NSW GOVERNMENT Family & Community Services

Review of approaches to prevent and respond to problem sexual behaviour in children and young people in out-of-home care

This review was conducted by the Parenting Research Centre. It provides an assessment of the evidence for approaches to prevent and respond to problem sexual behaviour in children and young people and a synthesis of consultations with select personnel in the field.

Report commissioned by the New South Wales Government Department of Family and Community Services

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August 2016

Disclaimer

The Parenting Research Centre does not endorse any particular approach presented here. The searches and consultations were conducted in February and March 2016. Readers are advised to consider new evidence and information arising since the publication of this review.

Acknowledgement

The Parenting Research Centre extends its gratitude to Stephen Smallbone, Dale Tolliday, Cathy Want, Laura Luchi, Kate McIntyre, Rebecca Magoffin, Karen Mahony, and Tracey New for their input into this review.

Suggested citation

Pourliakas, A., McDonald, M., Macvean, M., Shackleton, F., Clayton, O., Palmieri, R., & Michaux, A. (2016). Review of approaches to prevent and respond to problem sexual behaviour in children and young people in out-of-home care. Report prepared by the Parenting Research Centre on behalf of the New South Wales Government Department of Family and Community Services.

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Definitions

Term	Definition
Approach	Any intervention, therapy, treatment, practice, program or service designed to prevent or respond to problem sexual behaviour in children or young people.
Cognitive Behavioral Therapy (CBT)	A therapeutic approach that looks at the interaction between thoughts (cognitions), feelings and behaviours and how these can influence individual responses to a situation. It posits that a person's past experiences will influence how they interpret a situation.' (Roth, Eng, & Heimberg, 2002). In CBT, the therapist works collaboratively with the individual to teach them ways to monitor their cognition, to identify when 'cognitive distortions' (negative or unhelpful thoughts) may lead them to behave in unhelpful ways or to experience negative emotion. CBT treatment of problem sexual behaviour (PSB) often consists of psycho-education related to sexual arousal and cycles, identifying individual triggers for sexual arousal, accepting responsibility for PSB, identifying cognitive distortions regarding PSB, social skills training, empathy training and relapse prevention (Shenk & Brown, 2007).
Collaborative practice	The process by which agencies, authorities and other providers involved in a young person's care work together based on mutually agreed principles and policies of practice. In collaborative care, services can be coordinated and regularly evaluated, and duplicated or mismatched services and actions avoided. Ideally, it involves the caregiver and the young person themselves, and complex cases are managed by a case manager or coordinator (Chaffin et al., 2008).
Comparison group	The people who do not receive the approach that is being tested in a study. Comparison groups may have received no treatment or services, they may have received some form of standard treatment or services, or they may have received an alternative treatment or service that is not usually offered, but is still not the approach that is of interest being tested in the study.
Contextual approach	In working with PSB, refers to assessing, understanding and attempting to address factors in the child's environment not specific to the individual psychology or biology of the child. It is strongly linked with systems theory (see definition below). A contextual approach may consider aspects specific to the caregiver (e.g. the parent–child relationship, capacity of the caregiver to monitor and supervise the young person, caregiver warmth and support). Other aspects of the child's environment that are considered include: quality of other role models in the young person's life; discipline structures; availability of environmental opportunities for inappropriate behaviour; degree of sexual or violent stimulation currently or in the past; emotional, physical or sexual boundary violations in the child's home; traumatic situations or events; cultural, social and economic factors of the home and community; resilience, strengths and resources (Chaffin et al., 2008; Evertsz & Miller, 2012; Staiger, 2005).

Effect	A statistically significant effect (or change) in an outcome. For example, if an approach was found to have a significant effect on child behaviour, it would mean that an improvement in a behaviour was likely a result of a child's involvement in an approach.
Narrative approach	A therapeutic approach in which the therapist helps the individual to tell their life story and then re-tell their story in a way that focusses on the many skills, competencies, beliefs, values and abilities that will assist them to reduce their problems. This approach takes the stance of the individual being the expert in their own life, and views people as separate from any problems or 'pathologies' they may be experiencing. It takes into account the history and broader context of the individual (such as race, gender, class, sexual orientation and ability) when thinking about the problem, and externalises the problem, assisting the individual to re-examine their identity and choose a different path. Source: http://www.narrativetherapycentre.com/narrative.html
Non-randomised comparison or control	A form of study that involves at least two groups of participants, where one group participates in the approach or treatment of interest and the other receives another treatment or no treatment. Allocation to groups is not random, but may be based on other decisions such as convenience or choice.
Outcome	A measurable change or benefit to a child or other family member. It may be either an increase in a desired behaviour (for example, improved parenting practice) or a decrease in an undesired behaviour (such as reduced child protection notifications). *Target* outcomes are the outcomes that an approach aims to prevent, reduce, or improve.
Out-of-home care (OOHC)	A range of services for children and young people (0–18 years) who are unable to live with their parents, typically because of abuse or neglect (Goldsworthy, 2015; Shlonsky et al., 2013). Common types of OOHC in Australia include home-based family care such as foster and kinship care, as well as care in professionally administered settings such as residential care (Goldsworthy, 2015; Shlonsky et al., 2013). For this review, we also considered young people who are incarcerated as being in OOHC, as they are not residing with their families.
Pre–post approach design	A form of evaluation in which measures of child, young person, family member or service provider outcomes are taken before the intervention or treatment commences in order to establish a baseline. Measures are then taken after the approach or treatment to see if there have been any changes in outcomes. In this report we referred to pre–post approach designs when there was one group of children or young people in the study, and their outcomes were not compared to those of another group.
Problem sexual behaviour (PSB)	Sexual behaviour that is outside normal developmental activity and has a detrimental effect on a child or young person's engagement in everyday tasks (NSW Department of Health, 2005; Staiger, 2005). There are three ways behaviour can be problematic. First, the behaviour interferes with the development and relationships of the child, puts them at risk, violates rules, is self-abusive and/or is defined by the child themselves as a problem. Second, the behaviour leads others to feel uncomfortable, occurs at an in appropriate time or place, conflicts with family or community values, and is abusive. Third, the

	behaviour can involve coercion and unequal power (Staiger, Kambouropoulos, Evertsz, Mitchell, & Tucci, 2005).
Randomised controlled trial (RCT)	A form of study in which participants are allocated at random to different groups (a treatment group and at least one other group such as no treatment, services as usual, or an alternative treatment) for the purpose of seeing if there are differences between the groups as a result of an approach. RCTs are rigorous study designs and provide the best opportunity of determining if changes to outcomes are a result of an approach rather than due to chance or other factors.
Recidivism	Occurs when a person continues, repeats or resumes an undesired behaviour, such as a criminal act. In the case of this report, it is repeating, resuming or continuing problem sexual behaviour.
Single group	Studies that involve only one group of participants and do not compare their outcomes with another group.
Systems Theory	A theory developed by Urie Bronfenbrenner that looks at child development through the context of the environment of the child and the system of relationships, from individual to global, that makes up this environment. It takes into account the interacting factors within the child (biological and psychological), the child's family, community and society that can steer development. It argues that change or conflict in any layer will ripple through and affect other layers (Praquette & Ryan, 2001). Also referred to as Ecological Systems Theory.
Target of problem sexual behaviour	A child or young person who has been abused or exposed to or witnessed problem sexual behaviour or been targeted by another person's inappropriate or harmful sexual behaviour. Also referred to as a victim.
Victimisation	Occurs when a child or young person is victimised or becomes a victim. Victimisation may refer to becoming a victim of another child or young person's problem sexual behaviour, or it may relate to other forms of victimisation such as previous exposure to violence or abuse perpetrated by adults.

1. Executive Summary

1.1. Background

Problem sexual behaviour (PSB) is sexual behaviour that falls outside the typical developmental activity of children or young people. It has a detrimental impact on the child engaging in the behaviour and on those who are the targets[1] of that behaviour, such as other children and young people. It often also has a detrimental impact on others in the child's life, such as family and friends.

There are several common risk pathways for the development of PSB in children and young people, such as trauma, neglect, abuse, developmental delays, behavioural problems, socio-economic disadvantage and exposure to domestic and family violence. However, these risk pathways lead to PSB in only a small number of children. Similarly, juvenile sexual offending does not appear to be associated with a higher risk of committing sexual offences as an adult.

PSB may, however, lead to ongoing social and emotional problems in children and young people. The effects on young people who are targets of PSB can be significant.

Out-of-home care (OOHC) is a range of services for children and young people who are no longer able to live with their families, often due to abuse or neglect. In some cases, children or young people may have been placed in OOHC due to their PSB. Others in OOHC may be at greater risk of developing PSB due to trauma or abuse in their past. While PSB can occur and is problematic in any setting, this report is primarily concerned with PSB in OOHC.

A range of approaches are used to improve outcomes for children and young people engaging in problem sexual behaviour in OOHC and in other settings. Types of approaches may include interventions, therapies, treatments, practices, programs, or services. For simplicity, we typically use the word 'approach' within this report to refer to all of these types of approaches.

1.2. Objectives and research questions

This review was guided by these overarching research questions:

1. What approaches have been used to prevent and respond to problem sexual behaviour among children and young people?
2. What approaches have been used to prevent and respond to problem sexual behaviour among children and young people in OOHC settings, including foster care, residential care, respite care and kinship care?

Where there are targets of PSB involved, the scope of the review includes only PSB where other children and young people have been the targets, rather than child-to-adult abuse. Other settings outside the OOHC context are also drawn on.

[1] In this report, the term 'target' is used to refer to a person who is exposed to the PSB of a child or young person.

1.3. Methodology

This review comprised three elements:

- a rapid evidence assessment
- one-off consultations with seven professionals working in the New South Wales (NSW) child protection field
- a desktop search.

1.3.1. Rapid evidence assessment

The rapid evidence assessment (REA) involved a systematic search of the international published and unpublished literature dated 2002 onwards to identify studies that evaluated approaches for preventing and responding to PSB. We searched five academic databases and the websites of nine organisations. Studies were selected using pre-determined criteria. We also sought recommendations from experts in the field. Books, chapters, theses, conference papers, presentations, abstracts and non-English language publications were not included. We assessed evidence for the identified approaches using a rating scale based on rigour of study design, effect on child outcomes, ongoing or lasting effects (continuing after the completion of the approach), and replication of effect in another study.

For this analysis, we wanted to identify changes in child outcomes that were less likely to be due to chance. Therefore, in order to be considered as having a reasonable amount of evidence to support it, an approach needed to be tested against a control (comparison) group that did not receive the same approach, and to have found statistically significant improvements in at least one outcome compared to the control group. However, even the presence of a control group is insufficient to instil confidence that an approach is actually 'effective', since there is wide variation in the type and quality of studies. Therefore, these positive results should ideally have been tested and replicated using randomised controlled trials (RCTs), the type of study with the greatest internal validity (i.e., the findings were less likely to be due to sampling or experimenter bias). It should also have demonstrated maintenance of effect at follow-up. In other words, there should be observable benefits for the group participating in the approach at, for example, 6 or 12 months after the end of the approach, rather than simply at the end of treatment.

Rating categories, detailed in the body of this report, were:

- Well Supported (WS)
- Supported (S)
- Promising (Pr)
- Emerging (E)
- Pending (Pe)
- Limited Evidence (LE)
- Failed to Demonstrate Effect (FDE)
- Concerning Practice (CP).

This rating process relies on high-quality systematic reviews with meta-analyses in order for approaches to be rated Well Supported. Approaches rated Well Supported,

Supported, or Promising were considered to potentially have better evidence for improving outcomes of children and young people for the purpose of this REA because they utilised RCTs, demonstrated some sustained benefit, and had findings that were observed in more than one study. However, those not rated Well Supported may require further research to increase confidence in this approach in an Australian OOHC setting.

Approaches rated Emerging or Pending include at least one RCT with benefits found in favour of the approach and no harm found to participants. Approaches rated Emerging are considered to represent better evidence because they have shown lasting benefits of the approach at least six months after the approach has finished. Approaches rated Pending have not demonstrated any lasting benefits but improvements in outcomes have been seen directly after the approach has ended. However, replication of these results are needed to lend more confidence to findings.

A rating of Limited Evidence does not necessarily mean that the approach does not work. However, without a randomised comparison or control group, we cannot be sure that any benefits seen were due to the approach itself, or to some other factor to do with the participants, setting or generic social support. Initial results from less rigorous studies may indicate that these approaches appear positive and have possible benefit to participants, but further research with more rigorous study designs are needed to confirm the effectiveness of this approach.

An approach rated Failed to Demonstrate Effect can include at least one RCT, multiple studies or systematic reviews (i.e., studies of high rigour). However, the weight of all this evidence combined shows the approach has no beneficial effect for participants. No evidence of harm or risk to participants is found.

Approaches rated as Concerning Practice have demonstrated through multiple studies of high-rigour evidence that the approach does harm, has a negative effect on participants or puts participants at risk.

1.3.2. Consultations with New South Wales child protection personnel

We also conducted four consultations with seven professionals[2] working in the child protection field to obtain information about (a) relevant studies and resources (that we may not have been able to source via the other methodologies utilised) and; (b) 'on the ground' perspectives regarding approaches to prevent and respond to PSB.[3]

Consultees included; Dale Tolliday, the Clinical Advisor to the New Street Services within NSW Health; Catherine Want, a practitioner and trainer in the area of child sexual assault and domestic violence since 1985 and currently a counsellor at Rosie's Place; and Laura Luchi, a registered psychologist who has been working in a variety of settings with children, families and professionals impacted by trauma and abuse since 1995.

Within this report, the information provided by consultees is treated as expert opinion: an accurate representation of the knowledge and experiences of a small

[2] Three professionals were consulted separately and one consultation involved the other four professionals.

[3] Each professional was consulted once. Consultations were undertaken over the phone, using a semi-structured format, and where necessary clarifying information was provided via email.

number of highly experienced, knowledgeable professionals working in the field of child welfare and child protection in NSW. After the information was collected from consultees, it was analysed and organised according to the key questions of interest.

1.3.3. Desktop search

In addition, a desktop search was conducted to identify further resources that may be of use in responding to PSB.

1.3.4. Analysis of findings

Findings from the REA, consultations and desktop search were synthesised around the research questions and objectives.

Consideration was also given to the recently developed Quality Assurance Framework for OOHC in NSW (QAF)[4]. We considered the relevance of responses to improving overall outcomes across the domains proposed in the QAF — safety, permanency, and wellbeing (cognitive functioning, physical health and development, mental health, social functioning, and cultural and spiritual identity).

[4] To read the QAF, see http://www.facs.nsw.gov.au/__data/assets/file/0007/377674/QAF_Section_3_Quality_Assurance_Framework.PDF

1.4. Findings

Key findings arising from this review are presented in Box 1.

Box 1: Key findings

- There is limited evidence to suggest 'what works' in prevention and response to problem sexual behaviour (PSB) in children and young people in out-of-home care or settings generally.
- Systematic reviews generally found that some form of treatment for children and young people engaging in PSB is better than no treatment at all.
- Multisystemic Therapy – Problem Sexual Behavior (MST-PSB) and approaches based on Cognitive Behavioral Therapy (CBT) are the most widely researched approaches for responding to PSB in children and young people.
- Systematic reviews indicated that studies assessing MST-PSB were typically more rigorous than those testing CBT and they demonstrated better effects on recidivism.
- The approach with the highest rated evidence for responding to PSB is MST-PSB; however, it is currently not available in out-of-home care settings or in Australia.
- When responding to PSB, workers and professionals should consider all aspects of the child or young person's life, involve birth and foster families, and collaborate with each other and with the young person's carers.
- Most approaches identified in the rapid evidence assessment focused on responses to PSB with little or no consideration for prevention or early intervention.
- Most literature is heavily skewed toward approaches for males over 10 years of age who are engaging in more severe forms of PSB and who are referred to as sexual offenders.
- Supports for targets of PSB were not identified in the evidence of this review.
- When reported, most approaches identified in the rapid evidence assessment indicated a minimum requirement of masters-level qualified and trained professionals when responding to severe forms of PSB.
- There do not appear to be benefits for the use of mandatory registration of sexual offenders on rates of sexual recidivism.
- The body of research in Australia is in the early stages of development, with most studies on this topic being conducted in the USA.

1.4.1. Studies identified

Our REA identified 47 papers relevant to this review. Thirty-five papers reported 30 evaluations of 26 approaches for preventing or responding to PSB. Five systematic reviews synthesised the findings of studies that evaluated the effects of approaches designed to reduce PSB. The remaining seven papers evaluated the US legislation on mandatory registration of young people who have been convicted of serious sexual offences. These papers on legislation were considered relevant to this review as they aim to deter young people from sexually offending and to prevent sexual recidivism.

The seven legislation evaluations and five systematic reviews were not subject to rating and were considered separately from the remaining 35 papers. The next sections provide a brief overview of the findings from the papers identified in the REA, with additional information from the consultations added where appropriate.

1.4.2. Evaluations of approaches for preventing and responding to problem sexual behaviour

The 35 papers reporting approaches that were rated in this review included 30 evaluations of 26 approaches for preventing or responding to PSB. There were 10 approaches related to OOHC settings, 10 in other settings, and six included children or young people in the family home and in OOHC. Table 1 summarises the 26 approaches identified. Findings related to the 35 articles reporting evaluations follow.

We rated the 26 approaches identified in the REA for effectiveness. One approach was rated Supported (Multisystemic Therapy – Problem Sexual Behavior, MST-PSB) and one was rated Emerging (Group Cognitive Behavioral Therapy, Group CBT).

All studies identified in the REA reporting on the effectiveness of MST-PSB and group CBT were implemented outside of the OOHC setting. MST-PSB is for young people aged 10–17 years who have committed a sexual offence[5] in addition to exhibiting other antisocial behaviours. The aim of MST-PSB is to decrease PSB and other problematic behaviours and reduce OOHC placements. Group CBT is for children 5–12 years with PSB. Therapy is delivered in a clinic-based setting and aims to reduce PSB, improve psychosocial functioning and improve attitudes towards sex and sexuality.

The remaining approaches identified in the REA, particularly in the OOHC setting, may have some benefits for children and young people, but there was limited evidence to determine if they were effective.

Two approaches were identified in the NSW context, New Pathways Residential Treatment Program (in the OOHC setting) and the network of New Street Adolescent Services (both the OOHC and general settings). Both are currently rated as Limited Evidence. According to the consultees, approaches delivered in NSW public settings appear to take a narrative therapy or systems based approach. The review did not provide a clear indication of what approaches are being used in private practice in NSW. However, the consultees indicated that some private practitioners may be using CBT.

The one preventive approach identified in the REA (Gender violence/Sexual harassment prevention program) had some positive findings; however, it was not demonstrated to be specifically effective in preventing PSB, although it may reduce victimisation.[6]

[5] 'Sexual offences' and 'sexual offenders' are terms used in this report to match the language used in papers when referring to young people engaging in PSB who have committed, been charged with, or convicted of sexual offences.

[6] Victimisation is when a person is victimised or becomes a victim. Here this refers to young people becoming a victim of gender violence or sexual harassment.

Table 1: Summary of approaches included in the rapid evidence assessment

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Approaches within the out-of-home-care setting						
Approaches for young people aged under 10 years						
The Intensive Program	LE	Individual and group-based program for foster carers of children aged under 12 years with PSB. Family involved: Yes Study design: Single group with post-approach testing only	USA	Gender: Male and female Age: Mean, 9.5 (range, 8–12) Sample size: 33 program foster carers and 10 program manager/senior staff.	May be helpful in reducing PSB, and providing safety and stability to young people who engage in PSB. Program foster carers and program staff consider safety planning, home visits by program managers and a normalising and stabilising environment to be key in contributing to those outcomes for young people.	The influence of extra-program counselling and intervention in producing these outcomes is unclear. Interviews only No comparison group No follow-up measures Small sample size
Approaches for young people aged over 10 years						
Cognitive Behavior Therapy	LE	In this study, CBT was evaluated with a 14-year-old sexual offender[7]. Family involved: Yes Study design: Case study	USA	Gender: Male Age: 14 years Sample size: 1	Suggests that CBT has the potential to be modified and adapted for young people with a disability in an OOHC setting and may then be helpful in reducing PSB.	Single-participant case study, which is the least rigorous study design with no way of knowing if benefits are due to chance or can be generalised to large number of young people

[7] The term sexual offender is used in this report when discussing papers that have used this phrase to refer to young people engaging in PSB who have committed, been charged with or convicted of sexual offences.

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
The Gateway	LE	Residential individual and group-based treatment for sexual offenders aged 11–16 years Family involved: No Study design: Single group with pre- and post-approach testing	UK	Gender: Male Age: Range 11–16 years Sample size: 34	May bring about improvements in child and adolescent psychosocial functioning, as well as a reduction in attitudes and beliefs related to recidivism risk. Unhelpful beliefs regarding the targets of PSB were not found to improve.	Unclear if improvements due to comprehensive residential treatment program (SWAAY) offered to all participants concurrently, or due to the Gateway Small sample size No comparison group No follow-up measurements taken
Interpersonal Skills Program	LE	Individual and group-based residential treatment for young people aged 7–17 years with PSB Family involved: Yes Study design: Single group with pre and post-approach testing	USA	Gender: Male and Female Age: Mean 12.3 (range 9–18) years Sample size: 58	May be helpful in improving functional impairment, decreasing sexually deviant interests and increasing sexually appropriate interests in young people.	Small sample size No comparison group No follow up measurements taken Did not measure rates of PSB
Approach based on covert sensitisation	LE	Group-based residential treatment for sexual offenders aged 12–18 years Family involved: No Study design: Single group with pre- and post-approach testing	Canada	Gender: Male Age: Mean 16.1 (range 13.3–21.3) years Sample size: 87	May lead to a reduction in the rate of deviant sexual fantasies, an increase in the rate of 'normal' fantasies, and an improvement in a young person's ability to interrupt or disrupt deviant fantasies.	Unclear if benefits due to overall participation in inpatient sex-offender treatment program Lack of appropriate statistical testing Small sample size No comparison group No follow-up measurements taken

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Multiple-Family Group Intervention	LE	Individual and group-based therapy of adolescents in juvenile detention for sexual offences Family involved: Yes Study design: Single group with pre- and post-approach testing	USA	Gender: Male Age: Mean 15.7 (range 12–19) years Sample size: 115	May be helpful in improving a young male adolescent offenders' ability to regulate his emotions, reduce internalising and externalising behaviour and improve his ability to relate to and depend on his caregivers. May also be helpful in reducing recidivism. One year follow up is a strength.	Difficult to separate effects of this approach from other treatments provided in detention No comparison group
Naltrexone	LE	Pharmacological treatment, in this case for sexual offenders aged 13–17 years who are in an inpatient program Family involved: No Study design: Single group with pre- and post-approach testing	USA	Gender: Male Age: Mean 15.2 (range 13–17) years Sample size: 21	May be helpful in reducing frequency of masturbation and fantasising in adolescent male sexual offenders.	Participants also using other medication for mental illness Side effects regarding mood or psychosocial function not examined Small sample size No comparison group No follow-up measurements taken
The New Pathways Residential Treatment Services	LE	Individual and group-based therapy for sexual offenders aged 12–17 years who are in residential treatment Family involved: Yes Study design: Single group with pre- and post-approach testing	NSW, Australia	Gender: Male Age: Range 14–16 years Sample size: 12	May be helpful in reducing risk factors for recidivism, improving behavioural outcomes, improving engagement in learning and improving health behaviours and self-care.	No statistical testing Not all participants had finished approach when measures taken Small sample size No comparison group No follow up measurements taken

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
A 'Self-contained' residential treatment for juvenile sex offenders	LE	Individual and group-based therapy for sexual offenders aged 8–18 years who are in juvenile detention Family involved: Yes Study design: Non-randomised comparison group design	USA	Gender: Male Age: Mean 14.4 (range 8–18) years Sample size: 256	May be helpful for young males in reducing overall recidivism rates, when compared to a general approach offered within detention. However, both approaches appear to be helpful in reducing rates of recidivism for sexual offences. The 10 year follow up adds strength to findings.	No randomisation to two groups
Thought Change System	LE	Individual and group-based therapy for sexual offenders aged 11–19 years, in residential treatment Family involved: Yes Study design: Non-randomised comparison group design	USA	Gender: Male Age: Range 11–19 years Sample size: 24 across two studies	May be helpful in improving psychological function, improving externalising behaviour, reducing sexually deviant beliefs and reducing recidivism risk.	Statistical tests not ideal Small sample size No follow-up measurements taken No randomisation to groups
Approaches outside and within the out-of-home-care setting						
Approaches for young people aged under 10 years						
Approaches based on behaviour therapy	LE	Two case studies of behaviour therapy for children engaging in PSB, delivered individually in residential treatment for one study, and in the home and school for the other study Family involved: Yes in one study, no in the other Study design: Case studies	USA and New Zealand	Gender: Male and female Age: Range 8–9 years Sample size: 2	May be helpful in reducing PSB for young people and may also be useful for young people with cognitive impairment.	Single participant case study designs, which is the least rigorous study design with no way of knowing if benefits are due to chance or can be generalised to large number of young people

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Approaches for young people aged over 10 years						
New Street Adolescent Services	LE	Individual and group-based therapy delivered in clinics to young people aged 10–17 years who have committed sexual offences but have not been prosecuted Family involved: Yes Study design: Non-randomised comparison group	NSW, Australia	Gender: Male and female Age: Range 10–17 years Sample size for study 1: 100 Sample size for study 2: 116	May be helpful in reducing recidivism, reducing PSB and improving safety outcomes for young people. The authors noted recidivism rates were higher for those who withdrew from the approach, and emphasised the importance of engaging young people. Length of follow up was a strength.	Small sample size No randomisation to groups
Personal/Social Awareness Program	LE	Individual and group-based therapy delivered in various settings to adolescent sexual offenders Family involved: Yes Study design: Single group with pre- and post-approach testing	USA	Gender: Male Age: Not reported Sample size: 122	May be helpful in reducing recidivism rates for young adolescent males for both sexual and non-sexual crimes. For those who withdrew from the approach, recidivism rates tended to be higher. Long-term follow up of 23 years is a strength.	No comparison group Replication needed
SAFE Network Auckland, WellStop in Wellington and STOP in Christchurch	LE	Individual and group clinic-based program for sexual offenders aged 10–18 years Family involved: Yes Study design: Non-randomised comparison group	New Zealand	Gender: Male Age: Mean 14.4 (range 8–18 years) Sample size: 681	May be helpful in reducing rates of reoffending (both sexual and non-sexual) when the young person goes on to complete the approach. Large sample size is a strength. Median follow up of 4.5 years a strength.	No randomisation to groups A drop-out comparison group is not ideal, as these young people may have characteristics that set them apart from the treatment group (e.g. more vulnerabilities, more severe PSB, ethnicity).

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
SAFE Network Wilderness Therapy	LE	Group-based therapy in camp setting for adolescent sexual offenders Family involved: No Study design: Single group with post-approach testing only	New Zealand	Gender: Male Age: Mean 16 (range 13–18) years Sample size: 7	May be helpful in improving peer relationships, improving self-efficacy and self-esteem, and improving responsibility-taking for offending behaviour in young adolescent males.	Young people engaged in SAFE Network at same time, as such, benefits found may be due to overall approach Interviews only PSB not measured Small sample size No comparison group No follow-up measures taken
Turn the Page	LE	Individual home- and clinic-based treatment for 12–18 year olds with PSB. Family involved: Yes Study design: Single group with post-approach testing only	UK	Gender: Male Age: Mean 12–18 years Sample size: 13	May assist young males in understanding what unacceptable sexual behaviours are and their triggers for PSB. May also help them develop new strategies to manage these in the short term. A good therapeutic relationship and developing motivation for change were noted as helpful in gaining these outcomes. Authors state that the manual should not be used in isolation and further work with the context of the young person — engaging and supporting the young person's caregiver and other professionals — is needed.	Small sample size No comparison group No follow up measures taken Interviews only
Approaches outside the out-of-home-care setting						
Approaches for young people aged under 10 years						

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: Preschool Program	LE	Clinic-based group program for children aged 3–7 years who have engaged in PSB toward another child Family involved: Yes Study design: Single group with pre- and post-approach testing	USA	Gender: Male and female Age: Mean 4.9 (range 3–7) years Sample size: 85	May be helpful in reducing PSB and symptoms of PTSD, particularly for older children and female children. Was not found to be helpful in reducing other childhood behaviour problems or symptoms of depression.	Small sample size No comparison group Young people were also offered other treatments during approach, so hard to know which approach led to benefits.
Group Cognitive Behavior Therapy	E	Clinic-based group program for children aged 5–12 years with PSB Family involved: Yes Study design: Randomised controlled trial with long-term follow up	USA	Gender: Male and female Age: Mean 8 (range 5–12) years Sample size: 291	May be effective in reducing PSB, when compared to a comparison group (Psychodynamic Play Therapy). Is a strong RCT research design with long-term follow up and randomisation to groups.	Replication needed, particularly in Australian context
The Transformers Program	LE	Clinic-based individual therapy for children under the age of 12 who engage in PSB Family involved: Yes Study design: Non-randomised comparison group	Victoria, Australia	Gender: Male and Female Age: Mean 9.27 years Sample size: 16	May be helpful in reducing PSB and anger, improving empathy and improving knowledge and understanding in young people with PSB. Comparison group and long-term follow up a strength.	Small sample size No randomisation to groups Finding for both groups were not compared statistically. As such, findings are less objective and harder to replicate.
Approaches for young people aged over 10 years						

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Fight with Insight	LE	Clinic-based group therapy and group boxing program for sexual offenders aged 12–18 years who demonstrate PSB following their own abuse Family involved: Yes Study design: Non-randomised comparison group	South Africa	Gender: Male and female Age: Range 12–19 years Sample size: 27	When compared to CBT, Fight With Insight may be helpful in improving insight and social functioning and reducing recidivism among young people who engage in PSB. CBT alone may be more helpful in improving empathy.	Small sample size No randomisation to groups No follow-up measures taken Interviews only
Griffith Youth Forensic Service	LE	Home-based individual treatment for sexual offenders aged 10–16 years Family involved: Yes Study design: Single group with pre- and post-approach testing	QLD, Australia	Gender: Male Age: Mean 16.1 years Sample size: 104	May reduce recidivism and be equally beneficial to Indigenous and non-Indigenous youth, and appropriate to run within remote Queensland communities. Length of follow up measures is a strength.	Small sample size No comparison group
Mirtazapine	LE	Pharmacological treatment, in this case for young people aged 5–12 years engaging in PSB who are not responding to or suitable for education programs. Family involved: No Study design: Single group with pre- and post-approach testing	Turkey	Gender: Male and female Age: Mean 12.4 (range 5.2–16.4) years Sample size: 10	May be helpful in reducing excessive masturbation in young people with Autism Spectrum Disorder.	Side effects (e.g. weight gain) experienced by all participants need to be weighed against benefits. All participants taking concurrent medications: unknown if Mirtazapine or other medications led to outcomes. Small sample size No comparison group

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Multisystemic Therapy for Youth with Problem Sexual Behaviors	S	Therapy for sexual offenders aged 10–17 years, delivered on an individual basis in settings convenient to participants, such as home, school and the community Family involved: Yes Study design: Two RCTs with long-term follow up	USA, Canada	Gender: Male and female Age: Mean 14 years Multiple studies with various sample sizes	Appears to be effective for improving outcomes in young people with PSB, by reducing PSB and recidivism. May also be helpful for improving other mental health and behaviour outcomes, such as delinquency, school grades, externalising behaviour and substance use.	Findings have not yet been replicated in Australian context, with children in out-of-home-care or with different abilities. A stronger comparison group of a well-evaluated approach (e.g., CBT) would be ideal
SafeCare Young People's Program	LE	Individual and group-based program for young people aged 12–17 years who have engaged in PSB, particularly intrafamilial PSB Family involved: Yes Study design: Single group with pre- and post-approach testing	WA, Australia	Gender: Male Age: Mean 13.8 (range 11–15) years Sample size: 12	May be helpful in improving family communication, reducing impulsivity, increasing emotional control and self-esteem and improving personal responsibility taking. May not be as helpful in improving victim empathy and in producing relapse prevention plans. Long-term follow up is a strength.	Small sample size No comparison group Interviews only
Youth with Sexual Behavior Problems	LE	Individual and group-based clinic treatment for sexual offenders aged 10–18 years Family involved: Yes Study design: Single group with pre- and post-approach testing	USA	Gender: Male Age: Mean 14.31 (range 11–17) years Sample size: 26	May be helpful in improving parent–child relationships and psychosocial functioning for young people with aggressive PSB. PSB did decrease, but the change was not statistically significant.	Small sample size No comparison group No longer term follow up of measures
Approaches to prevent problem sexual behaviour						

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Gender violence/Sexual harassment prevention program	LE	School-based group gender violence and sexual harassment prevention program for children in the 6th and 7th grades Family involved: No Study design: RCT with long-term follow up	USA	Gender: Male and female Age: Range 11–13 years Sample size: 1639	May be helpful in reducing rates of victimisation for both males and females equally. May also be helpful in reducing non-sexual violence towards peers. May be less helpful in reducing sexual violence perpetration towards peers and dating partners. Large sample size, comparison group and randomisation are strengths of this study.	Not found to be helpful for preventing rates of sexual violence towards peers and dating partners. Replication in Australian context needed, paying attention to influence of gender

E = Emerging; LE = Limited Evidence; RCT = randomised controlled trial; S = Supported.

*The age of children or young people may be different in description and in study. Sometimes an approach was designed for a particular age group, but the age of study participants did not match the intended age group.

† Limitations to study designs make studies less rigorous and reduce our confidence in their findings. Limitations include:

Interviews only: No statistical testing was completed. As such, findings are less objective and harder to replicate
No comparison group: There is no way to determine if changes are a result of the approach or due to chance or other factors.
No randomisation to groups: There is no way to determine if changes are a result of the approach or due to chance or some factor to do with the participants
No follow-up measures: There is no way of knowing if benefits are maintained long term.
Small sample size: There is no way to know if benefits can be generalised to a large number of young people.

1.4.3. Findings from systematic reviews

Despite some methodological limitations in the studies included in the five systematic reviews, findings suggest that some form of treatment may be better than no treatment at all, that CBT-based therapies may have some benefits, but perhaps multisystemic therapies (such as MST-PSB) have greater gains in young people, and that involvement of families, parents or carers in treatment is important.

1.4.4. Evaluations of United States legislation

The US registration legislation[8] mandates that young people committing serious sexual offences will have their details recorded in a registry accessible by organisations and people such as schools and employers. These young people will be monitored in the same way as adult offenders, that is, they will be monitored for a period ranging from 25 years to life. The intention is that registration may act as a deterrent and reduce sexual recidivism. But evaluations of the legislation indicate there is no difference in recidivism rates of those placed and not placed on registries: rates of both are low. The legislation did not act as a deterrent and may have made prosecutors less likely to move on sexual assault charges.

The search conducted as part of the REA that identified the evaluations of US legislation did not identify evaluations of any legislation in Australia.

1.5. Discussion

This review provided a synthesis of evaluations of approaches for responding to PSB, and the views of select personnel working in the child protection field. Recommendations for the field are also suggested. A summary of these is provided in Box 2, with further details towards the end of this executive summary.

1.5.1. Quality of the evidence

There is currently limited evidence for approaches to prevent and respond to PSB in children and young people and the quality of the evidence is typically low. On the whole, there is little definitive evidence regarding what might work for preventing and responding to PSB in OOHC settings in Australia. There is somewhat stronger evidence for addressing PSB in general settings which can be used as guidance for addressing PSB in OOHC settings. However, as there may be context-specific changes required when implementing an approach in an OOHC setting, these should be considered and evaluated.

[8] Sex Offender Registration and Notification Act (SORNA; Title 1 of the Adam Walsh Child Protection and Safety Act of 2006).

Box 2: Recommendations

1. Base practice on a sound theoretical framework

In the absence of a strong evidence base for preventing and responding to problem sexual behaviour (PSB), practice should be based on a sound theoretical framework, for example, systemic frameworks, Cognitive Behavioral Therapy (CBT) frameworks or a narrative approach.

2. Trial new approaches in the Australian out-of-home care setting

Multisystemic Therapy – Problem Sexual Behavior **(**MST-PSB), and approaches based on CBT frameworks have been widely researched in the international literature but not in Australia and not in out-of-home care (OOHC) settings. MST-PSB shows good results for young people with more severe PSB. As such, the next step in responding to more severe PSB in OOHC should be to trial MST-PSB and approaches based on CBT frameworks in Australia and in the OOHC setting.

3. Establish plans for the implementation and ongoing evaluation of approaches

Prior to commencing implementation of approaches, clear plans should be established for how implementation will be carried out and monitored. Approaches, both established and adapted, need to be evaluated for efficacy and effectiveness.

4. Investigate and evaluate prevention and early intervention strategies

This review found little guidance for prevention and early intervention of PSB and so further investigation is needed. Guidance may be available in the literature on PSB approaches that have not been evaluated, or from outside the PSB field. Behavioural management approaches may represent a suitable option.

5. Involve and engage children, young people, families and carers

Engagement and retention of children, young people and families in any approach is vital to improving outcomes. Children and young people need support to engage in approaches. Involving birth families and carers can potentially foster the engagement of children and young people.

6. Investigate current and required training and support needs of out-of-home care staff, child protection staff, and carers

This review has highlighted a need for more information on training and support for staff and carers, acknowledging that different staff and carers may have varying needs. Staff and carers need to be supported and trained to have the skills, knowledge and capacity to suitably identify and respond to PSB in children and young people.

7. Investigate current and appropriate qualification requirements for all out-of-home care staff, child protection staff and therapeutic staff

A need for more information on the qualification requirements of staff working with children and young people engaging in PSB has been emphasised in this review. Some approaches may have minimum qualification standards. Ensuring staff have the requisite specialist skills and qualifications is necessary for providing effective responses to PSB.

8. Investigate effective ways of engaging and collaborating with kinship and foster carers, residential care workers and other stakeholders

Findings of this review demonstrate a need to consider the whole context in which PSB is occurring and to take a holistic approach to support for children and young people. Collaboration with all agencies and personnel involved with the child is critical to care.

