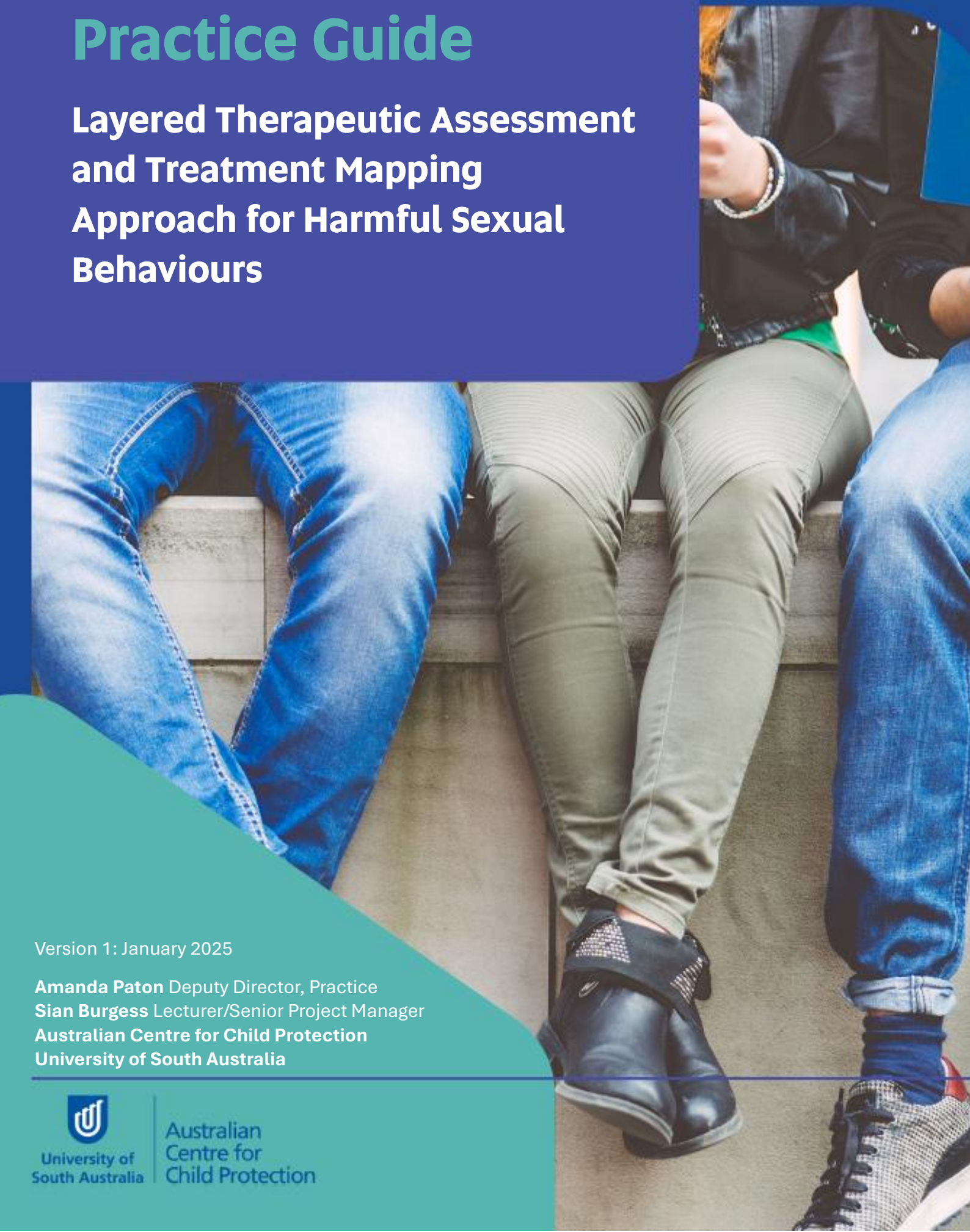
Practice Guide

Layered Therapeutic Assessment and Treatment Mapping Approach for Harmful Sexual Behaviours



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Acknowledgements

We respectfully acknowledge the Kaurna and Whadjuk Noongar Aboriginal and Torres Strait Islander Peoples and their Elders past and present, who are the Traditional Owners of the lands that are now home to the Australian Centre for Child Protection's offices in Adelaide and Perth.

