was sexually abused by two other boys at the home in the 1960s, who beat him when he told other boys about the abuse. FP gave evidence that he did not tell officers at the home about the abuse because he feared they would not believe him and he would be 'flogged for telling lies'.²⁶⁵ Normalised violence and emotional and physical intimidation by staff and other residents were features of a number of other historical institutions we examined in our public hearings where children were sexually abused by other children. These included, but were not limited to, the Parramatta Training School for Girls,²⁶⁶ the Retta Dixon Home,²⁶⁷ and institutions run by the Christian Brothers in Western Australia.²⁶⁸

In the *Youth detention centres, Victoria* case study, the Royal Commission found that the placement of older children with younger children increased the risk of children being sexually abused by other children at the Turana Youth Training Centre, Winlaton Youth Training Centre and Baltara Reception Centre during the 1960s to the early 1990s.²⁶⁹

In most jurisdictions since 1990, placing older children with much younger children in residential institutions has become less common than it was previously. However, we have heard from survivors in private sessions who described being sexually abused by older boys in contemporary youth detention. 'Jeffrey' told us he was raped by older boys in a recreation room of a youth detention centre and threatened with serious harm if he told anyone.²⁷⁰ 'Tony Blake' told us he was raped by the older boy who shared his cell.²⁷¹ 'Dermott' described older boys in youth detention sexually abusing younger boys, including him, in the showers.²⁷² While the placement of older and younger children together appears to be less common in contemporary times, we are concerned that this may still be a risk within residential settings, such as boarding schools or youth detention facilities.

Closed institutions, which tend to prioritise discipline, order and conformity, can dehumanise children and create environments in which they are at greater risk of abuse.²⁷³ Our examination of child sexual abuse in schools, including our discussion of boarding schools, is contained in Volume 13, *Schools*. For our discussion of child sexual abuse in contemporary detention environments, see Volume 15, *Contemporary detention environments*.

We also discuss institutional leadership, governance and culture and its relationship to child sexual abuse in Volume 6, *Making institutions child safe*.

Bullying, initiation and bastardisation practices

We refer to sexual abuse in the context of bullying, degrading or humiliating treatment as ‘sexualised bullying’. During the course of our inquiry, we learned that some children behaved in sexually aggressive ways towards other children in institutional contexts characterised by high levels of both informal and ritualised bullying of children by other children, and bastardisation practices. Many of the harmful sexual behaviour allegations that occurred in the context of bullying or bastardisation practices (routine humiliation as part of initiation, also known as ‘hazing’) involved male children, both as victims and as the children who exhibited the harmful sexual behaviours.²⁷⁴

Bastardisation practices in the Australian Defence Force

In *Case Study 40: The response of the Australian Defence Force to allegations of child sexual abuse (Australian Defence Force)*, we learned of widespread abuse of younger recruits by older recruits in the Naval Junior Recruit Training Establishment in HMAS Leeuwin, which occurred at least until 1972. The abuse took place within an informal hierarchy in which older recruits physically and sexually abused more junior recruits.²⁷⁵ In our report we accepted that bastardisation practices existed at HMAS Leeuwin and that senior staff members knew of and tolerated rites of initiation within an unofficial hierarchy among junior recruits.²⁷⁶ These practices included ‘blackballing’ or ‘nuggeting’ – a practice that involved a junior recruit being held down by other recruits while boot polish, toothpaste or another substance was forcibly smeared on his genitals or anal area, sometimes with a hard brush. Some survivors who tried to report abuse to staff were either disbelieved or else told that the abuse was a ‘rite of passage’.²⁷⁷

In *Case Study 51: Institutional review of Commonwealth, state and territory governments (Institutional review of Commonwealth, state and territory governments)*, Vice Admiral Raymond Griggs, Vice Chief of the Australian Defence Force (ADF), gave evidence about changes within the ADF regarding child safety. In that evidence, Vice Admiral Griggs said that following the *Australian Defence Force* case study, the ADF took ‘immediate steps to ensure that the wider Defence and ADF Cadets organisations were made aware of the issues’ and made ‘plans to implement changes and revise policy’.²⁷⁸ This included accelerating the development of Defence Youth Safety Training²⁷⁹ and developing ‘One Cadet’, a new approach to reform based on improving accountability and streamlining lines of accountability.²⁸⁰ Vice Admiral Griggs told us during the *Institutional review of Commonwealth, state and territory governments* case study that this was ongoing work²⁸¹ and that an annual report on ADF Cadet matters will be provided to government and made publicly available.²⁸²

Over time, sexualised bullying can become normalised, making it more difficult for both adults and children to identify harmful sexual behaviours. This may make it possible for such behaviours to occur with little fear of consequence. For example, research notes that violence can be normalised in the context of sports and that, in such environments, sexualised bullying may not be recognised or could be seen as unavoidable.²⁸³ Research we commissioned also suggests that normalisation of harm within some institutions has enabled children to sexually abuse others as part of initiation practices for sporting clubs or teams.²⁸⁴ Some institutional cultures may tolerate and even validate bullying as an appropriate expression of a form of hyper-masculinity.²⁸⁵

In our *Harmful sexual behaviours of children in schools* case study we heard that in some institutions, sexualised bullying exhibited by boys was often dismissed or justified by adults as ‘boys being boys’.²⁸⁶ In this case study, one survivor gave evidence that ‘the internal discipline and the esprit de corps was driven entirely by the senior boys ... I don’t believe that any boy was ever suspended or expelled for bullying in my time at King’s’.²⁸⁷

During the same case study, Mr Peter Green, former Boarding Housemaster of Trinity Grammar School, gave evidence that ‘rumbling’ in the boarding house of Trinity Grammar school was:

When a boy might decide to grab another one, have a bit of a wrestle around the place. It could be where you’ve got a situation where a number of the boys start playing a game of football and they will develop into a rumble, where they’re tackling each other and whatever.²⁸⁸

Mr Green went on to say that rumbling ‘would be a very physical interaction between the boys and both boys come out of it at the end of it laughing and having a good time’.²⁸⁹

In his statement to this same public hearing, survivor CLA described how the culture of ‘rumbling’ precipitated sexual assaults:

I remember the first round of assaults by the two perpetrators as incidents where wrestling got out of hand. Every incident mirrored itself in that one of the boys would start to wrestle me, then the other would jump in and pin me down. I believe Mr Green, Mr Scott and Mr Cujes called these ‘rumbling’. As these incidents kept reoccurring, the more violent and invasive they became. This went on for many weeks.²⁹⁰

These organisational cultures are not just a concern of the past. For example, in one private session, we heard from ‘Tristan’, who told us that in 2013, as a teenager, he experienced sexualised bullying and abuse when on an interstate sporting trip. He told us that, because of his young age compared to most of the other boys in his sporting team, he was designated the ‘team bitch’. Initially, he thought the teasing was in the spirit of fun. However, he told us that on the trip, the other boys tied him up with duct tape and one boy told him, ‘face it, you’re going to get raped’. He also told us he did not resist being tied up to begin with because he thought it was just another case of ‘mucking around’.²⁹¹

Similarly, another survivor, 'Cy', told us in a private session about boys being sexually abused by older boys as part of initiation into a sporting club. 'Cy' told us about a hazing ritual that escalated to older boys inserting tubes of heat cream and squeezing the contents into younger boys' rectums, as well as digital rape. 'Cy' told us the culture at the club was highly sexualised and that coaches at the club encouraged new senior teams to continue the 'ritual'. 'Cy' said that this abuse escalated and that, during one training camp, he found a boy lying in the shower block of the camp who had been raped by a number of older boys.²⁹²

Hierarchical cultures and structures among children

We heard that children in leadership positions or who have been afforded a level of authority by an institution may exploit their greater access to, and power over, other children with whom they have contact. In our *Harmful sexual behaviours of children in schools* case study, Mr John Williams gave evidence about the hierarchical system operating at The King's School where he had been sexually abused. Mr Williams said that the students in Year 12 were called 'sir' and they would punish and order around the younger students.²⁹³ Mr Williams told that us he was subjected to the following rituals performed by older boys: 'socking' involved older boys putting socks into a tennis shoe and belting younger students across the backside;²⁹⁴ another ritual involved 'blackballing', where older boys tied younger boys to a tree and then blackened their testicles with raven oil.²⁹⁵

Similarly, survivor CLG stated that while he was a student and boarder at The King's School, he was a 'frat' to an older boy who forced CLG to watch him masturbate, then made CLG clean his room and military uniform. CLG gave evidence that he was also made to clean the rooms and military uniforms of other senior boys. He said that he was subjected to a number of cruel acts of physical abuse from the older boys, such as ear slapping, nipple twisting, ball grabbing and 'blackballing'.²⁹⁶

The experiences outlined in these case studies align with research from the United Kingdom that suggests prefect systems in boarding schools and inadequate adult supervision can facilitate institutionalised bullying.²⁹⁷

Supervision and oversight

A lack of, or ineffective, supervision and external oversight is a key risk factor for child sexual abuse in institutional contexts.²⁹⁸ We heard in our public hearings that institutions in which children were sexually abused did not have adequate day-to-day supervision of children or any effective regular external oversight.²⁹⁹

Poor supervision within out-of-home care placements may be a key issue enabling children to engage in harmful sexual behaviours. For example, we examined historical residential institutions that lacked the staffing and resources to adequately supervise children or supervise adults' interactions with children. In the *Youth detention centres, Victoria* case study, we accepted that overcrowding was a serious problem at Turana Youth Training Centre, Winlaton Youth Training Centre and Baltara Reception Centre, and that this overcrowding hindered the provision of adequate supervision at these institutions.³⁰⁰ We were satisfied that supervision of residents was inadequate to keep them safe from sexual abuse, particularly at night.³⁰¹ Survivor Mr Joseph Marijancevic gave the following evidence:

Well, there was generally [no supervision]. Your Honour, there was an inspection around about 8 or 9 and, after that, nobody came. The distance of the staff quarters, because the staff slept on the premises, was fairly significant, so you could yell, shout, muck up and nobody could hear you, where they were.³⁰²

The Investigative Committee of the Commission to Inquire into Child Abuse in Ireland (2009) heard from complainants that older male children at St Joseph's Industrial School, Tralee, sexually abused younger boys in the toilets and dormitories.³⁰³ This 2009 Commission concluded that 'an inadequate and indifferent regime of supervision allowed older boys to prey on younger boys'.³⁰⁴

In the *Youth detention centres, Victoria* case study we heard about several instances of child sexual abuse that occurred in the context of ineffective supervision. One survivor, BDF, told the Royal Commission she was sexually abused at Winlaton Youth Training Centre during 'movie nights', even though staff were present in the hall. One night some of the older residents from the Goonya section took her to the front of the room, held her down and sexually abused her. BDF believed staff should have seen her being taken to the front row.³⁰⁵

In the *Australian Defence Force* case study, survivors gave evidence that many of the incidents of child sexual abuse they experienced occurred at night after 'lights out', when staff were not in the accommodation blocks.³⁰⁶ The nature and extent of abuse at HMAS Leeuwin was the subject of an inquiry in 1971, undertaken by his Honour Trevor Rapke QC, and in 2012 an independent review by the Defence Abuse Response Taskforce (DART) examined allegations of sexual and other abuse within the Australian Defence Force, including historical abuse.³⁰⁷ We agree with findings from both these inquiries that supervision at HMAS Leeuwin was 'inadequate' and created an environment in which abuse could occur.³⁰⁸

We also heard issues around supervision and oversight in more contemporary institutional contexts. For example, in our *Harmful sexual behaviours of children in schools* case study we examined how Shalom Christian College handled a 2006 disclosure that a female student had been sexually assaulted on school grounds by a group of male students. Mr Christopher Shirley, the principal of the school at the time of the incident, gave evidence about the physical infrastructure of the school in 2006. He acknowledged that there was a serious problem with security in both the boys' and girls' dormitories. He said that the 'older-style' female boarding accommodation allowed free access after 'lock in' for any of those boarders to move about inside without being detected by house parents. All windows were able to be opened and each window was secured by an 'older-style' security screen. Exit doors were fitted with an older style magnetic security detector.³⁰⁹

Mr Shirley said:

The 'old' set up of the dorms allowed the potential for child-on-child abuse (sexual or otherwise). Allowing 40 plus students a decreased level of night-time supervision in the dorms elevated management problems and permitted a less safe boarding environment than we would wish.³¹⁰

Research we commissioned suggested that boarding schools provided greater opportunities for children to display harmful sexual behaviours due to the substantial amount of time that children of different ages spend together, the greater opportunities for children to be alone with another child or children unsupervised, and the fact that children have less access to parents and carers for protection.³¹¹

Harmful sexual behaviours by groups of children

During our case studies we have heard many examples where survivors were sexually abused by a group of children. We heard about groups of male and female children displaying harmful sexual behaviours in both contemporary and historical contexts.

For example, in the *Parramatta Training School for Girls* case study we heard evidence from former residents about group attacks by girls who also lived in the institution. Ms Robin Kitson, a former resident, told us:

I was sexually abused by other girls at the home on two occasions. The first was during the day when we were locked in the dormitory and made to clean it. Three or four of the older girls held me down and abused me with a broomstick. Other girls saw it happen but couldn't help because they were scared too. The same thing happened on another occasion a couple of weeks later with the same ringleader but a few different girls attacking me. They thought it was a joke. They were laughing about it.³¹²

In the *Australian Defence Force* case study, survivors gave evidence of being assaulted and abused by groups of fellow recruits and apprentices. For example, CJU told the Royal Commission that one night he was dragged out of bed by a group of senior apprentices as punishment for reporting an earlier incident of physical abuse. The senior apprentices smeared vegemite over his stomach, groin, genitals and legs before they brought a dog to lick the vegemite off him. CJU gave evidence that the senior apprentices then turned him over, so he was kneeling, and pushed the dog against his backside. The senior apprentices told him ‘that’s what you get for dobbing on us’.³¹³

In our *Harmful sexual behaviours of children in schools* case study we examined how Shalom Christian College handled a disclosure by a student, CLF, that she had been sexually assaulted on the grounds of the school by a group of male students. Ms Amy Bridson, the school counsellor at the school, gave evidence that CLF had made a disclosure to her about sexual abuse by multiple boys and it was ‘horrific’.³¹⁴ CLF’s mother EAL gave evidence that CLF ‘changed’ after her experience at Shalom Christian College.³¹⁵ CLF has self-harmed, attempted suicide and is well known to the police. She has had drug-induced psychotic episodes and was on antidepressant and antipsychotic medications. CLF’s parents gave evidence that the male students involved were convicted of charges, but that these charges were subsequently downgraded, with none of the boys serving jail time.³¹⁶

International research suggests juvenile sex offenders may be more likely to offend in groups than adult sex offenders.³¹⁷ One study from the United States that analysed data on children reported to the police for an alleged sexual offence against a child found that that 24 per cent of these cases had one or more co-offenders, compared with 14 per cent of adults who were the subjects of similar reports.³¹⁸ Research from the United Kingdom suggests there is a need to assess and respond to the role that peers play in children’s harmful sexual behaviours.³¹⁹

There is little research specifically on the role that institutional culture plays in influencing group dynamics and children exhibiting harmful sexual behaviours in groups. However, we are of the view that this is an area of concern that warrants further research and attention. We believe that children who display harmful sexual behaviours in groups are likely to have been influenced by the culture of the institution in which the behaviours occurred.

We believe institutional leadership and institutional culture are overarching factors that provide strong situational influences on children’s behaviours. ‘Institutional culture’ refers to the assumptions, values, beliefs and norms upheld by an institution about what are appropriate and inappropriate attitudes and behaviours.³²⁰ Leaders establish and facilitate the institution’s culture. They play a critical role in governance, including the development, implementation and monitoring of policies and practices that can either support child safety or enable abuse.

A positive, child-focused institutional culture is key to protecting children against sexual abuse and can facilitate appropriate responses.³²¹ By contrast, a culture that enables abuse is one that accepts or endorses harmful attitudes and behaviours. See Volume 6, *Making institutions child safe* for a detailed discussion about institutional culture and our recommendations to improve children's safety in institutions.

Understanding and awareness of children's harmful sexual behaviours

A lack of understanding and awareness of harmful sexual behaviours in children may contribute to the risk of children being sexually abused. If leaders in institutions do not ensure staff know their obligations to identify and respond appropriately to harmful sexual behaviours, staff will not be able to protect the safety and wellbeing of children in their care. In many of the institutions we examined, staff had no education or training about healthy sexual development for children, or on how harmful sexual behaviours exhibited by children could amount to the sexual abuse of other children.

In our *Harmful sexual behaviours of children in schools* case study we heard evidence from EEA that his son, CLA, experienced bullying and sexual abuse at Trinity Grammar School.³²² EEA told us that on one occasion CLA was suspended from school for a weekend. EEA stated that the only details he and his wife, EAB, were given regarding the suspension was that it arose from CLA's participation in a 'rumbling incident' in the boarding house, where he was part of a group of boys that had put boot polish on another boy, CLB.³²³ EEA and EAB requested an interview with the Boarding Housemaster, Mr Robert Scott. EEA said that Mr Scott described the incident as 'minor' and just 'boys being boys'.³²⁴ EEA gave evidence that it was 'horrifying' to look back and realise that, at that time, CLA was being sexually abused and had been for months.³²⁵

Research we commissioned found confusion among children in residential care regarding appropriate and inappropriate sexual behaviour.³²⁶ This may result in harmful sexual behaviours being misconstrued as normal sexual experimentation.³²⁷ Staff education and training on the difference between age-appropriate sexual activity and sexual abuse is a key component of a child safe institution. In Chapter 4, we discuss how institutional responses to harmful sexual behaviours exhibited by children can be improved through the provision of training and education to staff in institutions about healthy and harmful sexual behaviours for children. This suggests a need for education and training for all staff in institutions on how to identify, react and respond to children with harmful sexual behaviours.

Sex education

Studies have identified a lack, or an inappropriate level, of sexual knowledge and sex education as a feature of older children who have exhibited harmful sexual behaviours.³²⁸ In the *Nature, cause and impact of child sexual abuse* case study, Dr Letourneau gave evidence that:

children often don't know that what they're doing is wrong. We do a poor job – and when I say 'we' I mean adults in general, and in virtually every country – we do a really poor job of explaining to children what are the rules of the road as they begin to become sexual.³²⁹

We are of the view that sex education and sexual abuse prevention education must be universally implemented and accessible to all children. It must be culturally safe, appropriately tailored and developmentally appropriate. Such programs must include content on consent, equality, coercion and the impact that harmful sexual behaviours can have on the child or young person who exhibits the behaviours and on their victims. These programs should also ensure children are made aware that other children, and not just adults, may sometimes pose a risk. We discuss our recommendations for improving sex education for children in Chapter 4.

2.9.3 Theories about adult perpetrators do not apply to most children who exhibit harmful sexual behaviours

Research suggests children with harmful sexual behaviours tend to act impulsively rather than in a premeditated manner when they cause harm to other children.³³⁰ Children's impulse control and decision-making functions are still developing.³³¹ Some children have difficulty understanding that their behaviours are harmful. For these reasons, it is inappropriate to apply the same frameworks used to analyse the motivations of adult perpetrators when considering children with harmful sexual behaviours.

Caution needs to be exercised in applying theories about preconditions for sexual abuse, or any similar framework based on studies of adult male perpetrators, to the majority of children who exhibit harmful sexual behaviours.³³² There is consensus among practitioners that few children engaging in harmful sexual behaviours are motivated by a pre-existing sexual preference for children.³³³ As Dr Letourneau told us in the *Nature, cause and impact of child sexual abuse* case study:

there are some adolescents who are preferentially attracted. It is a distinct minority relative to other reasons.

...there are many situational reasons that might explain these behaviours, and I would argue that that's the bulk of the kids who engage in these behaviours, is for more situational reasons.³³⁴

Further, while some children do appear to have taken advantage of some institutional environments – such as inadequate supervision – to harm other children, in many cases, they may have done so in environments where abusive adults were doing the same thing.³³⁵ We are of the view that it is very likely these children modelled their behaviour on what they had seen adults doing without consequence.

Some older children, particularly males, who exhibit harmful sexual behaviours that reach the criminal threshold appear to offend in similar ways to adult perpetrators. There are, for example, some adolescent offenders who are sexually aroused by children³³⁶ and in private sessions we heard about several male adolescents who, like adult perpetrators, used gifts to overcome their victim's resistance.³³⁷ In a private session, 'Maree' told us when she lived in an orphanage in the 1970s she was sent on holiday with a host family, including a teenage son. We heard that the son sexually abused 'Maree' during the holiday in exchange for chocolate.³³⁸ However, research indicates that such behaviours by children are a 'distinct minority' and most children with harmful sexual behaviours appear to act impulsively rather than in a premeditated manner.³³⁹ Additionally, children's motivations and their ability to regulate their behaviour change as they age.³⁴⁰

2.10 Children's capacity for rehabilitation

2.10.1 Legal principles and child development

Children with harmful sexual behaviours who enter the criminal justice system are treated differently to adult perpetrators of child sexual abuse.³⁴¹ The United Nations Committee on the Rights of the Child has articulated the basis for responding differently to children as follows:

Children differ from adults in their physical and psychological development, and their emotional and educational needs. Such differences constitute the basis for the lesser culpability of children in conflict with the law. These and other differences are the reasons for a separate juvenile justice system and require a different treatment for children. The protection of the best interests of the child means, for instance, that the traditional objectives of criminal justice, such as repression/retribution, must give way to rehabilitation and restorative justice objectives in dealing with child offenders. This can be done in concert with attention to effective public safety.³⁴²

The developmental importance of the early years of a child's life is well established. Infants' and young children's brains develop faster in the first few years of life than at any other time in life,³⁴³ and early childhood – which spans the prenatal period to eight years of age – is the most critical stage of human development.³⁴⁴ According to the World Health Organization, 'what happens before birth and in the first few years of life plays a vital role in health and social outcomes'.³⁴⁵

Children's development continues well beyond their early years. Research shows substantial changes in brain development into the early twenties.³⁴⁶ This affects the decision-making capacity of children and young people.³⁴⁷ We know from the research literature that children are 'more at risk of a range of problems conducive to offending – including mental health problems, alcohol and other drug use and peer pressure – than adults, due to their immaturity and heavy reliance on peer networks'.³⁴⁸

Recognising these inherent differences between adults and children has led social and legal policymakers to differentiate children from adults.

Criminal justice is an important element of the spectrum of responses to children with harmful sexual behaviours. Although only a small number of children will require a criminal justice response, we recognise that serious sexual abuse committed by children may have severe, possibly lifelong consequences for the victims, and that juvenile sex offenders can present serious threats against which the community requires protection.

2.10.2 Do children's harmful sexual behaviours continue into adulthood?

Studies into recidivism indicate most children's harmful sexual behaviours will cease in childhood, with average sexual recidivism rates for children ranging from 3 to 14 per cent.³⁴⁹

As we heard from psychologist Dr Margaret Cutajar in the *Nature, cause and impact of child sexual abuse* public hearing, 'offending in children tends to peak at about 17, with sexual offending, and then dramatically reduces ... The likelihood of it continuing is low'.³⁵⁰ In the same public hearing, Dr Letourneau agreed with this assessment and stated that 'the vast majority of children who have been adjudicated for a sexual offence will not go on to engage in a second sexual offence'.³⁵¹

In Australia, studies of children with harmful sexual behaviours who have attended therapeutic treatment show low rates of the behaviours recurring post-intervention:

- A 2016 study of 104 male youths who had committed serious sexual offences and were being treated by the Griffith Youth Forensic Service in Queensland showed three participants sexually reoffended in the 2.5 year follow-up period. This equated to around 3 per cent of participants.³⁵²
- A 2014 study of 100 (mostly male) children aged between 10 and 17 years who had sexually abused children and were referred to New Street Adolescent Services for therapeutic intervention looked at data over a seven-year period. The study found the sample had a 33 per cent recidivism rate for all types of offending, including sexual offending.³⁵³ The sample had a 7 per cent recidivism rate for sexual offending.³⁵⁴

In the *Nature, cause and impact of child sexual abuse* public hearing, Dr Letourneau also noted that:

The severity of the offence does not seem to be a key factor in recidivism for kids. It should be a key factor in what you choose to do with a child ... It's certainly an indicator for treatment needs.³⁵⁵

There are methodological challenges in accurately calculating recidivism rates.³⁵⁶ In particular, recidivism studies focus on children who have committed criminal sexual offences, and as a result these studies do not capture the rates at which children with problematic sexual behaviours and less severe harmful sexual behaviours continue to exhibit these behaviours. However, available data from recidivism studies challenges the common assumption that children who commit sexual offences will become adult sex offenders. Recidivism studies indicate many young people who have committed a sexual offence do not continue to sexually offend in adulthood.³⁵⁷

A 2010 meta-analysis of male adolescent sexual offenders suggests there are two primary risk factors that may indicate whether harmful sexual behaviours in childhood are likely to continue past adolescence. These are: antisocial characteristics, including a criminal history, and sexual deviance, including atypical sexual interests.³⁵⁸ However, based on current research and knowledge about recidivism, it is not possible to predict which children with harmful sexual behaviours will continue the behaviours.

Research that examines the histories of adolescents with harmful sexual behaviours shows that young people often exhibited problematic sexual behaviours when they were younger, and that these behaviours escalated over time. For example, a retrospective review of the case files of 700 young people in the United Kingdom who had been referred to a therapeutic service between 1992 and 2000 because of their harmful sexual behaviours suggested that the young people were most often referred to the service because of a particular act of harmful sexual behaviour. The researchers also found there were accounts of previous, unaddressed problematic and harmful sexual behaviours for many of the young people in the study and that, without support and intervention, these behaviours escalated into more serious and harmful acts.³⁵⁹

This suggests that it is important to identify and respond to all children with problematic and harmful sexual behaviours early so they can receive support, assessment and appropriate interventions. Specialist assessment can identify and plan interventions that are tailored to the child's particular needs, background, and situation so that the harmful sexual behaviours are more likely to cease and less likely to escalate.

Endnotes

- 1 For example, Name changed, private session, 'Maddie Jean'.
- 2 Name changed, private session, 'Helena'.
- 3 For example, see M Chaffin, L Berliner, R Block, TC Johnson, WN Friedrich, DG Louis, TD Lyon, IJ Page, DS Prescott & JF Silovsky, 'Report of the ATSA task force on children with sexual behavior problems', *Child Maltreatment*, vol 13, no 2, 2008, pp 200–1; W O'Brien, *Problem sexual behaviour in children: A review of the literature*, Australian Crime Commission, Canberra, 2008, pp 6–8; S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, UK, 2014, pp 16–7, 42; S Hackett, J Phillips, H Masson & M Balfe, 'Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers', *Child Abuse Review*, vol 22, no 4, 2013, p 24.
- 4 S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, UK, 2014, pp 65–7; C Hargreaves & B Francis, 'The long term recidivism risk of young sexual offenders in England and Wales—enduring risk or redemption?', *Journal of Criminal Justice*, vol 42, no 2, 2013, pp 13–4, 17; MF Caldwell, 'Quantifying the decline in juvenile sexual recidivism rates', *Psychology Public Policy and Law*, vol 22, no 4, 2016, p 419; Transcript of E Letourneau, Case Study 57, 28 March 2017 at 27423:12–15.
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- 6 See for example Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 3: Anglican Diocese of Grafton's response to child sexual abuse at the North Coast Children's Home*, Sydney, 2014, pp 13–4; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 5: Response of The Salvation Army to child sexual abuse at its boys homes in New South Wales and Queensland*, Sydney, 2015, pp 20–4; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 17: The response of the Australian Indigenous Ministries, the Australian and Northern Territory governments and the Northern Territory police force and prosecuting authorities to allegations of child sexual abuse which occurred at the Retta Dixon Home*, Sydney, 2015, pp 22, 26–7; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 11: Congregation of Christian Brothers in Western Australia response to child sexual abuse at Castledare Junior Orphanage, St Vincent's Orphanage Clontarf, St Mary's Agricultural School Tardun and Bindoon Farm School*, Sydney, 2014, p 25; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 30: The response of Turana, Winlaton and Baltara, and the Victoria Police and the Department of Health and Human Services Victoria to allegations of child sexual abuse*, Sydney, 2016, pp 30–5; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 33: The response of The Salvation Army (Southern Territory) to allegations of child sexual abuse at children's homes that it operated*, Sydney, 2016, pp 45, 54, 62, 65, 70; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 40: The response of the Australian Defence Force to allegations of child sexual abuse*, Sydney, 2017, pp 28–31, 52–5; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 41: Institutional responses to allegations of the sexual abuse of children with disability*, Sydney, 2017, pp 36–7.
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- 11 Australian Bureau of Statistics, *4519.0 Recorded Crime, 2015-16: Table 20 - youth offenders, sex and principal offence by age*, Australian Bureau of Statistics, Canberra, 2017, Table 1: Principle Offence recorded by police for all offenders for sexual assault and other related offences; Table 18: Principal Offence recorded by police for youth offenders aged 10–17 years for sexual assault and related offences.
- 12 Australian Bureau of Statistics, *4519.0 Recorded Crime, 2015-16: Table 20 - youth offenders, sex and principal offence by age*, Australian Bureau of Statistics, Canberra, 2017, Table 1: Principle Offence recorded by police for all offenders for sexual assault and other related offences; Table 18: Principal Offence recorded by police for youth offenders aged 10–17 years for sexual assault and related offences.
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- 14 D Finkelhor, R Ormrod & M Chaffin, *Juveniles who commit sex offences against minors*, Office of Justice Programs, U.S. Department of Justice, Washington, 2009, p 3.
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16 L Bromfield, C Hirte, O Octoman & I Katz, *Child sexual abuse in Australian institutional contexts 2008–2013: Findings from administrative data*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017.

17 L Bromfield, C Hirte, O Octoman & I Katz, *Child sexual abuse in Australian institutional contexts 2008–2013: Findings from administrative data*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 208–9. This study considered recent allegations of child sexual abuse reported to police in all jurisdictions between 1 July 2008 and 30 June 2013. A recent allegation is an allegation where the offence took place no more than five years prior to the report.

18 L Bromfield, C Hirte, O Octoman & I Katz, *Child sexual abuse in Australian institutional contexts 2008–2013: Findings from administrative data*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 210. In that report, ‘Offender’ is defined as a ‘Person alleged to have or believed to be responsible for child sexual abuse’ and is used interchangeably with the term ‘perpetrator’.

19 For detailed information on limitations surrounding perpetrator data, see L Bromfield, C Hirte, O Octoman & I Katz, *Child sexual abuse in Australian institutional contexts 2008–2013: Findings from administrative data*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 208–211.

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23 A Ferrante, *Police responses to child sexual abuse 2010–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 137–8, 141, Table 4.8.

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32 Transcript of W O’Brien, Case Study 45, 20 October 2016 at 21671:6–22; Royal Commission into Institutional Responses to Child Sexual Abuse, Treatment of child to child sexual abuse private roundtable, Sydney, 2015.

33 Transcript of W O’Brien, Case Study 45, 20 October 2016 at 21654:45–21655:16. For examples of this language reflected in legislation, see *Children and Young Persons (Care and Protection) Act 1998* (NSW) and *Children, Youth and Families Act 2005* (Vic).

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- 42 W O'Brien, *Australia's response to sexualised or sexually abusive behaviours in children and young people*, Australian Crime Commission, Canberra, 2010, p 12; W O'Brien, *Problem sexual behaviour in children: A review of the literature*, Australian Crime Commission, 2008, p 7; Royal Commission into Institutional Responses to Child Sexual Abuse, *Treatment of child to child sexual abuse private roundtable*, Sydney, 2015.
- 43 Transcript of E Letourneau, Case Study 57, 27 March 2017 at 27419:21–29.
- 44 Royal Commission into Institutional Responses to Child Sexual Abuse, *Treatment of child to child sexual abuse private roundtable*, Sydney, 2015.
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63 For example, see M Chaffin, L Berliner, R Block, TC Johnson, WN Friedrich, DG Louis, TD Lyon, IJ Page, DS Prescott & JF Silovsky, ‘Report of the ATSA task force on children with sexual behavior problems’, *Child Maltreatment*, vol 13, no 2, 2008, pp 200-1; W O’Brien, *Problem sexual behaviour in children: A review of the literature*, Australian Crime Commission, Canberra, 2008, pp 6-8; S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014, pp 16-17, 42.

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74 Australian Bureau of Statistics, *Australian and New Zealand Standard Offence Classification (ANZSOC) (third edition)*, Australian Bureau of Statistics, Canberra, 2011, pp 34–35: non-assaultive sexual assault refers to ‘offences of a sexual nature, or intent thereof, against another person that do not involve physical contact with the person and where the person does not give consent, gives consent as a result of intimidation or deception, or consent is proscribed (i.e. the person is legally deemed incapable of giving consent because of youth, temporary/permanent (mental) incapacity or there is a familial relationship)’. It includes the production, possession, distribution or display of pornographic or abusive material of a child under the age of consent; sexual servitude offences; voyeurism, gross indecency and wilful exposure.

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79 A Ferrante, *Police responses to child sexual abuse 2010–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 143, Table 4.13.

- 80 Australian Bureau of Statistics, *4519.0 Recorded Crime, 2015-16: Table 20 - youth offenders, sex and principal offence by age*, Australian Bureau of Statistics, Canberra, 2017.
- 81 Australian Bureau of Statistics, *4519.0 Recorded Crime, 2015-16: Table 20 - youth offenders, sex and principal offence by age*, Australian Bureau of Statistics, Canberra, 2017.
- 82 There is agreement in the literature that children are more likely to be able to be rehabilitated and experience behavioural change, compared to adults, because children are still developing. See section 2.10 of this volume for more detailed discussion on this issue.
- 83 MF Caldwell, 'Quantifying the decline in juvenile sexual recidivism rates', *Psychology Public Policy and Law*, vol 22, no 4, 2016, p 419. In this meta-analysis of 106 studies and more than 33,000 cases over the past 30 years, reoffending rates for sexual offences of children who had been adjudicated for a sexual offence were less than 5 per cent. In the most recent 33 studies since 2000, the rate of sexual reoffending fell to less than 3 per cent.
- 84 See for example: Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 30: The response of Turana, Winlaton and Baltara, and the Victoria Police and the Department of Health and Human Services Victoria to allegations of child sexual abuse*, Sydney, 2016, pp 52–5. In this case study we found that the placement and interaction of children admitted as wards of the Department with children committed as juvenile offenders, and of older children with younger children, increased the risk of child sexual abuse by another child or children. The risk of sexual abuse of children by other residents was increased by the placement and interaction of children admitted as wards of the Department with children committed as juvenile offenders, and of older children with younger children. We also found that the supervision of residents was inadequate to keep them safe from sexual abuse, particularly at night.
- 85 P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 25–7.
- 86 P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 25–7.
- 87 Almost two-thirds (63.2 per cent) of all private session accounts of child sexual abuse by another child occurred in out-of-home care. See Table 10.4 in Section 2.6.
- 88 I Katz, A Jones, B Newton & E Reimer, *Life journeys of victim/survivors of child sexual abuse in institutions: An analysis of Royal Commission private sessions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 95–96.
- 89 I Katz, A Jones, B Newton & E Reimer, *Life journeys of victim/survivors of child sexual abuse in institutions: An analysis of Royal Commission private sessions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 95.
- 90 I Katz, A Jones, B Newton & E Reimer, *Life journeys of victim/survivors of child sexual abuse in institutions: An analysis of Royal Commission private sessions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 96. See also for example: Name changed, private session 'Helen Christine'.
- 91 Name changed, private session 'Myra'.
- 92 T Moore, M McArthur, S Roche, J Death & C Tilbury, *Safe and sound: Exploring the safety of young people in residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, pp 37–8, 40.
- 93 T Moore, M McArthur, S Roche, J Death & C Tilbury, *Safe and sound: Exploring the safety of young people in residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 40.
- 94 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 73.
- 95 See, for example MacKillop Family Services, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 22 April 2016, p 2; Relationships Australia, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, pp 3, 10; The Victorian Aboriginal Child Care Agency, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, pp 5–6; Commission for Children and Young People, *"...as a good parent would...": Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, Commission for Children and Young People, Melbourne, 2015; EP Mullighan, *Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse*, Commission of Inquiry, South Australia, Adelaide, 2008, pp 294, 337.
- 96 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and harmful sexual behaviours of children in schools*, Sydney, 2017, p 36.
- 97 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and harmful sexual behaviours of children in schools*, Sydney, 2017, pp 36–7.
- 98 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and harmful sexual behaviours of children in schools*, Sydney, 2017, p 37.
- 99 Name changed, private session 'Marsha'.
- 100 Name changed, private session 'Marsha'.
- 101 Name changed, private session 'Matthias'.
- 102 Name changed, private session 'Matthias'.
- 103 Name changed, private session 'Lochie'.

