

Response: Issues Paper 10

Advocacy and Support and Therapeutic Treatment Services

This submission is about children and young people with problem sexual behaviour and sexually abusive behaviour because these groups of children are often victims themselves and create other victims. Hence, it seems appropriate to address the services that work for this cohort and to look at unmet needs.

Topic A: Victim and survivor needs and unmet needs

1. What advocacy and support and/or therapeutic treatment services work for children with PSB and young people with SAB?

Children and young people who exhibit problem sexual behaviour (PSB) and sexually abusive behaviour (SAB) require advocacy, support and therapeutic treatment services, similar to victims and survivors of sexual assault, appropriate to their needs. Children exhibiting PSB and SAB may present with background trauma issues, given the prevalence of family violence, pornography exposure, cumulative harm and sexual abuse victimisation. It is important to treat children and young people exhibiting PSB and SAB, given these behaviours, if unchecked, may lead to other youth being victimised. As well, lack of treatment may result in reducing children with PSB and SAB opportunities to engage in positive life experiences.

There is considerable evidence that intervening early with children and young people exhibiting SAB can help to prevent ongoing and more serious sexual offences (Pratt, Miller & Boyd, 2010; Pratt, 2013; Pratt 2015; Rich, 2003, 2005) Programs provided to children and adolescents may result in changes difficult to replicate with adult sex offenders due to the entrenchment of their behaviours. Thus it is important that children and young people exhibiting PSB and SAB have access to timely and effective treatment programs.

Until 2007, the Criminal Division of the Children's Court could direct youth to treatment as part of sentencing, where a young person was convicted of a sexual offence. Adolescent treatment programs could only be accessed following a finding of guilt. The provisions within the Children, Youth and Families Act (CYFA) 2005 resulted in alternate paths into treatment. These were voluntary or when a child and their family did not voluntarily seek help. Specific sexual assault and child-focused services were funded across Victoria to provide therapeutic treatment services to 10-14 year olds. This was achieved by the creation of Therapeutic Treatment Orders (TTO) administered by Therapeutic Treatment Boards (Pratt, Miller & Boyd, 2010; Pratt, 2013. Pratt 2014).

Referrals to Sexually Abusive Behaviour Treatment Services (SABTS) come from police, parents/carers, health professionals, schools, government departments and statutory authorities such as DHHS and courts. Since 2007, SABTS-provided treatment has been found to meet best-practice success rate levels and thus has assisted in preventing a significant number of young people potentially moving into adult offending. Whilst it is clear that very few youth continue offending into adulthood, it is also clear that treatment halves recidivism (Rich, 2003).

Across Victoria, 12 agencies (9 of them CASAs) undertake PSB and SAB therapy, ensuring total geographic coverage. The majority of these agencies work with 10-14 year olds, with many also working with much younger children (under ten years) and the older cohort (up to 18 years).

Standards of Practice developed by CEASE, the peak body for the SABTS system, ensure consistent, ethical, best practice approaches. CEASE Standards of Practice are endorsed by the Australian and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA) which is the Australian and New Zealand professional association for the whole of the sexual abuse field.

Children exhibiting PSB/SAB will only be removed from home where assessment indicates that their risk to others with whom they reside cannot be managed safely. A variety of placement options are utilised, including kith and kin, foster care, and residential placement options. In all placement situations, those caring for SAB/PSB youth must form close relationships with their treating SABT service provider.

Currently, consideration is being given to expanding TTO interventions to include 15-18 year olds. Given Youth Justice Interventions currently provide an excellent continuum following TTO work for 10-14 year olds, changes will require a robust and considered approach to ensure this age group has a treatment service which provides a level of service commensurate with that provided to 10-14 year olds.

Practitioners who work within the TTO/SABTS system are provided with an ongoing training program which allows for six one-day trainings and 4 peer mentoring sessions per annum. This training is aimed at practitioners of all levels of experience, from beginner through to advanced practitioner status. National and international experts have been engaged to provide this training, which has successfully met its goals to raise the expertise of the SABTS workforce and to ensure consistency of the model of treatment across agencies and across the state. The State-wide Principal Practitioner for child protection includes the SABTS portfolio in their work duties. Whilst the training program is very successful, expanded funding would allow the training and mentoring program to be expanded.

2. What does not work or can make things worse or be harmful for children with PSB and young people with SAB? What do children with PSB and young people with SAB need but not receive?