We are honoured to recognise our connection to the Kaurna and Whadjuk Noongar lands, and their history, culture, and spirituality through these locations, and we strive to ensure that we operate in a manner which respects their Elders and ancestors. We also acknowledge the other Aboriginal and Torres Strait Islander People of lands across Australia where we conduct business.

We would also like to acknowledge that this research was completed with grant funds from Western Australian Department of Communities as part of a larger project of work focusing on developing solutions for responding to children and young people who have displayed harmful sexual behaviours.

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Contents

Introduction

Sexual behaviour develops at birth and evolves throughout an individual's development and maturation. While sexual behaviour is a normal and healthy part of many children and young people's development, for some, behaviour can become concerning and harmful. These behaviours are commonly referred to as harmful sexual behaviours (HSB).

In Australia, the National Office for Child Safety in consultation with the National Clinical Reference Group, developed the following working definition of HSB:

> *Harmful sexual behaviours are sexual behaviours displayed by children and young people that fall outside what may be considered developmentally or socially appropriate, may cause harm to themselves or others, and occur either face to face and/or via technology. When these behaviours involve others, they may include a lack of consent, reciprocity, and mutuality, and may involve the use of coercion, force, or misuse of power.*
>
> (Attorney-General's Department, 2023)

Whilst several frameworks are available to assist front line practitioners in understanding a child's sexualised behaviour along a continuum —from behaviours considered normal, healthy, or developmentally appropriate to those that are concerning or harmful (Hackett, 2010; Paton & Bromfield, 2024; True Relationships and Reproductive Health, 2015) — this Practice Guide seeks to extend these frameworks by providing a holistic approach for practitioners working in a child protection or therapeutic treatment role with children and young people who have displayed HSB.

This framework introduces a layer assessment and treatment map, fundamental principles for assessing risk and enhance safety, and key domains required when implementing a components-based approach to treatment identification and matching (although the latter is not discussed in detail here).