104 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017.

105 A Ferrante, *Police responses to child sexual abuse 2010–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 142, Table 4.10.

106 See for example, name changed, private session ‘Kane’ and the evidence from BMC in Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 33: The response of The Salvation Army (Southern Territory) to allegations of child sexual abuse at children’s homes that it operated*, Sydney, 2016, p 54.

107 A Ferrante, *Police responses to child sexual abuse 2010–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 138, 141, Table 4.9. Note, 24 per cent of victims were male and gender was missing for remaining 9 per cent of victims.

108 JA Hunter, AJ Figueredo, NM Malamuth & JV Becker, ‘Juvenile sex offenders: Toward the development of a typology’, *Sexual abuse: A Journal of Research and Treatment*, vol 15, no 1, 2003, p 33.

109 N Parry, ‘Such a longing’: Black and white children in welfare in New South Wales and Tasmania, 1880–1920’, University of New South Wales, 2007, pp 125–6, 141, 191; Australian Institute of Health and Welfare, *National Child Protection Data Collection National Framework indicator 0.2 Out-of-home care*, 2017, www.analytics.aihw.gov.au (viewed 27 June 2017).

110 A Ferrante, *Police responses to child sexual abuse 2010–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 141, Table 4.9.

111 A Ferrante, *Police responses to child sexual abuse 2010–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 141, Table 4.9.

112 There is no further breakdown available on type of disability.

113 G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse in institutional contexts*, Sydney, 2016, p 44.

114 G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse in institutional contexts*, Sydney, 2016, p 43; PM Sullivan & JF Knutson, ‘Maltreatment and disabilities: A population-based epidemiological study’, *Child Abuse & Neglect*, vol 24, no 10, 2000, pp 1257–1273; D Finkelhor & LM Jones, *Have sexual abuse and physical abuse declined since the 1990s?*, Crimes Against Children Research Center, Durham, 2012.

115 G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse in institutional contexts*, Sydney, 2016, pp 7, 31–2; People with Disability Australia, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper 3: Child Safe Institutions*, 2013, p 3.

116 G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse in institutional contexts*, Sydney, 2016, p 1; Commonwealth of Australia (2005) *Protecting vulnerable children: A national challenge. Second Report on the inquiry into children in institutional or out-of-home-care*, Parliament House, Canberra, p 142.

117 S Robinson, ‘Preventing abuse of children and young people with disability under the National Disability Insurance Scheme: A brave new world?’, *Australian Social Work*, vol 68, no 4, 2015, p 471; S Robinson, *Enabling and protecting: Proactive approaches to addressing the abuse and neglect of children and young people with disability*, Children with Disability Australia, Clifton Hill, 2012, pp 9–10.

118 T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 85–87.

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120 Name changed, private session ‘Asad’.

121 Name changed, private session ‘Dorothy’.

122 Name changed, private session ‘Dorothy’.

123 For example: Name changed, private session, ‘Barry Stephen’; Name changed, private session, ‘Stuart Andrew’; Name changed, private session, ‘Krispin’.

124 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and harmful sexual behaviours of children in schools*, Sydney, 2017, p 17.

125 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and harmful sexual behaviours of children in schools*, Sydney, 2017, pp 71–6.

126 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and harmful sexual behaviours of children in schools*, Sydney, 2017, p 74.

127 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and harmful sexual behaviours of children in schools*, Sydney, 2017, p 75. Exhibit 45-047, ‘Statement of EAM’, Case Study 45, STAT.1205.001.0001_R at 43.

128 W O’Brien, *Australia’s response to sexualised or sexually abusive behaviours in children and young people*, Australian Crime Commission, Canberra, 2010; S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014; S Hackett, J Phillips, H Masson & M Balfe, ‘Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers’, *Child Abuse Review*, vol 22, no 4, 2013; Transcript of D Tolliday, Case Study 45, 3 November 2016 at 22819:5–22820:8.

129 S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014.

130 A Ferrante, *Police responses to child sexual abuse 2010–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 141, Table 4.9; see also L Laing, D Tolliday, N Kelk & B Law, ‘Recidivism following community based treatment for non-adjudicated young people with sexually abusive behaviors’, *Sexual Abuse in Australia and New Zealand*, vol 6, no 1, 2014, p 42.

131 D Finkelhor, R Ormrod & M Chaffin, *Juveniles who commit sex offences against minors*, Office of Justice Programs, U.S. Department of Justice, Washington, 2009, p 4.

- 132 S Hackett, J Phillips, H Masson & M Balfe, 'Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers', *Child Abuse Review*, vol 22, no 4, 2013; S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014, p 37.
- 133 The tendency to minimise or under-respond to girls displaying harmful sexual behaviours is discussed in S Hackett, D Holmes & P Branigan, *Operational framework for children and young people displaying harmful sexual behaviours*, National Society for the Prevention of Cruelty to Children, London, 2016, p 65.
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- 135 Name changed, private session 'Stew'.
- 136 Name changed, private session 'Trent James'.
- 137 Names changed, private session 'Tristan and Bonnie'.
- 138 Name changed, private session 'Elise'.
- 139 I Katz, A Jones, B Newton & E Reimer, *Life journeys of victim/survivors of child sexual abuse in institutions: An analysis of Royal Commission private sessions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 97.
- 140 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, pp 36–9. See also DM Vandiver & G Kercher, 'Offender and victim characteristics of registered female sexual offenders in Texas: A proposed typology of female sexual offenders', *Sexual Abuse: A Journal of Research and Treatment*, vol 16, no 2, 2004; L Miller, 'Sexual offenses against children: Patterns and motives', *Aggression and Violent Behavior*, vol 18, no 5, 2013.
- 141 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016; see also M Tardif, N Auclair, M Jacob & J Carpentier, 'Sexual abuse perpetrated by adult and juvenile females: An ultimate attempt to resolve a conflict associated with maternal identity', *Child Abuse & Neglect*, vol 29, no 2, 2005.
- 142 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 30: The response of Turana, Winlaton and Baltara, and the Victoria Police and the Department of Health and Human Services Victoria to allegations of child sexual abuse*, Sydney, 2016, p 8.
- 143 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 30: The response of Turana, Winlaton and Baltara, and the Victoria Police and the Department of Health and Human Services Victoria to allegations of child sexual abuse*, Sydney, 2016, p 37.
- 144 Royal Commission into Institutional responses to Child Sexual Abuse, *Report of Case Study No 7: Child sexual abuse at the Parramatta Training School for Girls and the Institution for Girls in Hay*, Sydney, 2015, pp 13–14.
- 145 Royal Commission into Institutional responses to Child Sexual Abuse, *Report of Case Study No 7: Child sexual abuse at the Parramatta Training School for Girls and the Institution for Girls in Hay*, Sydney, 2015, p 15.
- 146 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 30: The response of Turana, Winlaton and Baltara, and the Victoria Police and the Department of Health and Human Services Victoria to allegations of child sexual abuse*, Sydney, 2016, pp 17–9; Royal Commission into Institutional responses to Child Sexual Abuse, *Report of Case Study No 7: Child sexual abuse at the Parramatta Training School for Girls and the Institution for Girls in Hay*, Sydney, 2015, pp 33–5.
- 147 A Ferrante, *Police responses to child sexual abuse 2010–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 141, Table 4.9.
- 148 Australian Bureau of Statistics, *4519.0 Recorded Crime, 2015–16: Table 20 - youth offenders, sex and principal offence by age*, Australian Bureau of Statistics, Canberra, 2017.
- 149 Australian Bureau of Statistics, *4519.0 Recorded Crime, 2015–16: Table 20 - youth offenders, sex and principal offence by age*, Australian Bureau of Statistics, Canberra, 2017.
- 150 S Hackett, J Phillips, H Masson & M Balfe, 'Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers', *Child Abuse Review*, vol 22, no 4, 2013.
- 151 D Finkelhor, R Ormrod & M Chaffin, *Juveniles who commit sex offences against minors*, U.S. Department of Justice, Washington, 2009.
- 152 *Crimes Act 1914* (Cth) s 4M; *Criminal Code Act 1995* (Cth) s 7.1; *Children (Criminal Proceedings) Act 1987* (NSW) s 5; *Children, Youth and Families Act 2005* (Vic) s 344; *Criminal Code Act 1899* (Qld) s 29(1); *Criminal Code Act Compilation Act 1913* (WA) s 29; *Young Offenders Act 1993* (SA) s 5; *Criminal Code Act 1924* (Tas) s 18(1); *Criminal Code 2002* (ACT) s 25; *Criminal Code Act* (NT) s 38(1).
- 153 Transcript of W O'Brien, Case Study 45, 20 October 2016 at 21657:36–21658:6.
- 154 See, for example A Ferrante, *Police responses to child sexual abuse 2010–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 137–8, Table 4.8, Figure 5; S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014; D Finkelhor, R Ormrod & M Chaffin, *Juveniles who commit sex offences against minors*, U.S. Department of Justice, Washington, 2009; S Hackett, J Phillips, H Masson & M Balfe, 'Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers', *Child Abuse Review*, vol 22, no 4, 2013. See also Victorian Law Reform Commission, *Sexual offences: Final report*, Victorian Law Reform Commission, Melbourne, 2004, p 461.
- 155 A Ferrante, *Police responses to child sexual abuse 2010–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 138, Figure 5. 'Adolescent peer sexual abuse' is defined in footnote four as being where both the offender and the victim were known to be aged under 18 at the time of the incident, either the offender or victim was aged over 12, and the difference in ages was two years or less.

- 156 JA Hunter, AJ Figueredo, NM Malamuth & JV Becker, 'Juvenile sex offenders: Toward the development of a typology', *Sexual abuse: A Journal of Research and Treatment*, vol 15, no 1, 2003, p 33.
- 157 W O'Brien, *Problem sexual behaviour in children: A review of the literature*, Australian Crime Commission, Canberra, 2008, pp 10–11; S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014, pp 28–30. See also, Transcript of E Letourneau, Case Study 57, 27 March 2017 at 27422:18–45.
- 158 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, pp 26–8.
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- 160 S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014, pp 28–30; W O'Brien, *Problem sexual behaviour in children: A review of the literature*, Australian Crime Commission, Canberra, 2008, pp 13–8; S Hackett, J Phillips, H Masson & M Balfe, 'Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers', *Child Abuse Review*, vol 22, no 4, 2013, p 232–45; R Pratt, 'The clear, the not so clear and the downright confusing: How pornography impacts risk assessment of children and adolescents who sexually harm', ANZATSA Conference, 2015; MAH Horvath, L Alys, K Massey, A Pina, M Scally & JR Adler, *Basically porn is everywhere – A rapid evidence assessment on the effects that access and exposure to pornography has on children and young people*, Office of the Children's Commissioner for England, London, 2013; E Vizard, N Hickey, L French & E McCrory, 'Children and adolescents who present with sexually abusive behaviour: A UK descriptive study', *The Journal of Forensic Psychiatry & Psychology*, vol 18, no 1, 2007, pp 59–73; JA Hunter, AJ Figueredo, NM Malamuth & JV Becker, 'Juvenile sex offenders: Toward the development of a typology', *Sexual Abuse: A Journal of Research and Treatment*, vol 15, no 1, 2003, 27–48; A Gray, WD Pithers, A Busconi & P Houchens, 'Developmental and etiological characteristics of children with sexual behavior problems: Treatment implications', *Child Abuse & Neglect*, vol 23, no 6, 1999, pp 601–621.
- 161 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and harmful sexual behaviours of children in schools*, Sydney, 2017, p 14.
- 162 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and harmful sexual behaviours of children in schools*, Sydney, 2017, p 15.
- 163 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 41. A descriptive typology was developed by M O'Brien & W Bera, 'Adolescent sexual offenders: A descriptive typology', *Preventing Sexual Abuse*, vol 1, no 3, 1986, pp 1–4: the typology classified juveniles who commit sexual abuse into seven categories: naïve experimenters, undersocialised child exploiters, sexual aggressive, sexual compulsives, disturbed impulsives, group influenced offenders and pseudo-socialised. However, when the typologies were used to develop risk assessment instruments, there was no empirical evidence that the seven categories could be distinguished from each other. See also BL Bonner & L Berliner, *Children with sexual behavior problems: Assessment and treatment—Final report*, National Center on Child Abuse and Neglect, Administration for Children, Youth and Families, U.S. Department of Health and Human Services, 1999, pp 31–6. It was noted in M Chaffin, L Berliner, R Block, TC Johnson, WN Friedrich, DG Louis, TD Lyon, IJ Page, DS Prescott & JF Silovsky, 'Report of the ATSA task force on children with sexual behavior problems', *Child Maltreatment*, vol 13, no 2, 2008, p 202 that efforts to distinguish between types of children with harmful sexual behaviours result in substantial overlap, which suggests distinct subtypes may not exist. Lastly, M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, also noted there is some indication that adolescents who abuse younger children may have higher rates of sexual disorders (including paedophilia) or lower social skills than those who abuse children of a similar age, however further investigation is required.
- 164 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 41.
- 165 M Chaffin, L Berliner, R Block, TC Johnson, WN Friedrich, DG Louis, TD Lyon, IJ Page, DS Prescott & JF Silovsky, 'Report of the ATSA task force on children with sexual behavior problems', *Child Maltreatment*, vol 13, no 2, 2008, p 202.
- 166 D Weatherburn, B Lind & S Ku, *Social and economic stress, child neglect and juvenile delinquency*, NSW Bureau of Crime Statistics and Research, Sydney, 1997.
- 167 Royal Commission into Institutional Responses to Child Sexual Abuse, *Treatment of child to child sexual abuse private roundtable*, Sydney, 2015. See also CEASE, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper No 10: Advocacy and Support and Therapeutic Treatment Services*, 2015; Uniting Church in Australia, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper No 10: Advocacy and support and therapeutic treatment services*, 2015.
- 168 W O'Brien, *Problem sexual behaviour in children: A review of the literature*, Australian Crime Commission, Canberra, 2008, p 12; C Veneziano & L Veneziano, 'Adolescent sex offenders: A review of the literature', *Trauma, Violence, & Abuse*, vol 3, no 4, 2002, p 250.
- 169 S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014, p 29; M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 44.

- 170 M Chaffin, L Berliner, R Block, TC Johnson, WN Friedrich, DG Louis, TD Lyon, IJ Page, DS Prescott & JF Silovsky, 'Report of the ATSA task force on children with sexual behavior problems', *Child Maltreatment*, vol 13, no 2, 2008, p 205; M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, pp 41–2; Transcript of E Letourneau, Case Study 57, 27 March 2017 at 27422:25–45.
- 171 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, pp 46, 48.
- 172 Transcript of W O'Brien, Case Study 45, 20 October 2016 at 21655:20–28. See also W O'Brien, *Australia's response to sexualised or sexually abusive behaviours in children and young people*, Australian Crime Commission, Canberra, 2010, pp 14–5.
- 173 Transcript of E Letourneau, Case Study 57, 27 March 2017 at 27422:25–45.
- 174 See for example, W O'Brien, *Australia's response to sexualised or sexually abusive behaviours in children and young people*, Australian Crime Commission, Canberra, 2010, pp 14–5; S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014, pp 39–41; M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, pp 44–5; CEASE, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper No 10: Advocacy and Support and Therapeutic Treatment Services*, 2015, p 1; Uniting Church in Australia, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper No 10: Advocacy and support and therapeutic treatment services*, 2015. The Victorian Department of Human Services case practice model also notes that between around 35 and 50 per cent of children with problem sexual behaviours have experienced physical or emotional abuse, or neglect. J Evertsz & R Miller, *Children with problem sexual behaviours and their families*, Victorian Government Department of Human Services, Melbourne, 2012, p 13. See also Transcript of M Watson, Case Study 45, 3 November 2016 at 22820:28–40. Dr Watson spoke about providing treatment to Aboriginal and Torres Strait Islander children who had harmful sexual behaviours, many of whom have histories of trauma.
- 175 S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014, pp 40–1.
- 176 R Wild & P Anderson, *ampe akelyernemane meke mekarle (Little Children are Sacred): Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, Northern Territory Government, Darwin, 2007, p 63.
- 177 T Moore, M McArthur, S Roche, J Death & C Tilbury, *Safe and sound: Exploring the safety of young people in residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 7.
- 178 See, for example, Children's Protection Society, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper No 10: Advocacy and Support and Therapeutic Treatment Services*, 2015; CEASE, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper No 10: Advocacy and Support and Therapeutic Treatment Services*, 2015; Association of Children's Welfare Agencies, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, Consultation paper: Institutional responses to child sexual abuse in out-of-home care, 2016; Life Without Barriers, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2013.
- 179 Transcript of D Tolliday, Case Study 45, 3 November 2016 at 22819:5–13.
- 180 Transcript of D Tolliday, Case Study 45, 3 November 2016 at 22819:15–19.
- 181 D Tolliday, 'How might sexual behaviour by a child be connected to the child's exposure to violence?', Presentation to the Children's Hospital at Westmead, 2010, www.slideserve.com/cael/how-might-sexual-behaviour-by-a-child-be-connected-to-the-child-s-exposure-to-violence (viewed 17 August 2017).
- 182 KPMG, *Evaluation of New Street Adolescent Services: Final Report*, NSW Kids and Families, Sydney, 2014, p 21.
- 183 Royal Commission into Institutional Responses to Child Sexual Abuse, Treatment of child to child sexual abuse private roundtable, Sydney, 2015; See also CEASE, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper No 10: Advocacy and Support and Therapeutic Treatment Services*, 2015.
- 184 R Pratt, R Miller & C Boyd, *Adolescents with sexually abusive behaviours and their families*, Victorian Department of Human Services, Melbourne, 2012, p 25.
- 185 State of Victoria, *Royal Commission into family violence: Summary and recommendations*, State of Victoria, Melbourne, 2016, p 219. Submissions from the Centre Against Sexual Assault (CASA) Forum, Bendigo Community Health Services and Gippsland Centre Against Sexual Assault advised that family violence is the highest co-occurring factor for children referred to the Sexually Abusive Behaviours Treatment Service (SABTS).
- 186 Transcript of K Flanagan, Case Study 57, 27 March 2017 at 27415:7–23.
- 187 P Staiger, N Kambouropoulos, J Evertsz, J Mitchell & J Tucci, *A preliminary evaluation of the transformers program for children who engage in problem sexual behaviour*, Australian Childhood Foundation, Melbourne, 2005. Eighteen per cent of the 152 children attending treatment were living away from their parents due to risk of family violence, p 30. The backgrounds of the parents were also analysed and 24 per cent reported experiencing domestic violence, p 36.
- 188 D Kenny, K Siedler, T Keogh & A Blaszczyński, *Clinical characteristics of Australian juvenile sex offenders: Implications for treatment*, Collaborative Research Unit, Department of Juvenile Justice, 1999. This study analysed 70 pre-sentence reports of juvenile sex offenders in contact with the New South Wales Juvenile Justice Department for the period 1996 to 1998 with the aim of developing the first developmental and clinical profile of Australian juvenile sex offenders.
- 189 D Kenny, K Siedler, T Keogh & A Blaszczyński, *Clinical characteristics of Australian juvenile sex offenders: Implications for treatment*, Collaborative Research Unit, Department of Juvenile Justice, 1999, Table 2.

190 C Hawkes, 'Description of a UK study of onset of sexually harmful behaviour before the age of ten years in boys referred to a specialist assessment and treatment service', *Child Abuse Review*, vol 20, no 2, 2011. This study found 70 per cent of the children referred to a service for 'sexually harmful behaviour' had been exposed to violence involving caregivers prior to entering treatment, p 86, Table 2.

191 JA Hunter, AJ Figueredo, NM Malamuth & JV Becker, 'Juvenile sex offenders: Toward the development of a typology', *Sexual Abuse: A Journal of Research and Treatment*, vol 15, no 1, 2003, p 33.

192 A Gray, WD Pithers, A Busconi & P Houchens, 'Developmental and etiological characteristics of children with sexual behavior problems: Treatment implications', *Child Abuse & Neglect*, vol 23, no 6, 1999, p 607.

193 A Gray, WD Pithers, A Busconi & P Houchens, 'Developmental and etiological characteristics of children with sexual behavior problems: Treatment implications', *Child Abuse & Neglect*, vol 23, no 6, 1999, p 607.

194 State of Victoria, *Royal Commission into Family Violence: Summary and recommendations*, State of Victoria, Melbourne, 2016, p 238.

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271 Name changed, private session, 'Tony Blake'.

272 Name changed, private session, 'Dermott'.

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 navy and some male boarding schools. These rituals included older children painting the genitals of new recruits with
 boot polish or covering them in heat cream. See, for example, Name changed, private session 'Stew'; Name changed,
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279 Exhibit 51-003, 'Statement of Raymond James Griggs on behalf of the Department of Defence', Case Study 51,
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292 Name changed, private session, 'Cy'.

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294 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 45: Problematic and
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3 Current responses to children with harmful sexual behaviours

3.1 Overview

In this chapter we examine past and current institutional and societal responses to children with harmful sexual behaviours.

Institutions should play a key role in protecting children from harmful sexual behaviours by being alert to the risk of such behaviours and acting to ensure that children with harmful sexual behaviours are supported to stop the behaviours. However, in our public hearings we were told of many institutions that did not protect children from sexual abuse by other children;¹ did not respond effectively to complaints about children displaying harmful sexual behaviours;² and did not provide appropriate support to victims of those behaviours or ensure that the children who had exhibited harmful sexual behaviours received appropriate intervention.³

We believe all problematic and harmful sexual behaviours by children should be acknowledged and taken seriously. These behaviours require a response that is proportionate to the nature of the behaviours displayed and the context in which the behaviours have occurred, as well as the circumstances of the child displaying them.

In this chapter we also set out current government policy with respect to children with harmful sexual behaviours. The Council of Australian Governments (COAG), in the National Framework for Protecting Australia's Children 2009–2020, has recognised the need to address this issue.⁴ However, Australia lacks a consistent, coordinated approach for doing so, with considerable variance in approaches across jurisdictions.⁵

In this chapter we also discuss what we have learned about the current status of systems that can and should respond to children with harmful sexual behaviours. Our suggestions for improvements to these systems are discussed in Chapter 4.

3.2 Institutional responses to children with harmful sexual behaviours

This section outlines what we heard in our public hearings and private sessions about major deficiencies in institutional responses to children who have exhibited harmful sexual behaviours. Institutions play a key role in ensuring children who exhibit harmful sexual behaviours receive help to cease engaging in the behaviours and in reducing the risk they pose to other children. Inappropriate responses from institutions can enable further abuse and can also prevent victims from receiving support. These issues were highlighted in our *Case Study 45: Problematic and harmful sexual behaviours of children in schools (Harmful sexual behaviours of children in schools)*.

Some of the poor institutional responses to children engaging in harmful sexual behaviours that we have identified from our public hearings and private sessions are:

- not identifying that harmful sexual behaviours were occurring⁶
- minimising the harmfulness of the sexual behaviours rather than recognising them as serious matters requiring action⁷
- inadequate institutional policies and procedures for handling complaints about children engaging in harmful sexual behaviours⁸
- not referring children for assessment of their harmful sexual behaviours⁹
- not communicating with affected parties, including parents or carers of the child engaging in the harmful sexual behaviours and the parents or carers of the child victim/s¹⁰
- responding to the harmful sexual behaviours by excluding the victim/s from the institution or isolating them.¹¹

We discuss each of these issues in more detail below. For information on institutional responses to child sexual abuse more generally, see Volume 7, *Improving institutional responding and reporting*, which includes examples of how institutions have responded to child sexual abuse by adult perpetrators.

3.2.1 Not identifying harmful sexual behaviours

In our *Harmful sexual behaviours of children in schools* case study, we heard of the importance of staff in institutions being properly equipped to identify harmful sexual behaviours exhibited by children.¹² However, we also heard of many instances where these behaviours were either not detected or not taken seriously, allowing them to continue and to sometimes escalate.

Our *Harmful sexual behaviours of children in schools* case study considered the case of CLF, who was sexually assaulted by other students at Shalom Christian College in Queensland in 2006, when she was 14 years old. In February that year, CLF was sexually assaulted by a male student at the school.¹³ Staff reported this assault to the principal, Mr Christopher Shirley, but he did not report CLF's allegations to the Child Safety Department, or the Juvenile Aid Bureau of the Queensland Police.¹⁴ In addition, the school recorded the complaint as 'inappropriate behaviour' rather than as sexual assault.¹⁵ One month later, CLF was again sexually assaulted on the Shalom Christian College grounds, this time by a group of four boys.¹⁶ This time the principal notified the Child Safety Officer, who made a report to the police based on information received from the principal. As recorded by the police, the report did not disclose non-consensual or forced sexual activity. Instead, it suggested that the incidents were consensual and that CLF's accounts may be unreliable.¹⁷ CLF's parents told us that they were not notified that CLF had been sexually assaulted in February 2006 until the days leading up to the Royal Commission's public hearing in November 2016. CLF's father, EAM, said he was 'stunned and angry' they weren't informed.¹⁸ EAM's evidence was that he feels that had they known what had happened,

‘we would have taken her away from that place, because of the serious nature of it ... and this other thing wouldn’t have happened’. He also said he would have checked that the school reported the incident to the authorities. CLF’s mother, EAL, told us, ‘if I had know[n] that incident happened, if I’d been given one phone call, my daughter wouldn’t have been there for the second one’.¹⁹

In a private hearing for the same case study, we heard of an incident involving an older student attempting to place a condom on a younger student over their clothing. A parent reported the behaviour of the older student to the principal. The principal discussed the incident with the supervisor from the NSW Department of Education. The principal then reported the incident to the NSW Department of Family and Community Services. We were told that at the time, the principal did not regard the allegations as being ‘overly’ serious. When the principal met with the parent of the child who was subjected to the sexualised behaviour, the principal showed the parent a form that had a list of illegal products on it. We were told the principal said to the parent that condoms were not on the list and that they were therefore ‘considered a legal product to be brought into the school’. The principal later accepted that the child’s sexualised behaviour might indicate that there were other issues that needed to be considered.²⁰

We heard of additional challenges that can arise when harmful sexual behaviours are exhibited by a child with disability. At our private roundtable on schools, experts noted a tendency to ignore or overlook the harmful sexual behaviours of children with communication or cognitive impairment on the basis of their disability.²¹ We also heard that adults in institutions can misinterpret quite innocuous behaviours displayed by a child with disability as harmful sexual behaviours, resulting in the child experiencing unwarranted accusations and interventions.²²

A factor that may contribute to individuals within institutions failing to identify children’s harmful sexual behaviours is a lack of training regarding these behaviours. In our *Harmful sexual behaviours of children in schools* case study, the headmaster of one private school gave evidence that there are no modules relating to children with harmful sexual behaviours in staff training offered within the independent schools system.²³ His evidence was that this gap in training exists even though children’s harmful sexual behaviours are a known and longstanding problem, particularly in boarding schools.²⁴

3.2.2 Concealing, minimising and misinterpreting harmful sexual behaviours

A consistent theme that we heard about from victims and survivors was of institutions denying, minimising, concealing, misinterpreting and ignoring children’s harmful sexual behaviours. Minimising, which we heard about in our *Harmful sexual behaviours of children in schools* case study,²⁵ can include overlooking problematic or harmful sexual behaviours, or incorrectly seeing these behaviours as developmentally appropriate, or ‘child’s play’.²⁶ We heard of individuals within institutions implying that incidents of children displaying harmful sexual behaviours was not abuse – or believing that when incidents became the subject of complaints it meant they were being blown out of proportion.

In a private session, 'Olwyn' told us about the sexual abuse of her six-year-old son 'Peter' by a seven-year-old classmate in the toilets at school.²⁷ 'Olwyn' told us the abuse involved a number of instances of the classmate kissing and licking 'Peter's' penis, and having 'Peter' do the same to him. She told us that when 'Peter' disclosed the abuse to her, she reported it to the school principal. 'Olwyn' said she found the principal's response disturbing. She told us he minimised the harmful sexual behaviours by telling her he understood children's desire to sexually experiment and that it was not surprising in 'Peter's' age group. 'Olwyn' told us the principal said, 'Don't make a big deal out of it'.²⁸

In another private session, 'Felix' told us he was sexually abused by other students at a Victorian boarding school in the 1980s, and that the housemaster threatened him to 'keep quiet' about it.²⁹ 'Felix' told us he experienced bullying at the boarding school from the outset, which, over a three-year period, escalated to sexual abuse. 'Felix' said the abuse culminated in an incident where he was attacked by five boys while he was trying to get back to his room. 'Felix' told us that four boys held him down while the fifth boy anally raped him. He said the housemaster found out about the sexual abuse from one of the boys involved and responded by informing 'Felix' that he and the boys had agreed to keep quiet about what had happened. 'Felix' said the housemaster told him that if he complied with this silence, the housemaster could guarantee he would be given marks of 80 per cent in all of his classes. 'Felix' told us he wanted the incident reported to the police. Instead, the housemaster asked him to sign a contract promising not to disclose what had happened, because 'I can't expel them ... [boys from our school] can't go to jail'. 'Felix' said the housemaster and two lawyers told him they would 'destroy' him and those he cared about if he ever told anyone what had happened.³⁰

We also learned during our inquiry how the trauma and distress displayed by some children with communication impairments who had been sexually abused can be misinterpreted by others as a symptom of their disability.³¹ In Volume 4, *Identifying and disclosing child sexual abuse* we explain in more detail how, in common with all victims of child sexual abuse, victims with disability may withdraw, regress or display signs of anxiety, sudden aggression or sexualised behaviours when they have been sexually harmed.³² When adults misconstrue these behaviours and attribute them to disability rather than recognising them as a sign of distress or trauma, the abuse is not detected. When the trauma arises from harmful sexual behaviours by another child, the child responsible for the abuse is not identified. In these ways, a lack of understanding about disability and the effect of a child's impairment can hinder effective responses to problematic or harmful sexual behaviours by children.

In a private session, 'Charmaine' told us about her experience of a school failing to consider the meaning of the behavioural signs of distress shown by her son, 'Sebastian', who has disability, and limited verbal skills.³³ 'Charmaine' told us that when 'Sebastian' was 12 years old he was sexually abused at his school by another boy, 'Derek'. 'Sebastian's' behaviour deteriorated and he started to spit frequently and to laugh hysterically. 'Charmaine' said she approached 'Sebastian's' school teacher in an attempt to find out what was wrong. However, instead of identifying the behaviours as a sign that 'Sebastian' had been harmed, his school teacher told 'Charmaine' they were probably due to 'Sebastian' going through puberty.

Dissatisfied with this explanation, 'Charmaine' said she questioned 'Sebastian' about whether anything had occurred. She told us: 'I asked 'Sebastian' had anyone touched his penis or put their penis to him or touched him with their penis. And he said, "No, 'Derek' say keep it a secret"'. 'Charmaine' said that when she told him it was okay to tell her, 'Sebastian' said, 'Me say "no, no, no and no" ... but he not listen ... He suck my penis'.

'Charmaine' said she found out that 'Derek' had forced 'Sebastian' to engage in oral sex in the boys' toilets at school on a number of occasions. She told us she reported this to both the school and the police but was disappointed with their responses. 'Charmaine' said the school did not offer any counselling and, when she rang the police, they said it was not worth reporting because the child responsible for the abuse also had developmental delay.

3.2.3 Lack of institutional policies and procedures for complaints about harmful sexual behaviours

We heard from a number of private sessions attendees that staff within institutions did not know what to do when a disclosure or complaint was made about a child sexually harming another child. 'Elise' told us her daughter 'Katie' disclosed that she had been sexually abused by 'Mia', one of her best friends at school. 'Elise' said 'Katie' reported the abuse to her teacher on the day the incident occurred, and the teacher made a mandatory report to the NSW Department of Family and Community Services. 'Elise' said that when she followed up the matter with the school principal a few days later, the principal:

was quite perplexed as to – well, her exact words were, 'I'm waiting for the CEO of the Catholic Education Office to call me. I'm not entirely sure what to do', which really doesn't give you a lot of confidence on this end of the table.³⁴

'Elise' told us she was concerned for both girls but that no leadership was shown by the school in addressing the issues. Further, she said, 'Mia's' family began to intimidate 'Katie', some of the school staff, the principal and other parents. 'Elise' told us, 'as soon as we walked out of that school – you could hear the sigh of relief ...'³⁵

3.2.4 No therapeutic assessment or intervention

As discussed in Chapter 2 of this volume, children with harmful sexual behaviours are a diverse group that may display a spectrum of these behaviours. Depending on the age of the child and the nature of the harmful sexual behaviours, children may require different types of intervention. Practitioners with relevant qualifications and experience should assess children with harmful sexual behaviours to determine the most appropriate intervention for them.³⁶ Despite this, we heard of many cases where institutions did not refer children who had exhibited harmful sexual behaviours to services where they could receive an assessment or appropriate intervention.

We acknowledge that in many instances this may have been because of a lack of services, particularly in regional and remote areas, or a lack of knowledge about the services that were available and how they could be accessed. We discuss this, and other issues with therapeutic treatment, in Chapter 5 of this volume.