- Responsive, timely targeted intervention
- Stable staffing in Child Protection, some CASAs and other agencies providing PSB and SABTs
- Insufficient ability to match youth in residential placements due to systems stress and lack of placement options. Unskilled and/or trained residential staff
- schooling situations which do not provide innovative education models that support a child's therapeutic as well as educational needs
- An awareness of cultural factors for each child.
- An ability to work across family systems and other domains in which the young person engages. Some agencies continuing to treat children engaging in PSB/SAB as adult 'predators' and view rehabilitation as unachievable
- A workforce which requires further and ongoing training to ensure consistency of model, reliability when assessing risk, and ability to work with all members of a family where sibling sexual abuse has occurred,

3. What helps or facilitates access so children with PSB and young people with SAB receive what they need? What are the barriers to receiving advocacy and support and/or therapeutic treatment and how might those barriers be addressed?

Young people and children and who are victims as well as exhibiting SAB and PSB need similar approaches to children and young people who are purely victims.

- Items that help or facilitate:
 - The capacity to obtain timely appointments
 - Thorough robust and recognised clinical assessment
 - The ability to return to a service whenever you need to
 - Stable staffing model for the residential care staff and therapeutic staff
 - Higher level training for residential staff
 - The ability to provide safe placement for all children which at times may require separate facilities for children and young people who engage in PSB and SABs and those who are victims of child sexual abuse, whilst acknowledging that a well trained and resourced residential system would, in most cases, be able to manage placement situations.
 - Flexible schooling models
- Barriers – same as for question 2 above

4. How well do advocacy and support and/or therapeutic treatment services currently respond to the needs of children with PSB and young people with SAB? How could these services be shaped so they better respond to secondary victims?

Overall a multi-systemic approach for children and young people with PSB and SAB and their families allows for an individual assessment and treatment plan that is tailored to increase the likelihood of achieving a return to a positive developmental pathway which does not include SAB. This approach does not target the SAB/ PSB alone, but rather targets cognitive, emotional, behavioural, family and peer issues that may have contributed or played a role in the young person’s SAB. Consequently, it is important that therapeutic treatment services respond well to secondary victims who are often family members.

There appears to be an inconsistency in how agencies respond to the needs of secondary victims. This is often related to funding levels and general capacity. If there is a waiting list of several months systems are unlikely and unable to broaden the category of people you see, even in SABTs programs.

There needs to be:

- Better understanding, through training and consultation, of the effects for families of having a child with PSB or SAB
- An agreed definition of what constitutes a secondary victim in the case of SAB.

Topic B: diverse victims and survivors

1. What existing advocacy and support and/or therapeutic treatment services are available that cater to the specific needs of diverse PSB and SAB groups? What types of models and approaches are used to address the particular needs of these populations?

People with a disability, both physical and cognitive, experience difficulty in engaging with SABTs. Services need to be accessible to people with a physical/intellectual disability, and experienced in working with children with PSB and young people with SABs. This work takes more time and

enhanced/different skills to treating other young people. This requires additional training. Furthermore, additional resources are required to provide the external supports that are often required

Cultural consultants/partners are required when working with CALD clients.

2. How could the needs of children with PSB and young people with SAB from diverse backgrounds be better met? What should be in place to ensure they receive the advocacy and support and/or therapeutic treatment they require?

See questions 1 above, plus:

It is important to make the physical surroundings within an agency welcoming for all groups of people, for example rainbow stickers. Autism/ASD/ADD populations may need timeout/time in rooms.

3. What would better help victims and survivors in correctional institutions and upon release?

Joint planning between corrections, child protection, counselling services to ensure continuity of services and assessment of placements prior to release. Greater collaboration between Corrections and the services that will be working with young people when they are living in the community.

Topic C: Geographic considerations

1. What challenges do service providers face when trying to respond to the needs of children with PSB and young people with SAB outside metropolitan areas (e.g. those living in regional, rural or remote areas)?

- Lack of public transport
- Travel time and distance
- Geographical isolation
- Lack of affordable housing including public housing
- High indigenous populations
- Increasing refugee communities within rural and regional areas
- Lack of interpreting services
- Insufficient staffing in rural, remote areas to enable diverse approaches to be taken to treatment, for example running groups
- Lack of both technological skills and up to date technology which could easily be utilised to defeat the 'tyranny of distance' in many circumstances.

2. What would help victims and survivors outside metropolitan areas? Are there innovative ways to address the geographical barriers to providing and receiving support?

