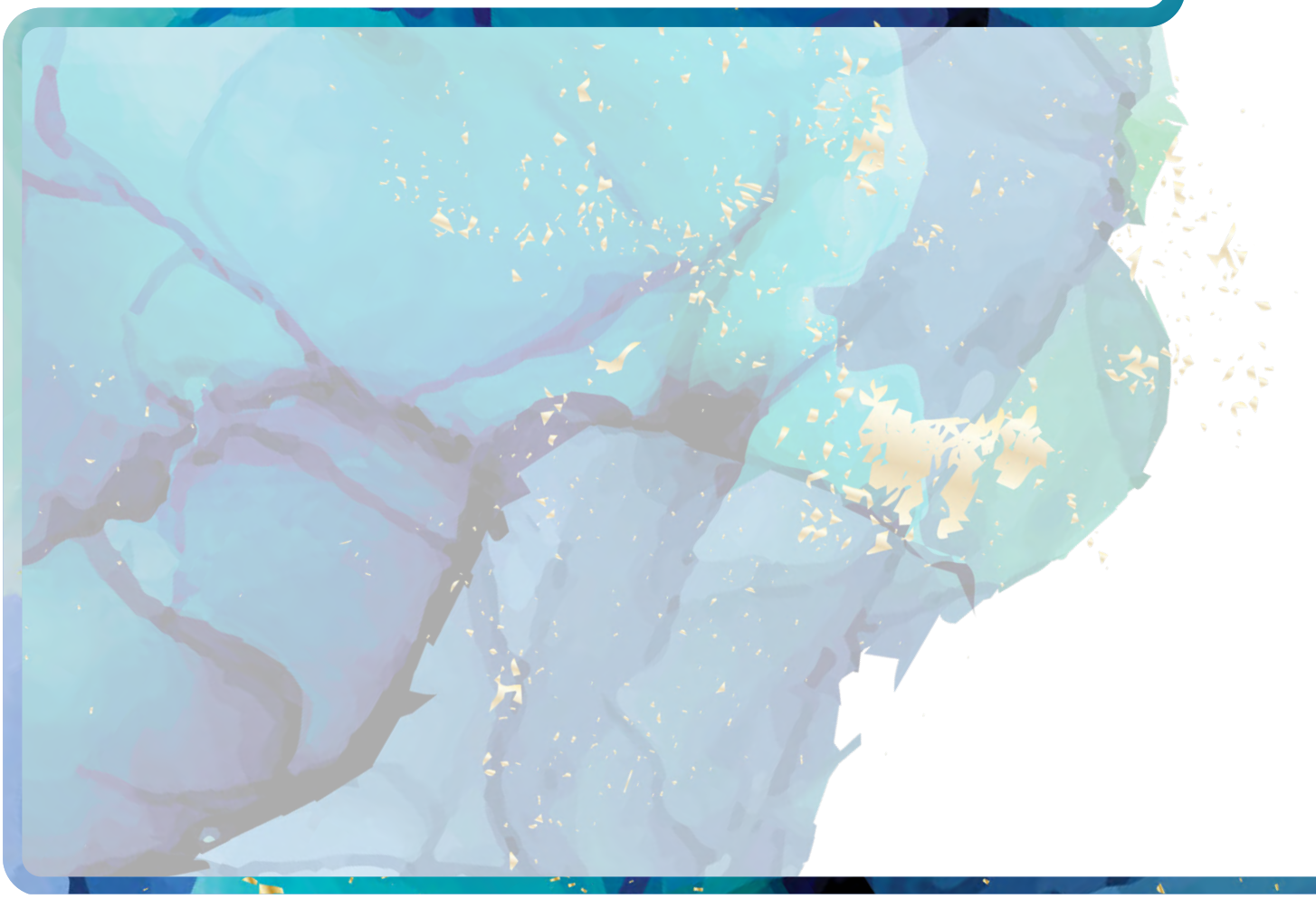
GOVERNMENT OF
WESTERN AUSTRALIA

Framework for understanding and guiding responses to harmful sexual behaviours in children and young people



Developed in partnership with the Australian Centre for Child Protection, Western Australia

University of South Australia | Australian Centre for Child Protection, Western Australia

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This Framework

The Framework for Understanding and Guiding Responses to Harmful Sexual Behaviours in Children and Young People (the Framework) has been developed for the Western Australian child protection and community services sector. It aims to build a better and more cohesive understanding of harmful sexual behaviours (HSB) in children and young people across WA to support practitioners, policy makers and carers to provide responses that are safe, effective and trauma informed.

The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission), highlighted HSB as a significant issue, dedicating an entire volume to guide the country's response to better understanding and responding to this ongoing concern. It defined 'children with harmful sexual behaviours' as children and young people under 18 years of age who have sexual behaviours that fall outside the range typically accepted as normal for a child/young person's age and level of development (Royal Commission into Institutional Responses to Child Sexual Abuse 2017). The term 'harmful sexual behaviours' recognises the seriousness of these behaviours together with the significant impact they can have on children and young people who have been affected, particularly where an appropriate response is not provided.

This Framework is a conceptual map of research evidence, relevant theoretical underpinnings, general practice principles and practice wisdom. **It contains four pillars that seek to guide practice and policy responses within the child protection community of WA:**

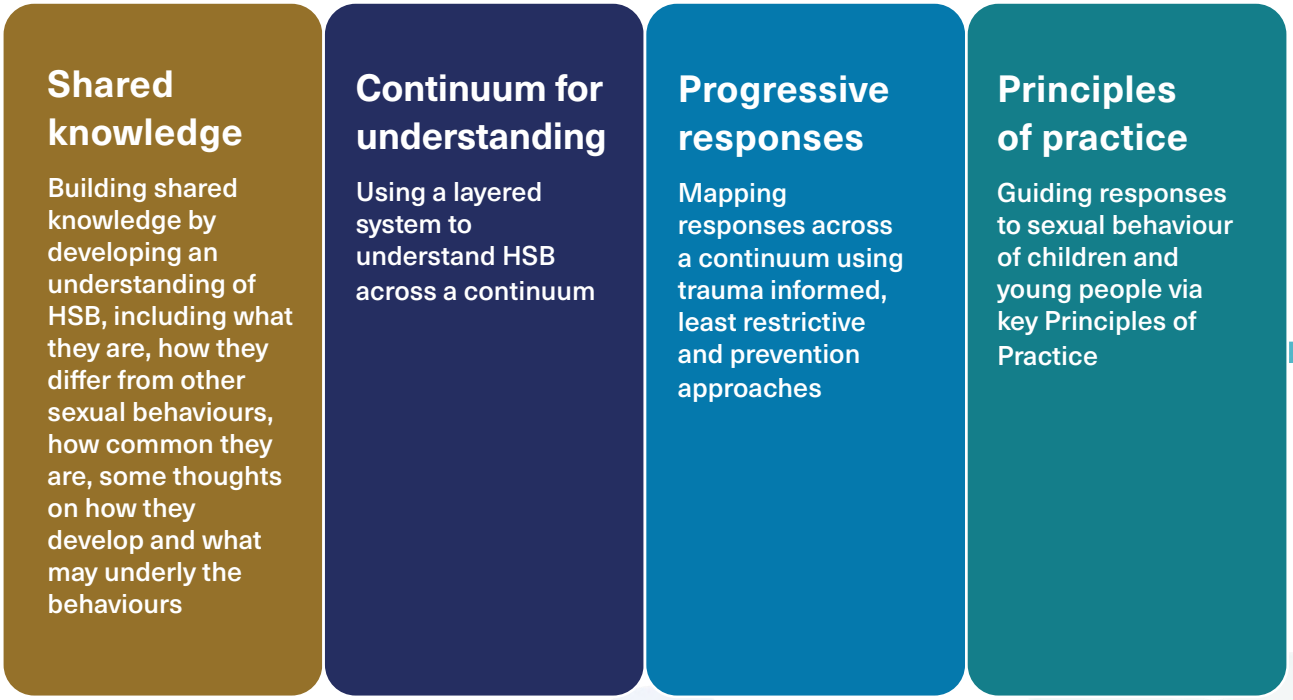

Figure 1: The four pillars

Acknowledgements

The Department of Communities and Australian Centre for Child Protection proudly acknowledges Traditional Custodians throughout Western Australia and recognises their continuing connection to their lands, families and communities. We pay our respects to Aboriginal and Torres Strait Islander people and cultures, and to Elders past and present.

Contributors

This Framework has been developed with local and national experts from the Australian Centre for Child Protection (ACCP) alongside various Department of Communities (Communities) staff. Some significant contributors included:

- Amanda Paton, Deputy Director, Practice – ACCP WA
- Professor Leah Bromfield, Director – ACCP
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- Sian Burgess, Practice Specialist – ACCP WA
- Dr Sarah Cox, Research Fellow – ACCP
- Dr James Herbert, Senior Research Fellow – ACCP WA
- Department of Communities staff including Aboriginal and cultural advisors.

Communities staff contributed through a series of consultations about HSB and the Framework. This included staff from metropolitan and regional WA, residential care, secure care, psychology services and district child protection offices.

In addition, various Government agencies involved with supporting children, young people and families impacted by HSB have also reviewed and provided comment where appropriate.

Message from the Minister

In 2021, the WA Government made the decision to invest in building the evidence base to inform identification of, and responses to children and young people exhibiting harmful sexual behaviours.

The Australian Centre for Child Protection Western Australia is leading this work which will improve how we understand harmful sexual behaviours (HSB), measure community need, improve our responses and support workforce development. The Framework for Understanding and Guiding Responses to Harmful Sexual Behaviours in Children and Young People is the first product from the collaboration with ACCP WA and an essential first step for improving the way we work.

The Framework will support development of a shared understanding about HSB, will directly inform service delivery including collaboration between agencies, and will provide the foundation knowledge from which workforce development activities are developed.

These are the essential building blocks to ensure that individual practitioners, services and service systems are able to provide the right supports at the right time to children and young people exhibiting HSB, to preserve their social and emotional wellbeing, and to safeguard the children and young people around them, in their family and community.

The Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) found that over 30 per cent of all survivors who shared their stories with the Commission had experienced sexual abuse from another child or young person. An entire volume of the Royal Commission final report is dedicated to the work we need to do to safeguard all children and young people in our community including those exhibiting HSB. The WA Government is committed to this work and will substantially progress the Royal Commission recommendations related to HSB, through the collaboration with ACCP-WA.

Simone McGurk MLA

Minister for Child Protection; Women's Interests; Prevention of Family and Domestic Violence; Community Services

The WA context

This Framework has been developed for the WA service context. It is intended to build upon existing, relevant child protection and family support policies and procedures and to inform the development of future policies. These include (but are not limited to):

- Stability and Connection Planning policy.
- Residential Care Sanctuary Framework.
- Policy on Child Sexual Abuse.
- Casework Practice Manual.
- Secure Care Practice Manual.
- Residential Care Manual.
- Protocol for standard of care and allegations of abuse in care.

The role of the Department of Communities

Communities is WA's major human services department bringing together vital services and functions that support individual, family and community wellbeing. Communities works collaboratively with partners across government and the community services sector to deliver disability services, child protection, housing, and community and regional initiatives.

Communities has a statutory role in protecting and caring for WA children and young people who are in need of protection and supporting families and individuals who are at risk or in crisis. Communities child protection responsibilities are set out in the Children and Community Services Act 2004 and operationalised through practice frameworks, policies and procedures.