In a private session, we heard from 'Nicole' about her daughter, 'Amy', who has autism and attention deficit hyperactivity disorder, as well as learning difficulties.³⁷ 'Nicole' told us that 'Amy' was sexually abused by her only friend at school, 'Natalie', in the mid-2000s. 'Amy' was in Year 6 at the time. 'Nicole' said that on a number of occasions, 'Natalie' took 'Amy' into the toilets at school and undressed her, masturbated and penetrated her. 'Nicole' said that as soon as she found out about 'Natalie's' harmful sexual behaviours, she made a complaint to the school's acting principal, who offered counselling for 'Amy' and asked whether 'Nicole' wanted to press charges against 'Natalie'. 'Nicole' told us her response was:

No, but I want you to investigate what's happening to 'Natalie'. She has knowledge of sexual behaviour practices that are not appropriate for her age. Where does she get that from? ... I want it looked into ... I'm not angry but I'm concerned for her welfare.³⁸

Despite 'Nicole' suggesting that 'Natalie' was in need of assessment and intervention, the school never arranged for this to occur. 'Nicole' told us the school took no further action after her conversation with the acting principal.³⁹

We heard evidence in our *Harmful sexual behaviours of children* case study of institutions not referring children with harmful sexual behaviours for assessment and intervention. As discussed earlier in this section, we heard evidence that CLF was sexually assaulted by four boys while on the grounds of Shalom Christian College in Queensland.⁴⁰ Despite staff at the school becoming aware of this incident, they did not refer the boys responsible for any form of assessment or intervention or arrange a therapeutic assessment or counselling support for CLF or her parents.

3.2.5 Poor communication with parents and carers

In our *Harmful sexual behaviours of children* case study, experts told us about the importance of institutions informing parents or carers when a child is affected by harmful sexual behaviours, either as a victim, a witness or the child causing the harm.⁴¹

We heard of many instances where parents were not told by an institution about their child being sexually harmed by another child. In our *Harmful sexual behaviours of children* case study, we heard evidence that Trinity Grammar School in Sydney became aware that a student, CLA, had been sexually abused by other students, but did not inform CLA's parents. CLA's parents only learned about the abuse a month later, when they were contacted by child protection authorities. In evidence, CLA's father stated:

For a school that prided itself on its pastoral care and its open communications with parents, I think how we found out was appalling. The school should have contacted us directly, as soon as they reasonably knew that something had happened to our son, some four weeks before receiving a phone call from [Department of Community Services].⁴²

In a private session, 'Lorelli' told us about her difficulty in getting any information concerning the sexual abuse of her seven-year-old son, 'David'. 'Lorelli' told us that 'David' was harmed by another child's sexual behaviours in a respite care facility for children with disability. 'Lorelli' said she was not provided with details about the event or the child responsible, and 'David' did not have enough speech to tell her what had happened. She said it took three years and a Freedom of Information request before she was able to obtain basic details about the incident and who was responsible. She told us she was then able to access a file note that indicated 'David' had been found naked in another boy's room with the other boy lying on top of him. Until she accessed this file note 'Lorelli' had thought the abuse had been perpetrated by a staff member, and that the child protection department was trying to protect him. 'Lorelli' stated: 'When the incident happened in the beginning they didn't even contact me ... it even took them three years to even say, "Yeah, we have acknowledged it". Why three years?'⁴³

3.2.6 Institutions excluding or isolating victims

We heard of many instances where institutions did not act to ensure the physical safety of either the victim of a child's harmful sexual behaviours or the child who caused harm, or to separate them. We heard that sometimes institutions responded to a child sexually harming another child by excluding the victim from the institution, or isolating them within it.

In a private session, we heard from ‘Cinthia’, who told us how her son ‘James’ was effectively excluded from his school after being sexually victimised by two classmates.⁴⁴ ‘Cinthia’ said the abuse occurred over a number of years but only came to light when ‘James’ became uncharacteristically angry and reluctant to go to school. ‘Cinthia’ told us that she asked ‘James’ to explain why he had hit one of his classmates, which prompted ‘James’ to disclose the abuse, telling her that two boys had been regularly slapping his bottom and grabbing his genital region.⁴⁵ ‘Cinthia’ told us she found out the school was aware of the abuse. However, she said that when ‘James’ told his teacher what was happening, the teacher got all three boys – ‘James’ and the two boys responsible for the abuse – together to talk about it. ‘Cinthia’ told us that this intervention was ineffectual and the abuse continued daily. ‘Cinthia’ said she contacted the school, and although it agreed to put a safety plan in place to separate ‘James’ from the two boys, it did not adhere to the plan. ‘Cinthia’ told us the principal said to her, ‘I know what sexual abuse is – this is not it’.⁴⁶ Eventually the principal suggested that a different school might be more suitable for ‘James’ and withdrew the offer of a place for ‘James’ in an affiliated secondary school.⁴⁷

In our *Harmful sexual behaviours of children in schools* case study we heard about CLF, who was sexually assaulted on the grounds of Shalom Christian College by four male students aged between 15 and 17.⁴⁸ CLF’s father, EAM, told us that the school principal, Mr Christopher Shirley, told him that the boys involved were in ‘lockdown’ at the school and that CLF had been ‘isolated’ and sent to the Crystal Waters Campus ‘for her own safety’. EAM said he understood Crystal Waters to be a place where children were sent when they were ‘mucking up’.⁴⁹ CLF’s mother, EAL, told us that when she first saw CLF after the sexual assault, CLF told her the alleged offenders were walking around the school like nothing had happened.⁵⁰ CLF’s parents withdrew her from Shalom.⁵¹

3.3 Government policies related to children with harmful sexual behaviours

This section outlines current government policy related to children with harmful sexual behaviours. We discuss the Council of Australian Governments’ (COAG’s) National Framework for Protecting Australia’s Children 2009–2020, which explicitly recognises the need to target children’s harmful sexual behaviours as part of a broader strategy to prevent child sexual abuse and child sexual exploitation. We also outline state and territory government policies on children’s harmful sexual behaviours within education, child protection and mandatory reporting systems. We note that while all state and territory governments have policies related to children with harmful sexual behaviours, these policies do not cover primary, secondary and tertiary intervention for these behaviours in a comprehensive manner.

3.3.1 The National Framework for Protecting Australia's Children

The issue of children with harmful sexual behaviours has received national policy recognition under COAG's National Framework for Protecting Australia's Children 2009–2020 (the National Framework).⁵² The National Framework was developed by the Australian Government, state and territory governments and non-government organisations, through the Coalition of Organisations Committed to the Safety and Wellbeing of Australia's Children, and endorsed by COAG in 2009. It sets out Australia's overarching policy for protecting children. It is underpinned by a public health model and its central goal is to reduce child abuse and neglect.

In a public health approach, primary or universal prevention strategies aim to prevent abuse from occurring by providing information and education to the broader community, including to all families and children. Secondary prevention initiatives are more intensive and are focused on the early detection of risk. They are directed at vulnerable and at-risk families and children who have shown signs of needing additional assistance, with an emphasis on providing support as early as possible to help prevent emerging safety issues from escalating. Tertiary interventions are targeted at children and families where a problem has been identified that needs an intensive and tailored response.⁵³

Children with harmful sexual behaviours are explicitly referenced in Strategy 6.2 of the National Framework.⁵⁴ This strategy includes an action item that state and territory governments, with federal government support for research, should 'Investigate best practice therapeutic programs for children displaying sexually abusive behaviours'.⁵⁵ Strategy 6.2 is intended to contribute to the outcome of preventing child sexual abuse and sexual exploitation.⁵⁶

The National Framework is being implemented through a series of three-year action plans. The First Action Plan ran from 2009 to 2012 and COAG identified as one of its key outcomes a report that was published in 2010.⁵⁷ This report mapped existing therapeutic intervention services available to children with harmful sexual behaviours across the country and identified a range of impediments to providing comprehensive, specialist therapeutic intervention services to children with harmful sexual behaviours in Australia. These included an overburdened sector that remains unregulated and, in some locations, lacking a commitment to specialised training, supervision, accreditation, evaluation and ongoing research on best practice. The challenges felt by the sector also stem from a broader lack of awareness about the issue in professional contexts and in Australian society more generally. The report identified the need to address geographic and demographic gaps in the provision of tertiary services, including residential therapeutic services.⁵⁸

3.3.2 Current state and territory government policies

We asked state and territory governments for information and materials about current policies applicable to children with harmful sexual behaviours. Each jurisdiction responded with information about policies, programs and initiatives operating across the various government departments of education, health and human services, corrective services and family and community services.

Despite the existence of the National Framework, Australian jurisdictions have not yet adopted a nationally consistent approach to preventing, identifying and responding to children with problematic and harmful sexual behaviours. Every jurisdiction has incorporated the issue of children with harmful sexual behaviours into its policies in some way, but the nature and scope varies considerably and, as yet, there is minimal evidence of their effectiveness. No state or territory government has a comprehensive and coordinated policy approach for preventing, identifying and responding to children with harmful sexual behaviours. Most of the information and materials provided to us related to education, child protection and mandatory reporting to child protection authorities, which we discuss in the following section. Further work is needed to consolidate and coordinate knowledge about the best approach to prevention and intervention for harmful sexual behaviours by children.

Education policies

Primary prevention policies and initiatives to prevent child sexual abuse are aimed at all members of the community but particularly children, young people, parents and carers. Primary prevention can increase awareness and understanding of appropriate and inappropriate sexual behaviours, help people to recognise early warning signs that children may be at risk, and generally increase the capacity to respond effectively if harmful sexual behaviours do emerge.⁵⁹ We discuss in detail the importance and effectiveness of primary prevention within the public health approach for preventing child sexual abuse in Volume 6, *Making institutions child safe*.

In response to our request, all Australian state and territory jurisdictions provided us with information and/or materials regarding policies and programs that – while not explicitly addressing children’s harmful sexual behaviours – could reasonably be expected to contribute to the prevention of such behaviours. These policies and programs are administered primarily through the states’ and territories’ education departments, and are either incorporated into the school curriculum or delivered by specialist non-government organisations such as Bravehearts, the National Association for Prevention of Child Abuse and Neglect and Safe4Kids.

Most of these schools-based education initiatives are focused on issues such as personal safety and protective behaviours, relationships and sexuality. Examples of some of the education policies and programs that could reasonably be expected to contribute to the prevention of harmful sexual behaviours behaviour are:

- The New South Wales Department of Education’s mandatory Personal Development, Health and Physical Education curriculum. A new K–10 syllabus is under development and teachers currently teach K–6 and 7–12 syllabuses.⁶⁰ These syllabuses include components in which students are taught strategies for responding to potential sexual abuse, including from peers and older children. The curriculum includes age-appropriate materials related to establishing and maintaining non-coercive relationships and strengthening attitudes and values related to equality, respect and responsibility. Support materials to assist teachers of students with high support needs include guidance on dealing with sensitive issues, such as appropriate touch.⁶¹
- The Western Australian Department of Education Student Behaviour Policy requires schools to document and implement a plan to support positive student behaviour.⁶² In its response to us, the Department stated that the Student Behaviour Policy encourages schools to use positive educational responses to promote socially appropriate behaviour and to minimise or eliminate harmful sexual behaviours – and that students displaying misconduct (which would include harmful sexual behaviours) must be provided with the individualised support needed for them to learn appropriate social behaviour.⁶³
- The Queensland Department of Education developed a program in partnership with the Daniel Morcombe Foundation for schools to adopt, in consultation with the school community. The Daniel Morcombe Child Safety Curriculum aims to teach children from Year 2 through to Year 9 about personal safety and awareness, with several of the lesson plans presenting scenarios involving children displaying harmful sexual behaviours.⁶⁴

We have very little data on the effectiveness of these policies and programs, or whether they cater to the needs of children with disability. Further details on child sexual abuse prevention policies and curricula in Australian school systems is discussed in Volume 6, *Making institutions child safe*, and in the research reports referred to in the chapter.⁶⁵

In Chapter 4 of this volume we discuss education as part of a primary prevention strategy for children with harmful sexual behaviours, and we outline our suggestions for improving the system.

Child protection (including mandatory reporting) policies

There is considerable variation in the extent to which children's harmful sexual behaviours are incorporated into each jurisdiction's child protection policy framework. Children displaying harmful sexual behaviours is an emerging policy issue. We are encouraged by the information provided by some jurisdictions that suggests the issue is starting to be addressed in a more comprehensive way. Some of the resources that have been developed and implemented by governments to specifically address how to respond to children's harmful sexual behaviours include:

- The Department of Family and Community Services in New South Wales includes children's harmful sexual behaviours as both an indicator of abuse and a potential category of child sexual abuse within its Mandatory Reporter Guide.⁶⁶ It has developed guidelines specifically for responding to a child or young person who has displayed sexually abusive behaviour towards another child or young person.⁶⁷ The Department's practical kit for child protection practitioners to identify, understand and respond to child sexual abuse includes a dedicated chapter on working with children who display harmful sexual behaviours.⁶⁸
- South Australia's Department for Education and Child Development has developed resources jointly with Catholic Education South Australia and the Association of Independent Schools of South Australia for staff and volunteers in education and childcare settings. These include guidelines for recognising and responding effectively to incidents of problematic sexual behaviours involving children and young people,⁶⁹ and guidelines on protective practices for staff who are interacting with young people.⁷⁰
- The Victorian State Government Child Protection Manual includes standalone policies and procedures, and advice and protocols for addressing allegations, investigations and related processes involving children with harmful sexual behaviours.⁷¹ It also provides practice tools to guide practitioners working with children with problematic sexual behaviours and their families,⁷² and adolescents with sexually abusive behaviours and their families.⁷³

Child protection responses may be necessary and appropriate for children with harmful sexual behaviours, particularly if the behaviours demonstrate that they or other children are at risk of harm and there are no adults present who can provide support and protection. However, child protection is typically a reactive and overstretched system that has some inherent limitations. We believe child protection should not be the focus of government and community attention for children with harmful sexual behaviours. Rather, we believe that expertise and funding should be directed towards prevention and early intervention to address children's harmful sexual behaviours. In our *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts (Nature, cause and impact of child sexual abuse)*, Ms Karen Flanagan, a child protection specialist with Save the Children Australia, advocated for more to be spent in early intervention:

mandatory protection ... protects a very narrow part of our population ... ratcheting up mandatory reporting or employing more people who are doing the frontline is not, in my opinion, going to protect more children.⁷⁴

We suggest that governments expand on their current policy frameworks and ensure a range of interventions are available to address children's harmful sexual behaviours, aligned to the varying levels of need and risk that different behaviours present.⁷⁵ In Chapter 4 of this volume, we outline how a public health approach to prevention can be applied to improve the response to children with harmful sexual behaviours.

We further discuss the child protection system response to children with harmful sexual behaviours in Australia in Section 3.4.3 of this volume.

3.4 Current systems that can respond to children with harmful sexual behaviours

Children require support to establish sexual behaviours that are healthy for their stage of development, and to address any underlying trauma that has contributed to their behaviour. There is:

a wealth of research that indicates that early life and family experiences are very important to development, and that many young people who display sexually harmful behaviour have experienced abuse at some stage, whether sexual, physical, emotional or neglect.⁷⁶

Child-safe institutions should have policies and procedures that outline how staff and volunteers should respond to allegations and incidents of children displaying harmful sexual behaviours, particularly when those behaviours are directed towards another child.

There are several systems, separate to and outside of institutions in which harmful sexual behaviours may have occurred, that can and should respond when a child exhibits harmful sexual behaviours. These include systems for:

- therapeutic intervention
- child protection
- criminal justice.

It should be noted that some children who display harmful sexual behaviours do not receive any of these responses, for reasons discussed in Section 3.4.1.

Therapeutic intervention, child protection and criminal justice system responses may overlap, and a child with harmful sexual behaviours may need and may receive more than one of these responses.

Most institutions will interact with the child protection and criminal justice systems – either voluntarily or through formal and statutory arrangements – when they respond to a child with harmful sexual behaviours.

In this section we briefly outline what we have learned about how these systems currently respond to children with harmful sexual behaviours. The responsibility for administering, funding and delivering these systems sits with the state and territory governments rather than the Australian Government. Consequently, there are differences in how these systems are structured and how they operate. We have not provided a detailed breakdown by jurisdiction but we have, where relevant, highlighted key differences.

In Chapter 4 of this volume we outline how these systems might be improved.

3.4.1 No response or intervention

We can assume that some children who exhibit harmful sexual behaviours receive no response from any of the systems that are currently able to respond. There are a number of reasons for this, including:

- Under-reporting. As we outlined in Volume 2, *Nature and cause*, child sexual abuse is in general under-reported. As is the case for child sexual abuse perpetrated by adults, data on the extent of children sexually abusing other children is limited and is not uniformly collected across jurisdictions. Little is known about the extent of harmful sexual behaviours by children that are undetected, unreported or do not meet the criminal threshold. Research suggests that less than 30 per cent of all sexual assaults on children are reported.⁷⁷ Only a minority of children who have experienced child sexual abuse tell their parents or carers and only a minority of those parents or carers report the abuse to the authorities.⁷⁸ During our inquiry we heard of adults not reporting children exhibiting harmful sexual behaviours in institutional settings to external government authorities.⁷⁹
- Adults, both in institutions and in the broader community, often fail to recognise children's harmful sexual behaviours. They may not understand that harmful sexual behaviours can have serious consequences and that intervention is necessary to ensure the safety of both the child with the behaviours and other children.⁸⁰ We discuss and provide examples of this occurring in an institutional context in Section 3.2 of this volume.
- Ignoring or denying the harmful nature of the behaviours. In some instances adults may know and understand that a child's harmful sexual behaviours are abusive, but actively deny the harm caused. As discussed in Section 3.2.2, in some cases institutions have denied and ignored the harm caused to children by other children's sexual behaviours. The parents or carers of children who have engaged in harmful sexual behaviours may ignore or deny the behaviours because they feel shame or self-blame, or because they may be reluctant to involve the police or welfare authorities.⁸¹

3.4.2 Therapeutic intervention

Chapter 5 of this volume discusses therapeutic assessment and interventions for children with harmful sexual behaviours in detail, including what we have been told about current issues and limitations. We outline what is currently available for children with harmful sexual behaviours, and make a recommendation to improve assessment and both the quality and availability of therapeutic intervention.

3.4.3 Child protection systems

In Australia, it is the state and territory governments that have statutory responsibility for protecting children from child abuse and neglect.⁸² Relevant departments are responsible for the safety and welfare of children who have been or are currently at risk of being physically, sexually, or emotionally abused or neglected, or whose parents or carers are unable to provide adequate care or protection. Departments are legislatively and operationally focused on familial abuse but may respond to allegations of child sexual abuse in institutional settings. The threshold for intervention by child protection authorities differs across jurisdictions.

As we have noted, in a small number of situations a child protection response may be necessary and appropriate for children with harmful sexual behaviours. The child's behaviour may place other children at risk, but, as noted, research tells us that children who exhibit harmful sexual behaviours may also themselves be at risk of harm, or in need of care and protection.⁸³ This may be because of the effects of the behaviours on the child's development. It may also be that harmful sexual behaviours are connected to a history of abuse, exposure to domestic violence, trauma, or neglect.⁸⁴

Children, young people and their families can be referred to various early intervention and family support services as part of or in addition to the child protection response. In this sense, the child protection system could potentially be a pathway to support and access to therapeutic treatment services for some children with harmful sexual behaviours. The information we have received from state and territory governments indicates this is only under a very restrictive set of circumstances and is not widely available. Access to such support is structured differently across different jurisdictions.

In this section we outline the key components of the child protection system relevant to children with harmful sexual behaviours.

Reporting to child protection authorities

Mandatory reporting to child protection authorities

Mandatory reporting laws have been enacted in every Australian state and territory.⁸⁵ Under these laws, certain individuals ('mandatory reporters') must report suspected cases of child abuse and neglect to a nominated government department or agency, which is typically the lead department or agency responsible for child protection. Upon receiving a mandatory report, the nominated department or agency may assess the report, investigate the risk of harm (usually in collaboration with the police if sexual offences are suspected) and take steps to protect the safety and wellbeing of any affected children.⁸⁶

In all states and territories, teachers, doctors, nurses and at least some members of the police force are mandatory reporters.⁸⁷ The inclusion of additional groups of individuals as mandatory reporters, and the threshold required to activate a reporting obligation, varies across jurisdictions. The Northern Territory is the only state where mandatory reporting of child sexual abuse applies to everyone.⁸⁸

In all states and territories, mandatory reporters are required to report child sexual abuse that has occurred or is occurring.⁸⁹ In New South Wales, Victoria, Queensland and the Northern Territory, a mandatory reporter is also required to report where a child is at risk of future abuse by any person.⁹⁰ In South Australia and Tasmania, a mandatory reporter must report risk of future abuse by a household member.⁹¹

The Victorian and Queensland legislation qualifies the obligation to report. In these jurisdictions, a mandatory reporter is only required to make a report if a child is at risk of significant harm and the child's parents or carers have not protected, or are unlikely to protect the child from harm.⁹² Such a qualification can create confusion and uncertainty by requiring the mandatory reporter to assess the parents' or carers' capacity and will to protect the child.

There is no express provision in the mandatory reporting legislation of any state or territory for reporting that a child has exhibited harmful sexual behaviours. Where children sexually abuse other children, the child victims may, but will not always, be the subject of mandatory reports to child protection authorities. A child exhibiting harmful sexual behaviours can be reported under mandatory reporting laws if they are considered at risk of harm from the behaviours, or in need of care and protection for another reason.

For a comprehensive discussion of the legislation and practices for mandatory reporting of child abuse to child protection authorities in each state and territory refer to Volume 7, *Improving institutional responding and reporting*.

Guidance for mandatory reporters

All jurisdictions provide mandatory reporters with some form of written guidance on their reporting duty on the website of their child protection authority. However, the quality and usefulness of this guidance varies by jurisdiction. Common shortcomings include that the guidance is not written in plain English, restates the legislation without providing further information, is outdated and/or is poorly presented. The presence of harmful sexual behaviours is commonly included as one of the indicators that a child may have been sexually abused,⁹³ but is not addressed in every jurisdiction's online resources, either as an indicator of abuse (for the child displaying the behaviours), or a type of abuse (if directed towards another child). Both New South Wales⁹⁴ and Queensland⁹⁵ do include options for reporting children with harmful sexual behaviours in their online mandatory reporter guides.

Some institutions or sectors with staff members who have mandatory reporting obligations to child protection have dedicated units responsible for providing training, guidance and advice to reporters. During stakeholder consultations, we heard about the benefits of these dedicated units.⁹⁶ In Queensland, government school principals can contact one of seven dedicated regional child safety officers for advice on their and their staff members' mandatory reporting requirements.⁹⁷ In New South Wales, Child Wellbeing Units (CWUs) operate in the four government agencies that account for the majority of mandatory reports to the FACS Child Protection Helpline – the NSW Police Force, NSW Health, FACS and the Department of Education.⁹⁸ The CWUs in these agencies advise, support and educate their staff, including by helping them to identify whether a risk of harm to a child or young person warrants a mandatory report.⁹⁹

Dedicated units are more common in the government sector and there is a lack of access to dedicated units or bodies for mandatory reporters who work in the non-government sector.

Voluntary reporting to child protection authorities

Most states and territories have enacted provisions in their child protection legislation that articulate the right and capacity of individuals to make voluntary reports to their child protection authority.¹⁰⁰ The right and capacity to make a voluntary report of child sexual abuse exists whether or not it is enshrined in legislation.

Victoria is the only jurisdiction that expressly provides for reports to be made to the child protection authority about a child (aged from 10 to 14) where the reporter believes that the child has exhibited harmful sexual behaviours and is in need of therapeutic treatment.¹⁰¹ People who make such reports in good faith are protected by legislation against allegations that they have engaged in unprofessional conduct or contravened other obligations to maintain confidentiality.¹⁰²

Once an individual has reported that a child is in need of therapeutic treatment, the Secretary of the Victorian Department of Health and Human Services must, as soon as practicable, investigate the report 'in a way that will best promote the provision of assistance and, where appropriate, therapeutic treatment to the child'.¹⁰³ If the Secretary receives the report from a person other than a police officer, they may refer the matter to the Victorian Therapeutic Treatment Board for advice.¹⁰⁴ On referral, the Therapeutic Treatment Board must provide advice to the Secretary as to whether it is appropriate to seek a therapeutic treatment order in respect of the child and the Secretary must consider this advice.¹⁰⁵ If the Secretary confirms the need for therapeutic intervention, the child and their family can undertake this voluntarily or by order of the Children's Court.¹⁰⁶

These reporting arrangements are linked to a legislative obligation to investigate the harmful sexual behaviours and, where appropriate, to intervene for the purposes of therapeutic intervention.¹⁰⁷ This increases the opportunity to intervene to the benefit of both the child with harmful sexual behaviours and the victims of such behaviours.

Therapeutic orders

New South Wales and Victoria are the only states with child protection laws that specifically recognise the need to respond to children with harmful sexual behaviours with a therapeutic intervention. The legislative frameworks in both states provide grounds for responding with an intervention on the basis of a child's harmful sexual behaviours alone – no other form of harm or risk of harm needs to be identified for eligibility.

The following section discusses the nature and background of the specific provisions in New South Wales and Victoria for therapeutic treatment orders.

New South Wales

The Children's Court of New South Wales may make an order requiring a child under 14 years old to attend a therapeutic program relating to sexually abusive behaviours, and requiring the parents or carers of a child to take whatever steps are necessary to enable a child to participate in a program.¹⁰⁸

The Court may also order the child's parent or carer to attend a therapeutic program relating to sexually abusive behaviours or to attend any other kind of therapeutic program.¹⁰⁹ The therapeutic program may be one that requires a participant to reside at a particular location for part or all of the time the program is being conducted.¹¹⁰

The Court may not make a therapeutic treatment order until it has been presented with and has considered the provisions of a therapeutic plan that outlines the program proposed for the child.¹¹¹ Further, it may not make an order if the child is or has been convicted in criminal proceedings arising from the same sexually abusive behaviours.¹¹²

To the best of our knowledge, there is currently no publicly available evidence about the efficacy of the provisions.¹¹³

Victoria

Child protection laws in Victoria specifically recognise the need to respond to children with sexually abusive behaviours. The *Children, Youth and Families Act 2005* (Vic) makes provision for therapeutic treatment orders for children between the ages of 10 and 15. The Victorian Royal Commission into Family Violence recommended this Act be amended to extend the therapeutic treatment order regime to young people aged 15 to 17 years.¹¹⁴

If a child protection authority determines that a child needs therapeutic treatment following a report relating to harmful sexual behaviours, an application for therapeutic treatment order can be made to the Family Division of the Children's Court of Victoria. The Court can mandate access to treatment in circumstances where a child and their family or carer does not voluntarily seek help. These orders require a child to attend a treatment program; they may also require the child's parent or guardian to take any necessary steps to enable the child to attend the treatment.¹¹⁵

The Children's Court can also make a therapeutic treatment placement order.¹¹⁶ A placement order requires a child to be removed from home, but only where it is necessary to ensure the child's attendance at a treatment program. In the case of Aboriginal and Torres Strait Islander children, placement orders must incorporate a cultural plan for the child.

These provisions do not replace the role of the police in receiving reports and investigating and prosecuting sexual offences. Where a child aged 10 and over has allegedly committed a sexual offence and it is reported to a child protection agency, that agency is still required to report it to the police.¹¹⁷

Care and protection orders

Each state and territory has its own child protection laws that provide for the making of orders designed to protect a child's welfare (that is, care and protection orders).¹¹⁸ There are different legislative criteria for the making of these orders. In jurisdictions other than New South Wales and Victoria, these criteria do not expressly cover children who have harmed others as a result of their sexual behaviours.

New South Wales

In New South Wales the Children's Court may make a care order in relation to a child or young person if it is satisfied that the child or young person is in need of care and protection for any reason including because the child or young person has been, or is likely to be, physically or sexually abused or ill-treated.¹¹⁹ In cases where a child is under the age of 14, the reasons for making a care order may include that the child has exhibited sexually abusive behaviours and an order of the Children's Court is necessary to ensure his or her access to, or attendance at, an appropriate therapeutic service.¹²⁰ If the Secretary of the Department of Family and Community Services is aware that a child between 10 and 13 years of age has exhibited sexually abusive behaviours, the Secretary must inform a police officer of all relevant circumstances before making a decision whether or not to apply for a care order.¹²¹

There is no specific provision for a care order to be made in respect of a child who is aged 14 or over who has exhibited sexually abusive behaviours.

Victoria

In Victoria the Children's Court may make a protection order if it finds that a child is in need of protection.¹²² A child is in need of protection if one of a number of grounds exist.¹²³ These grounds include that the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type; and that the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type.¹²⁴

Another ground is that the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents or carers have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.¹²⁵

It is not clear whether any of these grounds would justify the making of a protection order on the sole basis of a child exhibiting sexualised or sexually harmful behaviours. The Victorian Law Reform Commission reported in 2004 that there was judicial disagreement as to whether the Children's Court was empowered to make a child protection order in relation to a child whose 'need for protection' (the statutory test) was based solely on the fact that the child was sexually abusive.¹²⁶

Other jurisdictions

Protection orders in other states and territories generally require that a child has been harmed or is at risk of harm, is in need of protection, and does not have a parent or parents who can provide adequate care or protection.¹²⁷ For example, in Western Australia a child is considered in need of protection if the child has suffered, or is likely to suffer, harm as a result of the child's parent or parents being unable to provide adequate care or effective medical, therapeutic or other remedial intervention for the child.¹²⁸ In the Northern Territory a court must make a temporary protection order if satisfied that there are reasonable grounds for believing a child is in need of protection and the proposed order is urgently needed to safeguard the wellbeing of the child.¹²⁹ A child is in need of care and protection in defined circumstances, including if the child has suffered or is likely to suffer harm or exploitation because of an act or omission of a parent of the child, or if the child is not under the control of any person and is engaged in conduct that causes or is likely to cause harm to the child or other persons.¹³⁰

The child protection system as a response to children with harmful sexual behaviours

As Professor Louise Newman pointed out in our *Nature, cause and impact of child sexual abuse* case study:

One of the current difficulties is that we have a child protection focus which might be reasonable at identifying risk, but that doesn't translate into clinically informed trauma focused interventions and support. We are not doing much in the way of actually helping people deal with the terrible anxiety they have if they do disclose any of their own risk issues or fears that their children will be removed and we seemingly have a system that really has very limited options because we haven't integrated, in my opinion, a mental health or a therapeutic response with a protective response.¹³¹

The fact that a child has harmful sexual behaviours may not itself meet the relevant statutory criteria for reporting to child protection authorities or for a care and protection order. Orders generally require that the child has been harmed or is at risk of harm.¹³²

This means that, in most states and territories, there is no express legal basis upon which child protection agencies can respond to children with harmful sexual behaviours. Child protection laws in Queensland, Western Australia, South Australia, Tasmania and the Northern Territory provide for care and protection for victims of reported sexual abuse, but do not specifically provide for a child protection response for a child displaying harmful sexual behaviours.

Where a child protection agency determines that a child does not need care or protection, the police have not been involved, and the child is not engaged in the criminal justice process, there is no way to respond to a child's harmful sexual behaviours unless the child's family or carer seeks assistance.

3.4.4 Criminal justice system

We address all aspects of the criminal justice system as it relates to juvenile offenders in our *Criminal justice* report.¹³³ In this section we summarise that chapter and discuss potential limitations of the system as a tertiary response to children with harmful sexual behaviours. These include barriers to charging and convicting children with harmful sexual behaviours, missed opportunities for early intervention where children are dealt with by the criminal justice system and a lack of pathways to therapeutic intervention whether through diversion, sentencing or while children are in detention.

Criminal justice is an important part of the range of responses for children with harmful sexual behaviours. Although only a very small proportion of offences dealt with by Australian courts are juvenile sex offences,¹³⁴ we recognise that serious sexual abuse committed by children may have severe, possibly lifelong consequences for victims, and that juvenile sex offenders can present serious threats against which the community requires protection. The harmful sexual behaviours of some children, particularly as they develop closer to adulthood and when the behaviours are directed towards another child, may warrant a period of detention or other criminal justice responses.

We also recognise that if a child receives a specialist assessment that identifies the appropriate therapeutic interventions for them, harmful sexual behaviours can reduce or cease altogether, and the wellbeing of the child can improve. This may reduce offending and therefore minimise harm. We are of the view that it is far better to identify problematic and harmful sexual behaviours and intervene early to engage the child in therapeutic treatment, rather than waiting until the child or young person has come to the attention of the criminal justice system.

We note that the Australian Defence Force has its own military justice system. In *Case Study 40: The response of the Australian Defence Force to allegations of child sexual abuse* we looked at specific instances of child sexual abuse at HMAS Leeuwin; the Army Apprentice School, Balcombe; and the Australian Defence Force Cadets.¹³⁵ It is outside the scope of our Final Report to discuss the military justice system, but recommendations for its improvement were made in the 2011 DLA Piper *Report of the Review of allegations of sexual and other abuse in Defence*.¹³⁶ We make general recommendations about the legal system in our *Criminal justice* report.¹³⁷

Juvenile offenders in the criminal justice system

Only some harmful sexual behaviours by children might potentially constitute criminal offending. In order to meet this threshold:

- the child must be regarded by the law as having criminal responsibility for their actions, and
- the behaviour must constitute the physical element of a criminal offence.

In all Australian jurisdictions, the minimum age of criminal responsibility of a child is 10 years.¹³⁸ That is, children under the age of 10 cannot be charged or prosecuted for acts that would – with the required mental element – constitute crimes.

From the age of 10 until a child turns 14, there is a common law presumption against criminal responsibility.¹³⁹ That is, it is presumed – unless the prosecution proves otherwise – that a child in this age group does not possess the necessary knowledge or capacity to know that his or her conduct was wrong.¹⁴⁰

Diversiory methods

Formal court proceedings are not the only option for dealing with offences committed by children. Diversion from the criminal justice system may occur at different points within the system, such as police contact, pre-court meetings, and court-ordered alternatives to detention.¹⁴¹ Diversiory methods may be set out in legislation or organisational initiatives, such as police guidelines or pilot projects.¹⁴² In its submission to the Royal Commission, the Law Council of Australia informed us that:

research has also shown that diverting young children away from the criminal law system has the most beneficial results in terms of reducing recidivism, and it follows that society benefits more from keeping young children away from the criminal law system than putting them into it.¹⁴³

Legal academics Kate Warner and Lorana Bartels observe that:

In accordance with article 40.3 of the Convention on the Rights of the Child and rule 11 of the Beijing Rules, which create a preference for diversion over formal judicial proceedings, there is a strong emphasis on diversion in each of the Australian jurisdictions.¹⁴⁴

Typically, diversion is used for less serious offences, and it is not available in most jurisdictions for serious indictable offences, including serious sexual offences.

