

**STANDARDS OF PRACTICE  
FOR  
PROBLEM SEXUAL BEHAVIOURS AND  
SEXUALLY ABUSIVE BEHAVIOUR  
TREATMENT PROGRAMS**

**Auspiced by ANZATSA: PO Box 72, East Bentleigh**

## TERMS OF REFERENCE

### Background

CEASE has developed out of a need to provide the Government with a point of contact during the discussions around the development of Therapeutic Treatment Orders and legislative change towards this end. CEASE had its origins in the Offender Program Manager's Meetings which commenced in 2003. These were attended by MAPPS, CPS, ACF, Berry Street Shepparton and SECASA.

Since the original meetings the *Children, Youth and Families Act 2005* has been enacted and has as its guiding principle when providing services to children and their families, the Best Interest Principles. These principles are adhered to by the Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Programs.

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### Terms of Reference

1. To provide the Government with a central contact point for matters in relation to problematic sexual behaviours and sexually abusive behaviours.
2. Membership is open to all agencies working with children exhibiting with problematic sexual behaviours and young people with sexually abusive behaviours.
3. The Chair will be elected by a majority vote for two year terms in the December meeting.
4. To share information and knowledge in relation to current issues and trends within the field and encourage collaborative practice and communication.
5. To provide advice to the Government on the improvement of services for children and young people with problematic sexual behaviours and sexually abusive behaviours.
6. To develop standards for service provision within the field.
7. To provide leadership in the field.
8. Promotion of best practice in the field.
9. To adhere to and review annually the Standards of Practice.

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ABUSIVE BEHAVIOUR TREATMENT PROGRAMS**

**REVISED MARCH 2016**

### **A note on language.....**

The terms *problem sexual behaviour* (PSB) in relation to children under 10 years and *sexually abusive behaviour* (SAB) for children and young people 10 years and less than 17 years are used to clearly distinguish between these age groupings in terms of both their level of development and “criminal” responsibility. In the state of Victoria children from the age of 10 years are deemed to be criminally responsible for sexual offences.

The legislation underpinning Therapeutic Treatment Orders (TTO) in Victoria refers to the *sexually abusive behaviour* of children and young people 10 years and less than 15 years. The terms are therefore not intended to indicate subjective evaluations of the significance of the behaviour but rather to provide a consistent use of language.

Much of the early work in this area defines the PSB of pre-pubescent children as occurring in the context of “the absence of consent; involve[ing] the use of threat of force or force; coercion, and [may include] a disparity of age, level of development or size”. This definition has subsequently been accepted as identifying the contextual elements of SAB exhibited by children and adolescents (10 and less than 15 years) (Assessment and Treatment of Sexual Abuse (ATSA) Taskforce, 2006; Ryan, 2000, Boyd, 2006; Longo & Prescott, 2006).

The term *problematic sexual behaviour* has been broadly adopted to describe behaviour of a sexual nature irrespective of age that is both outside that behaviour accepted as “normal” for their age and level of development and occurs to the detriment of the child’s or young person’s engagement in activities of normal functioning. This may include behaviours such as excessive self-stimulation or excessive preoccupation with pornography that isolates them from normal social and/or learning opportunities and does not include the sexual abuse of others.

### **A note on approach...**

The SABTS program uses language which externalises problem sexual behaviours or sexually abusive behaviours from the child/young person. It is not about avoiding responsibility for actions rather it recognizes that developing children are likely to internalize 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. Many children and young people outgrow the behaviour and generally, after therapeutic treatment, do not continue to sexually abuse.

It is equally important to include immediate and extended family members in treatment to gain new understandings of the behaviour and to promote acceptance of the child or young person as a fully functioning family member. Exclusion, hostility and a stance which continually blames the child/young person can be counterproductive and push that child/young person to an isolated

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position within the family. Such a position can leave the child/young person with few options for socialization and healthy family and social relationships.

The SABTS program has been developed with the underpinning philosophy that first and foremost the “clients” are children and young people who, due to their age and level of development, are understood and engaged within the context of their families and the broader ecological systems with which they interact. This includes systems such as their peer group, school community, and the communities in which they live and the associated community organisations they may belong to.

The focus is, therefore, upon drawing from all of these areas to develop an understanding of the *PSB or SAB* for each individual and family in terms of the dynamic relationships between the identified strengths, risks and needs both within and across these ecological domains.

The theoretical areas of influence that have informed the development of the Therapeutic Treatment Model in Victoria include Feminist and Child Development theories, integrated with findings from the neurobiological, trauma, attachment and post traumatic stress fields.

This has reflected the consistent findings in the peer reviewed literature that identified common sets of risk variables within the developmental histories of these children and young people that may include disrupted attachment patterns, early persistent experiences of trauma, early exposure to sexually explicit material, exposure to family violence, impoverished and under resourced sole parents and neglect. A further consistent finding however is that despite these findings there is no predictive set of variables or typology for *PSB or SAB* as these variables are also evident in the histories of other same-aged clinical populations (Chaffin, Letourneau & Silvosky, 2002; Duane & Morrison, 2004; Elcovitch, Latzman, Hansen & Flood, 2009; Creedon, 2004; Perry, 2001; Rich, 2006; van der Kolk, 2003).

Essentially, there is no one size fits all approach to the treatment of children and young adolescents who exhibit *PSB or SAB* and their families. This work requires a broad based ecological approach to assessment for each child or young person and family and the treatment plan is then informed by this.

What we know is that families can provide a protective environment and reduce risk. They are pivotal to a shared understanding of the sexually abusive behaviours and the therapeutic process. It is understood that the child and/or young person, within their level of developmental understanding, is responsible for their behaviours; however, not for the social context in which they are performed. The child/young person subjected to the abuse is never to blame for the abuse.

## **Aims and Objectives of Standards of Practice**

### **Aims**

The Standards of Practice present a minimum set of requirements for services and service goals to ensure equity of access and quality of care for delivery of services. The Standards define and describe the quality of service provision.

The Standards of Practice Manual sets out standards that are benchmarks in providing quality service which act as guidelines for workers in organisations providing treatment for children and young people with problem sexual behaviours and sexually abusive behaviours. The Standards recognise the specific challenges facing rural and remote services, and which include recruitment and retention of staff and providing equitable and timely access to treatment. The Standards include minimum requirements for working collaboratively with statutory agencies and other services.

### **Objectives**

- To provide an accountability mechanism to service users, Department of Human Services, Department of Justice, and CEASE
- To provide standards for service provision
- To provide a framework for developing consistency of quality across the program
- To provide guidelines for service development
- To foster innovative and creative practice
- To encourage communication and collaborative practice with key partners including Victoria Police Sexual Offences and Child Abuse Investigation Teams (SOCIT), Child Protection and Out of Home Care providers
- To provide leadership in the field
- To ensure culturally sensitive and diverse services
- To recognise the specific vulnerability of children and young people with PSB/SAB and their families

### **Statement of Principle**

The Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Program rely on the Best Interest Principles outlined in the *Children, Youth and Families Act 2005* as its guiding principle when providing services to children and their families.

Division 2, Section 10:

1. The best interests of the child must always be paramount.
2. When determining whether a decision or action is in the best interests of the child, the need to protect the child from harm, to protect his or her rights and to promote his or her development (taking into account his or her age and stage of development) must always be considered.
3. In addition, consideration must be given to the following, where they are relevant to the decision or action –

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- a. the need to give the widest possible protection and assistance to the parent and child as the fundamental group unit of society and to ensure that intervention into the relationship is limited to that necessary to secure the safety and wellbeing of the child;
- b. the need to strengthen, preserve and promote positive relationships between the child and the child's parent, family members and persons significant to the child;
- c. the need, in relation to an Aboriginal child, to protect and promote his or her Aboriginal cultural and spiritual identity and development by, wherever possible, maintaining and building their connections to their Aboriginal family and community;
- d. the child's views and wishes, if they can be reasonably ascertained, and they should be given such weight as is appropriate in the circumstances;
- e. the effects of cumulative patterns of harm on a child's safety and development;
- f. the desirability of continuity and stability in the child's care;
- g. that a child is only to be removed from the care of his or her parent if there is an unacceptable risk of harm to the child;
- h. if the child is to be removed from the care of his or her parent, that consideration is to be given first to the child being placed with an appropriate family member or other appropriate person significant to the child before any other placement options is considered;
- i. the desirability, when a child is removed from the care of his or her parent, to plan reunification of the child with his or her parent;
- j. the capacity of each parent or other adult relative or potential care giver to provide for the child's needs and any action taken by the parent to give effect to the goals set out in the case plan relating to the child;
- k. access arrangements between the child and the child's parents, siblings, family members and other persons significant to the child;
- l. the child's social, individual and cultural identity and religious faith (if any) and the child's age, maturity, sex and sexual identity;
- m. where a child with a particular cultural identity is placed in out of home care with a care giver who is not a member of that cultural community, the desirability of the child retaining a connection with their culture;
- n. the desirability of the child being supported to gain access to appropriate educational services, health services and accommodation and to participate in appropriate social opportunities;
- o. the desirability of allowing the education, training or employment of the child to continue without interruption or disturbance;
- p. the possible harmful effect of delay in making the decision or taking the action;
- q. the desirability of siblings being placed together when they are placed in out of home care;
- r. any other relevant consideration.