Communities works proactively with families to keep children with them, safe at home. In circumstances where a child is in need of protection, and removed to care of the CEO, Communities works with the child's carer(s) and family to provide them with a safe, stable and culturally secure placement.

To support this mandate, Communities provides and funds a range of child safety and family support services throughout the state, including child sexual abuse therapeutic services and Indigenous Healing Services.

Communities' role in assessing and responding to child sexual abuse, which is inclusive of sexual harm caused by other children and young people includes:

- Assessing the wellbeing (safety, protective and support needs) of the child/ren involved.
- Assessing protectiveness by ascertaining whether parental factors:
  - » have contributed to the sexual abuse
  - » may lead to placing the child at risk of sexual abuse; and
  - » may impact their ability to provide adequate support or protection to the child.
- Referring the allegations to the Western Australia Police Force and childFIRST as appropriate.
- Undertaking Child Assessment Interviews in relation to an allegation of child sexual abuse (regardless of the age of the person causing the sexual harm) where a criminal offence may have occurred, and an assessment is being undertaken to determine if harm has occurred and whether the child is in need of protection.
- Providing protection and care for children in circumstances where parents have not protected or are unlikely or unable to protect their child from harm or further harm.
- Assessing the safety of specific children and young people who have contact with a person (regardless of age) convicted by the Courts, or assessed by the Communities to have harmed a child.
- Assessing and responding to Sexually Transmitted Infections (STIs) in children under 14 years of age.
- Joint investigations with the Western Australia Police Force in communities experiencing multiple reports of child sexual abuse.
- Providing or arranging for the provision of support and counselling services to the child and family as required.

In addition, Communities is also a partner in the Multi-agency Protocol for Education Options for Young People charged with Harmful Sexual Behaviours.

Communities also has a role in responding to concerns about children being forcibly engaged or married to older men. Child sexual abuse of a criminal nature falls outside of Communities mandate unless there are indicators that the parent/ caregiver may not have been protective.

Criminal responsibility for minors and legal age of consent

In Western Australia, Section 29 of the Criminal Code provides that a child cannot be found criminally responsible under the age of 10 years. A child under the age of 14 is not 'criminally responsible for an act or omission, unless it is proved that at the time of doing the act or making the omission [they] had capacity to know that [they] ought not to do the act or make the omission.'

In WA, the Criminal Code provides that a young person or child under the age of 16 cannot legally consent to having sex or the distribution of an intimate image. However, the age of consent is 18 years of age if there is a position of power or authority in the relationship (for example, between a teacher and student or a sports coach and team member).

Mandatory reporting

In Western Australia, the legislation covering mandatory reporting of child sexual abuse is the Children and Community Services Act 2004 (the Act). Currently, under Section 124B of the Act, doctors, nurses, teachers, police officers, midwives and boarding supervisors are required to make a mandatory report if they form a belief, on reasonable grounds, during the course of their paid or unpaid work, that a child has been the subject of sexual abuse or is the subject of ongoing sexual abuse. This is inclusive of sexual abuse by another child or young person.

Aligned with the Royal Commission into Institutional Responses to Child Sexual Abuse recommendations (Royal Commission into Institutional Responses to Child Sexual Abuse 2017, 7.3), WA is expanding the occupational groups required to make a mandatory report to include ministers of religion, psychologists, school counsellors, out-of-home care workers, youth justice workers and early childhood workers. Department of Communities officers and assessors who visit residential care and secure care facilities will also become mandatory reporters. (Children and Community Services Amendment Act, 2021). Changes to the legislation were passed by the Western Australian Government in October 2021 and will commence coming into effect in a staged implementation plan between 1 November 2022 and 1 May 2025. The amendments will also implement the Royal Commission recommendation that ministers of religion will not be exempt from mandatory reporting on the basis of information disclosed in or in connection with a religious confession (Royal Commission into Institutional Responses to Child Sexual Abuse 2017, 7.4).

The National context

Whilst child protection, health, justice and policing are state-based responsibilities, understanding and responding to HSB in the WA context is influenced by the National context. For example, the National Strategy to Prevent and Respond to Child Sexual Abuse (2021–2030) (National Strategy) and the National Centre for the Prevention of Child Sexual Abuse (National Centre) will both have an influence on future policy and practice guidelines as Royal Commission recommendations to drive national standards and understanding in this space are implemented.

The National Strategy will implement Royal Commission recommendations 6.1–6.3 (related to creating child safe communities through prevention) and, more broadly, will contribute to and support the implementation of over 42 recommendations, including advocacy, support and therapeutic treatment to victims and survivors, and responses to children with HSB.

The scope of the National Strategy is broader than primary prevention and awareness-raising, including initiatives under the following five priority themes:

- **Priority Theme 1:**
  Education and building child-safe cultures
- **Priority Theme 2:**
  Supporting and empowering victims and survivors
- **Priority Theme 3:**
  Enhancing national approaches to children with harmful sexual behaviours
- **Priority Theme 4:**
  Offender prevention and intervention
- **Priority Theme 5:**
  Improving the evidence base

The National Centre, guided by the National Office for Child Safety (National Office), has been established to address child sexual abuse by reducing stigma, promoting help-seeking and supporting good practice. The National Office anticipate that the National Centre will work as the delivery vehicle for some of the initiatives under the National Strategy and will be working in partnership with states and territories to ensure alignment of effort. It is expected that the National Centre will commence operation in 2022, and its work across priority themes 3 and 5 will guide future practice (Department of Social Services, 2021).

Pillar 1: Building shared knowledge

Childhood and adolescence are filled with periods of steady and rapid development and growth. From birth, children learn from their experiences, relationships, connection to community and the world around them more broadly. Progress through developmental stages typically occurs on a relatively predictable trajectory, with foundational skills and abilities being attained with continuous movement onto increasingly complicated or nuanced development and skill acquisition. However, for children and young people who have experienced harm, either singular or cumulative, this normal development can be interrupted, derailed or stalled altogether.

Like other areas of development such as motor skills and language acquisition, sexual and gender identity development begins from birth and continues through childhood and adolescence. Children learn through appropriate, natural and adaptive sexualised behaviour or play and exploration. Children who experience disruption to their developmental trajectory may also display behaviour and play that is not developmentally usual or expected, including HSB. Like many behaviours and developmental disruptions, HSB are best understood along a continuum of severity, intensity and impact within each psychosocial stage of development.

The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) defined 'children with harmful sexual behaviours' as children and young people under 18 years of age who have sexual behaviours that fall outside the range typically accepted as normal for a child/young person's age and level of development (Royal Commission into Institutional Responses to Child Sexual Abuse 2017). The term 'harmful sexual behaviours' recognises the seriousness of these behaviours together with the significant impact they can have on children and young people who have been affected, particularly where an appropriate response is not provided.

The term HSB is often used interchangeably with the term 'problem sexual behaviours.' However, this Framework suggests the term HSB is best understood as an inclusive term that includes concerning, very concerning and serious and extreme behaviours across a continuum. Behaviours in this spectrum vary considerably and are impacted by a variety of factors. These include developmental expectations, the emotional experience of children involved, the context within which the behaviour occurs, persistency and frequency of the behaviour, and the level of coercion, power and control displayed by one child over another.

This concept is closely tied to forms of child sexual abuse, including institutional child sexual abuse, dating violence and child sexual exploitation. The figure below highlights the overlap of these forms of child sexual abuse.

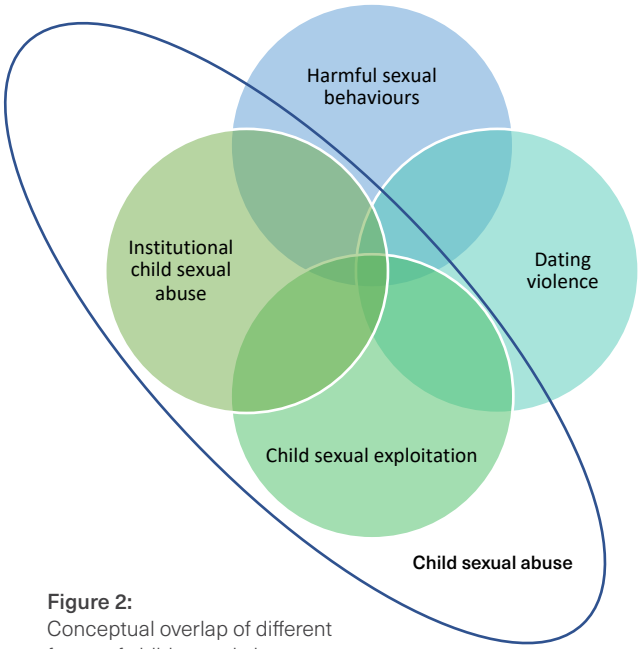
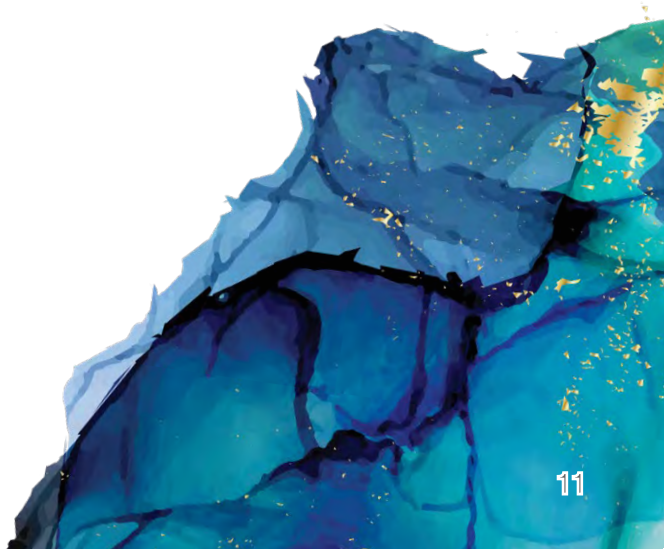


Figure 2:
Conceptual overlap of different forms of child sexual abuse

Often discussed together, there is considerable overlap in the presentation of, characteristics of the children involved in, and impact of these concepts. Correlation and overlap in the population of children involved in these would suggest that there may be some causal relationship between HSB, child sexual exploitation and dating violence, although this is still progressing. In addition, there is increasing understanding from the Royal Commission that HSB also occurs within institutional settings and can be a form of institutional child sexual abuse. Whilst it is critical to acknowledge the overlap within this Framework, and many of the principles and responses outlined within are applicable to all forms of child sexual abuse, the Framework does not extend to describe these in-depth or provide a continuum for understanding these sometimes-related behaviours in children and young people.



The power of language

HSB is an umbrella term chosen to convey both the impact and type of behaviour displayed by children and young people. As noted above it, includes behaviours that are deemed outside developmental and societal expectations and are concerning, very concerning or serious/extreme. Behaviours vary across the continuum in impact, intensity and concern. The term HSB has been specifically chosen over other terms such as problematic or abusive as it directly describes the impact of the behaviour to children, young people, families and community.

Similar to the use of HSB as a broad term, the language we use to describe individual children is also important. It is critical that their behaviours are not pathologised or placed within our traditional adult constructs. A child and young person's sexual and social awareness, cognitive capacity, and emotional maturity are distinctively different from adults. By their very nature, they are still developing their sense of identity, how they see themselves in the world, and how they relate to others. This includes at its core their sexual and role identity, sexual preferences and general understanding.