One of the main methods used to divert young people away from formal court proceedings is police cautioning. Cautioning may either be formal or informal, and may be regulated by legislation or by administrative guidelines. Typically, a formal caution involves the young person admitting the conduct and then the police officer giving the young offender a warning at the police station in the presence of a family member.¹⁴⁵ Typically, cautioning is only available for minor offences at the discretion of the police officer, with few exceptions.¹⁴⁶

Youth justice conferencing is a model of restorative justice that aims to assist the young person to understand the impact of their actions by facilitating a meeting between the young person and members of the community who have been affected by their actions, including the victim if they wish to attend. Youth justice conferencing is generally available in all states and territories for juvenile offending, although it may not be available for sexual offences by juveniles.¹⁴⁷

Young people may be diverted from the criminal justice system into therapeutic treatment programs.¹⁴⁸ In the period before a child is charged and subject to criminal court proceedings, diversion into these programs appears to be a largely discretionary practice directed by police and community services.¹⁴⁹ Victoria is the only jurisdiction with legislation directed at diverting children with sexually abusive behaviours from the criminal justice system by encouraging or requiring them to participate in therapeutic treatment programs. We discuss the Victorian model in more detail in our *Criminal justice* report¹⁵⁰ and in Section 5.3.4 of this volume.

Prosecution

Charges will be laid where an allegation is not considered appropriate for diversion. Prosecution guidelines exist to assist police and public prosecutors to decide whether the suspected criminal offence will be the subject of prosecution.¹⁵¹ In most states and territories, there are prosecution guidelines and policies that set out special considerations that apply to the prosecution of juveniles.¹⁵²

All states and territories make provision for treating children who are prosecuted for criminal offences as juveniles rather than as adults. While the terminology and definitions vary, in each state and territory other than Queensland, children under 18 years of age are treated as juveniles in the criminal justice system.¹⁵³ In Queensland, children under 17 years of age are treated as juveniles in the criminal justice system.¹⁵⁴

The Children's Courts have broad jurisdiction to hear and determine allegations of sexual offences committed by children; however, where a matter is heard will depend on the specific offence or charge, and some jurisdictions refer the most serious sexual offences to an adult court.¹⁵⁵

Courts that exercise criminal jurisdiction with respect to children are required by legislation to adhere to principles specific to the sentencing of children in most circumstances, other than serious offences in some jurisdictions.¹⁵⁶

While there are differences between states and territories, generally court processes may be modified where a juvenile is being prosecuted. The court may have an obligation to explain the proceedings to the child, and proceedings will generally follow the simpler procedures applying in the lower courts (magistrates or local courts), even for more serious offences. The proceedings may take place in a closed court and there may be greater restrictions on publishing the proceedings.¹⁵⁷

Sentencing

The purposes and principles of sentencing are discussed in our *Criminal justice* report.¹⁵⁸ Certain elements of those purposes and principles are given greater or lesser weight in sentencing juveniles.

Historically, under the common law, the rehabilitation of a young offender was given more weight than considerations such as punishment and general deterrence.¹⁵⁹ However, the circumstances of a case, such as the seriousness of the offence or the adult-like behaviour of the child,¹⁶⁰ could bring the balance of these principles closer to their application to adult offenders.

Article 40(1) of the United Nations Convention on the Rights of the Child requires parties to recognise the right of every child who is accused or convicted of a criminal offence to be treated in a manner consistent with ‘the desirability of promoting the child’s reintegration and the child’s assuming a constructive role in society’.¹⁶¹

Rehabilitation of the offender is the central focus of juvenile sentencing provisions in Australia. Legislation in each state and territory provides that detention is to be viewed as a measure of last resort when sentencing a juvenile offender.¹⁶²

There are a number of policy considerations underlying this requirement, including the view that incarceration increases the chances of recidivism – and reduces the prospects of rehabilitation – by placing juvenile offenders who may have committed less serious offences in an environment with more serious offenders. Detention is also regarded as being more stressful for children than adults due to their greater vulnerability to both physical and emotional harm. The Australian Law Reform Commission has identified that detention can have serious social and developmental consequences for children.¹⁶³

Where a child is tried and sentenced in the Children’s Court jurisdiction (or a higher court exercising the Children’s Court’s jurisdiction), there are usually sentencing options available to the Children’s Court under separate legislation to the relevant jurisdiction’s sentencing legislation for adults (and juvenile offenders that fall within the adult jurisdiction).¹⁶⁴ Where a juvenile offender is tried in a higher court because the charged offences are excluded from summary jurisdiction, or otherwise because of the severity of the offences committed, the relevant higher court may have more sentencing options available to it.¹⁶⁵

The non-custodial options available to courts when sentencing juvenile offenders include:¹⁶⁶

- cautions
- fines
- conferences
- community service
- supervision orders.

For further detail see our *Criminal justice* report.¹⁶⁷

In the 2015–16 financial year, community service and supervision orders were the most commonly imposed form of sentence for juvenile sex offenders, accounting for 37 per cent of sentences imposed for juvenile sex offenders, compared with 25.3 per cent of sentences for all offences.¹⁶⁸

Community service and supervision orders are regarded as the most onerous sentencing option after a detention or custodial order. The comparatively high rate of use of such orders in relation to sexual offences suggests that juvenile sexual offending is treated more seriously than many other offences committed by juveniles.

Sanctions that are commonly imposed on both adult and young offenders – such as good behaviour bonds, probation, and community service – are examples of community service and supervision orders. In some jurisdictions there are also community-based supervision orders that can only be imposed on juvenile offenders.¹⁶⁹ The focus on rehabilitation in sentencing juvenile offenders is most apparent in these orders, which combine the punitive effect of restrictions on liberty with elements focused on rehabilitation, such as attendance at specified programs.

These orders provide courts with alternatives to detention that may offer significant benefits for juvenile offenders in terms of their reintegration into society.¹⁷⁰

Detention

In all Australian states and territories it is open to the courts to sentence juvenile offenders to a period of detention in a youth detention facility.

Custodial sentences are imposed on juvenile offenders when no other sentencing option is considered appropriate. A custodial sentence is more likely to be imposed for juvenile sexual offenders than for juvenile offenders generally.¹⁷¹

In general, offenders under 18 are detained in separate facilities to adult detainees, although there are variations across jurisdictions.¹⁷² In some jurisdictions, juveniles may be ordered to serve their detention in an adult correctional facility.¹⁷³

While community-based supervision may be considered to be more effective for rehabilitation purposes, there is also supposed to be a significant focus on rehabilitating young offenders who are sentenced to full-time detention.

Juvenile justice agencies in states and territories may provide case management services that are intended to enhance rehabilitation by having a caseworker provide individual attention to an offender. The stated aim of these services is to involve the child in decisions about suitable educational, vocational and recreational programs tailored to the needs of the child.¹⁷⁴ Offence-specific rehabilitation programs, including those that target sexual offending, may be provided in detention centres.¹⁷⁵

The criminal justice system response to children with harmful sexual behaviours

As already noted, a minority of children with harmful sexual behaviours will receive a criminal justice response.¹⁷⁶ In some instances, a criminal justice response is inappropriate because the child who caused sexual harm to another child is below the minimum age to be held criminally responsible for their actions. Children aged under 10 cannot be charged or prosecuted because the law considers them to be incapable of forming the required state of mind to commit any crime. For children between 10 and 13 years of age, the prosecution must prove the accused child undertook the harmful actions and that he or she understood that these actions were seriously, criminally wrong (as opposed to, for example, being merely ‘rude’ or ‘naughty’). Evidence other than the seriousness of the conduct itself is required. We discuss the law on *doli incapax* in our *Criminal justice* report.¹⁷⁷

Even where children are old enough to be deemed criminally responsible for their behaviours, they may not be charged with or convicted of a criminal offence. The police agency or department responsible for public prosecutions in the relevant jurisdiction may determine there is inadequate evidence for a prosecution to proceed.¹⁷⁸

Australian and international research over several decades has shown that, of the complaints of child sexual abuse that are reported to police, only a small proportion (between 8 and 15 per cent) result in prosecution and conviction.¹⁷⁹ The statistics are generally lower for juvenile offenders and show a decreasing trend over time in the number of prosecutions finalised.

The Australian Bureau of Statistics data on the finalisation of sex offence cases in the Children’s Courts in the financial year 2015–16 shows that prosecutions against juveniles were more likely to be withdrawn when compared with prosecutions for other offences. Of cases where juveniles were charged and prosecuted for sexual offences, 9.5 per cent resulted in an acquittal, 49.7 per cent were proven guilty and 20.5 per cent were withdrawn by the prosecution. The percentage of sex offence matters withdrawn by the prosecution was more than twice the percentage withdrawn for other matters prosecuted in the Children’s Courts (9.4 per cent).¹⁸⁰

Diversionary options at earlier stages of the criminal justice process (such as cautions and conferencing) are often unavailable for children charged with child sexual offences. In most states and territories a court can order a child charged with a sexual offence to participate in therapeutic intervention only if they are convicted, as a sentencing option.¹⁸¹ Consequently, children with harmful sexual behaviours who come to the attention of the criminal justice system, but are not convicted, are often not eligible for therapeutic treatment that may assist them to cease the behaviours.¹⁸² Victoria is the only jurisdiction in which legislation expressly provides for the diversion of children who are or may be charged with sexual offences to therapeutic treatment.¹⁸³ In Victoria a ‘therapeutic treatment order’ compels a child with harmful sexual behaviours, charged with a sexual offence, to attend a therapeutic intervention program instead of being subject to a criminal proceeding. During sentence proceedings, orders for therapeutic intervention are at the discretion of the courts.

For some children who exhibit harmful sexual behaviours and sexually offend against other children, a criminal justice response can be both appropriate and sufficient to help them cease their behaviours. In the *Nature, cause and impact of child sexual abuse* public hearing Dr Elizabeth Letourneau, Professor at the Johns Hopkins Bloomberg School of Public Health and Director of the Moore Center for the Prevention of Child Sexual Abuse in the US, told us:

It is clear to me from the data that being identified is a potent – being formally identified as having engaged in this behaviour has a potent effect on the future behaviour of children, and there are certainly children – and families, I should say – for whom that serves as a sufficient intervention.¹⁸⁴

For others, a criminal justice response may be appropriate, but will not be sufficient. Dr Letourneau explained:

There are other children and families who will need more intensive services to ensure that they keep their child safe, they do a better job of parenting and surrounding the child with the kind of supervision that he or she may need, but indeed there are adolescents who have engaged in these behaviours for whom limited intervention, if any, would be the way to go.¹⁸⁵

We know that detention alone is unlikely to be an effective response in stopping harmful sexual behaviours from recurring.¹⁸⁶ Research suggests that detaining children in youth detention facilities may increase the likelihood of these children committing further crimes (not limited to sexual offending).¹⁸⁷ Legislation in most states and territories expressly provides that children and young people in detention should have access to ‘medical or other treatment’.¹⁸⁸ However, no specific provision is made for therapeutic intervention for detainees who are exhibiting, or have exhibited, sexually abusive behaviours.

At present, there is a lack of therapeutic intervention programs for children with harmful sexual behaviours who are in youth detention. Apart from Victoria’s Male Adolescent Program for Positive Sexuality (MAPPS),¹⁸⁹ little specialist support is available in youth detention. Also, MAPPS is limited in that it is tailored for boys and not for girls, nor for children with disability. There is also a gap in therapeutic intervention programs delivered in youth detention that are culturally safe for Aboriginal or Torres Strait Islander children or children from culturally or linguistically diverse backgrounds.

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- 91 *Children's Protection Act 1993* (SA) s 10; *Children, Young Persons and their Families Act 1997* (TAS) s 14(2)(b).

- 92 *Child Protection Act 1999* (Qld) s 13E(2)(b); *Children, Youth and Families Act 2005* (Vic) s 162(1).
- 93 See, for example, the Australian Capital Territory guide on reporting abuse and neglect, which lists ‘Sexually explicit behaviour, play or conversation inappropriate to the child or young person’s age’ and ‘Inappropriate or excessive masturbation’ as indicators of sexual abuse: Child and Youth Protection Services, *A guide to reporting child abuse and neglect in the ACT*, ACT Government Publishing Services, Canberra, 2014, p 7; and the South Australia guidance for mandatory reporters which includes ‘inappropriate sexual behaviour based on the child’s age’, ‘promiscuous affection seeking behaviour’ and ‘excessive masturbation which does not respond to boundaries or discipline’ as possible indicators of sexual abuse: Government of South Australia Department for Child Protection, *Indicators of abuse or neglect*, 2017, www.childprotection.sa.gov.au/reporting-child-abuse/indicators-abuse-or-neglect (viewed 6 June 2017).
- 94 NSW Government, *ChildStory Reporter: Welcome to the NSW Mandatory Reporter Guide*, www.reporter.childstory.nsw.gov.au/s/mrg (viewed 6 June 2017).
- 95 Queensland Department of Communities, Child Safety and Disability Services, *Online Child Protection Guide*, 2017, www.communities.qld.gov.au/childsafety/partners/our-government-partners/queensland-child-protection-guide/online-child-protection-guide (viewed 11 August 2017).
- 96 Royal Commission into Institutional Responses to Child Sexual Abuse, Schools private roundtable, Sydney, 2015.
- 97 Royal Commission into Institutional Responses to Child Sexual Abuse, Schools private roundtable, Sydney, 2015.
- 98 Family and Community Services NSW, *Keep Them Safe Factsheet No 4a: Child Wellbeing Units*, Family and Community Services NSW, 2013.
- 99 Family and Community Services NSW, *Keep Them Safe Factsheet No 4a: Child Wellbeing Units*, Family and Community Services NSW, 2013.
- 100 See for example, *Children and Young People Act 2008* (ACT) s 354; *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 24; *Child Protection Act 1999* (QLD) s 13A; *Children, Youth and Families Act 2005* (Vic) s 28. See also *Children’s Protection Act 1993* (SA) s 12.
- 101 *Children, Youth and Families Act 2005* (Vic) ss 185, 244.
- 102 *Children, Youth and Families Act 2005* (Vic) ss 189(a), (b).
- 103 *Children, Youth and Families Act 2005* (Vic) s 210(1).
- 104 *Children, Youth and Families Act 2005* (Vic) ss 245(2), (3).
- 105 *Children, Youth and Families Act 2005* (Vic) ss 245(6), (7).
- 106 *Children, Youth and Families Act 2005* (Vic) s 248.
- 107 *Children, Youth and Families Act 2005* (Vic) s 210.
- 108 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 75(1).
- 109 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 75(1B).
- 110 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 75(2A).
- 111 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 75(3).
- 112 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 75(2).
- 113 A Shlonsky, B Albers, D Tolliday, SJ Wilson, J Norvell & L Kissinger, *Rapid evidence assessment: Current best evidence in the therapeutic treatment of children with problem sexual behaviour, harmful sexual behaviour, and children who have sexually offended*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 68–9.
- 114 State of Victoria, *Royal Commission into Family Violence: Summary and recommendations*, State of Victoria, Melbourne, 2016, vol II, p 238.
- 115 *Children, Youth and Families Act 2005* (Vic) s 249.
- 116 *Children, Youth and Families Act 2005* (Vic) s 252.
- 117 *Children, Youth and Families Act 2005* (Vic) s 187.
- 118 *Children and Young People Act 2008* (ACT); *Children and Young Persons (Care and Protection) Act 1998* (NSW); *Care and Protection of Children Act* (NT); *Child Protection Act 1999* (Qld); *Children’s Protection Act 1993* (SA); *Children, Young Persons and Their Families Act 1997* (Tas); *Children, Youth and Families Act 2005* (Vic); *Children and Community Services Act 2004* (WA). For commentary, see Child Family Community Australia, *Australian child protection legislation*, Australian Institute of Family Studies, Canberra, 2014.
- 119 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 71.
- 120 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 71(1)(f).
- 121 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 42(1).
- 122 *Children, Youth and Families Act 2005* (Vic) s 274(a).
- 123 *Children, Youth and Families Act 2005* (Vic) s 162(1).
- 124 *Children, Youth and Families Act 2005* (Vic) ss 162(1)(d) and (e).
- 125 *Children, Youth and Families Act 2005* (Vic) s 162(1)(f).
- 126 Victorian Law Reform Commission, *Sexual offences: Final report*, Victorian Law Reform Commission, Melbourne, 2004, p 470.
- 127 *Child Protection Act 1999* (Qld) s 10; *Children and Community Services Act 2004* (WA) s 28(2); *Care and Protection of Children Act* (NT) s 20; *Children’s Protection Act 1993* (SA) s 6(2); *Children, Young Persons and Their Families Act 1997* (Tas) s 4. In the Northern Territory a protection order could be made on the sole ground that a child was exhibiting sexually abusive behaviours, but only if the child is not under the control of any person and is engaged in conduct that causes or is likely to cause harm to the child or other persons.
- 128 *Children and Community Services Act 2004* (WA) s 28(2)(d).
- 129 *Care and Protection of Children Act* (NT) s 105(1).
- 130 *Care and Protection of Children Act* (NT) ss 20(a) and (d).

Transcript of L Newman, Case Study 57, 30 March 2017 at 27786:41–27787:4

For example, under s 10 of the *Child Protection Act 1999* (Qld), a child must have suffered or be suffering significant harm, or at risk of suffering harm, and the child's parents are unable or unwilling to protect the child; under s 42 of the *Children, Young Persons and their Families Act 1997* (Tas), a child must be at risk of being or likely to be abused or neglected.

Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017, pp 387–473.

Of a total of 602,759 defendants for all criminal matters finalised in Australian criminal courts in 2015–16, only 684, or 0.1 per cent, were defendants in sexual assault and related matters finalised in Children's Courts: Australian Bureau of Statistics, *4513.0 – Criminal Courts, Australia, 2015-16 Table 1 Defendants finalised, Summary characteristics by court level, 2008–09 to 2015–16*, 2016, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4513.02015-16?OpenDocument (viewed 29 August 2016).

Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 40: The response of the Australian Defence Force to allegations of child sexual abuse*, Sydney, 2017.

Appendix 35: The ADF military justice and administrative systems (Catherine Cawte and Craig McConaghy) in GA Rumble, M McKean & D Pearce, *Report of the Review of allegations of sexual and other abuse in Defence: Facing the problem of the past*, Commonwealth of Australia, Canberra, 2011, pp 599–645.

Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice*, Sydney, 2017.

Crimes Act 1914 (Cth) s 4M; *Criminal Code Act 1995* (Cth) sch 1 (*Criminal Code* (Cth)) s 7.1; *Children (Criminal Proceedings) Act 1987* (NSW) s 5; *Children, Youth and Families Act 2005* (Vic) s 344; *Criminal Code Act 1899* (Qld) sch 1, cl 29(1); *Criminal Code Act Compilation Act 1913* (WA) Appendix B, sch 1, cl 29; *Young Offenders Act 1993* (SA) s 5; *Criminal Code Act 1924* (Tas) sch 1, cl 18(1); *Criminal Code 2002* (ACT) s 25; *Criminal Code Act* (NT) sch 1, cl 38(1).

For New South Wales, see *Treffiletti & Ors v Robinson & Anor* (Unreported, Supreme Court of New South Wales, Woodward J, 9 February 1981); *DK v Rooney*, (Unreported, Supreme Court of New South Wales, McInerney J, 3 July 1996); *R v CRH* (Unreported, Supreme Court of New South Wales Court of Criminal Appeal, Smart, Newman and Hidden JJ, 18 December 1996); *R v LMW* [1999] NSWSC 1343. For Victoria, see *R v ALH* [2003] VSCA 129; (2003) 6 VR 276. For South Australia, see *The Queen v M* (1977) 16 SASR 589. The presumption is enshrined in legislation in the other jurisdictions: *Crimes Act 1914* (Cth) s 4N; *Criminal Code* (Cth) s 7.2; *Criminal Code* (Qld) s 29(2); *Criminal Code* (WA) s 29; *Criminal Code* (Tas) s 18(2); *Criminal Code 2002* (ACT) s 26; *Criminal Code* (NT) s 38(2).

The presumption against criminal responsibility for children from the age of 10 until they turn 14 varies slightly between the jurisdictions that have established the presumption by legislation. It is generally based on either the child's actual knowledge that his or her conduct was wrong or on the capacity to know: G Urbas, 'The Age of Criminal Responsibility', *Trends and issues in crime and criminal justice*, vol 181, 2000, pp 3–4.

C Cunneen & RD White, *Juvenile justice: Youth and crime in Australia*, 5th edn, Oxford University Press, Oxford, 2015, p 346.

C Cunneen & RD White, *Juvenile justice: Youth and crime in Australia*, 5th edn, Oxford University Press, Oxford, 2015, p 347.

Law Council of Australia, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Criminal justice*, 2016, p 30.

K Warner & L Bartels, 'Juvenile sex offending: Its prevalence and the criminal justice response', *UNSW Law Journal*, vol 38, no 1, 2015, p 58.

K Warner & L Bartels, 'Juvenile sex offending: Its prevalence and the criminal justice response', *UNSW Law Journal*, vol 38, no 1, 2015, p 58.

K Warner & L Bartels, 'Juvenile sex offending: Its prevalence and the criminal justice response', *UNSW Law Journal*, vol 38, no 1, 2015, p 58. Warner and Bartels observe that Victoria operates differently when cautioning young offenders because cautions are governed by operational instructions rather than legislation. Victoria Police will only consider a caution for sexual or related offences in exceptional circumstances and will obtain advice as to suitability from the Manager of the Sexual Crimes Squad.

See for example *Youth Offenders Act 1997* (NSW) s 8 which largely excludes sexual offences from the Act; *Young Offenders Act 1993* (SA) ss 4, 8 which only allows police to refer 'minor offences' for a family conference.

In New South Wales, the New Street Program provides counselling services to children and young people aged 10 to 17 years with sexually abusive behaviour, where that behaviour has been investigated and confirmed by JIRT or NSW Family and Community Services, and the child must not be currently engaged with the juvenile justice system. KPMG, *Evaluation of New Street adolescent services: Final report*, NSW Kids and Families, Sydney, 2014, pp 1, 29.

We have been told by the New South Wales Police Force, and by legal professionals who undertake defence work in relation to juvenile offenders, that police divert juvenile offenders to treatment on a case by case basis: Information provided by the New South Wales Police Force to the Royal Commission into Institutional Responses to Child Sexual Abuse by email dated 17 February 2017; Legal Aid NSW, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Criminal justice*, 2016, p 27.

Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017.

We discuss the decision to prosecute in our Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice*, Sydney, 2017, pp 272–80.

See, for example, *Statement of Prosecution Policy and Guidelines 2005* (WA), p 11; *Prosecution Guidelines* (NT), Guideline 10.6; *Statement of Prosecution Policy & Guidelines 2014* (SA), p 8; *Prosecution Guidelines* (NSW), Guideline 19.

NSW: 'child' *Children (Criminal Proceedings) Act 1987* (NSW) s 3; Vic: 'child' *Children, Youth and Families Act 2005* (Vic) s 3(1); Qld: 'child' *Youth Justice Act 1992* (Qld) s 6 and sch 4; WA: 'young person' *Young Offenders Act 1994* (WA) ss 3, 4; SA: 'youth' *Young Offenders Act 1993* (SA) s 4; Tas: 'youth' *Youth Justice Act 1997* (Tas) s 3; ACT: *Magistrates Court Act 1930* (ACT) s 288 (giving the Children's Court jurisdiction); NT: 'youth' *Youth Justice Act* (NT) s 6.

154 *Youth Justice Act 1992* (Qld) s 6 ‘child’ and sch 4.

155 In New South Wales, the Children’s Court has jurisdiction to hear and determine any offence by a child other than a serious children’s indictable offence: *Children (Criminal Proceedings) Act 1987* (NSW) ss 3, 28. Children charged with serious sexual offences are generally referred to the District Court of New South Wales: *District Court Act 1973* (NSW) s 166; *Criminal Procedure Act 1986* (NSW) s 46. The District Court of New South Wales is to deal with the child found guilty of a serious indictable offence according to law, and alternatives to sentencing, such as cautions and conferences, are not available for those serious offences: *Children (Criminal Proceedings) Act 1987* (NSW) s 17; *Young Offenders Act 1997* (NSW) s 8. In Victoria, the Children’s Court has jurisdiction over all sexual offences: *Children, Youth and Families Act 2005* (Vic) s 516. In Queensland, the Children’s Court has jurisdiction for all indictable offences involving a child generally: *Youth Justice Act 1992* (Qld) s 99, sch 4; *District Court of Queensland Act 1967* (Qld) s 61. The Western Australian Children’s Court has exclusive jurisdiction to hear and determine offences alleged to have been committed by a child: *Children’s Court of Western Australia Act 1988* (WA) s 19. In South Australia, the Youth Court has broad jurisdiction to hear and determine cases of child sexual abuse by a youth, with some exceptions: *Young Offenders Act 1993* (SA) ss 4, 17. A youth charged with an indictable offence can be dealt with in the same manner as an adult: *Young Offenders Act 1993* (SA) ss 17(3)(b), (c). In Tasmania, the Youth Justice Division of the Magistrates Court has jurisdiction to hear and determine a charge against a youth under the age of 18 years: *Youth Justice Act 1997* (Tas) ss 3, 161(1). Where an offender is at least 14 years of age and under 18 years, serious sexual offences must be dealt with in the Supreme Court: *Youth Justice Act 1997* (Tas) ss 3, 161. In the Australian Capital Territory the jurisdiction of the Children’s Court includes any offence not carrying a maximum penalty of life imprisonment: *Magistrates Court Act 1930* (ACT) ss 288(1)(a), (b). The Northern Territory Youth Justice Court has exclusive jurisdiction over all charges in respect of summary or indictable offences allegedly committed by a youth: *Youth Justice Act* (NT) s 52(1)(a).

156 For example, in Western Australia, s 7 of the *Young Offenders Act 1994* (WA) sets out 13 principles in performing functions under the Act (including the functions of courts in criminal court proceedings).

157 A Hemming, ‘Chapter 130, VII, (11): Criminal proceedings against children and young persons’ in *Halsbury’s Laws of Australia*, LexisNexis, Sydney, 2017.

158 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017.

159 S Beckett, L Fernandez & K McFarlane, *Provisional sentencing for children*, NSW Sentencing Council, Sydney, 2009, p 22.

160 S Beckett, L Fernandez & K McFarlane, *Provisional sentencing for children*, NSW Sentencing Council, Sydney, 2009, p 22.

161 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990), art 40(1).

162 *Children (Criminal Proceedings) Act 1987* (NSW) s 33(2); *Children, Youth and Families Act 2005* (Vic) s 410(1)(c); *Youth Justice Act 1992* (Qld) s 150(2)(e); *Young Offenders Act 1994* (WA) s 120; *Young Offenders Act 1993* (SA) s 23(4); *Youth Justice Act 1997* (Tas) ss 5(1)(g), 80; *Children and Young People Act 2008* (ACT) s 94(1)(f); *Youth Justice Act 1992* (NT) s 81(6).

163 Australian Law Reform Commission, *Seen and heard: Priority for children in the legal process*, Australian Government Publishing Service, Sydney, 1997, [20.1].

164 The different sentencing options for eligible juvenile offenders are discussed in detail in Chapter 37.8 of Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017, pp 387–467.

165 For example, in Victoria, higher courts with jurisdiction (generally the County and Supreme Courts) may sentence a child under either the *Children, Youth and Families Act 2005* (Vic) (with some sentencing restrictions) or the *Sentencing Act 1991* (Vic). The sentencing of the juveniles in *R v AEM Snn*; *R v KEM*; *R v MM* [2002] NSWCCA 58 (13 March 2002) 37.8 of Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017, pp 391, 455, 458, 467 is an example of the approach to sentencing juveniles in the higher courts in New South Wales.

166 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017, pp 425–439.

167 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017, pp 425–439.

168 Australian Bureau of Statistics, *4513.0 – Criminal Courts, Australia, 2015–16: Defendants proven guilty*, 2017, www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4513.0~2015-16~Main%20Features~Defendants%20proven%20guilty~5, Table 10 (viewed 22 May 2017).

169 Examples of community-based supervision orders are the Youth Supervision Order (YSO) and Youth Attendance Order (YAO) in Victoria, and the Youth Community-Based Order (YCBO) and Intensive Youth Supervision Order (IYSO) in Western Australia. These are discussed in more detail in Chapter 37.8 of Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017, pp 431, 459–60.

170 Australian Law Reform Commission, *Seen and heard: Priority for children in the legal process*, Australian Government Publishing Service, Sydney, 1997, [19.41].

171 In 2011–12, 15.7 per cent of juvenile sexual offenders were sentenced to custody in a detention centre compared with 6.1 per cent of juvenile offenders in general. See Australian Bureau of Statistics, *4513.0 – Criminal Courts, Australia, 2011–12*, Children’s Courts, Australia, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4513.02011-12, Table 8, [viewed 29 August 2017].

172 For example, in New South Wales, a court may order that a person under the age of 21 who has been sentenced to a term of imprisonment serve the sentence as a juvenile offender: *Children (Criminal Proceedings) Act 1987* (NSW) s 19. There is a similar provision in Victoria, which applies if the court is satisfied that there are reasonable prospects for the rehabilitation of the offender or that the offender is particularly impressionable, immature or likely to be subjected to undesirable influences in an adult prison: *Sentencing Act 1991* (Vic) s 32. In Victoria, children between the ages of 10 and 14 may be sentenced to be detained at a youth residential centre, while offenders between the ages of 15 and 21 may be detained in a youth justice centre: *Children, Youth and Families Act 2005* (Vic) ss 411, 412.

173 For example, in Victoria, the Youth Parole Board may transfer a detainee aged 16 or older to an adult prison where the person has engaged in conduct that threatens the good order and safe operation of the youth justice centre and cannot be properly controlled in a youth justice centre: *Children, Youth and Families Act 2005* (Vic) s 467.

174 Australian Law Reform Commission, *Seen and heard: Priority for children in the legal process*, Australian Government Publishing Service, Sydney, 1997, [20.43].

175 Youth programmes are summarised at Australian Institute of Health and Welfare, *Youth justice supervision in the states and territories*, 2017, www.aihw.gov.au/youth-justice/states-territories (viewed 1 August 2017). Examples include the Victorian Male Adolescent Program for Positive Sexuality (MAPPS): Victorian Department of Human Services, *Male Adolescent Program for Positive Sexuality – MAPPS*, 2011, www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/programs/youth-specific/male-adolescent-program-for-positive-sexuality-mapps (viewed 23 August 2017); Griffith Youth Forensic Services in Queensland: Griffith Youth Forensic Service, *GYFS overview*, 2017, www.griffith.edu.au/criminology-law/griffith-youth-forensic-service/gyfs-information/gyfs-overview (viewed 23 August 2017).

176 As noted by the Victorian Law Reform Commission, *Sexual offences: Final report*, Victorian Law Reform Commission, Melbourne, 2004, pp 468–9, only one in seven reports of sexual offences against children by children resulted in any charge being laid. Reasons for this include that the child is presumed criminally incapable or police consider a conviction unlikely because of the difficulties associated with child witnesses providing statements.

177 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017.

178 See, for example, Victorian Law Reform Commission, *Sexual offences: Final report*, Victorian Law Reform Commission, Melbourne, 2004, p 469.

179 J Cashmore, A Taylor, R Shackel & P Parkinson, *The impact of delayed reporting on the prosecution and outcomes of child sexual abuse cases*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 34.

180 Australian Bureau of Statistics, *4513.0 – Criminal Courts, Australia, 2015–16*, 2017, www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4513.0~2015-16~Main%20Features~Defendants%20finalised~4, Table 4 (viewed 20 August 2016).

181 W O’Brien, *Australia’s response to sexualised or sexually abusive behaviours in children and young people*, Australian Crime Commission, Canberra, 2010, p 47.

182 W O’Brien, ‘Youth Justice: challenges in responding to young people convicted of sexual offences’, *Deakin Law Review*, vol 16, no 1, 2011, pp 133–54, pp 142–4.

183 *Children, Youth and Families Act 2005* (Vic).

184 Transcript of E Letourneau, Case Study 57, 27 March 2017 at 27470:34–47.

185 Transcript of E Letourneau, Case Study 57, 27 March 2017 at 27470:34–47.

186 K Richards, ‘What makes juvenile offenders different from adult offenders’, *Trends and issues in crime and criminal justice*, vol 409, 2011, pp 6–7. This report discusses the criminogenic nature of incarceration, where prisons are seen as ‘universities of crime’ and inmates learn new ways to offend from other inmates. Richards states that the criminogenic influence of detention settings may be especially true for children, who are more susceptible to peer influence.

187 K Richards, ‘What makes juvenile offenders different from adult offenders’, *Trends and issues in crime and criminal justice*, vol 409, 2011, pp 6–7. ‘It is widely recognised that some criminal justice responses to offending, such as incarceration, are criminogenic; that is, they foster further criminality. It is accepted, for example, that prisons are ‘universities of crime’ that enable offenders to learn more and better offending strategies and skills, and to create and maintain criminal networks. This may be particularly the case for juveniles, who, due to their immaturity, are especially susceptible to being influenced by their peers’.

188 See, for example, *Children and Young People Act 2008* (ACT) s 180(2)(d); *Youth Justice Act 1992* (Qld) s 253(5) and sch 1, cl 19(f); *Youth Justice Act 1997* (Tas) s 129(1); *Children, Youth and Families Act 2005* (Vic) s 482(2).

189 Exhibit 51-11, ‘Response to the Royal Commission’s request relating to therapeutic treatment services or programs’, Case Study 51, DHS.3001.012.0001 at 0009.

4 Improving responses to children with harmful sexual behaviours

4.1 Overview

We have identified numerous issues with existing institutional, governmental and formal systems that respond to children with harmful sexual behaviours.

At the institutional level these include:

- not understanding children's harmful sexual behaviours well enough to identify or take them seriously
- not referring children for therapeutic assessment and interventions
- inadequate institutional policies to guide staff in responding appropriately to incidents of sexual abuse by another child.

State and territory policies regarding children with harmful sexual behaviours have developed in response to the needs of different sectors, with some policies more comprehensive than others.¹ Overall, Australia lacks a comprehensive overarching framework to guide formal systems and individual institutions and practitioners on how to provide effective, consistent responses to children with harmful sexual behaviours. We believe governments should take leadership in this area.

Children with problematic and harmful sexual behaviours are a diverse group and their behaviours fall across a broad spectrum, from lower-level behaviours that may not harm other children through to highly coercive and abusive behaviours that can and do cause much harm. In addition, each child with harmful sexual behaviours has their own background, situation and circumstances that should be considered when responding.

We are of the view that Australia should adopt a public health approach as an overarching framework for preventing and responding to children with harmful sexual behaviours, both within institutions and in the broader community. Children with problematic and harmful sexual behaviours need access to interventions that align with the public health model (spanning primary, secondary and tertiary intervention) so that the response they receive can be tailored to the behaviours they have exhibited, their situation and background, and the institution in which the behaviours occurred.

In this chapter we outline primary and secondary prevention strategies in a public health model. Tertiary intervention strategies, particularly assessment and therapeutic intervention, are discussed in Chapter 5 of this volume.