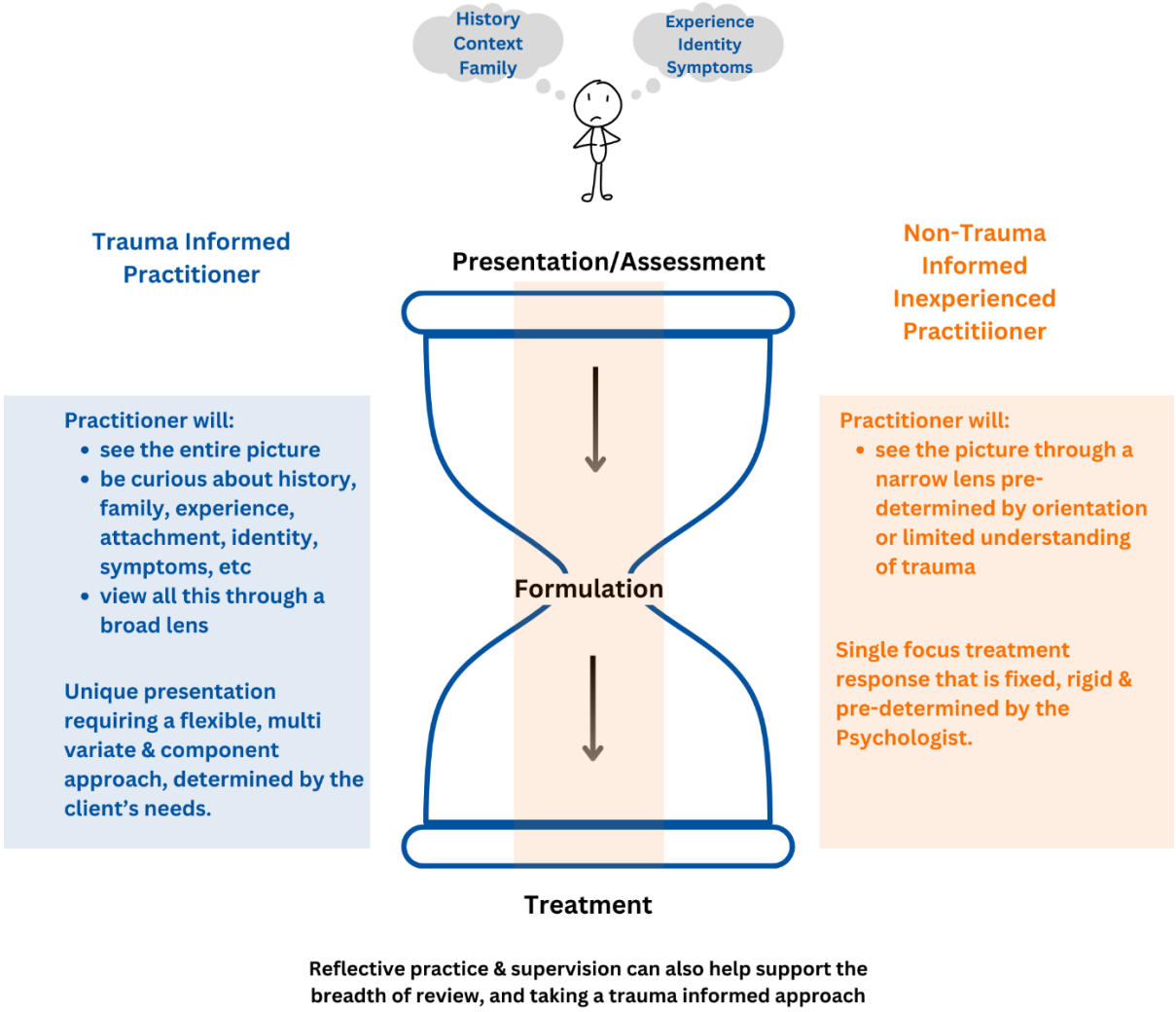
Using a trauma informed lens

When it comes to working with children and young people who have experienced abuse and trauma, it is essential to consider multiple theoretical perspectives. There is no "one-size-fits all" approach.

The diagram below demonstrates that, rather than viewing each child through one particular theoretical lens (e.g., a behavioural approach), viewing them through a trauma-informed perspective incorporates a broader range of theories and allows for a comprehensive understanding of each child's unique experiences and needs.

Figure 1.

Taking a broad theoretical and trauma informed approach to assessment and treatment



This approach to assessment and treatment mapping for children and young people who have displayed HSB adopts an eclectic and holistic approach to ensure that each child is considered individually through a trauma-informed lens, where the behaviour is understand within its broader context.

Layered Therapeutic Assessment

There are several factors and layers of information that contribute to our understanding and assessment of concern and harm. These factors relate to the child, their family or kin, and the broader community. Both the child's individual capacity and their contextual environment play a role in understanding and therefore responding to HSB.