9. Investigate appropriate approaches for supporting targets of problem sexual behaviour

Little guidance was found in this review regarding supports for children and young people who are targets of PSB. Guidance may be available in the literature on PSB approaches that have not been evaluated, or from outside the PSB field, such as in the literature on child sexual abuse where the perpetrator is not specifically another child or young person.

1.5.2. Countries where the studies were conducted

Most of the studies in the REA were from the USA. Five approaches were evaluated in Australia — Griffith Youth Forensic Service, New Street Adolescent Services, New Pathways Residential Treatment Services, SafeCare[9] Young People's Program and the Transformers Program.

1.5.3. Approach delivery, mode and setting

Approaches identified in the REA were more often delivered in both group and individual format (*n*=12), rather than to the individual alone (*n*=8) or to groups (*n*=6). Delivery location was varied; however, approaches were more often delivered in clinic settings (*n*=9) or in the young person's residential care facility (*n*=6).

1.5.4. The children and young people

All but one approach in the REA was designed to intervene with children or young people already engaging in PSB, rather prevent PSB. A large proportion of the evaluations identified included male, adolescent sexual offenders.

Of the 35 papers reporting evaluations of approaches, 20 indicated that a proportion of the participants had a history of some form of abuse (12 papers did not report this information). The consultees also noted that in their work, the majority of young people engaging in PSB tend to have a significant history of abuse and trauma in their background and come from environments with multiple vulnerabilities, such as family violence.

1.5.5. Child outcomes

All 35 of the papers identified in the REA reported outcomes relevant to mental health. Most of the approaches in the REA reported measures of sexual recidivism, and little on other child outcomes. Conversely, the consultees did not refer to recidivism in their discussions on supporting children and young people engaging in PSB. However, it should be noted that they were not directly asked about outcomes of interest in their work. Instead, their focus was more broadly on the whole child or young person. Although the review is therefore not able to comment more broadly on the outcomes targeted in approaches in the NSW context, it should be noted that when examining New Pathways, Milne et al. (2009) did measure outcomes related to cognitive and social outcomes in the QAF, as well as mental health.

1.5.6. Targets of problematic sexual behaviour

The REA found that the targets of the young person's PSB often included a wide mix of peers, children, family, adults and animals and no studies included or excluded young people based on the targets of the PSB.

[9] Note that this is not the same as or an adaptation of the SafeCare model that is currently being trialled by the NSW Department of Family and Community Services (FACS) in collaboration with Georgia State University in NSW.

1.5.7. Caregiver involvement in support for children and young people

Most of the approaches in the REA involved family members to some extent. Approaches were more likely to include family members if the children were not in OOHC. Family members refers to birth families, their kin carers, guardians or foster parents.

The consultees confirmed the need to include foster and kinship carers and parents in service provision. Consultees reported observing a lack of contact between OOHC staff and birth families when addressing PSB, and that this could be problematic if or when reunification occurs.

1.5.8. The context in which problem sexual behaviour occurs

Several of the papers in the REA reported that the approaches considered the context in which PSB was occurring, and the consultees also stressed the importance of this. This includes taking into account family relationships, the array of services, the broader community engagement and collaboration with key people and services involved in the child's life (e.g. parents, foster or kinship carers, family, teachers, service providers) and undertaking ongoing assessments of the child's environment. Many authors noted that the contextual elements contributing to PSB are highly individual and an accurate understanding of the context allows for an appropriate individualised response. Consultees were of the view that a therapist only working one-on-one with a child is typically not an effective response to PSB. This view was echoed in many of the approaches identified in the REA.

1.5.9. Qualifications, training and support for staff and carers

Not all papers in the REA identified the qualifications of personnel, but those that did referred to them as psychologists, social workers, psychiatrists, therapists, clinicians and medical professionals who had received at least master's level training in these professions. These professionals were also typically involved when considering the more severe end of the PSB continuum, particularly when sexual offences had occurred and more intensive treatment was required. In addition, 17 of the 35 papers reporting evaluations in the REA indicated that training was provided to staff.

The consultees identified a need for more training and support for OOHC staff when working with birth families. They also stated that OOHC staff, child protection staff and therapists working with children and young people engaging in PSB are in need of suitable qualifications, training and support to assist them to identify and respond to PSB effectively.

1.5.10. Gaps in knowledge

Due to limited evidence in this developing field of study, the review does not point clearly to any set of approaches that may be effective for the OOHC setting in particular, in NSW or Australia.

Although MST-PSB currently appears to have the best-available evidence for responding to more severe PSB in young people, it has not yet been evaluated in an OOHC or Australian setting. There is also currently limited evidence on responses for young people under 10 who engage in PSB, although research does suggest young children do engage in PSB. The exception to this is Group CBT, which has been rated in this review as Emerging for more severe PSB in a general setting only.

There is limited knowledge regarding what approaches are being used in the private practice setting in NSW. The most widely researched approaches — MST-PSB and CBT — have not yet been evaluated and do not appear to be in wide-scale use in Australia.

There is a gap in knowledge regarding what works to prevent PSB and what works for intervening early in responding to PSB, as much of the research has focused on work with young people referred to as 'sexual offenders'. Few approaches included children and young people with less-severe forms of PSB, and only one study was identified in the REA that was preventive.

Furthermore, there is no current guidance from the REA or in the field (according to consultees) on addressing PSB when working towards reunification with birth families, following a separation. This was reported as a particular concern by the consultees.

The REA also found no approaches for child protection practitioners in preventing or responding to PSB.

There is a lack of evidence in research, and very little detail available from the consultees, regarding how to support the targets of PSB. This is particularly needed within an OOHC setting where children and young people may be at greater risk of becoming targets of PSB.

In the REA, many of the evaluated approaches formed only part of an overall treatment. It was difficult to isolate the effects due to the intervention from those of the overall treatment approach, particularly in the OOHC setting. A lack of clarity in reporting of approaches also made it difficult to establish which aspect of an approach was being evaluated.

Qualification and training details were sometimes absent from the papers included in the REA so there are gaps in our knowledge about qualification requirements for delivering some approaches. While this review has provided some views on the qualifications and training required of practitioners working with young people with PSB in NSW, a complete picture of this across the state has yet to be established. It is also unclear what types of support for staff or carers are most beneficial, particularly when less-severe kinds of PSB need to be addressed.

The REA found limited measurement of the array of outcomes identified in the QAF. The exception to this was measurement of PSB outcomes, in particular, sexual recidivism, which falls under the QAF domain of mental health within the wellbeing outcomes.

Significant gaps were evident in the reporting of the effects of approaches for females who in engage in PSB. Although research does suggest that females do engage in PSB. Females were mostly either excluded from evaluations due to low numbers, or offered modifications of existing approaches without clear rationale. Some studies suggest approaches may influence males and females differently, as the contextual factors contributing to their PSB may differ. As such, the effects of gender require further consideration and research.

Gaps were also noted in approaches for particular population groups, for example, ethnically diverse groups. Limited research in the REA was found evaluating approaches for Aboriginal and Torres Strait Islander children or those from culturally and linguistically diverse (CALD) backgrounds.

1.5.11. Limitations of this review

This review represents a fairly comprehensive and balanced view of approaches to PSB because it combines an REA and consultations with members of with the child protection field. However, the review was limited to a small number of consultations, and none with private practitioners. Input from a wider scope of practitioners, either by interview or survey, would have added to the depth of this review.

The REA involved a rigorous search of various academic databases, organisation websites, and requested papers from experts. However, it is not a systematic review and some relevant approaches may not have been uncovered in the search. Due to time limitations, we were unable to check reference lists for further studies or contact study authors for additional studies or data. Further to this, inclusions were limited to those in English published from 2002 onwards. Due to time constraints, books, theses, conference abstracts and presentations were also excluded.

1.5.12. Factors to consider when implementing approaches in the New South Wales out-of-home care context

Preventing and responding to PSB in children and young people, and conducting research in this area, is complex. This complexity is compounded in OOHC settings. Various issues to consider when selecting and implementing responses to PSB in the NSW OOHC context are listed below, with further detail in the full report.

1.5.12.1. Consider if the approach suits the setting

Some of the approaches identified here in general settings have not been implemented and evaluated with children and young people living in OOHC. This means that we do not yet know the evidence for these approaches in OOHC settings. Due to the limited evidence available for OOHC settings broadly, let alone for specific OOHC settings, further research is required to determine if and how these different contextual factors may impact on the effectiveness of a specific approach. Prior to implementing an approach, consider if this approach is suitable for use with children and young people in particular OOHC settings. For example, the practical considerations of implementing an approach in a residential care setting may be different to those in a home-based setting (e.g. foster or kinship care). Differences may include the degree of supervision feasible within that setting, age of children, and the consistency and availability of caregivers.

1.5.12.2. Consider applicability for the Australian service context

Few of the approaches identified here have been evaluated in the Australian context. It is unclear whether these treatments are being used in private practice in NSW or Australia. Therefore the applicability of some of these approaches to the Australian context is not known. These factors need not be a limitation when selecting approaches. Approaches that are not currently available in Australia may be suitable for use in the NSW context, with appropriate implementation support and training.

1.5.12.3. Consider the target population of the approach

Consideration should be given to whether an approach is suitable for the children and young people of interest. When selecting suitable approaches, it is necessary to analyse the client population in detail in order to select what has the best chance of working. For example, is the approach most suitable for younger children or older children? Is the approach suitable given the severity of PSB? One approach may not fit all, so several individualised approaches may be needed. Consider also the

cultural suitability of the approach. Working with Aboriginal and Torres Strait Islander families requires engagement with their communities.

1.5.12.4. Consider the complexities of families involved in out-of-home care

The REA revealed that most of the children and young people in these studies had experienced prior trauma or abuse and the consultees reported a similar pattern — the majority of children and young people who engage in PSB have experienced abuse and significant levels of trauma. Children and young people entering OOHC are typically from families with complex needs. These needs should be taken into account when supporting children. For children who are restored to their families, particular consideration should also be given to responding to the broader, complex needs of the family and ongoing support for families to manage the PSB.

1.5.13. Recommendations

The following recommendations are based on the REA and consultations with a selection of personnel in the child protection field.

1.5.13.1. Base practice on a sound theoretical framework

In the absence of a strong evidence base on effective approaches, it is recommended that practice is based on a sound theoretical framework that has been researched and deemed to be effective in other settings more broadly. This will enable a consistent approach with young people and their caregivers and also draw in elements of an evidence-based approach. The REA indicated that systems theory[10] (e.g. MST-PSB), CBT approaches[11] and narrative approaches[12] — frameworks with strong theoretical grounding — are often chosen for young people engaging in PSB. Any implementation of these theory-based approaches in the field then requires rigorous evaluation to determine if they are working in context.

1.5.13.2. Trial new approaches in the Australian out-of-home care setting

Given the international evidence for MST-PSB and the use of CBT as theoretical frameworks in several approaches, it is worth considering if these could be trialled in OOHC in Australia. The field appears to be at a stage where large-scale evaluations could be undertaken, randomising participants to MST-PSB, CBT or a narrative approach. This would also take into account current ethical concerns of randomising a high-risk young person to a no-treatment control group. MST-PSB is currently not available in Australia, and studies of MST-PSB overseas have not included children in OOHC. However, it is ready for dissemination, suggesting that implementation

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[10] A theory of development that examines the whole context when understanding the child. This includes individual elements such as biology or psychology, the child's family, community and society and how these interact to influence development (Praquette & Ryan, 2001).

[11] A therapeutic approach that looks at the interaction between thoughts (cognitions), feelings and behaviours and how these can influence individual responses to a situation. It posits that a person's past experiences will influence how they interpret a situation (Roth et al., 2002).

[12] A therapeutic approach that works with the individual to develop their life story and to re-tell that story in a way that focuses on their skills, beliefs and values to assist them to reduce their problems. It takes into account the history and broader social context of the individual (Source: http://www.narrativetherapycentre.com/narrative.html).

supports and resources exist for it to be packaged up and introduced to other countries. It could be extended to an OOHC trial in Australia, should this be considered a suitable option by policymakers and the MST-PSB developers.

1.5.13.3. Establish plans for the implementation and ongoing evaluation of approaches

Prior to commencing implementation of approaches for preventing and responding to PSB, clear plans should be established for how implementation will be carried out and monitored. This is particularly critical given that few of the approaches described in this review have previously been implemented in the NSW OOHC context. If approaches are adapted for the local context, this should be done in a manner that is planned and structured and includes monitoring of continuous quality improvement of services. Any adaptations would need to consider if there are any minimum requirements for implementing approaches and all approaches would need to be tested for efficacy and effectiveness. Further research could also be undertaken to clearly identify the range of approaches being used by services and practitioners in the private practice setting in Australia.

1.5.13.4. Investigate and evaluate prevention and early intervention strategies

Although this review has not identified evidence for prevention and early intervention, there is a need to identify and evaluate approaches relevant to these circumstances in order to help support children, young people and caregivers, and to intervene before problems escalate. Possible direction may be available in the literature on non-evaluated PSB approaches or even from outside the PSB field. The majority of children and young people engaging in PSB, including those in OOHC, will first engage in less-severe forms of PSB, which may escalate if not addressed. Potentially suitable behavioural management approaches to trial when intervening early with PSB are available in publications by British Columbia Government (1999) and Smallbone (forthcoming, 2016).

Behaviour management responses can be implemented by OOHC staff, foster and kinship carers, schools, birth families and others involved in the child's life, if provided with appropriate support and training. If the behaviour does not resolve with appropriate behaviour management, or if the behaviour is at the more severe end of the PSB continuum, an approach by a specialised clinician may be warranted.

According to the findings of the REA, these behaviour management approaches do not yet appear to have been evaluated with children and young people engaging in PSB. If steps are taken in Australia to implement such approaches, they would benefit from evaluation.

1.5.13.5. Involve and engage children, young people, families and carers

There is a need for the involvement and support of birth families. This includes while families are in the OOHC system, during transition back to the family home, and after the child or young person has returned home. Involvement with foster and kinship carers is also important while children and young people are involved in OOHC and as they transition back to the family home or out of care.

Engagement in any approach is vital to improving outcomes. Factors that facilitate or act as barriers to engaging young people and their families in approaches are currently well known. However, many approaches in the REA reported high drop-out rates. Some studies found that outcomes were worse for those who dropped out compared with those who received no treatment, highlighting the importance of

engagement in approaches. Some studies also found that involving the birth family or caregiver increased engagement of the young person in an approach. It is not clear whether methods of engagement are being implemented in the context of addressing PSB. This needs to be addressed.

Consultees noted a concern that personnel working in this field may not have the capacity, knowledge or skills to effectively engage the young person and their caregivers. Skills training in counselling may be one way to improve these skills. In addition, they may not have the resources to effectively engage the young people and caregivers (e.g. an isolated private practitioner who often works alone).

1.5.13.6. Investigate current and required training and support needs for out-of-home-care staff, child protection staff and carers

There is need to investigate and ensure foster and kinship carers, child protection staff and residential care staff in metropolitan, regional, rural and remote areas have accessible and appropriate training and support (e.g. supervision) on how to identify, understand, address and respond to PSB.

As part of this support, it is important that foster and kinship carers, child protection staff and residential care staff have the skills, knowledge and capacity to work in collaboration with therapeutic care staff to ensure consistency between therapeutic and OOHC settings. Residential care staff may need specific training, support and supervision to manage the complexities of PSB within residential care settings. These training and supports should then be appropriately evaluated to ensure they are effective. Consistent and appropriate responses from OOHC carers are equally critical, highlighting the need of appropriate support for carers also in this regard.

1.5.13.7. Investigate current and appropriate qualification requirements for all out-of-home care staff, child protection staff and therapeutic staff

It was noted in the findings of the REA that qualifications of therapeutic staff and OOHC staff were at minimum masters- level trained when managing severe levels of PSB. The views of the consultees also strongly supported appropriate qualifications for therapeutic, OOHC and child protection staff. However, training level and qualification was not consistently reported across all approaches. It is also currently unclear which qualifications may be most appropriate in the NSW context. This requires further investigation.

Working with PSB in young people is an area of practice where many inaccurate myths and assumptions, if acted upon as fact, may prove detrimental to young people. Alternatively, a lack of education regarding the environmental factors and vulnerabilities that can contribute to severe PSB may lead to inappropriate management or response to PSB, a lack of effective reduction or prevention of PSB and/or may put other young people at risk.

Given this, it appears vital that any staff responding to and preventing PSB have the appropriate knowledge, skills and capacities to take these complexities and vulnerabilities into account in their work. It is important that investigations be conducted into what the appropriate levels of knowledge, skills and capacities are and whether this requires particular qualifications of a particular standard.

1.5.13.8. Investigate effective ways of engaging and collaborating with kinship and foster carers, residential care workers and other stakeholders

Carers require support to engage in responses to PSB. One approach suggested by a consultee was a coaching model. Consider also whether the qualifications of staff match the requirements of approaches being used to respond to PSB.

It is also vital when working with young people who engage in PSB to effectively engage other stakeholders involved in the young person's environment. A holistic approach requires that all stakeholders are effectively involved in managing the PSB (e.g. school teachers, counsellors, extended family or OOHC staff).

1.5.13.9. Investigate appropriate approaches for supporting targets of problem sexual behaviour

Little was gleaned in this review regarding responses and supports for targets of PSB, and so further investigation is required in order to determine what supports may be helpful for targets of PSB, particularly in an OOHC setting.

1.5.14. Conclusion

This review of approaches to PSB in OOHC summarises the developing international literature and provides context to these findings in the form of consultations with members of the child protection field. Acknowledging the challenges of working and researching in this area, this review provides an overview of the state of the evidence and a suggested way forward, highlighting the key need to consider the context surrounding the child or young person and their family, and to provide appropriate, quality support and training to the staff and carers working with children and young people engaging in PSB.

2. Background

2.1. Defining problematic sexual behaviour

Although there has been historical denial of PSB among children and adolescents in Australia and internationally (Chaffin et al., 2008; O'Brien, 2008), the sexual behaviour of children and young people is best understood according to a continuum; from healthy, age-appropriate behaviour, to behaviours that are abusive towards others (Chaffin et al., 2008; NSW Department of Health, 2005). Problem sexual behaviour (PSB) is outside normal developmental activity and has a detrimental effect on a child or young person's engagement in everyday tasks (Chaffin et al., 2008; NSW Department of Health, 2005; Staiger, 2005). PSB is not considered a medical or psychological syndrome in itself but a group of behaviours that fall outside of societal and developmental norms. As such, what is considered PSB is highly context dependant and may differ based on cultural norms (Chaffin et al., 2008). It should also be kept in mind that behaviours that are inappropriate in one context, may be acceptable in another context (e.g. in private) (Chaffin et al., 2008; NSW Department of Health, 2005; Staiger, 2005).

Defining problem sexual behaviour — and distinguishing between problem sexual behaviour and sexually abusive behaviour — is a fraught process (Chaffin et al., 2008; O'Brien, 2010; Staiger, 2005). The terminology used to describe these behaviours can be stigmatising and negatively impact a child or young person's self-identity (Boyd & Bromfield, 2006; Chaffin et al., 2008; O'Brien, 2010). Furthermore, although there is a general consensus regarding what behaviour is sexually abusive, there are a number of issues to consider when using the term to describe the behaviour of children and young people. For example, in some jurisdictions, such as Victoria, the term 'sexually abusive behaviour' is only used for children over a certain age — that is, when they can be deemed criminally responsible for their behaviour (Evertsz & Miller, 2012). This has practical implications for the nature of the approach required.

For younger children, it is thought helpful to understand PSB based on the intensity or severity of the PSB on a continuum from normal sexual behaviour, to problematic behaviour, to serious or very concerning sexual behaviour. This is often dependent on the age of the young person and the context of the behaviour[13] (Chaffin et al., 2008; Pratt, Miller, & Boyd, 2012; Victorian Government, 2012).

[13] Further information on age normative and problematic sexual behaviour can be found here:
Victorian Government Department of Human Services (2012) - http://www.dhs.vic.gov.au/__data/assets/pdf_file/0011/713693/problem-sexual-behaviour-or-sexually-abusive-behaviour.pdf;
For further information specific to young child, please refer to Evertsz, J., & Miller, R. (2012) - http://www.dhs.vic.gov.au/__data/assets/pdf_file/0003/644772/children-problem-sexual-behaviours-families-specialist-practice-resource-2012.pdf

For older children, the behaviour can still be thought of us existing on a continuum. However, when the age of criminal responsibility is reached, deciding on whether a behaviour is sexual abusive or not becomes pertinent. It is suggested that issues of consent, equality or power differentials within the relationship or use of coercion are utilised when deciding if a behaviour is sexually abusive or can cause harm[14] (Chaffin et al., 2008; Pratt et al., 2012; Victorian Government, 2012).

Attempts have also been made to develop sub-types of PSB in order to tailor treatments to these subtypes. These may focus on the type of PSB or the target of the behaviour. However, findings suggest that it is the overall intensity and severity of the PSB that is most important, rather than any differences in the kind of PSB engaged in (Chaffin et al., 2008).

For this report, we use the term 'problem sexual behaviour' (PSB) to refer to the entire continuum of behaviours that are inappropriate or harmful for the young person engaging in the behaviour or any target of their behaviour. We include PSB among younger children (0–10 years) and older children (11–18 years), and PSB with and without an obvious target. In all jurisdictions in Australia the statutory minimum age of criminal responsibility is 10 years of age (Australian Institute of Criminology, 2005; Urbas, 2000). As such, the responses required will to need to take the age of the young person into account for legal considerations.

2.2. The impact of problematic sexual behaviour

For PSB that involves a victim, the harms experienced are comparable to the harms experienced by adult victims of sexual assault (Evertsz & Miller, 2012; NSW Department of Health, 2005; Pratt et al., 2012). Boyd and Bromfield (2006) note, 'the age of the offender does not determine the degree of harm caused to the victim. Intrusive acts of abuse by a school peer or sibling can be just as frightening and serious as abuse by an adult' (p. 4).

Children and young people who engage in PSB may experience negative social interactions and encounter stigmatised responses from adults, which impede their self-concept (NSW Department of Health, 2005). Furthermore, these behaviours may lead to long-term behavioural patterns: evidence indicates that a proportion of adult sex offenders engaged in PSB in their childhood and/or adolescence (Evertsz & Miller, 2012; NSW Department of Health, 2005; Pratt et al., 2012).

2.3. The relationships between problematic sexual behaviour, sexual abuse and sexual offending

Despite this link between adult sexual offences and PSB in childhood, most young people with sexually abusive behaviours do not go on to become adult offenders (Chaffin et al., 2008; Pratt et al., 2012). However, treatment for young people was often conducted in a framework suited to adults (Chaffin et al., 2008; O'Brien, 2008; Pratt et al., 2012). Although the exact numbers can vary, it has been noted that

[14] For further information on age normative and problematic sexual behaviour specific to adolescents, please refer to Pratt, R., Miller, R., & Boyle, C. (2012) - http://www.dhs.vic.gov.au/__data/assets/pdf_file/0005/589721/adolescents-sexually-abusive-behaviours-families-specialist-practice-resource-2012.pdf;

recidivism rates for adolescents who have engaged in sexually abusive behaviour tend to be low, especially when compared to adult offenders (Batastini, Hunt, Present-Koller, & DeMatteo, 2011; Chaffin et al., 2008; Nisbet, Rombouts, & Smallbone, 2005; O'Brien, 2008; Pratt et al., 2012). It has also been found that children who engage in PSB are at no greater long-term risk of committing sexual offences (2–3%) after appropriate short-term outpatient treatment, when compared with other child clinical populations (Chaffin, 2008). This demonstrates the qualitative difference between sexual offending in young people compared to adults, and that the behaviour in young people is responsive to appropriate treatment.

The relationship between prior sexual abuse history and later sexual offending has recently begun to be tested. A study by Leach, Stewart, and Smallbone (2016) found that, although a prior history of sexual abuse was an important contributor to later sexualised behaviour, only 4% of sexual offenders as adolescents or adults had confirmed sexual abuse histories.

The general consensus among scholars is that the majority of children and young people who engage in PSB are not driven by a pre-existing sexual preference for children, rather their behaviour is the consequence of their specific contexts or situations. In other words, the behaviour is not innate to the child or young person, but the result of environmental influences that shape their options and decision-making processes (O'Brien, 2008).

2.4. Risk pathways for problematic sexual behaviour

Although we know something about the circumstances in which PSB can occur, there is no definitive causal explanation for these behaviours. Children who engage in PSB are heterogeneous and, as such, O'Brien (2008) notes that, 'to generalise about [them]…is likely be harmful' (p. 7). In the Leach et al. (2016) study, exposure to poly-victimisation (multiple notifications for maltreatment and multiple types of harm) was the strongest predictor for sexual offending and other types of offending. It appears that a combination of risk factors is perhaps a stronger influence in engaging in PSB as an adolescent, or sexually offending as an adult, than sexual abuse alone (Chaffin et al., 2008; Leach et al., 2016). A number of common possible risk pathways have been identified, and each risk factor adds additional vulnerability for the child engaging in PSB. It is important to keep in mind that these risk pathways only lead to PSB in a small number of children (Chaffin et al., 2008; NSW Department of Health, 2005; Pratt et al., 2012).

Risk factors include:

- trauma — especially trauma during the early years
- chronic, long-term neglect
- sexual, physical or emotional abuse
- being a witness of or exposed to family violence
- learning difficulties and developmental delays[15]

[15] Lovell notes that the majority of adolescents with learning difficulties who engage in problem sexual behaviour have been subjected to physical or sexual abuse, or neglect (Lovell in O'Brien, 2005).

- psychological, emotional and behavioural problems
- living in a highly sexualised environment, including exposure to sexually explicit media
- socio-economic disadvantage (Boyd & Bromfield, 2006; Chaffin et al., 2008; Evertsz & Miller, 2012; O'Brien, 2008, 2010; Pratt et al., 2012; Staiger, 2005).

2.5. Prevalence of problematic sexual behaviour

Measuring rates of PSB among children and adolescents is difficult because denial or minimisation means that it is often not reported (Staiger, 2005). Over the past decade some useful Australian data have been identified. In 2005, data from Victoria, South Australia, Queensland and New South Wales (NSW) indicated that 9–16% of all sexual assaults or child sexual abuse cases were committed by young people under 18 years of age (Boyd & Bromfield, 2006). Data from 2002–2003 in NSW indicates that the proportion of child sexual assault cases involving a perpetrator under the age of 10 is much smaller: between 4–6% (NSW Department of Health, 2005).

It is important to note, however, that even with these data the scope of the problem is difficult to determine as each jurisdiction measures a slightly different phenomenon.[16] For example, the 2005 data from NSW (cited above) pertains to presentations of child sexual abuse cases to sexual assault services, whereas the Victorian data pertains to alleged offenders of non-rape sexual assault and rape as reported to Victoria police (i.e. not limited to child sexual abuse) (NSW Department of Health, 2005).

Data from different sources also vary considerably. For example, in 2003, a report by the Child Protection Society in Victoria estimated that 20–40% of child sexual assaults are committed by individuals under the age of 18 — higher than the aforementioned 9–16% (Flanagan & White, 1997, as cited in Staiger, 2005). Another study estimated an even higher figure: 30–50% of sexual offences targeting children are committed by adolescents (Ryan and Lane in O'Brien, 2010).

Much of the literature focuses on sexually abusive behaviour perpetrated by adolescents. The targets of this behaviour are most often younger than the perpetrator (Pratt et al., 2012); however, relationship and dating violence (i.e. peer-to-peer) has also been identified as a concern (Boyd & Bromfield, 2006). Where the target is younger than the adolescent engaging in the behaviour, the victims are almost equally boys and girls, but where the target is a peer, the victim is more likely to be female (Boyd & Bromfield, 2006). Sibling victims are more likely to be female and under the age of 11 (Pratt et al., 2012). Some research suggests that sibling sexual abuse is the most common type of intra-familial abuse (Boyd & Bromfield, 2006; Evertsz & Miller, 2012).

2.6. Problem sexual behaviour in out-of-home care

Out-of-home care (OOHC) refers to a range of services for children and young people (0–18 years) who are unable to live with their biological parents, typically

[16] See Boyd and Bromfield, 2007, p. 3 for complete table.

because of abuse or neglect (Goldsworthy, 2015; Shlonsky et al., 2013). As of 30 June 2014, just over 43,000 Australian children were living in OOHC (Goldsworthy, 2015).

A range of different types of OOHC exist in Australia including:

- *Foster care* is provided in a home-based setting by a foster carer. Around 41% of children in OOHC in Australia are in foster care (Australian Institute of Health and Welfare, 2016).
- *Kinship care* is provided in a home-based setting by an adult (or adults) who is known to the child (e.g. aunt, grandparents, family friend). Around 49% of children in OOHC in Australia are in kinship care (Australian Institute of Health and Welfare, 2016; Kiraly & Humphreys, 2013).
- *Residential care* is a form of group care provided in a residential building staffed by paid personnel. Around 5% of children in OOHC in Australia are in residential care. Residential care is primarily used for children and young people with complex needs, and large sibling groups. Children and young people in residential care are typically older than children and young people in home-based care (Australian Institute of Health and Welfare, 2016; Child Family Community Australia, 2015).
- *Other* forms of OOHC include family group homes, private boarding arrangements and lead tenant households. Around 5% of children in OOHC in Australia are in one of these other forms of care (Australian Institute of Health and Welfare, 2016; Child Family Community Australia, 2015).

PSB is a concern in any setting, but is a particularly important issue in OOHC for three key reasons:

- Some children and young people are in OOHC because their PSB poses a risk to other family members (Boyd & Bromfield, 2006; Evertsz & Miller, 2012; Pratt et al., 2012; Sexual Assault Support Service, 2015).
- Because of their traumatic histories, children and young people in OOHC are at greater risk of developing PSB (Mildon & Jones, 2014).
- Children and young people in OOHC are at risk of becoming targets of PSB, especially if they have an intellectual disability or are otherwise disempowered (Evertsz & Miller, 2012; Mildon & Jones, 2014).

A scoping review on practice elements to prevent child sexual abuse in OOHC (South et al., 2015) found that, where the relationship between the perpetrator and the victim is identified, a proportion of reported child sexual abuse incidents in OOHC involve a child engaging in PSB (as opposed to a caregiver perpetrating sexual abuse). According to the authors, child-to-child sexual abuse is an issue that requires substantially greater attention.

2.7. Scope and purpose of this review

The purpose of this review is to identify and describe approaches for preventing and responding to PSB among children and young people in OOHC settings.

There are a range of approaches that might be used to improve outcomes for children and young people engaging in PSB. Types of approaches may include interventions, therapies, treatments, practices, programs, or services. For simplicity,

we typically use the word 'approach' within this report to refer to all of these types of approaches.

This is an exploratory project that systematically maps research and evaluations and acknowledges current practice. A range of approach options is included for consideration or adoption in the future.

Consideration will also be given to the recently developed Quality Assurance Framework for OOHC in NSW (QAF)[17] and how responses scoped are relevant to improving overall outcomes for children and young people in OOHC across the domains proposed in the QAF — safety, permanency, and wellbeing (cognitive functioning, physical health and development, mental health, social functioning, and cultural and spiritual identity).

This project aimed to cover approaches for prevention and intervention for children and young people with PSB. This includes approaches that are solely for the child or young person with PSB, as well as multicomponent approaches, addressing the needs of the children with PSB, their carers, as well as any children or young people who have been the targets of the PSB. Approaches that are solely for children and young people who have been targets of problematic child sexual behaviour are also in scope.

Sexual abuse perpetrated by adults is out of scope. Studies that include a mixture of child- and adult-perpetrated sexual abuse were not considered. It would not have been possible to obtain an understanding of the approaches in studies that included mixed perpetrator populations.

Child-to-adult sexual abuse was out of scope in this review, but if the targets were a mixture of adults, children and young people, these approaches were included.

Approaches to prevent and respond to PSB outside the OOHC context are also considered in order to draw on evidence and learnings from other settings.

2.8. Research questions

Two overarching research questions drove this review:

1. What approaches have been used to prevent and respond to problem sexual behaviour among children and young people?
2. What approaches have been used to prevent and respond to problem sexual behaviour among children and young people in OOHC settings, including foster care, residential care, respite care and kinship care?

The following questions were also taken into consideration during data collection, analysis and synthesis:

1. What practices, policies and principles exist for preventing and responding to problem sexual behaviour in different types of OOHC settings?

[17] To read the QAF, see http://www.facs.nsw.gov.au/__data/assets/file/0007/377674/QAF_Section_3_Quality_Assurance_Framework.PDF

2. What types of system response is needed to respond to and prevent problem sexual behaviour?
3. What practice standards exist for the management of problem sexual behaviour?
4. In what ways have carers been involved in approaches for preventing and responding to problem sexual behaviour among children and young people?
5. What skills and qualifications are required of statutory child protection and OOHC workers to identify and respond to problem sexual behaviour (both in the literature and in practice)?
6. What work is done with birth families while children are in OOHC?
7. What proportion of children displaying problem sexual behaviour are also victims?
8. How do approaches compare based on the following factors:
    - child age (<10 problem behaviour vs. 10–17 abusive behaviour)
    - child gender
    - the relationship between perpetrator and target (siblings, peers, other children)
    - the type of OOHC setting (foster, residential, respite, kinship)
    - ethnicity, Aboriginal and Torres Strait Islander, other culturally diverse groups
    - different abilities (e.g. mental health problems, disabilities)
    - delivery mode (individual vs. group work, timeframe)
9. What factors need to be considered when implementing the identified approaches in the NSW and OOHC contexts?

2.9. Structure of this report

Review methodology is presented in the next section, followed by the findings, centred on the questions used to guide the consultation process. Findings are organised so that approaches for OOHC and other settings can be distinguished, as can approaches for younger versus older children. Evidence for approaches is presented first in the findings, followed by information primarily obtained from the consultees, including policies, practice standards and principles. A discussion section draws together the various aspects of the review, and considers implications and recommendations for practice.

3. Methodology

This review was conducted with input from a subject matter expert (SME), Stephen Smallbone, Professor of Criminology, Griffith University, Queensland (see Appendix 6.1 for Professor Smallbone's biography). Professor Smallbone assisted with the development of search terms and in the sourcing of background material. He also assisted with feedback at the draft stage of the report.

The review comprised three elements:

- a rapid evidence assessment
- consultations with selected members of the child protection field
- a desktop search.

3.1. Rapid evidence assessment

A rapid evidence assessment (REA) was conducted to determine the evidence for approaches to prevent and respond to PSB.

REAs are reviews that accelerate or streamline full systematic reviews (Gannan, Ciliska, & Thomas, 2010). Systematic reviews remain the most rigorous method of reviewing the evidence for approaches. However, systematic reviews can be costly in terms of the time and personnel required, taking at least a year to conduct (Hemingway & Brereton, 2009). REAs can provide quick summaries of what is already known about a topic or approach, and usually take between two and six months. REAs use systematic review methods to search and evaluate the literature, but the search may be less comprehensive than a full systematic review. REAs are particularly useful when there is uncertainty about the effectiveness of a policy or service, or when a decision on evidence-based practice is needed within months.

Examples of methods used to make reviews more rapid include placing limitations by language or date of publication, limiting the range of electronic databases searched, and limiting the geographical context or setting to ensure that evidence gathered can be readily applied to the context of interest. Study designs, populations and approach types can also be limited depending on the research questions. These limitations mean that the volume of literature to be synthesised can be reduced to a manageable level given time constraints, while retaining the objectivity and transparency of inclusion that are characteristic of systematic reviews.

The REA used in this review involved a search the following academic databases in March 2016: PsycInfo, Embase + Embase Classic, Social Services Abstracts, Sociological Abstracts, and Criminal Justice Abstracts. Search terms used for these databases appear in Appendix 6.2.

Key organisation websites, as detailed in Table 2, were also searched, using publication lists and search functions, for relevant evaluations of approaches.

Table 2: Key organisation websites searched for evaluations

Organisation	Website
Australia's National Research Organisation for Women's Safety	www.anrows.org.au
Australian Institute of Criminology	http://www.aic.gov.au/index.html
Australian Institute of Health and Welfare (AIHW)	http://www.aihw.gov.au
Australian Research Alliance for Children and Youth (ARACY)	http://www.aracy.org.au/
Child Family Community Australia (CFCA), Australian Institute of Family Studies	https://aifs.gov.au/cfca/
Child, Youth and Family New Zealand	www.cyf.govt.nz
National Institute for Health and Care Excellence	www.nice.org.uk
National Society for Prevention of Cruelty to Children	www.nspcc.org.uk
Social Care Institute for Excellence	http://www.scie-socialcareonline.org.uk/

Evaluations of approaches were also sought from our SME, from the NSW Department of Family and Community Services (FACS), and from consultees in the child protection field (see below).

Evaluations of approaches were accepted if they were dated after 2002 and pertained to children aged 0–18 years with PSB (as outlined in the definitions section). Approaches for targets[18] of PSB were also accepted. Any study designs were included.

Studies reporting evaluations of approaches for adult perpetrators of sexual abuse were excluded, as were papers reporting populations that were a mixture of child and adult perpetrators. Studies with adult survivors of childhood sexual abuse were not considered. Due to resource constraints we did not include books, book chapters, theses, conferences papers, presentations, abstracts or non-English language papers. Studies dated pre-2002 were not included. We also excluded case studies of only one child or young person, unless they related to an approach identified in another study that was included in the REA.

3.1.1. Assessment of effectiveness

Conducting research with children and young people engaging in PSB presents various challenges. According to Nisbet et al. (2005) these include:

- heterogeneity in the populations and within treatments

[18] In this report, the term 'target' is used to refer to a person who is exposed to the PSB of a child or young person

- the ethical challenges of not treating some young people in order to make comparisons
- the use of sexual offending recidivism as the primary outcome, which may not be a reliable or suitable measure of actual re-offending and PSB
- confounding variables in evaluation, such as increased monitoring resulting in an increase number of observed offences (if you are watching someone, you are more likely to see when they are offending)
- age as a confounder in assessing the impact of treatments over time when criminal behaviour in adolescents typically declines during mid-late adolescence anyway
- low rates of recidivism in general make it difficult to determine if there is any statistically significant difference between groups.