4.2 Framing a range of interventions

4.2.1 The public health approach to prevention

In Volume 6, *Making institutions child safe* we detail what we have learned and our recommendations related to creating child safe communities through prevention. In that volume we recommend that Australia apply the public health approach to the prevention of child sexual abuse. The public health approach is an established model that has been applied in many countries to address child protection issues.² We believe a public health model can be applied in Australia to address and prevent problematic and harmful sexual behaviours exhibited by children.

Responding to the complex issues involved in child sexual abuse and harmful sexual behaviours by children require multiple, complementary initiatives.³ We are of the view that community-based initiatives, delivered concurrently with changes to institutional policies and procedures and the provision of effective therapeutic interventions, can build a robust system to address the issue of harmful sexual behaviours exhibited by children.

The public health approach to prevention is typically described as three levels of intervention: primary, secondary and tertiary. When the model is tailored to the issue of children with harmful sexual behaviours, those three levels of intervention can be described as follows:⁴

- **Primary prevention** aims to prevent child sexual abuse through interventions across the Australian population, regardless of risk. Prevention for problematic and harmful sexual behaviours by children may include initiatives to address broader societal and institutional factors that enable harmful sexual behaviour by children. Children's safety initiatives, child safe institutions and protective behaviours education are included in this category.
- **Secondary prevention**, or early intervention, aims to prevent harmful sexual behaviours by identifying and working with children at higher risk of harmful sexual behaviours, including working with children displaying lower-level problematic sexual behaviours to prevent those behaviours from escalating into more high-risk harmful sexual behaviours. Such interventions may include training for staff in institutions to help them recognise at-risk children and know how to react and respond when they notice and identify harmful sexual behaviours displayed by children. They may also include education strategies for the child and their parents or carers.
- **Tertiary intervention** is applied after harmful sexual behaviours have occurred. It is designed to prevent recurrence and minimise the harm associated with child sexual abuse. Tertiary intervention initiatives include the assessment of children who have exhibited harmful sexual behaviours and tailored therapeutic services for individual children and their parents or carers. Therapeutic, child protection and criminal justice interventions fall within the category of tertiary intervention.

Experts at our private roundtable on the topic of therapeutic interventions for children with harmful sexual behaviours told us they endorse a prevention approach for addressing the issue, but said that there is very little focused activity around prevention initiatives for problematic and harmful sexual behaviour by children.⁵

We believe the public health approach to prevention provides a useful overarching framework for governments to organise and direct resources to children with problematic and harmful sexual behaviours. This approach would ensure that attention is directed to prevention as well as tertiary intervention.

4.2.2 A range of interventions

As discussed in Chapter 2, children may exhibit a wide variety of sexual behaviour problems. The spectrum ranges from problematic sexual behaviours that are limited to harming the child displaying those behaviours, in terms of their own development, to violent and abusive behaviours that victimise other children, adults or animals. Behaviours can be as divergent as an eight-year-old masturbating excessively, compared to a group of teenagers sexually assaulting a younger child. Because of this broad spectrum of behaviours, we believe a wide variety of interventions should be available so that individual children can access those that best fit their behaviours, needs and situation.

In England, the absence of a national strategy led to what has been described as a ‘patchy and relatively uncoordinated’ response to children and young people with harmful sexual behaviours.⁶ To address this situation, two not-for-profit organisations focused on promoting child safety, the National Society for the Prevention of Cruelty to Children and Research in Practice, developed a framework of guidelines to promote coordinated, multi-agency responses to children’s harmful sexual behaviours.⁷ This framework points to the need for a ‘continuum of responses’ whereby children with harmful sexual behaviours undergo assessment to identify the best way to address concerning behaviours.⁸ Under this framework, responses range from parental education in strategies to help the child, through to specialist therapeutic interventions for the most complex cases.⁹ The framework is intended to help practitioners gain a better understanding of the issues related to children with harmful sexual behaviours and to reduce practitioners’ anxiety about how to address these problems.¹⁰

We propose that a similar range of interventions be made available for children in Australia. The range of interventions available should align with the public health framework to span prevention, early intervention and tertiary responses for children who have exhibited, or are at risk of exhibiting, harmful sexual behaviours. We are of the view that this range of interventions would allow responses to be better targeted to children’s particular behaviours, situations and contexts.

Figure 10.2, as follows, shows a range of interventions for children with harmful sexual behaviours that can span the public health framework.

Our proposed range of interventions includes those in the area of criminal justice. These responses should be available when the severity of harm and continuing risks from a child's behaviours make this appropriate, and where children who meet the legal requirements for criminal responsibility have engaged in harmful sexual behaviours that meet the criminal threshold for offending.

In our *Criminal justice* report we discuss how the criminal justice system can better deal with children who sexually offend.¹¹ In addition, Chapter 5 of this volume discusses the role of the criminal justice system as a potential pathway to therapeutic intervention for some children with harmful sexual behaviours who would otherwise not have access to therapeutic services. We consider how to improve access to, and delivery of, effective therapeutic interventions for children who have sexually offended, to prevent recurrence of harm.

Recommendation 10.1

The Australian Government and state and territory governments should ensure the issue of children's harmful sexual behaviours is included in the national strategy to prevent child sexual abuse that we have recommended (see Recommendations 6.1 to 6.3)

Harmful sexual behaviours by children should be addressed through each of the following:

- a. primary prevention strategies to educate family, community members, carers and professionals (including mandatory reporters) about preventing harmful sexual behaviours
- b. secondary prevention strategies to ensure early intervention when harmful sexual behaviours are developing
- c. tertiary intervention strategies to address harmful sexual behaviours.

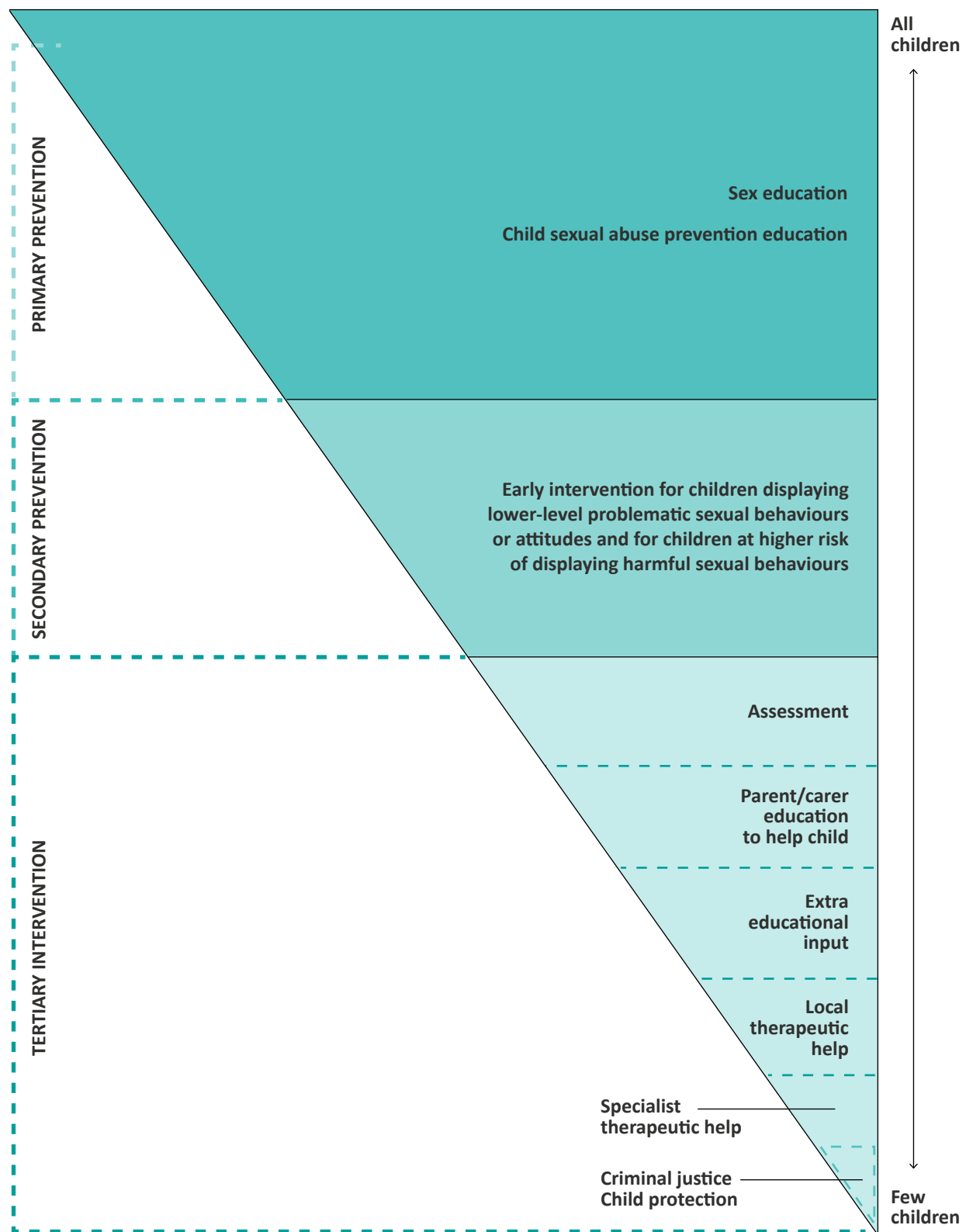


Figure 10.2 – A range of interventions for children with problematic and harmful sexual behaviours that span the public health approach to prevention

4.2.3 Australian Government leadership

Child safety, which includes protecting children from other children's harmful sexual behaviours, requires national leadership. There should be a coordinated national effort to prevent these behaviours and to prevent their recurrence when they have taken place. The Australian Government's response should drive a range of multi-agency interventions across all states and territories, with a coordinated, interdisciplinary response from relevant agencies.

The first action plan of the National Framework for Protecting Australia's Children 2009–2020 called for an investigation into best practice therapeutic responses to sexually abusive behaviours by children.¹² This was conducted in 2010 and mapped specialised therapeutic services available in Australia 'designed to effect positive behavioural change and thus divert young people with sexualised behaviours from the juvenile justice system'.¹³ The report paid particular attention to accessibility of services for Aboriginal and Torres Strait Islander children.

We are of the view that the National Framework for Child Safety we recommend in Volume 6 (see Recommendation 6.15) should incorporate specific reference to problematic and harmful sexual behaviours exhibited by children. The National Framework for Child Safety should explicitly address prevention initiatives as well as the need for therapeutic responses.

4.2.4 Collaboration

Children with harmful sexual behaviours interact with a range of institutions. These institutions may include child protection services, the police, health and mental health services, disability services, therapeutic treatment services, juvenile justice agencies and specific institutions in which a child has exhibited harmful sexual behaviours. We heard that interaction with multiple institutions is especially likely to be the case for children who have complex needs that cannot be addressed by a single agency.¹⁴ We are of the view that, where appropriate, agencies working to achieve primary and secondary prevention of and tertiary interventions for harmful sexual behaviours should collaborate with one another.¹⁵

Experts told us that collaboration is particularly important in complex situations involving a number of stakeholders, such as when children exhibit harmful sexual behaviours in a school context.¹⁶ In the United Kingdom, as noted, the National Society for the Prevention of Cruelty to Children has published a framework specifically to support coordinated multi-agency responses to children with harmful sexual behaviours.¹⁷ The framework argues that 'There is an obvious need for a more coordinated and consistent approach to the issue, that recognises both the risks and needs of children displaying harmful sexual behaviours'.¹⁸

The New South Wales Government submission to our consultation paper in relation to criminal justice suggested that a number of institutions have significant roles to play in responding to the issue of children with harmful sexual behaviours, and suggested that ‘clarity of practice across institutions about what steps are appropriate and necessary is important’.¹⁹

We have heard that children with disability, Aboriginal and Torres Strait Islander children and children from culturally and linguistically diverse backgrounds are often excluded from mainstream services providing therapeutic interventions for harmful sexual behaviours, or that the behaviours are not addressed because the services are not yet able to provide culturally safe or appropriately tailored interventions.²⁰ For example, in our consultations an expert told us children with disability can have problems finding a service willing to take them:

I think that there is quite a bit of fear around providing supports and services ... I have seen all too often that there is an understanding or belief held that there has to be expertise in working with people with intellectual disability before a practitioner can take on a referral for a child or young person with intellectual disability.²¹

Agencies responding to children with harmful sexual behaviours who are children with disability, Aboriginal or Torres Strait Islander children, or children from culturally and linguistically diverse backgrounds should work collaboratively with other service providers as appropriate.

As outlined in Chapter 2, many children who have exhibited harmful sexual behaviours have had contact with other agencies prior to the behaviours being identified.²² Where appropriate, agencies responding to children’s harmful sexual behaviours should engage with any other service providers already supporting the children involved.

4.3 Primary prevention

Primary prevention initiatives target the general community. They are aimed at preventing harmful sexual behaviours from arising in any children, and improving community awareness and understanding of harmful sexual behaviours. In this section we outline the key primary prevention initiatives that should be available to deal with the issue of children’s harmful sexual behaviours.

4.3.1 Improving community awareness and identification of harmful sexual behaviours

As discussed in Chapter 2 of this volume, there is a lack of awareness and understanding of the problem of children’s harmful sexual behaviours in the general community. This can mean that the behaviours are not identified as harmful or not recognised in the early stages. This can result in an inappropriately minimal or inappropriately excessive response. As noted by Dr Wendy O’Brien, expert on children with problematic or harmful sexual behaviours in schools: ‘where there is insufficient knowledge about childhood sexual development, and what is and is not appropriate, there is a tendency to either “catastrophise or minimise” the behaviours’.²³

We believe that efforts should be made to improve the community's understanding of children's harmful sexual behaviours, to increase identification of these behaviours, to support early help-seeking and referral and to enable adults to react and respond in a way that is proportional to the behaviours that have occurred. In *Case Study 45: Problematic and harmful sexual behaviours of children in schools (Harmful sexual behaviours of children in schools)* we heard that a community education initiative could build on the positive change that has come about as a result of the work of the Royal Commission. As Dr O'Brien observes:

with the Royal Commission, we're actually at a juncture where we could potentially change the narrative and start to do the community education that is required and that will elicit the sensitive and respectful responses that have in mind the safety and wellbeing of both children with these behaviours but also children that are subjected to them ...²⁴

Community education should be delivered to all adults and children. This education should outline the differences between developmentally appropriate and harmful sexual behaviours by children. The education should be non-stigmatising and should help children to differentiate between appropriate and harmful sexual behaviours by providing them with clear guidance about appropriate sexual behaviours, expectations and norms.

More easily accessible general guidance on the differences between healthy and harmful sexual behaviours for children would also assist adults to respond appropriately to lower-level problematic sexual behaviours. It would ensure that adults do not respond unnecessarily to behaviours that are developmentally appropriate and that they do not have a disproportionate response to lower-level behaviours. This form of guidance has been provided in the form of 'traffic light' tools, developed by practitioners, which illustrate and explain differences between healthy and harmful sexual behaviours in children.²⁵ Governments could build on these or similar resources to provide more comprehensive information. This additional information could include: why children may engage in harmful sexual behaviours; the impacts of the behaviours on victims; and guidance on services and supports that are available for both victims and children with harmful sexual behaviours.

We believe the Australian Government and state and territory governments should ensure that community education about harmful sexual behaviours is delivered across all jurisdictions and is accessible to all communities. This community education should incorporate the experiences of, and produce material relevant to, diverse populations, taking into account factors such as gender, age, cultural context and disability.

In Volume 6, *Making institutions child safe* we recommend the Australian Government, in partnership with state and territory governments, develop and implement a national strategy for child sexual abuse prevention. This national strategy should include initiatives designed to reach all Australians to raise awareness, increase knowledge and change problematic attitudes related to child sexual abuse, and to promote and direct people to related prevention initiatives, information and help-seeking services. We recommend that this proposed national strategy include efforts to address children's harmful sexual behaviours (see Recommendation 10.1).

4.3.2 Child sexual abuse prevention education

Child sexual abuse prevention education programs provide information and training to children and their parents and carers on preventing child sexual abuse.²⁶ Programs targeted at children are designed to equip them with skills to protect themselves from sexual abuse and to encourage help-seeking if abuse has occurred. Programs for parents and carers aim to equip them with the skills to support their children to apply what they have learned.

Child sexual abuse education programs should incorporate content that is designed to prevent children being sexually abused by other children. These programs should cover:

- the impact that harmful sexual behaviours can have on children who are the victims of these behaviours
- the factors that may contribute to children exhibiting harmful sexual behaviours
- how to recognise and protect against children's harmful sexual behaviours in both physical and online settings, with reference to factors such as consent, equality and coercion in relationships between children
- where to go for support if a child is victimised or is at-risk of being victimised by another child
- how children can support a peer who discloses that another child has harmed them.²⁷

Programs for children

We have heard that adequate child sexual abuse prevention education is not currently available to most children. An audit we commissioned of primary school-based sexual abuse prevention policies for children aged five to 12 years found that no Australian school system had a standalone child sexual abuse prevention policy and one-third of the audited school systems had no publicly available child protection policy. Only a small minority of school systems promoted the teaching of child sexual abuse prevention by including directives within the base child protection policy.²⁸ Even where mainstream sex education is available, the material may not be available in appropriately tailored or culturally safe formats for children with disability,²⁹ Aboriginal and Torres Strait Islander children,³⁰ and children from culturally and linguistically diverse backgrounds.³¹

We believe all children should receive child sexual abuse prevention education. The programs need to be evidence-based and delivered by appropriately skilled people. Content should be tailored so it meets the needs of all children, including children with disability, Aboriginal and Torres Strait Islander children and children from culturally and linguistically diverse backgrounds. Programs should be regularly evaluated to ensure they deliver their intended outcomes.

In Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts (Nature, cause and impact of child sexual abuse), Professor David Finkelhor, a sociologist specialising in research on child sexual abuse, told us that the very existence of such education programs for children is preventative because it dissuades perpetrators:

[Youth-focused education programs] are rather effective in promoting safety in organisations as well, because when potential perpetrators know that children in these organisations have gotten this kind of training, they recognise that it's going to be hard to keep these children quiet if they do do something, so they are deterred in that way as well.

[These programs] operate on all these levels, they are relatively low cost, they can be combined with a variety of other prevention topics and modalities, and ... the evidence shows that children learn the concepts, they acquire the skills, that disclosure does actually occur when they have been exposed to these topics, that the learning is sustained over time and that there is reduced perpetration as well as reduced victimisation.³²

We are of the view that, as an important part of the preventative approach to children with harmful sexual behaviours, sex education programs for children should address the issue of pornography and its impact on children's attitudes around sexuality, gender and relationships.³³ Programs like this are currently available to some children.³⁴

In addition to child sexual abuse prevention education delivered to children through schools, community education can be delivered through other institutions. Activities are currently being undertaken by a number of organisations including the National Rugby League³⁵ and the Australian Football League.³⁶ We are also aware of other community education programs such as the Sex and Ethics Program.³⁷ These programs assist young people, particularly boys, to develop decision-making skills that demonstrate care towards themselves and others, including potential sexual partners.

For a broader discussion of child sexual abuse prevention education, see Volume 6, *Making institutions child safe*.

Programs for parents and carers

Through our consultation processes, stakeholders identified that child sexual abuse prevention education programs for parents and carers are a priority.³⁸ Research indicates that parents and carers often have inadequate knowledge and resources to educate their children effectively about sexual abuse.³⁹ Research also suggests that children learn more when teachers and parents or carers are the instructors of sex education.⁴⁰

Five state governments – New South Wales, Victoria, Queensland, Western Australia and South Australia – provided the Royal Commission with copies of, or information about, resources available to parents and carers regarding children’s harmful sexual behaviours:

- In coordination with optional programs developed or adopted in Queensland schools, a range of eLearning, video and written resources is made available by the Queensland Government to parents and carers regarding sexual behaviours and respectful relationships.⁴¹
- The South Australian Government provides fact sheets to carers to assist in understanding, managing and responding to children’s harmful sexual behaviours.⁴²
- Victoria’s Department of Health and Human Services provides guidance for parents and carers on age-appropriate sexual behaviours for children and what treatments are available.⁴³ It also provides training to kinship and foster carers in managing children’s harmful sexual behaviours.⁴⁴
- Western Australia’s Department for Child Protection and Family Support has an eLearning program for parents and carers on child protection and sexual abuse, and works with high-risk families, in which children are at increased risk of developing harmful sexual behaviour, to address a range of concerns aimed at diverting these cases from the child protection system.⁴⁵ The Western Australian Government also provides funding to a number of service providers that deliver training and workshops, including on topics related to child sexual abuse, respectful relationships and protective behaviours.⁴⁶
- The NSW Department of Family and Community Services provides a practical kit for child protection workers to work with parents and carers to help them respond protectively to their child. Resources are available for parents and carers.⁴⁷ Through its Education Centre Against Violence, NSW Health offers resources for parents and carers and delivers community engagement and education programs relating to sexual assault, child abuse and domestic and family violence for Aboriginal and Torres Strait Islander women, men and communities.⁴⁸

In addition to written resources, the New South Wales and Western Australian governments administer and/or fund generalised education and training programs for parents and carers.

We believe such education programs should aim to give parents and carers the skills to support their children to be able to recognise other children's harmful sexual behaviours and to protect themselves from these behaviours. The programs could also make parents and carers aware of the links between harmful sexual behaviours by children and adverse childhood experiences, including prior exposure to domestic violence and inappropriate sexual activity, as well as children's exposure to pornography. To effectively engage parents and carers, institutions must ensure that prevention education programs are culturally safe and appropriately tailored to all parents and carers.

4.4 Secondary prevention

Research suggests early intervention can be effective in preventing children's problematic sexual behaviours escalating to the point where they cause harm to other children and negatively affect the child's own development.⁴⁹ In our *Harmful sexual behaviours of children in schools* case study, practitioner Ms Sharmaine Williams, speaking in the context of Indigenous boarding environments, told us:

[early intervention] is about giving families and communities the tools, the resources, the support, the training that they need to be able to manage these behaviours before they get to that level ...⁵⁰

Staff in institutional contexts also need the tools, resources, support and training to facilitate early intervention. In their regular and ongoing contact with children, staff in educational or other child-related institutions may witness early instances of problematic sexual behaviours or be the initial point of contact when it is reported.⁵¹ It is important that staff have the skills to react and respond, including ensuring the child receives appropriate assessment and early intervention.⁵²

Training in early intervention should target staff in institutions, students undertaking tertiary education courses in education and human services (such as health, teaching, social services and early childhood education), as well as children and their families. In our *Harmful sexual behaviours of children in schools* case study, Dr O'Brien told us that, in her view, educators were not well trained in responding to children's harmful sexual behaviours:

I think we are unreasonable in our expectations for educators if we assume that the training that they have before they enter their teaching career equips them for [dealing with harmful sexual behaviours] ... So we do need to change, I think, the culture within schools, but that needs to be done in practical ways. I think that increasing the level of knowledge that tertiary-qualified teachers have about child wellbeing would be a good start.⁵³

Dr O'Brien gave evidence that providing pre-service training to teachers on child development and child wellbeing would help teachers identify early warning signs of harmful sexual behaviours, preventing these behaviours from escalating and additional harm being caused.⁵⁴ This was reiterated by Professor Gwynnyth Llewellyn, Director of the Centre for Disability Research and Policy, in the *Nature, cause and impact of child sexual abuse* case study. Professor Llewellyn told us that behaviour issues for children with intellectual disability are frequently attributed to the presence of disability.⁵⁵ She told us that further training is necessary to improve the capacity of the disability, education and human services workforce to respond adequately to these issues.⁵⁶

A broader discussion of early intervention initiatives to address child sexual abuse is contained in Volume 6, *Making institutions child safe*.

4.4.1 Guidance on children's healthy and harmful sexual behaviours

In Chapter 2 of this volume, we described how staff in institutions can face significant issues identifying harmful sexual behaviours exhibited by children in their care. It can be challenging for staff within institutions to identify these behaviours, due to a range of factors, including levels of professional training, experience, social attitudes and values.⁵⁷ Research we commissioned suggests that many professionals working with children, as well as members of the wider community, have limited knowledge about what constitutes healthy and conversely harmful sexual behaviours in children.⁵⁸

A recent Australian study of educators, from primary schools, preschools and childcare facilities across all jurisdictions, found that though they could identify some aspects of healthy and problematic sexual behaviours exhibited by children, the educators' knowledge was not comprehensive.⁵⁹ Most of the participants in this study believed that more education and training should be offered to help teachers identify and respond to children's problematic and harmful sexual behaviours.⁶⁰

In research we commissioned into the safety of children in residential care, the child participants who were consulted felt staff needed to develop a better appreciation of the risks to children of sexual abuse and other harm. They also felt staff should better inform and educate children about potential threats, the help available to them, and how to protect themselves.⁶¹ The education staff provide to children should include information about healthy and developmentally appropriate sexual behaviours, harmful sexual behaviours and risks from adult perpetrators.

We also believe staff need to be watchful and proactive when they are aware that children have been exposed to sexualised abuse or other forms of trauma, such as domestic violence and substance abuse. As we discuss in Section 2.9.1 of this volume, these factors are known to increase the risk of children developing harmful sexual behaviours. As an essential component of early monitoring, staff need to both note that a potentially problematic behaviour has been recognised, and also consider what it means.

We believe the Australian Government and state and territory governments should ensure relevant departments and agencies provide professionals in child-related roles with clear guidance on harmful sexual behaviour by children. Guidance should provide staff with an adequate level of knowledge to distinguish between healthy and harmful sexual behaviours for children who are in their care, and should equip staff to react and respond appropriately when they notice problematic or harmful sexual behaviours. The guidance should be widely distributed and accessible online. A number of resources are currently freely available for this purpose. We do not endorse any particular tool. However, some examples are included at Appendix B.

We believe this type of guidance should be readily accessible for all staff in child-related roles within institutions. Guidance on identifying children's harmful sexual behaviours should be tailored to staff working in different sectors, where relevant. Staff and carers in higher risk environments for children – including out-of-home care, schools, and youth detention settings – should be prioritised in terms of receiving guidance.

In our *Harmful sexual behaviours of children in schools* case study, we heard from Dr Steve Florisson, who was speaking in the context of Indigenous boarding school environments, and who told us that

training by itself is great but it is not enough. You have to have good systems, good policies, good leadership in place, because you can train staff, but if they aren't supported by good leadership, it won't work ...⁶²

In Volume 7, *Improving institutional responding and reporting* we provide guidance on best practice institutional responses to complaints about harmful sexual behaviours by children. Guidance for individuals within institutions about healthy and harmful sexual behaviours can help with the initial components of a best practice response, which are to identify and name harmful sexual behaviours as such, convey to the victims that the harm to them is recognised and tell the child who displayed the harmful sexual behaviours that their behaviour is wrong.⁶³

4.4.2 Targeted secondary prevention

Secondary prevention aims to educate and intervene early with children who are at higher risk of displaying harmful sexual behaviours. The purpose is to prevent behaviours developing or prevent already existing lower-level problematic sexual behaviours from escalating. While primary prevention strategies promote broad awareness of the difference between healthy and harmful sexual behaviours, secondary prevention entails action. Secondary interventions could include targeted education for staff and parents in responding to children who have indicated early signs of problematic sexual behaviours, or specialised training for staff and children in high-risk institutions where behaviour has not yet occurred, but where there are known situational risks.

In our public hearings, private sessions and research we have heard about factors that may contribute to children displaying harmful sexual behaviours. These include:

- adverse childhood experience, such as abuse and neglect or family violence
- intellectual impairment, learning difficulties and emotional and behavioural disorders, including conduct disorders
- being in out-of-home care
- being in institutions with high-risk cultures (for example, some hyper-masculine elite sporting clubs, male boarding schools, or defence force settings)

4.5 Improving institutional policies and systems

Institutions can play a role at all levels of a public health approach to prevention of harmful sexual behaviours displayed by children. Child-focused institutions, particularly schools, are key to the prevention initiatives currently delivered to children and young people. Staff in institutions can also be better equipped to recognise harmful sexual behaviours, to distinguish between healthy and harmful sexual behaviours, and to engage children in early intervention when it may be necessary.

Institutions can also participate in tertiary responses to children with harmful sexual behaviours, including facilitating referrals to appropriate assessment and therapeutic intervention, and participating in supporting children within their normal environment when it is safe to do so. Tertiary interventions for children with harmful sexual behaviours are discussed in detail in Chapter 5.

This section deals with improving institutional responses to children who exhibit harmful sexual behaviours. This expands on work in other volumes. Volume 6, *Making institutions child safe* includes discussion of the creation of child safe institutions through prevention education. Volume 7, *Improving institutional responding and reporting* gives detailed guidance about how institutions should handle complaints of child sexual abuse. Volume 8, *Recordkeeping and information sharing* considers how to strengthen information sharing both between institutions and across different Australian jurisdictions to better prevent and respond to child sexual abuse. Finally, for institution-specific information about improving institutional responses to children who exhibit harmful sexual behaviours, refer to Volumes 12 to 16.

4.5.1 Institutional policies for dealing with children's harmful sexual behaviours

We heard evidence that all professionals working with children need clear policies and protocols so they can respond to complaints of children's harmful sexual behaviours in an informed manner that prioritises the safety of all children.⁶⁴ However, we have also heard about many institutions that do not have adequate policies and procedures for handling these types of complaints.⁶⁵

Along with guidance about distinguishing healthy and harmful sexual behaviours (see Section 4.3), institutions should develop policies for staff to follow when responding to a child who exhibits harmful sexual behaviours.⁶⁶ Problematic and harmful sexual behaviours by children can cause high levels of anxiety and confusion for staff, and staff require training to be able to respond appropriately.⁶⁷

In our *Harmful sexual behaviours of children in schools* case study, we heard evidence from Dr O'Brien that all professionals working with children require:

very clear protocols and guidelines and education on how they can respond when an incident occurs; because when an incident occurs and, for example, a teacher may become aware of that, a teacher may witness that or they may have a child that runs to them in distress because they have been subjected to behaviours of some kind, a teacher, without training and perhaps responding to the repugnance of the issue and out of profound concern for the child before them, is at risk of panicking in that moment and the resulting response is likely then to be inappropriate.⁶⁸

As discussed in Chapter 3, we were told by private sessions attendees that staff within institutions often did not know what to do when a complaint was made about a child sexually abusing another child.⁶⁹

Clear policies on how to deal with children exhibiting harmful sexual behaviours allow individuals within an institution to react to the behaviours in a calm manner and respond to incidents appropriately, giving priority to the safety of all children involved.

As discussed in more detail in Volume 7, *Improving institutional responding and reporting*, we believe that every institution that has contact with children should have a complaint handling policy that clearly explains how to manage a complaint about a child with harmful sexual behaviours. Policies should be simple, clear and accessible. They should clearly set out a range of matters, such as who will be responsible for handling a complaint, who will investigate the complaint, how the institution will communicate with affected parties (including parents), and the timeframe for finalising the outcomes of the complaint handling process.

As we outline in Volume 7, once individuals within an institution identify that a child has exhibited harmful sexual behaviours, an institutional response should involve:

- monitoring the immediate and longer-term safety and wellbeing of all children involved, including the victim, the child with harmful sexual behaviours and any children who may have witnessed the incident
- complying with all reporting obligations, including reporting to police and child protection if necessary
- communicating with the children involved, their parents or carers and relevant agencies, including child protection and police
- documenting what has happened and sharing relevant information with other agencies, where necessary.

In Volume 6, *Making institutions child safe* we outline the 10 national Child Safe Standards we have identified as essential to making an institution safer for children. Standard 6 focuses on institutional complaint handling processes. However, all 10 standards should inform an institution's complaint handling process, and its policies and procedures, to create an environment where children, families and staff feel empowered to raise complaints and where these complaints are taken seriously.

Complaint handling policy and procedure

We set out the essential parts of a complaint handling policy and procedure in Volume 7, *Improving institutional responding and reporting*. This section is a summary of the generic elements needed in an institution's complaint handling policy and is tailored to responses that may involve children with harmful sexual behaviours.

An effective complaint handling policy and procedure should clearly outline roles and responsibilities, approaches to dealing with different types of complaints, and obligations to act and report. The essential components that a child safe institution's complaint handling policy and procedure should cover to meet the standard are:

- making a complaint
- responding to a complaint
- investigating a complaint
- providing support and assistance
- achieving systemic improvements following a complaint.