Along with the Best Interest Principles, the program will be guided by the *Victorian Charter of Human Rights and Responsibilities Act 2006*.

For Aboriginal and Torres Strait Islander clients and their families accessing services, the program model will be guided by the *Aboriginal Cultural Competence Framework* to provide better outcomes for Aboriginal children and their families.

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## **Program Goals**

In preparing this section of the Standards of Practice, acknowledgement is given to ideas drawn from the New Street Ethos Statement developed by New Street Adolescent Service, Sydney West Area Health Service, NSW regarding that organization's underlying principles and philosophies.

Protection of children.

- To assist children and young people to:
  - Cease their sexually abusive behaviours.
  - Address the harm caused by their past behaviours.
  - Develop safe, respectful and responsible ways of behaving.
  - Address harm caused by their own experiences of abuse, if this has occurred.
  - Reduce their vulnerability and increase resilience.
  
- To assist families to:
  - Meet the emotional and physical developmental needs of their children.
  - Address the harm caused to relationships resulting from sexual and other abusive behaviours.
  - To promote and nurture safe respectful family practices.
  - To challenge secrecy and promote open communication within the family and healthy family relationships
  
- To contribute to community awareness of issues relating to sexual abuse and promote community safety.
  
- To contribute to the growth of knowledge and experience in addressing sexually abusive behaviour by children and young people.

## **Program Principles**

- Safety of children and young people is paramount.
  
- Children sexually abused by children and young people experience comparable harm to those abused by adults.
  
- Children and young people who have abused must be considered within the context of their age, development, family, education and broader community.
  
- Sexual Abuse is not the identity of children and young people who sexually abuse.
  
- All children and young people have the capacity to develop healthy and respectful ways of being and not continue to engage in sexually abusive behaviour

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- Measures to treat a young person who has been sexually abusive should promote and take into account their wellbeing
- It is important that family/carers participate in all interventions to contribute to the progress and changes for their child and to ensure open communication and improved family relating, where this is deemed to be in the young person's best interests.
- Practitioners need to be clear and inform the young person and parents/carers about their responsibilities for PSB/SAB and the implications of having a police charge and record
- It is imperative practitioners work to establish collaborative practices with all agencies and professionals involved with the family.

## **THERAPEUTIC TREATMENT ORDERS**

### ***Children, Youth and Families Act 2005***

*The Children, Youth and Families Act 2005 (CYFA)* (the Act) recognises that a therapeutic intervention for children exhibiting sexually abusive behaviours is more appropriate than a criminal response.

The Act makes provisions for reports to be made to the Department of Health and Human Services regarding a child aged over 10 and under 15 years who has exhibited sexually abusive behaviours and who the reporter reasonably believes is in need of therapeutic treatment. These reports can be made by:

- Any member of the community (including SABT providers)
- Victoria Police
- The Criminal Division of the Children's Court

The Act provides for the Secretary to investigate these reports, and where necessary, apply to the family division of the Children's Court for a therapeutic treatment order (TTO). Where a child needs to be placed out of their home to ensure their attendance and participation in an appropriate program, a therapeutic treatment placement order (TTPO) can also be applied for.

### **Therapeutic Treatment Orders**

A child may be placed on a Therapeutic Treatment Order (TTO) and/or a Therapeutic Treatment Placement Order (TTPO) if the Family Division of the Children's Court is satisfied that the child has exhibited sexually abusive behaviours and the order is necessary to ensure the child's access to, or attendance at an appropriate therapeutic treatment program. The orders remain for up to 12 months but can be extended for a further 12 months.

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Section 185 of the Act sets out the grounds for a report about a child in need of therapeutic treatment; that is a child who has exhibited sexually abusive behaviours: “Any person who believes on reasonable grounds that a child who is 10 years of age or over but under 15 years of age is in need of therapeutic treatment (as defined in section 244) may report to the Secretary that belief and the reasonable grounds for it.”

Where Child Protection receives a report regarding a child or young person in need of therapeutic treatment from a source other than Police (e.g. SABT provider), Child Protection must notify the Police at the point of intake in order for the Police to make an assessment of the need to commence a criminal investigation.

Where a child/young person and family have been referred to a therapeutic treatment service in a voluntary capacity and have failed to engage in therapy, the therapeutic treatment service should make a ‘child in need of therapeutic treatment report’ to Child Protection. Child Protection must classify the report a Therapeutic Treatment Report (TTR) and proceed with an assessment regarding the suitability of a TTO. This is because the family and child have not engaged in a therapeutic treatment service and a TTO may be necessary to ensure the child’s access to, or attendance at an appropriate therapeutic treatment program. Child Protection has the option to refer the matter to the Therapeutic Treatment Board for advice as to whether it is appropriate to seek a TTO in respect of the child/young person.

### **Therapeutic Treatment Board**

The Act provides for the establishment of the Therapeutic Treatment Board (TTB), made up of 16 representatives from: Victoria Police, Office of Public Prosecutions, one or more health services the Minister considers appropriate, and the Department of Health and Human Services. Members of the Therapeutic Treatment Board are appointed by the Governor in Council.

The role of the Board is twofold. First to evaluate and advise the Minister on services available for the treatment of children in need of therapeutic treatment and second, to provide advice to Child Protection regarding the suitability of a TTO for a child aged between ten and 14 years.

### **Intervention**

Following Child Protection’s investigation (and referral to the TTB where required) a decision regarding the appropriate intervention with the child must be made. The options for intervention are:

- No therapeutic treatment is required either due to the reported sexually abusive behaviours not being confirmed, or the child or young person and their family require other supports but not therapeutic treatment; or
- A TTO is not appropriate as the family and child have indicated their willingness for the child

to attend and participate in treatment voluntarily; or

- Although the family is ambivalent, with some support and time, the family may be able to ensure their child receives any treatment they require without the need for a TTO, so it would be appropriate for Child Protection to work with the family for up to 90 days from the report without applying for a TTO; or
- An application for a TTO would be appropriate, with the child remaining in their parents' care; or
- An application for a TTO would be appropriate, along with an application for a TTPO, because placing the child will be necessary for the treatment of the child; or
- The child's behaviours and criminal charges are so serious that it is Child Protection's assessment that the child's behaviours cannot be managed with a TTO, mandated treatment service such as MAPPS overseen by Youth Justice may be more appropriate.

Recent amendments to the *Children, Youth and Families Act 2005* now enable children attending treatment in a voluntary capacity to be afforded the same protection as a child subject to a TTO.

These protections are:

### **Admissibility of statements made in treatment by a child either voluntarily or whilst subject to a TTO**

Any statement made by a child when participating in therapeutic treatment either voluntarily or whilst subject to a TTO is not admissible in any criminal proceedings in relation to charges against the child associated with the sexually abusive behaviour (s. 251 CYFA). Evidence obtained from other sources may still form the basis for criminal charges.

The s.251 provisions does not remove or lessen the responsibility of the SABTs provider, or mandated professional to make a report to Child Protection where they believe a child is in need of protection, pursuant to section 184 of the CYFA. The SABT agency must report all disclosures of abuse of another child to Child Protection to enable investigation and notification of police. The young person may still be charged with a criminal offence as police have been able to obtain independent evidence to pursue the charges. If this were to occur, and where the child is placed on a TTO, child protection may consider revoking the TTO.

