<NUMBER> CHILDREN WITH SEXUALISED BEHAVIOURS IN OUT OF HOME CARE

Related Policies

Child Safety Policy. WMV

Responding to allegations of physical and sexual assault. WMV

Scope

These procedures apply to the following persons: individuals elected to Wesley Mission Victoria boards, committees and sub committees, permanent and casual employees, volunteer carers, mentors or other volunteers, contractors, sub contractors, agency staff providing care in WMV facilities or on behalf of WMV, persons working as "lead tenants", students completing practical work or other placements and any other person involved with Wesley Mission Victoria.

Hereafter in this policy the individuals listed above are referred to as "stakeholders"

These procedures are consistent with the requirements of the Children with problem sexual behaviours and their families. Specialist practice resource. DHS 2012.

Definitions and Abbreviations

Problem sexual behaviours *or sexualised behaviours refers to sexual behaviour by children including excessive masturbation, sexual approaches to adults, play with overt sexual themes, forced sexual behaviour, sex play with other children and an obsessive interest in pornography. The term problem sexual behaviour generally refers to instances where all children involved in the behaviour are under the age of 10.*

Sexually abusive behaviours *refers to the use of a child's power, authority or status to engage another party in sexual activity which is unwanted or where, due to the nature of the situation the other party is not capable of giving consent (for example, animals or children who are younger or who have a cognitive impairment. Physical force or threats may sometimes be used. Sexual activity may include peeping, fondling, masturbation, oral sex, penetration of a vagina or anus using a penis, finger or object or exposure to pornography. This is not an exhaustive list.* *(Therapeutic Treatment Board)*

Sexual assault – rape: *Alleged penetration or attempted penetration (anal, oral or vaginal)*

through the use of physical force, intimidation and/or coercion without the other person's consent.

Sexual assault – indecent: *Unwanted sexual actions forced upon a person against their will, through the use of physical force, intimidation and/or coercion. Examples are unwelcome kissing or touching in the area of a person's breasts, buttocks or genitals. Indecent assault can also include behaviour that does not involve actual touching, such as forcing someone to watch pornography or masturbation.*

Problem sexual behaviour

Problem sexual behaviour or sexualised behaviours refers to sexual behaviour by children including excessive masturbation, sexual approaches to adults, play with overt sexual themes, forced sexual behaviour, sex play with other children and a preoccupation or obsessive interest in pornography. The term problem sexual behaviour generally refers to instances where all children involved in the behaviour are under the age of 10. Children under the age of 10 are deemed unable to provide consent to sexual activity under the law and cannot be held criminally responsible for their behaviour.

Information regarding adolescents with sexually abusive behaviours is provided at the end of these procedures. Examples of age appropriate and concerning sexual behaviours for children 0 – 18 years old are included as a reference in Attachment 1.

Problem sexual behaviour can involve a single incident which suggests the child has sexual knowledge inconsistent with their age or stage of development, a pattern of behaviours which does not respond to corrections by adults, behaviours that do not involve others but which are excessive and interfere with daily activities or sexual behaviours that impact and disturb others.

Children who display problematic sexual behaviours are more likely than others to have been sexually abused, suffered physical or emotional abuse, exposed to pornography, inappropriate adult interaction or have witnessed parental family violence.

The following range of factors is commonly associated with children who display sexualised behaviours;

- Family backgrounds characterised by stress and deprivation
- Psychological and emotional problems including anxiety, withdrawal, oppositional defiant disorder and depression
- Trauma resulting in disturbances in memory and attention, lessened ability to trust, play cooperatively and negotiate relationships with others, increased anxiety and personality disorders.
- A history of disrupted attachment with parents or primary caregivers.
- Learning difficulties and limited ability to control emotions and behaviour.

Planning to keep children safe:

Research suggests a child with problem sexual behaviours should not be placed with younger children or

those vulnerable due to a disability or history of disrupted development or socialisation.