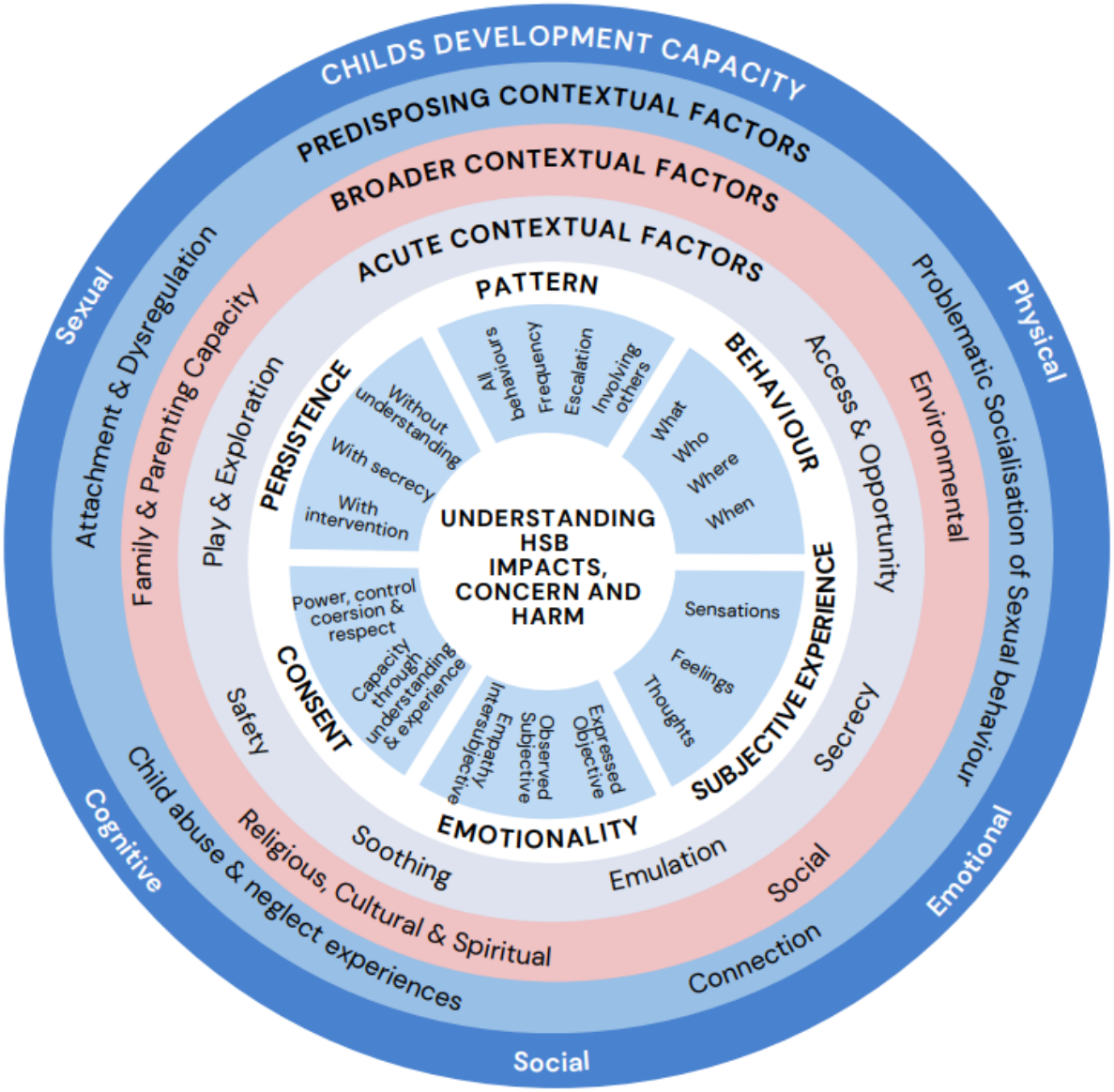
This approach emphasises the need for holistic and multifaceted assessment, seeking information beyond the specific HSB concerns. It is underpinned by the understanding that gathering broad personal and contextual information enables more effective identification of the pathways that have led the child or young person to develop HSB, the factors maintaining this behaviour, the level of concern and risk associated with the HSB, and the factors that can be used to enhance safety.

Figure 2 below provides a map or overview of the layers and domains pertinent in assessing HSB. Information relating to each domain, once known, can begin to shape our responses and treatment plans.