The s.251 provision is only relevant to the Criminal Division of the Children's Court. Any statement made by a child in treatment regarding further harm to children, or harm to themselves, is admissible in the Family Division of the Children's Court.

### **Section 354 and s.354A) Hearing about an adjourned case**

Section 354 and 354 (A) of the Act sets out what can occur when the court hears the adjourned criminal proceedings. If the court is satisfied that the child has attended and participated in the therapeutic treatment program either voluntarily or under a TTO, the court must discharge the child

without further hearing of the criminal proceedings.

Amendments to section 354 (4) also includes criteria regarding the content of a therapeutic treatment report for the SABTs to provide in order for the Court to be satisfied that the child has attended and participated in an appropriate therapeutic treatment program before the child is discharged from the criminal proceedings. The amendments state that the Court must have regard to:

- The child's attendance record
- The nature and extend of the child's participation
- Where or not the child's participation was to the satisfaction of the therapeutic treatment provider; and
- The opinion of the therapeutic treatment provider as to the effectiveness of the treatment.

***The amendment applies to children who attend treatment voluntarily or those subject to a TTO.***

## **REFERRAL PATHWAYS TO SABTS AND PROCEDURES**

### **Criteria for Referral**

Sexually Abusive Behaviours Treatment Services (SABTS) are funded state-wide in Victoria. Each agency is funded to provide services to children and young people in a geographical location. Contact details for these services, including locations, are given on page 31.

Children and young people referred for treatment to address problem sexual behaviours or sexually abusive behaviours must meet the following criteria:

- The child/young person has displayed problem sexual behaviours or engaged in sexually abusive behaviours;
- The child/young person resides within the region serviced by the SABTS agency or specialist therapeutic provider
- The child/young person is aged between 0-18 years, unless referring to MAPPS where referrals are received for young people aged 10-21 years.
- The child needs to be assessed to determine if they are at risk of abuse or at immediate and serious risk of further SAB. If so, a report to child protection should be made.
- If the sexually abusive behaviours constitute a criminal offence, a report to Police is required.

### **Referral Pathways**

Individual agencies receive referrals from families, Child Protection, Police, criminal division of the Children's Court, schools and other community organisations. All referrals to MAPPS are received from Youth Justice once there is a finding of guilt for that young person. The family of the child/young person being referred for treatment must consent to the referral, unless a Youth Justice Order, or a Therapeutic Treatment Order / Therapeutic Treatment Placement Order has been made which compels the young person to attend treatment.

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In the majority of cases, young people 10-21 years found guilty by the court of committing a sexual offence and placed on a Youth Justice Order are referred to MAPPS at the Adolescent Forensic Health Service, Royal Children's Hospital. MAPPS is the primary provider of treatment for young people subject to a Youth Justice Order who have committed sexual offences. However, there may be times where it is appropriate for other SABTS agencies to provide treatment for such young people.

### **Information Exchange**

It is generally agreed that an ecological approach to sexually abusive behaviour treatment is in the child/young person's best interests. Sharing information between service providers can be important in ensuring that treatment needs are being met. It is critical that children/young people and their family are informed about their rights to confidentiality and informed consent is obtained prior to exchanging information.

Information is generally exchanged in the following ways:

- secondary consultation for non-statutory service providers, such as out of home care agencies, education staff, Family Services practitioners, and other professionals working with the child/young person;
- case and care meetings;
- referral to other agencies, including SABTS agencies;
- reports to Police, Department of Health and Human Services, Department of Justice and other statutory agencies as required;
- written quarterly progress reports (including reports for those on TTOs) from SABT Services to child protection if the child is a client of the department.

## **PRACTITIONER REQUIREMENTS**

### **Education and Training**

Practitioners providing treatment for young people who have engaged in sexually abusive behaviours need to be trained, resourced and supervised regularly to maintain professional standards. In consultation with a nominated University, the Australian and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA), CEASE will work towards the development, of a Graduate Diploma for workers in the sexually abusive behaviours, problem sexual behaviours and sexual assault and family violence field. CEASE provide a leadership role in providing training and education to the broader community in this area.

## **Minimum Standards for Practitioners**

Practitioners are required to:

- Be currently working in a professional counselling capacity
- Be qualified as a social worker, psychologist or other relevant professional
- Practice in accordance with the Code of Conduct and Ethics of both their own profession and the Australian and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA)
- Have extensive experience working therapeutically with children, young people and their families.
- Have a minimum of fortnightly supervision with a supervisor experienced in the area of working with children and young people with PSB/SAB and families.
- Have a minimum of 5 days per year for full time employees of professional development about problem sexual behaviour and sexually abusive behaviours and family work. Part time employees should receive a pro rata professional development entitlement.
- Have experience in understanding the impact of PSB/SAB on the family
- Use an ecological approach to counselling

## **RISK ASSESSMENT**

*Key Issues to Consider in Preparing a Risk Assessment*

### **Risk of continuing to engage in problem sexual behaviours/sexually abusive behaviours**

Risk can be broadly understood in terms of key issues:

- Are there any factors in the child/young person's life that may prevent the young person from ceasing the behaviour?
- Will the child/young person engage in this behaviour again?
- If so when and with whom?
- What are the emerging patterns of behaviour?
- Where do they sit on the continuum of behaviours (severity)?
- What are the risks?
- Why is the young person exhibiting the behaviour?
- Important to look at context for both children and young people
- What was happening in child's/young person's history?
- Length of time behaviour was occurring?
- What are the triggers to the behaviour?

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## Timing and Timeliness of Report

It is important that assessments are conducted in a timely manner and a caution placed on reports that assessments may no longer be applicable beyond six months or if major changes have occurred in the child/young person's life.

## Risk to the Child

- Is the child/young person exposed to environmental factors such as drug abuse, domestic or family violence, and/or emotional abuse?
- Has the child/young person been sexually abused? Is the child/young person having ongoing contact with the abuser? A report may need to be made to DHHS Child Protection under the *Children, Youth and Families Act (2005)* and the Best Interest Principles.
- Danger of disconnection from family as a result of being out of home.

## Risk Assessment

Risk assessment should recommend the least intrusive option to bring about change. It should include any key elements of treatment that need to be included in any therapeutic intervention.

Risk assessment documents need to identify the dynamic nature of engaging in sexually abusive behaviours. Risk in re-engaging in sexually abusive behaviours will increase and decrease according to the absence or presence of a range of factors and circumstances. For example, where a particular stressor is present in the young person's environment, risk may increase, whereas risk may decrease when that stressor is mitigated by access to specific support people and supervision.

Assessments should emphasise that:

- Adolescent sexually abusive behaviour and adult offending are not the same
- Adolescent sexually abusive behaviours are generally motivated by different factors and cannot be categorized as one homogenous group
- The field is developing an increased understanding of different client groups and behaviour such as:
  - Sexually reactive behaviour as a result of sexual abuse
  - Non sexually reactive behaviour – No history of sexual victimization. Behaviour occurs in the context of other family/environmental and sociological factors including gendered, cultural, structural and social factors.
  - Behaviour which is anxiety driven, poor coping and social skills, ADHD, impulsive behaviour, developmental and/or intellectual disabilities.
  - Anti social Sexually Abusive Behaviours. It is unclear how dominant these issues are. High risk of non-sexual criminal type behaviour patterns emerging.
  - Sexually Abusive Behaviours as mechanism for coping with poor family circumstances.
  - Sexually Abusive Behaviours as comfort or curiosity about sex.

Appendix 1 provides useful information to assist practitioners when making an assessment. Please note this information is intended to be used as a guide only. Professional judgement should guide practitioners' use of recommended assessment measures and suggested assessment format. It is not intended that all measures be used in every assessment, or that the assessment format necessarily be followed precisely.

## **TREATMENT**

### **Guiding Principles of Treatment Models**

Treatment goals for these groups vary although there are commonalities in treatment. A review of the literature indicates that there are four essential components of treatment models:

- Community safety
- Preventing further harm
- Addressing harm caused
- Promoting well-being

Work with children and young people with problem sexual behaviours and sexually abusive behaviours, and their family, incorporates the Four Pillars of Trauma-Sensitivity (Sanctuary Model):

- Safety
- Emotion management
- Loss
- Future

A combination of the following treatment modalities is essential:

- Individual work
- Family work
- Eco-systemic interventions
- Group Work an option

Treatment models need to be flexible enough to accommodate the developmental needs of all children and young people, and their families. This may include children with learning and language difficulties, developmental delays and varying levels of intellectual ability.