Acknowledging that these challenges exist, the REA included some descriptions of the strengths and limitations of each study in narrative form. In order to identify which approaches may present the best evidence, we also applied a predetermined rating scale to the identified approaches.

All included approaches were rated according to the scale in Figure 1 as described in more detail below. This rating scale uses tight criteria to ensure that high evidence ratings are only given to approaches tested and found to have an effect using rigorous designs, and that the effects on outcomes for children and young people were maintained once the participants were no longer involved in the approach (maintenance of effect, or lasting benefit). RCTs are rigorous study designs and provide the best opportunity of determining if changes to outcomes are a result of an approach rather than due to chance or other factors. Ideally, we would also aim to observe replication of effects, with the benefits of an approach assessed in more than one study. Use of this scale enables more confident statements about the degree of effectiveness of the reported approaches. The rating process also relies on high-quality systematic reviews with meta-analyses in order for approaches to be rated at the top level. This takes into account the additional rigour of systematic reviews and ensures that only those approaches with the best available evidence are singled out at the highest rating level.

Well supported: A well supported approach has the highest level of evidence. .At least two RCTs have found the approach to be both significantly and substantially more effective than the comparison group and that these benefits are measured and maintained at least 12 months after the approach has finished. Further to this, the approach has been found to be effective in a high quality systematic review with meta-analysis[19]. Lastly, it is important that studies show no evidence of harm or risk to participants.

Systematic reviews were considered high quality, if they met the following criteria:

- They addressed a clearly defined question.

[19] A meta-analysis is a statistical approach that combines results from several studies to estimate the overall effect of an intervention

- There was an a priori search strategy (clear protocol for search developed prior to commencing review) and clearly defined inclusion and exclusion criteria.
- They searched a minimum of three databases.
- Grey (unpublished) literature was specifically searched for.
- There was more than one rater for extraction of study information.

Supported: At least two RCTs have found the approach to be both significantly and substantially more effective than the comparison group and that these benefits are measured and maintained at least 12 months after the approach has finished. Lastly, it is important that studies show no evidence of harm or risk to participants. The level of evidence is not as high as those that are found in systematic reviews, as systematic reviews allow for the statistical combination and comparison of approaches by multiple study authors, reducing any potential bias in the approach.

Promising: At least two RCTs have found the approach to be both significantly and substantially more effective than the comparison group and that these benefits are measured and maintained for at least six months after the approach has finished. No evidence of harm or risk to participants is found.

Approaches rated Well Supported, Supported, or Promising are considered to have better evidence for improving outcomes of children and young people for the purpose of this REA because they utilised RCTs, have demonstrated some sustained benefit and these findings have been observed in more than one study. However, those not rated Well Supported may require further research to increase confidence in this approach.

Emerging: At least one RCT has found the approach to be both significantly and substantially more effective than the comparison group and that these benefits are measured and maintained for at least six months after the approach has finished. No evidence of harm or risk to participants is found. The strength of approaches rated Emerging is that they show a degree of sustained benefit once the participant is no longer involved in the approach.

Pending: At least one RCT has found the approach to be both significantly and substantially more effective than the comparison group at the completion of the approach. However, there is no evidence that the benefits of the approach are maintained for six months following the completion of participation in the approach. No evidence of harm or risk to participants is found. The strength of approaches rated Pending is that they have been tested using rigorous designs.

Limited Evidence: Studies may have compared the approach to another group of participants not receiving the approach; however, assignment to these groups was not random. Findings from these studies show that the approach may have some benefits and this lends initial support to the approach. However, as the design of these studies does not randomly place participants in groups and/or does not compare the benefits to another group, there is no way of knowing if it was the approach itself that was helpful, or something about the participants, setting or generic social support that led to the benefits. No evidence of harm or risk to participants is found. A rating of Limited Evidence does not necessarily mean that the approach does not work. Instead, we just do not have enough information in order to make a clear determination yet. Further research with more rigorous design is needed.

Failed to Demonstrate Effect: A systematic review and/or at least one RCT and/or multiple other studies or the weight of evidence show the approach has no beneficial effect for participants. No evidence of harm or risk to participants is found. Approaches rated Failed to Demonstrate Effect have shown through studies of high rigour (i.e. RCTs or a Systematic Review) that there is no benefit to participants.

Concerning Practice: There is evidence of harm or risk to participants. This evidence comes from a well-conducted systematic review that contains a comparison of at least two RCTs and statistical tests that combine the results of these studies, rather than a text summary of what was found. The systematic review has found that the overall evidence finds one or more harmful effects for participants. Alternatively, the overall weight of the evidence suggests a negative effect on participants. Approaches rated as Concerning Practice have demonstrated through multiple studies of high-rigour evidence that the approach does harm, has a negative effect or puts participants at risk.

3.2. Consultations with select personnel of the child protection field

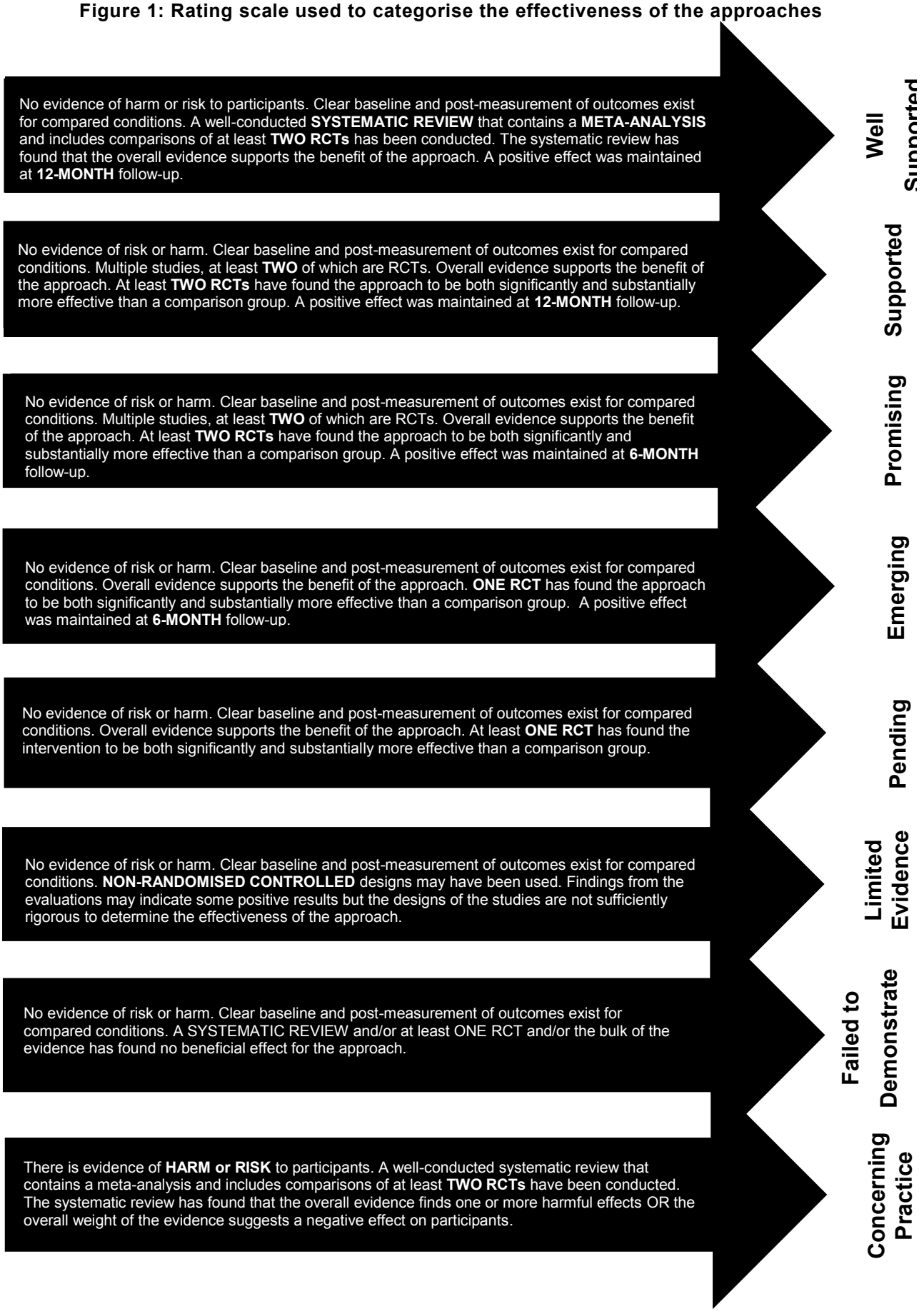
Four consultations were undertaken in March 2016 with seven professionals working in practice or policy related to PSB. FACS provided the names of relevant people to consult with. Consultations were conducted via telephone with:

- Dale Tolliday (New Street Services)
- Catherine Want (Rosie's Place)
- Laura Luchi (Anima Consulting)
- Kate McIntyre, Rebecca Magoffin, Karen Mahony and Tracey New, with Catherine Esposito observing (FACS group consultation).

The purpose of the consultations was to obtain information about (a) relevant studies and resources that we may not have been able to source via the other methodologies utilised; and; (b) 'on the ground' perspectives regarding approaches to prevent and respond to PSB. Consultations were undertaken over the telephone, using a semi-structured format and, where necessary, clarifying information was provided via email. Biographies of the consultees can be found in Appendix 6.3, along with consultation questions in Appendix 6.4.

Within this report, the information provided by consultees is treated as an accurate representation of the knowledge and experiences of a small number of highly experienced, knowledgeable professionals working in the field of child welfare and child protection in NSW. After the information was collected, it was analysed and organised according to the key questions of interest. Where the information provided by consultees aligned or contrasted with practice guidelines and other practice-based resources, this was noted.

Figure 1: Rating scale used to categorise the effectiveness of the approaches



3.3. Desktop search

In addition to seeking resources during consultations, we conducted a desktop search to identify resources that may be of use to organisations, policy makers and practitioners working with children and young people with PSB. We conducted a Google search for sexual behavio(u)r and sexualis/zed behavio(u)r, and searched Australian state, territory and federal government websites and key organisation websites for guidelines, practice standards and policies. Organisation websites searched for resources are listed in Table 3.

Table 3: Organisation websites searched for online resources

Organisation	Website
Gatehouse Centre	http://www.rch.org.au/gatehouse/
Berry Street	http://www.berrystreet.org.au
Victorian Centres Against Sexual Assault	http://www.casa.org.au
Australian Childhood Foundation	http://www.childhood.org.au
Children's Protection Society	http://www.cps.org.au
Laurel House	http://laurelhouse.org.au
True (Family Planning Queensland)	http://www.true.org.au
Australian Community Workers Association	http://www.acwa.org.au

3.4. Synthesis of findings

Findings from the REA, consultations and desktop search are synthesised in the following section according to the research questions outlined in Section 2.8. The three sources of the information are identified throughout the findings.

4. Findings

Key findings arising from this review are presented in Box 3.

Box 3: Key findings

- There is limited evidence to suggest 'what works' in prevention and response to problem sexual behaviour (PSB) in children and young people in out-of-home care or settings generally.
- Systematic reviews generally found that some form of treatment for children and young people engaging in PSB is better than no treatment at all.
- Multisystemic Therapy – Problem Sexual Behavior (MST-PSB) and approaches based on Cognitive Behavioral Therapy (CBT) are the most widely researched approaches for responding to PSB in children and young people.
- Systematic reviews indicated that studies assessing MST-PSB were typically more rigorous than those testing CBT and they demonstrated better effects on recidivism.
- The approach with the highest rated evidence for responding to PSB is MST-PSB; however, it is currently not available in out-of-home care settings or in Australia.
- When responding to PSB, workers and professionals should consider all aspects of the child or young person's life, involve birth and foster families, and collaborate with each other and with the young person's carers.
- Most approaches identified in the rapid evidence assessment focused on responses to PSB with little or no consideration for prevention or early intervention.
- Most literature is heavily skewed toward approaches for males over 10 years of age who are engaging in more severe forms of PSB and who are referred to as sexual offenders.
- Supports for targets of PSB were not identified in the evidence of this review.
- When reported, most approaches identified in the rapid evidence assessment indicated a minimum requirement of masters-level qualified and trained professionals when responding to severe forms of PSB.
- There do not appear to be benefits for the use of mandatory registration of sexual offenders on rates of sexual recidivism.
- The body of research in Australia is in the early stages of development, with most studies on this topic being conducted in the USA.

This section of the report presents the findings of all three elements of the review: REA, consultations, and desktop search. Findings are synthesised where possible, with synergistic and differing findings noted where applicable.

The REA identified 47 papers relevant to this review (refer to Appendix 6.5 for a figure depicting the flow of studies through the selection process). Thirty-five papers reported 30 evaluations of 26 approaches for preventing or responding to PSB. The remaining papers identified in the REA related to evaluation of legislation on mandatory registration of juvenile sexual offenders designed to deter and prevent sexual recidivism (*n*=7) and systematic reviews on the evidence for approaches for PSB (*n*=5).

We begin this section with a discussion of the findings arising from evaluations of legislation designed to prevent sexual abuse recidivism. This is followed by high-level evidence from systematic reviews regarding evaluation of approaches.

The subsequent sections are devoted to approaches that respond to or aim to prevention PSB, and have been rated to determine their effectiveness for improving outcomes. These are organised by setting, with approaches that apply to OOHC settings first, then a mix of settings including OOHC, and then settings outside the OOHC context. Approaches are also organised by younger and older age groups. Policies, practice standards and principles for working with children and young people engaging in PSB are covered next, then supports for targets of PSB and for parents and carers. Skills, qualifications and training follow this section, and then a final section reporting the occurrence of history of abuse in children and young people with PSB.

4.1. What is the evidence from evaluations of legislation designed to prevent sexual recidivism?

The REA identified seven papers reporting evaluations of the impact of US federal legislation relating to mandatory registration of juvenile sexual offenders in the USA (Batastini et al., 2011; Caldwell & Dickinson, 2009; Letourneau, Bandyopadhyay, Armstrong, & Sinha, 2010; Letourneau, Bandyopadhyay, Sinha, & Armstrong, 2009; Letourneau, Bandyopadhyay, Sinha, & Armstrong, 2009b; Letourneau & Borduin, 2008; Letourneau et al., 2013).

The legislation in question was Sex Offender Registration and Notification Act (SORNA; Title 1 of the Adam Walsh Child Protection and Safety Act of 2006). The legislation requires that young people over 14 years found guilty are classified into three tiers according to severity of the crime. The highest tier, level III, involves registration for 25 years to life, where registration means providing all personal and arrest details, DNA, and so on, to the registry, and being subject to probation and parole visits (Batastini et al., 2011).

All studies found that registration of juvenile (male) sex offenders did not have the intended effect of reducing recidivism. There was no difference in recidivism rates of those placed and not placed on registries (Batastini et al., 2011), and sexual offender registration legislation was found *not* to act as a deterrent (Letourneau et al., 2010). Sexual recidivism was found to be low in general in groups of young people meeting criteria for registration and in those that did not meet the criteria for registration (Letourneau & Armstrong, 2008). On scales designed to predict recidivism (Caldwell & Dickinson, 2009), there were few difference between those meeting and those not meeting the criteria for registration, and registration did not impact the risk of re-offending.

Letourneau et al. (2009b) found that with the implementation of registration laws, prosecutors were less likely to move forward on sexual and other assault charges, suggesting that the law may have had the unintended consequence of decreasing likelihood of prosecution. Letourneau and Caldwell (2013) noted that while there was no effect on sexual recidivism, those on the register were more likely to be charged with other offences. The authors speculated that the law may not impact the degree of offending behaviour, but rather may have increased surveillance of registered young people, thereby increasing their chance of being charged.

Findings from these studies were consistent. There appears to be no benefit of mandatory registration on sexual offence recidivism. Further to this, Batastini et al. (2011) suggests that the underlying assumption of this legalisation is that young people classified as level III are at higher risk of re-offending and should face the

same penalties as adults. According to Batastini et al. (2011), there is no evidence to support this assumption. In addition, there is no recognition of other factors that may predict sexual recidivism. Lastly, an unintended consequence of registration legislation may be that young people experiencing PSB will not seek suitable treatment.

Further consideration is needed to determine if there are any other worthwhile benefits or potential risks associated with this approach to PSB prevention.

4.2. What is the evidence from systematic reviews regarding responses to problem sexual behaviour in children and young people?

In this section, approaches to respond to PSB are presented, with findings from systematic reviews identified in the REA described first, followed by evaluations of specific approaches.

The REA identified five systematic reviews that examined the effects of approaches for children and youth with PSB (Dopp, Borduin, & Brown, 2015; Nisbet et al., 2005; Reitzel & Carbonell, 2006; St. Amand, Bard, & Silovsky, 2008; Walker, McGovern, Poey, & Otis, 2004).

4.2.1. Systematic review findings relevant to adolescents

Four systematic reviews identified in the REA evaluated the effectiveness of juvenile sexual offender treatments, primarily for males (Dopp et al., 2015; Nisbet et al., 2005; Reitzel & Carbonell, 2006; Walker et al., 2004). In general, these reviews found that receipt of some form of treatment, rather than no treatment at all, demonstrated benefits for young people, such as reduced rates of sexual recidivism.

Both (Dopp et al., 2015) and Reitzel and Carbonell (2006) included studies with some form of comparison sample, with Dopp et al. (2015) identifying 10 studies and Rietzel and Carbonell (2006) including nine studies. These two reviews found that most treatments evaluated were Multisystemic or based on Cognitive Behavioral Therapy (CBT). They concluded that studies evaluating Multisystemic Therapy – Problem Sexual Behavior (MST-PSB) were typically more rigorous than those testing CBT and demonstrated better effects. Both reviews noted that there is less clarity regarding the evidence for CBT, while Reitzel and Carbonell (2006) pointed out that there were some methodological concerns regarding most studies. Dopp et al. (2015) noted that there is a practice–evidence gap here, with more CBT-oriented treatments in the USA than multisystemic treatments for young people with PSB. Additional information regarding MST-PSB and CBT appears in the following sections of this report.

In contrast to the findings of Dopp et al. (2015) and Reitzel and Carbonell (2006), a review by Walker et al. (2004) involving 10 studies, found that CBT-based treatments had greater effect sizes compared to MST. It should be noted that the design of studies included in the Walker review is not clear, but did involve less-rigorous studies than in the reviews by Dopp et al. (2015) and Reitzel and Carbonell (2006).

A review by Nisbet et al. (2005) included a broad scope of study designs, from pre–post treatment studies involving no comparison group, through to randomised, controlled trials (RCT). Twenty-three studies covering various treatments were included. Despite the developing evidence base and low quality of studies in the

area, the authors noted that various lessons could be learnt. They found that the approaches with greatest benefits tended to be holistic, consider the various aspects of the young person's life, and involve community and family. Family inclusion in treatment had a great impact. These authors also commented on the benefits of different types of approaches (for further commentary on specific approaches, please refer to Nisbet et al., 2005).

As found in the reviews by Dopp et al. (2015) and Reitzel and Carbonell (2006), Nisbet et al. (2005) concluded that MST is effective for preventing further offences. The authors note that, while some of the effect sizes are small in evaluations of these treatments (meaning that the benefits do not appear to be large), this may still translate to notable gains for many young people. This is also worthwhile in terms of the costs needed for detaining and treating juvenile offenders (Dopp et al., 2015; Nisbet et al., 2005; Reitzel & Carbonell, 2006).

4.2.2. Systematic review findings relevant to younger children

One systematic review (St. Amand et al., 2008) investigated the elements associated with the effectiveness of approaches for children aged 12 and under who have PSB. Treatments varied, with some targeting PSB as the primary concern, and others primarily treating other issues, such as exposure to child sexual abuse, with PSB as a secondary target. Eleven studies were included in the meta-analysis of treatment elements.

Similar to Nisbet et al. (2005), St. Amand et al. (2008) found that the main agent of change in the treatments was the parent or caregiver. Treatments that did not include some level of caregiver involvement were not supported by the results of the meta-analysis. The element that was found to have the strongest association with reduction in PSB was 'parenting/behavior management skills'. Other parent elements with effect were 'rules about sexual behavior', 'sex education' and 'abuse prevention skills'. The child element with effect was 'self-control skills'. No difference was found between group versus individual or family therapy approaches. Greater effects were observed in preschool-aged rather than school-aged children.

The authors note that the lack of rigorous designs (single group, pre–post treatment with no comparison groups) used in the studies, and small sample sizes (few children and young people participated in the studies), present limitations of the findings, and they should be interpreted with caution (St. Amand et al., 2008).

4.2.3. Summary

In summary, despite some methodological limitations in the included studies, it appears from these systematic reviews that some form of treatment may be better than no treatment at all, that CBT-based therapies may have some benefits, but perhaps multisystemic therapies have greater gains in young people, and that involvement of families and parents in treatment is important.

4.3. What is the evidence from evaluations of approaches for responding to and preventing problem sexual behaviour

Following on from high-level evidence derived from systematic reviews, this section summarises the evaluations of approaches that were identified in the REA. Twenty-six approaches were identified, with 10 approaches related to OOHC settings, 10 in other settings, and six that included a mixture of children with their birth families or in

OOHC. The following sections describe these approaches and evaluations in details and are organised according to setting: OOHC, OOHC or general settings, and general settings. A section on prevention follows, along with additional approaches mentioned by the consultees.

Throughout the findings section, when describing PSB and those engaging in this behaviour, we have opted to use the language taken by the authors (.e.g. serious PSB, sexually aggressive PSB) to ensure we do not misinterpret their sample. However, we encourage the reader to refer to the overall definition of PSB provided at the beginning of the report and in the introduction section, for up-to-date and appropriate definitions of this behaviour.

4.3.1. What is the evidence for approaches responding to problem sexual behaviour in out-of-home care settings?

We describe here 10 approaches for responding to PSB in children and young people in OOHC settings. The REA identified one approach for young children aged under 10 years, and nine for older children. All 10 approaches were rated as Limited Evidence. These are organised into age groups and also alphabetically below, with additional information from consultees provided where appropriate. Ratings of these approaches are also included. Refer to Table 4 for a snapshot of these approaches.

4.3.1.1. Approach for children aged under 10

The Intensive Program – Limited Evidence

The Intensive Program is a foster family-based program developed for children aged under 12 years placed in OOHC with serious PSB (Ownbey, Jones, Judkins, Everidge, & Timbers). The program is a variant of the Professional Parenting Program of Appalachian Family Innovations in North Carolina, USA. The objectives of the approach are to reduce PSB and reduce future risk of the young person engaging in PSB.

The Intensive Program is delivered to foster parents of children who have been removed from their homes for reasons of neglect or physical/sexual abuse. Foster parents are provided with financial compensation for their involvement. Children are referred to the program for serious PSB involving others. The targets of the PSB tend to be a mixture of children, siblings, adults or animals. The total duration of the program is at least two years, but can continue to three or four years based on the needs of the young person. The program is delivered by program mangers; however, the qualifications and training of these individuals is unclear.

Table 4: Approaches within out-of-home care settings

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Approaches for young people aged under 10 years						
The Intensive Program	LE	Individual and group-based program for foster carers of children aged under 12 years with PSB. Family involved: Yes Study design: Single group with post-approach testing only	USA	Gender: Male and female Age: Mean, 9.5 (range, 8–12) Sample size: 33 program foster carers and 10 program manager/senior staff.	May be helpful in reducing PSB, and providing safety and stability to young people who engage in PSB. Program foster carers and program staff consider safety planning, home visits by program managers and a normalising and stabilising environment to be key in contributing to those outcomes for young people.	The influence of extra-program counselling and intervention in producing these outcomes is unclear. Interviews only No comparison group No follow-up measures Small sample size
Approaches for young people aged over 10 years						
Cognitive Behavior Therapy	LE	In this study, CBT was evaluated with a 14-year-old sexual offender[20]. Family involved: Yes Study design: Case study	USA	Gender: Male Age: 14 years Sample size: 1	Suggests that CBT has the potential to be modified and adapted for young people with a disability in an OOHC setting and may then be helpful in reducing PSB.	Single-participant case study, which is the least rigorous study design with no way of knowing if benefits are due to chance or can be generalised to large number of young people

[20] The term sexual offender is used in this report when discussing papers that have used this phrase to refer to young people engaging in PSB who have committed, been charged with or convicted of sexual offences.

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
The Gateway	LE	Residential individual and group-based treatment for sexual offenders aged 11–16 years Family involved: No Study design: Single group with pre- and post-approach testing	UK	Gender: Male Age: Range 11–16 years Sample size: 34	May bring about improvements in child and adolescent psychosocial functioning, as well as a reduction in attitudes and beliefs related to recidivism risk. Unhelpful beliefs regarding the targets of PSB were not found to improve.	Unclear if improvements due to comprehensive residential treatment program (SWAAY) offered to all participants concurrently, or due to the Gateway Small sample size No comparison group No follow-up measurements taken
Interpersonal Skills Program	LE	Individual and group-based residential treatment for young people aged 7–17 years with PSB Family involved: Yes Study design: Single group with pre and post-approach testing	USA	Gender: Male and Female Age: Mean 12.3 (range 9–18) years Sample size: 58	May be helpful in improving functional impairment, decreasing sexually deviant interests and increasing sexually appropriate interests in young people.	Small sample size No comparison group No follow up measurements taken Did not measure rates of PSB
Approach based on covert sensitisation	LE	Group-based residential treatment for sexual offenders aged 12–18 years Family involved: No Study design: Single group with pre- and post-approach testing	Canada	Gender: Male Age: Mean 16.1 (range 13.3–21.3) years Sample size: 87	May lead to a reduction in the rate of deviant sexual fantasies, an increase in the rate of 'normal' fantasies, and an improvement in a young person's ability to interrupt or disrupt deviant fantasies.	Unclear if benefits due to overall participation in inpatient sex-offender treatment program Lack of appropriate statistical testing Small sample size No comparison group No follow-up measurements taken

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Multiple-Family Group Intervention	LE	Individual and group-based therapy of adolescents in juvenile detention for sexual offences Family involved: Yes Study design: Single group with pre- and post-approach testing	USA	Gender: Male Age: Mean 15.7 (range 12–19) years Sample size: 115	May be helpful in improving a young male adolescent offenders' ability to regulate his emotions, reduce internalising and externalising behaviour and improve his ability to relate to and depend on his caregivers. May also be helpful in reducing recidivism. One year follow up is a strength.	Difficult to separate effects of this approach from other treatments provided in detention No comparison group
Naltrexone	LE	Pharmacological treatment, in this case for sexual offenders aged 13–17 years who are in an inpatient program Family involved: No Study design: Single group with pre- and post-approach testing	USA	Gender: Male Age: Mean 15.2 (range 13–17) years Sample size: 21	May be helpful in reducing frequency of masturbation and fantasising in adolescent male sexual offenders.	Participants also using other medication for mental illness Side effects regarding mood or psychosocial function not examined Small sample size No comparison group No follow-up measurements taken
The New Pathways Residential Treatment Services	LE	Individual and group-based therapy for sexual offenders aged 12–17 years who are in residential treatment Family involved: Yes Study design: Single group with pre- and post-approach testing	NSW, Australia	Gender: Male Age: Range 14–16 years Sample size: 12	May be helpful in reducing risk factors for recidivism, improving behavioural outcomes, improving engagement in learning and improving health behaviours and self-care.	No statistical testing Not all participants had finished approach when measures taken Small sample size No comparison group No follow up measurements taken

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
A 'Self-contained' residential treatment for juvenile sex offenders	LE	Individual and group-based therapy for sexual offenders aged 8–18 years who are in juvenile detention Family involved: Yes Study design: Non-randomised comparison group design	USA	Gender: Male Age: Mean 14.4 (range 8–18) years Sample size: 256	May be helpful for young males in reducing overall recidivism rates, when compared to a general approach offered within detention. However, both approaches appear to be helpful in reducing rates of recidivism for sexual offences. The 10 year follow up adds strength to findings.	No randomisation to two groups
Thought Change System	LE	Individual and group-based therapy for sexual offenders aged 11–19 years, in residential treatment Family involved: Yes Study design: Non-randomised comparison group design	USA	Gender: Male Age: Range 11–19 years Sample size: 24 across two studies	May be helpful in improving psychological function, improving externalising behaviour, reducing sexually deviant beliefs and reducing recidivism risk.	Statistical tests not ideal Small sample size No follow-up measurements taken No randomisation to groups

E = Emerging; LE = Limited Evidence; RCT = randomised controlled trial; S = Supported.

*The age of children or young people may be different in description and in study. Sometimes an approach was designed for a particular age group, but the age of study participants did not match the intended age group.

† Limitations to study designs make studies less rigorous and reduce our confidence in their findings. Limitations include:

Interviews only: No statistical testing was completed. As such, findings are less objective and harder to replicate

No comparison group: There is no way to determine if changes are a result of the approach or due to chance or other factors.

No randomisation to groups: There is no way to determine if changes are a result of the approach or due to chance or some factor to do with the participants

No follow-up measures: There is no way of knowing if benefits are maintained long term.

Small sample size: There is no way to know if benefits can be generalised to a large number of young people.

The core components of The Intensive Program are:

1. Selection and training of foster parents. This involves six session of over 30 hours duration. Specialised training topics consists of: Normal Development, Sexualised Children, Attachment Issues, and Treatment and Safety Planning.
3. Matching of young people to foster parents.
4. Weekly visits to the family by the program manager, to review treatment and safety planning.
5. The program managers are available 24/7 for phone consultations.
6. Safety planning and monitoring for the client[21].
7. Weekly group educational sessions for the young person, facilitated by two program managers. Topics appear to be based on a CBT framework
8. Weekly group sessions for foster carers, facilitated by a program manager. These are run concurrently with the young persons' groups. These sessions are semi-structured, focus on interpersonal support and supporting program learnings at home.
9. A normalising and stabilising effect of the fostering environment.
10. On-request respite services. Typically run for two weekends a month, or as needed.
11. Collaborative involvement of those involved in extra-program counselling, testing or other community services the child may be involved in. The professionals providing these services are included in program team meetings.

The REA identified one study from the USA in which the Intensive Program has been evaluated in a post-intervention only design (Jones, Ownbey, Everidge, Judkins, & Timbers, 2006). Jones et al. (2006) also provide qualitative updates on the progress of young people involved in an earlier evaluation of the program, which they cite (Ownbey et al., 2001). In the 2006 study, 33 program foster carers and 10 program managers and senior staff were asked to rank the importance of the various components of the program in addressing PSB. No further quantitative analysis was conducted. Program parents and program staff ranked safety planning and monitoring of greatest importance to addressing PSB. They also ranked selection and training of foster carers, program manager visits and the normalising and stabilising effect of the foster care environment of great importance in addressing PSB. Extra-program counselling and other services were considered least important to outcomes for the young person by the program parents.

In the earlier evaluation, Ownbey et al. (2001) completed a single group pre–post approach study of six young people aged 8 to 12 years (mean age = 9.5 years) and their foster parents involved in the Intensive Program. Five out of the six children involved in the program no longer engaged in serious PSB and became stable in

[21] Safety plans are written contracts which focus on appropriate behaviours, agreed to and signed by the young person, foster parents, and the program manager, and seek to clarify the role of supervision and monitoring for the family and child. They are updated and formally reviewed by senior staff regularly, and can be periodically relaxed as the young person's behaviour changes.

their placements and engaged in school or work. Unfortunately, one young male client was unable to be successfully contained within his placement, and continued to have difficulties with offending behaviour (sexual and non-sexual).

These findings suggest the Intensive Program may be helpful in reducing PSB, and providing safety and stability to young people who engage in PSB. It also appears that safety planning, home visits by program managers and a normalising and stabilising environment are considered by program foster carers and program staff to be key in contributing to those outcomes for young people. However, given the small sample size and lack of comparison group, these results should be interpreted with caution. The influence of extra-program counselling and intervention in producing these outcomes is also unclear. Further research addressing these limitations would be ideal.

4.3.1.2. Approaches for young people over 10 years of age

Cognitive Behavior Therapy – Limited Evidence

Only one study was found in the REA that evaluated a structured CBT approach in an OOHC setting. This US case study describes a 14-year-old boy with autism spectrum disorder and a cognitive disability who had been convicted of sexually assaulting two younger children, and who displayed PSB (Shenk & Brown, 2007).

At one sexual offence-specific treatment facility, he displayed public masturbation and PSB towards the facility's pets, so he was moved to the more secure facility 'Hands Up Homes for Youth' (HUH). At HUH, a modified version of CBT was provided to this young person, to take into account his cognitive disability. He attended daily group therapy as well as weekly individual therapy for a total of 46 weeks. The content of his individual therapy included exposure and response prevention, role-play, homework assignments, metaphor, and daily self-monitoring. The group therapy program included learning and applying skills for managing and reducing sexual arousal and deviancy, challenging cognitive distortions, enhancing empathic responding, relapse prevention plans, and communicating about emotional experiences. It was delivered by a qualified psychologist.

Following 46 weeks of individual CBT, this young male's recidivism risk score reduced from 52%, to 25% at six-month follow up. The young male also reported no longer masturbating to deviant sexual fantasies, no longer masturbating in public and an overall reduction in sexual arousal.

This suggests that CBT has the potential to be modified and adapted to young people with a disability in an OOHC setting and may then be helpful in reducing PSB. However, given the single-case study design of this approach, an evaluation with a large sample size will need to be conducted before any conclusions can be drawn.

The Gateway – Limited Evidence

The Gateway group program is run within the SWAAY (the acronym is not elaborated on by the authors) residential treatment program, based in the United Kingdom. The program targets males aged 11 to 16 years who have engaged in sexually harmful behaviour, and who present with other complex and diverse needs (e.g. targets of sexual maltreatment themselves and histories of physical and/or emotional abuse). The targets of the sexually harmful behaviour are varied. The aim

of the program is to reduce participants' risk of sexual recidivism, and to bring about improvements in psychosocial functioning.

As the name suggests, this approach is delivered via group therapy. Group numbers are kept to less than 20. It is unclear who delivers this program and what training is required. The Gateway is delivered on a weekly basis over a period of 18 months.[22] The length of time that participants spend in the program — and the intensity of their involvement (i.e. how many sessions they attend in total) — can be adapted depending upon their needs and abilities (e.g. emotional maturity, cognitive or behavioural difficulties).

The Gateway group program includes four core components: sex and relationships; decision making; rights and responsibilities; and a victim focus. Each component consists of various modules which range from three to five weeks in duration.[23] A Cognitive Behavior Therapy (CBT) approach is used, with specific components taken from the Rational Emotive Behaviour Therapy (REBT) model for group work.

In addition to accessing group therapy, young people involved in the Gateway also have access to weekly individual CBT-based therapy within the SWAAY residential treatment program (which may or may not be related to their PSB). In addition, their residential care includes education and other non-offence related treatments.

The REA identified one study that reported an evaluation of the Gateway program (Edwards, Whittaker, Beckett, Bishopp, & Bates, 2012). Edwards et al. (2012) used a pre–post approach design involving 34 young males, with no comparison group. The study aimed to determine the impact of the program on participants' psychosocial functioning and offence-related attitudes and beliefs.

Less than 20% of young people in this program were from an ethnic minority background. The study also found that the program catered to young people with different abilities: 35% of the sample had some degree of learning disability, 5.9% had been diagnosed with an autistic spectrum disorder (ASD) and over half (52.9%) had a diagnosis of conduct disorder.

At the completion of treatment, participants' perspective-taking ability, assertiveness, locus of control, emotional loneliness and anger had significantly improved. However, no improvements were found in impulsivity. The participants also demonstrated increased openness and honesty regarding their PSB.

Significant improvements at completion of the program were also found in offence-related attitudes, behaviours and sexual interests such as: justifications for PSB; cognitive distortions; distortions regarding the victim; hyper-masculinity; and empathy for girls and women. Cognitive distortions regarding the victims of their own PSB were not found to significantly improve. Recidivism risk was also found to reduce, with significant reductions found post-treatment in deviant sexual interests, deviant sexual preoccupations and offence-supportive attitudes, and significant improvements in willingness to change.

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[22] http://www.swaay.co.uk/our-services/Therapeutic-Services-Further

[23] It is unclear how many modules there are in total and what other components are included in addition to the four listed here.

These findings suggest the approach may bring about improvements in child and adolescent psychosocial functioning, as well as a reduction in attitudes and beliefs related to recidivism risk. Unhelpful beliefs regarding the targets of PSB were not found to improve. However, due to the small sample size, lack of comparison group, and no longer term follow up, further rigorous testing of this program is needed. In addition, as the Gateway is offered within a comprehensive residential treatment program (SWAAY) it is difficult to determine whether improvements due to the Gateway program alone, or due to other non-offence related therapies offered within SWAAY. Future research comparing SWAAY alone, with SWAAY plus the Gateway will be beneficial.

Interpersonal Skills Program – Limited Evidence

The Interpersonal Skills Program (ISP) is for young people aged 12–17 who have a history of aggressive PSB. This program is offered within a psychiatric residential treatment program, for young people aged 7–17 with a wide range of severe emotional and behavioural problems. The aim of the program is to change deviant sexual interests and improve functional impairments for youth with PSB.

The ISP is delivered to the young person and their family using a multimodal and holistic approach. It is offered to males and females who have significant functional impairment, abuse histories and mental health concerns, and who have been found to engage in aggressive PSB. The targets of the PSB are peers or other children.

The ISP is delivered as twice weekly group therapy sessions, weekly individual therapy and weekly family therapy. These sessions focus on developing social and emotional skills and relapse-prevention skills, based on a CBT treatment model. It also offers sex education and education regarding laws around sexual assault. Family therapy focuses on any systemic issues that may undermine treatment. A six-week parent psycho-education program is also offered to the young person's caregiver. The average length of stay in this program is 30 months; however, it is unclear whether all components of the ISP are engaged in for the entirety of the young person's residential stay. The program is delivered using education videos, role playing, experiential exercises and homework assignments (workbooks and handouts). It is unclear who delivers the program and what training they may have.