Societal and cultural norms influence our understanding and responses to children and young people with HSB, often causing fear and concern that their behaviour is deviant, abusive, and will lead to long term issues with sexual relationships and behaviour into adulthood. Sexualised behaviour within childhood and adolescence is distinctive from adults' sexual behaviours. Although sexual preferences and identity formation are recognised during adolescence, child and adolescent behaviour and sexual expression do not necessarily predict adult behaviour.

There is an overall lack of a common understanding and consistent approach to children and young people with HSB in WA and, arguably, across Australia. A lack of understanding may result in children and young people with HSB being vulnerable to stigmatisation, discrimination and being stereotyped with labels such as sexual deviates, sexual perpetrators, or sex offenders that they carry through to adulthood.

Children with developmentally inappropriate, concerning, very concerning and serious/extreme sexual behaviours are not adult offenders. Whilst it is important not to minimise or ignore the HSB, it does not define the individual, and children should not be labelled by their behaviours.

Terms such as 'perpetrator', 'predator' or 'paedophile' should never be used to describe a child, young person or their behaviour. Instead, 'child or young person with or displaying harmful sexual behaviours' is more appropriate. The term 'offender' may be used (although it should still be discouraged) in the circumstances (particularly within the WA justice system or by the Western Australia Police Force) where a young person has engaged in HSB which have reached the threshold for a criminal offence and where they have been charged and convicted of that offence. However, outside of the justice system, the term 'offender' is often unhelpful in describing the child or their actions as it can carry stigmatised or stereotyped connotations.

Children and young people who are given labels will often take on those labels as part of their identity and will act to the descriptors of the label. Descriptors, as noted in the second Pillar of this Framework, can be useful to convey the depth of the behavioural concern that the child is currently displaying. Still, caution must always be used, given the developmental nature of the behaviour.

How common is the behaviour?

Much like identifying the prevalence of child sexual abuse within the community, determining the prevalence of children and young people engaging in HSB is fraught with difficulty (Bromfield, Hirte, Octoman, & Katz, 2017). This is partly due to varying definitions of what constitutes HSB and associated data collection issues, but also due to the secrecy within which child sexual abuse occurs regardless of who is causing the harm.

A review of available literature in Australia by El-Murr (2017) concluded that, in general, studies locally find rates between 30 to 60 per cent of all experiences of childhood sexual abuse are carried out by other children and young people. Herbert and Bromfield (2018) noted a similar figure of 31 per cent (named offenders 10 to 19 years within a forensic setting) in a local WA sample during their review of the Multiagency Investigation and Support Team. Whilst there is data available for criminal offences related to young people who have been convicted of sexual assault in WA, this data is fraught and only represents a very small portion of behaviour within the HSB continuum. While multiple international studies have been undertaken, adding to the case that HSB in children and young people is an issue, while offering little to help understand the enormity of that issue within context, particularly in the WA context.

Some thoughts on how HSB develops

The Royal Commission highlighted that children with HSB have often been victims themselves, often with histories of adverse experiences in childhood, including trauma, prior sexual and physical abuse and exposure to family violence and harmful pornography. However, some young people who have not been exposed to these adverse childhood experiences also demonstrate HSB, and many young people who have been victims of maltreatment do not display HSB.

Research has demonstrated that HSB are often influenced by a variety of risk and protective factors occurring at the individual child, family, peer, school, neighbourhood, and community levels. There is certainly no single explanation for sexual behaviours, no more than there is a one-size-fits-all method for addressing them. However, there are a range of characteristics and circumstances that heighten children and young people's vulnerabilities. Experiences that fall within the broad term of Adverse Childhood Experiences (child abuse and household dysfunction) (Felitti et al., 1998) have been seen at increased rates within children and young people with HSB:

- Experience of child sexual abuse (Aebi et al., 2015; Friedrich et al., 2001)
- Experience of other forms of child abuse; physical abuse, emotional abuse, neglect and family violence (with 80 per cent of some samples of children with HSB also having experienced family violence) (Fox, 2017; Malvaso, Proeve, Delfabbro, & Cale, 2020)
- Caregiver instability, absence and/or difficulties with parent-child attachment relationships (Malvaso et al., 2020; O'Brien, 2008)
- Exposure to pornography and/or adult sexual activity (Malvaso et al., 2020; Wright, Tokunaga, & Kraus, 2016)

In addition, some characteristics or groups of children are more vulnerable than others to developing these behaviours:

- Children with a learning disability (Hackett, Phillips, Masson, & Balfe, 2013; Seto & Lalumiere, 2010)
- Children with impulsivity, social difficulties and difficulty with following rules (O'Brien, 2008)
- Male children (some samples note 97 per cent males) (Friedrich et al., 2001; Hackett et al., 2013)
- Children living in out of home care

HSB are often demonstrated due to a child or young person's lack of internal controls and understanding of boundaries and appropriate sexual interactions with others. As such, children with disability, for example, may not be aware of the impact their sexual expressions are having on others.

Common pathways in HSB presentations

There are two general models for conceptualising and understanding how HSB develops. One is to see the behaviour through a needs-led or unmet need approach commonly used in understanding challenging behaviour, (ie, removing the 'type' of behaviour), the other is through a series of pathways that seek to understand the behaviour in terms of its sexual expression, Cavanagh-Johnson (1999), and Hackett, Holmes, and Branigan (2016) .

The needs-led, or unmet need style approach sees challenging behaviour of any form as a means of fulfilling a need in the individual. The behaviour is a way of communicating that need to others, and unfortunately in the right circumstance both present (stressors, environment, context etc) and pre-existing (personality style, temperament, past behaviour patterns etc), the method of communication or behaviour is problematic and challenging to others. This principle is often used when exploring the origins of behaviour within the context of trauma, i.e. What we see on the tip of the iceberg is the aggressive behaviour, but what lies underneath the water is emotional distress, trauma reminders and other complex trauma symptoms. **The iceberg diagram below is a simple representation of how HSB behaviour may be driven or led by needs from underneath.**

Figure 3: What's underneath the surface leading to the HSB

Neither model is preferred over the other for understanding HSB, and in fact this framework encourages the integration of the two models.

The diagram below brings together some typologies (or groups) of presentations to help articulate some common themes or clusters of HSB, that include a complex milieu of characteristics and circumstances. The information in this diagram is informed by the work of Tucker (2017) who uses a needs-led approach, and those by Gil and Shaw (2014), Cavanagh-Johnson (1999), and Hackett, Holmes, and Branigan (2016) who utilise a conceptual model incorporating the sexual content of the behaviour; it is then built upon with contemporary clinical practice for this Framework.

Figure 4: Common pathways of HSB developing

What are the impacts of HSB?

Harmful sexual behaviours in children and young people are significant and require our attention and response because they are, by their very definition, potentially harmful to the child, their family and carers and at times to the wider community. Targeted early intervention is needed to minimise the impacts these behaviours can have on the child or young person displaying the behaviour, and on any other children exposed to or experiencing the behaviour. While the particular impacts of HSB may vary from child to child depending on their circumstances, life experiences and unique personal attributes, they are nonetheless devastating and often pervasive.

Children and young people exposed to HSB

Children and young people can be significantly affected by the HSB of their peers. Impacts may range from feeling uncomfortable and ashamed when exposed to HSB to significant health and mental health issues (when exposed to extreme and violent acts by a peer). Research suggests that, some children and young people who have experienced sexual abuse or harm by another child or young person display many of the same trauma impacts as children sexually harmed by adults (Shaw, Lewis, Loeb, Rosado, & Rodriguez, 2000: O'Brien, 2010) and are at risk of experiencing life-long impacts, including trauma.

Immediate and long term adverse effects of exposure to HSB can encompass physical and psychological health, neurobiological development, interpersonal relationships, connection to culture, and sexual identity. Like all forms of child abuse and neglect, the impacts are individualised and may exist across a child's different functional domains.

Children and young people exposed to HSB may experience flashbacks and nightmares or develop ongoing learning, social, and behavioural difficulties. They may feel upset, angry, fearful and confused. Some children may also experience feelings of shame and guilt, blaming themselves for 'getting into the situation' or being unable to stop it, especially if they started as willing participants. They can also be humiliated and shamed by others, even if they are the victim of the behaviours. These impacts can lead to longer-term problems with future intimate relationships, mental health and wellbeing.

Many complex and interconnected factors may influence how children and young people are affected by sexual abuse. While no single factor can accurately predict how an individual will respond, some factors appear to influence either the severity or type of impacts they experience, including:

- the characteristics of the abuse (such as the type, duration, and frequency)
- the relationship of the perpetrator to the child (including power differential and age differences)
- the social, historical, and institutional contexts of the abuse
- the victim's circumstances, experiences, and characteristics (such as age, gender, disability, prior maltreatment, and experiences with disclosing the abuse) (Royal Commission into Institutional Responses to Child Sexual Abuse 2017)

Children or young people who display HSB

HSB in most instances not only causes harm to those around them but also to the child or young person displaying the behaviour. Children and young people displaying HSB visible to others are frequently labelled, marginalised or stigmatised by their peers and the adults around them because these behaviours are not socially acceptable. They may be pigeonholed as dangerous by other adults and prevented from participating in school activities, play dates or sporting events. These labels and the views of others tend to stick with the child or young person, being carried with them across environments and over time into adulthood. When this occurs, it can lead to a spiral of other mental health and social difficulties for the child or young person, because they begin to feel hopelessly isolated, bad, ashamed and different. They may become angry, seek to isolate themselves further, and become less willing to engage in supports or interventions for their behaviour (and the underlying issues) if early intervention is not provided. Self-harm and suicide ideation may be apparent in extreme cases where appropriate supports are not provided, particularly in older adolescents.

Engaging in HSB can also lead to criminal charges and legal consequences for children and young people who are aged above the age of criminal responsibility and where their behaviours are deemed illegal. The age of criminal responsibility is the age at which a child is considered by law to have understood that their actions were wrong and can face criminal charges. All Australian states and territories currently have this age set at ten years of age. Any child over ten years who engages in HSB toward another child or young person may be criminally charged in certain circumstances. If convicted, they may be subject to custodial sentences, probations and sanctions that limit their freedoms and future opportunities. Whilst this is not common when viewed within the broad scope of HSB, the impacts are devastating for a young person.

As noted previously, many children and young people who develop HSB are also victims of child abuse themselves. They have often been exposed to adverse childhood experiences, leading to a range of complex trauma symptoms similar to those children who have experienced child sexual abuse. Further, many children and young people who display HSB lack understanding about respectful relationships and boundaries and can have difficulty developing and maintaining peer relationships. Due to their limited understanding of personal boundaries, many are also vulnerable to peer isolation. For some, their indiscriminate friendliness and inability to understand boundaries results in a vulnerability that may place them at increased risk of being sexually victimised and exploited by others.

Cultural considerations

When working with children and young people displaying HSB and their families, we need to be mindful of cultural issues from our very first interactions and at every step through our work with them, the specifics of which will vary according to your role. Culture can impact how HSB are reported, understood and viewed by individuals and families. It is helpful to explore the understanding, language and meaning held by the children, young people and their families early on in your work with them. Being curious and open in your enquiry will reduce the likelihood of incorrect assumptions being made and the child, young person, or family feeling misunderstood or unheard. It is also important to enquire about any cultural implications or consequences for the child relating to their HSB, such as shame, social exclusion or impact on cultural standing. Once you have this information, you must consider how this may impact the child, their circumstance and your work with them.