Placement with older children who have problem sexual behaviours or adolescents with sexually abusive behaviours is also considered unwise. (Children with problem sexual behaviours and their families)

- Prior to the placement of a child with identified sexualised behaviours an assessment must be made of the risks to other children by the child's case manager in consultation with the care team, residential or home based carers and the child's school (as appropriate). If the child has a current or past therapist, they must be included or consulted.

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- Carers must be provided with all relevant information regarding the nature, severity and circumstances of the problem sexual behaviours of any child in their care.

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The assessment must include any relevant information regarding sexualised behaviour directed toward other children or adults. It must clearly identify and assess the nature of the problematic behaviour and address the risks the behaviour may pose to other children, identify known situations which trigger the behaviour and the times or situations where risks may be increased.

- Following the assessment a safety plan must be developed incorporating strategies to address the identified risks. The safety plan must form part of the care plan and be reviewed regularly at care plan meetings.

Safety planning must address;

- Identification of other children in placement likely to be vulnerable or targeted to engage in sexual activity and strategies to keep them safe
- Any restrictions on venues or play with others.
- Appropriate monitoring of bathing, bedtime and sleeping arrangements. Any identified need to rearrange bedrooms to ensure greater ability to monitor after bedtime.
- Requirements for monitoring the child's behaviour and need for "line of sight" monitoring.
- Any restrictions and monitoring requirements on television, computer, mobile phone use and strategies to prevent access to pornography via other means.
- Appropriate non stigmatising strategies which address triggers to the behaviour (if known) to be implemented consistently by all carers and the child's school as appropriate.
- Consideration of risks to other children not living in the same placement as the child including visitors to the unit, friends, siblings, relatives of home based carers, other children at the child's school, family contact/ access issues.
- Consideration of any likely sexual approaches to carers or other adults and

strategies to address this behaviour. (see below)

- Consideration of times where additional support for carers will be required to ensure relief for carers from constant monitoring of the child's behaviour over time.

  Treatment of problem sexual behaviours may span a lengthy period of time. It is critical safety plans are reviewed regularly and strategies are implemented consistently over that period.

- Arrangements for recording of events of sexualised behaviour/actions taken and access or distribution of this information to other care team members and therapists.

  Successful therapeutic interventions require good communication and regular exchange of relevant information between the therapist, care team and carers to maximise consistent management of problem behaviours.

- Arrangements for review of the plan

- The case manager and care team must consider the appropriateness of a referral ~~(~~or consultation~~)~~ with the regional Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Service for an assessment, and therapy (as appropriate) if such a referral has not been made in the past.

- Where a child in placement with no prior history displays sexualised behaviours which cause concern or harm to others, the supervisor or program manager must be informed as soon as possible. The supervisor must ensure the child's case manager is informed and a care team meeting scheduled to discuss the behaviour, need for a safety plan, review and potential referral as outlined above. The cause of the behaviour including the possibility the child may have been sexually abused whilst in placement must be investigated.

- Stakeholders and carers must remain vigilant in their monitoring and implementation of agreed safety plans to ensure the safety of other children and consistent management of the problem behaviour.

Practical responses to children and young people engaging in sexualised behaviours

Children display sexualised behaviours for a range of reasons including past abuse and trauma, confusion about sexuality and sexual activities, anxiety about relationships, exposure to explicit material and curiosity. The choice of appropriate strategies to manage and reduce the behaviour should reflect a comprehensive assessment of the child, the nature of the behaviour and child's abuse, familial and placement history.

The DHS "Children with problem sexual behaviour and their families ~~specialist~~ specialist practice resource" identifies three goals in responding effectively to problem sexual behaviour:

1. Encourage communication: Adults should model calm and clear discussion about behaviour

2. Develop empathy: Adults can assist a child to understand the impact of their behaviour upon

others.

3. Promote accountability: Adults can assist the child to develop the ability to think before acting.

It is important the child receives consistent messages regarding inappropriate behaviours and that such behaviour is responded to immediately, calmly and in accordance with the safety plan.