Whilst the map looks at classical features of any thorough psychological assessment, including predisposing factors, it reshapes our thinking of precipitating and perpetuating factors as broader and acute contextual factors. Moving toward the centre of the map (in the figure below), the domains become more specified to the HSB and include behaviour, pattern, persistence, consent, emotionality, and subjective experience. The framework is closely aligned with Paton & Bromfield's (2024) *Layered Continuum for Understanding HSB* and embeds principles of child development, trauma-informed practice, and cultural safety. This practice guide should be read in conjunction with the *Understanding Harmful Sexual Behaviours: A Layered Continuum practice guide* (Paton & Bromfield, 2024).

The information gathered across these layers and domains should be integrated using clinical expertise to create a comprehensive understanding of the child or young person via case conceptualisation or case formulation. This information should also contribute to the development of a risk assessment and plans to enhance safety, as well as treatment planning (including parent/caregiver support).

Figure 2.
Conceptual Assessment Map for Harmful Sexual Behaviours



Five layers

This section provides detailed information on each of the five essential layers of assessment information aligned with the conceptual assessment map illustrated in Figure 2. These layers provide a structured approach to gathering information to inform our understanding and response to HSB concerns. By exploring each layer in detail, practitioners can gain a deeper understanding of the influences on behaviour, enabling more effective and individualised tailoring of responses and intervention supports.

1. Child's developmental capacity

This information directly relates to the young person's functional abilities across their developmental domains (physical, emotional, social, cognitive and sexual). It should include identifying their strengths, areas of challenge, previous assessments or clinical investigation outcomes, and any existing supports or interventions.

2. Predisposing contextual factors

Predisposing contextual information primarily encompasses experiences and emotional and relational challenges related to the young person that have disrupted their expected sexual development trajectory. This may include experiences of abuse or other childhood trauma, attachment difficulties or problems with regulation, poor or problematic connections (within themselves and with others), and problematic socialisation of sexual behaviour and interactions.

Considering connection and disconnection as a predisposing contextual factor

While particularly important for Aboriginal and Torres Strait Islander children and families, the concept of connection—and the impact of disconnection—is relevant and critical for all children, young people, and families. Strong connections across these domains leads to an overall picture of health and wellbeing for children and young people.

Concerns in one or multiple domains can lead to unmet needs, loss, and disconnection from others and the world around them. Staff should possess a sound understanding of this model and incorporate it into their client assessments.

For Aboriginal and Torres Strait Islander children, young people, and families, it is critical to recognise and understand the enormity and devastating impact of colonisation and forced infant removal, which has, in many instances, lead to intergenerational, collective, historical or cultural trauma. While individual children and young people may not always identify these intergenerational and collective traumas, their effects persist, contributing to disconnection across multiple areas. This disconnection often results in unmet needs, which may sometimes be expressed as challenging behaviour.

The National Aboriginal Health Strategy (1989) and Ways Forward report (1995) developed a holistic Aboriginal and Torres Strait Islander understanding of wellbeing, titled social and emotional wellbeing (SEWB) model. The SEWB framework reflects

holistic Aboriginal concepts of health and wellbeing that recognises the importance of culture, history, and Aboriginal ways of knowing, being and doing (National Aboriginal and Islander Health Organisation, 1979).

> *"Aboriginal health does not mean the physical wellbeing of an individual, but refers to the social, emotional, and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole-life-view".*
>
> (Gee et al., 2014, pg. 56)

The SEWB Framework is underpinned by nine guiding principles (Social Health Reference Group, 2004):

- Health as holistic
- The right to self-determination
- The need for cultural understanding
- The impact of history in trauma and loss
- Recognition of human rights
- The impact of racism and stigma
- Recognition of the centrality of kinship
- Recognition of cultural diversity
- Recognition of Aboriginal strengths

3. Broader contextual factors

Information about broader contextual factors explores elements not directly linked to the young person but that profoundly shape their developmental trajectory, belief systems, relational patterns, and environmental interactions. This encompasses factors such as the functional capabilities of parents and the broader family system, religious, cultural, and spiritual influences, broader social systems surrounding the child, and the dynamics within home, school, and other environments.