Family members or carers need to be included in treatment for good outcomes.

The treatment models target both voluntary and mandated clients on a Therapeutic Treatment Order or other child protection order.

### **Children and Young People with Autism Spectrum Disorder or Intellectual Disability**

Bonner and Berliner provided two group treatment approaches for children aged 6 – 12 with sexual behaviour problems. Both CBT and dynamic play therapy were found to be effective in reducing children's inappropriate or aggressive sexual behaviour. Neither treatment approach was found to be significantly more effective than the other. At the two year follow up, approximately equal

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numbers of children in each group CBT 15% and DPT 17% had an additional report of sexual behaviour problems. A 10 year follow up study found the rate of sex abuse perpetration reports among former children with sexual behaviour problems who received brief focused treatment was no different from that found among general outpatient clinic children with ADHD (2 – 3%) (Chaffin 2008).

Children and young people with a disability tend to be overrepresented amongst those referred for treatment. Ayland and West (2006) developed The Good Way model, a strengths-based program using a Narrative Therapy approach. This approach is particularly relevant for children and young people with a disability as clients readily come to appreciate their strengths and good qualities and begin to step away from their own negative labels and in so doing begin to accept responsibility for the choice over which 'side' would have greatest influence over their behaviour. An evaluation of the model noted the model is successful in facilitating engagement, disclosure and learning about programme concepts.

### **Young People 10 – 15 years**

Adolescents are generally harder to engage in counselling than other age groups. Greenwald (2009) notes that young people with problem behaviours are notoriously difficult to help and that 'treatment often fails to lead to client change. The presence of neglect, abuse or abandonment in childhood as well as difficulties in developing close stable relationships, leading to social and emotional isolation are variables that appear to be correlated with sexually abusive behaviour.

The trauma and attachment treatment approach assumes that individuals have a universal need for safety, attention, acceptance, nurturance and care. Theorists argue that the process for meeting these needs is sometimes via abusive behaviour. They argue there are similarities between anxiety arousal and sexual arousal from a learning and limbic system perspective and these can lead to an overlap of the sexual and attachment behavioural systems. (Crittenden 1997 p 40) (Marshall 1989).

The focus of treatment (Crittenden, 1997 p 208) is on addressing the impact of trauma and attachment issues on behaviour and relationships. This includes gathering information on subtle or internalised cognitions and behaviours that were the consequence of the child's trauma experience.

A phase-oriented treatment approach which includes a shift of focus over time based on client needs, support tolerance, control and motivation is used. (p209) Theorists argue the fundamental goal in treating abusive behaviour should not be defined merely as the absence of abuse in relationships but as the increased capacity to engage and maintain stable, mutual and intimate relationships with others.

Patterson, DeBaryshe & Ramsey (1989) Reid, Patterson and Snyder (2002), have developed a dynamic developmental model for antisocial behaviour. The reinforcement for coercive behaviour model describes an at-risk child who is reinforced in the family environment for acting-out behaviour and who learns to favour this behaviour as a way of managing impulses and frustrations to the exclusion of pro-social alternatives.

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Alan Jenkins (1990, 1998, 2009) has developed an invitational model of engagement and intervention to assist young people who have sexually abused to make choices that will lead them towards responsibility and respect of self and others. The model invites young people to be accountable for their actions and to promote fairness, respect and an ethical stance.

### **Individual Work**

Treatment models will include individual work with:

- The child/young person who has engaged in the behaviours
- Their parent(s)/carer(s)
- Their siblings (including siblings they abused)
- Other significant people from extended family, Out-of-Home Care or community.

Victims of sibling sexual abuse and their family members should also be routinely referred for treatment. Their involvement in therapy is crucial to the 'recovery' of the family unit from the abuse, and ensures that the victims' experience remains a central part of treatment.

Non-sibling victims and their families should be supported and advised of treatment options. When victims and children engaging in PSB/SAB are members of the same extended family or close friends, it may be important to allow the separate treatment components to work closely together.

Individual treatment for children and young people who have engaged in problematic or sexually abusive behaviours may include the following themes:

- Rights and responsibilities (legal, social, familial)
- Impacts of problem sexual behaviours (on self and others)
- Victim experiences, including Trauma and Loss
- Identifying triggers
- Developing emotional intelligence and empathy (understanding one's own feelings, as well as those of others)
- Strengths based work developing social skills, self-esteem, confidence, communication
- Support networks
- Emotional and behavioural management/regulation
- Managing unsafe behaviours/creating safety
- Shame and disadvantage
- Healthy sexuality
- Gender/stereotypes/masculinity

- Other bullying behaviour and violence

Individual treatment for parents and carers may include the following themes

- Legal consequences of the behaviour for the child
- Managing unsafe behaviours/creating safety
- Providing appropriate supervision
- Rights and responsibilities (legal, social, familial)
- Parenting a child with emotional or behavioural difficulties
- Discussing puberty and sexuality and what constitutes healthy sexual behaviour.
- Impact of the problem sexual behaviours on parent's relationships, lifestyle and the family.
- Their own reactions – guilt, fear, loss, shame.
- Dealing with community responses
- Utilising support networks
- Rebuilding trust
- How to manage the PSB/SAB
- Addressing issues which may impact on parent's capacity to provide a safe and stable environment for their child/ren. Such issues may include mental health, substance use, and family violence.

### **Family Work**

Family work is a valuable modality of treatment

- All family members must to be invited to be involved in treatment, unless such involvement is contra-indicated
- Practitioners need to assertively engage with families as there is significant shame and stigma associated with the behaviour which needs to be addressed to promote good outcomes.
- Such an approach is likely to promote better treatment options

The goal of family work is multifaceted:

- To provide education and a frame of reference for parents
- To provide skills to parents to help their children recover from and manage the behaviour.
- To rebuild relationships in the family and extended family that have been damaged by the abusive behaviours

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- To use the enhancement of the relationships to:
  1. provide a supportive environment for the young person to address their abusive behaviour
  2. support the recovery of the victim/s of sexual abuse
  3. support the recovery of the abusing child and
  4. address attachment and antisocial difficulties
- To address the safety needs in the family
- To support strengths based approach in treatment.

Family work may include parent-child/carer-child, couple, sibling and whole-of-family sessions. Sessions may focus on a range of treatment themes (see those listed above). It may also bring in extended family members and significant others. If a child or young person has been removed from home family work is critical, family reunification should remain a high-priority treatment goal unless irremediable risk issues exclude this option.

Many treatment providers deliver models of treatment that necessitate the involvement of families in therapy. Services which target children and young people have found that the involvement of families in treatment is essential in producing best outcomes for the child and young person exhibiting problem sexual behaviours. In cases of sibling sexual abuse, the involvement of the family in treatment is particularly vital. Funding arrangements take into account the need for family work.

### **Group Work**

Treatment services in Victoria have demonstrated that the viability and efficacy of group work modalities of treatment for problem sexual behaviours/sexually abusive behaviours are dependent on several factors including:

- the age of the target group
- the nature of the sexual behaviours
- the number of clients who may be eligible
- the availability of appropriate facilities and adequately skilled facilitators
- the capacity of families and systems to support a young person's/child's regular attendance at group

Group work for parents can also be an effective form of intervention.

Group work for children, young people and parents may form a chosen modality of treatment where a service provider has identified that:

- there is a demonstrable need
- that sufficient client numbers exist to make this viable
- where such an approach is likely to promote better treatment outcomes i.e. not lead to iatrogenic effects

Group work may best act as a complementary treatment modality to individual and family-based methods of treatment and can be used to address issues related to problem sexual behaviours, such as social skills, rather than addressing the behaviours themselves.

Funding arrangements allow for sufficient flexibility such that services can provide group programs when they are likely to prove viable and beneficial.