Stakeholders should;

- Clearly and calmly request the child to stop the behaviour.
- Speak to the child privately if the behaviour is occurring in the presence of others but preferably within sight of others
- Comment on the behaviour, and not use language which makes the child feel embarrassed, ashamed or demeaned.
- Be clear and firm that the behaviour is not appropriate.
- Discuss with the child the effect of the behaviour upon others and assist them to develop the ability to modify their behaviour out of concern for others.
- Provide a consequence of the behaviour consistent with the child's behaviour management or safety plan.
- Ensure the safety and wellbeing of any child who has been victimised or upset by the behaviour. Reassure the child, explain the incident was not their fault and provide reassurance as required. Follow up with the child later to ensure their wellbeing. Encourage the child to tell the stakeholder or another adult if the behaviour occurs again. Inform the stakeholder's direct supervisor, victim's case manager and care team. Consider the need for referral of the child to the regional Centre Against Sexual Assault for counselling as appropriate.

  If there is concern regarding potential for the child to bully or intimidate the victim, clear messages should be provided to the child that this is not okay and carers should monitor that this does not occur.
- Document the behaviour, child's responses and explanations and carer actions to inform the case manager, care team and the child's therapist as appropriate.
- Ensure any physical contact with the child is consistent with the requirements of the "Appropriate physical contact with children guidelines" which are attached to these procedures.

Sexual assaults by children aged 10 years and over

- Stakekeholders must report sexual assaults by children aged 10 and over to the police and manage such situations in accordance with the WMV "Responding to allegations of physical or sexual

assault" procedures.

Sexualised behaviours by children and young people toward stakeholders

Some children and young people may actively seek affection, physical contact or a close relationship with an adult caregiver or other adult person that is inappropriate.

- Stakeholders must ensure all actions are consistent with the WMV Child Safety Procedures, particularly with regard to maintenance of professional boundaries, monitoring and physical contact with children.

- Stakeholders must remain calm and sensitively deter a child or young person if they attempt to engage the stakeholder in behaviour of a sexual nature.

  Stakeholders must clearly indicate to the child that the behaviour is not appropriate and help the child understand the importance of personal boundaries and impact of the behaviour upon others. Care should be taken to focus upon the behaviour and not attempt to embarrass or shame the child.

- Stakeholders who are subject to sexualised behaviour or sexual advances from a child or young person must respond in accordance with the child's safety/ management plan and report the instance to a direct supervisor or program manager as soon as possible. Supervisors must attend to the support needs of stakeholders when informed of such situations.

  The incident and actions taken must be documented. The care team and therapist should be informed and the safety plan amended (as required) to address the behaviour

- Stakeholders must not under any circumstances engage in intimate or sexual behaviour of any kind with a child or allow sexualised behaviour to continue without acting.

- Stakeholders who observe behaviours in other stakeholders (or other adults) they view as inappropriate or who receive disclosures from children regarding inappropriate behaviour must advise their direct supervisor or program manager of this information as soon as possible**.**

Adolescents with sexually abusive behaviours

Some young people with histories of sexual abuse, chronic neglect, exposure to family violence or adult sexual activity may use their power or authority to engage in sexual activity with individuals who are unable to provide consent due to their age or disability.

The most common target of abuse by adolescents with sexually abusive behaviours occurs predominantly against younger children or those vulnerable due to disability. This information is of particular importance for stakeholders involved in placement safety planning and home based or residential carers.

The Children's Court may make a Therapeutic Treatment Order requiring an adolescent with sexually abusive behaviours to undertake a period of therapeutic treatment in order to prevent the potential for more serious offences. Some young people subject to a therapeutic treatment order will be placed in out of

home care.

- Sexual assaults of children by a child over the age of 10 must be reported to the police and managed in accordance with the "Responding to allegations of physical and sexual assault procedures" WMV. Children under the age of 10 cannot be held criminally responsible for their actions.

Organisational responses to problem sexual behaviour and sexually abusive behaviours

Program and senior managers should consider the following ongoing mechanisms to address the occurrence of problem sexual behaviour and sexually abusive behaviours in out of home care.

- Ongoing protective behaviours and sex education for children in out of home care likely to be exposed to problem sexual behaviour or sexually abusive behaviours.
- Strategies which encourage and maximise safe disclosure by victims of abuse.
- Education to ensure all staff and volunteer caregivers can recognise and act on indicators of abuse.