The REA identified one study in which the ISP has been evaluated (Jones, Chancey, Lowe, & Risler, 2010). The study employed a pre–post approach design with no comparison group. It was conducted in the USA and involved 58 young people from 9 to 18 years old. Jones et al. (2010), measured functional impairment, deviant sexual interest and appropriate sexual interest to test the effectiveness of the ISP. Functional impairment was found to decrease from intake to the end of admission. Deviant sexual interests were also found to decrease, but only sexually violent interests were found to statistically significantly decrease. Sexually appropriate interests were found to increase statistically significantly by the end of treatment.

These findings suggest this approach may be helpful in improving functional impairment, decreasing sexually deviant interests and increasing sexually appropriate interests in young people. However, the strength of the research at this stage is low. Further research on the ISP with a comparison group, long-term follow up and measurement of rates of PSB is needed.

Approach based on covert sensitisation – Limited Evidence

Covert sensitisation is a technique used to reduce deviant sexual fantasies. It involves interrupting a deviant sexual fantasy with an image or thought that is unpleasant or highly negative.

The REA identified one study of an approach based on covert sensitisation (Aylwin, Reddon, & Burke, 2005). It was offered to males aged 12–18 years who had committed 'very serious and invasive assaults' (Aylwin et al., 2005, p. 233) against a child, or another young person or adult, and were in a residential sex offender program within a psychiatric unit in Alberta Hospital, Canada. In this study, young people were referred to this residential program, and were transferred from custodial institutions, or directly from court. The objective of the study was to report the change in prevalence of deviant sexual fantasies and masturbation rates following covert sensitisation.

The therapy was delivered weekly to participants in a face-to-face, group therapy setting. The average period of time that participants spent in covert sensitisation treatment was 31.5 weeks. The duration of each group therapy session is unclear. This approach is reported to be delivered by 'therapists', but the training and qualifications of those therapists is unclear.

During this approach, young people are instructed in the covert sensitisation technique. This involves the young person incorporating or inserting unpleasant or aversive thoughts (called 'safeguards') into a deviant sexual fantasy as it is occurring. Violent or aggressive safeguards were discouraged. Some examples of safeguards include:

- 'police interrupting the assault
- deviant acts being broadcast over their school's public address system
- the sound of the air-lock doors at the young offender facility
- bugs crawling on their victims or themselves' (Aylwin et al., 2005, p. 232)

Participants were encouraged to record their sexual fantasies (and whether these were interrupted) in a log, and these were reviewed and discussed during group therapy. Further clinical goals of group therapy were to promote honesty, develop insight, identify patterns in sexual fantasies, and give and receive feedback.

Young people participating in this approach were also offered other treatments as a part of their inpatient stay. These included; anger management, communication skills training, cognitive distortion identification, promoting personal responsibility, increasing insight, and improving interpersonal relationships.

The study by Aylwin et al. (2005) used a pre–post design involving 87 young people with no comparison group. Although the age range in this treatment is typically 12–18 years, the age range in this study was 16–21 years.

The study found that the reported frequency of deviant fantasies increased considerably during the first five months of treatment (by 380%), and then began to steadily decline. The rates of normal fantasies followed the opposite pattern, with a decline initially in the early months of treatment, followed by an increase. The proportion of deviant fantasies was also found to decrease relative to all fantasies. The authors noted that deviant fantasies remained predominant and were more often frequently paired with masturbation. However, the ability to disrupt deviant fantasies

was also found to improve, with an increase from 20% to 70% by the later stages of treatment.

These findings suggest that covert sensitisation may lead to a reduction in the rate of deviant sexual fantasies among young people who have engaged in PSB, an increase in the rate of 'normal' fantasies, and an improvement in a young person's ability to interrupt or disrupt deviant fantasies. However, the quality of the evidence is poor as it is based on the findings of a single study that did not use suitable statistical tests. It is also difficult to separate the benefits from the overall benefits of participating in an inpatient sex-offender program. Further research about this technique would benefit from a comparison group and more suitable statistical analysis.

Multiple-Family Group Intervention – Limited Evidence

The Multiple-Family Group Intervention (MFGI) is for adolescents who sexually offend and includes their families. The objective of the approach is to reduce rates of reoffending, reduce maladaptive emotion regulation and to reduce problematic internalising and externalising behaviours. It is delivered to adolescents in juvenile correctional facilities and their families in face-to-face individual and group therapy sessions. Sexual offences may have occurred with younger siblings, family members, or others in the community.

During MFGI, adolescents undergo a threefold process of intervention: (1) learning of basic emotion regulation skills; (2) interactive group therapy; and (3) role-playing and altering past PSB events with the use of learnt skills. Over eight sessions, young people and their families meet with facilitators for an hour and a half, twice a month for a period of four months. The intervention is delivered by masters-level marriage-and-family therapy trainees or therapists.

During their time in the correctional facility, young people also have access to individual therapy and educational groups.

The REA identified one study in which MFGI has been evaluated (Keiley, Zaremba-Morgan, Datubo-Brown, Pyle, & Cox, 2015). This single-group pre–post intervention study conducted in the USA involved 115 adolescent males aged 12 to 19 years (average 15.7 years) and their caregivers. Data were collected at pre- and post-intervention, and one year after the intervention. It was found that difficulties with both internalising and externalising behaviours decreased from pre-test to post-test and remained low at follow up. This change was found to be related to significant decreases in maladaptive emotion regulation. A significant increase in adolescent reports of attachment dependence on others, and decrease in attachment anxiety about abandonment were also found at post-test, and these too were related to the decrease in maladaptive emotion regulation. As a group, there was no change for adolescents' in their closeness to others. Mother and father reports of adolescents' behaviour confirmed these findings. Rates of recidivism following the intervention were also found to be low; 4% for sexual offences and 19% for nonsexual offences.

These findings suggest this approach may be helpful in improving a young male adolescent offenders' ability to regulate his emotions, reduce internalising and externalising behaviour and improve his ability to relate to and depend on his caregivers. It may also be helpful in reducing recidivism. These findings need to be interpreted with caution due to the lack of comparison group. It is also difficult to separate the effects of this approach from other treatments provided as part of

detention. Further research randomly allocating the young person to the MFGI or usual treatment at the correctional facility would be beneficial.

Naltrexone – Limited Evidence

Naltrexone is a long-acting opioid often used to assist people who are withdrawing from other opioids, such as heroin. In the context of this REA, one USA study was identified in which naltrexone was used to decrease sexual arousal in young people aged 13 to 17 years who have been convicted of a sexual offence against a peer or other child and reside in an inpatient sexual offenders program. These young people tended to have comorbid mental illness or to have been the victims of trauma themselves (Ryback, 2004).

Naltrexone was found to have an effective dose range of 100 mg to 200 mg. To find this effective range, young people at first started on 50 mg per day for four days. The dose was then increased every four days until a clinical response occurred. It was delivered by a trained and qualified medical professional.

Ryback (2004) used a single-group, pre–post approach design involving 21 males aged 13 to 17 years. The author notes that young people in this study were taken off naltrexone after two months, as the administration body requested more time for an 'extensive informed consent statement' (Ryback, 2004, p. 983) from parents and guardians. Young people then resumed treatment again after 11–26 days. Data were collected over a period of two years, although it is unclear exactly when data for these results were taken. All participants were taking other forms of psychotropic[24] medication for their co-occurring mental illness.

It was found that no clear benefits of naltrexone were found below 100 mg a day or above 200 mg. Seventy-one percent of patients found clinical benefits of naltrexone use if the dose was between 100 mg and 200 mg. The average frequency of masturbation for these patients reduced from an average of two times per day to two times per week initially, to three times a week for those who successfully continued the drug. Fantasies were found to reduce from a frequency of five times per day to an average of once a day. These behaviours were found to resume when naltrexone was discontinued, but to reduce again on recommencement. No changes in clinical chemistries, liver function or complete blood count were found. The average use was 12.1 months, with a range of 4.5–21 months. Six patients discontinued after three months due to a lack of clinical response.

These findings suggest that naltrexone may be helpful in reducing frequency of masturbation and fantasising in adolescent male sexual offenders. However, the small sample size, lack of statistical testing or control group, and concomitant psychotropic medication use mean these results must be interpreted with significant caution. The issues with informed consent at the beginning of the approach, also lead to concerns in regards to the quality of this evaluations beyond its research design. Furthermore, although blood tests were conducted, no other side effects in regards to the young person's psychosocial function or mood appear to have been

[24] Medication capable of effecting the mind, emotions and behaviours. They may be used to treat mental illness or developmental disabilities such Attention Deficit Hyperactivity Disorder, depression, or psychosis.

measured. Further trials with a control group, no simultaneous pharmacological medication use and more detailed tracking of side effects would strengthen results.

The New Pathways Residential Treatment Services – Limited Evidence

The New Pathways Residential Treatment Services (New Pathways) is for males aged 12–17 years with high or complex needs who have committed a sexual offence. This approach was identified in the consultations as currently available in NSW. According to the consultees, New Pathways is run through a charity called Youth Off the Streets. It is a residential program based in the NSW Southern Highlands.

The overall aim of the approach is to reintegrate the young person in the community by minimizing the risk of reoffending, promoting positive personal and social adjustment, and restoring any relationships damaged by PSB.

New Pathways is delivered in a face-to-face, multimodal format. It provides group and individual therapy, family contact plans and education. It is based on the Good Way model (originally developed in New Zealand), and provides a strengths-based and narrative-therapy approach with a focus on relapse prevention (Ayland & West, 2006). The Good Way Model proposes that everyone has a 'good side' and a 'bad side' which lead to either a 'good way' (positive outcomes) or a 'bad way' (negative outcomes). This approach is tailored to the needs of the individual and delivered for a duration of nine months up to two years. During the approach, young people receive therapeutic and behaviour management treatment, focused on everyday issues as well as PSB. They also receive education. The young person aims to make progress through the seven 'coloured islands' of the Good Way model, representing different stages of progress in treatment. The final stage is an apology, community reintegration and, where appropriate, family reunification. Although family therapy is not provided, the caregivers are involved in treatment planning and contact plans to encourage reunification. Family contact plans are developed with the aim of providing structured supportive environments for family visits

The approach is delivered by a caseworker, program manager and psychologist who are accredited[25] with the NSW Child Sex Offender Counsellors Accreditation Scheme through the Office of the Children's Guardian (Office of the Children's Guardian, 2015). According to the consultees, accreditation does not require the use of a specific therapeutic approach but does require supervision by another accredited private provider.

The REA identified one study in which the New Pathways has been evaluated (Milne et al., 2009). This study used a single-group, pre–post approach design with 12 young males in NSW. The evaluation looked at outcomes for young people recruited to the approach from January 2008 until an unspecified time point in 2009. It is unclear how frequently outcomes were measured. At the time of measurement, six clients had left the service: four due to violent behaviour unable to be managed on site, one due to stalled progress and referral outwards, and one exiting as they had completed involvement as planned. Two of those with violent behaviour left after a

[25] In NSW, private providers who deliver these services require accreditation through the Office of the Children's Guardian.

month and the authors report no progress was made. There is no evidence of the young people who did not complete participation engaging in further sexual offences. The one young person who did complete also did not engage in any further sexual offending.

Of the six clients remaining in the service at measurement, there was no report of any sexual offending during their time at New Pathways. The authors also reported positive change towards reduction of risk factors for sexual reoffending and improved behavioural outcomes. For all young people, improvement in family relationships was found to be variable. In regards to education, four of the young people who exited but had engaged with the service for a period of time were involved with further training or were employed. For those remaining in the service, attendance rates and engagement in learning increased. Improvements in self-care, and health and wellbeing were also found for all young people currently in and exiting the service.

These findings suggest this approach may be helpful in reducing risk factors for recidivism, improving behavioural outcomes, improving engagement in learning and improving health behaviours and self-care. However, these findings need to be interpreted with caution due to the small sample, lack of statistical testing, no comparison group and majority of clients having not completed participation at the time of measurement. Further research with a longer evaluation time frame, comparison group and statistical analysis of quantitative data would strengthen findings.

A 'Self-contained' residential treatment for juvenile sex offenders – Limited Evidence

This 'self-contained' residential treatment is aimed at young people aged 8–18 years who have engaged in aggressive PSB that has resulted in detention. The purpose of the approach was to reduce rates of sexual and non-sexual recidivism.

The treatment is delivered to the young person and their caregiver in group, individual and family therapy formats. Young people in this approach are housed in dedicated units, separated from the general detention population. It is delivered over an average period of between 14–18 months, but this can be variable depending on needs of the young person. Individual and group psychotherapy based on a CBT model is offered to the young person, as well as group psycho-education and family therapy. The number and duration of sessions is unclear. Treatment is individualised; however, there are ten general goals and eight core treatment activities that all young people must complete. They receive CBT treatment with the inclusion of general relapse prevention strategies. The treatment is delivered by senior psychologists, clinical social workers, institutional counsellors and juvenile correctional officers. All clinic staff are licensed or certified sexual offender treatment providers (Commonwealth of Virginia Commission on Youth, undated; Waite et al., 2005).

The REA identified one study in which a 'self-contained' residential treatment for juvenile sex offenders was evaluated (Waite et al., 2005). The treatment group were known as 'self-contained' as they were not housed within the general detention population, rather they were housed in a separate residential unit. They were then compared to young people in general detention. Waite et al. (2005) tested the effectiveness of this treatment in a non-randomised comparison group design involving 256 young males in the USA (n = 144 in treatment group and n = 122 in

comparison group). The comparison group was also offered CBT in individual and group format as part of its treatment.

For young people in this study, the targets of PSB tended to be peers or children, the behaviour was aggressive (the majority of young people were convicted of rape or molestation) and participants had multiple prior offences. A large proportion of the study participants were from a minority ethnic group and approximately 20% had a previous history of being targets of sexual abuse themselves.

The young people in this study were followed for 10 years after their release from detention. It was found that both groups had low recidivism rates for sexual offences with an overall rate of 4.7%, with an at-risk time of over five years. The most likely re-arrest was for a non-sexual offence. When comparing the two groups, the self-contained treatment group had a lower predicted re-arrest rate overall and for all classes of offence, they demonstrated a longer mean time to re-arrest (47.8 months versus 64.01 months). There was also a significant difference in re-arrest rates for all offences favouring the self-contained group, with 47.2% rate of re-offending compared to 70.5%.

These findings suggest that treating young people who have been convicted of a sexual offence in dedicated facilities, rather than with the general detention population, may be helpful for young males in reducing overall recidivism rates. However, both programs appear to be helpful in reducing rates of recidivism for sexual offences. The presence of a large sample size, comparison group and 10-year follow up in this study lends some strength to the conclusions. However, as the young people were not randomly allocated to the different groups, the results should be interpreted with caution.

Thought Change System – Limited Evidence

The Thought Change System (also known as Mode Deactivation Therapy) is for males aged 11–19 years who are in residential treatment for juvenile sexual offenders. The objective of the approach is to reduce psychological distress, reduce recidivism and to reduce sexually deviant beliefs.

Developed by Apsche and colleagues (Apsche, Evile, & Murphy, 2004; Apsche & Ward, 2003), the approach has been designed for young males with a prior history of trauma (including physical, sexual or emotional abuse), disordered personality traits or mental health difficulties, such as posttraumatic stress disorder (PTSD). It is also intended for young people who have previously failed treatment or are thought to be treatment resistant.

The treatment is delivered in three phases of group therapy over a total of 16 weeks duration. The young people also participate in individual and family therapy and also have psychiatric, educational, vocational and recreational therapeutic services provided. Mean length of stay is 18 months and can range from 12 to 23 months. The number and frequency of sessions received during this time are unclear. The approach is delivered by a therapist, although the training and qualification of that therapist is unclear.

During the approach, young people receive a comprehensive assessment and case conceptualisation specific to their PSB. The young person then works through a Thought Change Book during their therapeutic treatment. The content focuses on identifying negative thoughts and cognitive distortions, understanding how these thoughts can influence mood and behaviour and finding alternative ways to respond

(such as imagery, relaxation and balance training). It also works on increasing responsibility, developing victim empathy and psycho-education regarding appropriate sexual behaviour, substance use and the mental health system. It is based on principles of Dialectical Behaviour Therapy, an extension of the CBT model.

The REA identified two studies in which the Thought Change System or Mode Deactivation Therapy has been evaluated in the USA (Apsche et al., 2004; Apsche & Ward, 2003). The first study used a non-randomised comparison group design (Apsche & Ward, 2003). Fourteen young males participated. Testing occurred at 12 months after participation commenced, although young people may have continued to be engaged in this program following this time. The approach was compared to general CBT, although it is unclear how many young people were in each group. At 12 months, it was found that mean scores on externalising behaviour, internalising behaviour, critical pathology and sexual recidivism risk were lower when compared to the general CBT group.

Another study used a single group pre–post test design involving 10 young males (Apsche et al., 2004). Measures were taken at six and 12 months, although some young people may have continued to be engaged in the treatment following this time. These authors found a decrease in the psychological distress and aggressive beliefs of these young people, as well as a reduced sexual offending risk at 12 months. However, not all of these measures changed significantly.

These findings suggest this approach may be helpful in improving psychological function, improving externalising behaviour, reducing sexually deviant beliefs and reducing recidivism risk. However, the study quality was quite low, with a small samples, and the statistical tests used were not ideal. Further rigorous research with a larger sample size and stronger statistical testing would be beneficial.

4.3.2. What is the evidence for approaches responding to problem sexual behaviour in both out-of-home care and general settings?

In addition to the approaches delivered only in OOHC, the REA identified six approaches that have been used in either the OOHC setting or in other environments (refer to Table 5 for a summary). All six approaches have been found to have Limited Evidence and five of the six were for young people aged over 10 years. Consultee remarks are added where appropriate.

4.3.2.1. Approach for children under 10 years of age

The REA identified one approach that was for children aged under 10 years with problem sexual behaviour, as described below.

Approaches based on behaviour therapy – Limited Evidence

This REA identified two studies in which behaviour therapy has been evaluated with young people engaging in PSB (Fyffe, Kahng, Fittro, & Russell, 2004; Patterson & Scott, 2013). In these studies, behaviour therapy was delivered to young people of varying ages and in different settings depending on where the behaviour was frequently occurring, including the home, clinic or in an OOHC setting, with the aim of reducing the incidence of PSB.

Table 5: Approaches within and outside the out-of-home care setting

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Approaches outside and within the out-of-home-care setting						
Approaches for young people aged under 10 years						
Approaches based on behaviour therapy	LE	Two case studies of behaviour therapy for children engaging in PSB, delivered individually in residential treatment for one study, and in the home and school for the other study Family involved: Yes in one study, no in the other Study design: Case studies	USA and New Zealand	Gender: Male and female Age: Range 8–9 years Sample size: 2	May be helpful in reducing PSB for young people and may also be useful for young people with cognitive impairment.	Single participant case study designs, which is the least rigorous study design with no way of knowing if benefits are due to chance or can be generalised to large number of young people
Approaches for young people aged over 10 years						
New Street Adolescent Services	LE	Individual and group-based therapy delivered in clinics to young people aged 10–17 years who have committed sexual offences but have not been prosecuted Family involved: Yes Study design: Non-randomised comparison group	NSW, Australia	Gender: Male and female Age: Range 10–17 years Sample size for study 1: 100 Sample size for study 2: 116	May be helpful in reducing recidivism, reducing PSB and improving safety outcomes for young people. The authors noted recidivism rates were higher for those who withdrew from the approach, and emphasised the importance of engaging young people. Length of follow up was a strength.	Small sample size No randomisation to groups

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Personal/Social Awareness Program	LE	Individual and group-based therapy delivered in various settings to adolescent sexual offenders Family involved: Yes Study design: Single group with pre- and post-approach testing	USA	Gender: Male Age: Not reported Sample size: 122	May be helpful in reducing recidivism rates for young adolescent males for both sexual and non-sexual crimes. For those who withdrew from the approach, recidivism rates tended to be higher. Long-term follow up of 23 years is a strength.	No comparison group Replication needed
SAFE Network Auckland, WellStop in Wellington and STOP in Christchurch	LE	Individual and group clinic-based program for sexual offenders aged 10–18 years Family involved: Yes Study design: Non-randomised comparison group	New Zealand	Gender: Male Age: Mean 14.4 (range 8–18 years) Sample size: 681	May be helpful in reducing rates of reoffending (both sexual and non-sexual) when the young person goes on to complete the approach. Large sample size is a strength. Median follow up of 4.5 years a strength.	No randomisation to groups A drop-out comparison group is not ideal, as these young people may have characteristics that set them apart from the treatment group (e.g. more vulnerabilities, more severe PSB, ethnicity).
SAFE Network Wilderness Therapy	LE	Group-based therapy in camp setting for adolescent sexual offenders Family involved: No Study design: Single group with post-approach testing only	New Zealand	Gender: Male Age: Mean 16 (range 13–18) years Sample size: 7	May be helpful in improving peer relationships, improving self-efficacy and self-esteem, and improving responsibility-taking for offending behaviour in young adolescent males.	Young people engaged in SAFE Network at same time, as such, benefits found may be due to overall approach Interviews only PSB not measured Small sample size No comparison group No follow-up measures taken

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Turn the Page	LE	Individual home- and clinic-based treatment for 12–18 year olds with PSB. Family involved: Yes Study design: Single group with post-approach testing only	UK	Gender: Male Age: Mean 12–18 years Sample size: 13	May assist young males in understanding what unacceptable sexual behaviours are and their triggers for PSB. May also help them develop new strategies to manage these in the short term. A good therapeutic relationship and developing motivation for change were noted as helpful in gaining these outcomes. Authors state that the manual should not be used in isolation and further work with the context of the young person — engaging and supporting the young person's caregiver and other professionals — is needed.	Small sample size No comparison group No follow up measures taken Interviews only

E = Emerging; LE = Limited Evidence; RCT = randomised controlled trial; S = Supported.

*The age of children or young people may be different in description and in study. Sometimes an approach was designed for a particular age group, but the age of study participants did not match the intended age group.

† Limitations to study designs make studies less rigorous and reduce our confidence in their findings. Limitations include:

Interviews only: No statistical testing was completed. As such, findings are less objective and harder to replicate
No comparison group: There is no way to determine if changes are a result of the approach or due to chance or other factors.
No randomisation to groups: There is no way to determine if changes are a result of the approach or due to chance or some factor to do with the participants
No follow-up measures: There is no way of knowing if benefits are maintained long term.
Small sample size: There is no way to know if benefits can be generalised to a large number of young people

While the behaviour therapy was primarily delivered to young people, caregivers and teachers may also have been involved. It was typically delivered individually and face to face and, although there was no set duration or number of sessions, it was usually short term (weeks to months). Session duration ranged from 20 minutes to one hour. Sessions were delivered by a therapist. The qualifications and training of therapists is unclear.

During participation in the approach, young people received a thorough assessment, functional analysis of the PSB (observation to determine the function or purpose of the behaviour), followed by the development of a behaviour modification plan. This plan was then carried out in an individual therapy session by the therapist, or where the young person typically carried out this behaviour (e.g. at home or at school) by a caregiver or teacher. Behaviour modification plans typically included positive reinforcement for alternative behaviour and negative reinforcement for PSB. Education about appropriate behaviour may also have been included for the caregiver or young person.

The study by Patterson and Scott (2013) was conducted in New Zealand and involved an eight-year-old girl with inappropriate masturbation. These authors found a complete cessation of inappropriate masturbation after eight weeks of behaviour therapy and implementation of a behaviour management plan by the caregiver and teachers of the young girl. The main focus was implementing the plan in the natural environment. The behaviour remained ceased at a six-week post-treatment follow up.

Fyffe et al. (2004) utilised behaviour therapy in a USA study with a nine-year-old boy with a traumatic brain injury and seizure disorder. This was implemented over a period of 40 sessions of 20 minutes duration, in a clinic associated with the residential treatment centre of the young person. They found a 94% reduction in PSB of this young boy and an increase in appropriately communicating for attention.

These findings suggest that behaviour therapy can be helpful in reducing PSB for young people and may also be useful for young people with cognitive impairment. However, the quality of this research is quite low. Further research utilising a pre–post comparison group design, ideally with randomisation and with multiple participants would increase the strength of these findings.

4.3.2.2. Approaches for young people over 10 years of age

New Street Adolescent Services – Limited Evidence

The network of New Street Adolescent Services is for young people aged 10–17 years referred to a clinic-based program in NSW, Australia, after having committed a sexual offence. At the time of writing, New Street services were provided across four sites, three of which were rural and one of which was based in Sydney, NSW. The aim of these services is to improve outcomes and create a safe environment for the young person, and reduce recidivism. Consultees discussed these services at length and additional information can be found in the section on practice standards.

New Street Adolescent Services are delivered to young people who have committed but not been criminally prosecuted of a sexual offence. In this population, the targets of the PSB tend to be peers, children, siblings or other young family members. There can be a mixture of young people living at home or in OOHC. A proportion of the population also tend to be from Aboriginal and Torres Strait Islander, or culturally and linguistically diverse (CALD), backgrounds.

New Street services utilise an identified evidence-based model with clinical support from a Clinical Advisor. This model is based on multi-systemic and invitational approaches, involving strong collaboration with appropriate stakeholders, particularly the young person's family. Mr Tolliday reports the approach is trauma-informed, includes culturally competent principles, restorative justice principles and also a focus on safety planning and responding to family violence. It is delivered in individual group and family therapy format over a period of approximately two years. A thorough assessment taking from six to twelve weeks occurs initially and treatment is then tailored to the needs of the young person. Treatment is intensive for the first 12 months (occurring weekly or fortnightly) and becomes less intensive over time. Group therapy involves the young person with their family. There is also significant work with the family, school and in other relevant contexts, with the aim of creating a safe and secure environment. During the participation in these services, young people receive content which focuses on building personal responsibility for their actions in harming others at a developmentally appropriate level.

Those providing the program are qualified psychologists or social workers and need to be accredited to provide services to young people who engage in PSB[26]. Internal training is also provided. New Street involves a particular focus on engaging Aboriginal and Torres Strait Islander young people and their families and Aboriginal and Torres Strait Islander workers are involved in service delivery. Internal training on being culturally competent in managing diversity and also policies regarding cultural competency are provided. A senior clinical advisor is also present to provide clinical supervision and consultation to service coordinators. An Aboriginal Community Matters Advisory Group is also involved in the governance of New Street services (NSW Kids and Families, 2014).

This REA identified two studies in which New Street Adolescent Services had been evaluated (Laing, Tolliday, Kelk, & Law, 2014; NSW Kids and Families, 2014). Laing et al. (2014) tested the effectiveness of the New Stress Adolescent Services in a non-randomised comparison group study in NSW. Fifty young people who were involved in the services over a five-year recruitment period were compared and matched to 50 young people who were unable to be offered the program due to lack of places. Recidivism data was tracked over a period of seven years. Significantly fewer criminal charges and personal violence charges were found to occur for the completers, when compared to the no-treatment group and those who had withdrawn from the study. No significant differences were found in sexual reoffending (although rates were low overall at 7%).

Another study (NSW Kids and Families, 2014) followed all young people referred from January 2009 to June 2013 to the network New Street Services across NSW (N = 116). Outcomes were measured at six months, at case closure and three months after case closure. It was found that 78% of completers had taken responsibility for their behaviour, 89% had ceased their PSB, with a 3% rate of recurrence at three-month follow up (a similar rate was found for Aboriginal clients), 43% of clients with safety issues at assessment had improvements in their overall safety during the program, and only 2.4% of clients were charged with an offence during their involvement with New Street Services.

[26] Under the NSW Child Sex Offender Counsellor Accreditation Scheme (NSW Kids and Families, 2014).

These findings suggest New Street Services may be helpful in reducing recidivism, reducing PSB and improving safety outcomes for young people with PSB. The authors noted recidivism rates were high for those who withdrew from the program, and thus emphasised the importance of engaging young people. They also noted an increase in the use of the service by Aboriginal and Torres Strait Islander young people, following their focus on engaging this population. It is encouraging to note their outcomes were comparable to non-Aboriginal and Torres Strait Islander young people. The length of follow up in these studies was a strength. However, these findings need to be interpreted with caution due to the small sample sizes and lack of randomisation. Further research replicating these results with a larger sample size and random allocation to group would be helpful in strengthening conclusions.

Personal/Social Awareness Program (P/SA) – Limited Evidence

Personal/Social Awareness Program (P/SA) is for adolescent males who live in the family home, in group homes, in OOHC, or another type of living situation, and have engaged in a range of PSB type. The purpose of the program is to prevent subsequent criminal sexual behaviours as measured by criminal recidivism (arrest rates, charges, convictions).

P/SA is delivered to the adolescents and their families in face-to-face group and individual therapy. A wide range of PSB types can be targeted in this program, including sexually aggressive PSB. Family therapy is based on a family systems model. Individual therapy is based on principles of child sexual health, systems theory, social group work theory and interpretive approaches, with a focus on inclusiveness, non-discrimination and a non-judgemental stance.

It is delivered in weekly three-hour psychotherapy groups, one-hour individual psychotherapy sessions twice-a-week, two-hour conjoint family therapy session twice-a-week, 27-hour 'marathons' twice-a-month, and two-day family educational/sexual awareness seminars held twice-a-year called the 'Family Journey' (Seabloom, 1983). Successful completion of the program occurred when the adolescent and family met agreed-on criteria for growth and change. Treatment was delivered by trained staff who were masters-level social workers and psychologists.

Individual therapy focused on sensitive issues. These were then discussed in family and group therapy sessions when appropriate. The 27-hour 'marathon' took place in a retreat setting. The Family Journey used both large and small group sessions, with extensive use of media to address various topics of human sexuality. The mean length of treatment for those who completed was 1.26 years. Some young people remained in the program for two years.

The REA identified one study in which P/SA has been evaluated (Seabloom, Seabloom, Seabloom, Barron, & Hendrickson, 2003). This USA study used a single-group longitudinal design involving 122 male adolescents and their parents. It was found that at 14 to 23 years post-program, there were no arrests or convictions for sex-related offences in the population of participants who successfully completed the program. These young people were also less likely to be arrested or convicted across all crime categories. A conviction rate of 8% for sex-related crimes was found in the group of participants that withdrew from treatment. The authors also found that those living with their parents were more likely to complete the program.

These findings suggest that P/SA may be helpful in reducing recidivism rates for young adolescent males for both sexual and non-sexual crimes. For those who withdrew from the program, recidivism rates tended to be higher. The long-term follow up of up to 23 years is a strength of this study. However, due to the lack of comparison group, these findings should be interpreted with caution.

SAFE Network Auckland, WellStop in Wellington and STOP in Christchurch – Limited Evidence

SAFE Network Auckland, WellStop Wellington and STOP Christchurch are three New Zealand based programs offered to young people aged 10–18 years who have been found to sexually offend. The objective of the approach is to reduce reoffending, both sexual and non-sexual. It is offered in a specialised community treatment setting.

The participants include a mix of young people from Maori or part-Maori backgrounds, Pacific backgrounds and other CALD groups. A history of childhood sexual and physical abuse, and behavioural and mental health problems is often present in the young people referred to these programs. The targets of these young people tend to be primarily children who are family members or peers, but some young people may also infrequently target adults.

All programs include face-to-face individual, family and group work components and also system reviews for a period of up to two years, depending on the needs of the young person. In addition, the SAFE Network provides Wilderness Therapy and education. The WellStop program provides case conferences and sessions with a significant other. STOP also provides consultations, case reviews, telephone sessions and case conferences.

At times, therapies are delivered as experiential or expressive therapies, such as games and play; music; active pursuits; sports; and camps. The programs can also be tailored for different abilities, such as intellectual disability or developmental delay. The content of the program is delivered in a holistic framework, which aims to focus on client strengths, the development of prosocial skills and positive life goals. Maori health models are also incorporated into the program for Maori clients.

Individual session duration is approximately one hour, and group sessions are approximately two hours. The exact number and frequency of sessions is unclear. The training and qualifications of staff are also unclear.

The REA identified one study in which the New Zealand programs were evaluated (Lambie, 2007). It also identified one study in which Wilderness Therapy was evaluated separately (details on this can be found below). The study by Lambie used a non-randomised comparison group design and involved 681 young people to test the effectiveness of SAFE Network, WellStop and STOP. Young people recruited to the programs were followed up over 10 years (median 4.5 years) and compared with those who dropped out of the program and those who did not receive treatment. It was found that those who completed the program had significantly lower sexual reoffending rates (2%) than the drop-out (10%) or no-treatment group (6%). There was no significant difference in non-sexual reoffending between the treatment (38%) and no-treatment group (44%), however, both had significantly lower reoffending rates compared with the treatment drop-out group (61%).

These findings suggest this group of New Zealand approaches may be helpful in reducing rates of reoffending (both sexual and non-sexual) when the young person goes on to complete the program. However, in consultations, Mr Tolliday noted that

this program had a high drop-out rate. While the large sample size and comparison groups add some strength to these findings, the use of a drop-out comparison group is not ideal. There may be some characteristics that particularly sets that group apart from the treatment group and thereby skews results. In future research, young people randomised to different kinds of treatment would strengthen findings.

SAFE Network Auckland's Wilderness Therapy – Limited Evidence

Wilderness Therapy, referred to above, is an approach run by SAFE Network Inc. It is for adolescents who have committed sexual offences, and are living at home with family, in foster care, or in residential care. The aim of the approach is to improve self-esteem and self-efficacy, develop an internal locus of control, improve behaviour and reduce recidivism.

Wilderness Therapy is delivered on a group basis in face-to-face activities. Sexual offences involved contact with another person, ranging from rape to indecent assault. Targets of PSB are both extra-familial (e.g. female adults not known to the offender, female children known to the offender) and intra-familial (e.g. siblings and other younger relations).

Wilderness Therapy is a form of experiential group therapy whereby adolescents attend camps as part of the SAFE Network Inc. program. Wilderness Therapy camps are usually four to six days long and involve activities such as tramping (hiking), rafting and mountain biking. They also include group therapy with a focus on themes of disclosure or victim empathy. Adolescents typically attend two to three camps during the average 12–24 months in the SAFE program. The approach is delivered by therapists with background training including psychotherapy, counselling and psychodrama.

The REA identified one study in which Wilderness Therapy was evaluated (Somervell & Lambie, 2009). This New Zealand study used a qualitative single-group design with seven males aged 13–18 (average 16 years). Outcomes were measured only after attendance at the camp. At the time of measurement, young people in the study had been involved in the SAFE program for anywhere from two to 14 months. A model was built through thematic analysis based on data collected in adolescent interviews. The benefits of Wilderness Therapy were analysed thematically. It was found that participants reported that enhanced relationships, particularly with peers, were a key outcome of the camp. They also reported that successfully meeting challenges during Wilderness Therapy assisted in developing self-efficacy. The opportunity to rely on others, and also to be relied upon, assisted in strengthening a sense of self. In addition, improved relationships with peers led to an increase in positive regard. Young people and therapists reported a belief that the intense nature of the camping experience assisted in outcomes that could not be achieved in weekly group therapy. The intense nature of activities also assisted with developing motivation and engagement in the process. Further to this, young people identified that the previous three themes assisted in aiding disclosure and taking responsibility for their offending behaviour.

These findings suggest this approach may be helpful in improving peer relationships, improving self-efficacy and self-esteem, and improving responsibility-taking for offending behaviour in young adolescent males. Recidivism as an outcome was not measured and so it is unclear how this approach may affect future offending behaviour. Given the small sample size, lack of comparison group and lack of

quantitative measures, these findings need to be interpreted with caution. In addition, as young people were also concurrently engaged in the SAFE Network approach described above, it is unclear which effects are specific to Wilderness Therapy and which to SAFE Network. Future research where participants are randomly allocated to Wilderness Therapy or no Wilderness Therapy would help to strengthen conclusions.

Turn The Page – Limited Evidence

Turn the Page is a service for males aged 12–18 with PSB, offering a manualised treatment known as Change For Good. It is offered to young people across both home and OOHC settings by the National Society for the Prevention of Cruelty To Children (NSPCC), a UK charity focussed on child protection. The aim of the approach is to reduce PSB while increasing socially acceptable behaviours, enhance psychosocial functioning, increase optimism and improve wellbeing.

Turn The Page is offered in individual therapy sessions and is aimed at young males who have engaged in a wide range of PSB, including behaviours directed towards peers or young children. It is delivered over 30 sessions. Twenty-six of these are structured one-to-one sessions. The four remaining sessions are kept flexible to address the young person's individual needs. The approach is delivered by Children's Services Practitioners who are trained in the manual's use. Parents and carers can choose to attend the individual sessions and are encouraged to support home tasks. The approach adopts a cognitive behavioral approach, and at times also draws on attachment, mentalisation, psychodynamic and systems theories. The is grouped into four modules: (1) Engagement and Motivation; (2) Relationships and Perspective Taking; (3) Self-regulation of Emotions; and (4) Relapse Prevention. Sessions are an hour in length, have a consistent format for structuring the session, and a number of exercises or tasks to complete, including between session 'home tasks'

The REA identified one study in which Turn The Page has been evaluated (Belton, Barnard, & Cotmore, 2014). Belton et al. (2014) utilised a qualitative case study approach conducted in the UK, with 13 young males in total. They tested the effectiveness of Change for Good at two months post-program completion. It was found that some young people had developed a greater understanding of the types of sexual behaviour that are acceptable and unacceptable. The young people became more aware of the triggers of harmful sexual behaviour and had learnt strategies to manage these. Young people also felt more confident and less withdrawn.

Approach length influenced motivation, as did external pressure to attend from parents, carers, and referrers, but not consistently. The relationship with the practitioner was also important for the young person to remain engaged in the approach. Caregiver involvement in the approach appeared important in encouraging good outcomes. However, therapists at times did not have the capacity to encourage this. The authors also found that the young person often found it difficult to remain engaged in strategies following the approach without the support of the therapists. The authors acknowledged that the manual cannot be used in isolation from the context the young person is in and that work with the caregivers and other professionals is vital. The young people in the study were often found to have past experiences of abuse, neglect or changes in OOHC placements.

These findings suggest this approach may assist young males in understanding what unacceptable sexual behaviours are and their triggers for PSB. It may also help them develop new strategies to manage these in the short term. A good therapeutic relationship and developing motivation for change were noted as helpful in gaining these outcomes. However, the authors state that the manual should not be used in isolation and further work with the context of the young person — engaging and supporting the young person's caregiver and other professionals — is needed. Due to the small sample size, and lack of comparison group and statistical testing, the findings need to be interpreted with caution. Further research with a larger sample size, quantitative measures and a comparison group would add strength to findings.