4. Acute contextual factors

This information adds detail that facilitates understanding the factors that may have led to the behaviour occurring where and when it did, as well as the function or purpose the HSB may serve for the young person. For example, whether the behaviour is aligned with sexual play and exploration and occurred due to spontaneous access and opportunity to a younger, unsupervised child in the home.

5. Harmful sexual behaviour specific information

This information relates directly to the HSB concern/s for which the young person was referred to the service for. The information includes details about what occurred, patterns and persistency of the behaviour, information relating to the use of power, coercion and control, and the emotionality and subjective experiences of the young person with regard to the behaviour.

Gathering Information Across the Layers

Assessment should be viewed as a continuous process that extends from referral to discharge. While there may be critical points in the process where an assessment and/or formulation is formally documented, a practitioner should always engage in ongoing assessment, gathering information, testing hypotheses, and refining their treatment approach. This process of continued assessment helps the practitioner to make micro adjustments to treatment planning to ensure the child or young person receives the most effective and tailored treatment approach for their needs.

Gathering comprehensive information from multiple sources helps to ensure an accurate and holistic assessment. This process involves collecting data from various stakeholders and utilising different methods to capture a complete picture of the child or young person's circumstances and needs.

Importance of the therapeutic relationship

The quality of the information gathered across the layers outlined above often rely on the strength of the therapeutic relationship between the child or young person and the therapeutic practitioner. This is particularly relevant for the layer relating to the HSB specific-information layer, which explores the underlying motivating influences behind the development of the behaviour.

This information —especially details related to emotional experiences and internal narratives—is often only disclosed once a strong therapeutic relationship has been established, which may occur well into the therapeutic process. Rather than a one-directional exchange, this relationship should be viewed as mutual and dynamic. As trust develops, the therapist provides psychoeducation, insights, and understanding, enabling the child or young person to reflect on their behaviour (to the best of their capacity) and gradually share their internal experiences more fully.

Practitioners should adopt a trauma-informed and gentle approach to gathering information to minimise the child, young person and their caregivers' feelings of discomfort or shame. Considerable care should be taken during assessment, as it may be that the initial assessment information is limited due to the newness of the therapeutic relationship.

Mechanisms to gather information

Interviews and observations

Interviews and discussions with the child or young person can provide insight into their perspective, experiences, and feelings regarding their behaviours and current situation. Similarly, conversations with parents or guardians can offer valuable contexts, such as family dynamics, developmental history, and previous behavioural concerns. Alongside direct exploration of information across the layered map, practitioners should be using general observation to further inform the assessment. Observation of behaviour and non-verbal cues within the relationship between child/ young person and their caregiver, effective response when discussing the behaviours and related contextual information, observation of capacity and alignment or not with reported capacity, and observation of general presentation each interaction and over time.

Extending this to include other caregivers or important people in the child or young person's life can also be important. Speaking with other kin, teachers, justice workers, or other professionals working with the child, young person or family is an important step in the assessment process. These individuals can provide additional perspectives on the child or young person's behaviour in different contexts, such as at school or in community settings, and can provide further context on the family dynamics, other contextual concerns, and strengths.

Background material, files, and reports

Reviewing existing files and reports is a critical component of gathering information. These documents may include previous psychological assessments, medical records, educational reports, police or justice reports and other relevant documentation. This historical data provides a baseline understanding of the young person's behavioural patterns, interventions that have been attempted, and their outcomes. Reviewing these records helps identify trends and patterns that inform assessment and intervention planning.