### **Eco-systemic Interventions**

Eco-systemic interventions applicable to this population may include:

- working with schools
- working with extended family, significant others and occasional carers
- working with peers and the community
- collaboration with other professionals working the child/young person/family
- outreach to the client's local environment
- working with child protection and SOCIT
- working with Out-of-Home care providers

Funding arrangements presume eco-systemic interventions. In many instances it is valuable to meet with schools to discuss management plans and to develop Safety Plans. In rural areas outreach capacity is essential to effective service delivery. Work with extended family, peer and community groups may be particularly important to children and young people in care, or who are isolated from their immediate family. In rural areas practitioners can provide secondary consultation to other professionals in remote locations to assist them in providing the family interventions. Within funding provided the use of petrol vouchers, transport tickets and or video conferencing are recommended to assist families to access treatment.

## **SAFE PLACEMENT**

### **Safe Placement Guidelines**

In preparing this section of the guidelines, acknowledgement is given to the "safe placement" guidelines developed in the Children's Protection Society and the Initial Parent/Carer Assessment of the AIM Program in the UK (Morrison and Henniker 2006).

A safe placement is one in which a child is safe from further sexual, physical and/or psychological harm. The risk to other children should be minimised. Such a placement is one that protects a young person with sexually abusive behaviours by minimising both the risk and opportunity of the

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behaviour re-occurring. Safe placement considerations have particular relevance for children who normally reside together. Typically this would be a sibling group in which an older sibling has sexually abused a younger sibling. However the considerations equally apply to other circumstances or family arrangements in which children reside together.

### **Basic Principles in Relation to Removal and Reunification**

1. Removal should only be considered as last option
2. Reunification plan should be developed at the commencement of treatment
3. Safety plans always need to be in place
4. Review needs to occur on a regular basis

### **Statutory considerations**

In discussion with parents it is not unusual to have to address the role, or potential role, of statutory agencies. Consideration must be given to reporting sexual offences committed by young people with sexually abusive behaviours. The following legislative framework guides the decision-making around reporting:

a) In accordance with the *Children, Youth and Families Act (CYFA) 2005* S.10, all decisions should take into consideration the best interests of the child. This can be complex when weighing up the best interests of the victim alongside the best interests of the young person alleged to have caused sexual harm. However the best interests of the victim would usually prevail over the young person engaging in the sexually abusive behaviour.

b) When making a decision around whether to report to Child Protection, defer to provisions made in *CYFA 2005* S.162 (d) “the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type”.

c) When making a decision to report to Police, consideration is given to the *Crimes (Sexual Offences) Act 2006*. The reported sexually abusive behaviours must constitute a criminal act in accordance with the Act in order for treatment practitioners to consider reporting the disclosed information. Further considerations are set out below which inform a decision to report to Police.

### **Safety factors**

Many factors must be taken into account when assessing whether a young person who has displayed sexually abusive behaviours can safely remain at home with other children. Consideration of such factors can be an ongoing process from the intake phase, through counselling and as a consideration at the conclusion of treatment. These include a combination of parental and child factors.

#### *Parents*

The role of the parents is crucial in ensuring safety. The following factors are important to assess:

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- a) The response of the parents to disclosure of abuse. It is recognised that parents can feel torn between the needs of their children, particularly in situations where an allegation is denied by a sibling. Preferably a parent believes a disclosure, or is at least open to the possibility of it being truthful. It is important to understand that parental response may change through the process of assessment and engagement.
- b) The manner in which a disclosure is managed by parents can be an important indicator as to their capacity to maintain a safe environment. A contrast may be a parent who immediately sought help and a parent who sought to conceal a disclosure.
- c) The parent's attitude toward their children and the abuse. The parents' attitude toward who is responsible for the abuse and the significance of the abuse is important to clarify.
- d) The parents' commitment to a safety plan and likely capacity to implement this.
- e) Parents need to cooperate with agencies. In particular, they need to be supportive of counselling for their children. For a young person who has caused sexual harm this would often be with a specialist treatment service and attendance at the insistence of the parents. Ideally the victim of abuse would be encouraged to attend their own counselling. A commitment for parental participation in the counselling process should also be sought (i.e. family work).
- f) Parents must support and commit to restricting access of the young person to potential victims within or outside the household. This applies to all areas of the young person's life such as school, family, employment and social settings. A high level of supervision may be required.

### *Children*

The following factors relating to all of the children in the family contribute to the assessment of safety:

- a) The ages of the children in the home.
- b) The nature of the relationship between the child/ren and the young person who has engaged in sexually abusive behaviours.
- c) The history, nature and features the other children have of the young person's sexually abusive behaviours, including whether he/she has acknowledged the behaviour.
- d) The history, nature and features of any other problematic or aggressive behaviour by the young person.
- e) The response, presentation and view of the known victim following disclosure of abuse.
- f) The young person's behaviour in other contexts such as school and with peers.
- g) Whether the child/ren have been interviewed by Child Protection.
- h) Current stressors in the young person's environment which could act as potential triggers for the sexually abusive behaviour.

## **Responsibility of Treatment Providers**

Treatment providers need to recognise the onerous position of parents when considering if children can remain together following the disclosure or discovery of sibling abuse. When separation does occur, the prospect of reunification should be a focus of intervention from the commencement of assessment and treatment.

In order to be in a position to consider the best interests of all of the children, a care team approach to communication between counsellors is encouraged. This is particularly important when practitioners work in different programs within one agency or across agencies. Regular review meetings provide an opportunity to consider whether separation of siblings (should this occur) continues to be a therapeutic recommendation. Consent should be sought from parents and children for communication to occur between practitioners involved with family members.

## **Recommendation of Separation and Reunification**

The therapeutic needs of victims of sibling abuse and of the sibling who has caused harm will be an important consideration, both in decision making about children residing together and their being reunited in the event of a prior separation.

*From the perspective of the victim, the following factors are important:*

- That a child has had an opportunity to process the experience of abuse. In particular that the child has an appropriate level of understanding for their age, as to who is responsible for abuse;
- That they will not experience a sense of blame, or at least this is minimised as much as possible, and that they form some understanding of the experience in the story of their life.
- To address any adverse impacts of abuse.
- That in future contact with a sibling they have both a sense of physical and emotional safety. Some form of apology or restitution may assist in this regard.

*With regard to a young person who has caused sexual harm, the following factors are important:*

- A range of potential treatment factors has been discussed earlier in this document. Progress in these areas would be particularly relevant in sibling abuse situations.
- He/she is able to discuss his/her abusive behaviour and appropriate to his/her age, be able to acknowledge an appropriate level of responsibility.
- He/she is able to understand the influences/motivations of the abusive behaviour; to have strategies to manage these in the future.
- He/she is able to demonstrate some understanding of the impacts of the abuse upon the sibling and other family members. Some form of apology may follow from this.
- He/she is able to address other difficult behaviours such as aggression.
- He/she is able to communicate his/her views/needs, particularly to his/her parents.

## Parental progress

The role of parents to support the children in counselling is of great importance. Working toward establishing a home environment that ensures physical safety and supports emotional well being is essential. A supportive stance to the sibling who has caused harm includes holding them to account for their actions. In turn the quality of the parental relationship will be a significant influence on the conduct of the children, particularly around managing conflict and restoring trusting relationships.