4.3.3. What is the evidence for approaches responding to problem sexual behaviour in general settings?

Following on from a discussion of approaches delivered in OOHC and a mixture of OOHC and other settings, we now describe nine approaches delivered in non-OOHC settings that were identified in the REA. One approach was rated Supported (MST-PSB) and one was rated Emerging (Group CBT). The remaining eight approaches were rated Limited Evidence. Three approaches were found to be evaluated with children aged under 10 years, and six were for older children (refer to Table 6 for further detail). We have noted consultee comments related to these approaches where relevant. Approaches are organised by age and then alphabetically.

4.3.3.1. Approaches for children under 10 years of age

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: Preschool Program – Limited Evidence

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: Preschool Program (referred to here as CBT for preschool-aged children) is for children aged three to seven years who have engaged in PSB towards another child. It is conducted in the clinic of a mental health service for children. The objective of the program is to eliminate PSB and to increase prosocial behaviour and coping skills.

CBT for preschool-aged children is delivered to children and their caregivers as a face-to-face therapeutic program. Group components for both children and their caregivers are conducted separately, with 20–30 minutes at the end of each session to bring the families together. It is delivered in 12 weekly 90-minute sessions by masters- or doctorate-level qualified psychologists, with training and experience in CBT for children. It can also be delivered by other licensed mental health practitioners[27]. Group sizes are kept to between three and seven members. One to three additional co-therapists can be used to assist in running the group, depending on group size. Co-therapists can be graduate-level psychology students completing placements.

During the program, children receive education and training in: '(a) body awareness and “safe” and “unsafe” touching; (b) maintaining physical boundaries; (c) relaxation; (d) impulse control skills; (e) abuse prevention skills; and (f) feeling identification and

[27] http://www.cebc4cw.org/program/children-with-sexual-behavior-problems-cognitive-behavioral-treatment-program-preschool-program/

expression skills' (Silovsky, Niec, Bard, & Hecht, 2007). This is delivered using developmentally appropriate group activities such as singing, colouring, puppet play and other games. Caregivers receive psycho-education regarding sexual development and PSB, methods of responding to and preventing PSB, strategies to enhance parent–child interactions and also behaviour management techniques[28]. These are delivered through methods of active learning and group support. The child and caregiver group components are then followed by 20–30 minutes for group family work. This gives the opportunity for both children and their caregivers to practice their skills, to receive feedback on their use and for the therapists to model behavioural management strategies.

The REA identified one study in which CBT for preschool-aged children has been evaluated (Silovsky et al., 2007). In a single-group pre–post intervention study design conducted in the USA, 85 children were recruited to the program. Contrary to most research in the area, 58% of the children in sample were female. However, due to rates of drop out and non-completion of measures, only 31 children were included in the analysis of data. It is also worth noting that 13% of children in the sample were found to meet criteria for PTSD and 20% to meet criteria for major depressive disorder.

Silovsky et al. (2007) measured PSB, childhood behaviour problems, symptoms of PTSD and of major depressive disorder. These were measured at intake, pre-treatment and immediately post-treatment. The period from intake to pre-treatment varied from 0 to 16 weeks, depending on the time between recruitment and the beginning of the next group program.

It was found that from intake to the end of treatment, PSB significantly decreased. Thirty-six percent of the children scored below the clinical range in a measure of PSB at post-treatment (at intake, all children scored in the 99th percentile on this measure). It was also found that the longer the child and their caregiver spent in the group treatment program, the greater the improvements in PSB. The authors also found a significantly greater impact for female children and older children in this program. However, no significant differences were found in childhood behaviour problems, or depression symptoms. A significant reduction was found in trauma symptoms from intake to post-treatment.

These findings suggest that CBT for preschool-aged children may be helpful in reducing PSB and symptoms of PTSD, particularly for older children and female children. It was not found to be helpful in reducing other childhood behaviour problems or symptoms of depression. However, due to the small sample, lack of comparison group and concurrent treatment, these results need to be considered with caution. Further rigorous research including a comparison group, uniform measurement of outcomes and a larger sample size is needed to confirm these findings.

[28] Silovksy et al. (2007) delivered Parent Child Interaction Therapy to caregivers as a behavioural management technique. However, they stated any evidence-based behavioural management strategy can be utilised here.

Table 6: Approaches outside the out-of-home care setting

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Approaches for young people aged under 10 years						
Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: Preschool Program	LE	Clinic-based group program for children aged 3–7 years who have engaged in PSB toward another child Family involved: Yes Study design: Single group with pre- and post-approach testing	USA	Gender: Male and female Age: Mean 4.9 (range 3–7) years Sample size: 85	May be helpful in reducing PSB and symptoms of PTSD, particularly for older children and female children. Was not found to be helpful in reducing other childhood behaviour problems or symptoms of depression.	Small sample size No comparison group Young people were also offered other treatments during approach, so hard to know which approach led to benefits.
Group Cognitive Behavior Therapy	E	Clinic-based group program for children aged 5–12 years with PSB Family involved: Yes Study design: Randomised controlled trial with long-term follow up	USA	Gender: Male and female Age: Mean 8 (range 5–12) years Sample size: 291	May be effective in reducing PSB, when compared to a comparison group (Psychodynamic Play Therapy). Is a strong RCT research design with long-term follow up and randomisation to groups.	Replication needed, particularly in Australian context
The Transformers Program	LE	Clinic-based individual therapy for children under the age of 12 who engage in PSB Family involved: Yes Study design: Non-randomised comparison group	Victoria, Australia	Gender: Male and Female Age: Mean 9.27 years Sample size: 16	May be helpful in reducing PSB and anger, improving empathy and improving knowledge and understanding in young people with PSB. Comparison group and long-term follow up a strength.	Small sample size No randomisation to groups Finding for both groups were not compared statistically. As such, findings are less objective and harder to replicate.
Approaches for young people aged over 10 years						

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Fight with Insight	LE	Clinic-based group therapy and group boxing program for sexual offenders aged 12–18 years who demonstrate PSB following their own abuse Family involved: Yes Study design: Non-randomised comparison group	South Africa	Gender: Male and female Age: Range 12–19 years Sample size: 27	When compared to CBT, Fight With Insight may be helpful in improving insight and social functioning and reducing recidivism among young people who engage in PSB. CBT alone may be more helpful in improving empathy.	Small sample size No randomisation to groups No follow-up measures taken Interviews only
Griffith Youth Forensic Service	LE	Home-based individual treatment for sexual offenders aged 10–16 years Family involved: Yes Study design: Single group with pre- and post-approach testing	QLD, Australia	Gender: Male Age: Mean 16.1 years Sample size: 104	May reduce recidivism and be equally beneficial to Indigenous and non-Indigenous youth, and appropriate to run within remote Queensland communities. Length of follow up measures is a strength.	Small sample size No comparison group
Mirtazapine	LE	Pharmacological treatment, in this case for young people aged 5–12 years engaging in PSB who are not responding to or suitable for education programs. Family involved: No Study design: Single group with pre- and post-approach testing	Turkey	Gender: Male and female Age: Mean 12.4 (range 5.2–16.4) years Sample size: 10	May be helpful in reducing excessive masturbation in young people with Autism Spectrum Disorder.	Side effects (e.g. weight gain) experienced by all participants need to be weighed against benefits. All participants taking concurrent medications: unknown if Mirtazapine or other medications led to outcomes. Small sample size No comparison group

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Multisystemic Therapy for Youth with Problem Sexual Behaviors	S	Therapy for sexual offenders aged 10–17 years, delivered on an individual basis in settings convenient to participants, such as home, school and the community Family involved: Yes Study design: Two RCTs with long-term follow up	USA, Canada	Gender: Male and female Age: Mean 14 years Multiple studies with various sample sizes	Appears to be effective for improving outcomes in young people with PSB, by reducing PSB and recidivism. May also be helpful for improving other mental health and behaviour outcomes, such as delinquency, school grades, externalising behaviour and substance use.	Findings have not yet been replicated in Australian context, with children in out-of-home-care or with different abilities. A stronger comparison group of a well-evaluated approach (e.g., CBT) would be ideal
SafeCare Young People's Program	LE	Individual and group-based program for young people aged 12–17 years who have engaged in PSB, particularly intrafamilial PSB Family involved: Yes Study design: Single group with pre- and post-approach testing	WA, Australia	Gender: Male Age: Mean 13.8 (range 11–15) years Sample size: 12	May be helpful in improving family communication, reducing impulsivity, increasing emotional control and self-esteem and improving personal responsibility taking. May not be as helpful in improving victim empathy and in producing relapse prevention plans. Long-term follow up is a strength.	Small sample size No comparison group Interviews only
Youth with Sexual Behavior Problems	LE	Individual and group-based clinic treatment for sexual offenders aged 10–18 years Family involved: Yes Study design: Single group with pre- and post-approach testing	USA	Gender: Male Age: Mean 14.31 (range 11–17) years Sample size: 26	May be helpful in improving parent–child relationships and psychosocial functioning for young people with aggressive PSB. PSB did decrease, but the change was not statistically significant.	Small sample size No comparison group No longer term follow up of measures

E = Emerging; LE = Limited Evidence; RCT = randomised controlled trial; S = Supported.

*The age of children or young people may be different in description and in study. Sometimes an approach was designed for a particular age group, but the age of study participants did not match the intended age group.

† Limitations to study designs make studies less rigorous and reduce our confidence in their findings. Limitations include:

Interviews only: No statistical testing was completed. As such, findings are less objective and harder to replicate

No comparison group: There is no way to determine if changes are a result of the approach or due to chance or other factors.

No randomisation to groups: There is no way to determine if changes are a result of the approach or due to chance or some factor to do with the participants

No follow-up measures: There is no way of knowing if benefits are maintained long term.

Small sample size: There is no way to know if benefits can be generalised to a large number of young people

Group Cognitive Behavioral Therapy – Emerging

Group Cognitive Behavioral Therapy (CBT) is for young children between 5 and 12 years with PSB. Therapy is delivered in a clinic-based setting and it aims to reduce PSB, improve psychosocial functioning and improve attitudes towards sex and sexuality. Group CBT has been rated Emerging in this REA as it has demonstrated effectiveness in one RCT and this effect has been maintained for at least six months after the approach completion.

Group CBT is delivered to young people and their caregivers as a manualised 12-session group therapy program. Parents and their children attend groups separately. The recipients of the approach can exhibit a wide range of PSB. They may have mental health concerns or trauma histories. In this approach, children with intellectual disabilities or with severe PSB unable to be managed in an outpatient setting are excluded. Sessions are generally delivered weekly and are one hour in length. Therapists delivering the approach are qualified psychologists. They also receive training in delivering the manualised Group CBT and are provided with weekly supervision and training.

During Group CBT, young people receive behaviour modification and psycho-education regarding appropriate sexual behaviour, self-regulation strategies, concrete sexual behaviour rules and sex education. The young people learn about the influence of negative or unhelpful thoughts and beliefs on their emotions and behaviour, and learn alternative ways to respond to those. Caregiver groups include education regarding developmentally normal and atypical sexual behaviour, and specific child management skills for addressing PSB, using behavioural therapy approaches.

The REA identified one study in which Group CBT was evaluated (Carpentier, Silovsky, & Chaffin, 2006). Group CBT was evaluated using an RCT of a 12-week group CBT program offered to children with clinically significant PSB, in the USA. The authors compared Group CBT to Psychodynamic Play Therapy, and also compared outcomes with the general clinic population of young people with mental health difficulties. A total of 291 young people aged 5–12 years participated in the study and the therapy was delivered in an outpatient mental health setting. Sixty-four young people were in the CBT group, 71 in the play therapy control and 156 in the general clinic population control. They were tested at pre-intervention and post-intervention, and also had a one-year, two-year and ten-year follow up after pre-testing.

The REA identified the study with the ten-year follow-up data. Carpentier et al. (2006) found that at the ten-year follow up the CBT group had significantly fewer sexual offences than the play therapy group, and their rates of sexual offending were similar to those of the general clinic group (2% and 3% respectively). No significant group differences were found in non-sexual offences. Although general psychosocial functioning was also measured, this was not reported on in the ten-year data.

These findings suggest this approach may be effective in reducing PSB, when compared with Psychodynamic Play Therapy. Because they are from an RCT with long-term follow up and randomisation, these findings are particularly strong. They would benefit from replication in a country other than the USA.

The Transformers Program – Limited Evidence

The Transformers Program (TP) is for young people aged 0–12 years who engage in PSB. The objective of this program is to provide assessment, treatment and management for these children, and their families. The consultees indicated that this program is available in NSW, and was previously known as Dimensions Training.

The TP is delivered to young people under 12 and their caregivers, in a clinic-based group or individual therapy format. It is based on CBT principles and systems theory. Young people are excluded if they do not have a stable living environment, if the caregivers are unable or unwilling to be involved, or if the child has a major developmental delay or intellectual disability. Before the program, a thorough assessment of the child and family is conducted (4–6 sessions). They are then offered group therapy or individual therapy if group work is not indicated for the child. The number of sessions provided and duration of the program as a whole is unclear. It is also unclear what precludes a child from group therapy.

Children receive activities that incorporate: developing personal responsibility for behaviour; identifying triggers to sexual behaviour; responding differently with difficult feelings; developing insight and empathy; enhancing self-intervention skills; developing social skills; and improving self-esteem and self-confidence. The parents are offered a parallel group program that offers: understanding and responding to needs of the child; appropriately responding to protection needs; providing appropriate discipline; education regarding PSB; responding appropriately to PSB; coping with their own emotions and supporting their child to cope with theirs; identifying and changing familial factors contributing to the child's PSB; and utilising professional support networks. The professionals involved in the program also consulted with and liaised with other health professionals involved in the child's care. The training and qualifications of those providing the treatment are unclear.

The REA identified one study in which the TP was evaluated (Staiger et al., 2005). Staiger et al. (2005) tested the effectiveness of the TP in an Australian (Victoria) non-randomised comparison group design with pre–post testing and a two-year follow up involving 16 children. The comparison group was a group of children who had received the four to six sessions of assessment, but not the treatment. The targets of the PSB tended to be peers, children or young family members. The majority of the children referred to the program tended to have prior history of emotional, physical or sexual abuse. About half had a mental illness or learning difficulty.

A pre-to-post improvement in PSB and anger was found for both the program and comparison groups. However, only the treatment group had improved empathy, sexual knowledge, awareness of personal risk and self-intervention abilities (referred to as 'program learning'). There were no significant changes in depression or responsibility taking for either group. The treatment group was followed up after two years, at which point PSB continued to decrease, depression decreased, levels of anger, responsibility taking and program learning were maintained and an increase in empathy was found. However, these were not tested statistically.

These findings suggest this program may be helpful in reducing PSB and anger, improving empathy and improving knowledge and understanding in young people with PSB. However, these findings should be interpreted with caution due to the small sample size and lack of statistical comparison with a control group. Further

research with a larger sample size, randomisation to different groups and statistical comparison to a control group would help to strengthen findings.

4.3.3.2. Approaches for young people over 10 years of age

The REA identified five approaches for responding to PSB in non-OOHC settings with young people aged over 10 years. Descriptions of these follow.

Fight with Insight (FWI) CBT plus boxing intervention – Limited Evidence

Fight with Insight (FWI) is for young people aged 12–18 years who have demonstrated PSB following experiences of their own abuse. The aim of the approach is to reduce recidivism, increase insight into PSB and improve social functioning.

FWI is delivered to the young people in a clinic-based setting in the form of CBT group therapy with the addition of boxing. FWI is delivered weekly over 12 weeks by trained facilitators and boxing coaches. However, the type of training and qualifications of facilitators is unclear. During the approach, young people receive a weekly boxing session followed by a CBT group therapy session. Parents of the children are also offered a support group. The content of the approach involved conflict resolution, problem solving, anger management, impulse control, taking responsibility, victim empathy and education regarding sex and sexuality.

The REA identified one South African study in which FWI was evaluated (Draper, Errington, Omar, & Makhita, 2013). Draper et al. (2013) used a non-randomised comparison group design involving 27 young people to test the effectiveness of FWI, when compared with young people only receiving group CBT. Although FWI is open to both males and females, there was only one female participant in the CBT-only group in this study. Focus group discussions and interviews with approach staff following the approach revealed that both groups reported improved recidivism rates, improved insight and improved social functioning. During the focus groups, it was noted that those in the FWI group were more specific about the changes and learning they received during the 12-week program. However, it was also found that young people in the CBT-only group discussed principles of empathy more frequently than those in the FWI group.

These findings suggest that FWI may be helpful in improving insight and social functioning and reducing recidivism among young people who engage in PSB. CBT alone may be more helpful in improving empathy. A strength of this study was the use of a comparison group; however, as this study was qualitative in nature and only measured outcomes at one time point, our confidence in these conclusions is limited. Further research on this approach using quantitative measures and multiple measurements would increase the reliability of the results.

Griffith Youth Forensic Service (GYFS) – Limited Evidence

The Griffith Youth Forensic Service (GYFS) is for young people aged between 10 and 16 years guilty of sexual or sexually motivated offences in Queensland. The purpose of the service is to provide treatment services to convicted young people;

and to undertake specialist forensic psychological assessment for the Queensland Department of Justice and Attorney General[29].

GYFS is facilitated by psychologists who are trained to undertake clinical assessment and provide treatment services. These clinicians provide home-based face-to-face, individual treatment to young people who have been referred to GYFS by the court. Clinicians provide individualised treatment, using approaches that were reported to be evidence based (Allard, Rayment-McHugh, Adams, Smallbone, & McKillop, 2016).

The delivery method of the service varies depending on whether the young person lives in a metropolitan, regional, rural or remote location. Treatment is over multiple non-consecutive days across several weeks or in week-long blocks. During the treatment, the young person, their family, peers, school and community, as well the sexual offence/s itself, are assessed. A risk assessment for the young person is also conducted, and an individualised treatment and risk management plan are developed and monitored. Therapy is provided in individual, rather than group, formats (Allard et al., 2016).

The REA identified one study in which GYFS had been evaluated (Allard et al., 2016). Allard et al. (2016) used a single-group, pre–post intervention design to test the effectiveness of the treatment in terms of the prevention of recidivism of sexual and other offences. Treatment length varied from 77 to 1001 days (mean = 435.8 days). The study used subgroup analyses to compare males aged 10–16 years from Indigenous and non-Indigenous cultural backgrounds, and residing in remote and non-remote communities. Offending histories from the Queensland Police Service were used to compare offences before and after treatment.

Participants were followed up 2.5 years after treatment was completed. Results showed that only six of the initial 104 study participants reoffended after completing treatment. No reoffending rate differences were found between Indigenous and non-Indigenous young people, or between young people living in remote communities and those not living in remote communities.

These findings suggest that GYFS may be equally beneficial to Indigenous and non-Indigenous youth, and appropriate within remote Queensland communities. However, the absence of a comparison group, the use of retrospective data, and some incompleteness and inconsistencies in data collection present limitations. Future research with an alternative research design would strengthen findings.

Therapeutic engagement has also been investigated in the context of GYFS (Smallbone, Crissman, & Rayment-McHugh, 2009). In a sample of 105 Australian court-referred adolescent male sexual offenders participating in GYFS, Smallbone et al. (2009) analysed predictors of engagement in therapy. Results suggest that Indigenous race, negative peer relationships, and impulsivity/antisociality were associated with poorer therapeutic engagement. In response to these findings, attempts were made to improve engagement by increasing the capacity of treatment partners to work with the high-risk groups, shifting responsibility for engagement

[29] The Griffith University website provides useful information about the Griffith Youth Forensic Service (https://www.griffith.edu.au/criminology-law/griffith-youth-forensic-service).

from the youth and their families to the treatment professionals, and by increasing cultural competence of staff. These efforts particularly focused on engagement of higher-antisocial and Indigenous young people and their families. Following implementation of this modified approach with a new sample of 54 young males, it was found that there were improvements in therapeutic engagement for both Indigenous and non-Indigenous young people, however Indigenous young people remained less engaged than non-Indigenous.

Mirtazapine – Limited Evidence

Mirtazapine is a pharmacological intervention. In the context of PSB, Mirtazapine has been used with young people who are not responding to usual educational programs or who engage in PSB at a level of severity that prevents their participation in such programs.

The REA identified one study in which mirtazapine was evaluated (Coskun, Karakoc, Kircelli, & Mukaddes, 2009). In this study, mirtazapine was used for young people aged 5–16 with a diagnosis of an autism spectrum disorder (ASD) who also engaged in excessive masturbation, with or without other PSB. The objective of the approach was to reduce excessive masturbation.

Mirtazapine was delivered to the young people in a clinic-based setting. Dosage began at 7.5–15 mg a day. The aim was then to increase the dosage of mirtazapine to a maximum of 30 mg a day, depending on the clinical response or any adverse effects noted for the young person. The duration required for this treatment is currently unclear. It is prescribed by trained and qualified psychiatrists.

Coskun et al. (2009) tested the effectiveness of mirtazapine in a Turkish single-group pre–post-test design involving 10 young people aged 5–16 years with a diagnosis of ASD. The time from pre-testing to post-testing was two weeks, although some children who took longer to respond had their post-test taken at four weeks. At post-test, it was found that there was a significant improvement in levels of masturbation. Six out of the 10 young people also showed improvements in other PSB. However, every child had at least one side effect possibly related to mirtazapine. These included increased appetite, weight gain and sedation. Other less frequently reported side effects were tremor in hands, pain in legs, worsening of previously existing constipation, and increased water consumption and urinary frequency. However, no young people ceased the medication due to the side effects. It is unclear how long the young person remained on the medication.

These findings suggest this approach may be helpful in reducing excessive masturbation in young people with ASD. However, due to the small sample size, lack of control group and multiple young people taking concurrent medications (such as risperidone) these findings are not strong. The benefits found also need to be carefully weighed against the side effects: every child experienced at least one (e.g. increased appetite, weight gain and sedation). Further research addressing these gaps would be beneficial.

Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB) – Supported

The REA found seven papers reporting on three studies of MST-PSB (Borduin & Dopp, 2015; Borduin, Schaeffer, & Heiblum, 2009; Henggeler et al., 2009; Letourneau, Chapman, & Schoenwald, 2008; Letourneau, Henggeler, et al., 2009; Letourneau et al., 2013; Letourneau, Schoenwald, & Sheidow, 2004). Overall it was

rated Supported in the REA. It has demonstrated effect in at least two RCTs and those effects have maintained for at least 12 months after approach completion. There was evidence regarding MST-PSB in the systematic reviews; however, as the systematic reviews found did not meet the necessary methodological criteria, the rating for MST-PSB remains at Supported, rather than Well Supported (refer to methods section for this criteria).

Clinically adapted from Multisystemic Therapy (MST), MST-PSB is specifically designed for adolescents who have committed sexual offences in addition to exhibiting other antisocial behaviours. Targeting young people aged between 10 and 17 years, MST-PSB's main objectives are to decrease PSB and other problematic behaviours, and to reduce OOHC placements. Young people are excluded from the approach if they are currently in OOHC, have evidence of psychosis or a severe intellectual disability.

Treatment is provided by masters-level therapists, clinically trained in the human services field. They work together with community-based professionals such as case-workers, parole/probation officers, and school professionals. Treatment is provided in the young person and family's natural environment such as their home, school and their local community.[30]

A functional assessment of the young person's social environment forms the foundation of their treatment plan. Treatment is tailored specifically to factors driving the young person's PSB, as well as deficits in cognitive processes, family and peer relations, and school performance. Intensive services are provided face-to-face with the young person and their family for approximately five to seven months, with an average of three one- to two-hour therapy sessions per week. Therapists are also available to address clinical problems 24 hours a day, seven days a week.

Content addressed in therapy sessions is based on CBT and structured family therapy, with significant focus on the aspects of the young person's social ecology that are functionally related to PSB (e.g. PSB, out-of-home placement and family and peer relations). Family members engage in family therapy to gain guidance skills and are encouraged to develop social support networks. The REA identified three studies in which MST-PSB outcomes have been evaluated (Borduin et al., 2009; Letourneau, Henggeler, et al., 2009; Letourneau et al., 2004).

MST-PSB Study One

The first study of MST-PSB uncovered in the REA included two papers (Letourneau et al., 2008; Letourneau et al., 2004), which used a sub-set of participants collected from an earlier paper conducted by Schoenwald, Sheidow, Letourneau, and Liao (2003) in the USA and Canada. As the original paper by Schoenwald et al. (2003) did not examine PSB, it has not been included in the REA. This study aimed to 'transport' MST to a community mental health setting in a pre-post single group design and to examine whether MST is able to reduce PSB, as well as other internalising and externalising behaviours and offending behaviour. As such, this

[30] Sourced from the California Evidence-Based Clearinghouse http://www.cebc4cw.org/program/multisystemic-therapy-for-youth-with-problem-sexual-behaviors/detailed and the State of Florida's website (http://www.myflorida.com/apps/vbs/adoc/F17815_ResidentialReferenceGuidePt.4.pdf).

study is one of the first examining MST–PSB. It should be kept in mind that these authors did not include young people with aggressive forms of PSB, and looked at inappropriateness and frequency of any PSB instead.

The first paper by Letourneau et al. (2004) included participants aged 5–19 years. Outcomes measured included rates of PSB, other externalising behaviours, internalising behaviours, psychosocial functioning and arrest or incarceration data during treatment. Young people were split into sub-groups based on the severity of PSB ('few' PSBs, 'substantial' PSBs or no PSBs). From the initial assessment, 413 youths were identified as having few PSBs, 166 youths as having substantial PSB, and 943 as having No PSB. Approximately 61% of the sample were from a minority background, and approximately 29% of the sample were female. Young people in this study spent an average of approximately 4.3 months in treatment. Outcomes measured included internalising behaviour, externalising behaviour, psychosocial functioning, and arrest or incarceration during treatment. Post-testing was completed approximately five to seven months after pre-testing, on completion of the approach. Outcomes indicated that all groups showed statistically significant improvements in internalising behaviour, externalising behaviour and psychosocial functioning. For the two PSB groups specifically, rates of PSB, other externalising behaviour problems and internalising problems were statistically significantly lower and also clinically significantly lower at the end of treatment. Psychosocial functioning had also statistically significantly improved. No differences were found between groups for arrest or incarceration data during treatment.

In a follow up paper with the same participants, Letourneau et al. (2008) measured PSB and other behaviour problems 6 and 12 months after approach completion. They also examined measures of general non-sexual offending and sexual offending up to 48 months following approach completion. However, for this paper, Letourneau et al. (2008) split participants into two groups rather than three (PSB vs. no PSB). Statistically significant improvements in internalising and other externalising behaviours as well as psychosocial functioning was found for both groups. PSB was also found to decrease for the PSB group, although this was not examined statistically. In addition, no statistically significant difference between PSB and no-PSB groups for rates of both sexual offending and general non-sexual offending were found, indicating that there was no increased risk of offending for young people with PSB following treatment.

Overall, these papers demonstrate initial evidence that MST-PSB may be useful for improving externalising, internalising, psychosocial functioning as well as reducing mild-moderate PSB. Although a strength of this study is its large sample size, findings should be interpreted with caution due to the lack of a true comparison group. Participants were split into groups after they had received treatment and had their outcomes measured, meaning no randomisation to treatment occurred.

MST-PSB Study Two

The second study examining MST-PSB was reported in two papers (Borduin & Dopp, 2015; Borduin et al., 2009). In the first paper, Borduin et al. (2009) conducted an RCT in the USA testing MST-PSB outcome effectiveness. Participants included 48 mainly male juvenile sexual offenders with an average age of 14 years and their caregivers. Approximately 95% of the sample were male.

Participants were randomised to MST-PSB (*n*=24) or the usual community service (UCS, *n*=24). Usual care was reported to be group- and individual-based CBT offered through the juvenile justice service in an outpatient setting. Both groups averaged 30 weeks treatment. The MST-PSB participants' length of treatment time ranged from 14.3 to 63.7 weeks.

Outcomes measured included rates of recidivism, psychiatric symptoms, behaviour problems, family relationships, peer relationships, self-reported measure of delinquency and also parent and teacher reports of school grades. Data was collected before the approach and immediately after the approach (post-testing). Recidivism data was also collected to an average of 8.9 years after treatment.

At post-testing, young people in the MST-PSB group were found to have statistically significantly improved school grades, psychiatric symptoms, behaviour problems, family relationships, peer relationships and self-reported rates of delinquency. The authors found that these measures worsened across all measures in the UCS group. Comparing rearrest and incarceration data, the study found the MST-PSB participants showed statistically significantly fewer arrests for sexual crimes (8.3% vs. 45.8%, respectively), 70% fewer arrests for other crimes (29.2% and 58.3% respectively) and 80% fewer days in detention facilities than UCS participants.

The second paper from this study examined the cost-effectiveness of MST-PSB compared to UCS (Borduin & Dopp, 2015). MST-PSB was found to produce economic benefits. Please refer to Borduin and Dopp (2015) for further details.

This study by Borduin et al. (2009) demonstrated that MST-PSB may be effective in improving psychiatric symptoms, behaviour problems, family and peer relationships and self-reported rates of delinquency. It may also bring about improvements in school grades. In addition, it appears to have a beneficial impact on rates of reoffending. All these appear to improve outcomes over and above a comparison group. The study design of the RCT and the length of follow up for recidivism data lend strength to these conclusions. However, a larger sample size would strengthen confidence in findings.

MST-PSB Study Three

The third study examining MST-PSB included three papers in total (Henggeler et al., 2009; Letourneau, Henggeler, et al., 2009; Letourneau et al., 2013). The first paper, also an RCT, involved 127 mainly male juvenile sexual offenders with a mean age of 14.6 years (11–18 years) and their caregivers (Letourneau, Henggeler, et al., 2009). Young people were randomised to MST-PSB (n=68) or a treatment as usual group (TAU, *n*=63). TAU involved outpatient services offered through the juvenile justice system, delivered by treatment probation officers. Measures were taken within 72 hours (or pre-test) of recruitment, six months post-recruitment (or post-test, taken after approach completion), and 12 months post-recruitment (or follow-up test), which was approximately five months after approach completion. Outcomes measured included PSB, delinquency, internalising and externalising symptoms, substance use issues and OOHC placements. At follow up, results showed that participants of MST-PSB had statistically significantly lower PSB, delinquency and substance use issues and OOHC placements than the comparison group, however MST-PSB had no impact on externalising and internalising symptoms. Further analyses by Henggeler et al. (2009) showed that improvements in outcomes were statistically significantly related to improved caregiver follow-through on discipline,

decreased caregiver disapproval of youth's friends and decreased caregiver reports of youth association with deviant versus conventional peers.

Letourneau et al. (2013) published a 24-month follow-up paper (approximately 17 months after approach completion for the MST-PSB group), of the Letourneau, Henggeler, et al. (2009) paper. They found reductions in PSB and OOHC placements remained statistically significantly lower for the MST-PSB group when compared to the TAU group. No differences were found in self-reported delinquent behaviour; however, youth in the MST-PSB were less likely to report any criminal behaviour. Differences found in substance use issues in the earlier study were not maintaining at follow up.

This study shows that MST-PSB may be helpful at improving PSB, delinquency, substance use issues and OOHC placements immediately after the approach. It may also lead to longer term benefits for PSB, some delinquent behaviour and OOHC placements, but not for substance-use issues. The strengths of this study are the randomisation of young people to a comparison group and the 17-month follow up period. However, findings could be strengthened with replication and a larger sample size. The use of adolescent self-report measures of inappropriate sexual behaviours that were not fully validated, and self-report of delinquency are limitations of these studies.

MST-PSB Findings Combined

Taking the three studies together, limitations include the small sample sizes and the lack of comparison to another well-known approach, such as CBT. MST-PSB has also yet to be evaluated outside of the USA and with measures of delinquency that are not self-report. Furthermore, the strict inclusion criteria of participants excludes those in OOHC, with significant psychiatric problems and with an intellectual disability. This limits the applicability of these findings to young people in the OOHC setting and with different abilities. During consultations, Mr Tolliday also repeated the concern regarding the strict inclusions and exclusion criteria of MST. Findings would be strengthened with an evaluation run in the Australian OOHC context, with a comparison to another well-researched approach, such as CBT and with the inclusions of children with different abilities.

While there are some noted limitations of these evaluations of MST-PSB, the three studies suggest community-based approaches using evidence-based treatments for adolescents with antisocial behaviour may be adapted for juveniles with PSB with favourable results. The evidence suggests that MST-PSB is effective for reducing PSB and reducing rates of recidivism. It may also be helpful for improving other mental health and behaviour outcomes, such as delinquency, school grades, externalising behaviour and substance use. As such, it has been rated as Supported in the general setting in this review.

SafeCare Young People's Program (SYPP) – Limited Evidence

SafeCare[31] Young People's Program (SYPP)[32] specialises in the treatment of home-based adolescents aged 12–17 years who have experienced or engaged in

[31] Note that this is not the same as or an adaptation of the SafeCare model that is currently being trialled in NSW.

inappropriate sexual conduct, particularly intra-familial adolescent sex offenders (IASO). The aim of the program is to reduce intra-familial PSB.

SYPP is delivered to young people who engage in PSB who often have their own history of victimisation[33]. The program utilises psycho-education, cognitive behavioral, psychodynamic, and systems theory approaches. Group therapy is the primary mode of program, with individual therapy tailored to individual needs.

At the commencement of the program, families complete a six-week assessment phase, reviewing aspects of the abuse, protection needs, prior victimisation, family relationships, and treatment goals. Treatment plans are then individualised to the needs of each client and his/her family. Therapy is provided in both individual and group formats. Caregivers are able to participate in the therapy sessions. During the program, young people receive the major components of SYPP including targeting the sexual offending cycle (e.g. develop awareness of cognitive distortions, antecedent motives), victim empathy, relapse prevention (e.g. identify high-risk situations, learning coping strategies, self-monitoring), social skills, protective behaviours, and family relationships. Aspects of inappropriate sexual behaviour are addressed during the 10-week group therapy component of the program (Grant et al., 2009; Halse et al., 2012).

The REA identified one study in which SYPP was evaluated (Halse et al., 2012). Halse et al. (2012) tested the effectiveness of SYPP in a single-group pre–post study design in Western Australia. Twelve male adolescents aged 11 to 15 years were involved. Participants were drawn from a larger study of 38 young people (Grant et al., 2009). Half of the participants had been diagnosed with a psychiatric disorder and most reported some form of prior victimisation. The targets of the PSB tended to be peers, children or young family members. Using qualitative analyses of data collected 12 months after commencement of therapy, it was found that all participants reported they were certain that they would not behave in a sexually inappropriate way again. Participants reported the most changes occurred in their levels of impulsivity, emotional control, self-esteem, and personal responsibility. They also reported improvements in communication with their family members. There was little evidence of improvement in empathy for their victim and relapse prevention plans were not found to be strong.

These findings suggest that SYPP may be helpful in improving family communication, reducing impulsivity, increasing emotional control and self-esteem and improving personal responsibility taking. It may not be as helpful in improving victim empathy and in producing relapse prevention plans. The long-term follow up in this study lends strength to the conclusions. However, due to the lack of quantitative measures, comparison group and randomisation, findings should be interpreted with caution. Further research utilising quantitative measures, a comparison group and randomisation would be beneficial.

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[32] Mr Tolliday has informed the review authors that funding for this project has been withdrawn.

[33] Victimisation is when a person is victimised or becomes a victim. In this report, victimisation may refer to becoming a victim of another child or young person's problem sexual behaviour, or it may relate to other forms of victimisation such as previous exposure to violence or abuse perpetrated by adults.

Youth with Sexual Behavior Problems – Limited Evidence

Youth with Sexual Behavior Problems (YSBP) is for males aged 10–18 years who sexually offend. It is delivered in an outpatient clinic or community mental health setting. The purpose of the approach is to assist the young people to refrain from engaging in PSB, improve psychosocial functioning and reduce parenting stress.

The YSBP is a multimodal treatment delivered to young males and their families in the form of individual treatment, group treatment, family therapy and case management. It is delivered in weekly group therapy for both young people and their parents, in monthly individual therapy, monthly mixed family groups as well as monthly family sessions. The duration of this approach is typically 18 months, but this can be tailored to the individual based on their progress. Young females with PSB referred to YSPB are not offered the group component of the program, as the developers believe mixed gender groups would be problematic. YSPB is delivered by licensed therapists. The qualification and training of these therapists is unclear.

During the approach, young people receive content '…on the development of healthy boundaries, victim empathy, personal responsibility, understanding the connection between thoughts, feelings and behaviours, and safety and relapse prevention plan' (Greaves & Salloum, 2015, p. 180). The parent groups include psycho-education and skill building regarding sexuality, sexual behaviour and parenting. The approach is delivered along with an age-appropriate workbook, using a CBT framework.

The REA identified one study in which the YSBP has been evaluated (Greaves & Salloum, 2015). Greaves and Salloum (2015) tested the effectiveness of the YSBP using a single-group pre–post intervention design. The study involved 26 males aged 11–17 and was conducted in the USA. The young males receiving this approach tended to have histories of trauma and their targets of PSB tended to be peers or children. Pre-testing was completed at intake, post-test was completed on average 167.4 days after the pre-test. It is unclear if post-testing signified the end of the young person's treatment, or if they continued YSPB after testing. Findings suggest that there were significant improvements in psychosocial functioning, parenting stress and parent–child dysfunction. However, although sexual interests, attitudes and behaviours were found to decrease, this was not statistically significant.

These findings suggest this approach may be helpful in improving parent–child relationships and psychosocial functioning for young people with aggressive PSB. However, these results should be interpreted with caution due to the small sample size, no comparison group, no longer term follow up, and lack of standardised time points for post-testing.

4.3.4. What is the evidence for approaches to prevent problem sexual behaviour?

The REA identified only one evaluated approach designed to prevent PSB: the Gender violence/Sexual harassment prevention program. This program is for young people over 10 years of age in a school setting and was rated Limited Evidence. Refer to Table 7 and the description below for more information.