In considering the factors that increase a child or young person's vulnerability to developing HSB, cultural considerations must be taken into account. Of particular note are those related to Aboriginal and Culturally and Linguistically Diverse (CALD) populations. The Royal Commission (2017, p. 38) heard via submissions that:

"Children and young people from particular communities such as Aboriginal and Torres Strait Islander children, children with disability and children from CALD backgrounds were more likely to encounter circumstances that increased their risk of abuse in institutions [and] reduced their ability to disclose or report abuse. Reasons for this related to experiences of prior trauma and intergenerational trauma."

O'Brien (2010) reports Aboriginal children engaged in harmful sexual behaviours are more likely to have experiences of trauma loss and alienation, physical and/or sexual abuse, and to have been exposed to family violence. O'Brien suggests that treatment responses for Aboriginal children and young people displaying HSB, particularly those residing in Aboriginal communities, should heavily focus on addressing the contextual factors of systemic disadvantage that constitute risk pathways to these behaviours. These factors include care arrangements, overcrowding, and homelessness rather than the child's individual behaviour and should be focused on once safety planning has been implemented to ensure the safety of the child and others around them.

It is important that we treat information relating to HSB in Aboriginal children particularly carefully, as recent studies show Aboriginal children and young people aged over ten years are 6.5 times more likely to be charged by police for a sexual offence and 10.4 times more likely to be charged with a violent offence than non-Indigenous people (Allard, 2010).

It is okay to feel uncertain or underinformed about cultural issues related to HSB. However, it is essential you remain aware of this and seek guidance and input from cultural experts when required.

Nature of HSB in residential care

Children and young people in residential care are more likely to display and be exposed to HSB than their peers in other forms of care, who, in turn, are more likely to encounter it than others not living in out of home care. Unfortunately this is not a concern unique to WA or even Australia, with studies from all over the world articulating this trend and the complex milieu of factors that contribute to and maintain HSB, (Attar-Schwartz, 2014; Collin-Vézina, Coleman, Milne, Sell, & Daigneault, 2011; Euser, Alink, Tharner, van IJzendoorn, & Bakermans-Kranenburg, 2013; Moore, McArthur, & Death, 2020). Like WA, many jurisdictions continue to invest heavily in this area in an attempt to grapple with these complex issues, contribute to research in an effort to better understand the underlying causes and develop fit for purpose response models and frameworks within residential settings.

Children and young people in residential care who display or are exposed to HSB are also at-risk of experiencing sexual exploitation by both their peers in residential care and by adults and other young people outside of residential units (Gatwiri, Cameron, Mcpherson, & Parmenter, 2020). Examples of sexual exploitation highlighted in recent Australian inquiries include facilitated prostitution, sex for shelter and adult-child sexual abuse (Bruce & Mendes, 2008). The international literature suggests that there are a number of individual and contextual factors for this situation. These factors are described below.

Individual factors

Children and young people are placed in residential care due to experiences of abuse, neglect and trauma, often because other care options are not available or have broken down (Bath, 2008; Green & Masson, 2002). These adverse and ongoing traumas can play a part in children and young people's use of HSB and vulnerabilities that can increase the likelihood of their exposure. In particular, many young people who display HSB are placed in residential care because foster and kinship carers are not willing or adequately equipped to manage their behaviours (Moore, McArthur, Heerde, Roche, & O'Leary, 2016). At the same time, especially vulnerable children and young people who have not used HSB (including those with disability, mental health issues and limited connections) are more likely to live in residential care and be exposed to their peers' behaviours (Bath, 2008).

Many children and young people in residential care have also not been exposed to healthy and appropriate relationships and may have distorted views about appropriate expressions of sexuality (Moore, McArthur, Death, Roche, & Tilbury, 2016). HSB are often displayed when children and young people have not been taught appropriate or healthy ways of expressing themselves or managing their traumas and emotions. For example, research has suggested that without other strategies for self-soothing and emotional regulation, and with an absence of appropriate opportunities to be comforted, feel loved or cared for, many children and young people often have poor boundaries and use, or are exposed, to inappropriate expressions (Zaniewski, Dallos, Stedmon, & Welbourne, 2020). With poor self-esteem and low expectations of what

types of relationships they deserve, children and young people in residential care can also be less empowered to resist or report their exposure to HSB in these settings.

Although most young people who exhibit HSB display less of these behaviours as they transition to adulthood, there is some evidence that young people in residential care are more likely than children and young people not in care to continue using HSB into adulthood. This continuation may occur when their psychosocial needs are unmet and effective therapeutic responses remain unprovided (Friedrich et al., 2005). This does not mean that there should be an expectation that life-course offending is probable, only that more interventions should be enacted for this cohort (McKibbin, 2017).

Contextual factors

The international literature highlights several contextual factors that increase the likelihood that children and young people in residential care will display or be exposed to HSB. Unlike most home environments, HSB sometimes occur in residential care due to the cultures that reinforce inaction and the nature of relationships established in these units.

The cultures of some residential care units can either cast children and young people as being asexual (and any sexual expressions as problematic) or as hypersexual (with HSB being excused or minimised) (Barter, 2006). This affects how workers in these settings identify and respond to instances of HSB and their willingness to have appropriate conversations and intervene when concerns about young people's expressions of sexuality emerge (Charles, Coleman, & Matheson, 1993). Macho, misogynistic and homophobic cultures and cultures that either promote or turn a blind eye to problematic behaviours also enable HSB to occur, as do those where workers feel unwilling or ill-equipped to identify and prevent HSB from occurring (Bruce & Mendes, 2008; Green, 2005). Conversely, in residential care units where staff are empowered to play a role in encouraging healthy sexual development, there is an increased likelihood that appropriate conversations with young people about their needs and behaviours will take place, which in turn can reduce the likelihood that HSB will occur (Green, 2001).

International studies have also demonstrated that some young people use HSB (including sexual harassment and intimidation) as a means of asserting power and status in peer hierarchies, particularly when young people feel disempowered (Barter, 2003; Moore et al., 2020; Moore, McArthur, Death, et al., 2016; Moore, McArthur, Heerde, et al., 2016).

Although the prevalence of HSB in residential care is significant, there is an argument that the increased surveillance of children and young people in these settings also increases the likelihood that concerning behaviours will be identified.

Pillar 2: Understanding harmful sexual behaviours across a continuum

Using a layered system

Models first suggested by Cavanagh-Johnson (1999), and Hackett, Holmes & Branigan (2016), and supported by Meiksans, Bromfield & Ey (2017), all suggest that a continuum-based approach should be taken to understand HSB, recognising that HSB includes a range of behaviours of varying severity, deviation from the norm, and impact. This Framework utilises Paton and Bromfield's (2022) layered approach to understanding and responding to HSB across a continuum. This approach was developed with the WA service system in mind. Paton and Bromfield's HSB Continuum builds on the work of previous continuum's, adding additional layers (developmental stage, social and environmental context etc), providing additional practice guidance for different developmental stages, and using less stigmatising labels to better enable the continuum to be used as a practice tool between disciplines.

Detailed in Table 1 on the right, the continuum classification of sexual behaviour displayed by children is designed to guide practitioners' understanding and response to a range of behaviours. The proposed continuum extends from sexual behaviour that is Developmentally Appropriate through to that which may be considered HSB, inclusive of concerning, very concerning and serious/extreme sexual behaviours. The continuum should be used in a layered manner. Practitioners should first look to review the behaviour in terms of a child or young person's developmental age and stage (physically, psychologically, socially, and cognitively), the social and environmental context within which the behaviour occurs, and through any relevant cultural lens. Once this level of assessment is complete, additional factors must be considered at the bottom end of the continuum. These additional factors include persistency and frequency of the behaviour, the emotional experience of the child or young person when the behaviour is displayed (and observed or uncovered), as well as the dynamic created when another child is involved in the behaviour, specifically with regards to the concepts of respect, mutuality and consent. All behaviours of a sexual nature displayed by children and young people must be understood against the backdrop of this context of complex inter-related considerations to ensure accurate identification and appropriate responses.

Of particular note in the continuum is the explicit consideration of the quantum of the behaviour in terms of frequency and persistency. It is not uncommon for children and young people with HSB to display behaviours simultaneously from across the continuum or for these behaviours to escalate across the continuum over time. While it is critical to assess each behaviour within the individual context, consideration should also be given where patterns or clusters appear over time, even when most behaviours may be deemed within the lower end of the continuum.

Table 1: Layered continuum for understanding harmful sexual behaviours

Descriptor	Developmentally appropriate	Developmentally inappropriate	Concerning	Very concerning	Serious/extreme
General description	The type of behaviour is expected for the child's developmental stage; it is seen as socially acceptable and aligned with community expectations. It is typically considered appropriate sexual expression and/or exploration. Sexual behaviours may be displayed in inappropriate contexts, particularly by younger children.	Sexual behaviour is developmentally, socially, contextually and/or culturally inappropriate. Considered on the fringe of being developmentally acceptable. May be displayed as a single incident behaviour that is slightly outside the developmental norm or behaviour that may be outside the developmental norm but readily accepted within a social peer group or set context.	**Behaviours in this series are considered Harmful Sexual Behaviours. This is because they can cause harm to either the child or young person displaying the behaviours, or any other child or young person involved.** Behaviour that is clearly outside developmental expectations. May also include developmentally inappropriate behaviours displayed as part of a pattern of behaviour. Regardless of context, the behaviour is generally socially unacceptable even within diverse peer groups.	This behaviour is clearly outside developmental expectations and is considered socially unacceptable. It is often intrusive and harmful to the child/young person displaying the behaviours and/or others. A child's intent or motivator of the behaviour may also differ markedly from the norm in this group. They may disregard the other child's wishes or resistance over gratification of themselves.	An extension of behaviours that are 'Very Concerning', 'Serious/ Extreme' behaviours may include elements of physical violence, sadism, degradation, and be highly intrusive and harmful to others. Particularly in early adolescence and adolescence, these behaviours may evoke sexual arousal linked to levels of violence and use of power and force.
Persistency and frequency	Sexual behaviours displayed outside of appropriate contexts are typically one-off play/ peer-based. Child or young person responds to redirection or explanation about appropriate context as required. Generally seen in early adolescence and adolescence as healthy experimentation or in pre-school aged children exploring their bodies.	Often single incidents that can be shifted with minimal boundary setting, psychoeducation and/or redirection.	May be single incident, but typically repeated and sometimes compulsive/ driven behaviour.	Often repeated but not always compulsive, behaviour can sometimes be seen to escalate in level and frequency over time.	Behaviour is often persistent and accompanied by rigid or ingrained patterns of thought that have developed over an extended period. Behaviour is likely to continue without specialised therapeutic intervention.
If involving another child or young person	The behaviour is mutual and reciprocal with no power differential or coercion. ***may not be at the legal age of 'consent'**	Generally consensual, reciprocal and includes mutuality with no or minimal power differential or coercion. Possible self-induced pressure to fit in with peers	May involve inequity in power, lack of respect or reciprocity for the other and limited mutuality.	Will likely include a lack of respect for the rights of the other child, inequity in power, disregard for the concept of mutuality (particularly in early adolescence and adolescence where sexual gratification is a motivator) and will often involve coercion or force.	Often involves force, coercion, threats, and deception with limited respect for the rights of the other.
Emotional experience	Generally positive, with displayed curiosity, giggling, laughter and joy.	Generally positive and curious although often met with embarrassment if exposed.	Often accompanied with complex feelings of guilt, remorse and/or shame*, particularly where the child or young person is aware the behaviour may not be appropriate. May have feelings of confusion if there is a lack of understanding of sexual development for children with disability. ***shame is an internal expression of humiliation and distress that may manifest in many ways. Particularly for those with a history of childhood trauma, external expression of shame varies and may include anger and hostility.**	An extension of emotions associated with those in the 'Concerning' group but with greater intensity. May have feelings of confusion if there is a lack of understanding of sexual development for children with disability or special needs.	Varies widely and is often related to the motivating and causal factors of the behaviour, though can include shame, anger and pleasure.