Psychometric Assessments

While it is not advisable to reply too heavily on psychometric assessments, they can serve as helpful additions to a broader assessment process, providing an additional layer of information. This is particularly useful when assessments include versions where both the child or young person and their carer or other person can complete a set of standardised questions, allowing for a comparative perspective.

Standardised tools can be used to measure various aspects of mental health, behaviour, and wellbeing, as well as a range of developmental domains including adaptive behaviour, cognitive ability, memory, and language etc. They can be used to identify specific areas of concern and track changes over time. However, the usefulness of a tool relies on several key factors, including its design, intended purpose, target population, and the qualifications and competence of the practitioner administering it.

Using a tool that lacks validation, is applied for unintended purposes, or is used with an inappropriate population can lead to misleading and potentially harmful and detrimental outcomes for the child or young person. Appendix A includes a summary of the essential factors for practitioners to consider when choosing a psychometric tool to use with children and young people who have displayed HSB (Paton et al., 2024). These factors help practitioners evaluate the tool's effectiveness, its suitability for the specific purpose and demographic, and whether they possess the necessary skills and training for its administration and interpretation.

Figure 3.

How to select the right tool to assess risk for children and young people who have displayed harmful sexual behaviour.

Source: Paton et al. (2024).

Therapeutic Responses, Treatment, and Care

Once a comprehensive assessment has been completed using the layered assessment approach, a treatment plan can begin to form. Practitioners must synthesise the information gathered during the assessment to identify the clients' strengths, as well as the challenges and underlying factors contributing to the child or young person's development of HSB, and any other presenting issues. It is important to recognise that multiple influences—including individual, relational, family, environmental, and broader community factors—may have played a role in the development or maintenance of the HSB.

Any therapeutic treatment plan should be developed with the child, young person, their family/ kin and/or significant others. There should be a clear relationship between areas of concern highlighted in the assessment, the importance of these areas of concern (considering the impact of these on functioning and overall wellbeing, prioritisation of these areas by the child or young person and their capacity to work with this area at that time), and the targeted treatment approach inclusive of goals, modality, specific activities and inclusion of supporting care team members in any treatment plan.

On a practical level, treatment tasks involve creating a plan by aligning interventions with symptoms, prioritising their sequence, executing chosen interventions, regularly monitoring progress, revisiting the young person's evolving treatment needs, and planning discharge and case closure upon goal attainment.

Treatment may encompass a diverse range of interventions and strategies aimed at fostering healing, ensuring safety, easing distress, and nurturing overall wellbeing. There is no 'one-size-fits-all' approach, and a range of responses is required to effectively respond to each child or young person's needs, presentation, support structure, community, cultural connection, wellbeing and capacity. There must be flexibility in the therapeutic approach and the specific techniques and interventions used to accommodate the unique preferences of the child, young person and their support network.