Gender violence/Sexual harassment Prevention Program – Limited Evidence

The Gender violence/Sexual harassment (GV/SH) prevention program is for children in sixth and seventh grade who live at home. The objective of the program is to reduce rates of victimisation and perpetration in both boys and girls.

During the program, classrooms are allocated to one of two curricula: (1) an interaction-based curriculum, or (2) a law-and-justice curriculum. The program lessons focused on 'personal space' and 'boundaries', and distinguishing permissible behaviours from those that are not. The law-and-justice curriculum centred on discussion around the consequences of not obeying boundaries, laws, definitions, information, and data about penalties for sexual assault and sexual harassment, and consequences for perpetrators of GV/SH. The interaction-based treatment centred on noticing the ways that boundaries have been crossed or violated, forming relationships, understanding the continuum between friendship and intimacy, understanding when behaviour is wanted or unwanted, and the role of bystander intervention. The curriculum aimed to address negative attitudes and beliefs about dating violence. Both curricula contained five 40 minute lessons and were taught over five consecutive weeks. GV/SH was run by a female educator with previous experience in teaching violence prevention in schools.

The REA identified one study in which the GV/SH prevention program has been evaluated (Taylor, Stein, & Burden, 2010b). This RCT was conducted in the USA and involved 123 sixth and seventh grade classrooms (n=1639 students), with students aged 11 to 13 years. The sample included slightly more girls than boys and many participants had experienced dating violence prior to the study. Classrooms were randomly assigned to the program group (to receive one of the two curricula) or to the no-treatment control group. The control condition received standard health education available in their school districts, which did not include information regarding dating violence prevention. Timing of survey administration included a baseline survey, two follow-up surveys immediately post-treatment (wave 2), and six months post-treatment (wave 3).

Table 7: Approach to prevent problem sexual behaviour

Approach name	Rating	Description*	Location	Participants	Findings	Limitations†
Gender violence/Sexual harassment prevention program	LE	School-based group gender violence and sexual harassment **prevention** program for children in the 6th and 7th grades Family involved: No Study design: RCT with long-term follow up	USA	Gender: Male and female Age: Range 11–13 years Sample size: 1639	May be helpful in reducing rates of victimisation for both males and females equally. May also be helpful in reducing non-sexual violence towards peers. May be less helpful in reducing sexual violence perpetration towards peers and dating partners. Large sample size, comparison group and randomisation are strengths of this study.	Not found to be helpful for preventing rates of sexual violence towards peers and dating partners. Replication in Australian context needed, paying attention to influence of gender

E = Emerging; LE = Limited Evidence; RCT = randomised controlled trial; S = Supported.

*The age of children or young people may be different in description and in study. Sometimes an approach was designed for a particular age group, but the age of study participants did not match the intended age group.

† Limitations to study designs make studies less rigorous and reduce our confidence in their findings. Limitations include:

Interviews only: No statistical testing was completed. As such, findings are less objective and harder to replicate
No comparison group: There is no way to determine if changes are a result of the approach or due to chance or other factors.
No randomisation to groups: There is no way to determine if changes are a result of the approach or due to chance or some factor to do with the participants
No follow-up measures: There is no way of knowing if benefits are maintained long term.
Small sample size: There is no way to know if benefits can be generalised to a large number of young people

In an earlier paper by Taylor, Stein, and Burden (2010a) cited in the Taylor et al. (2010b) paper included in the current REA, it was found that young people in the interaction-based treatment had significantly lower rates of peer sexual violence victimisation, when compared to the law-and-justice-based treatment and control group. Unexpectedly, the study also found statistically significantly higher prevalence rates of 'any' violence against dating partners for both treatment groups, compared with the control group. The interaction-based treatment was associated with statistically significantly higher levels of prevalence of perpetrating sexual dating violence and any violence against a dating partner, at both wave 2 and wave 3.

The primary purpose of the paper identified in the REA (Taylor et al., 2010b), was to examine gender difference in the original findings by undertaking additional data analyses to those reported in the previous paper. No gender significant differences were found regarding victim outcomes. However, six months following the program, males were found to more frequently be victims of sexual and non-sexual violence from both peers and dating partners than females. Females were only found to more frequently experience sexual dating violence from partners immediately after the program.

In regards to perpetrator outcomes, most of the findings reported in the previous paper were confirmed. However, when analysing the results taking gender into account, statistically significantly lower rates of perpetrating 'any' peer violence and peer non-sexual violence for the law-and-justice-based group compared with the control group were found six months after the program. The program did not reduce the prevalence of perpetration of sexual violence. Overall, the program did not have a different effect on males and females. However, at wave 2 and wave 3, it was found that females perpetrated fewer incidents of sexual peer victimisation and sexual dating victimisation than males.

These findings suggest this program may be helpful in reducing rates of victimisation for both males and females equally. It may also be helpful in reducing non-sexual violence towards peers. However, it may be less helpful in reducing sexual violence perpetration towards peers and dating partners. For this reason, we have rated this approach as having Limited Evidence as a PSB preventive program.

The authors however argued that the increase in reported perpetration may be due to an increase in knowledge. This study also suggests that young males may be more frequently targets and perpetrators of PSB and other violence than females. The large sample size, comparison group and randomisation in this study lend strength to the study's conclusions. Replication in an Australian context, paying attention to the influence of gender, would be ideal.

4.3.5. Additional approaches identified by the consultees

Mr Tolliday reported that there are a range of private providers in NSW who deliver therapies and services to children aged 10–17 years who engage in PSB. These may be in OOHC or in other settings.

Ms Want indicated that Berry Street, the Australian Childhood Foundation and Every Child Every Chance (Victorian Government) have published extremely rich resources in regards to responding to children with PSB, which provides valuable Australian input and evidence. She states there are also many leading practitioners

and writers in the field (e.g. William Friedrich, Toni Cavanagh Johnson, Jane Gilgun) who have led the way and provided practitioners with solid 'practice paths'.

Ms Want indicated that 'those paths will of course be altered according to the therapeutic bias of practitioners, be it CBT, strength-based work, narrative [therapy], body-based therapy, but when addressing [PSB] the approach must sit in those initial solid practice frameworks.'

According to Ms Want, CBT has been the most widely evaluated practice in regard to PSB. However she believes there is overall agreement among those in the field that the type of therapeutic approach does not seem to be a factor in facilitating change for young children with PSB, providing there is a direct response to the PSB itself. Ms Want indicated that non-directive work such as play therapy or discussing the PSB in an 'engagement phase' in counselling does not appear to be helpful, especially to the child and the family. On the other hand, Ms Luchi stated she did not advocate for the use of CBT as a stand-alone approach.

The consultees were aware of a structured CBT-focussed program that was developed by Jane Gilgun and Toni Cavanagh Johnson, and a CBT model recommended by the Association for the Treatment of Sexual Abuse (for children under the age of 10), but these were not referred to among the approaches currently available in NSW.

Ms Want stated that the practitioners at Rosie's Place are informed by narrative therapy and the use of therapeutic techniques that externalise behaviour. She believes these are particularly effective in working with children and families regarding PSB. However, she emphasised that a holistic approach is most important, in terms of linking PSB to the child's external environment, as well as linking their internal state with a focus on emotional and sensory processing.

According to Ms Luchi, a family therapy approach, based in the work of John Caffaro, can be used in the context of discussions regarding the reunification of children from OOHC to the family home.

Consultees discussed the Keep Them Safe (KTS) outcomes evaluation (Cassells, Cortis, et al., 2014), in which two relevant approaches were critiqued. One, New Street Adolescent Services, has been described previously in this report. The other program relevant to this review is the Hunter New England Sexualised Behaviour (under 10s) Program, also known as SPARKS. This approach is provided to children and families where the child engages in PSB and may be at risk of placement in OOHC. According to the KTS report, the evaluation of the under-tens program showed some early signs of potential benefits; however, it lacked the rigour needed to determine the effectiveness of the program.

Consultees referred the Traffic Lights model (Family Planning Queensland, 2012)[34], which is to a tool that is sometimes used as a guide for identifying, understanding and responding to sexual behaviours in children and young people. 'Red' behaviours signal the need for immediate protection, 'orange' behaviours signal the need for monitoring and further support, 'green' behaviours are a part of normal, healthy

[34] A copy of this tool can be found at the following link: http://www.fpqteachers.com.au/wp-content/uploads/2014/06/Traffic-Lights-Sexual-Behaviours-6pages.pdf

development and provide opportunities to talk, explain and support the young person.

Ms Want noted that the Traffic Lights description of the range of sexual behaviours from normal to the more concerning is a useful tool. The use of the coloured lights (red, yellow, green) provides a clear way to describe the different behaviours and provides a child-friendly way of talking to children, families, schools and other practitioners to gain a unified understanding about the behaviours a child may be exhibiting.

However, Ms Want noted that the Traffic Lights model is often misused as an assessment tool that assesses behaviours only, rather than the reason or context for the behaviours. Consideration must always be given to the motivation behind the behaviour for the child, as well as to the context of a child's life. This is to ensure understanding of the place of the behaviour in a more holistic picture of what has been happening or is happening to the child.

Mr Tolliday was also critical of the Traffic Lights approach for similar reasons. He noted that the tool has the potential to be used in a manner that is 'too black and white'. Unfamiliar users may apply the tool in a rigid or fixed way, without reference to the dynamics inherent in behaviour, such as cultural or religious differences.

4.4. What policies, principles and practice standards exist for preventing and responding to problem sexual behaviour in out-of-home care settings?

Following on from the three sections that outline specific approaches for preventing and responding to PSB in various settings, this section of the report describes policies, principles and practice standards for working with children and young people engaging in PSB. Most of this information was gathered during consultations and some also from the desktop search.

Various resources relevant to practice were identified in the consultations and desktop search. Where these related directly to consultation conversations, these have been added into the text below. Names and URLS of additional resources can be found in the Appendix 6.6.

4.4.1. Policies identified

A number of policies designed to prevent and respond to PSB in OOHC settings were identified. Ms Want noted that her service, or in fact any service working with children and families where PSB has been identified, must work in a child protection framework. This may mean that Family and Community Services may already be involved and are the referring agency. However, if a family or school were to refer a child there must first be a notification to Family and Community Services to work towards a child protection response.

Ms Luchi and the FACS group both referred to a sibling case-coordination policy (NSW Department of Family and Community Services, n.d.-b), which outlines procedures for responding, reporting, (de)briefing, interviewing and assessing in cases of sibling abuse, as well as links to necessary forms Other policies referred to by the FACS group include: Safety and Risk Assessment (SARA) (Children's Research Center, 2012), Secondary Risk of Harm (NSW Department of Family and Community Services, n.d.-a), JIRT eligibility guidelines (NSW Department of Family

and Community Services, undated) and Standards for Minimum Requirements for OOHC providers (Office of the Children's Guardian, 2013).

Two policies that relate to the work of New Street Services (NSS) were identified by Mr Tolliday:

- a general policy in NSW that health services prioritise children and young people living in OOHC (the OOHC Health Pathways program)[35]
- an internal policy for ensuring Aboriginal and Torres Strait Islander clinicians are available for Aboriginal and Torres Strait Islander NSS clients (not all of whom are living in OOHC).[36]

The NSS policy for ensuring Aboriginal and Torres Strait Islander clinicians are available for Aboriginal and Torres Strait Islander clients reflects the guidelines of the Victorian Department of Human Services in regards to children and adolescents who engage in PSB (Evertsz & Miller, 2012; Pratt et al., 2012). For adolescents who present with sexually abusive behaviours, for example, the Department states that: 'involving an Aboriginal Child Specialist Advice and Support Service practitioner is essential for planning a culturally sensitive assessment and intervention' (Pratt et al., 2012, p. 19).

4.4.2. Principles identified

In comparison to the amount of information provided about policies by consultees, much more information was provided about the *principles* that informed consultees' work. Two principles were commonly identified by consultees (identified in at least three of the four consultations): recognising the contextual nature of PSB; and working in collaboration. Another common principle (identified in at least two consultations) was an individualised approach. Each of these common principles is explored further below.[37]

4.4.2.1. The contextual nature of problem sexual behaviour

Similar to many approaches identified in the REA, Mr Tolliday, Ms Want and Ms Luchi all noted the way in which the contextual nature of PSB informs their work and/or the work of their organisations.

Mr Tolliday noted the importance of context when treating young people who engage in PSB:

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[35] An evaluation of the KTS OOHC Health Pathways program (http://www.kidsfamilies.health.nsw.gov.au/current-work/programs/programs-and-initiatives/the-out-of-home-care-health-pathway-program/) in 2014 found that it demonstrated 'early positive results'. There is a high rate of children in OOHC being referred for health assessments; however, results vary considerably between local health districts and different types of health practitioner (Cassells, Duncan, et al., 2014).

[36] Mr Tolliday noted that this policy is based upon the recommendations of the Aboriginal Child Sexual Assault Taskforce.

[37] Other principles identified by consultees (noted by 1 consultee only) included: strength-based approaches (an important aspect of the Good Way approach and also reflected in the ethos of NSS); invitational approach (Mr Tolliday); restorative processes (Mr Tolliday); being directive in addressing PSB (Ms Want); and a trauma-informed approach (Ms Luchi).

'We take…a diametrically opposite position to the [idea that] sexually harmful behaviour [is] a psychological problem that exists in the young person alone. The evidence and the literature does not support that [view]. We work with [the young person's] community, family, context, [and] ensure they are well connected [to] primary carers, [so] we can… assist them in processing trauma.'

Ms Luchi was also supportive of an approach to treatment that involves multiple people within the child's life: 'This is not an individual problem, it's a contextual problem and the solution very much involves parents, carers, teachers, counsellors, case workers [and] the child.' She also noted the way in which professionals working with children and young people in OOHC may not recognise the contextual nature of the PSB, and how this can impact on treating the PSB:

'My experience is that in most foster families, kinship or other [family], it is very challenging to address these behaviours… Part of the problem is the supportive network and professional network often see the PSB as a child-centred problem rather than a symptom of a larger context and therefore expect the solution to be about fixing the child.'

Mr Tolliday also notes the importance of looking at context when seeking to address PSB among children and young people in OOHC, especially among those who have an Aboriginal and Torres Strait Islander background:

'The good things in the relinquishing family [are often] forgotten about or disrupted by the OOHC system…We've found [that] even where there has been significant harm done, in almost every case [there are some] people [in the relinquishing family who are interested in the children and would like to be connected…By and large, if we can safely connect our Aboriginal kids back to their families (include aunts, uncles etc.), the ways in which those young people settle is quite astonishing. That's where the importance of looking at the kid's whole picture, and not just the sexual behaviour, is so important.'

Of five core elements of effective practice for working with children and young people engaging in PSB, Ms Want referred to four that reflect a contextual perspective:

- having a family focus (i.e. not focusing solely on the child and the child's behaviour) — this was particularly evident in approaches included in the REA
- gathering information about what else is going on in the home and environment that might be creating stress
- gathering information about what might be going on in the school
- gathering information about what is going on in the neighbourhood/community.

This contextual focus is evident also in the process of assessment that is used at Rosie's Place, as Ms Want notes:

'You are doing an on-going assessment not only of the sexualised behaviours and whether or not they increase [or] decrease [but also] an on-going assessment of the child's emotional wellbeing, physical and psychological wellbeing, evidence of stressors within the family, child protection concerns, trauma history, domestic violence and other issues impacting on the safety and wellbeing of the children It is also imperative to locate strengths and resources within the family that can assist in a collaborative response to the concerns raised during the assessment process.'

A number of published guidelines support the view that context is critical to understanding and treating PSB, including those published by the Victorian Department of Human Services (DHS) (Evertsz & Miller, 2012; Pratt et al., 2012), the Association for the Treatment of Sexual Abusers (ATSA) (Chaffin et al., 2008), the Child Protection Society (Child Protection Society as cited within Sexual Assault Support Service, 2012), the Tasmanian Sexual Assault Support Service (Sexual Assault Support Service, 2012). South et al. (2015) also found evidence in line with this view.

For example, the ATSA states: 'Current and future environmental context may be more influential than individual child factors or the child's individual psychological makeup' (Chaffin et al., 2008, p. 202). The Child Protection Society lists 'acknowledging the importance of context' as a principle of good practice when working with children and young people displaying PSB (Child Protection Society as cited within Sexual Assault Support Service, 2012). South et al. (2015) noted that a recommendation common to two evaluations included in their scoping review of practice elements to prevent childhood sexual abuse in OOHC, was 'the need for holistic approaches addressing the needs of both caregivers and children' (p. 28).

O'Brien (2010) review pertaining to PSB also emphasised the importance of a context for children who engage in PSB: 'children engaging in PSBs are not motivated by a pre-existing sexual predilection for children but… their behaviour results from the particularities of their context of situation' (O'Brien, 2010, p. 11).

Further supporting the importance of considering context, both the DHS and ATSA recommend gathering information about the child or young person's home, family, school and broader social environment in order to understand PSB. The DHS states: 'it is important to adopt an ecological perspective when gathering information about problem sexual behaviour and to be mindful of multiple possible contributing factors… it is important to talk to multiple sources of information and to think systemically' (Evertsz & Miller, 2012, p. 23-24). Family violence is viewed by the DHS as a key area for consideration when gathering information about the child or young person's family.[38]

The importance of context is evident in approaches such as MST-PSB, which consider the whole young person and their family, supports, and community systems. Many approaches based on CBT and other approaches identified in the

[38] The Victorian DHS also advocates for a similar comprehensive 'contextual assessment' (ATSA called it ecologically focused assessment). DSH notes that 'any therapeutic intervention with the young person regarding their own abusive behaviour is unlikely to be effective if the abuse they themselves have experienced, or past trauma, remains unaddressed' (Pratt et al., 2012, p. 25). As with the approach described by Ms Want, in the information-gathering phase the DHS notes that the family and social environment and the issue of family violence are key areas for consideration. Working with the school was also noted as a principle of intervention for adolescents engaging in PSB and involving professionals in therapeutic agencies that are funded to provide therapeutic services to young people engaging in PSB. Also noted in the child PSB guide – the school can help in monitoring behaviours and changes in the child. ATSA highlights the importance of context: DHS child PSB guide: 'It is important to adopt an ecological perspective when gathering information about problem sexual behaviour and to be mindful of multiple possible contributing factors' (Evertsz & Miller, 2012, p.23) + be alert to family violence + build relationships and engage with children, families and other professionals.

report also included a contextual focus, demonstrating a consistent importance of this principal in both research and practice.

In summary, among the consultees there was strong support for a contextual approach to treating PSB which appears to be backed by the published guidelines. A contextual approach does not appear to be an approach in and of itself (although it can inform the way in which an approach operates – as the MST-PSB demonstrates), rather it is an approach that is used to gather information in order to understand the PSB and a principle that can inform treatment. A contextual approach involves working with multiple people in the child's life, as opposed to an approach that only focuses on the individual child. The justification for a contextual approach is that PSB is the result of 'the particularities of [a child's context]'.

4.4.2.2. Working in collaboration

Mr Tolliday, Ms Want and Ms Luchi all noted the importance of collaboration as a principle when working with children who engage in PSB. Mr Tolliday noted that collaboration, which involves working with the families of children and young people as well as other relevant agencies such as community services and schools, is a core principle informing the treatment of children and young people who attend New Street Services. The ethos statement of NSS also highlights the importance of collaboration:

> 'Research confirms that active involvement of parents/carers and a coordinated inter-agency approach is required for intervention to be effective. Most important of these is the active involvement of parents/carers.'

The findings of the REA suggest that families are typically involved in approaches for children and young people or they are also recipients of interventions. Some of the approaches in the REA indicated that collaboration between professionals was required.

Ms Luchi stated that working in isolation is the least effective approach for practitioners who are treating children and young people engaging in PSB because the treatment, 'very quickly becomes all about the child, and the child's problems'. Instead, Ms Luchi encourages a case-management approach, which facilitates collaboration via the involvement of multiple stakeholders (the family, the school etc.).

Ms Want also highlighted the importance of collaboration, stating that staff at Rosie's Place work closely with relevant agencies, taking part in a range of activities including: regular case reviews; phone consultations; and working with parents, grandparents, carers, residential homes, and schools. Her description of the process of assessment also implied the use of a collaborative approach:

> 'The assessment is on-going, but the initial assessment is critical to help determine how we [can] pull [other people] in to be part of the work.'

Ms Luchi described the impact of a non-collaborative approach to PSB for a child or young person in OOHC:

> 'I've worked with children and young people living in residential care settings who are engaging in sexually problematic behaviours or just beginning to display these behaviours. At times, residential care workers, unaware of the seriousness of this behaviour or possibly not knowing what to do about it, don't follow it up or

believe it to be an ongoing problem. Nothing further is done about it. However, the behaviour often continues without people noticing it again for a long time.'

The guidelines published by the Victorian DHS (Evertsz & Miller, 2012; Pratt et al., 2012), the ATSA, the Child Protection Society and the Tasmanian Sexual Assault Support Service also recommend a collaborative approach when working with children and young people engaging in PSB (Sexual Assault Support Service, 2012).

Collaboration with family and/or carers is noted as especially important by the DHS when working with children and adolescents engaging in PSB (Evertsz & Miller, 2012; Pratt et al., 2012). Reflecting Ms Luchi's emphasis on the importance of a collaborative approach with carers, including those in residential care, the DHS states that for teenagers engaging in PSB:

'ongoing communication between residential care staff or carers, specialised treatment providers, family members, members of the care team and the child protection practitioner is essential in making sure that the young person's progress is adequately monitored and to help plan for possible difficulties' (Pratt et al., 2012, p. 39).

In regards to interagency collaboration, the Tasmanian Sexual Assault Service notes that 'it is imperative practitioners work to establish collaborative practices with all agencies and professionals involved with the family.' The ATSA (2008) notes that collaboration could include: treatment providers, child welfare workers, foster parents, parents, schools, child care providers, juvenile justice staff and courts.

4.4.2.3. Individualised approach

Both Mr Tolliday and Ms Want emphasised the importance of an individualised approach, as opposed to the blanket use of a manualised program or a 'one-size-fits-all' approach. Ms Want emphasized the importance of acknowledging that all children and families are unique in so many ways and therefore the work must always start on this premise, rather than the blanket use of procedural approaches that run the risk of a one size fits all approach. Mr Tolliday stated:

> '[Our] treatment approaches are different. So we think that every individual and their family should be individually assessed and that points to a very individual intervention strategy.'

Mr Tolliday describes the use of 'core elements' in treatment, such as the use of risk and child behaviour assessment tools. These are 'anchors' in the treatment approach. However, he states that they 'step away from a manualised approach', preferring to use an 'invitational approach' influenced by the work of Alan Jenkins.[39]

The importance of an individualised approach is noted in the New Street Services statement of program principles:

> 'Children and young people sexually harm others for a range of reasons. There is no single cause for sexually harmful behaviour by children and young people. Consequently, intervention needs to be based upon individual assessment.'

[39] The Invitational Approach was developed by Alan Jenkins and is a model of engagement and intervention to assist people who have perpetrated family violence of sexual abuse. The model encourages accountability and promotes fairness, respect and ethical behaviour (Sexual Assault Support Service, 2012).

Similarly, when describing the different approaches used by therapists to respond to PSB, Ms Want stated that she thinks this diversity of approaches is:

> 'a fair approach because one of the problems about programs for kids is that a program tends to say there is a one-size-fits-all approach to problematic sexual behaviour and how you respond, and that's just not true.'

The importance of a treatment approach that reflects diversity of need is reflected in a number of authoritative guidelines regarding PSB among children and young people including the ATSA: 'Given the diversity of children with SBP, most intervention decisions should be made…on a case-by-case basis' (Chaffin et al., 2008, p. 200). The Child Protection Society lists 'taking account of individual needs' as a principle of good practice when working with children and young people displaying PSB (Child Protection Society as cited within Sexual Assault Support Service, 2012).

Some approaches found in the REA are consisted with this principle, offering individualised treatment plans based on a particular therapeutic approach. Alternatively, they allowed for flexibility with the number of sessions and topics covered, as long as core themes were addressed. This was not the case for all approaches, however, with some tending towards structured group treatments or a manualised approach. Although even within these approaches, thorough assessment and triaging was first conducted to ensure the young person was appropriate for the approach being offered. At this stage, there appear to be no evaluations comparing the two kinds of approaches — individualised and structured.

4.4.2.4. Practice standards identified by consultees

A number of specific practice standards were identified by consultees – some of which are still in development:

Both Ms Want and Mr Tolliday noted the upcoming release of NSW Health guidelines for working with children under 10 who present with PSB. The guidelines are designed to ensure that all of those children receive a service and is currently in draft form. Mr Tolliday outlined some of the features of these guidelines:

- The guidelines will not propose a 'one size fits all' approach. Every child or young person will be individually assessed and treatment will then be provided through the most appropriate primary NSW Health service, out of the following four:
    i. Child Sexual Assault where the child has also been identified as a victim,
    ii. Child Protection Counselling Service where the child also qualifies as a FACS referred victim of physical abuse or neglect,
    iii. Child and Adolescent Mental Health Service where the child has an identified mental health need (which includes trauma responses), and
    iv. Generalist Child and Family Health for the remainder.
- It will be proposed that the 16 Local Health Districts and specialist children's hospitals network each have an identified local coordinator. This will ensure children reach the right service in a timely manner and that each of the service streams are providing this as a specialist response.

- NSW Health's Education Centre Against Violence (ECAV) will provide the training for delivering services within these guidelines, which includes training in assessment and therapeutic responses.
- The therapeutic responses are to be within those in the Service Standards and Guidelines, a document that is still in draft form. While there is scope for practitioner choice, it must be within the scope of the Standards and Guidelines. At this stage, it is expected that all responses be contextual and include the family as a focus of response.

Practice standards within the individual organisations were also noted:

- New Street Services has clinical guidelines which are currently being consolidated with their practice standards. These practice standards and guidelines establish that NSS is holistic, contextual, developmentally focussed and not a clinical service for a child only (see sections above, 'The contextual nature of PSB' and 'Working in collaboration').
- Ms Want noted the collaborative practice standards at Rosie's Place. She noted that working in this way reflects the service's 'family systems level' approach — that is, working within the context of the child's family or, for those children and young people in OOHC, working with the carer-family or the residential setting.
- Ms Want described the treatment approach undertaken at Rosie's Place as following a directive rather than a set of practice standards. The focus is on immediate attendance to goal-setting and immediately addressing the problem behaviours:

  > 'We certainly say that — as a practice standard — addressing the problematic behaviour has to happen right from the start. Compared to our work with other kids, this work is quite directive. We set clear goals with the family in addressing the behaviours right from the start.'

4.5. What approaches exist to support targets of problem sexual behaviour?

The REA conducted as part of this review identified no evaluations of approaches to support targets[40] of PSB. The REA found that targets of the young person's PSB often included a mix of peers, children, family, adults and animals. No studies excluded young people based on the target of their PSB, or developed approaches with particular targets in mind.

South et al. (2015) highlights the importance of support for caregivers as a means of preventing children in OOHC from becoming the targets of sexual abuse (e.g. ensuring caregivers are able to balance demands to ensure adequate supervision of children engaging in PSB) (see Section 4.6 below) but does not specifically address the question of how to support children who are the targets of PSB. As no information in this area was uncovered, the remainder of this section describes the

[40] In this report, the term 'target' is used to refer to a person who is exposed to the PSB of a child or young person

consultees' views of approaches that exist to support children and young people who are targets of PSB by other children and young people.

The FACS consultation group, however, also noted that 'there is still a lack of knowledge about what to do… [about PSB] and for the behaviours when it's impacting on others.'

The only supports mentioned by consultees for the targets of the PSB were a family therapeutic approach, and sibling case coordination (NSW Department of Family and Community Services, n.d.-b).

Where a child or young person has been engaging in PSB with siblings or other children or young people in the household, Ms Luchi notes that 'a lot of work' needs to be done with the children or young people who were the targets of that behaviour because:

> 'The behaviour doesn't come out of nowhere. There are particular dynamics there that have created this bullying type [of] relationship.'

Ms Luchi stated that a family approach is necessary in these cases because it is a family dynamic and unless that dynamic changes, the sibling sexual abuse may continue when the family is reunited.

This area appears to need further evaluation and further development of policies and principles for practice.

4.6. What approaches exist to support parents and carers of children and young people with problem sexual behaviour?

Family involvement in approaches was highly evident in most approaches identified in the REA. Twenty-eight of the 35 papers identified in the REA stated that they included some degree of family or caregiver involvement. This was often in the form of assistance with safety planning, family therapy, group therapy for carers only, education groups or semi-structured support groups. The aim of this involvement was often to education parents and carers regarding PSB and normal sexual development, and to provide them with assistance and training in managing PSB appropriately. Some approaches also included an opportunity following separate therapy sessions, for carers and young people to come together to practice their newly learnt skills in the presence of those delivering the approach. At a minimum, some approaches encouraged caregivers to support their young person in completing therapy tasks between sessions.

While there appeared to be considerable variation in the level and type of involvement of families, we also found initial evidence that children and young people were more likely to complete their involvement in approaches when they had caregiver involvement (Belton et al., 2014; Smallbone et al., 2009). This requires further evaluation.

However, little information was found in the REA regarding supporting birth families to understand and manage PSB following separation and when managing reunification. The exception to this was the approach titled New Pathways, delivered in the NSW context (Milne et al., 2009). However, further information on this is sorely needed. There also appeared to be less carer involvement in approaches if the young person was in juvenile detention or a residential care facility, the reasons for which are unclear. This area requires further research.

Views from consultees were supportive of the notion that engaging birth families and foster and kinship carers is crucial. The remainder of this section provides a summary of the consultees' views about approaches for families.

A number of different types of supports were identified by consultees for the carers of children and young people with PSB in OOHC, as well as the birth parents of those children and young people (including those whose children are currently in OOHC). However, one member of the FACS group noted that there are 'huge gaps with equipping families [and] carers about how to work with…young people [engaging in PSB].'

Consultees noted that for carers, support includes:

- specialised training and support for Therapeutic Foster Carers[41]
- higher rates of pay for foster carers (because of the complexity of the young person's needs)
- training for OOHC carers on issues such as the impact of trauma on the brain
- information for carers of children and young people engaging in PSB on a range of practical issues such as protecting other children in the household, responding to PSB, and talking to the child about the behaviour[42]
- therapeutic support (delivered by private practice) (e.g. a family therapeutic approach).

In a review of existing studies, South et al. (2015) identifies other types of support required to meet the needs of caregivers of children engaging in PSB in OOHC. These include:

- addressing the practical aspects of training and support programs (e.g. balancing competing demands)
- additional support for kinship carers (as there may be a family history of sexual abuse)[43]
- holistic support for caregivers (e.g. information on children's backgrounds, caregiver education, safety planning)
- long-term training, support and treatment programs for caregivers
- providing caregivers with information about normative sexual development of children — including information about relevant history of children in their care and the needs of children engaging in PSB.

Importantly, South et al.'s (2015) review found that all the studies they identified which evaluated training, support or treatment programs for children engaged in PSB reported that caregivers expressed satisfaction with, and a perceived need for, training, support and treatment.

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[41] Mr Tolliday noted that Therapeutic Foster Carers in NSW were “rare”, in comparison to Victoria.

[42] One specific resource mentioned by the FACS group was a booklet for parents and carers entitled "Is this Normal? Understanding your child's sexual behaviour" produced by Queensland Family Planning.

[43] Kinship carers tend to receive fewer services and supports than non-kinship carers (Lin, 2014).

Mr Tolliday notes that NSS works with the foster care agency and the case manager to determine the most appropriate support for the OOHC carer.

For birth families where the child or young person is still living with the family, supports include:

- assistance to develop a safety plan (e.g. separating children into different bedrooms, putting locks on the bathroom door)
- information for parents on PSB[44]
- therapeutic support (private practice) (e.g. a family therapeutic approach).

For birth families where the child or young person is in OOHC, Ms Luchi noted a lack of supports in private practice and Mr Tolliday noted a 'broad lack of connection with relinquishing families' in the OOHC system generally.

The FACS group noted that support for relinquishing families will depend on the context. The types of support mentioned for this cohort (including, but not limited to, those supports provided within private practice) were:

- involvement in case planning, in those cases where there is a plan to reunite the family
- advocacy by the child protection worker or carer to reinitiate contact between the birth family and the child.

Ms Luchi noted a specific concern regarding families that have been reunited after a child with PSB has been living in OOHC:

> 'Sometimes, after children are initially separated with parental agreement, very little happens to address the [PSB] or the context in which it arose. [Because separation has occurred]… the risk level has apparently decreased for the victimised child… and intensive case management is seen as less of a priority. Professionals can be stuck here as there can be very few places to refer these children for informed, targeted intervention. Time goes by and parents start to wonder when their children can be re-united. The families sometimes slip off the child protection radar. The family re-unites and we don't know what happens after that. That's where… really good private practitioners have a place.'

Ms Luchi noted that in such cases, there's often less case management support available than there would be for a child who is unable to return to their birth family.

4.7. What skills, qualifications or training are required of statutory child protection workers or out-of-home care staff to identify and respond to problem sexual behaviour?

Seventeen of the 35 papers reporting evaluations in the REA indicated that training was provided to staff. Sixteen of the REA papers did not report the qualifications of staff responding to PSB. When reported, approaches were staffed by psychologists, psychiatrists, social workers, medical professionals, therapists or clinicians. These professionals were also typically involved when considering the more severe end of

[44] See footnote 42.

the PSB continuum, particularly when sexual offences had occurred and more intensive treatment was required. Further investigation regarding appropriately qualifications would be ideal.

Furthermore, no information was gleaned from the REA regarding the training, qualification and skills required when addressing less severe kinds of PSB, or when aiming to prevent PSB. This needs to be addressed in further research.

Given these gaps, the remainder of this section includes consultees' insights into the skill, training and qualification requirements of staff working with children and young people who may engage in PSB.

4.7.1. Child protection workers, counsellors and therapists

Ms Want and Ms Luchi both identified skills, qualifications and/or training required of statutory Child Protection, counsellors and therapists. Ms Want described the skills required for counsellors and therapists as:

- an ability to work with children who have experienced trauma
- familiarity with assessments[45]
- a capacity to be directive
- a capacity to work in a family-focussed and collaborative way (e.g. working with other services)
- an ability to identify the boundaries of their responsibilities (e.g. trusting that a health practitioner is able to provide adequate therapy to a child).

In regards to qualifications, Ms Luchi identified a trend towards employing child protection practitioners with nursing or teaching backgrounds and, as a result, a decrease in practitioners' capacity to assess, observe and respond to PSB. She argues that in order to work with children and young people engaging in PSB — and to work with children and young people who have experienced significant levels of trauma — practitioners require specific qualifications that are relevant to the field, such as social work, welfare or psychology. She notes that qualifications that are unrelated to the field typically do not translate to good practice. Ms Luchi's observation regarding staffing qualification requirements are consistent with the staffing, where identified, in the REA.

In general, Ms Luchi notes that, although there have been great improvements in some areas of practitioners' knowledge of PSB, it is her opinion that the lack of knowledge generally in NSW is still 'unacceptably high.' She advocates for specific training for practitioners who are going to be coming into contact with children and young people who might be engaging in PSB, noting that:

> 'Education is one of the keys because [PSB] is one of those areas that can be easily missed. It's inherently a secret kind of behaviour, it's a behaviour that is riddled with denial, secrecy and grooming behaviour, so education around this is really important.'

[45] The consultee did not specify which assessments she believed child protection workers needed to be familiar with.

Ms Luchi also noted that at the request of the Department of Community Services, she developed a training package for Joint Investigation Response Teams (JIRTs) that focuses on safety planning for adolescents with sexual behaviour problems.[46] The package focused on trauma-attachment practitioner work, based on current research, and encouraged a holistic, trauma-informed approach to understanding the problem.

4.7.2. Out-of-home care staff

The Victorian DHS advocates for training for carers of children in OOHC who are engaging in PSB to 'orient [the carer] and support them in assisting the child in their in care, because generally the behaviour is the symptom of an underlying, more complex issue' (Evertsz & Miller, 2012, p. 36). The Tasmanian Sexual Assault Support Service states that carers of children engaging in PSB need to 'have the appropriate skills, knowledge and attitude to support children to manage and gain control over their behaviours' (Sexual Assault Support Service, 2012, p. 46). South et al. (2015) identified numerous training and support measures for caregivers as key practice elements in interventions involving the prevention and treatment of PSB among young people in OOHC. For example, the interventions highlighted the need for caregivers to have knowledge of normative sexual development of children and information at the time of placement regarding the history of 'sexually abusive children' (p. 30).

The current REA found that only five of the 14 approaches for children in OOHC settings reported that personnel were trained. Consultees identified a range of different types of training for OOHC services and carers.

New Street Services provides structured training for OOHC services to enhance their skills in regards to understanding trauma, sexual behaviour, sexually harmful behaviours, and how to respond when issues arise in care. An Aboriginal version of this training package has been developed.[47]

The type of training provided to OOHC workers by New Street Services revolves around identification and response. Mr Tolliday describes the process of identification and response in terms of multiple 'layers' — some children and young people need re-direction and distractions, others need a more structured, consistent approach and a small proportion require specialist intervention. He identifies the required skills as identifying, assessing and communicating.

South et al. (2015) recommended the 'need for specific training and support for OOHC caregivers in their role as caregiver for children who are sexually abusive' (p. 30).

In line with this, Ms Want noted that carers in OOHC agencies:

[46] JIRTs comprise Community Services, NSW Police and NSW Health professionals. JIRTs undertaken joint investigations into child protection matters (Department of Community Services, 2016). Ref: http://www.community.nsw.gov.au/for-agencies-that-work-with-us/child-protection-services/joint-investigation-response-teams

[47] The Aboriginal version was developed with and delivered (or co-delivered) by Aboriginal staff.

> 'must not only be informed about the PSB of children in their care but must also be provided with ongoing support and training so they are in a better informed position to respond to and manage the behaviours of children in their care. The involvement of carers in therapy is critical as they are the ones who primarily care for and support the child. They must also be supported in this role'.