Behaviour that can be considered appropriate or harmful across the ages

To support the application of this continuum, tables 2 to 7 have been created as examples of sexual behaviours across a range of developmental stages described in terms of age, schooling and sexual development drawn from the work of child-developmental theories and mapped onto contemporary schooling levels in the Australian context.

- Infancy and Early Childhood: Approximately birth to 3 years
- Lower Primary School: 4 to 6 years
- Middle Primary School (Pre-pubescent): 7 to 9 years
- Upper Primary School (Pubescent): 10 to 11 years
- Lower High School (Early Adolescence): 12 to 14 years
- Upper High School (Adolescence): 15 to 17 years

These tables provide examples only and must be considered in terms of contemporary evidence as it arises. It does not remove the need for specialist consultation in this space, particularly where the behaviour is considered to be in the concerning, very concerning and serious or extreme end of the continuum.

Special note for adolescence

As young people progress in their development, they naturally begin to explore themselves and others in new and often sexual ways. Various behaviours across the early adolescence and adolescence groups are often considered 'appropriate' and 'typical' behaviour within modern social norms. However, some behaviours can still be considered a criminal offence or in contrast to our understanding of and legal application of the concept of consent. For example, while it is not atypical in modern Australian society for a 13-year-old to be engaging in progressed sexual activity such as oral sex (which is penetrative), or even vaginal sex, in WA, young people of this age are deemed under the law as unable to give consent.

Therefore, behaviours between developmentally appropriate and developmentally inappropriate, and then between developmentally Inappropriate and concerning may be fluid and extra care for application of context should be taken.

Exposure to and use of pornography

Society's interactions with the online world are increasing at an exponential rate, with multiple mobile devices, smartphones, computers and other internet-connected devices being common fixtures in our lives. Online interactions are no more apparent than in children and young people who are 'logging on' to various social media platforms, interactive gaming forums and online learning throughout their day. Unfortunately, with this increased exposure to the internet, children and young people are more readily exposed to unfiltered and often developmentally inappropriate content from various sources. Despite controls, this means children and young people can more easily access and be exposed to pornographic material online, whether intentionally or not.

Pornography is a term typically used to describe sexually explicit material that is generally intended to sexually arouse the viewer. Pornography can come in many different forms and include a variety of content that would be considered both common and extreme. Typically, this includes images, videos, text and cartoons or anime representing sexual themes, practises and scenarios. Contemporary access to pornography is generally via the internet, although printed material, DVD's and other image storage devices are also used to exchange, view and store pornographic material.

An inquiry undertaken by the House of Representatives Standing Committee on Social Policy and Legal Affairs (2020) found that children were most likely to first access online pornography between the ages of 10 and 13 years. A review by Quadara, El-Murr, and Latham (2017), noted that 44 per cent of children aged 9 to 16 years had been exposed to sexual images in the month before (with males being more likely), either via intentional searching or through accidental exposure while on the internet.

The impact of exposure to and consumption of online pornographic material on children and young people can be far-reaching. It can impact their knowledge and attitudes towards sex and relationships, including sexual violence, and influence their sexual behaviours and practices (Quadara et al., 2017).

Given this information, throughout the tables below, pornography is included even at young ages. While this is now a generally accepted experience that young children encounter, the impacts are potentially harmful. They, therefore, require both general and targeted intervention to prevent and resolve harmful impacts. This is particularly so when a child moves from accidental exposure to more repeated, purposeful searching for the material and as the material content becomes more explicit, violent or deviates from acceptable sexual norms of mutuality and consent.

Appropriate or harmful Behaviour across the ages

Table 2: Infancy and early childhood – approximately birth to 3 years

Developmentally appropriate	Developmentally inappropriate	Concerning	Very concerning	Serious/extreme
From birth, children will explore all their body parts equally, including the genitals; may include touching, holding, poking with fingers, pulling and unconscious masturbation. Play-based behaviour with others can include various games that involve children being naked, playing gender-based roles and make-believe games such as mums and dads, mums and mums, dads and dads; doctors and nurses; families; 'I'll show you mine if you show me yours', and so on. Children may also want to touch and/or look at the genitals of others around them in a natural curiosity as they work out how their bodies are the same and different. This is more common around bath and dressing time; they often enjoy being nude. Language expression and jokes can include conversations about bottoms, breasts, vaginas, penises, and general bodily functions.	Regular masturbation that can be redirected with little emotional impact on or distress for the child. Exposing themselves to others or seeking to look at other children's genitals outside play-based behaviour. Behaviour will usually dissipate with reinforcement of boundaries and redirection. Seeking opportunities to follow adults and other children into private areas such as toilets, bathrooms and bedrooms when changing in order to see or touch their genitals, bottom or breasts. Touching the genitals of animals.	Masturbation that occurs often, even after redirection. Play-based themes that are persistently sexual in nature, and/or demonstration through language or play of adult sexual themes. Seeking opportunities to watch others when undressed, in bathrooms or toilets. Invading other children or adults' private space to lift/move their clothing to see and/or touch their private parts or see their genitals, bottom or breasts.	Masturbation that is compulsive and occurs often. A preference for this activity over others. Masturbation that is rough or self-injurious. Play-based themes that are persistently sexual in nature even after redirection. Themes are simulated or demonstrated through play with other children, for example, simulating sex with or without clothes. Persistent touching of others' genitals and private parts and/or seeking opportunities to do so even after redirection. Use of sexually aggressive and/or explicit language.	Using force to engage other children in sexual activity regardless of the context of play (i.e: normal fantasy play). Use of explicit sexual acts within play on other children, such as oral sex, masturbation and penetration (penetration may be with finger/objects).

Table 3: Lower primary school 4 to 6 years

Developmentally appropriate	Developmentally inappropriate	Concerning	Very concerning	Serious/extreme
Play-based behaviour with others can include various games that involve children being naked, playing gender-based roles and make-believe games such as mums and dads, mums and mums, dads and dads; doctors and nurses; families; 'I'll show you mine if you show me yours', and so on. Children may also want to touch and/or look at the genitals of others around them in a natural curiosity as they work out how their bodies are the same and different. This is more common around bath and dressing time; they often enjoy being nude. Language expression and jokes can include conversations about bottoms, breasts, vaginas, penises, and general bodily functions. Children become more curious about gender, sexuality, where babies come from and other sexual-based concepts in this stage and ask caregivers a range of questions. Children may begin to explore their own bodies and genitals with more purpose, which may include behaviour more akin to masturbation.	Regular masturbation that can be redirected with little emotional impact/distress for the child. Exposing themselves to other children or seeking to look at other children's genitals outside play-based behaviour. Behaviour will usually dissipate with reinforcement of boundaries and redirection. Seeking opportunities to follow adults and other children into private areas such as toilets, bathrooms and bedrooms when changing in order to see or touch their genitals, bottom or breasts. Using language of a sexually explicit nature and/or including sexual themes in play such as open-mouth kissing and fondling. This behaviour can be redirected with appropriate prompts and cause little emotional impact or distress for the child. Persistent nudity in contexts where this may be considered inappropriate even after they have been redirected. Touching the genitals of animals.	Regular masturbation that interferes with other activities, occurs within an inappropriate context or location (e.g: a public space), or persists after redirection. Frequently exposing themselves in public or to other children. Invading other children or adults' private space to lift or move their clothing to see and/or touch genitals, bottoms or breasts. Using language of a sexually explicit nature and/or including sexual themes in play or when interacting with others (such as open-mouth kissing and fondling). Persisting to touch the genitals of animals even after redirection. Intentionally accessing pornography and/or playing video games with violent or sexual content.	Compulsive masturbation that interferes with other activities, occurs within an inappropriate context/location (e.g: a public space), is aggressive and/or self-injurious, and persists after redirection. Pursuing other children in an intimidating and/or aggressive manner in order to touch their private parts or engage them in sexualised behaviour. Using language of a highly sexually explicit nature and/or simulating sexually explicit acts in or out of play, such as oral sex and anal or vaginal penetration. Engaging significantly younger or more vulnerable children in sexualised behaviour. Frequently watching pornography.	Forcing other children to engage in sexual behaviour; may include force and include oral sex and penetration with objects. Persistently using language of a highly sexual and explicit nature. Taking photos of themselves or others' genitals or generally sexual images and/or sharing these types of images with others. Frequently watching and/or showing other children pornography.

Table 4: Middle primary school (Pre-pubescent) 7 to 9 years

Developmentally appropriate	Developmentally inappropriate	Concerning	Very concerning	Serious/extreme
Masturbation or touching of own genitals in private. Increased sense of privacy and more care with regards to toileting and changing in private. Increased curiosity about other children's genitals of the same and opposite gender, which may translate into looking and touching of familiar same-age children's genitals. Language expression and jokes continue to include conversations about bottoms, breasts, vaginas, penises, and general bodily functions. Increased curiosity and questions about gender, sexuality, where babies come from and other sexual-based concepts. Children will also begin to discuss having girlfriends or boyfriends, and behaviour may extend into handholding or kissing another child of a similar age. Exposure to pornography via accidental or 'curious searching' (e.g: while searching 'bottoms')	Masturbation that occurs within an inappropriate context or location (e.g: a public space) or persists after redirection to a private space. Lack of awareness of the need for privacy and, therefore, frequent nudity around others or in inappropriate contexts. Using language of a sexually explicit nature that persists after redirection. Engaging other children of a similar age in sexual behaviours, including fondling. Displaying sexual themes and actions in play with other children, though the behaviour can be redirected and modified. Intentionally accessing pornography and/or playing video games with violent or sexual content.	Regular masturbation that interferes with other activities or that occurs with other children. Frequently exposing themselves in public or to other children. Engaging significantly younger or more vulnerable children in sexualised behaviour. Invading other children or adults' private space to lift or move their clothing to see and/or touch their genitals, bottoms or breasts. Using language of a sexually explicit nature and/or including sexual themes in play or when interacting with others (such as open-mouth kissing and fondling). Frequently watching pornography.	Compulsive masturbation that interferes with other activities, and/or is aggressive and/or self-injurious. Pursuing other children in an intimidating and/or aggressive manner in order to touch their genitals, bottoms or breasts or engage them in sexualised behaviour. Using language of a highly sexually explicit nature and/or simulating sexually explicit acts in or out of play such as oral sex and anal or vaginal penetration. Frequently watching pornography to the exclusion of other activities.	Forcing other children to engage in sexual behaviour; may include force and include oral sex and penetration with objects. Persistently using language of a highly sexual and explicit nature. Taking photos of their or others' genitals (or generally sexual images) and sharing these with others. Frequently watching and showing other children pornography.