**Table 1: Safe Placement Matrix**

	<b>FACTORS TO CONSIDER REGARDING REMOVAL</b>	<b>REUNIFICATION</b>
<b>Young Person with Sexually Abusive Behaviours</b>	<ul style="list-style-type: none"> <li>• Age</li> <li>• Progress in treatment admissions regarding alleged offences</li> <li>• Accepting of external limits/supervision</li> <li>• Willing to participate in treatment</li> <li>• Attending treatment regularly</li> <li>• Assessment of the young person's position? (Acknowledgment? Wants to cease? What are his special needs? Does he want the safety of being away from home?)</li> <li>• History of multiple and/or serious offences</li> </ul>	Child Protection is responsible for making decisions regarding removal and reunification. However, the therapeutic treatment provider's assessment of safety should be provided to Child Protection for consideration in their decision making.
<b>Victim(s)</b>	<ul style="list-style-type: none"> <li>• Age</li> <li>• Involved in treatment</li> <li>• Able to address abuse</li> <li>• Assessment of victim's position – how safe does she/he feel and what are her/his needs?</li> </ul>	<p>The victim's physical safety is maximised.</p> <p>The child does not feel pressure to be responsible for reunifying the family.</p>
<b>Family</b>	<ul style="list-style-type: none"> <li>• Parents' level of co-operation/ acknowledgment/ agreement to work with safety plan.</li> <li>• How easily can a safety plan be constructed? (What are the resources available for this family from the broader system and extended family? What are the options for placing the young person?)</li> <li>• How safe is the general community?</li> <li>• Developmental needs of all children?</li> <li>• What are the needs of the other siblings?</li> <li>• Does the family accept the need for supervision?</li> <li>• Have all children affected been referred for assessment and counselling?</li> <li>• Are parents willing to be involved in their children's treatment where appropriate?</li> <li>• Good capacity to supervise adequately?</li> <li>• Compliance with statutory and treatment service's recommendations?</li> </ul>	<p>Families develop at different stages. The young person may be ready for reunification before family, or vice versa. Care team reviews are important in tracking the readiness of all family members to ensure reunification occurs at the right time.</p> <p>Responsibility for reunification should not be placed with the victim child.</p>

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## Appendix 1: Sexually Abusive Behaviour Treatment Programs 2016

Program/ Agency	Address	Phone	Counselling	Fax	Email/website
Australian Childhood Foundation (ACHF) <b>0 – 15 y.o</b>	579 Whitehorse Road, Mitcham P O Box 525 Ringwood 3134	1800 176 453 9874 3922	9874 3922	9879 7388	<a href="mailto:itucci@childhood.org.au">itucci@childhood.org.au</a> <a href="mailto:aweller@childhood.org.au">aweller@childhood.org.au</a> <a href="http://www.childhood.org.au">www.childhood.org.au</a>
Ballarat CASA <b>0 – 15 y.o</b>	Cnr Vale and Edward Streets Ballarat 3353 PO Box 577 Ballarat 3353	5320 3933	5320 3933	5320 3817	<a href="mailto:casa@bhs.org.au">casa@bhs.org.au</a>  <a href="http://www.ballaratcasa.org">www.ballaratcasa.org</a>
Barwon CASA <b>0 – 15 y.o</b> Geelong and Horsham/Wimmera	1/59-63 Spring Street Geelong West 3220 PO Box 245 Geelong 3220 25 Roberts Ave Horsham 3400	Geelong: 5222 4318 Horsham: 5381 1211	Geelong: 5222 4318 Horsham: 5381 1211	Geelong: 5223 2979 Horsham: 5381 1777	Geelong: <a href="mailto:asmin@barwoncasa.org">asmin@barwoncasa.org</a> Horsham: <a href="mailto:wimmera@barwoncasa.org">wimmera@barwoncasa.org</a> <a href="http://www.barwoncasa.org">www.barwoncasa.org</a>
Children’s Protection Society <b>0 – 17 y.o</b>	70 Altona Street, Heidelberg West 3081	9450 0900	9450 0900	9457 6057	<a href="mailto:reception@cps.org.au">reception@cps.org.au</a>  <a href="http://www.cps.org.au">www.cps.org.au</a>
Gatehouse Centre <b>0 – 15 y.o</b>	Royal Children’s Hospital, Flemington Road Parkville 3052	9345 6391 9345 6800 0407569579	9345 6391 9345 5522 (a/h)	9345 6453	<a href="mailto:Karen.Hogan@rch.org.au">Karen.Hogan@rch.org.au</a>  <a href="http://www.rch.org.au">www.rch.org.au</a>
Gippsland CASA <b>4 – 15 y.o</b>	41 Buckley Street, Morwell PO Box 1124 Morwell 3840	5134 3922 0447343922	5134 3922	5134 8094	<a href="mailto:fiona@gippscasa.org">fiona@gippscasa.org</a>
Loddon Campaspe CASA <b>0 – 15 y.o</b>	71 Bridge St Bendigo 3550 PO Box 764 Bendigo 3552	5441 0430	5441 0430	5444 6713	<a href="mailto:lccasa@lccasa.org.au">lccasa@lccasa.org.au</a>  <a href="http://www.lccasa.org.au">www.lccasa.org.au</a>
YHaRS Youth Health and Rehabilitation Service	Level 1, 131 Johnston Street Fitzroy, 3065 PO Box 2950 Fitzroy 3065	9415 8881	1800 458 685	9415 8882	<a href="http://www.ysas.org.au">www.ysas.org.au</a> <a href="mailto:contact@ysas.org.au">contact@ysas.org.au</a>
Mallee SAU <b>0 – 15 y.o</b>	Suite 1, 144-146 Lime Avenue Mildura 3502	5025 5400 0419508357	5025 5400	5025 5432	<a href="mailto:info@msau-mdvs.org.au">info@msau-mdvs.org.au</a>

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<b>Program/ Agency</b>	<b>Address</b>	<b>Phone</b>	<b>Counselling</b>	<b>Fax</b>	<b>Email/website</b>
	PO Box 1373 Mildura 3500				
<b>SECASA AWARE 4-18 y.o</b>	Dandenong MDC 1 Dandenong Street Dandenong 3164 SECASA 11 Chester Street, East Bentleigh PO Box 72 East Bentleigh 3165	8769 2200 0414 538 275	8769 2200	8769 2219	<a href="mailto:secasa@monashhealth.org">secasa@monashhealth.org</a>  <a href="http://www.secasa.com.au">www.secasa.com.au</a>
<b>South Western CASA 0 – 15 y.o</b>	279 Kororoit Street, Warrnambool 3280 South West Healthcare, Ryot St. Warrnambool 3280 (Postal)	5564 4144	5564 4144	5561 5116	<a href="mailto:casa@swh.net.au">casa@swh.net.au</a> <a href="mailto:mclapham@swh.net.au">mclapham@swh.net.au</a>
<b>Upper Murray CASA 0 – 15 y.o</b>	38 Green Street, Wangaratta P O Box 438 Wangaratta 3676	5722 2203	57 22 2203	5722 2329	<a href="mailto:kburns@umcasa.com.au">kburns@umcasa.com.au</a> <a href="mailto:admin@umcasa.com.au">admin@umcasa.com.au</a>

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## Appendix 2: Assessment Format

The Assessment format reflects the multi systemic/ ecological framework adopted by the REFOCUS Program, Gatehouse Centre (Quinton, Kambouridis and Whitehouse, 2010). The areas identified are included in all assessments and advised screening tools and psychological assessment tools to guide clinical judgment are proposed:

Areas	Assessment tools
<p><u>Risk of further PSB/SAB</u> <u>For adolescent males, ages 12-18,</u></p> <p><i>Empirically derived items.</i> Intended as a Guide to clinical formulation. Not intended for use as standalone instruments.</p>	<p>Estimate of Risk of Sexual offence Recidivism (ERASOR). (Worling &amp; Curwen, 2001)</p> <p>Juvenile Sex Offender Assessment protocol (J-SOAP-II). Robert Prentky, Ph.D and Sue Wrighthand, PhD; 2003</p>
<p>The Juvenile Risk Assessment Tool (J-RAT) is designed as a clinical guide for an initial risk evaluation of further sexual offence.</p> <p>The IM-RAT is designed to be used as an interim/ongoing evaluation of risk for sexual re-offense, and is not designed or intended to be used as an initial assessment instrument.</p>	<p>Initial Full Risk Assessment (J-RAT) Stetson School, Inc., 2007</p> <p>Interim Modified Risk Assessment (IM-RAT) Stetson School, Inc., 2007</p>
<p><u>Risk of further PSB/SAB</u> <u>For adolescent boys, ages 8-13</u></p> <p>LA-SAAT should be used for the initial assessment of risk for continued problematic sexual behaviour.</p> <p>LA-IRAT - general and broad clinical evaluation conducted periodically for the primary purpose of ongoing assessment regarding sexual adjustment and risk, as well as individual service planning.</p>	<p>Latency Age-Sexual Adjustment and Assessment Tool (LA-SAAT), Stetson School, Inc., 2007</p> <p>The Latency Age-Interim Risk Assessment Tool (LA-IRAT) Stetson School, Inc., 2007</p>
<p><u>Individual characteristics</u></p> <ul style="list-style-type: none"> <li>• communication skills</li> <li>• attitudes/beliefs</li> <li>• trauma</li> <li>• attachment style</li> <li>• skills – problem solving, social</li> <li>• mental health</li> </ul>	<ul style="list-style-type: none"> <li>• Behaviour Assessment Checklist for Children (BASC-II) self report (8 years +) Cecil R. Reynolds and Randy W. Kamphaus, 2004</li> <li>• Self report Strengths and Difficulties Questionnaire (SDQ) R. Goodman, 1997</li> <li>• Beck Youth Scales – anxiety, depression, self esteem, delinquency, anger</li> </ul>