Table 10.5 sets out generic complaint handling policy elements that are tailored to children exhibiting harmful sexual behaviours in institutions. Institutions should also be guided by any formal advice developed by state or territory governments about how to respond to complaints of children sexually abusing other children in their state or territory.⁷⁰

Table 10.5 – Elements of a complaint handling policy involving children’s harmful sexual behaviours

Element	Application to complaint handling policies about children exhibiting harmful sexual behaviours
Making a complaint	<p>Child safe institutions rely on people trusting that they can and should report children’s harmful sexual behaviours. To facilitate this, the policy should specify that anyone can make a complaint about a child’s harmful sexual behaviours. This includes victims, other children, parents and carers, staff and volunteers and adult survivors. The policy should state how to make a complaint.</p>
Responding to a complaint	<p>Who is responsible</p> <p>An institution is safer for children if the people in it have a strong sense of personal accountability and are held to account.⁷¹ At every level, staff need to accept that they are accountable for the way a complaint is handled. The policy should outline the individual/s in the institution who should be told about the complaint. The policy should state who in the institution is ultimately responsible for handling the complaint (for example, a school principal, or the manager of a group home).</p> <p>Responsibilities to report to external authorities</p> <p>The policy should set out when the institution is required to report details of the complaint to child protection agencies and/or the police, taking into account the age of the children involved and the nature of the harm caused.</p> <p>The policy should stipulate that if staff suspect that the child’s harmful sexual behaviours have emerged as a result of prior trauma such as sexual abuse, child protection authorities must be contacted. (See Volume 7, <i>Improving institutional responding and reporting</i> for our discussion of mandatory reporting). We consider the reporting template for Victorian schools a useful model.⁷²</p> <p>How to assess risks and establish safeguards</p> <p>The policy should outline how staff should assess the safety of the victim, any other vulnerable children, the complainant and the child causing harm. The policy should also specify the measures that the institution will implement to ensure the safety of all children concerned. Where the children live in or attend the same institution, the institution should put in place a risk management plan. The plan should address the needs of all children involved in the incident, as well as all other children in the institution who may be at risk of sexual harm.</p> <p>That plan should also explicitly state that where it is necessary to move the victim within or from the institution to ensure their safety, staff must clearly explain to the child that the move is not because he or she has done anything wrong.</p>

Element	Application to complaint handling policies about children exhibiting harmful sexual behaviours
Responding to a complaint	<p>How to respond to different types of complaints</p> <p>The complaint handling policy should outline how the institution will respond to a range of complaints, including:</p> <ul style="list-style-type: none"> • complaints from concerned parents and carers, staff and other adults • disclosures from children • historical complaints. <p>How to communicate with parents, carers, and third parties</p> <p>Procedures should be outlined for how the institution will inform parents, carers or guardians of the children involved in the complaint of what has occurred. This should be done in consultation with the police in circumstances where criminal conduct may be involved.</p> <p>This part of the institution’s complaint handling policy should address information exchange legislative and policy parameters. The legal framework for sharing information in these cases, and our recommendations for reform, are discussed in Volume 8, <i>Recordkeeping and information sharing</i>.</p>
Investigating a complaint	<p>Who will investigate and how the investigation should be conducted</p> <p>Limiting the number of people involved in responding to a complaint involving a child engaging in harmful sexual behaviours is important for the wellbeing of that child, the victim and other children involved. The policy should make it clear that staff are there to support children. Staff need to obtain basic information about what has occurred to decide what action to take.</p> <p>The seriousness and severity of harmful sexual behaviours identified in a complaint can vary. Every effort should be made to investigate each complaint. However, the level of investigation should be proportionate to the seriousness, frequency of occurrence and severity of the behaviours the complaint concerns. The investigation rationale should be documented.</p> <p>Institutions should not conduct in-depth interviews with any children in case the matter is referred to child protection authorities or police and this compromises their investigation.</p> <p>Where police are involved, the policy should specify that the institution should obtain advice from police as to whether it can or should conduct its own investigation.</p>

Element	Application to complaint handling policies about children exhibiting harmful sexual behaviours
How to implement outcomes	The policy should provide guidance on how the institution will inform all parties affected by the complaint, including parents or carers of victims and children with harmful sexual behaviours, of the outcomes of the investigation. This includes outcomes that are likely to result in the children involved remaining in the institution, where future contact between the children is likely.
Providing support and assistance	The policy should detail how the institution will develop support and behaviour plans for the children involved. It should provide templates for these support and behaviour plans for clarity and consistency. The policy should also include detail on any additional measures that may be required to meet the needs of children with specific vulnerabilities, such as children with disability or children in out-of-home care. The policy should note that children should be referred for assessment and therapeutic intervention, where required, and specify the processes that should be followed to make such referrals.
Achieving systemic improvements after a complaint is finalised	<p>The policy should outline the process the institution will undertake to learn lessons from any complaints about children exhibiting harmful sexual behaviour. Examining past complaints may assist the institution to reduce situational risk factors that enabled the abuse to occur, and/or to improve its response to abuse.</p> <p>The policy should be updated regularly to align with the most up-to-date research and practice literature on children with harmful sexual behaviours.</p> <p>The policy should also include detail on how the institution will monitor how effective the policy is, through measures such as how often teachers or other professionals in child-related roles in the institution are reporting complaints in accordance with the policy.</p>

Government agencies or peak bodies may be able to assist smaller institutions by providing templates for complaint handling policies. Such templates can then be tailored to suit the sector and/or institutions involved. The South Australian Government's policy for responding to problematic sexual behaviours of children in education and care settings, developed by educational agencies, is a useful model.⁷³ We also consider the Victorian Government's Principal's Checklist a useful tool to ensure that staff fulfil their obligations following an incident, disclosure or suspicion of harmful sexual behaviour by a student in Victoria.⁷⁴

An institution's policies should include information sharing protocols and address how an institution will meet its duty of care to ensure the safety of all children connected to it and prevent the recurrence of harm. As information sharing and managing risks to the safety and wellbeing of children are both challenging areas, we provide further guidance on these in Sections 4.5.2 and 4.5.3.

Volume 7, *Improving institutional responding and reporting* provides more detail on responding to all complaints about child sexual abuse. Volume 13, *Schools* also outlines the policies that schools should have in place to manage incidents and complaints regarding children with harmful sexual behaviours.

4.5.2 Information sharing by institutions

Where a child has displayed harmful sexual behaviours, an institution or individual may need to report that incident to police and/or to the relevant child protection agencies. There may also be a need for institutions or individuals to share information about that behaviour with:

- the parents, carers or guardians of the children involved in the incident
- others connected to the institution, including the parents and carers of children at the institution who were not involved in the incident
- other institutions and individuals with responsibilities relating to children's safety and wellbeing.

We have heard about institutions neglecting to share information about children with harmful sexual behaviours.⁷⁵ In some cases, not sharing information appears to be a result of concerns about the laws that govern information sharing, particularly privacy laws, or a concern about breaching a child's privacy.⁷⁶

Our examination of information sharing as set out in Volume 8, *Recordkeeping and information sharing* indicates that failure to share information about a child's harmful sexual behaviours can result in missed opportunities to identify and respond appropriately to these behaviours and to prevent their recurrence. At the same time, we acknowledge that information about a child who has displayed harmful sexual behaviours is extremely sensitive and inappropriate sharing of this information has the potential to result in long-term stigmatisation and discrimination. We have also heard that disclosing a child's history of sexual behaviour can place that child at risk of predatory behaviour by adults.⁷⁷

In Volume 8 we recommend reforms to improve the laws and other arrangements that govern information sharing, including in circumstances where a child has exhibited harmful sexual behaviours. These reforms would, in appropriate circumstances, enable information sharing about a child's harmful sexual behaviours between certain institutions (and relevant professionals) without consent. In Volume 8 we set out the need for safeguards to prevent inappropriate sharing of this type of information. In the following sections we discuss further our recommended reforms in this area.

Institutions should have policies and procedures to ensure information related to the safety and wellbeing of children is shared in an appropriate, timely and lawful manner. Those policies and procedures should also guide staff about how to handle sensitive information to avoid inappropriate use or disclosure of information. It is important to note that in some cases it may be necessary for an institution or an individual to obtain advice from police before sharing information, in order to avoid compromising police investigations and prosecutions. This is discussed further in our *Criminal justice* report.⁷⁸

Communicating with parents, carers and third parties about a complaint of child sexual abuse by a child can help to: ensure children are given enough support to tell their story; encourage any other victims to disclose abuse; keep relevant stakeholders informed and involved; and assist other institutions to keep children safe. Communicating with some third parties, such as other institutions and the media, can present challenges for institutions.

Sharing information with parents or carers of the children involved

Information sharing with the parents or carers of victims and of children with harmful sexual behaviours can help parents or carers to support their children's needs and manage risks to their children's safety. In private sessions we heard of instances where inadequate information sharing with parents and carers has limited their ability to understand changes in their children's behaviours and to respond appropriately to any harm that has occurred.⁷⁹

In our *Harmful sexual behaviours of children in schools* case study, the manager of AFL Cape York House in Cairns, Mr Richard Stewart, told us that there are inconsistencies with information sharing across jurisdictions in relation to Aboriginal and Torres Strait Islander students transitioning into interstate boarding environments:

Early this year a group of around 10 students went from a Northern Territory community to a school in Cairns ... there was some problematic behaviour among two or three of the children and the school made a decision to exclude all of the children. Those children all returned to their home community ... There was no exchange of information ... The point is that the quality of the transition varies enormously and the jurisdiction and the governance around the transition varies enormously, there is no standard, and the fact is that the most vulnerable children are those children placed into boarding environments that are generally of poorest quality.⁸⁰

Institutions should share information about an incident where a child or children have engaged in harmful sexual behaviours with the parents or carers of any children involved in that incident. A child may be involved as a victim, as the child with harmful sexual behaviours or as a witness to the incident. Information sharing in these circumstances is important because parents and carers are likely to be best placed to provide emotional support to their child following an incident of this kind. Dr O'Brien noted in her evidence in our *Harmful sexual behaviours of children in schools* case study:

[It is] important that parents and caregivers are made aware of what has occurred and that needs to occur immediately, and there are many reasons for this, but amongst these is the fact that the child will be seeking the support of the person that perhaps they are closest to. So a child that is newly traumatised should not be severed from their closest natural supports, which are their parents, so reporting to parents in a respectful, calm way is something that needs to occur.⁸¹

However, institutions should only share information with parents and carers to the extent that this is reasonable and necessary to manage risk and respond to trauma. This should be done in consultation with the police in circumstances where criminal conduct may be involved. The information shared should include:

- the nature of the harmful sexual behaviours that were disclosed or witnessed
- whether the matter has been referred to other agencies (including child protection, police or health) and which agency is leading the response and the investigation
- details of the contact person in the institution whom the parents or carers should contact about the matter
- the policy the institution is following to respond to the incident
- details of any relevant support services for the children involved
- what actions are being taken by the institution to ensure the children involved are safe and supported
- the outcome of the institution's complaint handling response
- if relevant, the outcome of any external law enforcement investigation, once finalised.

South Australian Government agencies have given guidance to staff in education and care settings about the information that should be shared with parents and carers, other staff within the institution and other professionals following a complaint of child sexual abuse by a child.⁸² We consider the guidance provided in *Responding to problem sexual behaviour in children and young people: Guidelines for staff in education and care settings* to be constructive in protecting against further risk of harm.⁸³

We were told through *Case Study 24: Preventing and responding to allegations of child sexual abuse occurring in out-of-home care* and submissions to our out-of-home care consultation paper about the importance of sharing information with carers about children in their care.⁸⁴ Sharing relevant and sufficient information with carers about the history of children proposed to be placed in their care is necessary for carers to make an informed choice to accept a placement. Inadequate information sharing about children's harmful sexual behaviours can undermine placement choice and stability and compromise the care provided, as well as jeopardising the safety of other children in carer households.⁸⁵

We recognise that in some out-of-home care settings, such as kinship and relative care placements in Aboriginal and Torres Strait Islander communities, information sharing with carers may create additional familial and cultural complexities.⁸⁶ Concerns about confidentiality and the privacy of children in care need to be carefully managed when sharing information with carers. However, these concerns must be balanced with the need to ensure, as much as possible, the safety and wellbeing of children in care, as well as other children in carer households. In Volume 12, *Contemporary out-of-home care* we discuss information sharing with carers in the out-of-home care sector in more detail.

Communicating with the institution's community, including other parents and carers

We recognise that there will be some instances in which an institution may need to communicate with the parents or carers of children at an institution who were not directly involved in an incident where a child has engaged in harmful sexual behaviours. For example, an institution may need to address misinformation spreading throughout the community or assure parents and carers that the institution has taken steps to respond to an incident.

However, institutions should exercise caution in doing so. Any information that is provided should not identify the children involved in the incident, or allow those children to be identified.⁸⁷

As we mentioned earlier, some government agencies have developed template parent and carer communication guides that can assist staff in education and care settings to respond to children's harmful sexual behaviours.⁸⁸ These guides suggest that, for parents and carers of children who are not involved in an incident, an institution should simply provide advice that an incident involving children has occurred, and that the institution has taken steps to mitigate potential risk to other children.⁸⁹ Communication of this nature should be made in consultation with any other agencies involved, including police or child protection agencies, to ensure no further harm is caused to the children involved.

Sharing information with other institutions or professionals

Information sharing between institutions and professionals with responsibilities related to children's safety and wellbeing is necessary to identify, prevent and respond to incidents and risks of child sexual abuse.⁹⁰ In particular, we were told that it is 'imperative that where information relates to a potential safety risk to the child concerned, or to other children within the school environment, this information be shared with the school staff at the student's new school'.⁹¹ We have also been told of the importance of information about a child's harmful sexual behaviours being shared with the agency or organisation responsible for arranging or supervising out-of-home care placements for that child.⁹² The timely provision of background information about children is a critical factor in assessment and placement matching by out-of-home care agencies, and their capacity to provide effective support for children with harmful sexual behaviours.⁹³

Across Australia, information sharing arrangements have been established to enable and sometimes require the sharing of information related to the safety and wellbeing of children for specified purposes. Information that can or must be shared under these arrangements may include information related to harmful sexual behaviours that have been displayed by a child. We consider legislative and administrative arrangements for sharing this information, and their limitations, in Volume 8, *Recordkeeping and information sharing*.⁹⁴

In Volume 8 we recommend that governments build upon these arrangements to establish a legislative scheme for the exchange of information related to children's safety and wellbeing for specific purposes, including information relevant to child sexual abuse in institutional contexts.

As we explain in Volume 8, information that could be shared under the scheme includes information about harmful sexual behaviours that have been displayed by a child, and information about a child's therapeutic needs arising from a history of abuse. We recognise the particular sensitivity of this type of information, and the need to consider risks to children that may arise from sharing it. We also discuss the need for guidelines to assist in decision-making about information sharing in particular circumstances. For example, while we note consent would not be required to share information under the scheme, we consider the need for a child's views about disclosure of their personal information to be taken into account in decision-making about information sharing. We describe some specific safeguards that could be implemented to prevent unauthorised sharing and improper use of information obtained under the scheme.

This information exchange would operate within and across a number of sectors that provide services to or for children. We have also considered the need for additional information sharing arrangements in certain sectors. In particular, we make specific recommendations to facilitate appropriate sharing of relevant information when a child transfers to a new school. This would include information that relates to the safety and wellbeing of that child and other children at the new school, such as information that a child has displayed harmful sexual behaviours.

4.5.3 Supporting children in institutions following an incident

Where a child has displayed harmful sexual behaviours, it is important that institutions respond in ways that promote the safety and wellbeing of all children involved. This includes the child with harmful sexual behaviours, any children who have been harmed, and any children who have witnessed the incident. Where appropriate and safe to do so, children should maintain contact with the institution in which the incident occurred. In addition, institutions should develop plans to ensure ongoing safety, to support victims and child witnesses, and to manage the behaviour of children who have exhibited harmful sexual behaviours. Planning therapeutic interventions to address harmful sexual behaviours is discussed in Chapter 5 of this volume.

Maintaining contact where safe to do so

In our *Harmful sexual behaviours of children in schools* case study, experts advised that removing a child from school is likely to dislocate them from their supports, including peers and friendship groups.⁹⁵ All children who have been involved in an incident where a child has exhibited harmful sexual behaviours, whether as victims, witnesses or the child with harmful sexual behaviours, should be able to continue their education.⁹⁶ During our *Harmful sexual behaviours of children in schools* case study, Dr O'Brien told us:

There will most certainly be instances in which it is not appropriate for a child to remain at the same school as the children whom they have subjected to sexualised behaviours, but for the reasons that I've outlined around peer attachments and natural supports and so on, it's very important that we try to work through these issues and arrive at a space where we can allow children to remain integrated into school settings. A child with these behaviours should not be stripped of the opportunity for an education ...⁹⁷

A child who has exhibited harmful sexual behaviours should only be removed from an institution, either temporarily or permanently, where this is considered essential to effectively manage safety risks within the institution. These risks may be to the safety of victims, other children or the child with harmful sexual behaviours. To exclude or remove a child, decision-makers within the institution should be satisfied that this action is necessary to protect the wellbeing of children in the institution, to keep the institution safe for all or to allow staff the opportunity to liaise with other agencies, including police.

Where an institution determines that the child can remain in the institution, because staff believe they can effectively manage the risk within the institution, a safety plan should be put in place.

Safety planning

Where a child has exhibited harmful sexual behaviours and will continue to reside in or attend the institution, we believe the institution must put a safety plan in place. The safety plan should address the needs of all the children involved in an incident. A safety plan should include support plans for victims and a behaviour plan for the child who exhibited harmful sexual behaviours. Government agencies or peak bodies may assist smaller institutions by providing templates for plans. Templates can be tailored to suit the sector or institutions involved.⁹⁸

Support plans for victims

Support plans for victims should identify the changes the institution will make to ensure their safety.⁹⁹ The plan should outline the agreed actions to be taken to help the child be and feel safe and protected. These actions will include actions by staff at the institution, other professionals, and parents or carers. Specific actions may include: offering counselling support for the victim and their family;¹⁰⁰ designating a trusted adult at the institution as someone to whom the child can talk about their concerns;¹⁰¹ and enhanced adult supervision of the location where the sexual abuse took place.¹⁰² The plan must stipulate any restrictions that have been placed on the child who caused harm to ensure the victim feels safe at the institution.¹⁰³

Behaviour plans for children who have caused harm

A behaviour plan for a child who has sexually abused another child or children should set out expectations for the child's future behaviour.¹⁰⁴ The behaviour plan should clearly state that the child is not to engage in further harmful sexual behaviours. The plan may contain specific behaviour goals and methods of positive reinforcement, details of any additional education to be provided to the child, and agreed consequences for deviating from acceptable behaviours. For example, the plan may specify how the child is expected to behave in the schoolyard, the bathroom, or, if in residential care, in other children's bedrooms.¹⁰⁵ The plan may include moving the child to ensure they are separated from the victim.¹⁰⁶

Volumes 12 to 16 contain further, institution-specific information on how to ensure the safety and wellbeing of children in institutions. For our broader work on best practice institutional responses to complaints of child sexual abuse across sectors see Volume 7, *Improving institutional responding and reporting*.

Endnotes

- 1 Chapter 3 of this volume outlines the development and current approaches in all jurisdictions to children with harmful sexual behaviours. See also W O'Brien, *Australia's response to sexualised or sexually abusive behaviours in children and young people*, Australian Crime Commission, Canberra, 2010.
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- 14 Royal Commission into Institutional Responses to Child Sexual Abuse, *Treatment of child to child sexual abuse private roundtable*, Sydney, 2015.
- 15 S Hackett, D Holmes & P Branigan, *Operational framework for children and young people displaying harmful sexual behaviours*, National Society for the Prevention of Cruelty to Children, London, 2016, p 34; S Hackett, *Exploring the relationship between neglect and harmful sexual behaviours in children and young people: Evidence scope 3*, National Society for the Prevention of Cruelty to Children, London, 2016, p 30.
- 16 For example, see: Transcript of A/D Supt G Marchesini, Case Study 45, 3 November 2016 at 22827:19–28; Transcript of R Bale, Case Study 45, 3 November 2016 at 22830:12–15, 22830:26–33.
- 17 S Hackett, D Holmes & P Branigan, *Operational framework for children and young people displaying harmful sexual behaviours*, National Society for the Prevention of Cruelty to Children, London, 2016.
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- 19 NSW Government, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Criminal justice*, 2016, p 22.
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5 Tertiary interventions for children's harmful sexual behaviours

5.1 Overview

Children displaying harmful sexual behaviours may require tertiary interventions to help them cease the behaviours. Tertiary interventions are targeted at children and families where a problem has been identified that needs an intensive and tailored response. Tertiary interventions include assessment, safety planning and therapeutic interventions as well as, in some cases, child protection and criminal justice system responses.

Research on harmful sexual behaviours, while limited, suggests that specialist therapeutic interventions, especially early interventions, can prevent or reduce children's harmful sexual behaviours.¹ For this reason, we believe it is important that children with harmful sexual behaviours have access to quality assessment and therapeutic intervention.

Effective assessment is about identifying and planning therapeutic interventions that will be best suited to the child's needs.² Assessment also aims to ensure the safety of the child with harmful sexual behaviours and those around them.

Sometimes the identification of harmful sexual behaviours will trigger a criminal justice and/or child protection response. Such responses may be necessary for some children.

In this section, we describe what we have learned about the benefits of responding to children with harmful sexual behaviours with quality assessment and therapeutic intervention. We outline how to improve access to assessment and therapeutic interventions and enhance the quality of therapeutic interventions for children.

5.2 Assessment and planning

When a child exhibits harmful sexual behaviours and is referred to a specialist practitioner, the first response should be to conduct an assessment of their behaviours in the context of their social network and developmental stage. This enables the practitioner to develop a safety plan and, where appropriate, to refer the child with harmful sexual behaviours to therapeutic treatment. Assessment may involve gathering information regarding:

- the behaviours displayed, including their onset, the types of behaviours, any changes in behaviour over time and any response by the child to a caregiver's attempt to correct or distract them from the behaviours³
- the child's family and social environment
- any known maltreatment or sexual abuse history
- medical and other history, including whether the child has an intellectual, cognitive or behavioural impairment and/or learning difficulties or existing mental health issues.⁴

Where the harmful sexual behaviours occurred in an institution, practitioners should develop an understanding of the institutional context as part of their assessment of the child.

Children's sexual behaviours should be understood along a spectrum of behaviours from developmentally appropriate to harmful.⁵ Identifying where a child's behaviour falls on this continuum, along with careful consideration of their particular situation, will help determine the types of interventions that might be prescribed.

For example, some children with harmful sexual behaviours may need to be removed from the institution where they have caused harm, at least while the assessment is being conducted, to ensure the safety of other children. In other instances, minimal intervention may be required. Effective assessment can both prevent the unnecessary use of specialist practitioners' time where problem behaviours might be less concerning and ensure earlier intervention in cases of higher concern.⁶ Where assessment determines that a child requires therapeutic intervention, the assessment process should establish clear expectations of what participating in therapy will involve for practitioners, agencies, family and – most importantly – the child with harmful sexual behaviours.⁷

The assessment should also attempt to examine any underlying reasons why the child is displaying harmful sexual behaviours – for example, underlying trauma that has not been addressed – and assess strengths and protective factors that can be used to manage or reduce the behaviours.⁸ The 2000 United Kingdom report, *Setting the boundaries: Reforming the law on sex offences*, outlines why all children with harmful sexual behaviours require assessment:

An apparently isolated incident may well be part of a much more entrenched pattern known only to the young person who abuses. Some will spontaneously self-correct, but we do not know which ones will and which ones will not. Prolonged work may be needed in some cases but assessment is needed in them all.⁹

Assessment and planning should be guided by clinical judgement and supported by frameworks or tools that are specifically designed for children with harmful sexual behaviours.¹⁰ Practitioners might draw on a combination of clinical knowledge and specific assessment tools when assessing risk and safety, or when planning for therapeutic intervention.¹¹ Children might be assessed differently using different assessment tools depending on whether they engage first with the child protection, criminal justice or health systems.¹² Regardless of the tools used, acknowledging that children with harmful sexual behaviours are a heterogeneous group is important, as assessment tools need to be flexible and developmentally appropriate.¹³ Specific types of assessment tools are discussed in Section 5.2.2. Some of the key issues that should be considered and addressed in the assessment and planning process are discussed in Section 5.2.1.

5.2.1 Key factors for assessment and planning

Regardless of the intervention approach, a number of key factors need to be addressed when conducting assessments of children with harmful sexual behaviours. These include establishing safety, identifying the child's social context and developmental stage, and engaging the child's parents or carers.

Safety

The first priority for assessment, planning and therapeutic treatment is to ensure safety for the victim and the child exhibiting harmful sexual behaviours as well as other children who have been harmed, their families and the wider community.¹⁴ This can involve establishing a formal safety plan. Safety planning identifies situations, relationships, thoughts and feelings that present risk, and plans for safer alternatives.¹⁵ Safety planning should consider risks to the child with harmful sexual behaviours, any other children who may be in contact with that child – including siblings – and children who may have been harmed by or witnessed the child's behaviours.¹⁶ Particular attention should be given to children who are vulnerable to abuse because of developmental delay or cognitive disability.¹⁷ Vulnerability to abuse can also be due to a range of other factors, such as prior trauma and social isolation.¹⁸ The factors that can increase the vulnerability of a child to sexual abuse is discussed in greater detail in Volume 2, *Nature and cause*.

Safety planning may need to consider whether the child displaying harmful sexual behaviours presents a risk of harm sufficient to require child protection measures. This may include considering whether or not the child can remain in the family home during intervention.¹⁹ In most cases, the behaviour of children under 12 years can be managed within the home.²⁰

Assessing the safety of the child with harmful sexual behaviours, the victim and others affected by their behaviours should happen in the initial assessment phase and be ongoing throughout the course of intervention. Safety assessments should take account of the norms of family and care relationships as they operate within a child's specific environment. Attention should be paid to culturally appropriate assessment, such as consideration of kinship relationships in Aboriginal and Torres Strait Islander communities.²¹

Social context

In *Case Study 45: Problematic and harmful sexual behaviours of children in schools (Harmful sexual behaviours of children in schools)* we heard that children with harmful sexual behaviours often have other issues that require attention.²² In conducting assessments, specialist clinicians should consider the extent to which the child's environment has influenced the development of their harmful sexual behaviours.²³ The assessment should explore how risk and protective

factors are improved or exacerbated by family, peer and school networks, wider community issues, as well as social cues the child receives through unsupervised access to mainstream media, the internet and pornography.²⁴ A contextual and systemic approach to assessment aims to ensure that interventions account for all aspects of a child's life.²⁵

A contextual and systemic assessment should examine a child's full range of behaviours in addition to their harmful sexual behaviours. For some children, harmful sexual behaviours fit into a spectrum of other antisocial behaviours, such as a conduct disorder.²⁶ For other children, harmful sexual behaviours stand out as unusual compared to the generally prosocial behaviours they display.

When conducting assessments, professionals should consider the child's range of behaviours as they occur within their environment, including in family, school and community contexts.²⁷ Having an understanding of the child's wider behavioural context assists in indicating whether the child requires intervention for any problematic or harmful behaviours in addition to the harmful sexual behaviours. For children who displayed harmful sexual behaviours in an institutional context, assessment should consider the environment and the culture of the institution where the abuse occurred and assess how the institution can support the child to stop the behaviours and stay safe.

Persistent sexualised behaviours might also indicate that the child has experienced previous trauma.²⁸ Treatment responses should be planned accordingly.

Developmental stage

Children with harmful sexual behaviours require assessments that are developmentally appropriate.²⁹ Children are continually developing in terms of their physical, emotional, cognitive and behavioural capabilities. Assessment should be framed within an understanding of the developmental stage of both the child exhibiting the harmful behaviours and any child who may have been harmed by the behaviours, including their functioning, chronological age and any physical or cognitive impairment. In our *Harmful sexual behaviours of children in schools* case study, Dr Wendy O'Brien, an expert on children with problematic or harmful sexual behaviours in schools, submitted that the assessment process should pay specific attention to a number of issues, including:

- the chronological age of the child exhibiting the behaviours and whether the behaviours are excessive to the developmental range for that age
- the developmental level of the child exhibiting the behaviours, including whether they have developmental delay, autism, or cognitive impairment

- any power imbalance between the child exhibiting the behaviours and the child who is subjected to those behaviours, including:
 - an age gap
 - inequalities in size, strength or status
 - the presence of a mental illness, developmental delay or cognitive, emotional or behavioural impairment, including conduct disorders
- the particular context in which the behaviours occur, noting that certain circumstances create temporary vulnerabilities or inequalities among peer aged children.³⁰

As we have outlined in Chapter 2 of this volume, many children displaying harmful sexual behaviours have experienced previous trauma. A comprehensive development and cognitive assessment must take full account of a child's trauma history and the implications this has on their functioning, wellbeing and relationships. Prior abuse or trauma can have an effect on the way a child develops attachment relationships.³¹

Support from parents and carers

Children with harmful sexual behaviours require supervision by safe and supportive parents or carers.³² As noted in a 2012 Victorian Government report:

The young person's family/carers are powerful allies in the process of safety planning, support and therapy. Support and engagement of them is a core component that leads to good outcomes.³³

When assessing a child's behaviours and situation, it is important to assess the capacity of their parents or carers to provide the level of supervision and support necessary. For parents and carers, supervising children who have exhibited harmful sexual behaviours can be highly demanding. Supervision plans should reflect the capacity of each parent or carer, and should include other identified supports where necessary.³⁴ Parental support and engagement in assessment and planning is important even in situations where a child is living away from home, including in out-of-home care.³⁵

5.2.2 Assessment tools

Evidence-based assessment tools can enhance and support structured clinical judgment.³⁶ Assessment tools should assess risk and also account for protective factors.³⁷ While there is considerable variation in socio-emotional, cognitive and physical development between children of the same age, current assessment tools for children with harmful sexual behaviours are age-specific as discussed below.

Assessment tools for children under 12 years

There are few specific assessment tools designed specifically for children aged under 12 years with harmful sexual behaviours.³⁸ This is due to a paucity of reliable research and clinical data about risk for these children.³⁹

Given this, assessment frameworks or questionnaires, rather than assessment tools, could be used with younger children to assess their developmental and trauma histories, as well as their social background and current living environment.⁴⁰ As with assessment tools, most relevant frameworks and questionnaires are not designed specifically for assessing harmful sexual behaviours, but for assessing trauma and abuse histories more broadly – for example, for trauma-informed assessment.⁴¹ Examples of suggested assessment frameworks and questionnaires for children under 12 include the:

- AIM (assessment, intervention and moving on)⁴²
- Child Behaviour Checklist⁴³
- Child Sexual Behaviour Inventory.⁴⁴

Practitioners need to employ the assessment framework or questionnaire which they consider most appropriate to the child's context based on their clinical judgment. There is currently no uniformity around which are considered most effective in working with children with harmful sexual behaviours. Experts have warned that assessment approaches and models designed for adolescents and children who sexually offend should not be used with children under 12 years and those with problematic sexual behaviours.⁴⁵

Assessment tools for adolescent boys aged 12 to 17 years

Some of the most commonly used clinical risk assessment tools for children aged between 12 and 17 years are the Juvenile Sex Offender Assessment Protocol II (JSOAPII) and the Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR).⁴⁶ Both were specifically designed for use with adolescent boys aged 12 to 17 years. Another commonly used model is AIM2.⁴⁷

Most age-specific assessment tools for children aged 12 to 17 years have only been validated with boys who do not have disability, and practitioners caution against using them with girls, children with disability and younger children (under 12).⁴⁸ Although these tools have limitations, practitioners report that they do assist in the assessment process.⁴⁹ However, given the limitations, there is a need to develop and validate specific assessment tools for a broader range of children.

Assessment tools for specific groups

There are few studies and little research on girls who display harmful sexual behaviours.⁵⁰ Promising examples of assessment tools and approaches that have been designed or used with girls include the current approach taken by Barnardo's Taith Service in the United Kingdom.⁵¹ AIM2 also has a component that can be used with girls aged 12 to 17 years, but suggests caution in its usage.⁵²

More work is also needed to develop assessment tools specifically for children with intellectual impairment and learning difficulties and tools that can take account of emotional and behavioural disorders, including conduct disorders.

5.2.3 Limitations of current assessment approaches

Inconsistent assessment approaches

The various theoretical frameworks and assessment tools developed to assist professionals in the assessment of children with harmful sexual behaviours can be useful.⁵³ However, the availability of different assessment frameworks and tools has given rise to the problem of professionals using inconsistent approaches to assessment.

A 2010 Australian study found significant variation in the theoretical underpinnings of the various clinical assessments for children with harmful sexual behaviours offered in Australia.⁵⁴ Research also highlights that inconsistent approaches to assessment are used in the United Kingdom.⁵⁵ The formal system a child with harmful sexual behaviours first comes into contact with may dictate which assessment approach is used, with the child protection, health and criminal justice systems potentially using different approaches.⁵⁶ This might mean children displaying similar behaviours are assessed using different tools or frameworks based on the system they are first referred to, and not on their specific behaviours.

Work has been conducted in the United Kingdom to develop an assessment tool that could be used across professional systems – including health, child protection and criminal justice. Some researchers suggest AIM and AIM2 may be a useful holistic framework for assessing children's needs, specific risks and identified strengths within the family.⁵⁷ AIM and AIM2 present a 'clinically adjusted actuarial model of assessment'.⁵⁸

Limitations of existing assessment tools

Existing assessment tools may be limited in a number of ways including:

- Variable predictive validity. Different assessment tools have different levels of accuracy in predicting the occurrence and recurrence of harmful sexual behaviours.⁵⁹ A 2013 review of literature on the predictive accuracy of a number of common risk assessment models found that ‘none of the tools showed unequivocally positive results in predicting future offending’.⁶⁰
- Existing tools are not consistently useful for assessing children of different ages, genders and development stages. As noted, few assessment tools have been specifically designed for children with harmful sexual behaviours who are under 12 years of age,⁶¹ and there has been little research on girls displaying harmful sexual behaviours and therefore few tested assessment tools.⁶²
- Children with harmful sexual behaviours with disability – including intellectual impairment, cognitive impairment, emotional or behavioural disorders and learning difficulties – may need tailored assessment approaches that take into account general literacy levels, high support needs related to speech, communication and conceptual understanding, and consideration of suggestibility.⁶³
- Aboriginal and Torres Strait Islander children may also need culturally tailored assessments that can take into account the strengths of family and kinship arrangements. Much of the existing research on children with harmful sexual behaviours is international (particularly from the United Kingdom and the United States) so does not consider the particular needs or cultural contexts of Aboriginal or Torres Strait Islander children. This may also be the case for other cultural communities.

An assessment tool that does not effectively take into account all relevant factors including age, disability and cultural context may lead to a practitioner choosing therapeutic interventions for a child that are not appropriate or effective.

Insufficient expertise to conduct assessments

Where professionals lack specific training or knowledge in the area of children with harmful sexual behaviours, they may conduct poor assessments that do not effectively respond to the complexities of these children’s needs.⁶⁴ The Western Australian Government’s submission to a study on responses to children’s harmful sexual behaviours in Australia noted that assessments were being conducted by professionals with insufficient expertise.⁶⁵ The submission stated that professionals, as well as caseworkers, carers and others, often lacked an understanding of children’s harmful sexual behaviours.⁶⁶ This aligns with what we heard during our consultations with experts in this area, who told us specialist expertise can be difficult to come by.⁶⁷

Another submission to this report, from the Australian and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA), also raised concerns about assessments being conducted by those with insufficient expertise. The ANZATSA submission stated: ‘the consequences of erroneous judgments may be life-long for the child, young person and, not least of all, vulnerable members of the community’.⁶⁸

5.2.4 Improving assessment

Based on the limitations discussed, there is a need to improve the types of assessment tools available for the diverse range of children with harmful sexual behaviours.

Research suggests that specialist assessment tools may be required for children with emotional, psychological and physical impairment (such as speech or hearing impairments), behavioural problems, educational difficulties, autism, attention deficit hyperactivity disorder and learning disabilities.⁶⁹ As indicated in Section 5.2.3, specialist assessment tools should assess for problems with general literacy, speech and communication deficits, conceptual understanding and suggestibility.⁷⁰ Assessing family dynamics (such as disciplinary practices, unclear sexual boundaries or parental favouritism) is important in general, but particularly so in cases of sibling sexual abuse, where a more comprehensive assessment is required.⁷¹

Although assessment tools are commonly applied and many practitioners report they are useful in their work with children with harmful sexual behaviours, they often fall short in providing a full understanding of a child’s context. There is a need for well-developed and contextually appropriate tools, which are supported by informed clinical judgement.⁷²

Internet, technology and pornography

Therapeutic intervention providers are increasingly concerned about children with harmful sexual behaviours who use the internet or other technology in inappropriate and unsupervised ways.⁷³ This can include engaging in ‘image-based abuse’ by photographing, filming or recording other children naked or engaged in sexual acts, as well as viewing or distributing these images.⁷⁴ It can also include downloading, distributing, producing or exposing other children to child exploitation material.⁷⁵

There is currently little research on the nature and extent of children exhibiting problematic and harmful sexual behaviours through the internet or other new media and technology. Consequently, there is likely to be inconsistencies in how professionals assess and respond to these types of behaviours.⁷⁶ In our view there is an emerging need for assessment tools that account for harmful sexual behaviours using the internet or other technology.

There is some research to suggest that some children who have been convicted of sexual offences identify as having a greater level of exposure to pornography than those who engage in non-sexual crimes.⁷⁷ Children may have been exposed to pornography by family members, carers or through their peer network, or they may also have sought it out independently. Assessments should explore a child's current access to pornography and whether parents or carers and other family members view pornography within the home.⁷⁸

Volume 6, *Making institutions child safe* discusses online child sexual abuse, including image-based abuse, in more detail.