Variations to Procedure

Service Specific Variations

Related Documents

Related Forms, Guidelines, other documents
Children with problem sexual behaviours and their families. Best Interests case practice model. Specialist practice resource. DHS. 2012 Adolescents with sexually abusive behaviours and their families. Best interest case practice model.

Specialist practice resource. DHS. 2012
Related Local Procedures
Protecting children at risk of sexual exploitation procedures. WMV Child Safety Procedures WMV Appropriate physical contact with children guidelines. WMV

External Context

Relevant Standards
Program requirements for residential care services in Victoria, DHS, 2014
Relevant Legislations / Regulations
Children, Youth and Families Act 2005

Revision Record

Version	*Date*	*Document Writer*	*Revision Description*

Attachment 1

Sexual behaviours for children 0 – 17 years

1. Sexual behaviours which are part of normal healthy development

The following behaviours are:

- spontaneous, curious, light hearted, easily diverted, enjoyable, mutual and consensual
- appropriate to the child's age and development
- activities or play among equals in terms of age, size and ability levels
- about understanding and gathering information, balanced with curiosity about other parts of life

These behaviours provide opportunities to talk, explain and support.

0 to 4 years

- comfort in being nude
- body touching and holding own genitals

- unselfconscious masturbation
- interest in body parts and functions
- wanting to touch familiar children's genitals during play, toilet or bath times
- participation in make believe games involving looking at and/or touching the bodies of familiar children eg "show me yours and I'll show you mine", playing 'family'
- asking about or wanting to touch the breasts, bottoms or genitals of familiar adults eg when in the bath

5 to 9 years

- increased sense of privacy about bodies
- body touching and holding own genitals
- masturbation, usually with awareness of privacy
- curiosity about other children's genitals involving looking at and/or touching the bodies of familiar children eg "show me yours and I'll show you mine", playing 'family'
- curiosity about sexuality eg questions about babies, gender, relationships, sexual activity
- telling stories or asking questions, using swear words, 'toilet' words or names for private parts
- use of mobile phones and internet in relationships with known peers

10 to 13 years

- growing need for privacy
- masturbation in private
- curiosity and seeking information about sexuality
- use of sexual language
- interest and/or participation in girlfriend or boyfriend relationships
- hugging, kissing, touching with known peers
- exhibitionism amongst same age peers within the context of play eg occasional flashing or mooning
- use of mobile phones and internet in relationships with known peers

14 to 17 years

- need for privacy
- masturbation in private
- accessing information about sexuality
- viewing materials for sexual arousal eg music videos, magazines, movies
- sexually explicit mutual conversations and/or use of humour and obscenities with peers
- interest and/or participation in a one on one relationship with someone of the same or other sex
- sexual activity with a partner of similar age and developmental ability (ability to consent must be considered)
- use of mobile phones and internet in relationships with peers

2. Sexual behaviours which cause concern:

They following behaviours are cause for concern because of:

- persistence, intensity, frequency or duration of behaviours
- the type of activity or knowledge for the age and stage of development
- inequality in age, size, power or developmental ability
- risk to the health and safety of the child or others

- unusual changes in a child's behaviour

These behaviours signal the need to monitor and provide extra support.

0 to 4 years

- masturbation in preference to other activities
- preoccupation with sexual behaviours
- persistently watching others in sexual activity, toileting or when nude
- explicit sexual talk, art or play
- following others into private spaces eg toilets, bathrooms to look at them or touch them
- pulling other children's pants down or skirts up against their will
- touching the genitals/private parts of other children in preference to other activities
- attempting to touch or touching adults on the breasts, bottom, or genitals in ways that are persistent and/or invasive
- touching the genitals/private parts of animals after redirection