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<ul style="list-style-type: none"> <li>• cognitive</li> <li>• personality</li> <li>• PSB/SAB</li> <li>• Antisocial behaviour</li> </ul>	<ul style="list-style-type: none"> <li>• Trauma Symptom Checklist for Children (TSCC) Briere,1996</li> <li>• Trauma Symptom Checklist for Young Children™ (TSCYC™), John Briere, PhD.</li> <li>• Children’s Sexual Behaviour Inventory (CSBI ) W. Friedrich, 1993 (parent administration children 3 years to 12 years)</li> <li>• Millon Adolescent Clinical Inventory (MACI) T. Millon et al, 1993</li> <li>• Other age appropriate and empirically derived assessments as indicated.</li> </ul>
<u>Family assessment</u>	Structured interview – <ul style="list-style-type: none"> <li>• Family and developmental history</li> <li>• Family resources</li> <li>• Family stability</li> <li>• Parental health – physical, mental health</li> <li>• Parental/family participation and cohesiveness</li> <li>• Parenting approaches and skills</li> <li>• Parent report – BASC-II or SDQ</li> <li>• Family environmental factors</li> </ul>
<u>School</u>	Interview – <ul style="list-style-type: none"> <li>• Relationships with child / young person and/or family</li> <li>• Current interventions to date</li> <li>• Current supports for child/ young person (i.e. Aide, mentoring, school psychologist)</li> <li>• Teacher Report – BASC-II or SDQ</li> <li>• Educational assessments – including cognitive – evidence of learning difficulties</li> </ul>
<u>Peer relationships</u>	<ul style="list-style-type: none"> <li>• Levels of social connection</li> <li>• Evidence of pro social peers</li> <li>• Levels of social support from parents, school, coaches...</li> </ul>
<u>Neighbourhood and community</u>	<ul style="list-style-type: none"> <li>• Levels of connection to community</li> <li>• Nature of connection</li> <li>• Support for connection from others</li> </ul>

### Description of Key Assessment Tools

A description of the nature and intention of any tool used should be included in the clinical report. This provides a rationale for the purpose and intention of the tool to inform readers who may not have this information (i.e. case managers, courts,). The following information has been provided by the REFOCUS Program, Gatehouse Centre (Quinton, Kambouridis and Whitehouse, 2010).

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## Risk Assessment

### I *General information about Risk Assessment*

#### **Static and Dynamic Risk Factors**

Historical behaviours and experiences are *static risk factors* because they have previously occurred and will remain unaltered over time (absent of new information).

*Dynamic risk factors* are those more associated with current behaviours, thoughts, feelings, attitudes, interactions, and relationships, which can change over time. Treatment is generally directed towards dynamic factors that can be re-assessed periodically, allowing an adequate period of time between assessments in order to reasonably note change.

#### **Protective Factors**

Protective factors represent relationships, attitudes, beliefs, skills, and other factors at play in the life of the juvenile that may help mitigate the level of risk in any given domain, or the overall level of risk. Although risk assessment tools may not assess protective elements, these should be considered and taken into account by the clinician in evaluating risk. In some cases, a low or no level of concern or risk in any individual risk element or risk domain may also represent a protective factor.

#### **Significance of Concern**

The clinician's judgment is used to assess the significance or severity of each particular risk element. *In absence of further clarifying information, "Unknown" should be treated as a significant area of concern.*

### II *Risk Assessment Tools*

#### 1. Estimate of Risk of Sexual offence Recidivism (ERASOR). (Working & Curwen, 2001)

The ERASOR is an actuarial risk assessment designed to assist evaluators to estimate the risk of a sexual re-offence ONLY for individuals aged 12-18 who have previously committed a sexual assault. Despite the obvious appeal of actuarial risk assessment devices, there are currently no empirical data to support the predictive validity of any such tool for adolescent sexual offenders. Many of the factors used in The ERASOR are included because of some agreement in professional clinical opinion and at least some research support based on The "ERASOR" Version 2.0 and retrospective studies with adolescent and/or adult sexual offenders. It is important to inform the audience that the overall risk rating is a clinical opinion based on the scoring guidelines outlined in The ERASOR.

***Evaluators should note that their estimates of risk of sexual recidivism are time limited.*** Most of the retrospective research that has been used to support the factors included in The ERASOR is based on follow-up data of 3 years or less, and no study used a mean follow-up period beyond 6 years. Given this fact, plus the rapid developmental changes (i.e., social, physical, familial, sexual, etc.) during

adolescence, it will be important to note that any risk predictions are strictly time limited and should be repeated after either a fixed time interval (such as 2 years) or following significant change in one or more of the risk categories.

Note: Requires reading of the ERASOR Manual, 2001. Sexual Abuse: Family Education & Treatment (SAFE-T) Program, Thistleton Regional Centre, Ontario Ministry of Children and Youth Services, SAFE-T Program, 51 Panorama Crt., Toronto, M9V 4L8 Ontario Canada  
James R. Worling, Email: [jworling@ican.net](mailto:jworling@ican.net).

2. The Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) Robert Prentky, Ph.D. Sue Righthand, Ph.D. 2003

The J-SOAP is a checklist whose purpose is to aid in the systematic review of risk factors that have been identified in the professional literature as being associated with sexual and criminal offending. It is designed to be used with boys in the age range of 12 to 18 who have been adjudicated for sexual offences, as well as non-adjudicated youths with a history of sexually coercive behavior.

Decisions about re-offence risk should not be based exclusively on the results from J-SOAP-II. J-SOAP-II should always be used as part of a comprehensive risk assessment. Like any scale that is intended to assess risk, J-SOAP-II requires ongoing validation and possible revision as more is learned about how J-SOAP-II works and about how best to assess the risk of youths who have sexually offended. Because the revised J-SOAP is a new scale and it is just at beginning of collecting predictive validity data on it, provide users are not able to be provided with cut-off scores for categories of risk at this point; this is all the more reason why scores from J-SOAP-II should not be used in isolation when assessing risk.

Note: free download from [www.csom.org/pubs/JSOAP.pdf](http://www.csom.org/pubs/JSOAP.pdf)

3. A. Initial Full Risk Assessment (J-RAT) Stetson School, Inc., 2007  
Interim Modified Risk Assessment (IM-RAT) Stetson School, Inc., 2007  
(males aged 12 – 18 years)
- B. Latency Age-Sexual Adjustment and Assessment Tool (LA-SAAT), Stetson School, Inc., 2007  
The Latency Age-Interim Risk Assessment Tool (LA-IRAT) Stetson School, Inc., 2007  
(boys aged 8 – 13 years)

These instruments were designed by the Stetson School, Inc., as tools to guide the clinical assessment of risk of further sexual offences by children and young people within their program.

The J-RAT is designed for the structured clinical assessment of adolescent males, ages 12-18, who have, or are alleged to have, engaged in sexually abusive behaviour. It is not designed to be used for younger children, adults or females. The J-RAT may also be used to assess individuals reported to have engaged in sexually inappropriate behaviour that may not be defined as sexually abusive. However, in this case, the J-RAT will not yield an assessment of risk for sexual re-offence, due to the absence of a history of SAB.

The J-RAT is a structured clinical tool used to assist trained clinicians in the assessment of risk for continued sexually abusive behaviour (recidivism). The J-RAT provides the evaluating clinician with a

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structured format for the assessment of risk, based upon factors frequently described in the professional literature as relevant to risk for sexual re-offence (recidivism) in juveniles. However, in many cases, there is little empirical evidence that any of these factors are strongly related to sexual recidivism, and debate exists about the capacity of a clinical assessment tool to accurately predict risk, and especially in children and adolescents. Nevertheless, the J-RAT is a structured and literature-guided (sometimes known as a structured, grounded, or anchored and empirically-based) assessment instrument.