She also noted that Rosie's Place works with OOHC carers to understand the importance of 'interactive repair' when caring for children, which involves:

> 'always responding to the behaviour and then responding to the child in a separate way. Not blaming, not shaming. Naming the behaviour as 'not okay, because it's not safe for you and it's not safe for other kids''.

Ms Want noted there are many programs in the area, she pointed to work by Dan Hughes and Kim Golding, Toni Single and the Circles of Security programs as examples.

Consultees also noted a number of concerns in regards to training for OOHC services and carers. Mr Tolliday expressed concern about the use of online training packages for educating the OOHC sector about PSB because the online method of delivery does not allow for sufficient discussion of the complexity of the issue.

> 'Online training [is] too much black and white…any sort of training in this space…needs to be face-to-face.'

He also expressed concern about training packages or resources that may suggest that a certain behaviour is definitely *not* a concern when in actual fact this behaviour *may* be of concern, depending on the context within which it is taking place.

> 'You have to ask, well what does [this behaviour] mean for the family, how much time is [the child] spending [engaging in this behaviour], is it interfering with the other parts of his life? [The child] could… also have an emerging mental illness, and he's using [this behaviour]… to mediate what is emerging.'

In response to these concerns, at the time of writing, Mr Tolliday gave information regarding a symposium being planned to address the issue of skills and knowledge required regarding PSB in OOHC. This is due to be held in 2016 by The Australian and New Zealand Association for the Treatment of Sexual Abuse, an organisation in which Mr Tolliday is a member. The main speakers are from the UK and have extensive experience in the foster care system and in relation to PSB specifically.

The Victorian Royal Commission into Institutional Responses to Child Sexual Abuse advocates that community service organisations 'should, wherever possible, recruit staff who have a combination of relevant qualifications and the appropriate personal skills and attributes' (Victorian Government, 2015, p. 31). The FACS group noted that the majority of OOHC carers would not have the entire set of skills they need to have and in regards to residential care, both Mr Tolliday and Ms Luchi noted a concern regarding the skills and qualifications of staff. Mr Tolliday stated:

> 'Resi[dential]-care… is probably the most challenging service to work with. [It's a] casual workforce, young, quite unskilled [in responding to PSB], [and has] high turn-over.'

Mr Tolliday noted that as a consequence of this lack of skills and qualifications, certain procedures are poorly managed, such as the process of deciding which children should be placed together, 'the worst case we had of this was an 11-year-

old girl being placed with three 13-year-old boys, two of whom were New Street Services clients.' The FACS group highlighted the importance of residential carers' ability to 'be a part of and help identify [a] safety network for [the] child [in their care]' because young people who are socially connected are less likely to re-offend.

This concern regarding the skills and qualifications of residential care workers is not confined to NSW. In a report on PSB of children and young people in Tasmania, the Tasmanian Sexual Assault Support Service (SASS) noted the Tasmanian Government's claim that 'staffing of some residential care arrangements is characterised by staff that do not have specialist professional training or accreditation…This has resulted in situations where the only service provided to the most chaotic and vulnerable children is adult monitoring rather than specific care intervention' (Sexual Assault Support Service, 2012, p. 47).

Since the OOHC sector moved from FACS Community Services to the NGO sector, Ms Luchi has observed a decrease in skills and qualifications in the sector — especially in residential care — which may have led to a decrease in the sector's capacity to apply foundational social work, psychology or welfare principles to understanding an issue like PSB. Ms Luchi also expressed an interest in coaching for carers so they can become 'informed supervisors.' She sees this as a gap in the foster care system:

> 'The problem is we ask…foster carers to supervise…children with problematic sexual behaviours but we don't define what effective supervision of these children is.'

It is worth noting that there is some guidance in the literature on this particular issue. Notably, Ryan (2011) provides an outline of what effective supervision means in this context. An 'informed supervisor' (i.e. the primary caregiver) needs to fulfil 11 requirements including: 'does not deny or minimise the youth's responsibility for, or the seriousness of, abusive behaviours'; 'is aware of the dynamic patterns associated with abusive behaviours and is able to recognise such patterns in everyday functioning'; and 'clearly articulates the rules governing the child's behaviour in their daily lives' (Ryan, 2011, p.232-233). South et al. (2015) also note the importance of supervision of young people engaging in PSB in OOHC, noting that supervision includes, but is not limited to: tight house rules, supervised play with other children, and installing intercom systems and alarms so caregivers know when children have left their bed at night.

It is also worth noting a joint initiative that sought to provide better support and consultation to residential carers to develop their knowledge and skills in caring for young people who have caused sexual harm. This included on-site consultation to residential care staff, regular liaison involving therapeutic treatment providers and residential care staff, and attendance at care team meetings (of residential care staff). The initiative demonstrated 'very positive outcomes for the care and support' of young people in residential care (Child Protection Society as cited within Sexual Assault Support Service, 2014, p.31).

4.7.3. Other training

In addition to training for Child Protection workers and OOHC services and carers, other forms of training that were noted included:

- Internal training for staff (at NSS) regarding working with diverse groups. This training package includes a series of modules including Aboriginal cultural competence.
- Mr Tolliday noted a training strategy for the NSW Health workforce to provide at least four service points for children under the age of 10 engaging in PSB, in each of NSW's 16 Local Health Districts, as well as the Children's Hospitals Network in Sydney. The FACS group noted a similar scheme whereby the Department of Health was aiming to 'skill up' their child and adolescent health units to treat children under the age of 10 years who are engaging in PSB.

4.8. What proportion of children and young people displaying problem sexual behaviour are also victims?

As noted previously, it was once assumed that the majority of children who engage in PSB have sexual abuse histories themselves. Sexual abuse is a risk factor for PSB; however, it is not clear to what extent one influences the other. A recent study found that, although a prior history of sexual abuse was an important contributor to later sexualised behaviour, only 4% of sexual offenders as adolescents or adults had confirmed sexual abuse histories (Leach et al., 2016).

In contrast to these findings, a history of some form of abuse was common amongst the participants in the studies included in the REA. Of the 35 papers reporting evaluations of approaches, 20 indicated that a proportion of the participants had a history of some form of abuse (12 papers did not report this information).

Consultees' views on history of abuse in children and young people engaging in PSB confirmed these findings. Both Ms Want and Ms Luchi noted that, in their experience, young children displaying PSB (under the age of 10–12) have all experienced significant trauma, including sexual abuse. Ms Luchi noted that in her practice, for children under the age of 12, *all* of those who displayed PSB had been sexually abused in some way:

> 'The proportion of [children] who [engage in PSB] behaviours in the absence of their own sexual victimisation…is very, very small.'

Among children over the age of 12, Ms Luchi noted that the picture is 'more complicated' but her view of the research suggests violence — especially domestic violence — is a common factor.

Ms Want also highlighted the association between PSB and exposure of children to violence and abuse, including domestic violence, emotional abuse, sexual abuse and neglect. Complex trauma, in the context of cumulative harm, seems to be evident when working with children with PSB. Among young children who engage in PSB she noted that that the most common form of trauma they had experienced was domestic violence, followed by drug and alcohol abuse and parental mental health, followed by sexual abuse.

Ms Want noted that, in addition to these traumatic experiences, young children who engage in PSB are typically living in disadvantaged circumstances (e.g. social isolation, limited resources, and violent neighbourhoods). She stated that, as Rosie's Place is located in a disadvantaged community, there must always be consideration of the socio-political context of children's and families' lives when addressing trauma and PSB.

> 'Social isolation, shattered families, poverty, lack of resources, exposure to community violence and fragmentation must be considered. Children don't grow in isolation, families don't grow in isolation and where they grow and how they are supported to grow matters.'

This is backed by current evidence which indicates that children who engage in PSB typically come from families with very low income levels (O'Brien, 2010; Staiger, 2005).

Ms Luchi noted that although some children and young people who engage in PSB come from privileged backgrounds, in almost all cases there are fundamental and significant problems in the family that are causing them to engage in coercive behaviour.

> 'I always promote, in my training, [the message] that you are not born into the world with a propensity to sexually abuse. It comes from somewhere. Most typically it comes from learning coercive dynamics [in combination] with unhealthy sexual [experiences] or traumatic sexualisation.'

The association between trauma and PSB is also noted in research. High rates of physical, emotional and sexual abuse are evident among children and young people who engage in PSB.

Mr Tolliday noted a gender-based difference at NSS — all the girls and young people who are NSS clients have 'trauma histories'. Recent data indicated that of the 30 girls attending the service, all but one girl had experienced multiple traumatic events involving multiple offenders. However, Mr Tolliday estimates that in comparison, two-thirds of the boys and young men that come to the service have a trauma history — even though the referral reports indicate a much lower rate of trauma (around 40%).

4.9. Summary

This findings section of the report has presented the evidence for various approaches to responding to PSB in children and young people in different settings, including OOHC. This information was derived from a REA and from consultations with members of with the child protection field. These findings have been concluded and complemented with consultee views on the state of the field and resources to support children, young people, families and staff.

5. Discussion

This review provides an assessment of the evidence for approaches to prevent and respond to PSB in children and young people. It also provides perspectives from members of the child protection field on practice, policies, standards and staffing. In this section we summarise the findings and gaps in the evidence and practice, discuss factors to consider when implementing approaches in the NSW OOHC context, and provide some recommendations. An overview of the recommendations, detailed later in this section, is provided in Box 4.

5.1. Summary of the findings

This section of the report draws together the findings from the various aspects of the review, such as demographics of the populations included in the review, and an overall assessment of the state of the evidence.

5.1.1. Included papers

The REA identified 47 papers relevant to preventing or responding to PSB in children and young people. Thirty-five papers reported 30 evaluations of 26 approaches for preventing or responding to PSB; 10 approaches related to OOHC settings, 10 approaches were in other settings, and six approaches included a mixture of children with their birth families or in OOHC. Five of the 47 papers were systematic reviews, and seven were evaluations of legislation on mandatory registration of juvenile sexual offenders designed to deter and prevent sexual recidivism.

5.1.2. Countries where the studies were conducted

The majority of the 35 papers evaluating approaches were from the USA (n=20), with one of those also involving Canadian participants. A further two papers were from Canada. Six papers were from Australia, with three of those from NSW (two New Street evaluations and one New Pathways). Three of the papers were from New Zealand and two from the United Kingdom. The remaining two papers were from South Africa and Turkey.

5.1.3. Approach delivery, mode and setting

Of the 26 approaches included in the REA, only one aimed to prevent PSB. The remaining approaches were designed to treat or intervene. Approaches were more often delivered in both group and individual modes (n=12), rather than individual alone (n=8) or to groups (n=6). Delivery location was varied; however, approaches were more often delivered in clinic settings (n=9) or in the young person's residential care facility (n=6). Two approaches were delivered in juvenile detention, two in the home and two in various settings. Other settings for delivery were: an inpatient facility, a combination of school and home, school, camp, a combination of home and clinic. No approaches found in the REA addressed approaches for child protection practitioners.

Box 4: Recommendations

1. Base practice on a sound theoretical framework

In the absence of a strong evidence base for preventing and responding to problem sexual behaviour (PSB), practice should be based on a sound theoretical framework, for example, systemic frameworks, Cognitive Behavioral Therapy (CBT) frameworks or a narrative approach.

2. Trial new approaches in the Australian out-of-home care setting

Multisystemic Therapy – Problem Sexual Be**havior (**MST-PSB), and approaches based on CBT frameworks have been widely researched in the international literature but not in Australia and not in out-of-home care (OOHC) settings. MST-PSB shows good results for young people with more severe PSB. As such, the next step in responding to more severe PSB in OOHC should be to trial MST-PSB and approaches based on CBT frameworks in Australia and in the OOHC setting.

3. Establish plans for the implementation and ongoing evaluation of approaches

Prior to commencing implementation of approaches, clear plans should be established for how implementation will be carried out and monitored. Approaches, both established and adapted, need to be evaluated for efficacy and effectiveness.

4. Investigate and evaluate prevention and early intervention strategies

This review found little guidance for prevention and early intervention of PSB and so further investigation is needed. Guidance may be available in the literature on PSB approaches that have not been evaluated, or from outside the PSB field. Behavioural management approaches may represent a suitable option.

5. Involve and engage children, young people, families and carers

Engagement and retention of children, young people and families in any approach is vital to improving outcomes. Children and young people need support to engage in approaches. Involving birth families and carers can potentially foster the engagement of children and young people.

6. Investigate current and required training and support needs of out-of-home care staff, child protection staff, and carers

This review has highlighted a need for more information on training and support for staff and carers, acknowledging that different staff and carers may have varying needs. Staff and carers need to be supported and trained to have the skills, knowledge and capacity to suitably identify and respond to PSB in children and young people.

7. Investigate current and appropriate qualification requirements for all out-of-home care staff, child protection staff and therapeutic staff

A need for more information on the qualification requirements of staff working with children and young people engaging in PSB has been emphasised in this review. Some approaches may have minimum qualification standards. Ensuring staff have the requisite specialist skills and qualifications is necessary for providing effective responses to PSB.

8. Investigate effective ways of engaging and collaborating with kinship and foster carers, residential care workers and other stakeholders

Findings of this review demonstrate a need to consider the whole context in which PSB is occurring and to take a holistic approach to support for children and young people. Collaboration with all agencies and personnel involved with the child is critical to care.

9. Investigate appropriate approaches for supporting targets of problem sexual behaviour

Little guidance was found in this review regarding supports for children and young people who are targets of PSB. Guidance may be available in the literature on PSB approaches that have not been evaluated, or from outside the PSB field, such as in the literature on child sexual abuse where the perpetrator is not specifically another child or young person.

5.1.4. The children and young people

Of the 35 papers reporting evaluations of approaches, 20 indicated that a proportion of the participants had a history of some form of abuse (12 papers did not report this information). The statements from the consultees were in strong agreement with this, as they noted that the majority of young people engaging in PSB tended to have a significant history of abuse and trauma in their background. Consultees also noted that many young people who engage in PSB come from environments with multiple factors that create vulnerabilities, such as domestic violence, histories of abuse and trauma, social isolation and deprivation.

The consultees also noted potential differences in the rates of previous trauma according to gender and age. They indicated that younger children more frequently have trauma backgrounds in comparison to adolescents, and that females almost always have experiences of trauma. They reported that adolescent males tend to have greater variation in their backgrounds, but a large proportion have a history of trauma or abuse. Prevalence studies were not included in the current REA, and as such, it cannot be certain whether these views are consistent with current research. However, they do appear consistent with the populations studied within the REA.

Only five of the 35 papers evaluating approaches were for children aged 10 years and under. These approaches included CBT, behaviour therapy, the Transformers Program and the Intensive Program. The bulk of the papers included young people over 12 years of age. Overall, 28 of the included papers had samples of young people with a mean age between 10 and 17 years, six with a mean age between 0 and 10 years (with some age ranges including children older than 10) and one paper not reporting age. The consultees also noted that until now there has been limited guidance in practice for working with under-tens.

Nineteen of the 35 papers in the REA reported studies that included at least 97% males, while only one was exclusively a female sample (one of the behaviour management studies). Females were often excluded from analysis due to small numbers, or offered modifications of the main approach being offered.

5.1.5. Severity of problem sexual behaviour

In regards to severity of PSB, 25 of the 35 papers evaluating approaches for young people with PSB referred to the young people as 'sexual offenders'. The majority of the other studies involved approaches for children and young people engaging in PSB that was considered severe or clinically significant, rather than approaches that could be considered early interventions. With the exception of one case study (Patterson & Scott, 2013), all studies reported that a proportion of the sample were engaged in PSB that included, at minimum, inappropriate touching of other children or young people.

5.1.6. Child outcomes

All 35 of the papers identified in the REA reported outcomes relevant to the mental health outcome domain outlined in the QAF. All 35 of these related to PSB outcomes, typically referred to as sexual recidivism, with other behaviour or mental health outcomes occasionally assessed also. Social functioning outcomes were reported in seven papers, permanency in three papers, and cognitive functioning outcomes in two papers. No papers reported cultural and spiritual identity, or physical health and development outcomes. Interestingly, none of the consultees

referred to recidivism. Their focus was more broadly on the whole child or young person. However, it should be noted that they were not directly asked about outcomes of interest in their work. Although the review is therefore not able to comment more broadly on the outcomes targeted in approaches in the NSW context, it should be noted that when examining New Pathways, Milne et al. (2009) did measure outcomes related to cognitive and social outcomes in the QAF, as well as mental health

5.1.7. Supporting targets of problem sexual behaviour

No studies were found for approaches that focussed on supporting the targets of PSB. This does not necessarily mean that these approaches do not exist. It may be the case that such approaches are covered in the literature concerning childhood sexual abuse. Further research in this area is needed.

The REA found that targets of the young person's PSB often included a wide mix of peers, children, family, adults and animals. As such, no studies excluded young people based on the target of their PSB, or developed approaches with particular targets in mind.

However, it was noted in the consultations that particular practice points are required when working with young people in families where sibling abuse has occurred. Ms Luchi and the FACS group noted that NSW has a sibling case-coordination policy for use when responding to cases of sibling abuse. Little other evidence or guidance was identified for supporting targets of PSB.

5.1.8. Specific populations

Five papers evaluated approaches specifically for young people with a developmental delay, learning difficulties, intellectual disability or diagnosis of autism spectrum disorder, or noted that they could be modified for these young people. Ten papers also included young people diagnosed with a mental illness in their sample. Nine papers did not report on different abilities in their sample. Some approaches, such as MST-PSB and the RCT examining CBT, actively excluded young people with different abilities from participation. Given young people with PSB are found to have a varied mix of abilities, these modifications require further consideration and testing.

The majority of papers examined approaches responding to PSB in non-minority or non-CALD backgrounds. Five papers aimed to modify or include indigenous, Maori or other CALD groups in their approaches. These were New Street Services, the GYFS, the Fight With Insight approach and the New Zealand-based approaches. Mr Tolliday noted that, within the New Street Services, policies for young people in OOHC were in use as well as policies pertaining to work with Aboriginal and Torres Strait Islanders clients.

The majority of papers also examined approaches responding to PSB with a primarily male sample. As such, it is difficult to know if any differences in gender exist or if approaches are equally effective for both males and females. One paper did compare outcomes by gender (Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: Preschool Program) and it is interesting to note they found outcomes for females improved at a significantly higher rate when compared to males. This indicated potential differences in the effects of an approach based on gender, but this requires much further consideration and research.

5.1.9. Caregiver involvement in support for children and young people

A consistent finding to emerge from the REA and consultations is the need for caregiver involvement in approaches responding to PSB in children and young people. Twenty-eight of the 35 papers identified in the REA that reported evaluations of approaches stated that the approaches included some degree of family or caregiver involvement. The aim of involving families was often to education parents and carers on the nature of PSB and normal sexual development, and to provide them with assistance and training in managing PSB appropriately.

We also found evidence that children and young people were more likely to complete approaches when they had caregiver involvement (Belton et al., 2014; Smallbone et al., 2009). Engagement in approaches is vital, with some studies finding that outcomes were worse for those who dropped out compared with those who received no treatment (Laing et al., 2014; Lambie, 2007).

The views of the consultees were also highly supportive of an approach that engaged birth families, caregivers and foster and kinship carers. They noted the importance of training and supporting carers in responding appropriately to PSB and also training and supporting OOHC staff and private practitioners in working with carers.

A study by Yoder, Hansen, Lobanov-Rostovsky, and Ruch (2015) highlights the need for family involvement in services. These authors conducted an evaluation of family involvement in services for children and young people with PSB. Results from the study suggest young people with higher family involvement in services, and those living in the family home, were more likely to successfully finish treatment. Although family service involvement showed little association with recidivism, young people in an in-home living situation were less likely to recidivate.

Less information was found in the REA regarding supporting birth families to understand and manage PSB following separation and when managing reunification. The exception to this was the New Pathways approach delivered NSW. In support of this, consultees also noted a lack of connection between OOHC services, private practitioners and relinquishing families, and suggested greater training and support was needed on the ground in this respect. They noted significant concern regarding the lack of guidance in this area.

Findings of the REA suggest that 75% of the approaches delivered in OOHC settings involved families (OOHC or relinquishing) to some extent. In contrast, all approaches in non-OOHC settings or in a mixture of OOHC and other settings involved families, predominantly the birth families. The approaches in the OOHC setting that did not involve caregivers tended to be in the juvenile detention setting, or an aspect of an approach that involved the child practising a strategy individually (e.g. covert sensitisation). This does not mean that engagement of birth parents and carers in these circumstances is necessarily less important, but that it may currently be under-used or under-represented in the literature. Given the importance of a young person's environment when managing PSB, much more consideration needs to be given in the literature regarding the influences of relationships with birth families after separation and after reunification on successful management of PSB in young people.

5.1.10. The context in which problem sexual behaviour occurs

As context is critical to PSB, the importance of a well-rounded, systemic approach was evidenced in the comments of the consultees and in several approaches in the REA; most notably MST-PSB, which is driven by ecological systems theory. This refers to assessing, understanding and attempting to address factors in the child's environment not specific to the individual psychology or biology of the child. For example, this includes taking into account family relationships, quality of role models, discipline structures, the array of services involved with the young person and family and the broader community when supporting children and young people. Consultees reported a view that a therapist *only* working one-on-one with a child is typically not an effective response to PSB. The practice standards uncovered during consultations also point towards the importance of considering and addressing the whole context within which the PSB is taking place, and the whole context of the child in delivery of services and supports.

When considering the whole context, this typically includes:

- working in a holistic way that considers all aspects of the child
- engaging and collaborating with multiple stakeholders (e.g. child or young person, family, foster or kinship carers, residential care staff, early childhood setting or school, doctor, social worker, counsellors and case workers)
- undertaking ongoing assessment of the child or young person's environment
- consideration of the service and broader community context
- supporting the caregivers and engaging the birth family for children and young people in OOHC (as stated above).

An accurate understanding of the context in this way allows for appropriate treatment and response to PSB, including safety planning. This then leads to an appropriately individualised approach being taken with the young person, which the consultees believed was highly important.

Although working in this way is important, in practice it appears complex and successfully working in this way may depend upon a number of factors outside of a practitioner's control. Consultees indicated practitioners often have multiple difficulties working with the whole context and that their capacity to do so depends on their workplace. They stated it may be easier for professionals working within larger non-government organisations and government to work in the above manner, when compared to professionals working in isolation (e.g. private providers). This is due to the combined capacity of these larger, well-networked organisations and these organisations often providing capacity for professionals to work in such a way. On the other hand, the consultees noted that the funding model and supports inherent in private work may restrict the ability of these practitioners to provide such treatment.

5.1.11. Qualifications, training and support for staff and carers

The importance of qualifications, training and skills of staff working with children and young people with PSB was another key finding of both the REA and consultations. Seventeen of the 35 papers reporting evaluations in the REA indicated that training was provided to staff. Of those that did, the approaches were predominantly concerned with addressing severe PSB and were often staffed by, at minimum, masters-level trained therapists (e.g. psychologists, psychiatrists, social workers,

medical professionals, therapists or clinicians). This may point to a need for higher qualifications when working with young people with severe PSB.

The views of the consultees also stressed the importance of qualifications, training and support of child protection, OOHC and residential care staff. One consultee, Ms Want, was of the opinion that an increasing number of child protection staff in NSW come from nursing and teaching backgrounds. She raised concerns regarding whether these qualifications were sufficient when working with children and young people who are especially vulnerable and have experienced significant trauma.

A number of consultees raised a similar concern with the overall training and support provided to residential care workers in this respect. They felt that some OOHC workers need further support to work effectively with children and young people who engage in PSB, and they expressed specific concerns regarding the knowledge, skills and capacities of residential care workers in this respect. They noted observing benefits to outcomes for young people and families when this support and training was appropriately provided and described training currently being provided on the ground, which they believed was effective for this purpose.

Analysis of relevant data regarding current training and qualifications of child protection and OOHC workers would be required to determine the current and required qualifications and training and whether they are effective. As such, it is not currently possible to ascertain the match between staff qualifications and training in the REA and in the NSW field.

The findings of this review highlight that more consideration needs to be given to the knowledge, skills and capacity of kinship and foster carers, as well as residential care staff. Where a child or young person engaging in PSB is not living at home, the capacity of the caregiver(s) to support them with issues such as PSB is especially important. Children and young people in OOHC have typically experienced significant levels of trauma, and as such are likely to require a more intensive level of support than children and young people engaging in PSB who are still living with their birth parents. Additionally, young people in residential care may arguably be at greater risk of becoming victims of PSB (perpetrated by other residents) as a result of social isolation and lower rates of supervision and monitoring in a residential care setting. This makes the supporting and the skilling-up of residential care workers of paramount importance when aiming to reduce or prevent PSB in these settings.

Training, support or appropriate qualifications for staff are important for a number of reasons. These are to ensure the professionals involved with young people have the knowledge, skills and capacity to:

- promote engagement with approaches
- work in a holistic way
- engage and collaborate with multiple stakeholders
- undertake case management
- engage the birth family
- assess the child or young person's environment on an ongoing basis
- support the caregivers to address those factors within their environment that are contributing to the behaviour.

5.1.12. Quality of the evidence

Systematic reviews are the most rigorous method for reviewing the quality of evidence. In the REA, we identified five systematic reviews; four evaluating the effectiveness of juvenile sexual offender treatments and one evaluating the effectiveness of approaches for children with PSB aged 12 and under. Consistent with the evaluations of specific approaches and with the consultations, results from the systematic reviews indicated that the quality of research in this area overall was quite low.

Of the 26 approaches assessed for effectiveness in the REA, one was rated Supported (MST-PSB) and one was rated Emerging (Group CBT); both were outside the OOHC context. One approach (Gender violence/Sexual harassment prevention program) had some positive findings in an RCT, but it did not demonstrate effectiveness as a PSB prevention approach.

The remaining approaches have not been evaluated rigorously enough to determine if they are effective for improving outcomes. This is not to say that they do not work, the evidence just does not yet allow us to determine this. Studies often had small sample sizes, a lack of randomisation and no comparison group. Fourteen papers included a comparison group. Again consistent with findings in systematic reviews, MST-PSB and approaches based on CBT were most frequently evaluated with a comparison group. The remaining approaches that included a comparison group were New Street Services, the New Zealand-based approaches and the Transformers Program. Three papers were also found to be case studies, the least rigorous type of evidence. These examined behaviour therapy and CBT in an OOHC setting. In the absence of more rigorous research, it is not possible to determine if these approaches work, or if they may possibly have harmful effects.

Harmful or unintended effects are not always considered, even in rigorous research, but may be more likely to be researched in medical interventions. For example, two papers in the REA evaluated the effectiveness of pharmacological interventions, mirtazapine and naltrexone. The quality of this research was low, with no comparison groups. In addition, all young people in these studies were concurrently taking other pharmacological medications for mental health concerns or behavioural management purposes, making it difficult to determine which medication resulted in which effects. The study examining naltrexone was also found to have issues with informed consent at the beginning of the approach, leading to concerns in regards to the quality of this evaluation beyond the research design. The side effects inherent in such treatments are also worth consideration. In regards to mirtazapine, all young people were found to have experienced at least one significant side effect. It is also unclear how side effects may differ depending on the combination of medications taken by young people. While these limitations do not seem encouraging, in the absence of more rigorous studies, it is not possible to make definitive determinations about these treatments.

It is also worth noting that none of the consultees mentioned the use of pharmacological treatments. It is unclear to what extent pharmacological treatments are being used in Australia for children and young people who engage in PSB. As it is also unclear whether the benefits of these medications outweigh the side effects and potential risk of harm to young people, much more stringent research in the area is required.

Additional to interventions, services and programs described above, seven papers were found in this REA evaluating legislation regarding juvenile sexual offender registration. Findings indicate that there is little evidence to support this approach, as there was no difference in recidivism rates of those placed and not placed on registries (Batastini et al., 2011), registration was not found to be a good predictor of future sexual offending (Caldwell & Dickinson, 2009), sexual recidivism of young people placed on registry and those not registered was equally low (Letourneau & Armstrong, 2008), implementation of sexual offender registration legislation was found not to act as a deterrent (Letourneau et al., 2010), and registration did not result in a risk of new adjudications (Letourneau et al., 2009b). Further to this, findings suggest that prosecutor decisions regarding serious sexual assaults were unintentionally impacted by the implementation of legislation. After implementation of the legislation, prosecutors were less likely to move forward with prosecuting sexual and non-sexual assault charges (Letourneau et al., 2010), perhaps due to the potential implications of conviction — that is, registration for 25 years to life. Further consideration of this approach, weighing the benefits against potential risks, are needed.

MST-PSB and CBT were the most frequently evaluated approaches, with more rigorous designs employed in the evaluations of MST-PSB. These approaches receive further consideration below.

5.1.13. Multisystemic Therapy – Problem Sexual Behavior

Three studies across five papers were identified that evaluated MST-PSB in a general setting. Overall, it was found that MST-PSB as an approach is useful in reducing PSB and rates of reoffending with an effectiveness rating of Supported found in this review.

Limitations of this research were noted through consultations and in findings of the REA and should be kept in mind. MST approach requirements include strict inclusion and exclusion criteria — young people in OOHC, not engaged in work or school or with severe mental illness or disability are typically excluded from evaluations. This makes generalising the results of MST-PSB to young people in OOHC or with different abilities difficult. Given the complex and multi-factorial vulnerabilities typically present in the home environments of these young people, this presents as a significant limitation to the potential usefulness of MST-PSB in general, as well as in the OOHC setting.

Consultee Mr Tolliday also noted that the comparison groups in the research are often unclear and that these usual approaches would be different to those offered in Australia. In addition. Mr. Tolliday noted that it can be difficult to successfully implement MST outside of the USA, and that evaluations of MST are often done by the approach designers or collaborators, presenting a potential perception of a conflict of interest. These limitations can be addressed by extending evaluations of MST-PSB to include a diverse range of young people, and comparing MST-PSB in RCTs to another well-known approach, such as CBT.

At this stage, it appears MST-PSB has not been brought to Australia. Although we are aware that general MST is in use in NSW. Given this approach presents with the strongest evidence base in the literature at present, it may be of benefit to attempt to replicate these findings in the OOHC context and in the Australian context.

5.1.14. Cognitive Behavioral Therapy

While systematic review findings suggest that MST-PSB may have greater gains for young people than CBT, the use of some elements of CBT in several approaches reported here suggest this approach warrants further discussion.

Three papers evaluating a structured CBT approach in the general setting were found. These papers tended to focus on young people aged under 12, which is noteworthy given the majority of approaches in the REA were for older children. One paper with a particularly strong study design found that 12 sessions of Group CBT for both the young person and their caregiver was effective in reducing rates of reoffending. This approach was rated Emerging in the REA. One additional paper evaluating CBT involved a comparison group (Fight With Insight), while another involved no comparison group (Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: Preschool Program). These papers found a reduction in PSB and also some additional improvements in psychosocial functioning. Consistent with the REA, consultee Ms Want stated that CBT is one approach of many that can be useful for young people, as it is fairly directive and a directive approach can be beneficial for young people. These approaches would benefit from replication in the Australian context and with adolescents.

We found only one paper examining a structured CBT approach in an OOHC setting, and this was a case study. Although the authors found a reduction in recidivism risk in the young person examined, the strength of this evidence is extremely low.

Of note, 12 of the 35 papers reported evaluations of approaches that used CBT as the main theoretical framework, but did not identify their approach as a CBT approach per se. More often they labelled their approach as 'based on principles of CBT'. This includes seven of the 12 papers about approaches in OOHC settings, and one of the six papers with a mixed population. They included various components of the CBT model provided to both young people and their caregivers. Although not counted in the above number, it is also of note that the therapeutic approach offered to young people within MST-PSB is also based on CBT. Given these are not packaged CBT approaches, it is unclear how strictly they adhere to a CBT framework. It also makes it difficult to ascertain which approaches are or are not CBT when conducting reviews of the literature. This will need to be examined and addressed in further research.

According to the systematic review findings, there is an evidence-to-practice gap in the field. Although CBT is a popular approach in practice (primarily in the USA), the quality of evidence is low. In the Australian context, Ms Want noted that CBT may be the preferred approach of Australian private practitioners, particularly with young people. However, we did not survey any practitioners in the private setting, so this cannot be stated with certainty

Consultees also noted that using CBT as an isolated treatment tool may fail to consider the context within which PSB takes place. Consultees indicated that CBT may be best combined with other approaches, such as narrative and strengths-based approaches and perhaps that is why we see various elements of CBT mixed with other approach elements in the REA.

In sum, CBT appears to have been evaluated frequently in the literature and with an evidence rating of Emerging for young people under 12 engaging in PSB. However, it has not been evaluated in the Australian context and is more frequently evaluated

as a component of a wider package. Any differences in theoretical adherence may significantly alter outcomes and acceptability of the approach for young people and their families. Further research regarding CBT would benefit from higher quality studies, and studies that evaluate the essential components of CBT that offer benefit to young people. This would give practitioners greater direction in the approach they take with young people.

5.1.15. Summary

Findings from the REA and consultations indicate that some form of treatment for children and young people engaging in PSB is better than no treatment at all. Findings also highlight the importance of working with the caregiver and holistically within context of the young person's environment in order to bring about a reduction in PSB and improvements in psychosocial functioning. They also point to the importance of suitable supports for carers and staff working with these young people, as well as suitable qualifications and training for staff, and ensuring any approaches offered have flexibility to meet the individual needs of the young person.

Overall, policies, principles and standards in the Australian context appear to be consistent with current evidence-based thinking (e.g. involvement of the family, systems-based work). However, further thinking and research is required in regards to the amount of training and level of qualifications most appropriate for various approaches responding to PSB.

Although the effectiveness of any particular therapeutic approach in the Australian context at this stage is unclear, we rated MST-PSB as Supported for use in young people in the general setting and CBT as Emerging for the use with young people under the age of 12. Narrative and systemic approaches have begun evaluation in Australia, but require much further evaluation for their effectiveness to be established.

Prevention studies may be helpful in reducing victimisation, but their benefits to reducing perpetration are currently unclear. Pharmacological interventions have significantly poor-quality evidence, and the benefits of such interventions need to be weighed carefully against harms to the young person. The use of legislation involving mandatory registration of juvenile sexual offenders for preventing sexual recidivism does not appear to have benefits for deterring sexual offending or preventing sexual recidivism.

Given the popularity of CBT-based approaches and the strength of evidence behind MST-PSB for young people, these require further evaluation in an Australian and OOHC context — paying particular attention to which aspects of the CBT model prove beneficial.

5.2. Gaps in knowledge

While this review has illuminated several evidence and practice consistencies, there are still gaps in our knowledge and understanding of this complex issue.

Although MST-PSB is currently the approach with the best evidence for young people engaging in more severe PSB, this has not yet been implemented or evaluated in the OOHC setting or in Australia. In fact, evaluations of MST-PSB tend to exclude young people who are not in a stable living arrangement. As such, we do not yet know if this approach will result in improved outcomes in settings such as

OOHC. Likewise, there were no Australian evaluations of CBT identified. An approach that utilised CBT within its therapeutic model was the only exception to this (the Transformers Program). Given the current evidence base for MST-PSB and the frequency of the use and evaluation of CBT internationally, this presents as a significant gap in the literature and in practice. This potential evidence-to-practice gap may be a result of limited evaluation in Australia. It may also in part be a reflection of the lack of strong guidelines for responding to and preventing PSB, and the limited evidence for effective approaches in the PSB field in general. This points to a need for more research in the Australian context and the development of strong guidelines for responding to and prevention of PSB.

This review did not seek information regarding what approaches are being used in private practice in NSW. All the practitioners we consulted worked in the public setting. According to the consultees, narrative and systems-based approaches appear to be frequently used in the public setting. Although some of these approaches have been evaluated, the research is still in early development. The most widely researched approaches — MST-PSB and CBT — do not appear to have been evaluated in Australia and do not appear to be in wide-scale use in Australia.

This review identified very limited high-quality evidence regarding what works for preventing and responding to PSB in children and young people in OOHC and, indeed, in any setting. This gap in knowledge is particularly evident in the area of prevention and early intervention, with only one preventive approach identified, and with the majority of studies evaluating approaches for children and young people engaging in PSB that would be considered at the more severe end of the continuum.

The REA found no information on addressing PSB when working towards reunification with birth families, following a separation. Consultees also noted a lack of guidance in this area in the field. This was reported as a particular concern by the consultees.

There are also significant research and practice gaps in knowledge about approaches specifically designed to support targets of PSB.

The REA also found no approaches for child protection practitioners in preventing or responding to PSB.

Many of the evaluated approaches in the REA formed only part of an overall treatment. At times it was difficult in the REA to isolate the effects due to the approach of interest from those of the overall treatment. Authors often tested a component of an approach, such as covert sensitisation, offered in a residential treatment setting. Young people in this setting were typically offered other forms of comprehensive treatment at the same time. Therefore, the approach evaluation could not establish whether it was the residential treatment setting as a whole, rather than the particular approach (e.g. covert sensitisation) that was contributing to outcomes. A lack of clarity in reporting of approaches also made it difficult at times to establish which aspect of an approach was being evaluated. Guidelines for reporting approaches that are currently widely available in the literature would help address this gap, as would randomising young people to receive the approach of interest or a usual treatment.

An additional gap in knowledge is the qualifications, support and training required for effective practice. Although deemed important by consultees, there was often poor reporting of qualifications and training of personnel in the studies in the REA. When

this detail was reported it was often in the context of an approach for PSB on the severe end of the continuum, or an approach for those referred to as 'sexual offenders'. This points to a need for higher qualifications when delivering intensive therapies. However, it is unclear what training, support and qualifications may be useful when responding to PSB on the less-severe end of the continuum. This requires much more clarity in order to deliver services suitably.

The REA found limited measurement of outcomes identified in the QAF, other than mental health outcomes. In the studies in this REA these outcomes were essentially PSB outcomes. Recidivism rates of sexual offences tend to be low, so this may not in fact be a useful outcome measure, as any effects (in particular, long-term benefits of the approach) will be difficult to establish statistically. More focus on other outcomes in identified in QAF is needed in the literature.

The REA found limited evaluations of studies involving children under 10. The exception to this was structured CBT approaches (rated here as Emerging). Consultees noted that different approaches may apply to young people under 10, in comparison to adolescents who are legally responsible for their actions and may face criminal charges. As such, it is vital that this gap in knowledge be addressed.