- Skype/telehealth resources
- Petrol vouchers/subsidised travel on V line and other transport networks
- Building capacity in smaller communities/partnerships with general agencies
- Training staff in rural and remote areas so they can use up to date technology.
- Funding for agencies to acquire up to date technology.

Topic D: Service systems issues

- 1. There is a range of terminology used to describe advocacy and support as well as therapeutic treatment services for victims and survivors of child sexual abuse. We provided our current working definitions in the introduction to this paper. Are these terms adequate and have they been defined appropriately? If not, what terminology and definitions should we consider using?**

SABTs programs use language which externalises PSB and SAB from the child/young person. It is not about avoiding responsibility, rather it recognises that developing children are likely to internalise a label such as 'sex offender' as part of their identity. A child does not have the capacity and perspective to separate the behaviour from the developing self. Almost all children and young people outgrow the behaviour and, after therapeutic treatment, do not continue to sexually harm. Recidivism rates are consistent for years across the world at around 6 to 8 percent.

It is important to utilise language that enhances safety rather than risk.

It is recommended that terminology such as PSB, SAB, SABTs continue to be used.

- 2. Given the range of services victims and survivors might need and use, in what practical or structural ways can the service system be improved so it is easier for victims and survivors to receive the advocacy and support and/or therapeutic treatment services they need?**
 - Extend Therapeutic Treatment Orders to 18 years old
 - Fund adequate PSB/SAB services in rural/remote areas
- 3. How can we ensure practitioners and workers are sufficiently skilled to provide advocacy and support and/or therapeutic treatment for adult and child victims and survivors, including those from diverse backgrounds?**

It is critical that practitioners who provide PSB and SAB programs are adequately trained, qualified and experienced. Agencies generally employ clinicians with appropriate skills and provide them with supervision and training. Training is provided through the SABTs Workforce Development Program that provides 6 x 1 day workshops and 4 peer mentoring sessions per year. This needs to be increased to ensure a well-trained, effective workforce.

Topic E: Evidence and promising practices

- 1. What promising and innovative practices (including therapies, interventions, modalities and technologies) for children with PSB and young people with SAB are emerging from practice-based evidence? Where are these available and who can access them?**

The SABTS system has a well formulated, best practice model with its basis in child development, trauma, and attachment and brain developmental principals. Promising and innovative practices emerging for victims and survivors and based on practice based evidence are certainly suggested by, for example, Van der Koll's long-term studies of the impacts of yoga-based therapies for trauma victims, brain-based research and our ability to understand impacts of therapeutic interventions in real-time due to MRI research, EMDR –focused interventions aimed at left-brain/right brain integration, trauma-focused CBT interventions, ACT (Harris) and Mindfulness-type interventions show promise. Interventions for institutional CSA will continue to emerge from the current royal commission. Restorative practices appear to also show promise as a part of a considered therapeutic approach.

2. What evaluations have been conducted on promising and innovative practices? What have the evaluations found?

There are longitudinal studies available but no Australian ones.

3. What other learnings are emerging from practice-based evidence or from grey literature (i.e. published reports and papers that have not been formally peer-reviewed, such as government reports) about supporting adult and child victims and survivors?

The shift to developmentally focused interventions for youth show us promise and move us from adult top down understandings of the impacts on children of SAB/PSB and sexual assault. Through this understanding we can engage in promising therapeutic interventions that take into account, for example, age and stage of abuse, and thus what impacts will be noted on development.

References:

Pratt, R.J. (2014) A therapeutic treatment model for sexually abusive behaviours in Victoria Australia: What does treatment look like? *Sexual Abuse in Australia and New Zealand*, (6)1, pp. 21-31.

Pratt, R.J. (2013) A community treatment model for adolescents who sexually harm: Diverting youth from criminal justice to therapeutic responses. *International Journal of Behavioural Consultation and Therapy*, (8)3-4, pp. 37-42.

Pratt, R.J, Miller, R, & Boyd, C (2010) *Adolescents who exhibit sexually abusive behaviours and their families*. Specialist Practice Guide for Department of Human Services, Victorian Government printer.

Rich, P. (2003) *Juvenile sexual offending: Understanding, assessing and rehabilitating*, John Wiley & Sons, New Jersey.

**Rich, P (2006) *Attachment and sexual offending: Understanding and applying attachment theory to the treatment of juvenile sex offenders*.
John Wiley & Sons, New Jersey.**

Rich, P (2011) *Understanding, assessing, and rehabilitating juvenile sexual offenders (2nd Edition)* John Wiley & Sons, New Jersey.

Carolyn Worth, Chair CEASE

27.11.15