Table 5: Upper primary school (Pubescent) 10 to 11 years

Developmentally appropriate	Developmentally inappropriate	Concerning	Very concerning	Serious/extreme
Masturbation or touching of own genitals in private. Masturbation can become more targeted toward sexual gratification. Increased sense of privacy; more care with regards to toileting and changing in private. Engaging in relationships with same-aged peers of the same and different gender and engaging with them in sexual affection such as hugging and kissing. Using sexually explicit language and displaying exhibitionism with peers, particularly in change rooms and bathrooms. Increased curiosity and discussion with peers about sex, sexuality, gender, pregnancy, puberty, and so on. Taking and sharing photos of themselves in various poses (clothed). Accessing pornography.	Regular masturbation that interferes with other activities or occurs in inappropriate contexts or locations (e.g:, a public space) or that includes other same-aged peers of the same or opposite sex in parallel or reciprocal masturbation. Disregard for privacy and regular exposure of themselves in public spaces even after redirection. Engaging in relationships and sexual behaviour with older individuals or behaviour that includes fondling of genitals. Using sexually explicit language that displays knowledge above their developmental age. Frequent displays of exhibitionism with peers, particularly in change rooms and bathrooms, even after redirection. Displaying voyeuristic behaviours with peers that is persistent. Regularly watching pornography.	Compulsive masturbation that interferes with other activities, and/or is aggressive, and/or self-injurious. Persistently displaying voyeuristic behaviours with peers that are persistent and/or include attempts to touch others' genitals. Engaging in relationships and sexual behaviour that includes mutual masturbation or oral sex (same-aged peers). Engaging significantly younger or more vulnerable children in sexualised behaviour and/or showing them pornography. Frequently watching pornography to the exclusion of other activities and/or using pornography to masturbate. Taking and sharing photos of themselves in various poses unclothed and/or exposing genitals	Forcing other children to watch them masturbate. Pursuing other children in an intimidating and/or aggressive manner in order to touch their genitals, bottoms or breasts or engage them in sexualised behaviour. Using language and/or behaviour of a sexual nature that seeks to degrade, humiliate, or threaten others. Engaging in sexual relationships with older individuals that include oral sex. Increased interest and watching pornography that includes sexually explicit acts including violence, group sex, children, and so on. Frequently watching and showing pornography to younger or more vulnerable children. Taking and sharing photos of themselves in sexually explicit poses unclothed and/or exposing genitals.	Forcing other children to engage in sexual behaviour; may include force and include oral sex and penetration with objects. Having vaginal or anal sex. Engaging in sexual behaviour with peers that includes group sex or having multiple sexual partners over time. Taking and sharing sexually explicit photos of others without permission and/or using coercion to gain such photos from others.

Table 6: Lower high school (early adolescence) 12 to 14 years

Developmentally appropriate	Developmentally inappropriate	Concerning	Very concerning	Serious/extreme
Marked by increased sexual curiosity to explore their own and others sexual motivations, sexual and gender identity, orientation and behaviour. Young people are experimenting with others and themselves. Age of consent, and potential criminal consequences of their actions becomes a complicating factor at this age for some children and young people. As in other elements of their life, they seek physical privacy and may begin to masturbate for purposeful sexual pleasure. They often continue to engage in the online world and may seek to explore sexual interest via accessing a variety of pornographic content. Some may also use this content during masturbation for sexual arousal. They will begin to explore intimate relationships with same-age peers of either sex and may have brief or ongoing sexual relationships that routinely include hugging, kissing, and fondling. They will continue to use sexually explicit language and exhibitionism with peers. This may extend to sexting and other forms of communication of a sexual nature. Young people will also continue taking and sharing photos of themselves in various poses (usually clothed). They may begin to push the boundaries with peers and the content shared.	Although precarious depending on the actual age of both young people involved, sexual relationships may progress to include mutual masturbation and oral sex. Engaging in intimate relationships with peers of up to a two-year age gap as their social networks expand. Masturbation that is more frequent or occurs in inappropriate contexts or not in private. Disregard for the privacy of self and others. Regular exploration of pornographic material or exploration of material that is explicit. Preoccupation with sexually explicit language or use of sexual language in inappropriate contexts. Sexting that is prolific or non-reciprocal with peers. Taking and sharing photos of themselves in various poses unclothed and/or exposing genitals. Given this can be deemed a criminal offence, this behaviour should be redirected. Persuading others to engage in sexting, share photos of themselves in various poses (usually clothed).	Sexual behaviours with others that includes vaginal or anal sex (with protection). Intimate relationships with individuals more than a two-year age gap. Compulsive masturbation that interferes with other activities, and/ or is aggressive, and/or self-injurious. Or where the young person feels compelled to do this in public. Use of sexually explicit language to intimidate others regardless of the type of communication. Preoccupation with watching pornographic material that interferes with other social experiences or includes sexually explicit content including violence and degradation. Invading others' privacy as a form of voyeurism. Taking and sharing photos of themselves in various poses (which may be considered sexually explicit), unclothed, exposing genitals, that persists after provision of information that this is not appropriate and may be deemed a criminal offence. Coercing or bribing others to engage in sexting or sharing photos of themselves in various poses (usually clothed).	Engaging in sexual behaviour with others that includes group sex or having multiple sexual partners. Using coercion or bribery to engage others in sexual behaviours of any level. Intimate relationships with individuals who are significantly different in age, and/or where there is a significant power or developmental difference. Regularly masturbating to sexually explicit and deviant pornographic material (e.g., containing animals, violence, children, and so on). Taking and/or sharing sexually explicit photos of others without their consent.	Preoccupation with masturbating to sexually explicit and deviant pornographic material (e.g: containing animals, violence, children, and so on). Frequently lying about their age for the purpose of engaging significantly older individuals in sexual activity. Forcing other children to engage in sexual behaviour; may include force and include oral sex and penetration with objects. Having unprotected vaginal or anal sex or engaging in sexual behaviour while intoxicated. Exchanging sexual behaviour/ acts for tangible or non-tangible things (e.g: drugs, food, alcohol, money, social inclusion, and so on). Taking and sharing sexually explicit photos of others without permission.

Table 7: Upper high school (adolescence) 15 to 17 years

Developmentally appropriate	Developmentally inappropriate	Concerning	Very concerning	Serious/extreme
In this stage, young people's sexual curiosity continues to increase as they begin to experiment even more with themselves and others. As they become more confident in their sexuality and interests, they may begin to explore more diverse sexual experiences and erotic material and behaviour. Engaging in sexual activity with both male and female partners. Privacy continues to be important, and they will continue to masturbate in private for sexual gratification. They continue to engage in the online world and may seek to explore sexual interest via accessing a variety of pornographic content; some may also use this content during masturbation for sexual arousal. They will continue to explore intimate relationships with peers of either sex and may have brief or ongoing sexual encounters that include oral, anal, and vaginal sex. Relationships will generally be with same age (or relatively) peers, consensual and reciprocal in nature. Sexual experiences are reciprocal in nature, such as mutual masturbation and oral sexual gratification of their partners becomes important. Sending and receiving sexually explicit texts and photos is relatively typical at this age.	Preoccupation with sexual behaviour and seeking intimate partners. Multiple sexual partners, frequently changing sexual partners, or engaging sexual partners that are substantially different in age. Engaging in sexual behaviour with others that includes more than one other person at a time (e.g: group sex. Seeking out pornographic material that is explicit and includes themes of violence and group sex. Communication with peers that is explicit, unwanted, or harassing, regardless of communication type used (e.g: using photos, text, or verbal communication). Lack of understanding of privacy and frequent exposure of self in public places (e.g: flashing genitals).	Compulsive masturbation that interferes with daily activities, is self-injurious, or occurs in public. Accessing pornographic material that is explicit, sexually aggressive and/or illegal, such as showing animals or children. Repeated exposure of genitals, bottoms and breasts in a public place with peers (e.g: flashing). Taking and sharing photos of themselves in sexually explicit poses unclothed and/or exposing genitals.	Lying about their age for the purpose of engaging significantly older individuals in sexual activity. Regularly masturbating to sexually explicit and deviant pornographic material (e.g: containing animals, violence, children, and so on). Engaging children or others who are developmental younger or vulnerable in sexual activity. Having unprotected vaginal or anal sex or engaging in sexual behaviour while intoxicated. Taking and/or sharing sexually explicit photos of others without their consent.	Compulsive masturbation that interferes with daily activities, cannot be contained to private places, and causes physical and emotional harm. This may include self-injurious behaviours and the compulsion to masturbate in public. Preoccupation with and regularly accessing pornographic material (may be while masturbating) that is explicit, sexually aggressive and/or illegal. Forcing or coercing others into sexual activity regardless of their age or developmental vulnerabilities. This may include the use of bribery, manipulation, blackmail, and so on. Exchanging in sexual behaviour or acts for tangible or non-tangible things (e.g., drugs, food, alcohol, money, social inclusion, and so on). Taking and sharing sexually explicit photos of others without permission and/or using coercion to gain such photos from others.

Pillar 3: Key principles of practice

This section outlines a key set of 10 principles that should guide practice related to sexualised behaviour for children and young people. This guidance includes both the support and guidance required for the development of healthy sexualised behaviours and early identification, prevention, and secondary and specialist tertiary responses to HSB.

1. Proactive responding

Through education and promotion of developmentally appropriate sexual development and behaviour, children can learn to develop healthy, meaningful, respectful and fulfilling relationships.

As with other areas of a child's development, sexual development requires appropriate education and guidance from those around them. As with complex or advanced skills, such as reading and writing, mathematics or playing certain sports, there is often an element of explicit instruction or teaching required in order to develop competence in a safe and healthy way. It is the same regarding sexual development. Helping children and young people explore their sexuality, relationships and intimacy in a safe and supported environment is key. Issues such as respect, consent, mutuality, body autonomy, gender, identity, and so on can all be explored through proactive discussions and education with children and young people at a developmentally appropriate level to support their learning and growth in this area.

Open communication and early discussion on a range of issues, (including pornography and others often considered 'taboo') can help to support our children and young people explore their sexual development safely.

2. Grounded in safety and respect for all children

Within the context of Child Safe Organisations and the United Nations Convention on the Rights of the Child, and inclusive of the individual and collective voice of the child.

HSB impact both the child responsible for the behaviour and those children that the behaviour is targeted towards. Safety is a paramount consideration for all children and young people when responding to HSB, both in terms of the behaviour that has already developed and the future potential risk of HSB occurring again with other children.

Safety is both a physical and psychological construct. Responses to HSB should seek to ensure all children and young people exposed to HSB are kept safe from future recurrence. Children and young people engaging in HSB also need to be safe psychologically, which can be addressed by being compassionate to their circumstances and avoiding causing shame. Key issues in this principle include the use of language (label the behaviour, not the child), managing appropriate confidentiality of children and families involved in the HSB, and responding holistically to the child and their circumstances.

3. Follow their pathway

Each child or young person displaying HSB has a unique story and pathway that led to the behaviour developing.

The development of HSB is a complex mix of individual, family and system characteristics, contexts and circumstances. Each child or young person has travelled a unique pathway within broad groups or themes of presentations; inappropriate sexual exploration, trauma driven sexual behaviours, distorted sexual development or sexually reactive behaviours. There is no 'one size fits all' approach to supporting children and young people displaying HSB. Any response must first begin with a curious and naïve enquirer approach to better understand the origins of the behaviour for the individual before a tailored response can be implemented.