5 to 9 years

- masturbation in preference to other activities, in public, with others and/or causing self injury
- explicit talk, art or play of sexual nature
- persistent questions about sexuality despite being answered
- persistent nudity and/or exposing private parts in public places
- persistently watching or following others to look at or touch them
- pulling other children's pants down or skirts up against their will
- persistently mimicking sexual flirting behaviour too advanced for age, with other children or adults
- touching genitals/private parts of animals after redirection
- use of mobile phone and internet with known and unknown people which may include giving out identifying details

10 to 13 years

- masturbation in preference to other activities, in public and/or causing self injury
- persistent explicit talk, art or play which is sexual or sexually intimidating
- accessing age restricted materials eg movies, games, internet with sexually explicit content
- persistent expression of fear of sexually transmitted infection or pregnancy
- marked changes to behaviour eg older or adult flirting behaviours, seeking relationships with older children or adults in preference to peers
- engaging in sexual activities with an unknown peer eg deep kissing, mutual masturbation
- oral sex and/or intercourse with a known partner of similar age and developmental ability
- using mobile phones and internet with unknown people which may include giving out identifying details

14 to 17 years

- sexual preoccupation which interferes with daily function
- intentional spying on others while they are engaged in sexual activity or nudity
- explicit communications, art or actions which are obscene or sexually intimidating
- repeated exposure of private parts in a public place with peers eg flashing

- unsafe sexual behaviour, including unprotected sex, sexual activity while intoxicated, multiple partners and/or frequent change of partner
- presence of sexually transmitted infection or unplanned pregnancy
- oral sex and/or intercourse with known partner of more than two years age difference or with significant difference in development
- arranging a meeting with an online acquaintance accompanied by a peer or known adult
- using mobile phones and internet to send or receive sexually explicit photos of another person with their consent

3. Sexual behaviours which indicate harm or potential harm

The following sexual behaviours indicate harm or potential harm because they are:

- excessive, compulsive, coercive, forceful, degrading or threatening
- secretive, manipulative or involve bribery or trickery
- not appropriate for the age and stage of development
- between children with a significant difference in age, developmental ability or power

These behaviours signal the need to provide immediate protection and follow up support.

0 to 4 years

- compulsive masturbation which may be self injurious, of a persistent nature or duration
- persistent explicit sexual themes in talk, art or play
- disclosure of sexual abuse
- simulation of sexual touch or sexual activity
- persistently touching the genitals/private parts of others
- forcing other children to engage in sexual activity
- sexual behaviour between young children involving penetration with objects, masturbation of others, oral sex
- presence of a sexually transmitted infection

5 to 9 years

- compulsive masturbation eg self injuring, self harming, seeking an audience
- disclosure of sexual abuse
- persistent bullying involving sexual aggression eg pulling/lifting/removing other children's clothing, sexually threatening notes, drawing, text messages
- sexual behaviour with significantly younger or less able children
- accessing the rooms of sleeping children to touch or engage in sexual activity
- simulation of, or participation in, sexual activities eg oral sex, sexual intercourse
- presence of a sexually transmitted infection
- persistent sexual activity with animals
- using mobile phones and internet which includes giving out identifying details or sexual images

10 to 13 years

- compulsive masturbation eg self harming, seeking an audience
- engaging vulnerable others in a process to gain sexual activity by using grooming techniques eg gifts, lies, flattery
- force or coercion of others into sexual activity

- oral sex and/or intercourse with a person of different age, developmental ability and/or peer grouping
- presence of sexually transmitted infection or pregnancy
- deliberately sending and/or publishing sexual images of self or another person
- arranging a face to face meeting with an online acquaintance
- sexual contact with animals
- sexual activity in exchange for money or goods
- possessing, accessing or sending child exploitation materials eg photos or videos of children naked or doing sexual activities

14 to 17 years

- compulsive masturbation eg self harming, in public, seeking an audience
- preoccupation with sexually aggressive and/or illegal pornography
- sexual contact with others of significant age and/or developmental difference
- engaging others in a process to gain sexual activity by using grooming techniques eg gifts, manipulation, lies
- deliberately sending and/or publishing sexual images of another person without consent
- arranging a meeting with an online acquaintance without the knowledge of a peer or known adult
- sexual contact with animals
- sexual activity in exchange for money, goods, accommodation, drugs or alcohol
- forcing or manipulating others into sexual activity
- possessing, accessing or sending child exploitation materials

Adapted by Family Planning Queensland from the Child at Risk Assessment Unit. (2000). *Age Appropriate Sexual Play and Behaviour in Children.* Canberra: Australian Capital Territory Government Community Care. 5-11.