Significant gaps were also evident for reporting of outcomes for females engaging in PSB. Although some approaches may be offered to both males and females, authors often excluded female participants from evaluations due to low numbers in the sample. Authors at times also offered modified versions of their approaches to females (e.g. females did not attend group therapies) and the rationale for this was unclear. What may have also contributed to this evidence gap is the large amount of papers examining juvenile sexual offender populations. Juvenile detention settings are typically segregated by gender, and the majority of research was conducted with males. A consequence of this is that it is difficult to know whether the approaches evaluated in the REA will be equally beneficial for females. The effects of gender require much further consideration and research.

A further gap noted in the research was the low inclusion rates of ethnically diverse groups. Limited research in the REA was found evaluating approaches for Aboriginal and Torres Strait Islander children and with children with CALD backgrounds, with only four papers including indigenous, Maori or other CALD groups in their approaches. Mr Tolliday also noted that that policies for working with Aboriginal and Torres Strait Islanders clients were in place within the New Street Services and this helped to increase the engagement of this population in the program. It also resulted in equivalent outcomes for these young people when compared to non-Aboriginal and Torres Strait Islander young people. This is an encouraging step for addressing this gap. Further research examining the effects of approaches for diverse populations, and ways to modify approaches to increase engagement of diverse groups, is needed.

5.3. Limitations of this review

This review represents a fairly comprehensive and balanced view of approaches to PSB as it combines a rigorous REA and consultations with members of the child protection field. However, the review was limited to a small number of consultations and included none with private practitioners. Input from a wider scope of practitioners, either by interview or survey, would have added to the depth of this review.

The REA involved a rigorous search of various academic databases, organisation websites, and requested papers from experts. However, it is not a systematic review. Due to time limitations, we were not able to check reference lists for further studies or contact study authors for additional studies or data. We also did not include books, theses, conference abstracts and presentations in this review. Further to this, inclusions were limited to 2002 onwards and to publications in English.

5.4. Factors to consider when implementing approaches in the New South Wales out-of-home care contexts

Preventing and responding to PSB in children and young people and conducting research in this area are complex matters. This complexity is compounded in OOHC settings. This section provides a discussion of some issues to consider when selecting and implementing responses to PSB in the NSW OOHC context.

5.4.1. Consider if the approach suits the setting

Some of the approaches identified here have not been implemented and evaluated with children and young people living in OOHC. In fact, a well-evidenced approach such as MST-PSB expressly excludes young people who are not living with their families. This means that we do not yet know the evidence for MST-PSB and some other approaches in OOHC settings, or their suitability for implementation in OOHC. Consider if these approaches are suitable for use with children and young people in OOHC settings and what the implications might be if the approach is delivered in OOHC. For example, there may be practical considerations when implementing an approach in a residential care setting, compared to a home-based setting (e.g. foster or kinship care) such as the degree of supervision feasible within that setting, age of children, and the consistency and availability of caregivers. It is likely that these contextual factors would need to be considered. However, due to the limited evidence available for OOHC settings generally, let alone for specific OOHC settings, further research is required to determine how these different contextual factors impact on the effectiveness of a specific approach.

5.4.2. Consider applicability for the Australian service context

Few of the approaches identified here have been evaluated in Australia. For instance, none of the consultees mentioned the use of pharmacological treatment for children and young people engaging in PSB. It is unclear whether these treatments are being used in NSW or Australia. It is possible that some approaches, such as CBT, are in greater use in NSW than was revealed in this review, but we are unsure to what extent.

Therefore the applicability of some approaches referred to in this report to the Australian context is not known. In addition, staffing requirements of the predominantly USA approaches in the REA do not appear to match the current staffing qualifications in the NSW OOHC context. These factors need not be a limitation when selecting approaches. Approaches that are not currently available in Australia may be suitable for dissemination into the NSW context, with appropriate implementation support and training. For example MST-PSB requires masters-level clinical supervision, as well as weekly one-hour consultation with an MST expert, but MST-PSB is dissemination ready and it has good in-build coaching support and adherence measures.

5.4.3. Consider the target population of the approach

Consideration should be given to whether an approach is suitable for the children and young people of interest. While all approaches deal with PSB, there are some other factors that should be taken into account. For example, is the approach more suitable for young children or older children? Is the approach suitable given the severity of PSB? The approach needs to flexible so that it is developmentally appropriate according to the age and skills levels of all participants, whether they are children, young people, parents or caregivers.

Many of the approaches described in this report are for adolescent males who have committed sexual offences. There is less evidence or guidance regarding younger children, females, and children and young people who engage in less-serious forms of PSB.

Consider also the cultural suitability of the approach. Working with Aboriginal and Torres Strait Islander families requires engagement with the Aboriginal and Torres Strait Islander community.

Consideration should also be given to differences in statutory thresholds for OOHC compared with these factors in the locations where the included studies were conducted.

When selecting suitable approaches, it is necessary to analyse the client population in detail in order to select what has the best chance of working for whom. One approach may not fit all, so several individualised approaches may be needed.

5.4.4. Consider the complexities of families involved in out-of-home care

The REA and consultations revealed that majority of the children and young people in these studies had experienced prior trauma or abuse, significant levels of trauma or multiple types of trauma. Children and young people entering statutory OOHC are typically from families with complex needs. These family members may have multiple issues, such as exposure to domestic and family violence, substance misuse, and mental health concerns, in addition to PSB and abuse. The broader family context, even after children have been placed in OOHC, should be considered when selecting approaches for responding to PSB. Children and young people in OOHC will typically require multi-component approaches to address the multiple problems that they and their families are or were experiencing, such as the approach offered in MST-PSB, which draws on ecological systems theory. For children who are restored to their families, particular consideration should also be given to responding to the broader, complex needs of the family, and providing ongoing support for families to manage the PSB.

5.5. Recommendations

Based on the REA of international studies and consultations with a selection of personnel in the NSW child protection field, we have developed the following recommendations for consideration.

5.5.1. Base practice on a sound theoretical framework

In the absence of strong evidence, it is even more vital that practice is based on theoretical frameworks. A consistent and coherent theoretical approach that takes into account current knowledge and best-practice principles in working with young

people engaging in PSB will be ideal for promoting positive outcomes and reducing harms. Although eclectic, approaches evaluated here often involved a select few theoretical frameworks — for example, a systems framework (such as MST-PSB), a CBT framework, or a narrative approach — all of which have strong theoretical grounding in other fields of practice. A conceptual knowledge of such approaches for those in the field is recommended. This will help to guide their practice with young people and their caregivers. Any implementation of these theory-based approaches in the field then requires rigorous evaluation to determine if they are working in context.

5.5.2. Trial new approaches in the Australian out-of-home-care setting

Given the international evidence for MST-PSB and the use of CBT as a theoretical framework in several approaches, it is worth considering if these could be trialled in OOHC and in the Australian context. The field appears to be at a stage where large-scale evaluations could be undertaken, randomising participants to MST-PSB, a CBT-based approach or a narrative approach. This would also take into account current ethical concerns of randomising a high-risk young person to a no-treatment control group. MST-PSB is currently not available in Australia, and studies of MST-PSB overseas have not included children in OOHC. However, it is ready for dissemination, suggesting that implementation supports and resources exist for it to be packaged up and introduced to other countries. It could be extended to an OOHC trial in Australia, should this be considered a suitable option by policymakers and the MST-PSB developers.

5.5.3. Establish plans for the implementation and ongoing evaluation of approaches

Prior to commencing implementation of approaches for preventing and responding to PSB, clear plans should be established for how implementation will be carried out and monitored. This is particularly critical given that few of the approaches described in this review have previously been implemented in the NSW OOHC context. If approaches are adapted for the local context, this should be done in a manner that is planned and structured and includes monitoring of continuous quality improvement of services. Any adaptations would need to consider if there are any minimum requirements for implementing approaches, and all approaches would need to be tested for efficacy and effectiveness. Further research could also be undertaken to clearly identify the range of approaches being used by services and practitioners in the private-practice setting in Australia.

5.5.4. Further investigate and evaluate prevention and early intervention strategies

Although this review has not identified evidence for prevention and early intervention, there is a need to identify and evaluate approaches relevant to these circumstances in order to support children, young people and caregivers, and to intervene before problems escalate. Possible direction may be available in the literature on non-evaluated PSB approaches or even from outside the PSB field.

The vast majority of children and young people engaging in PSB, including those in OOHC, appear to first engage in less severe forms of PSB. This may escalate if not addressed quickly and suitably. Children and young people with PSB can also experience a range of externalising behaviours in addition to PSB (e.g. conduct

problems, truancy, violence, dishonesty, stealing) (Chaffin et al., 2008), which are often responded to with behavioural management. Like these other behaviours, PSB may be reduced or eliminated with appropriate behavioural management. Examples of behavioural management approaches are briefly described below.

A resource developed by the British Columbia Ministry of Education suggests a tiered approach be taken when addressing PSB (British Columbia Government, 1999). They divide sexual behaviour into three levels: (1) normal; (2) a cause for concern; and (3) a cause for serious concern. The level of response increases with the increasing severity of the behaviour. Responding to all levels requires the adult modelling clear and calm communication, assisting the young person to develop empathy regarding the impact of the behaviour on others, and promoting accountability for the behaviour. At Level 1, clear communication and information is provided to the young person. At Level 2, the adult is required to confront and respond to the behaviour with a behavioural management plan. At Level 3, a more intensive response is required and it is recommended the young person is referred to specialist services, and that any appropriate notifications to child services are made.

Similar to this, Smallbone (forthcoming, 2016) provides recommendations for preventing adult sexual violence that may be applicable to this context also. It is recommended that a situational analysis of the behaviour be conducted to identify what is contributing to the behaviour, beyond the personality or traits of the individual. In order to prevent further sexualised violence, it is recommended the environment is changed so that the problem behaviour is made: (1) more difficult and inconvenient to enact; (2) more likely to be detected and punished; (3) less rewarding; (4) less tempting; and (5) less excusable. How these are addressed in the context of children and young people will depend on the setting for example, family home, OOHC, school.

These are responses that OOHC staff, foster and kinship carers, schools, birth families or others involved in the context of the child can implement with appropriate support. This would enable them to take an active role in responding to and preventing PSB.

If the behaviour does not resolve with appropriate behaviour management, or if the behaviour is at the more severe end of the PSB continuum, the approaches identified in the REA become relevant. This will often require input from more specialised clinicians.

According to the findings of the REA, these behavioural management approaches do not yet appear to have been evaluated with children and young people engaging in PSB. If steps are taken to implement such approaches in Australia, they would benefit from evaluation.

5.5.5. Involve and engage children, young people, families and carers

There is a need for ongoing involvement and support of families. This includes while children and young people are in OOHC, during transition back to the family home, and after the child or young person has returned home. A better connection between the OOHC system and the birth family would be beneficial while responding to a child or young person's PSB, and more broadly for the child and their family. Programs for families may be warranted, with specific investigation into the types of parent skills training that may be needed in early intervention and prevention approaches.

Engagement in any approach is vital to improving outcomes of children and young people, including those who engage in PSB. Factors that act as barriers and facilitators to the engagement of young people and their families are well known. However, many approaches in the REA reported high drop-out rates in their samples. It is not clear whether methods of engagement are being implemented in the context of addressing PSB. Approaches for preventing and responding to PSB are more likely to work when children, young people and families are effectively involved in the approach. As such, it is vital that factors that influence engagement be implemented in this context. The GYFS approach (Smallbone et al., 2009) is one example of how approaches can be modified to achieve this aim.

Consultees noted a concern that those working with the young person may not have the capacity, knowledge or skills to effectively engage the young person and their caregivers. In addition, they may not have the resources to effectively engage (e.g. an isolated private practitioner who often works alone). Skills training in counselling is integral to maintaining engagement and alignment, particularly with a challenging or hard-to-engage client group.

5.5.6. Investigate current and required training and support needs for out-of-home-care staff, child protection staff and carers

Following on from the review by South et al. (2015) that emphasised the importance of support for caregivers in OOHC, we note the importance of suitable training and support of all staff and carers who support children and young people engaging in PSB.

There is need to investigate and ensure that appropriate training and support for foster and kinship carers, child protection staff and residential care staff is accessible in metropolitan, regional, rural and remote areas, to help them identify, understand, address and respond to PSB. In the view of the consultees, some are already receiving such training and support, but it is not available across the board. Training also needs to be ongoing so that new staff and carers have access to it, especially in residential care where there is high turnover of staff. Training and coaching needs to include a continuous quality improvement process that can be coached and monitored, so that practitioners and new staff at differing skill levels can be provided with feedback that facilitates positive outcomes. As part of this support, it is important that foster and kinship carers, child protection staff and residential care staff have the skills, knowledge and capacity to work in collaboration with therapeutic care staff to ensure consistency between therapeutic and OOHC settings. Residential care staff may need specific support to manage the complexities of PSB within residential care settings. Consistent and appropriate responses from OOHC carers are equally critical, highlighting the need for appropriate support for carers also in this regard (see South et al. (2015) for caregivers support suggestions).

Consultees mentioned two training programs that are under development for working with under-tens. There is a need to investigate the effectiveness and limitations of different types of training in regards to this issue. Based on this review, training could include information on:

- considering the context of the behaviour
- considering practice principles such as collaboration, family involvement and individualisation

- ensuring holistic support for young people as well caregivers
- providing age-appropriate and culturally appropriate services
- setting clearly defined roles for staff
- clearly defining and measuring the desired outcomes for children and young people.

Any training or support offered to OOHC staff, child protection workers and carers should then be appropriately evaluated, to ensure it is effective.

5.5.7. Investigate current and appropriate qualification requirements for all out-of-home-care staff, child protection staff and therapeutic staff

The REA found that when qualifications of therapeutic staff and OOHC staff were reported, they were at minimum masters-level for management of severe levels of PSB. The views of the consultees also strongly supported appropriate qualifications for therapeutic, OOHC staff and child protection staff. One consultee stated that qualifications in the human services field (psychology, social work, welfare) was most appropriate in order to gain an accurate understanding of the complexities inherent in work with young people engaging in PSB. However, training level and qualification was not consistently reported across all approaches. Training and qualification needs may differ depending on the profession. It is also currently unclear from the literature which qualifications will be most appropriate when working with young people who engage in PSB in the NSW context, particularly when milder forms of PSB are considered.

Working with PSB in young people is an area of practice where many inaccurate myths and assumptions, if acted upon as fact, may prove detrimental to young people. An inappropriate response to mild to moderate PSB may lead to stigmatisation and further isolation of a young person. This may in turn leave the young personal vulnerable to further behavioural or emotional difficulties. Alternatively, a lack of education regarding the factors that can contribute to severe PSB may lead to inappropriate management of, or response to, PSB, which may put other young people at risk. In addition, given these young people often present with many vulnerabilities in their backgrounds themselves (such as trauma and abuse), the response from workers in this area must appropriately take these factors into account to be effective.

Given this, it appears vital that any staff responding to and preventing PSB have the appropriate knowledge, skills and capacities to take these complexities and vulnerabilities into account in their work. It is important to investigate what is appropriate in these circumstances, and whether particular qualifications of a certain standard are required. This will ensure consistency in staff capabilities and contribute to good outcomes for young people engaging in PSB.

5.5.8. Investigate effective ways of engaging and collaborating with kinship and foster carers, residential care workers and other stakeholders

In addition to training about PSB, carers and OOHC staff in particular will require ongoing support to engage in any required responses to PSB. A consultee suggested a coaching model as one approach to providing this support. Consider also whether the qualifications of staff in OOHC settings match the requirements of approaches being used to respond to PSB.

It is also vital when working with young people who engage in PSB to effectively engage and collaborate with other stakeholders involved in the young person's environment in the response. Given the context can often contribute to PSB, a holistic approach requires that all stakeholders are effectively involved in managing the PSB. This may require school teachers, counsellors, extended family or OOHC staff to be appropriately on board with any recommendations made by those working directly with the PSB.

5.5.9. Investigate appropriate approaches for supporting targets of problem sexual behaviour

Little was gleaned in this review regarding appropriate approaches for responding to, or supporting targets of, PSB, and so further investigation is required. Evidence for suitable approaches may exist in the general child sexual abuse literature, but the group of children of interest to the current review may very well be different than children who are sexually abused by adults, and may have different support needs. A better understanding of targets of PSB and how approaches might work with them is needed. If approaches need to be different for this population, compared to targets of adult-perpetrated abuse, these subtleties may be lost in the general child sexual abuse literature. An in-depth analysis of child sexual abuse literature may help to disentangle the extent of PSB target populations and the impact of approaches.

5.6. Conclusion

This review of approaches to PSB in OOHC summarises the developing international literature and provides context to these findings in the form of consultations with members of the child protection field. Acknowledging the challenges of working and researching in this area, this review provides an overview of the state of the evidence and a suggested way forward, highlighting the key need to consider the whole context surrounding the child or young person and their family, and to provide appropriate, quality support and training to the carers working with children and young people engaging in PSB.

6. Appendices

6.1. Subject matter expert biography

Stephen Smallbone is a psychologist and professor at the Griffith Criminology Institute. He worked as a prison psychologist before joining Griffith University in 1998. Professor Smallbone's research-practice team is concerned primarily with understanding and preventing sexual violence and abuse, with projects including clinical forensic practice with court-referred youth sexual offenders, risk assessment and management with adult sexual offenders, designing safer organisations for children, and place-based prevention of youth sexual violence. His publications include the books *Situational prevention of child sexual abuse* (Criminal Justice Press, 2006), *Preventing child sexual abuse: Evidence, policy and practice* (Willan, 2008), and *Internet child pornography: Causes, investigation and prevention* (Praeger, 2012).

6.2. Search terms used in rapid evidence assessment

Search terms used in OVID databases
1. ((sexual* behaviour*) adj2 (problem* or coercive or inappropriate or harm* or concern* or violen* or aggressive or abus* or devian* or unhealthy)).mp.
2. ((sexual* behavior*) adj2 (problem* or coercive or inappropriate or harm* or concern* or violen* or aggressive or abus* or devian* or unhealthy)).mp.
3. (Abuse-reactive or (abuse adj1 reactive)) or (Trauma-reactive or (trauma adj1 reactive)) or (Victim-perpetrator* or (victim adj1 perpetrator*)).mp.
4. ((sexualized) adj1 (child* or teen* or adolesce* or boy* or girl* or minor or minors or youth* or young people* or young person* or juvenile* or peer or peers)).mp.
5. ((sexualised) adj1 (child* or teen* or adolesce* or boy* or girl* or minor or minors or youth* or young people* or young person* or juvenile* or peer or peers)).mp.
6. ((sexual* offen*) adj2 (child* or teen* or adolesce* or boy* or girl* or minor or minors or youth* or young people* or young person* or juvenile* or peer or peers)).mp.
7. ((sexual* perpetrat*) adj2 (child* or teen* or adolesce* or boy* or girl* or minor or minors or youth* or young people* or young person* or juvenile* or peer or peers)).mp.
8. ((sex* crim*) adj2 (child* or teen* or adolesce* or boy* or girl* or minor or minors or youth* or young people* or young person* or juvenile* or peer or peers)).mp.
9. (child* or teen* or adolesce* or boy* or girl* or minor or minors or youth* or young people* or young person* or juvenile* or peer or peers).mp.
10. (Treatment* or program* or policy or policies or intervention* or service* or therap* or study or studies or child protect* or child welfare).mp.
11. or/1-3
12. 11 and 9
13. or/4-8
14. 12 or 13
15. 14 and 10

6.3. Consultee biographies

6.3.1. Dale Tolliday OAM

Mr Tolliday is the Clinical Advisor to the New Street Services within NSW Health. He works at the Sydney Children's Hospitals Network and NSW Health's Office of Kids & Families. Mr Tolliday's work with people who have sexually harmed others spans over 25 years. Prior to this, Mr Tolliday worked in a variety of child, adolescent and family mental-health settings.

Mr Tolliday's professional training is in social work and law. He has a particular interest in training and professional standards for people working with those who have sexually harmed children.

Mr Tolliday is a member of the Australian Association of Social Workers and a founding member and past President of the Australian and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA). Mr Tolliday is also a member of the accreditation panel of the Child Sex Offender Counsellor Accreditation Scheme (CSOCAS) administered by the NSW Children's Guardian.

6.3.2. Catherine Want

Ms Want has worked in the field of child sexual assault since her first days at Westmead Sexual Assault Centre (Grevillea Cottage) in 1985. She then moved to work as a counsellor at Rosie's Place, a non-government service in the outer western suburbs of Sydney. This service, established in 1986, provides counselling and support services to children, young people and family members impacted by the trauma of child sexual assault and domestic violence. Rosie's Place also works extensively with children under 10 with problematic/harmful sexualised behaviours who have a trauma history. The service is funded by the Department of Community Services, EIPP. Ms Want is currently the Manager of Rosie's Place.

Ms Want has also been a contracted trainer with the Education Centre Against Violence (ECAV), NSW Health, for over 25 years, providing training in specialist areas including child sexual assault and domestic violence. As part of her role with ECAV Ms. Want (along with another colleague from Rosie's Place, Christine Kulyk) provides training in regard to responding to children under 10 with harmful sexualised behaviours. Ms. Want and Ms. Kulyk are also part of a consultation committee with ECAV to produce resources for workers in this area of work.

6.3.3. Laura Luchi

Ms Luchi is a registered psychologist who has been working with children, families and professionals impacted by trauma and abuse since 1995 in the government, NGO and private sectors.

Ms Luchi's career began as a therapist working with women and children affected by family violence in a small community organisation in Sydney. Her interest in the field of violence and trauma grew and extended across the child protection spectrum with particular focus on sexual abuse and its trauma-related problems for children.

Whilst working in the fields of child sexual abuse and domestic violence, Ms Luchi discovered her passion for teaching and writing. In the twenty years since, she has written and delivered dozens of training packages across a range of trauma- and

supervision-related topics for child protection, police, education, counselling and out-of-home-care organisations.

Today, Ms Luchi's work centres around the dynamic and fascinating world of complex and developmental trauma in children and finds its expression in her work with professionals, carers and children alike.

6.4. Consultation guide

1. What practices, policies and principles are referred to in the service/s you work with for preventing and responding to problem sexual behaviour in different types of OOHC settings?
2. What practice standards are utilised in your service/s for the management of problem sexual behaviour in children and young people in OOHC?
3. What services, programs or treatments are available for children and young people in your agency? Then ask the follow up questions such as child age etc. Do you have a view on their effectiveness and evidence base?

NB. Clarify the following:

   a. Child age (<10 problem behaviour vs. 10–17 abusive behaviour)
   b. Child gender
   c. The relationship between the child who engages in the problem sexual behaviour and the target (siblings, peers, other children)
   d. The type of OOHC setting (foster, residential, respite, kinship)
   e. Ethnicity, Aboriginal, other culturally diverse groups
   f. Different abilities (e.g. mental health problems, disabilities)
   g. Delivery mode (individual vs. group work, timeframe)

4. In your service/s, what proportion of children who engage in problem sexual behaviour are also victims? Do treatment approaches differ depending on whether the child has been a target of sexual behaviour or a victim of sexual abuse?
5. In what ways have parents or carers been involved in approaches in your service for preventing and responding to sexual behaviours among children and young people?
6. What work is done in your service regarding problem sexual behaviour with birth families while children and young people are in OOHC?
7. What services and treatment approaches are currently available for children and young people engaging in problem sexual behaviour in NSW/Aus more broadly? Do you have a view on their effectiveness and evidence base?

NB. Clarify the following:

   a. Child age (<10 problem behaviour vs. 10–17 abusive behaviour)
   b. Child gender
   c. The relationship between the child who engages in the problem sexual behaviour and the target (siblings, peers, other children)

d. The type of OOHC setting (foster, residential, respite, kinship)
e. Ethnicity, Aboriginal, other culturally diverse groups
f. Different abilities (e.g. mental health problems, disabilities)
g. Delivery mode (individual vs. group work, timeframe)

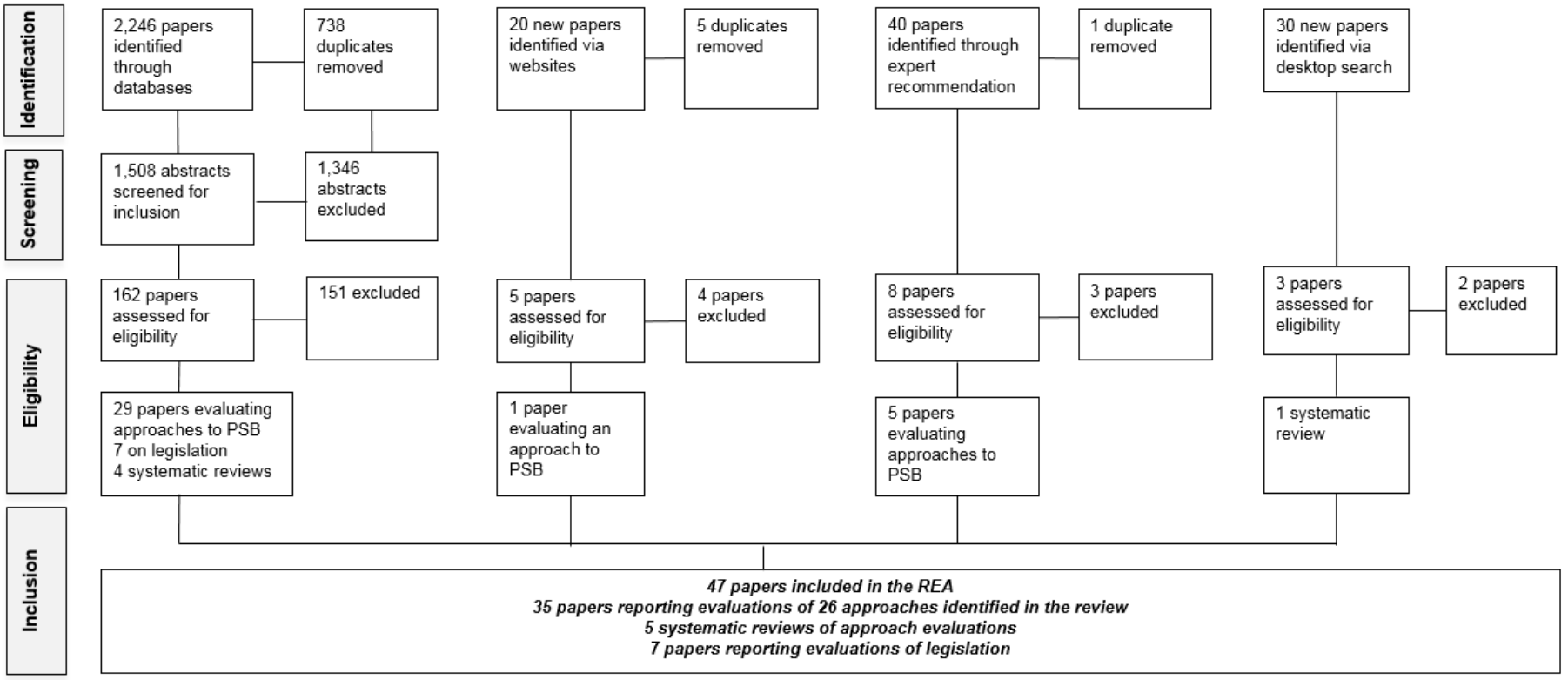
8. What skills and qualifications are required of statutory child protection and OOHC workers to identify and respond to problem sexual behaviour in children and young people in your services?
9. What types of system response is needed to prevent and respond to problem sexual behaviour in children and young people?
10. Do you have any written evaluations of services or programs? Can be published or unpublished (e.g. a report), but not just data or survey responses. (Needs to be a paper or report)

NB. Clarify the following:

a. Child age (<10 problem behaviour vs. 10–17 abusive behaviour)
b. Child gender
c. The relationship between the child who engages in the problem sexual behaviour and the target (siblings, peers, other children)
d. The type of OOHC setting (foster, residential, respite, kinship)
e. Ethnicity, Aboriginal, other culturally diverse groups
f. Different abilities (e.g. mental health problems, disabilities)
g. Delivery mode (individual vs. group work, timeframe)

6.5. Rapid evidence assessment flow chart

Figure 2: Rapid evidence assessment flow chart



6.6. Practice resources identified in this review

Title of resource	Website (where available)
Anglicare Tasmania (2015). Submission to: options paper: pathways to change: responding to problem sexual behaviour in Tasmania. Hobart, Australia, Anglicare Tasmania.	https://www.anglicare-tas.org.au/sites/anglicare-tas.org.au/files/Responding%20to%20Problem%20Sexual%20Behaviour%20-%20Anglicare%20Response%20to%20SASS%20Options%20Paper.pdf
Boyd, C. (2006). Practice Brief, No. 1: Young people who sexually abuse: Key issues. Practice Brief. AIFS, Australian Institute of Family Studies.	https://aifs.gov.au/cfca/sites/default/files/publication-documents/pb1.pdf
Boyle, M., Hills, K., Winton, H., & Barrie, J. (2013). Managing sexualised behaviour: guidelines. Alloa, UK, Central Sexual Health.	http://www.centralsexualhealth.org/media/6505/msb_guidelines.pdf
British Columbia Government (1999). Responding to children's problem sexual behaviour in elementary schools: a resource for educators. M. o. Education. Victoria, British Columbia, Canada, Author.	https://www.bced.gov.bc.ca/sco/resourcedocs/probsexbehave.pdf
Caffaro, J. V., & Conn-Caffaro, A. (1999). Assessment of sibling abuse Sibling abuse trauma: assessment and intervention strategies for children, families, and adults (1st ed., pp. 111-144). New York, USA: Routledge.	https://books.google.com.au/books?hl=en&lr=&id=HXeAAAAAQBAJ&oi=fnd&pg=PP1&dq=Sibling+abuse+trauma:+assessment+and+intervention+strategies+for+children,+families,+and+adults&ots=q2kweAhqk1&sig=5ZNS3L5Gdw387ewo_A87pMW49i4#v=onepage&q=Sibling%20abuse%20trauma%3A%20assessment%20and%20intervention%20strategies%20for%20children%2C%20families%2C%20and%20adults&f=false
Caffaro, J. V., & Conn-Caffaro, A. (1999). Sibling abuse interview Sibling abuse trauma: assessment and intervention strategies for children, families, and adults (1st ed., pp. 263-272). New York, USA: Routledge.	https://books.google.com.au/books?hl=en&lr=&id=HXeAAAAAQBAJ&oi=fnd&pg=PP1&dq=Sibling+abuse+trauma:+assessment+and+intervention+strategies+for+children,+families,+and+adults&ots=q2kweAhqk1&sig=5ZNS3L5Gdw387ewo_A87pMW49i4#v=onepage&q=Sibling%20abuse%20trauma%3A%20assessment%20and%20intervention%20strategies%20for%20children%2C%20families%2C%20and%20adults&f=false
CEASE (2012). Standards of practice for problem sexual behaviours and sexually abusive behaviour treatment programs. Melbourne, Australia, Australian and New Zealand Association for the Treatment of Sexual Abuse.	http://www.secasa.com.au/assets/Documents/cease-standards-of-practice.pdf
Centre for Excellence in Child and Family Welfare (2015). Submission - Issues Paper 4: preventing sexual abuse of children in out	https://www.childabuseroyalcommission.gov.au/getattachment/c18eba54-0418-4255-ba8c-4715142a71a7/19-Centre-for-

of home care. Royal Commission into institutional responses to child sexual abuse. Melbourne, Australia, Author.	Excellence-in-Child-and-Family-Welfa
Chaffin, M., Berliner, L., Block, R., Johnson, T., Friedrich, W., Louis, D., . . . Madden, C. (2008). Report of the ATSA task force on children with sexual behavior problems. Child Maltreatment 13(2): 199.	http://www.knesset.gov.il/committees/heb/material/data/H21-12-2009_14-05-13_maamar1.pdf
Child Sexual Abuse Committee of the National Child Traumatic Stress Network, & National Center on Sexual Behavior of Youth. (2009). Understanding and coping with sexual behavior problems in children: information for parents and caregivers. Los Angeles, USA: National Center for Child Traumatic Stress.	http://nctsn.org/nctsn_assets/pdfs/caring/sexualbehaviorproblems.pdf
Children's Research Center. (2012). The Structured Decision Making® System: safety, risk and risk reassessment. Policy and procedures manual implementation version. Last update: August 2012. Sydney, Australia: Family and Community Services.	
Community Workers Association (n.d.). Community Workers Association practice standards. Melbourne, Author.	http://www.acwa.org.au/resources/ACWA_Practice_Standards.pdf
Day, S. (2010). Keeping Children and Young People Safe from Harm, Abuse and Neglect. Northumberland, Northumberland Safeguarding Children Board.	http://beaufront-first-school.co.uk/downloads/Child-Protection-Policy.pdf
Department for Education Child Development (2013). Responding to problem sexual behaviour in children and young people: guidelines for staff in education and care settings. G. Groves. Adelaide, Australia, Government of South Australia.	http://www.decd.sa.gov.au/docs/documents/1/RespondingtoProblemSexual.pdf
Evertsz, J., & Miller, R. (2012). Children with problem sexual behaviours and their families: Best interests case practice model. Specialist practice resource. Melbourne, Australia: Victorian Government Department of Human Services	http://www.dhs.vic.gov.au/__data/assets/pdf_file/0003/644772/children-problem-sexual-behaviours-families-specialist-practice-resource-2012.pdf
Family Planning Queensland (2010) Positive and protective: identifying and responding to sexual behaviours in children and young people: foster and kinship carer training.	https://www.communities.qld.gov.au/resources/childsafety/foster-care/training/documents/ppt-sexual-behaviours.pdf
Family Planning Queensland (2012). Sexual behaviours in children & young people: A guide to identify, understand and respond to	http://www.nwhn.net.au/admin/file/content101/c6/Br_SexualBehaviours.pdf

sexual behaviours. Brisbane, Australia, True.	
Hands on Scotland (n.d.). Inappropriate sexual behaviour, Author.	http://www.handsonscotland.co.uk/page_pdfs/behaviours/inappropriate_sexual_behaviour_0.pdf
Inverclyde Child Protection Committee (2013). Risk management for children and young people with problem sexual behaviours: a multi-agency framework and protocol. Greenock, UK.	http://www.inverclydechildprotection.org/GetAsset.aspx?id=fAAxADAANwA5ADUAfAB8AEYAYQBsAHMAZQB8AHwANgB8AA2
Leversee, T. (2011). Comprehensive and individualized evaluation and ongoing assessment. In G. Ryan, T. F. Leversee, & S. Lane (Eds.), Juvenile sexual offending: causes, consequences, and correction (pp. 201-223). New Jersey, USA: Wiley & Sons.	https://books.google.com.au/books?id=O-5vTo2_VRIC&pg=PA201&dq=Comprehensive+and+individualized+evaluation+and+ongoing+assessment&hl=en&sa=X&ved=0ahUKEwiVyqWvrZDOAhUFFJQKHfYMBIkQ6AEIGzAA#v=onepage&q=Comprehensive%20and%20individualized%20evaluation%20and%20ongoing%20assessment&f=false
Luchi, L. (2014). Safety planning for adolescents who engage in sexually abusive behaviours: facilitators manual. Sydney, Australia, NSW Government.	
Luchi, L. (2014). Safety planning for adolescents who engage in sexually abusive behaviours: participants workbook. Sydney, Australia, NSW Government.	
Luchi, L. (2014). Safety assessment & planning for adolescents with sexually abusive behaviours. Sydney, Australia, Family & Community Services.	
Mason-White, H., & Pane, S. (2015). Responding to problem sexual behaviour and sexually abusive behaviour in Tasmania: position paper	http://www.sass.org.au/assets/SASS_Position_Paper_PSB-SAB.pdf
McCarlie, C. (2011). Risk management protocol for children and young people with problematic sexual and violent behaviours: a multi-agency framework. Ayr, UK, South Ayrshire Council.	http://www.south-ayrshire.gov.uk/documents/childprotectionsouthayrshireriskmanagementframework.pdf
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National Institute for Health and Care Excellence (Feb, 2016). Harmful sexual behaviour among children and young people - Draft Guideline. National Institute for Health and Care Excellence, NICE.	http://www.nice.org.uk/guidance/indevelopment/gid-phg66
Northern Territory Government (2015). Guidelines: sexual behaviour in children. D. o. Education, Author.	https://www.nt.gov.au/__data/assets/pdf_file/0006/258108/Sexual-behaviour-in-children-guidelines.pdf
NSW Department of Family and Community Services. (2011). Aboriginal consultation guide. Retrieved from Sydney, Australia	http://www.community.nsw.gov.au/__data/assets/pdf_file/0019/322228/aboriginal_consultation_guide.pdf
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NSW Kids and Families. (2013). Health assessment of children and young people in out-of-home-care (clinical practice guidelines). Sydney, Australia: NSW Government	http://www0.health.nsw.gov.au/policies/gl/2013/pdf/GL2013_010.pdf
NSW Ombudsman (2013). Defining reportable conduct: child protection practice update 2013. Sydney, Australia, NSW Ombudsman.	https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0013/5620/PU_CP_02_11_Reportable_Conduct_v3.pdf
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Pratt, R., Miller, R., & Boyd, C. (2012). Adolescents with sexually abusive behaviours and their families. Best interests case practice model: specialist practice resource. Melbourne, Australia, Victorian Government Department of Human Services.	http://www.dhs.vic.gov.au/__data/assets/pdf_file/0005/589721/adolescents-sexually-abusive-behaviours-families-specialist-practice-resource-2012.pdf
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Victorian Government. (2012). Problem sexual behaviour or sexually abusive behaviour. Melbourne, Australia: State of Victoria	http://www.dhs.vic.gov.au/__data/assets/pdf_file/0011/713693/problem-sexual-behaviour-or-sexually-abusive-behaviour.pdf
Victorian Government (2015). The Royal Commission into institutional responses to child sexual abuse: response to issue paper 4 - Preventing sexual abuse of children in out of home care. Melbourne, Australia, Author.	https://www.childabuseroyalcommission.gov.au/getattachment/2bd58e3d-d0c8-41ca-9c88-893efd4f89db/60-Victorian-Government

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