4. Collaborative and multidisciplinary

Understanding and responding to a child includes a care team approach inclusive of family, the broader care system and cross-agency collaboration.

Children and young people interact across a range of contexts through their development, including multiple agencies over time, such as local community, health and education. Some young people will also have interactions with child protection, police, mental health, and justice. Unfortunately, when HSB are present, children and young people may find themselves interacting with the entire raft of government agencies. This may be the case even when the HSB are at the most minimal form of inappropriate sexual behaviours, and even in the case of those children with minimal previous cross-agency involvement.

The quality of interagency collaborations is often an important factor in achieving the best outcome for the child or young person. It is not enough to identify those working with a young person; there needs to be a genuine opportunity to collaborate and contribute to the overall response and 'treatment' plan. This type of approach is often referred to as a multidisciplinary team or care team approach. The child/young person and their parent/guardian should also be a part of these teams. They work together for a shared goal of supporting the young person.

When multiple agencies are involved, issues such as information sharing, legislative responsibility, service models and agendas need to be established and worked through from the outset to avoid barriers to the process and to ensure consistent messaging and language is used with both the child or young person and their family. The team should be convened for the child's best interests and may work under an established Memorandum of Understanding at an agency level. Although clear information and regular updates from the family and child are important, clear expectations of behaviour, rules of engagement and roles of each participating member will also allow for greater outcomes.

5. Multi-layered

Intervention at the individual, family and community level required for change.

A child's development and behaviour does not occur in isolation. From the moment children are born, they are dependent on and interact with the world around them to grow, learn, and develop. Similarly, those that develop HSB do so from a complex interaction of a range of factors within and around the child or young person. Therefore, a response to HSB must also include interventions and responses across these multiple layers, including at the individual, family and community (including the school environment) level.

For example, consider a child who has developed HSB to a level that would be considered very concerning and outside the developmental norm for their age. Their assessment tells us this has occurred within the context of a highly sexualised home environment, where they may have been allowed open access to the internet and subsequently seen various forms of pornography. In addition, they may have experienced family violence, and at least one of their parents may be described as using a dominant and power-over parenting style.

An intervention that only focused on providing the young person with therapy for their behaviour, even if using evidence-based approaches, would fail to address and resolve the underlying concerns that contributed to the behaviour developing in the first place, and those factors that continue to maintain the behaviour. Further, it puts the responsibility solely on the child to manage and moderate their own behaviour, disregarding the developmental and biological predisposition of every child to learn from their environment and the relationships within it. Therefore, a layered response that provides therapeutic intervention to the individual, as well as psychoeducation and adjustment of the family environment, along with psychoeducation and environment modification within the school environment, is a more fitting and holistic response likely to yield success. By modifying the home environment, removing reinforcers, adjusting the parenting approach to remove easy access to pornography, and providing more scaffolding in the school environment around healthy relationships, respect, and safety, the young person would receive messages from multiple layers in their system that all work together.

6. Culturally informed and respectful

Inclusive of both Aboriginal and other diverse cultures, recognising connection to traditions that often see sexual development as part of a broader cultural construct.

As noted previously, children develop within a complex system, including their immediate environment and relationships. Their environment and relationships are heavily influenced by culture, including religious or belief systems, and connection to community. Ideals, morals, values, beliefs and sometimes roles (that may or may not be gendered) can be clearly defined within a certain culture, faith, or community. These boundaries help shape our development as children and young people, how we see ourselves in the world, and how we see ourselves within relationships. This can be particularly evident with the management of sexual development and views on sexuality which can be interpreted as a cultural construct with many differences between groups and belief sets.

Cultural diversity is therefore critical when working with or responding to HSB. Workers must be cognisant of the cultural and/or faith tradition within which children were raised and within which they have been influenced and currently belong, noting the impact of migration and colonisation on culture. This perspective can influence the conceptualisation of HSB in the initial stages of work with a young person and guide layered responses. For example, what is developmentally expected for a child or young person in one culture may be vastly different from what would be expected in another, as is the case in some communities where sexual expression (with self or others) may be forbidden until marriage. In this example, the child may typically present as less sexually expressive due to their environment and the modelling of relationships to which they are exposed. Other important aspects that workers should be aware of are harmful traditional practices within some cultural groups, such as early or forced marriage or the treatment of child sexual abuse or rape as 'taboo.'

7

Embedded in a sound psycho-social developmental understanding of children and young people

This population is unique in their development which is socially, sexually and cognitively distinct from adults.

An individual's developmental progression through childhood and adolescence is dynamic and fluid in their social, emotional, cognitive, physical and neurological capacity. Although development is generally sequential and often relies on acquiring new skills and capacity at one level before moving onto a more complex skill, development can sometimes be patchy and volatile. This is particularly so where there are relational and environmental impacts on the individual, such as child abuse and harm.

Adolescence is often marked with extreme developmental changes. These include significant physical and hormonal shifts that sometimes misalign with slower cognitive and executive functioning development. In addition, skills such as impulse control, problem-solving, and reasoning are yet to fully develop, given the brain's neurological capacity that is still emerging in the frontal cortex.

The capacity of a child and young person (even one close to the 'adult' age of 18 years) is vastly different to that of an adult. Therefore, even though some sexualised behaviours may appear similar to those displayed by adults with dysfunctional and abusive sexual behaviours, they are distinct and occur within a very developmentally different context.

The frontal lobe is still under-developed during childhood and adolescence. A child or young person is, therefore, more likely to be impacted by peer pressure; lack judgement and problem-solving skills; lack an understanding of the impact of their behaviour on others; be driven by their wants and desires; have little appreciation for the future and how their actions will impact this; feel as though they are invincible and have a poor regard for risk; and seek immediate gratification and lack impulse control. These characteristics, of course, improve during the development of a child. However, they impact an individual's capacity to moderate their behaviours. These developmental features often play a significant role in the progression of behaviours, and it is essential that they are incorporated into any responses to HSB.

The psychosocial stages of the development framework and attachment theory, alongside contemporary understandings of neurodevelopment, are a useful foundation for assessing a child or young person with HSB. Child and adolescent development impacted by childhood trauma and exposure to adverse childhood experiences can be identified through these theoretical lenses. The examples across the continuum for understanding HSB outlined in Pillar 2 offer a great illustration of how developmental norms are applied within this context. That is, behaviour that is noted as developmentally appropriate, inappropriate and harmful across the continuum is different depending on the developmental stage of the child. For example, normative behaviour for a 6-year-old, who is still a child, will be very different to that of a 12-year-old who is on the cusp of adolescence and puberty.

8 Based on contemporary thinking and scientific evidence

Recognising that children and young people displaying HSB is a growing area of understanding.

Literature and knowledge in this area are progressing, from an adult-based framework for understanding children's sexual behaviour, to a more contemporary evidence-informed understanding of the unique nature of child sexual development.

It is critical that responses to HSB be grounded in the latest evidence and understanding of this emerging area of practice. Any assessment and treatment practices should be reviewed, evaluated and adapted for different contexts and populations. Currently, there is limited empirical evidence for best service models and interventions, particularly for children under 10 years (Cox, Ey, Parkinson, & Bromfield, 2018). There are several models that have been evaluated as reducing HSB. However, these evaluations have several limitations and therefore lack evidence. Policies, processes and legislation should also be regularly reviewed as the evidence for best practice in responding to HSB develops.

9 Trauma-informed and Trauma-safe

In recognition that many of the children and young people who display HSB have been exposed to cumulative harm.

Given the aetiology of HSB and the co-occurrence of other adverse childhood experiences, inclusive of child abuse and neglect, it is essential that approaches to HSB are trauma-informed. Being trauma-informed recognises the multiple forms of trauma, the harmful impacts of trauma on the individual, family, community and broader culture, and the varied manifestations of impacts across the lifespan and throughout generations. Extending this trauma understanding means approaching others and designing services in ways that are trauma-safe and seek to empower individuals who have experienced trauma, and prevent further trauma via inappropriate relational interactions, service systems and activities.

Responses to HSB should be inclusive of a child's past and current experiences and seek to better understand the origins of the behaviour and how and why it is being maintained. Often the behaviour will be highly influenced by past trauma-laden experiences of the child. Therefore, responses that do not seek the resolution of influencing factors will be ineffectual at best and harmful at worst. Similarly, it must be recognised that HSB directed toward another child is a form of child sexual abuse. The impacts for a child or young person who has experienced this type of harm can be significant. Therefore, responses must be inclusive of all children involved.

The ripple effect of child protection and legal responses to HSB can cause unintended harm and trauma for the individuals involved. System responses that are punitive or involve entry into various justice or child protection systems can lead to separation of siblings and families and development of feelings of shame, guilt, abandonment and isolation, all of which can be traumatising for all involved. Consequently, service responses should respond with a trauma-informed and trauma-safe lens to avoid further traumatisation to the child/young person and others involved.

10.

Least restrictive strengths-based practice

Policy and intervention should be future-focused and least restrictive, based on the notion that change is possible for children and young people.

Least restrictive practice is based on the premise that there needs to be a balance between the right of a community, and individuals within it, to be safe and the right of an individual to be self-determined. Within this context, it represents the tension that often exists between the rights of the child or children currently impacted or potentially at risk from HSB, and the rights of the child or young person displaying the HSB. Any responses to HSB must therefore be least restrictive on the individual responsible for the behaviour to provide safety for others. This may be particularly challenging when balanced with the need to empower children who have been victimised by other children or young people displaying HSB. Nonetheless the restrictions should be proportionate and based on a strengths-based perspective.

For example, an 8–year old child who exposes their genitals to other children within the classroom environment should not be excluded from the school environment or removed from their home. Other children must be kept safe, but responses must be proportionate, least restrictive and strengths-based. Therefore, a more appropriate response would be to provide increased supervision to the child, minimise some play activities for a short time until safety can be ensured, provide psychoeducation on normal, healthy and safe play and sexual behaviour, and/or look for ways to praise positive, appropriate behaviour.

Pillar 4: Responses to behaviours across the continuum

Using the continuum presented earlier in Pillar 2 we can begin to better understand the nature of a child's behaviours and the impact on themselves and others. This enhanced understanding improves our capability to provide documented, measured, trauma-informed, culturally cognisant and developmentally aware responses. Understanding, categorising, and responding to HSB is dependent on context and can require a high level of clinical skill. Figure 5 below demonstrates the cumulative response across the continuum required as the behaviour progresses, noting that responses should begin with preventative psychoeducation to promote healthy sexual development, exploration and understanding. However, this type of response is also required within the response mix for behaviours that present further along the continuum (such as, concerning, very concerning, serious/extreme).

Whilst Figure 5 and the example responses presented in Table 8 act as a guide, they should not and cannot take the place of practice wisdom and consultation with other professionals. Particularly within the adolescent space, there is a delicate balance in applying the notion of legal consent alongside what may be harmful to a young person, what is developmentally appropriate, and what is considered typical behaviour in an ever-progressing, sexualised world. Regardless, responses should be progressive and proportionate as the behaviour moves along the continuum.