Attachment 2

Appropriate physical contact with children

Cultural considerations

Different cultures have varying attitudes to appropriate physical contact. Some also have strong views regarding physical contact between genders which has important implications for the care of children from these backgrounds. There are a range of culturally specific agencies which will provide guidance regarding appropriate care for children.

A significant number of children receiving services from WMV come from communities which have experienced significant violence and trauma in their countries of origin. The needs of these children are complex and significant and it is essential that program managers and stakeholders access relevant cultural information regarding appropriate physical contact and implement this

approach consistently. Approaches utilised must comply with the provisions of this policy.

Children with disabilities

Children with disabilities have a range of needs and it is likely stakeholders may be required to engage in a greater degree of physical contact than with other children. This may involve providing assistance with dressing and undressing, bathing or showering, toileting and other personal care needs. Children with disabilities may also engage in a range of sexualised behaviours toward stakeholders and others due to their disability.

Supervisors or program managers must provide comprehensive pre briefing information and direction to volunteer carers or others providing care to children regarding communication strategies where required, the management of sexualised behaviours including the need for additional staff to monitor or assist, recording or reporting arrangements and appropriate practice for bathing, toileting or personal care requirements. The behaviour of stakeholders must comply with the information, direction or management plans provided by supervisors at all times.

The vulnerability of children with disabilities means they have an increased reliance on adults to protect them from harm. Stakeholders must remain continually alert to verbal and non verbal cues from children and the behaviour of other stakeholders.

Appropriate physical contact

Physical contact between stakeholders and children must only occur when it is essential to the work role of the individual and appropriate to the activity and the needs of the child. Physical contact should take place in view of others wherever possible, undertaken only with the permission of the child and be appropriate to the child's age, developmental stage, disability, gender and cultural background. In all instances contact must be limited to completion of a specific task and for the minimum time necessary.

Physical contact between adults and children has the capacity to be misconstrued. Stakeholders must consider what is an appropriate response to a child or situation before acting.

The following considerations are a guide only. Their relevance to particular stakeholders will vary depending on the age, behaviour, disability and needs of children and the specific work environment.

- Touching a child between the neck and knees is generally inappropriate unless required to provide particular assistance. Contact with the bony areas of the body including the child's hand, arm, shoulder, upper back, elbow or head is preferable.
- Stakeholders must always ask a child's permission to touch and signs from the child that contact is unwelcome (such as stiffening or pulling away) must be respected.
- Where ever possible stakeholders should avoid physical contact with a child out of view of others.
- Physical gestures to provide comfort or congratulations should be non intrusive and accompanied with comforting or positive words. A sideways hug around the shoulder from a stakeholder to a child is more acceptable than around the waist. Care should be exercised to ensure these

situations do not occur in private.

- The use verbal directions or gestures is preferable for activities rather than physically moving the child to a particular location. Where touch is necessary always ask the child's permission and conform to the guidelines listed above.
- Stakeholder involvement with toileting, bathing or personal needs must reflect the child's individual management plan and where possible and appropriate, should be undertaken in view of another stakeholder.
- In some situations it may be necessary for stakeholders to discourage a child from unnecessary or inappropriate displays of affection including holding hands, hugs and cuddles. This should be done gently and in a manner which does not embarrass or offend the child.
- Stakeholders must not engage in any physical activity with a child which could be construed as sexually stimulating.
- Stakeholders must not initiate or respond to inappropriate or unnecessary physical contact with children, e.g.: tickling, massages.
- Stakeholders must not use physical punishment of children under any circumstances.
- Stakeholders must not use physical restraint of a child unless this is in accordance with an endorsed behaviour or crisis management plan. Methods of restraint should avoid contact with the areas of the groin or breasts.