Out-of-home care sector

Many children who enter the out-of-home care sector are vulnerable as a result of prior trauma and their removal from primary caregivers. Children with harmful sexual behaviours who are in out-of-home care often experience multiple placements, which can compound issues of attachment.⁷⁹ Foster carers are often reluctant to provide placements for children with harmful sexual behaviours, partly due to anxiety associated with any further such behaviour.⁸⁰ Foster carers and residential care workers are often provided with insufficient information about the nature of the harmful sexual behaviours a child has displayed, and assessments are rarely undertaken before a child is placed.⁸¹

In research we commissioned on the safety of children living in residential care, children nominated their peers as the biggest threat to their safety in residential care.⁸² This research also suggests that there are significant risks when children with harmful sexual behaviours are placed with children who have been sexually abused.⁸³ Additionally, it suggests that selection processes need to better match peers, particularly those in residential care, as well as carers and residential workers.⁸⁴ There is a clear need for improved, timely assessment to ensure appropriate placement and to guide effective support to carers or residential workers when children with harmful sexual behaviours are in out-of-home care. Volume 12, *Contemporary out-of-home care* provides a more detailed discussion of child sexual abuse in out-of-home care.

In our *Harmful sexual behaviours of children in schools* case study, Dr O'Brien submitted written evidence that children with harmful sexual behaviours require safe and stable placements, either in out-of-home care or in therapeutic care placements where necessary.⁸⁵ Therapeutic care placements focus on physical and psychological safety, self-regulation skills and strengths-based development, across the child's entire involvement with the out-of-home care sector.⁸⁶ Examples of such initiatives include the Sanctuary model which operates in several Australian jurisdictions.⁸⁷ Safe and secure placements provide practitioners with the time necessary to develop a comprehensive understanding of the issues surrounding the child's behaviours. This is particularly important when the child with harmful sexual behaviours cannot be safely and effectively managed in the home or in the community.

In cases of sibling sexual abuse, an initial separation of the siblings may be necessary to undertake an assessment.⁸⁸ This means either the child with the harmful sexual behaviours or the child being harmed may be placed in out-of-home care for a period of time.

There may also be situations where a child with harmful sexual behaviours who is living in out-of-home care harms another child in the placement and needs to be moved to another out-of-home care setting. In such instances, the needs of the victim should be prioritised and sensitive planning undertaken.⁸⁹ The safety of the child with harmful sexual behaviours must also be assessed and viewed in terms of both child protection issues and the current risk of them engaging in further sexually abusive behaviours.⁹⁰ The parents or carers and therapists supporting the victim need to be engaged in any decision-making regarding whether the child with harmful sexual behaviours can remain in the home (be it family home, foster placement, or residential home).

Assessment of children with harmful sexual behaviours in Australia is currently conducted haphazardly, with different processes in different sectors and jurisdictions. To ensure the availability of professional, high-quality assessment for children with harmful sexual behaviours, we make the following recommendation.

Recommendation 10.2

The Australian Government and state and territory governments should ensure timely expert assessment is available for individual children with problematic and harmful sexual behaviours, so they receive appropriate responses, including therapeutic interventions, which match their particular circumstances.

5.3 Therapeutic interventions

Services for children with harmful sexual behaviours are a relatively recent development in therapy.⁹¹ One review of responses to children with harmful sexual behaviours in Australia noted that these services relied on a heterogeneous group of clinical interventions with ‘divergent origins, philosophies, funding structures, treatment models, referral pathways, client placement capacity and clinical expertise’.⁹² This section describes what we have learned about therapeutic services for children exhibiting harmful sexual behaviours. We discuss what we have learned from the scientific literature and examine the range of programs currently in operation around Australia.

This section builds on our discussion of therapeutic treatment for victims and survivors of child sexual abuse in Volume 9, *Advocacy, support and therapeutic treatment services*.

5.3.1 Is therapy effective?

The study of harmful sexual behaviours by children is a developing field and there is only a small body of research examining different models of clinical practice. Therapeutic interventions for these children have evolved from behaviour modification programs heavily influenced by adult models of sex offender interventions delivered in prisons, towards an approach more tailored to children's developmental needs.⁹³ There is significant variation in the theoretical underpinnings of the clinical assessments and interventions offered across Australia. The research literature on this topic is of variable quality. To assist in our understanding of this literature, we commissioned a systematic review of current best available evidence about therapeutic interventions for children with harmful sexual behaviours.⁹⁴

The review found evidence for the effectiveness of Multisystemic Therapy (MST) in reducing a number of negative social outcomes – including sexual aggression, violence and recidivism.⁹⁵ MST is an intensive program delivered in the child's home and local community and mediated by the child's parent or carer.⁹⁶ MST follows an 'ecological' model, accounting for the connections between the child and the range of interconnected systems with which they interact, including their family, peers, school and community.⁹⁷ MST programs seek to involve these systems and relationships in maintaining behaviour change.⁹⁸ In the *Nature, cause and impact of child sexual abuse* case study, we heard from Dr Elizabeth Letourneau, a professor at the Johns Hopkins Bloomberg School of Public Health and Director of the Moore Center for the Prevention of Child Sexual Abuse in the United States. Dr Letourneau told us of the value of MST for children with harmful sexual behaviours:

One advantage of multi-systemic therapy is that therapists are trained – all of the work is done in the home and they collaborate with the victim's therapist. So they are trained very much to collaborate with other professionals who are in the ecology of the youth – that can be a probation officer, the therapist for the victim – to ensure their safety. Certainly safety is the most important component of all of these interventions.⁹⁹

When implementing MST, therapists draw on a range of approaches including cognitive and behavioural therapies and pragmatic family therapy approaches.¹⁰⁰ These therapeutic interventions are tailored to the child's individual, family, friendship, school and community environments,¹⁰¹ with a strong focus on developing the capacities of the child's parents or carers.¹⁰² Therapy is delivered individually rather than in a group context.¹⁰³ In addition, MST has a strong focus on continuous quality improvement as well as training and supervision of therapeutic staff.¹⁰⁴ MST is likely to be effective due to a combination of these factors – to date, there is no evidence pointing to any one factor underpinning the efficacy of this treatment.

The review we commissioned also identified a number of limitations in the literature on this topic. Much of the high quality research on the strength of MST for children exhibiting harmful sexual behaviours comes from the United States,¹⁰⁵ with only one eligible study identified that evaluated an Australian therapeutic service.¹⁰⁶ Further work and more high-quality evaluations

are needed to ensure that MST interventions are effective in the Australian context. There was also very limited quality research on the efficacy of MST for children with harmful sexual behaviours who have not had contact with the juvenile justice system.¹⁰⁷ In addition, there is limited research on effective therapeutic intervention for children under the age of 10 or for Aboriginal and Torres Strait Islander children.¹⁰⁸

Further, studies included in this review paid little attention to factors associated with children's harmful sexual behaviours such as past trauma, poverty, mental health, development delays or cognitive disabilities, family disruption or placement in out-of-home care.¹⁰⁹ These studies also rarely focus on measuring and improving the broader safety, wellbeing and development of children with harmful sexual behaviours. Rather, the majority of research was more narrowly focused on the recurrence of harmful sexual behaviours.¹¹⁰ Most of the research about children with harmful sexual behaviours is based on studies about therapeutic interventions.¹¹¹ Consequently, there is very little known about outcomes for children with problematic or harmful sexual behaviours who do not access treatment.

One of the key elements of MST is that it is mediated by the family or carers. Consequently, further work is required to develop MST for delivery in institutional settings, including in residential care settings.¹¹² This is particularly important because children and young people in out-of-home care who exhibit harmful sexual behaviours are likely to have more complex needs than other children and, as noted, may also have histories of trauma.

Other therapeutic approaches, techniques and practices show promise for children with harmful sexual behaviours, but have not yet been subject to high-quality evaluation.¹¹³ During consultations with practitioners we heard about a range of other models and approaches to working with children with harmful sexual behaviours that practitioners consider useful. We were told about promising practices including:¹¹⁴

- child-focused and family-centred approaches
- individualised treatment that can be tailored to the specific situation and the child's behaviours
- field-based models, where the practitioner travels to the child and family who needs the therapeutic intervention
- collaborative and multidisciplinary models, where agencies and practitioners work together to respond to the multiple issues that many children may be experiencing alongside problematic and harmful sexual behaviours
- the practitioner initially focusing their efforts on engaging the child, their family and their community in interventions to increase the likelihood of the child completing the therapeutic intervention
- responding to both past and current trauma that the child with harmful sexual behaviours may have experienced.

In addition, some of the evaluations that were included in our commissioned systematic review examined other therapeutic models and found them effective at reducing children's harmful sexual behaviours.¹¹⁵ For example, an evaluation of three community-based therapeutic treatment services in New Zealand found adolescents who completed treatment were less likely to reoffend, either sexually or non-sexually, compared with those who did not attend or dropped out of treatment.¹¹⁶

The programs in this evaluation used a range of therapeutic approaches including: strengths-based models applying narrative therapy techniques; psychoeducation cognitive behavioural therapy approaches with relapse prevention; social work support; individual, family and group therapy; reviews that involve meetings with the adolescents' wider support networks; and experiential and expressive therapies such as wilderness outdoor adventure programs. In addition, the programs were designed to be culturally appropriate for Maori adolescents.¹¹⁷ Clients and their families and carers identified several components of the programs that they saw as important for achieving positive outcomes. These included the holistic approach, creative treatment approaches, interventions for the individual, family and groups, the quality of the client–therapist relationship, and family support.¹¹⁸

In our *Harmful sexual behaviours of children in schools* case study we heard from Mr Dale Tolliday, clinical adviser to New Street Services, a New South Wales service for children who have sexually abused other children, and their families. Mr Tolliday told us that many clients of New Street Services had histories of trauma, some had significant developmental issues and some had considerable deficits in their social skills.¹¹⁹ We also heard from Dr Marshall Watson, a consultant child and adolescent forensic psychiatrist with SA Health, who told us that many of the Aboriginal children he has worked with had similar histories of trauma:

a lot of the kids, the youth that I see, not only have this one traumatic event, they have complex post-traumatic stress disorder; they have a life experience that has been marred by attachment difficulties, caregiver neglect, significant family adversity. What these kids do is – the behaviour is a re-enactment of the trauma, and we need to appreciate what the behaviour actually is ...¹²⁰

Research has identified the issue of trauma among children with harmful sexual behaviours.¹²¹ Histories of trauma may be particularly prevalent in children under 10 years of age who exhibit harmful sexual behaviours.¹²² Young people who exhibit harmful sexual behaviours and who also face other adverse circumstances are particularly at risk of continuing to exhibit these behaviours and may require more intensive support.¹²³ Further work is necessary to determine whether MST or other treatment modalities are effective in responding to the needs of children with harmful sexual behaviours and complex trauma.

In addition, we have been told of the importance of early intervention. In our *Harmful sexual behaviours of children in schools* case study, we were told of the importance of early intervention in preventing ongoing harm.¹²⁴ This is consistent with research on this topic, which suggests that early intervention can improve the identification of risk factors – such as previous exposure to neglect, abuse or trauma – which may be linked to harmful sexual behaviours.¹²⁵

The literature on evaluating therapeutic treatment for children with harmful sexual behaviours is emerging. We discuss the need for ongoing evaluation of therapeutic services to help grow the evidence base and improve practice further in Section 5.6 (which includes Recommendation 10.7).

5.3.2 Current therapeutic intervention in Australia

In this section, we outline therapeutic intervention services that were available in Australia in 2017 for children with harmful sexual behaviours. Some form of therapeutic intervention was available in every Australian jurisdiction. However, specialist interventions for children with harmful sexual behaviours are a fairly recent development and jurisdictions differ in the nature and extent of the interventions they offer.¹²⁶

The following is based on information provided by state and territory governments about the services they were funding in 2017.¹²⁷ In addition to the services discussed here, some privately operated counselling services provide interventions for children with harmful sexual behaviours.¹²⁸

Specialist services

Specialist services provide therapeutic interventions specifically designed for children with harmful sexual behaviours. These services are summarised by jurisdiction in Table 10.6, which is followed by a more detailed description of them. These services aim to improve the safety, welfare and wellbeing of participants, reduce the likelihood of a recurrence of harmful sexual behaviours and protect participants from becoming victims of crime, abuse or neglect.¹²⁹

Table 10.6 – Specialist services for children with harmful sexual behaviours by jurisdiction

Jurisdiction	Intervention	Eligibility
New South Wales	New Street Adolescent Services	Children aged 10 to 17 not convicted of a sexual offence
New South Wales	Sexualised Behaviours (under tens) Program (Sparks)	Children under 10 with problematic or harmful sexual behaviours
New South Wales	New Pathways Residential Program ^a	Children aged 10 to 17 not convicted of a sexual offence
Victoria	Sexually Abusive Behaviours Treatment Services	Children aged up to 18 following voluntary or mandatory referral
Victoria	Male Adolescent Program for Positive Sexuality	Children and young people aged 10 to 21 convicted of a sexual offence
Queensland	Griffith Youth Forensic Service	Children convicted of a sexual offence
Queensland	Mater Family and Youth Counselling Service	Children convicted of a sexual offence
South Australia	Adolescent Sexual Abuse Prevention Program (Mary Street) ^b	Children convicted of a sexual offence

^a Funding for New Pathways ceased in 2017

^b Mary Street stopped operating in 2016

New Street Adolescent Services

The New Street Adolescent Services program (New Street), administered by NSW Health, is a non-residential intervention program providing community-based early intervention for children and young people aged between 10 and 17 with harmful sexual behaviours. New Street provides support for clients for approximately two years.¹³⁰ It has operated since 1998, and in 2017 was delivering services from several metropolitan and regional sites across New South Wales, with an additional outreach service for remote locations.¹³¹

In response to a request for information, the New South Wales Government told us that the New Street program's therapeutic approach is systemic, trauma-informed and takes account of a child's developmental level and environmental context.¹³² This is consistent with the findings of the research review we commissioned.¹³³ New Street engages the child, their family and other services with which they are involved. The service seeks to address other issues in the young person's life that may impact on their behaviour, including school engagement and social isolation.¹³⁴ In addition, we were told that the New Street model emphasises restorative practices, with children being assisted to offer restitution for the harm have caused by their behaviours.¹³⁵

More than half of New Street's clients are children in out-of-home care.¹³⁶ We were told that, in complex family situations such as where parents have re-partnered or where there is family violence, additional practitioners may be allocated to work with the child, the caregivers, the out-of-home care agency, and the child's family of origin.¹³⁷ We were told that New Street works closely with child protection workers and uses a multi-agency approach to provide children, carers and families with the support they need to address issues in a child's environment.¹³⁸

In 2014, around one in four children participating in the program were Aboriginal or Torres Strait Islander children.¹³⁹ We were told that New Street seeks to respond to the needs of Aboriginal and Torres Strait Islander clients by employing Aboriginal and Torres Strait Islander workers, ensuring staff undertake cultural competence training and by adapting the program's approach to meet the needs of local communities.¹⁴⁰ Aboriginal and Torres Strait Islander workers undertake community engagement activities to raise awareness of the service and promote referrals from Aboriginal and Torres Strait Islander communities.

We were told that New Street engages staff who are professionally qualified and accredited in social work, psychology, psychiatry or counselling. Staff undergo a two-year orientation program and are supported by senior staff in their New South Wales local health district. Staff are also supported by a clinical orientation manual, and required to attend specialist NSW Health training courses.¹⁴¹

New Street is overseen by an inter-agency advisory committee.¹⁴² Each agency has specialised knowledge and expertise, and has responsibilities under the *Children and Young Persons (Care and Protection) Act 1998* (NSW). The committee advises on policy and broader governance considerations, but each New Street site is directly administered by a local health district.

Sexualised Behaviour (under tens) Program

The Sexualised Behaviour (under tens) Program, also called the Sparks Clinic, is a specialist therapeutic case management service for children under 10 with problematic or harmful sexual behaviours. It operates out of the NSW Hunter New England Local Health District and is funded by NSW Health. The program arranges and oversees specialist intervention, but does not itself provide a direct therapeutic intervention.¹⁴³ Evaluation of the Sparks Clinic suggests that there may have been benefits for children participating in the program.¹⁴⁴ However, this evaluation was limited by a lack of baseline, outcomes and comparison group data.¹⁴⁵

Sexually Abusive Behaviour Treatment Services

In Victoria, the Sexually Abusive Behaviour Treatment Services (SABTS) program provides specialist intervention services for children who have problematic or sexually abusive behaviours and who have not been convicted of a sexual offence. SABTS operates through a range of different agencies across metropolitan and regional Victoria.¹⁴⁶ Services are offered for children up to the age of 15, with some SABTS services supporting children up to the age of 18.

SABTS aims to address patterns of harmful sexual behaviours and restore the child with those behaviours to a normative developmental path.¹⁴⁷ Consistent with the findings of a review of research evidence we commissioned,¹⁴⁸ the program works with the child and their family, as well as the school and community.¹⁴⁹ The needs of each child and family referred to a service are assessed and a plan is prepared. The plan may include individual work with the child or young person who has engaged in the behaviours, their parent or carer, and other children affected, including siblings.¹⁵⁰ A plan may also include participation in group and family work. The duration of the intervention varies according to individual circumstances.

SABTS can be accessed through voluntary referral, referral by health professionals, schools, community services, child protection agencies or the police.¹⁵¹ Some children may be subject to Therapeutic Treatment Orders.¹⁵²

Male Adolescent Program for Positive Sexuality

Established in 1993 by the Royal Children's Hospital in Melbourne, the Male Adolescent Program for Positive Sexuality (MAPPS) provides therapeutic intervention for children and young men aged 10 to 21 following a sex offence conviction. It is also available for children on youth justice community-based orders and for those in Victorian youth detention facilities. Girls referred to MAPPS receive individualised intervention.¹⁵³

Victoria's Department of Health and Human Services identifies the program as based on a multi-modular cognitive behavioural therapy group approach, directed towards relapse prevention and maintenance of behavioural change. The program is based on an 'open group' model that allows young people to be inducted into the program at any time following sentencing.¹⁵⁴

The MAPPS program was last evaluated in 1998.¹⁵⁵

Griffith Youth Forensic Service

In Queensland, Griffith Youth Forensic Service (GYFS) provides specialist forensic psychological assessment and treatment services across the state to youth who are subject to a court sentence in relation to sexual offence matters.¹⁵⁶ The GYFS practice model is multi-systemic and collaborative.¹⁵⁷ This is consistent with a review we commissioned examining the efficacy of interventions responding to children with harmful sexual behaviours.¹⁵⁸ This service has not been evaluated so outcomes for the children who have participated in the program are unknown.

Mater Family and Youth Counselling Service

Located in Brisbane, the Mater Family and Youth Counselling Service assists young people who have sexually offended to change their behaviour. The service also assists families and provides support to young people who have been harmed. The service was evaluated in 2009, and was found to be in line with international best practice.¹⁵⁹

Generalist services

Generalist services provide therapeutic interventions for children with harmful sexual behaviours in the context of a broader mandate to children's psychological health and wellbeing. All Australian states and territories provide generalist therapeutic or counselling assistance to children with harmful sexual behaviours.¹⁶⁰ These services are predominantly provided to children aged 12 years and under and are accessed on a voluntary basis. Many receive funding under programs responding to victims of sexual assault.¹⁶¹

Table 10.7 identifies services that offer interventions for children with harmful sexual behaviours, and identifies those that offer specialist intervention.

Table 10.7 – Generalist services for children with harmful sexual behaviours by jurisdiction

Jurisdiction	Intervention	Eligibility
New South Wales	NSW Health Under 10s	Children aged under 10
	Individual psychological interventions	Children convicted of a sexual offence
Queensland	Laurel Place	Children aged up to 12
	Phoenix House	Children aged under 10
	Child and Youth Forensic Outreach Service	Children aged 10 to 17 not convicted of a sexual offence
	Corrective Services Counselling	Aged 17 and over convicted of a sexual offence in the adult system
South Australia	Sexualised Behaviour Therapy Program	Children aged under 10
	Forensic Psychological Assessment	Children aged under 7
	Youth Justice Psychology Services	Children convicted of a sexual offence
Western Australia	Child Sexual Abuse Therapeutic Services	Children aged up to 18 not convicted of a sexual offence
	Corrections (individual treatment)	Children convicted of a sexual offence
Tasmania	Sexual Assault Support Service	Children aged under 10
	Laurel House	Children aged under 10
	Family Violence Counselling and Support Service (Child and Young Persons Program)	Children aged up to 18 not convicted of a sexual offence
	Community Forensic Mental Health Services	Children aged between 10 and 17 charged but not convicted of a sexual offence
Australian Capital Territory	Melaleuca Place	Children aged under 10
Northern Territory	Mobile Outreach Service (MOS) Plus program	Children aged up to 18 not convicted of a sexual offence
	Sexual Assault Referral Centre	Children aged under 10
	Department of Correctional Services (Youth Sex Offending Program)	Children convicted of a sexual offence

Note: Victoria is serviced state-wide by the SABTS program discussed earlier¹⁶²

5.3.3 Limitations in current therapeutic interventions

Therapeutic interventions for children with harmful sexual behaviours are continuing to develop throughout Australia. Service delivery differs between states and territories,¹⁶³ and a number of agencies identified limitations in the therapeutic interventions available for children with harmful sexual behaviours.¹⁶⁴ In its submission to *Issues paper 10: Advocacy and support and therapeutic treatment services*, CEASE, the peak organisation for the SABTS program in Victoria, told us: services are not sufficiently timely; the lack of effective training and staff retention in service agencies hinders youth engagement; and there is a view among some service agencies that children with harmful sexual behaviours are ‘predators’ and are incapable of rehabilitation.¹⁶⁵

Conducting therapeutic interventions for children with harmful sexual behaviours is a ‘separate and specialised field of service provision necessitating specialist training and supervision for clinicians’.¹⁶⁶ However, we heard that few professionals working with children with harmful sexual behaviours have sufficient therapeutic expertise.¹⁶⁷ In *Case Study 24: Preventing and responding to allegations of child sexual abuse occurring in out-of-home care*, Ms Simone Jackson, executive director of the out-of-home care division within the Northern Territory Department of Children and Families, told us that in the Northern Territory, counsellors, psychologists and therapists provide therapeutic intervention for children who are in out-of-home care. However:

What we suffer from ... is the lack of expertise around sexualised behaviours or problem sexualised behaviours, and particularly young males with sexual offending, getting some expertise around that. We’ve often engaged experts from other jurisdictions, which is a very costly exercise.¹⁶⁸

We were told that while some services have accreditation arrangements,¹⁶⁹ practice standards are inconsistent and there is a possibility that interventions by unqualified practitioners may cause further harm.¹⁷⁰ The lack of widely applicable practice standards is compounded by a lack of education and training for psychologists, psychiatrists, social workers or counsellors in responding to this issue.¹⁷¹

Finally, effective therapeutic intervention for children with harmful sexual behaviours is limited by the lack of research on this topic. The review we commissioned of current best evidence in the therapeutic treatment of children with harmful sexual behaviours found that ‘there are few rigorous high-quality studies, especially for children outside the youth justice system’.¹⁷² While this review found evidence for the efficacy of MST,¹⁷³ these findings have not been thoroughly replicated in the Australian context or in treatment for specific vulnerable groups such as children in out-of-home care.¹⁷⁴

Service gaps for specific populations

There are a number of gaps in evidence and service delivery for particular groups of children with harmful sexual behaviours. We are concerned that service systems are currently unable to adequately address the needs of these children.

Children aged under 10

While we are aware of particular programs delivering services for children under 10 in certain areas,¹⁷⁵ we are not aware of any nationally consistent intervention response by Australian governments for children with harmful sexual behaviours in the under 10 age group. This issue has not been sufficiently identified. For example, the National Framework for Protecting Australia's Children 2009–2020 identifies the need for further treatment options for children with sexually abusive behaviours aged 10 to 15, but does not discuss the issue for children up to 10 years of age.¹⁷⁶

The limited service delivery for children aged under 10 with harmful sexual behaviours is compounded by a lack of research on effective treatment. Our commissioned review of research on the effectiveness of different forms of therapeutic treatment for children with harmful sexual behaviours identified a particular lack of evidence for effective treatment for this group.¹⁷⁷ Further research is needed to identify what therapeutic interventions are effective for children under 10 who have displayed harmful sexual behaviours.

As we discussed in Section 3.4.4 of this volume, the actions of children under 10 are generally not considered criminal. This limits the opportunity to build on the work of systems delivering services to older children with harmful sexual behaviours through the criminal justice system.

We are of the view that harmful sexual behaviours displayed by a child under 10 years of age should receive an assessment and appropriate response, including therapeutic treatment if required.

Children in out-of-home care

Several submissions to our *Consultation paper: Institutional responses to child sexual abuse in out-of-home care* noted there are insufficient therapeutic intervention services for children in out-of-home care who exhibit harmful sexual behaviours.¹⁷⁸ For example, the Truth, Justice and Healing Council submitted that:

The placement and treatment options for children with sexually harmful behaviours need to be identified and strengthened urgently as they are largely nonexistent. The Council acknowledges the Commission's finding that there is an insufficient treatment response for children who display sexually harmful behaviours and a shortage of expert advice and assistance for foster and kinship/relative carers. The impact this has on the sector is concerning, particularly for children, young people and carers who received little to no appropriate trauma-informed therapeutic intervention or support which often contributes to multiple placement changes for the young person involved.¹⁷⁹

We heard that children in out-of-home care who exhibit harmful sexual behaviours, as well as the children who are harmed by these behaviours, sometimes do not receive an appropriate therapeutic response.¹⁸⁰ We also heard that due to the limited number of appropriate therapeutic intervention services available, children may experience long delays before they receive any type of intervention.¹⁸¹

Of the specialist services we were told about, only the New Pathways residential treatment program in New South Wales provided services specifically for children with harmful sexual behaviours who are in out-of-home care.¹⁸² However it must be noted that this service has not been evaluated and outcomes for children who have completed the program are unknown.

Children with intellectual impairment and learning difficulties

Experts told us the practices and assumptions of therapeutic services, and the disability services sector, limit access for children with intellectual impairment, learning difficulties and behavioural and emotional disorders to therapeutic services for harmful sexual behaviours.¹⁸³ Services for children with harmful sexual behaviours are sometimes inaccessible to people with disability.¹⁸⁴ In its submission to our issues paper on *Advocacy and support and therapeutic treatment services*, CEASE told us:

People with a disability, both physical and cognitive, experience difficulty in engaging with SABTS. Services need to be accessible to people with a physical/intellectual disability, and experienced in working with children with [problem sexual behaviours] and young people with [sexually abusive behaviours]. This work takes more time and enhanced/different skills to treating other young people. This requires additional training.¹⁸⁵

We were told that collaboration between disability services and services for children with harmful sexual behaviours is limited,¹⁸⁶ and that as a result, children with disability are often referred to a generalist disability service provider, rather than to a specialist service for harmful sexual behaviours.¹⁸⁷

Regional and remote communities

There is a lack of specialist services for children with harmful sexual behaviours in regional and remote communities.¹⁸⁸ In addition, remote service delivery faces a number of additional issues including high staff turnover,¹⁸⁹ a lack of qualifications among local staff,¹⁹⁰ and logistical challenges associated with providing services in an 'outreach' format.¹⁹¹

Culturally safe services

For Aboriginal and Torres Strait Islander children displaying harmful sexual behaviours, issues associated with intergenerational and collective trauma may require additional, or different forms of, support.¹⁹² As we discuss in Volume 9, *Advocacy, support and therapeutic treatment services*, Aboriginal and Torres Strait Islander healing approaches go beyond individual or family-based interventions and are an important component of the therapeutic treatment sector.

Service providers told us particular approaches and expertise are needed to successfully engage Aboriginal and Torres Strait Islander children who display harmful sexual behaviours.¹⁹³ A number of submissions to the Royal Commission called for services to be culturally safe.¹⁹⁴ We also heard that therapeutic service providers had a shortage of Aboriginal and Torres Strait Islander support workers.¹⁹⁵

While we are aware of promising approaches among some specialist services to provide culturally safe services,¹⁹⁶ we are of the view that further work is required.

5.3.4 Improving access to therapeutic intervention

Increasing the number of therapeutic services

There are insufficient specialist therapeutic services for children with harmful sexual behaviours. Research we commissioned into therapeutic interventions for children's harmful sexual behaviours noted that services are not uniformly available across Australia.¹⁹⁷ We have been told the number of children receiving therapeutic interventions represents a small proportion of the actual need.¹⁹⁸ In our view, therapeutic interventions should be uniformly available for children with harmful sexual behaviours.

As discussed in Volume 9, *Advocacy, support and therapeutic treatment services*, investment in sexual assault services should consider the needs of regional and remote communities, include support for collaborative work across the service system to meet service gaps, and build and share knowledge and expertise across the whole service system.

The spread of Australia's population across metropolitan, regional and remote locations makes it difficult to provide equitable access to interventions. We also understand that while all jurisdictions have local therapeutic health workers, including social workers and community health workers, many are not trained in responding to children's harmful sexual behaviours, and some are not willing to work with children with harmful sexual behaviours.

Specialist intervention for children with harmful sexual behaviours should be available in every jurisdiction. The purpose of a specialist intervention is threefold:

- To provide specialist assessment of children's harmful sexual behaviours.
- To provide therapeutic intervention for individual children and their families and carers.
- To assist local therapists and practitioners to provide lower-level interventions for children with problematic and/or harmful sexual behaviours who have not harmed another child.

We are of the view that an adequately funded network of services is the best approach for providing therapeutic interventions for children who have displayed harmful sexual behaviours in institutional or other settings.

Recommendation 10.3

The Australian Government and state and territory governments should adequately fund therapeutic interventions to meet the needs of all children with harmful sexual behaviours. These should be delivered through a network of specialist and generalist therapeutic services. Specialist services should also be adequately resourced to provide expert support to generalist services.

Improving referral pathways to therapeutic services

In our *Harmful sexual behaviours of children in schools* case study, Dr O'Brien gave evidence concerning referral pathways into therapeutic intervention for children with harmful sexual behaviours. She told us:

Adults don't know the correct referral pathways, as these are different in each state and territory, they are not promoted centrally, and there is a profound reluctance in the community to acknowledge that we have a need for services of this kind.¹⁹⁹

Besides increasing the number of therapeutic intervention services, governments should promote access to therapeutic intervention by establishing clear referral pathways to these services. These pathways should include but not be limited to the criminal justice system because, as discussed in Chapter 2 of this volume, most harmful sexual behaviours by children do not reach the threshold for a sexual offence.²⁰⁰ We believe there should be voluntary access to therapeutic intervention, as well as compulsory participation through the child protection and criminal justice systems.

In this section, we discuss each of these referral pathways. We note that pathways to therapeutic intervention should always operate in a way that prioritises the safety and wellbeing of the victim, the child with harmful sexual behaviours, and any other children who are in contact with that child.

Criminal justice system pathways

It is incumbent on state and territory governments to ensure that children who have come into contact with the criminal justice system as a result of displaying harmful sexual behaviours receive an intervention that reduces the risk of such behaviours recurring. Interventions should be in line with evidence around effective practice for children who have sexually offended.²⁰¹ Assessment and therapeutic services should be available to juveniles at all stages of the criminal justice system, from initial police contact through to detention.

Child protection pathways

A large number of children with harmful sexual behaviours have contact with the child protection system.²⁰² These children should have clear referral pathways to assessment and, where necessary, therapeutic treatment. In addition, child protection agencies can contribute to secondary prevention by detecting at-risk children and families.

Voluntary referrals from institutions and caregivers

Voluntary engagement with a therapeutic intervention program is preferable to compelling a child to attend involuntarily.²⁰³ However, voluntary referrals to specialist services are not universally available across Australia.²⁰⁴ We believe a voluntary referral pathway to therapeutic interventions should be available in each jurisdiction. Staff within institutions, health and child protection professionals, parents and carers should be able to refer a child with harmful sexual behaviours directly to a service provider for assessment and therapeutic intervention. Voluntary referral pathways should be clear and information about available services should be widely available and accessible to institutions, professionals and parents and carers.

We also acknowledge that community education initiatives (see Section 4.2.2 and Recommendation 10.1 of this volume) are designed to improve the identification of children's harmful sexual behaviours. If those services are delivered, there is likely to be a corresponding increase in need for appropriate pathways to therapeutic interventions.

The Victorian model

The preceding discussion identifies that children with harmful sexual behaviours should be able to participate in therapeutic intervention either voluntarily or, where required for their own wellbeing and the safety of others, compulsorily via the child protection or criminal justice systems. Victoria is currently the only Australian jurisdiction with all of these pathways to therapeutic intervention in place. The Victorian model also promotes the collaboration between formal systems – the child protection, criminal justice and therapeutic service systems – that is necessary for children with harmful sexual behaviours to access therapeutic intervention through these pathways.

The Victorian scheme appears to enable more children with harmful sexual behaviours to access therapeutic interventions than other jurisdictions. It has particular value in facilitating therapeutic intervention for children with harmful sexual behaviours where the child or their parents or carers would not voluntarily access therapy. This includes facilitating this intervention for high-risk children charged with juvenile sexual offences.

There has been no formal evaluation of the Victorian scheme, although it appears promising in terms of increasing pathways to therapeutic intervention. We also have no evidence that the Victorian scheme has been better at reducing recurrence of harmful sexual behaviours in children attending therapeutic intervention than the arrangements in place in other jurisdictions. A comprehensive evaluation of the Victorian approach, particularly its impact on reducing the recurrence of children's harmful sexual behaviours as well as on improving clinical outcomes for the child, would be of benefit. This would increase the evidence available to inform the development of accessible pathways to therapeutic intervention across all Australian jurisdictions.

Recommendation 10.4

State and territory governments should ensure that there are clear referral pathways for children with harmful sexual behaviours to access expert assessment and therapeutic intervention, regardless of whether the child is engaging voluntarily, on the advice of an institution or through their involvement with the child protection or criminal justice systems.

5.3.5 Improving collaboration between generalist and specialist practitioners

There is a need for specialist practitioners to build professional alliances and work collaboratively in delivering therapeutic interventions to children with harmful sexual behaviours.²⁰⁵

We were told that many children do not require specialist, intensive therapy to address their harmful sexual behaviours.²⁰⁶ For some children, particularly those exhibiting problematic sexual behaviours where no other child was harmed, counselling from a generalist practitioner, with skills and knowledge in responding to harmful sexual behaviours, may be an adequate intervention.

Linkages between specialist and generalist practitioners begin with assessment.²⁰⁷ The assessment process can identify generalist interventions that may be of benefit for the child. In these instances, generalist interventions should be supported by specialist practitioners.