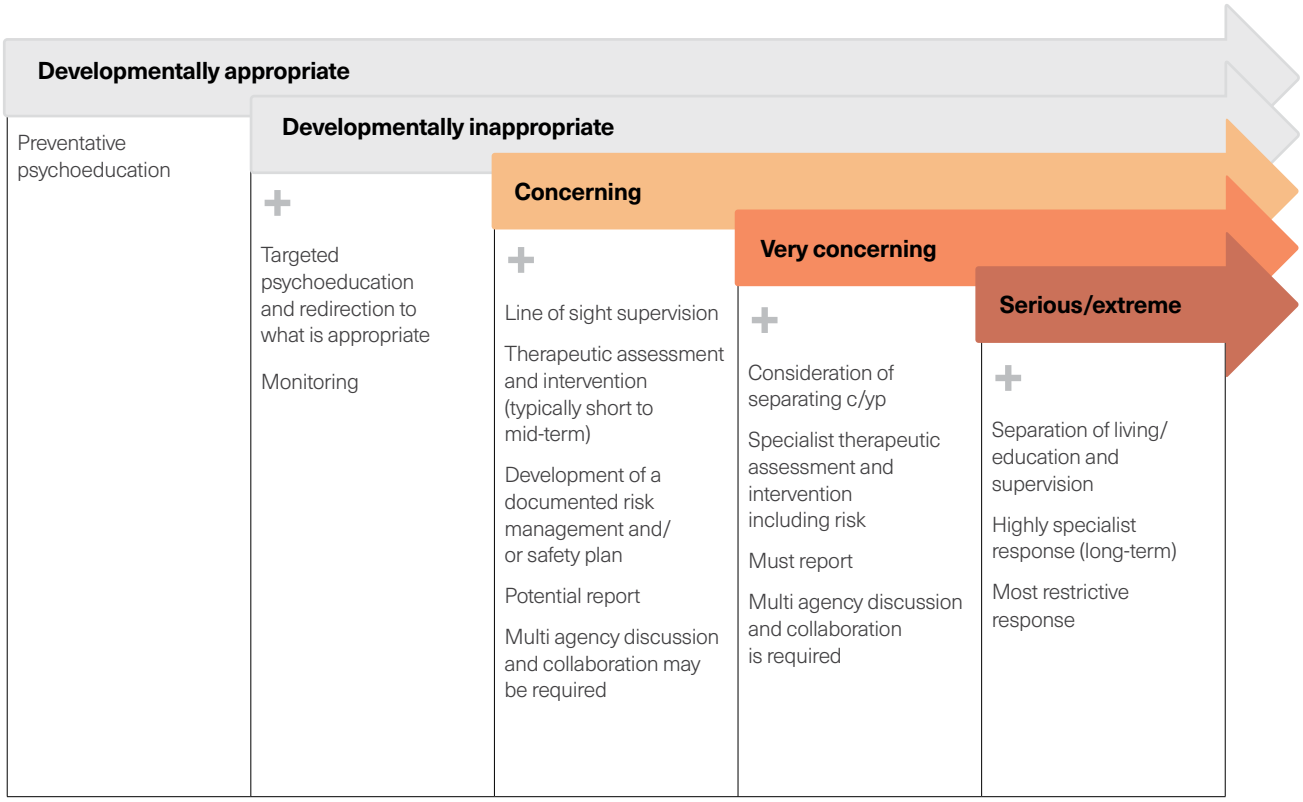


Figure 5: Progressive responses to HSB across the continuum

Table 8: Continuum for responding to HSB

Developmentally appropriate	Developmentally inappropriate	Concerning	Very concerning	Serious/extreme
Behaviour in this category typically requires no specialist or targeted intervention. Education on typical and healthy sexual development, gender, sexuality, relationships and other related areas should be provided to all children and young people (particularly those in vulnerable cohorts) at a developmentally appropriate level. Children can be gently redirected to alternative activities depending on age, or the behaviour can be used to generate discussion on healthy sexual expression and behaviour in an age-appropriate way. House, family and community rules and expectations of behaviour can also be reinforced as needed	Behaviour in this category typically requires minimal or no specialist or targeted intervention. Children can be gently redirected to alternative activities depending on age, and the behaviour should be used to engage them in discussion on healthy sexual expression and behaviour in an age-appropriate way. House, family and community rules and expectations of behaviour should be reinforced as needed to ensure children understand appropriate behaviour. Monitor the behaviour to ensure it does not continue and/or escalate and put in place any environment safety considerations as needed (e.g: proximal supervision).	**Behaviours at this level that involve other children may be reportable via mandatory reporting processes and require further response from child protection and possibly police regarding harm caused and any criminality. Children over the age of 10 years displaying behaviour within this series, particularly very concerning and serious/extreme may be subject to criminal charges.** Behaviour here will require some level of targeted therapeutic intervention, including assessment. When confronted with the behaviour, redirect the child to alternative activities and where other children are involved, ensure all are safe and provided with appropriate supports. House, family and community rules and expectations of behaviour should be explicit and reinforced as needed to ensure children understand appropriate behaviour. Provide appropriate therapeutic support and education on safe/appropriate behaviours and healthy sexual expression to the child initiating the behaviour. Children displaying these behaviours should not be left unsupervised with peers or other children younger or more developmentally vulnerable than them until the behaviours have dissipated. Document and monitor the behaviour to ensure it does not continue and/or escalate.	Behaviour here will require specialist and targeted therapeutic intervention, including assessment of risk. When confronted with the behaviour, redirect the child to alternative activities and where other children are involved, ensure all are safe and provided with appropriate supports. House, family and community rules and expectations of behaviour should be explicit and reinforced as needed to ensure children understand appropriate behaviour. Provide appropriate therapeutic support and education on safe/appropriate behaviours and healthy sexual expression to the child initiating the behaviour. Children displaying these behaviours should not be left unsupervised with peers or other children younger than them until the behaviours have dissipated. Where the child is living in a group home environment and/or with other younger or more vulnerable children (institutional or family environment), there may need to be a placement change or additional adult supervision to ensure safety. Caution must also be taken regarding the educational placement of children displaying these types of behaviours until the behaviours have dissipated. An assessment of risk here is critical to inform decision making. Document and monitor the behaviour to ensure it does not continue and/or escalate. Behaviour in this category must be reported to appropriate oversight bodies, including child protection and police services.	Behaviour here requires a highly specialist response, including targeted therapeutic intervention and assessment of risk. When confronted with the behaviour, redirect the child to alternative activities and where other children are involved, ensure all are safe and provided with appropriate supports. House, family and community rules and expectations of behaviour should be explicit and reinforced as needed to ensure children understand appropriate behaviour. Provide appropriate therapeutic support and education on safe/appropriate behaviours and healthy sexual expression to the child initiating the behaviour. Children displaying these behaviours should not be left unsupervised with peers or other children younger than them until the behaviours have dissipated. Where the child is living in a group home environment and/or with other younger or more vulnerable children (institutional or family environment), a placement review will be required to ensure the safety of the child and those other children around them. This may include the need for a placement change, additional adult supervision, or other safety planning. Caution must also be taken regarding educational placement of children displaying these types of behaviours until the behaviours have dissipated. An assessment of risk here is critical to inform decision making. Document and monitor the behaviour to ensure it does not continue and/or escalate. Behaviour in this category must be reported to appropriate oversight bodies, including child protection and police services.

Managing HSB within residential care – special considerations

Principles for reducing and responding to HSB in residential care

It is important to note that there is limited evidence of practice approaches that reduce the likelihood of HSB in residential care and therapeutic responses for those children and young people who demonstrate or experience HSB in residential care (Pourliakas et al., 2016).

Whole of agency and unit strategies to prevent and respond to concerns of HSB

Harmful sexual behaviours are more likely to be displayed in residential care units with particular cultures (as indicated above). As such, investment in whole of agency and whole of unit responses that challenge enabling cultures and empower staff and children and young people to raise concerns are often required (McKibbin, Halfpenny, & Humphreys, 2019). So too should agencies and units consider and respond to issues of power, gender and sexuality to both prevent HSB but also enable staff and children and young people to seek support (Green & Masson, 2002). Equipping staff with appropriate training, supervision and authorising them to take a proactive stance are all vital, as are policies and practice frameworks that embed sexual abuse prevention across all residential care work. Research has demonstrated the value of implementing whole-of-house psychoeducation programs (for staff, children, and young people), reinforced through policies and practices (McKibbin et al., 2019). This is particularly pressing as many staff, children, and young people in residential care mislabel harmful behaviours, with children and young people not identifying as victims (McKibbin, 2017).

The need to identify risk, protective factors and HSB and to act early

Research conducted by the Royal Commission highlighted the risks for children and young people in residential care, particularly concerning HSB. A central recommendation was to equip residential care staff and others working with children and young people to identify risks associated with HSB and to proactively act to prevent children and young people from engaging in HSB. Taking an ecological view that considers how individual and contextual risks and protective factors enable or reduce the likelihood of HSB is valuable (Hackett, Holmes, & Branigan, 2016). Promising practices include providing staff, children, and young people appropriate psychosexual education (McKibbin et al., 2019), close supervision (McKibbin, 2017), targeting grooming and problematic behaviours as they emerge, and empowering children and young people to raise concerns early.

The need to be driven by the needs and wishes of children and young people

A growing body of research suggests that preventative measures and interventions for young people engaging in or exposed to HSB (and other forms of violence and sexual abuse) need to be informed by their needs, wishes and preferences. Young people who have experienced HSB report improved confidence and engagement in responses when they believe that the approach is driven by their needs rather than external compliance requirements. Past victims have stressed the value of practices being informed by their experiences (Fernandez et al., 2016; Moore, McArthur, Death, et al., 2016).

The need to consider risks when determining placements

Across the literature, there is strong evidence that asserts the need for better decision-making tools and processes to be in place to ensure that vulnerable children and young people are not placed in unsuitable settings or with peers who may use HSB (McKibbin, 2017). Particular vulnerabilities to peer sexual violence, abuse and exploitation (as indicated above) should be identified when considering placement options, as should concerns related to young people's use of HSB. The capacity of staff teams and organisations to prevent HSB should also be considered when placement options are decided.

Importance of relationship-based practice

International research points to the centrality of worker-youth relationships in both preventing and responding to HSB. There is evidence that workers who have trustworthy relationships with young people and who are empowered to raise behaviours of concern can play a part in identifying and challenging behaviours before they become problematic (Lerpiniere et al., 2013). Similarly, survivor accounts suggest that children and young people who have been exposed to HSB or are concerned about the behaviours of their peers are more likely to seek support from a worker they trust (Moore et al., 2020). In both instances, such workers demonstrate that they are willing and able to openly discuss sensitive topics, appreciate the gravity of concerns, and are empowered to take deliberative action to respond. The accessibility, confidence in and perceived responsiveness of these staff influence young people's decisions to seek support (Green & Masson, 2002).

Therapeutic responses

There is strong evidence for the need to implement holistic, strengths-based treatment (Hackett et al., 2016; McKibbin et al., 2019) that understands the residential care context within which young people are engaging in HSB as well as their behaviours (Hackett et al., 2016). McKibbin's review of the international literature identifies programs that have been developed specifically for children and young people in residential care (McKibbin, 2017; McKibbin et al., 2019).

Multiagency practice responses for those young people with more significant HSB

In the literature, there is recognition that responses to the HSB of young people may need multiagency responses and collaboration when the behaviours are significant, and concerns for the safety of children and young people are ongoing (McKibbin et al., 2019). Engagement of residential care agency staff, child protection, therapists and other key stakeholders in joined-up service delivery, supported by shared goals and plans and collective decision-making, is promising.

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