The J-RAT is not a statistically based assessment instrument, nor does it have any psychometric properties. It is an organised method for the clinical assessment of risk for sexual re-offence based on the professional literature. However, in conducting a clinical assessment of risk there is little doubt that a structured and literature-based assessment tool, such as the J-RAT, offers a reasonable approach to assessment, and offers a more valid and reliable approach than an unstructured approach to risk assessment (in which no risk assessment tool is used, and assessment is based upon unstructured judgment alone).

The Latency Age-Interim Risk Assessment Tool (LA-IRAT) is a clinical instrument designed to re-assess the possibility or potential for continued problematic sexual behaviour in children and young adolescents who have previously engaged in sexually reactive behaviour, including behaviour that is sexually abusive in nature. Most typically, re-assessment occurs when the child is in, or completing, treatment for sexually behaviour problems. The LA-IRAT is intended and designed to be used in conjunction with and as follow-up to the Latency Age-Sexual Adjustment and Assessment Tool (LA-SAAT), which should be used for the initial assessment of risk for continued problematic sexual behaviour. The LA-SAAT is a clinical instrument designed to assess the extent and behaviours of latency-age children (pre-pubescent) who have engaged in sexually reactive behaviour. However, the primary purpose of the LA-SAAT is to assess the possibility (or risk) that sexually abusive or sexually inappropriate behaviour will continue in the future.

The LA-IRAT assessment is a general and broad clinical evaluation conducted periodically for the primary purpose of ongoing assessment regarding sexual adjustment and risk, as well as individual service planning. It is not intended for initial assessment, and cannot be used for that purpose, and instead allows for periodic (interim) re-assessment. The primary focus of the LA-IRAT is the assessment of dynamic risk factors over time, or those risk factors that are susceptible to change and thus targets of treatment, also serving as a measure of progress in treatment.

### III *Broader Clinical Assessment*

#### 4. The Behaviour Assessment System for Children – II (BASC-II)

The Behaviour Assessment System for Children 2nd Edition (BASC-2) is a **norm-referenced** diagnostic tool designed to assess the behaviour and self-perceptions of **children and young adults ages 2 to 25 years**. The BASC-2 is a multidimensional and multi-method tool since it measures numerous behavioural and personality characteristics through several report based measures. This includes Parent report, teacher report and Self report for children 8 years and older.

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The BASC-2 is a behavioural assessment tool that can be used:

- for treatment program planning, evaluation, and intervention,
- to assist with differential diagnoses when used in conjunction with the *DSM-IV*,
- to determine educational classification and programming assistance eligibility,
- with other tools featuring overlapping norms for increased accuracy and reliability,
- to assist in determining causes of problem behaviour for children with disabilities,
- for forensic evaluation.

Note: Administration and scoring for the TRS, PRS, and SRP should be completed by professionals or paraprofessionals that are familiar with testing procedures and with appropriate supervision. As with other 'Level C' instruments, score interpretation must be completed by professionals with formal graduate-level training or clinicians with training in psychological assessment. (reference: <http://ags.pearsonassessments.com>)

#### 5. The Strengths and Difficulties Questionnaire (SDQ) Robert Goodman, 1997

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire that asks about 25 attributes, some positive and others negative. The 25 items are divided between 5 scales of 5 items each, generalizing scores for conduct problems, hyperactivity, emotional symptoms, peer problems, and pro-social behaviour; all but the last are summed to generate a total difficulties score. Three versions exist: the self-report for ages 11-17; the parent or teacher form for ages 4-10; and the parent or teacher form for ages 11-17. The self-report version is suitable for young people aged around 11-16, depending on their level of understanding and literacy.

Several two-sided versions of the SDQ are available with the 25 items on strengths and difficulties on the front of the page and an impact supplement on the back. These extended versions of the SDQ ask whether the respondent thinks the young person has a problem, and if so, enquire further about chronicity, distress, social impairment, and burden to others. This provides useful additional information for clinicians and researchers with an interest in psychiatric cases and the determinants of service use ([Goodman, 1999](#)).

The follow-up versions of the SDQ include not only the 25 basic items and the impact question, but also two additional follow-up questions for use after an intervention. Has the intervention reduced problems? Has the intervention helped in other ways, e.g. making the problems more bearable? To increase the chance of detecting change, the follow-up versions of the SDQ ask about 'the last month', as opposed to 'the last six months or this school year', which is the reference period for the standard versions. Follow-up versions also omit the question about the chronicity of problems.

Note: the SDQ is a free download available in many languages and can be accessed from <http://www.sdqinfo.com/b1.html>

6. Trauma Symptom Checklist for Children (TSCC). John Briere, (1996)

The TSCC evaluates posttraumatic symptomatology in children and adolescents (ages 8 to 16, with normative adjustments for 17 year-olds), including the effects of child abuse (sexual, physical, and psychological) and neglect, other interpersonal violence, witnessing trauma to others, major accidents, and disasters. The scale measures not only posttraumatic stress, but also other symptom clusters found in some traumatized children.

The TSCC is a 54-item self-report instrument consisting of two validity scales: namely Under-response [UND] and Hyper-response (HYP]) and six clinical scales, namely Anxiety (ANX), Depression (DEP), Posttraumatic Stress (PTS), Sexual Concerns (SC), Dissociation (DIS), and Anger (ANG).

7. Trauma Symptom Checklist for Young Children™ (TSCYC™), John Briere, PhD

This test is based upon caregiver report and evaluates acute and chronic posttraumatic symptomatology in children aged 3-12 years with a focus on the Preschool Child.

The TSCYC is the first fully standardized and normed broadband trauma measure for children as young as 3 years of age. The TSCYC contains eight Clinical scales: Anxiety, Depression, Anger/Aggression, Posttraumatic Stress-Intrusion, Posttraumatic Stress-Avoidance, Posttraumatic Stress-Arousal, Dissociation, and Sexual Concerns, as well as a summary posttraumatic stress scale (Posttraumatic Stress-Total). These scales provide a detailed evaluation of posttraumatic stress, as well as information on other symptoms found in many traumatized children.

Note: Administration and scoring requires a four year degree with satisfactory completion of coursework in Test Interpretation, Psychometrics and Measurement Theory, Educational Statistics, or a closely related area.

8. Child Sexual Behavior Inventory (CSBI) Friedrich, W. 1993

The CSBI is used to obtain a caregiver's report of a wide range of sexual behaviours for use in the evaluation of children and is intended for parents of children from age 3 to approximately age 11 who have been sexually abused or who are suspected of having been sexually abused.

The Child Sexual Behaviour Inventory is based on the recognition of the fact that sexual abuse is related to the presence of precocious sexual behaviour in children (Freidrich, 1997). The 38 items cover a variety of domains, including boundary problems, exhibitionism, gender-role behaviour (i.e. interest in acting like or being a member of the opposite sex), self-stimulation, sexual anxiety, sexual interest, sexual intrusiveness, sexual knowledge, and voyeuristic behaviour (Friedrich, 1997).

9. Millon Adolescent Clinical Inventory (MACI) Author(s): Theodore Millon, PhD, Dsc, with Carrie Millon, PhD, Roger Davis, PhD, and Seth Grossman, PsyD., 1993

The MACI is a 160 item self-report inventory to assess personality styles, significant problems or

concerns, and clinical symptoms in adolescents. Using a true/false format, the MACI surveys a wide range of personality characteristics and clinical symptoms that tend to be a focus in psychological evaluations of teenagers who either have or are suspected of having emotional /or behavioural difficulties. Its use is warranted where professionals suspect psychological difficulties are affecting a teenager's performance.

Multi-scale personality inventories such as the MACI are designed to improve the clinician's understanding of an adolescent's personality and clinical symptoms, but there are other reasons for using such instruments. The MACI can be helpful in formulating diagnostic hypotheses, confirming clinical diagnoses, formulating treatment plans, or making decisions about case management and disposition planning. In addition, the MACI can be used as an outcome measure to evaluate changes in an adolescents functioning as a result of treatment and intervention.

Note: Purchase and administration of the test requires licensure to practice psychology independently, or a graduate degree in psychology or those trained in the interpretation of standardised tests (Pearson, 2005; Millon, 1993)