At our private roundtable on therapeutic interventions and service responses for children with harmful sexual behaviours, participants told us that some situations, such as working with children in regional or remote areas or with children with disability, required specialist clinicians to guide the work of generalist practitioners rather than provide therapeutic treatment themselves.²⁰⁸ This type of guidance could be in the form of regular contact with a specialist (via phone, email or face-to-face), frequent supervision sessions or training and development. Specialist support may assist to enhance the skills of generalists to work therapeutically with children with harmful sexual behaviours.

Multidisciplinary training for all service providers that work with children with harmful sexual behaviours could assist in creating a common language and understanding of each other's roles.²⁰⁹ Key service providers include police, social workers, psychiatrists, psychologists, child and adolescent mental health workers, generalist health workers, general practitioners, occupational therapists, speech pathologists, juvenile justice officers, child protection workers, educational staff from preschool to high school, residential staff and foster carers and kinship carers.

5.4 Best practice principles for therapeutic intervention

As noted, experts in the field of children with harmful sexual behaviours have suggested a principles-based approach to guide therapeutic interventions. Principles, informed by the best available evidence, provide an agreed framework for best practice. Within this framework different therapeutic models can be selected so therapy can be tailored to the child's specific needs and situation, according to expert assessment. In this way principles act as a benchmark for the quality and effectiveness of interventions.

In this section, we outline best practice principles for therapeutic interventions for children with harmful sexual behaviours. We note these are broad principles and the particular interventions will vary in accordance with the child's needs and the unique circumstances surrounding their behaviours.

Several sources informed the development of our best practice principles. These were:

- Two particular research reports we commissioned. The first of these examines current best available evidence on effective therapeutic intervention for children with harmful sexual behaviours.²¹⁰ The second considers the emergence of the trauma-informed approach to the provision of therapeutic services and the key principles underpinning this approach.²¹¹
- The 'operational framework' proposed by the National Society for the Prevention of Cruelty to Children and the Research in Practice organisation. As noted in Chapter 4 of this volume, in 2016 these organisations published a framework for responding to children's harmful sexual behaviours in the United Kingdom.²¹² This framework, which is evidence-informed, includes key principles for effective intervention with children.

- The CEASE Standards of Practice for Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Programs.²¹³ The standards outline requirements in relation to equity of access and quality of care for therapeutic services working with children with harmful sexual behaviours. CEASE, which developed the standards, is as noted, a peak organisation that provides guidance related to children with harmful sexual behaviours. The standards have been adopted by the Victorian Government for its funded service providers, and endorsed by the Australian and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA).

We used these sources, as well as our public hearings, private sessions and consultations with experts, to identify best practice principles for therapeutic intervention for children with harmful sexual behaviours. Rather than adopting an existing set of principles, we selected only those principles that were supported by the research we commissioned and the most current standards of good practice for working with children with harmful sexual behaviours.

We have identified nine best practice principles for therapeutic intervention for children with harmful sexual behaviours, which are relevant to children of all ages. These are:

1. a contextual and systemic approach should be used²¹⁴
2. family and caregivers should be involved²¹⁵
3. safety should be established²¹⁶
4. there should be accountability and responsibility for the harmful sexual behaviours²¹⁷
5. there should be a focus on behaviour change²¹⁸
6. developmentally and cognitively appropriate interventions should be used²¹⁹
7. the care provided should be trauma-informed²²⁰
8. therapeutic services and interventions should be culturally safe²²¹
9. therapeutic interventions should be accessible to all children with harmful sexual behaviours.²²²

The first five principles are targeted toward specialist interventions for harmful sexual behaviours by children. The remaining four principles are generic to all types of therapeutic intervention and are consistent with the principles for therapeutic treatment services we outline in Volume 9, *Advocacy, support and therapeutic treatment services*.

We explain each of these nine principles in the section that follows.

5.4.1 A contextual and systemic approach should be adopted

Research suggests that for therapeutic interventions for children with harmful sexual behaviours to be effective they should be contextual and systemic, taking into account a child's environment and the connections between different parts of their lives.²²³ Interventions should reflect the range of relationships the child is in, including their relationships with their family, neighbourhood, school and community.²²⁴ The CEASE standards of practice, together with the available research, suggest that a contextual and systemic approach may include:²²⁵

- work with schools
- work with extended family, significant others and occasional carers
- work with peers and the community
- collaboration with other professionals working with the child and family, including child protection and out-of-home care providers.

The therapeutic intervention should be clearly communicated within the network of institutions and services supporting the child and their family. Safety should be a prime consideration for both assessment and therapeutic intervention.²²⁶ Clinical approaches that focus on the individual child without involving their parents/caregivers and institutions in the child's wider environment appear less effective.²²⁷

5.4.2 Family and caregivers should be involved

Research suggests that involving the family and/or carer of a child with harmful sexual behaviours, as well as the institutions with which the child regularly interacts, in therapeutic intervention helps support and promote behaviour change and good outcomes for the child.²²⁸ This should not be an adjunct to the therapeutic process but rather a core element of effective intervention.²²⁹ There are several reasons why a focus on families and caregivers is important.

First, sending a child to a therapist for an hour a week, without also including behaviour change strategies in the home and in the other environments in which the child is regularly engaged, is unlikely to help them to cease their harmful sexual behaviours.²³⁰ Given children spend more time at home or in residential care settings than they do in therapy, most opportunities for 'teachable moments' will occur when they are with their family or carer.²³¹ Parents and carers play a particularly important role in behaviour management and promoting positive behaviour change. They are often capable of reinforcing a child's positive behaviours and curbing or stopping the negative ones.²³²

Parents and carers should not be expected to have expert knowledge. We believe practitioners should be responsible for equipping parents and carers with techniques and strategies that contribute to and support behaviour change for the child. Parents and carers must be able to provide appropriate support and supervision, and develop rules and clear boundaries for the child with harmful sexual behaviours.²³³

A second reason for involving family members and carers in therapeutic intervention is that it enables practitioners to address issues in the child's home environment that may be contributing to, or sustaining, the harmful sexual behaviours. For example, the child may be living within an overly sexualised or a highly repressive family environment that may be affecting their development.²³⁴ Addressing such issues will be necessary in supporting the child to stop their harmful sexual behaviours.

Importantly, involving parents and carers in the therapeutic intervention also provides an opportunity for them to receive support, as they may carry an emotional burden regarding their child's harmful sexual behaviours. The CEASE standards of practice highlight that 'practitioners need to assertively engage with families as there is significant shame and stigma associated with the behaviour which needs to be addressed to promote good outcomes'.²³⁵

If a decision is made to place a child with harmful sexual behaviours into out-of-home care, even where this is only for a short period of time, experts should assess whether the child's family should be included in the therapeutic intervention. Experts consider it best practice to include the family, where safe and appropriate.²³⁶ The CEASE standards of practice state that, if a child has been removed from the home, family reunification should remain a high priority in the therapeutic intervention, unless there are permanent risks that exclude this as an option.²³⁷

In working with families and significant others, practitioners should take into account that, in some cases, understandings of what constitutes a family may be broader and more complex than western notions of the nuclear family. This is particularly true for Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds.

5.4.3 Safety should be established

The primary focus during assessment and at the start of therapeutic intervention should be to establish safety for the child with harmful sexual behaviours, the children who may have been sexually abused and any children who may have witnessed the abuse.²³⁸ Family, caregivers and other agencies should be involved in developing safety strategies that provide safe and appropriate ways of managing the child's behaviours, while respecting confidentiality.²³⁹ Safety planning should consider the range of factors in the child's life that may result in harm, including patterns of high-risk behaviours, situations and relationships.²⁴⁰ The safety plan should identify risks to the child with harmful sexual behaviours, other children with whom the child interacts, and children who have previously been harmed by the child's behaviours including children who may have witnessed the harmful sexual behaviours.²⁴¹ Practitioners should continue to assess safety throughout the course of therapeutic intervention, as risks to safety can change.

The safety plan should engage all services involved with the child with harmful sexual behaviours, as well as the child's parents or carers. This may involve establishing informal or formal undertakings between the parents or carers and child protection.

5.4.4 There should be accountability and responsibility for the harmful sexual behaviours

Therapeutic intervention for children with harmful sexual behaviours should assist the child to acknowledge and take responsibility for their behaviours.²⁴² Being accountable and taking responsibility for harmful sexual behaviours is especially important where another child has been a victim of the behaviours. Children with harmful sexual behaviours need to understand that they are responsible for their behaviours, they can stop the behaviours from happening again and can learn to do this with help and support from people around them.²⁴³

At first, the child with harmful sexual behaviours needs to develop an understanding of why the behaviours were abusive. Many children with harmful sexual behaviours may not have a clear understanding of sexual abuse nor understand consent, coercion and unequal power.²⁴⁴ The process of understanding how harmful sexual behaviours can affect other people, including victims, is critical to addressing the beliefs and attitudes that can both support the harmful sexual behaviours and allow the child engaging in them to justify or rationalise their actions.²⁴⁵ Exploring and challenging these types of attitudes can help the child with harmful sexual behaviours to cease the behaviours, and can help prevent any relapse.²⁴⁶

The inclusion of the victim's voice in the therapeutic intervention for the child with harmful sexual behaviours can assist in the process of a child taking responsibility and accountability for the harm they have caused. For example, knowledge of the impact of the sexual abuse on the victim can be helpful. Experts suggest that this can be provided through channels such as victim statements or other forms of correspondence in which victims outline their thoughts and emotions. Experts caution that such correspondence should only be shared via practitioners.²⁴⁷

5.4.5 There should be a focus on behaviour change

Children with harmful sexual behaviours need support to cease these behaviours. There are some children who will stop the harmful sexual behaviours when they are provided with a safe environment and other minimal interventions such as education on what is acceptable sexual behaviour. However, some children require therapeutic intervention. The aim of a therapeutic intervention that is focused on behaviour change is to guide the child towards understanding appropriate (prosocial) and safe ways to behave.²⁴⁸ Depending on the child's age and developmental ability, this may involve discussions about boundaries, consent, coercion and power in relationships.

Practitioners should identify factors that contribute to a child's harmful sexual behaviours and those that support more positive behaviours.²⁴⁹ To achieve behavioural change, the child's environment must support changes in behaviour, rather than undermine them.²⁵⁰ For instance, a practitioner who provides weekly therapeutic intervention to a child from a chaotic and traumatic home environment cannot expect that child to change their behaviours without also addressing what is happening within the home.

An understanding of the child's entire circumstances as well as engagement with the family during therapeutic work can assist in developing sensitive and effective strategies for behaviour change.²⁵¹ These circumstances may include challenges the child is experiencing at school, at home or in their social life. For instance, during adolescence, peers and social networks external to the family become very important to children.²⁵² Where peers and social networks are constructive and promote positive behaviours, interventions should aim to harness aspects of these relationships. Where these relationships pose a risk to behaviour change, practitioners should carefully consider how to address the negative aspects of these relationships and move the child to more supportive networks.

5.4.6 Developmentally and cognitively appropriate interventions should be used

Children with intellectual impairment and learning difficulties tend to be over-represented amongst those referred to specialist therapeutic intervention for harmful sexual behaviours.²⁵³ For therapeutic interventions to be effective they must be tailored to each child's needs. This includes using approaches that are appropriate to the child's age and developmental stage, as well as accommodating any learning and language difficulties, developmental delays, cognitive impairments, emotional and behavioural disorders (such as conduct disorders), and other support needs as a result of disability.²⁵⁴

Research suggests that talk therapy may be ineffective for a range of children. This includes children under five years old, those who lack verbal skills, and children with developmental delays, cognitive disability and emotional and behavioural disorders, including conduct disorders.²⁵⁵ In such cases, talk therapy may fail to take into account developmental psychology, socialisation, gender (particularly for boys) and the impact of trauma on development. Where assessed as necessary, the therapeutic intervention should incorporate multidisciplinary practice for children who do not respond to talk therapy.²⁵⁶

Even in situations where children have the capacity to engage in talk therapy, the initial focus of an intervention should be rapport building and relationship development.²⁵⁷ Research has found that new neural pathways in the brain may develop through these types of relationship-building experiences.²⁵⁸

Practitioners should have an understanding of the impacts of trauma on brain development, including the role that disrupted or dysfunctional attachment can play in a child's capacity for emotional self-regulation.²⁵⁹ In order to align with the neurobiological research, developmentally appropriate therapeutic interventions should incorporate an understanding of how attachment relationships can improve outcomes.²⁶⁰ Therapists develop relationships with the child and their family and these relationships have the capacity to provide new and important experiences of safety and attachment.²⁶¹

5.4.7 The care provided should be trauma-informed

As discussed in Chapter 2 of this volume, trauma is present in the backgrounds of many children with harmful sexual behaviours.²⁶² As outlined in Volume 9, *Advocacy, support and therapeutic treatment services*, the trauma-informed approach provides a framework for service provision by which the practices, policies and culture of an organisation and its staff are responsive to the impacts of trauma on the wellbeing and behaviour of service users.²⁶³ Service systems that are trauma-informed recognise the impacts of trauma and respond holistically to the experiences and complex needs of the child concerned.²⁶⁴

Research we commissioned identified that trauma-informed care should include the following principles:

- 'having a sound understanding of the prevalence and nature of trauma arising from interpersonal violence and its impacts on other areas of life and functioning
- ensuring that organisational, operational and direct service provision practices and procedures don't undermine and indeed promote the physical, psychological and emotional safety of children
- adopting service cultures and practices that empower consumers in their recovery by emphasising autonomy, collaboration and strengths-based approaches
- recognising and being responsive to the lived, social and cultural contexts of children (for example, recognising gender, race, culture and ethnicity), which shape both their needs as well as recovery and healing pathways
- recognising the relational nature of both trauma and healing'.²⁶⁵

This commissioned research underlined the need to implement trauma-informed care across the therapeutic service system and at all levels.²⁶⁶ Volume 9, *Advocacy, support and therapeutic treatment services* provides a detailed discussion on the importance of trauma-informed care for victims and survivors.

5.4.8 Therapeutic intervention should be culturally safe

At our private roundtable on therapeutic treatment for children with harmful sexual behaviours, we were told that cultural respect and cultural competency should be ‘core business’ for treatment services.²⁶⁷ Research commissioned by us into trauma-informed approaches to child sexual abuse confirms the importance of cultural safety in responding to the needs of survivors.²⁶⁸ The research lists five organisational principles of a trauma-informed system of care, including ‘recognising and being responsive to the lived, social and cultural contexts of consumers (for example recognising gender, race and ethnicity)’.²⁶⁹ State and territory governments have informed us of a number of ways in which they have actively worked to improve cultural competency in therapeutic treatment services for children with harmful sexual behaviours.²⁷⁰ The wider literature on counselling and therapeutic treatment also acknowledges the importance of taking cultural meanings and processes into account, to support the therapeutic process.²⁷¹

We believe cultural safety is a necessary component of therapeutic interventions for harmful sexual behaviours to effectively engage children and their families, and to support therapeutic outcomes. This is particularly important for Aboriginal and Torres Strait Islander communities.

5.4.9 Therapeutic intervention should be accessible to all children with harmful sexual behaviours

Although there are limitations in the quantitative data, some research suggests that the number of children receiving therapeutic intervention for harmful sexual behaviours represents just a fraction of the underlying need.²⁷² During our private roundtable on therapeutic treatment, there was agreement from service providers, government officials and academic experts from around the country that demand for services for children with harmful sexual behaviours exceeds current capacity to respond.²⁷³

As noted throughout this volume, children with harmful sexual behaviours are a diverse group. We heard that there are specific populations within this group that are less likely to access therapeutic interventions for their harmful sexual behaviours.²⁷⁴ These populations generally consist of children who may require more tailored interventions involving a number of agencies. More work is needed to ensure that therapeutic interventions are available and accessible, and that they tailor to the particular needs of:

- girls
- children with intellectual impairment, learning difficulties and emotional and behavioural disorders, including conduct disorders
- children under the age of 10
- children in out-of-home care
- children in regional and remote locations.

Recommendation 10.5

Therapeutic intervention for children with harmful sexual behaviours should be based on the following principles:

- a. a contextual and systemic approach should be used
- b. family and carers should be involved
- c. safety should be established
- d. there should be accountability and responsibility for the harmful sexual behaviours
- e. there should be a focus on behaviour change
- f. developmentally and cognitively appropriate interventions should be used
- g. the care provided should be trauma-informed
- h. therapeutic services and interventions should be culturally safe
- i. therapeutic interventions should be accessible to all children with harmful sexual behaviours.

5.5 Developing the therapeutic workforce

In this section, we address how training and workforce development can be improved to promote the professional skills of practitioners who work with children with harmful sexual behaviours. We also consider the importance of professional supervision in supporting practitioners and ensuring the quality of the services they deliver. Based on our investigation of these issues, we make a recommendation regarding training and professional supervision for practitioners who work with children with harmful sexual behaviours.

5.5.1 Training and workforce development

There appears to be limited research about the type and level of training that practitioners working with children with harmful sexual behaviours have received.²⁷⁵ The systematic review we commissioned suggested that quality improvement processes for therapeutic interventions should include training for practitioners working in the area of children with harmful sexual behaviours.²⁷⁶ International literature shows that there are few training opportunities for practitioners working in this area.²⁷⁷ In our consultations with Australian experts, we heard there is a need for more training ‘to counter the paralysis among practitioners’ that comes with the idea that this area ‘is about sex offending’ and is ‘a thing that only specialists do’ so ‘I have nothing to contribute’.²⁷⁸

Training for practitioners working with children with harmful sexual behaviours should have a number of features. It should be evidence-based and educate practitioners about trauma-informed and culturally safe practice. Research suggests that specific training around the different subgroups of children with harmful sexual behaviours is also required for practitioners to deliver effective therapeutic interventions.²⁷⁹ This includes training about specific populations of children with harmful sexual behaviours including girls, children from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander children, and children with disability.

As discussed in Chapter 2, many children with harmful sexual behaviours have prior trauma histories. For this reason, many of these children will require trauma-specific interventions. Volume 9, *Advocacy, support and therapeutic treatment services* identifies factors that support therapeutic services to deliver effective interventions. One of these factors is that staff should have the necessary skills to deliver the service. Practitioners working with children with harmful sexual behaviours should receive training on trauma specific interventions.

In addition to training, minimum standards should be developed for the workforce of practitioners who work with children with harmful sexual behaviours. When we consulted with experts, we were told about the need to adopt standards and benchmarks for professional qualifications, clinical supervision, clinical practice, staff retention, culturally safe practice and systems and provision of specialist practice resources.²⁸⁰

Training should be evidence-based and should also be evaluated to ensure that it is effective. Evaluation should consider the impact of training on professional practice as well as the impact on practitioners' attitudes, awareness and self-efficacy, not merely participants' experience of any given course.²⁸¹

5.5.2 Supervision

In addition to supporting those working with children with harmful sexual behaviours through training, we heard that it is critical to provide practitioners responding to children with harmful sexual behaviours with professional supervision.²⁸²

Professional supervision is distinct from management in that it aims to foster the practitioner's clinical capacity rather than ensure that their day-to-day activities are in line with the relevant agency's priorities. Professional supervision should, wherever possible, be conducted externally in order to avoid conflicts of interest and to provide practitioners with the opportunity to debrief and reflect on their clinical experiences.

Professional supervision is an important means of supporting the therapeutic workforce to provide quality services. Professional supervision allows opportunities for peer support and knowledge exchange outside of the context of a formal training course.²⁸³ Continued exposure to traumatic content without supervision and support can lead to burnout,²⁸⁴ which can cause disruption to treatment for children with harmful sexual behaviours and undermine the effectiveness of the workforce as a whole.²⁸⁵ Supervision supports staff retention²⁸⁶ and the management of vicarious trauma.²⁸⁷ We were told by a range of organisations in submissions,²⁸⁸ and in our consultations with experts,²⁸⁹ that supervision is an important means of promoting service quality, ensuring safety and maintaining practitioners' wellbeing.

Supervision and debriefing for professional staff should be conducted regularly. Professional supervisors external to the organisation can be used.²⁹⁰ Where applicable, supervision may be conducted in a group or individually. Although supervision is generally conducted face-to-face, it can also be conducted using communications technology – for example, web-conferencing or telephone – where necessary. Using communications technology for supervision may be particularly important for practitioners working in rural or remote areas who require the expert support of specialists working in metropolitan areas.

In addition to professional supervision, cultural supervision should be provided to Aboriginal and Torres Strait Islander staff and any staff working with Aboriginal and Torres Strait Islander children, families or communities.²⁹¹

Recommendation 10.6

The Australian Government and state and territory governments should ensure that all services funded to provide therapeutic intervention for children with harmful sexual behaviours provide professional training and clinical supervision for their staff.

5.6 Improving evaluation of therapeutic interventions

Evaluation is necessary to improve the implementation and delivery of therapeutic interventions for children with harmful sexual behaviours, to inform practice and to demonstrate the impact of an intervention in the short term, as well as sustainable long-term changes.²⁹² Evaluation is needed to show what works, for whom, and in what setting. Evaluation can also indicate which parts of an intervention are effective and which require improvement. Evaluation is particularly important for emerging fields because it advances the limited evidence base and provides a positive direction for the development of new interventions.

Research we commissioned shows that few high-quality evaluations of current Australian therapeutic interventions for children’s harmful sexual behaviours have been conducted, which aligns with what we heard during consultations.²⁹³ At our private roundtable, an expert practitioner told the Royal Commission that a common issue with evaluating the success of therapeutic interventions for children with harmful sexual behaviours is that:

evaluations compare their successful treatment outcomes with the kids that they were not successful with and then make claims that their program was successful. But, of course, the actual outcome is that the proposal is, in a sense, a failure if it does not successfully engage with the kids who are the most difficult to engage because they are the ones that are most likely to wreak havoc down the track.²⁹⁴

Short-term pilot projects that do not provide funding or time for longer-term evaluations are also unlikely to build a body of knowledge and progress the field substantially. Linking evaluation to funding is an important step in ensuring service providers remain accountable for ceasing harmful sexual behaviours by children. Evaluations also allow funding bodies to direct resources to those providers who are delivering better outcomes and prioritise their funding for continuation or expansion.

We are of the view that any government-funded therapeutic interventions should be rigorously evaluated to ensure these interventions deliver positive short-term and long-term outcomes for children with harmful sexual behaviours and their families. Once services have shown that they are consistently delivering interventions that reduce or cease harmful sexual behaviours by children, both generally and for specific populations, further evaluations should be undertaken to test cost-effectiveness and implementability in other contexts. The results of these evaluations should be shared with the field to inform and strengthen practice.

Recommendation 10.7

The Australian Government and state and territory governments should fund and support evaluation of services providing therapeutic interventions for problematic and harmful sexual behaviours by children.

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services or programs for children under 18 who exhibit problem sexual behaviours or sexually abusive behaviours or
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Department of the Chief Minister, Northern Territory Government, information provided to the Royal Commission
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- 164 South Eastern Centre Against Sexual Assault, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper No 9: Addressing the risk of child sexual abuse in primary and secondary schools*, 2015; People with Disability Australia, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues paper No 10: Advocacy and support and therapeutic treatment services*, 2015, p 4; Children's Protection Society, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper No 10: Advocacy and support and therapeutic treatment services*, 2015, p 6.
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APPENDICES

Appendix A Relevant terminology

Table A.1 – Terminology commonly used by practitioners, policymakers and academics

Descriptor	Description
Problematic, inappropriate or concerning sexual behaviours	These terms are generally applied to behaviours exhibited by children under the age of 10. ¹ Problematic behaviours are generally considered to be those without overt victimisation, but which may cause the victim to experience distress or to reject the child exhibiting the behaviours. They include behaviours such as persistent self-stimulation or use of sexual language. ² They may include behaviours such as touching other children's genitals or using sexual language, where an intent to cause harm to the other child is lacking. ³
Sexually reactive behaviours	This term is used to apply to sexual behaviour problems in children which appear to be trauma-related, originating from sexual abuse the child has experienced. ⁴ Children may re-enact the sexual abuse they experienced or become hyper-sexualised; however, any harm to others is not intentional. ⁵
Sexually abusive behaviours	This term is generally applied to behaviours exhibited by children over the age of criminal responsibility. In Australia, it applies to those aged 10 to 17 years. ⁶ Sexually abusive behaviours involve non-consensual, coercive, manipulative or predatory elements and are often characterised by power imbalances related to age, size or status. ⁷ They are likely to involve behaviours that would be classified as sexual offences in legislation.
Sexual offending	This applies to behaviours by children who have been convicted of a sexual offence. In Australia, this term can be applied to children aged 10 to 17 years. ⁸
Sexually harmful behaviours or harmful sexual behaviours	These are umbrella terms used to describe any sexual behaviour that is developmentally inappropriate, may be harmful towards one's self or others, or may be abusive towards another child, young person or adult. ⁹ Subject matter experts in the United Kingdom ¹⁰ and New Zealand ¹¹ commonly use these terms.

Appendix B Examples of existing guidance on children's sexual behaviours

There are existing tools and resources that describe what is developmentally expected and accepted for children's sexual development, and conversely what should be considered problematic or harmful sexual behaviours. Some examples are outlined below. We note that each tool or resource was developed for a particular purpose and may not be generalisable to all institutions or situations. We do not endorse any particular tool.

In addition to the models outlined below, other resources about children's sexual behaviours include information on how to distinguish developmentally appropriate behaviours from harmful sexual behaviours at particular ages.¹²

Traffic lights tool

The traffic lights tool was developed by True Relationships and Reproductive Health (previously Family Planning Queensland), a Queensland-based women's sexual health agency.¹³ It has also been adapted for use in the United Kingdom.¹⁴ This tool was endorsed by Dr Steve Florisson, coordinator of Boarding Training Australia, during our *Harmful sexual behaviours of children in schools* case study¹⁵ and by Ms Holly Brennan, General Manager of Education and Community Services for Family Planning Queensland, in *Case Study 24: Preventing and responding to allegations of child sexual abuse occurring in out-of-home care*.¹⁶

The traffic lights tool classifies children's sexual behaviours into the following categories:¹⁷

- **Green** – developmentally expected sexual behaviours, displayed between children of similar age or developmental ability. Such behaviours are spontaneous, mutual and consensual.
- **Amber** – sexual behaviours that are of potential concern due to age or developmental differences between the children involved, as well as factors such as activity type, frequency, duration or context. These behaviours may need to be assessed and could require monitoring or some low-level intervention to ensure they stop and do not escalate further.
- **Red** – harmful sexual behaviours that indicate a need for immediate intervention and assessment to determine the appropriate type of intervention for the child and their particular situation. They may involve secretive, compulsive, threatening or degrading sexual behaviours. Some of these behaviours may be considered criminal in Australia if the child is aged over 10 and it is established that the child understood that what they were doing was legally wrong.¹⁸

Table B.1 provides examples of sexual behaviours that fall into the green, amber and red categories for children of specified age groups.

Table B.1 – Select examples of green, orange and red sexual behaviours in children¹⁹

Age group	Examples of green behaviours	Examples of amber behaviours	Examples of red behaviours
0–4 years	<ul style="list-style-type: none"> • Comfort in being nude • Holding own genitals • Wanting to touch familiar children’s genitals when in bath 	<ul style="list-style-type: none"> • Masturbation in preference to other activities • Explicit sexual talk, art or play • Pulling other children’s clothes down against will 	<ul style="list-style-type: none"> • Compulsive masturbation • Simulation of sexual touch or sexual activity • Persistently touching genitals of other people
5–9 years	<ul style="list-style-type: none"> • Solitary masturbation • Asking questions about sexuality and babies • Playing family 	<ul style="list-style-type: none"> • Persistent nudity or exposing of genitals in public places • Persistently mimicking sexual flirting behaviour • Persistently watching or following others to look at or touch them 	<ul style="list-style-type: none"> • Persistent bullying involving sexual aggression • Sexual behaviour with much younger children • Accessing rooms of sleeping children to engage in sexual activities
10–13 years	<ul style="list-style-type: none"> • Solitary masturbation • Use of sexual language • Hugging, kissing, or touching known peers 	<ul style="list-style-type: none"> • Persistent expression of fear of sexually transmitted infection or pregnancy • Marked changes to behaviours such as seeking relationships with older children 	<ul style="list-style-type: none"> • Force or coercion of others into sexual activity • Sexual activity in exchange for money or goods • Possessing photos of naked children
14–17 years	<ul style="list-style-type: none"> • Viewing materials for sexual arousal • Sexually explicit mutual conversations with peers • Sexual activity with a partner of similar age/developmental ability 	<ul style="list-style-type: none"> • Sexual preoccupation which interferes with daily function • Explicit communications which are sexually intimidating • Unsafe sexual behaviours, such as unprotected sex 	<ul style="list-style-type: none"> • Preoccupation with sexually aggressive or illegal pornography • Engaging others in sexual activity via grooming processes • Distributing sexual images of another person without their consent

Guidance from the Victorian Department of Health and Human Services

The Victorian Department of Health and Human Services provides guidance on sexual behaviours for children aged 12 and under. This guidance, including examples of age-appropriate, concerning and very concerning sexual behaviours for children in different age groups, is included in Table B.2.

Table B.2 – Select examples of sexual behaviours of children²⁰

Age group	Age-appropriate	Concerning	Very concerning
0–4 years	<ul style="list-style-type: none"> • Touching or rubbing their own genitals • Showing others their genitals • Playing doctors and nurses 	<ul style="list-style-type: none"> • Persistent masturbation that does not cease when told to stop • Forcing another child to engage in sexual play • Chronic peeping 	<ul style="list-style-type: none"> • Sexual play including forceful anal or vaginal penetration with objects • Persistently touching their genitals to the exclusion of other childhood activities
5–7 years	<ul style="list-style-type: none"> • Occasional masturbation • Kissing and flirting • Dirty words or jokes with peer group 	<ul style="list-style-type: none"> • Continually touching their own genitals in public • Persistent use of dirty words • Chronic peeping 	<ul style="list-style-type: none"> • Rubbing their genitals on other people • Talking about sex and sexual acts habitually
8–12 years	<ul style="list-style-type: none"> • Occasional masturbation • Kissing and flirting • ‘show me yours and I’ll show you mine’ with peers 	<ul style="list-style-type: none"> • Attempting to expose others’ genitals • Group masturbation 	<ul style="list-style-type: none"> • Chronic pornographic interest • Sexually explicit threats • Simulating intercourse with peers with clothes off

Guidance from the Australian Centre for the Study of Sexual Assault

The Australian Centre for the Study of Sexual Assault published a resource about young people who sexually abuse, to assist in distinguishing between ‘normal’ sexual behaviours and concerning or abusive behaviours in adolescents. This information is reproduced in Table B.3.

Table B.3 – Normal and concerning/abusive sexual behaviours of adolescents²¹

Normal adolescent sexual behaviours	Concerning/abusive behaviours
Masturbation in private	Masturbation causing physical harm or distress to self and others; public masturbation
Mutual kissing	Unwanted kissing
Sexual arousal; sexual attraction to others	Voyeurism; stalking; sadism (gaining sexual pleasure from others’ suffering)
Consensual touching of other’s genitals; consensual sexual intercourse; consensual oral sex	Non-consensual groping or touching of others’ genitals; coercive sexual intercourse/sexual assault; coercive oral sex
Behaviour that contributes to positive relationships	Behaviour that isolates the young person and is destructive of their relationships with peers and family

Endnotes

- 1 *Child, Youth and Families Act 2005* (Vic), s 244; R Pratt, R Miller & C Boyd, *Adolescents with sexually abusive behaviours and their families*, Victorian Department of Human Services, Melbourne, 2012, p 12: Pratt refers to sexualised behaviour or problem sexual behaviour.
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- 4 S Hackett, D Holmes & P Branigan, *Operational framework for children and young people displaying harmful sexual behaviours*, National Society for the Prevention of Cruelty to Children, London, 2016, p 13; T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 58 citing KA Kendall-Tackett, LM Williams & D Finkelhor, 'Impact of sexual abuse on children: A review and synthesis of recent empirical studies', *Psychological Bulletin*, vol 113, no 1, 1993.
- 5 T Cavanagh Johnson, *Helping children with sexual behavior problems: A guidebook for professionals and caregivers*, 4th edn, J Roberts, Institute on Violence, Abuse and Trauma, San Diego, 2014; C Carson & The AIM Project, *AIM Assessment and Intervention for children under 12 years who display harmful sexual behaviour*, The AIM Project, London, 2014, p 14.
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- 9 S Hackett, D Holmes & P Branigan, *Operational framework for children and young people displaying harmful sexual behaviours*, National Society for the Prevention of Cruelty to Children, London, 2016, p 12, derived from S Hackett, *Children and young people with harmful sexual behaviours*, Research in Practice, Devon, 2014.
- 10 S Hackett, D Holmes & P Branigan, *Operational framework for children and young people displaying harmful sexual behaviours*, National Society for the Prevention of Cruelty to Children, London, 2016, p 12; National Institute for Health and Care Excellence, *Harmful sexual behaviour among children and young people: NICE guideline*, National Institute for Health and Care Excellence, London, 2016; N Ghani, *Now I know it was wrong: Report of the parliamentary inquiry into support and sanctions for children who display harmful sexual behaviour*, Barnardo's, Essex, 2016.
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- 16 Transcript of H Brennan, Case Study 24, 1 July 2015 at 14860:6–14861:6.
- 17 True Relationships and Reproductive Health, *Sexual behaviours in children and young people*, Family Planning Queensland, Queensland, 2012.

- 18 In all Australian jurisdictions, a child under 10 years of age cannot be held criminally responsible for, or found guilty of, an offence. See *Crimes Act 1914* (Cth) s 4M; *Criminal Code 2002* (ACT) s 25; *Children (Criminal Proceedings) Act 1987* (NSW) s 5; *Criminal Code Act* (NT) s 38(1); *Criminal Code Act 1899* (QLD) s 29(1); *Young Offenders Act 1993* (SA) s 5; *Criminal Code Act 1924* (Tas) s 18(1); *Children and Young Persons Act 1989* (Vic) s 127; *Criminal Code Act Compilation Act 1913* (WA) s 29. In all Australian jurisdictions, children over 10 and under 14 years of age have a conditional presumption that they are criminally incapable and it must be proven that the child understood what they did was wrong. See *Crimes Act 1914* (Cth) s 4N; *Criminal Code 2002* (ACT) s 26; *Criminal Code Act* (NT) s 38(2); *Criminal Code Act 1899* (QLD) s 29(2); Tas: *Criminal Code Act 1924* s18(2); *Criminal Code Act Compilation Act 1913* (WA) s29; NSW, Vic, SA: common law *doli incapax*. We discuss the law on *doli incapax* in Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts VII–X*, Sydney, 2017.
- 19 True Relationships and Reproductive Health, Sexual behaviours in children and young people, Family Planning Queensland, Brisbane, 2012.
- 20 J Evertsz & R Miller, *Children with problem sexual behaviours and their families*, Victorian Government Department of Human Services, Melbourne, 2012, pp 8–10.
- 21 C Boyd & L Bromfield, *Young people who sexually abuse: Key issues*, National Child Protection Clearinghouse, Canberra, 2006, p 2.



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