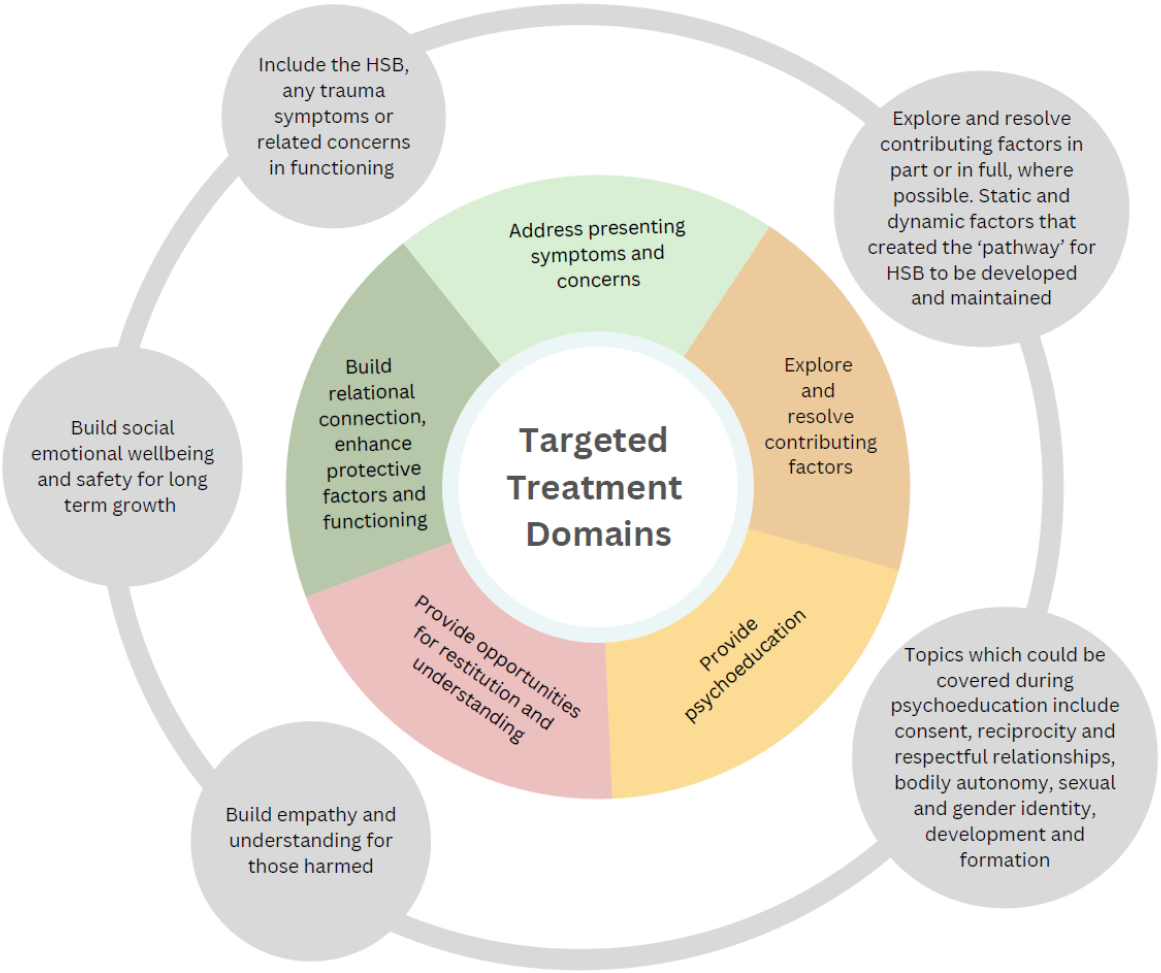
A treatment framework must foster reflection and decision-making aligned with the individual's needs and evidence-based practices (inclusive of research, lived experience, practice knowledge and cultural wisdom).

Some suggested treatment domains

While every individual will have a unique intervention plan tailored to their specific requirements, practitioners must consider a core set of targeted treatment domains when developing these plans. These domains, depicted in Figure 4, are aligned with the Layered Assessment Map discussed above and influenced by literature which explores some of the common influencing or contributing factors to HSB developing and being maintained (Cavanagh-Johnson, 1999; Gil & Shaw, 2014; Hackett, Holmes, and Branigan, 2016, McKibbin et al., 2024; Tucker, 2017). Although various strategies,

actions and emphasis in treatment may be employed to address the domain needs of each young person, the inclusion of all domains ensures that treatment progress is maximised through the application of a comprehensive, multifaceted intervention approach.

Figure 4.
Targeted Treatment Domains



Components based treatment mapping

A components-based treatment matching, that begins with a thorough assessment across the layers as outlined above, will inform the treatment plan. Stepping away from a diagnosis or even the construct to look more closely into the symptoms and functional impact of each individual area is required. As suggested within the hourglass figure presented above (Figure 1), adopting a broad approach across the multiple layers allows the practitioner to keep an open mind, rather than starting with a preconceived notion of diagnosis and treatment match.

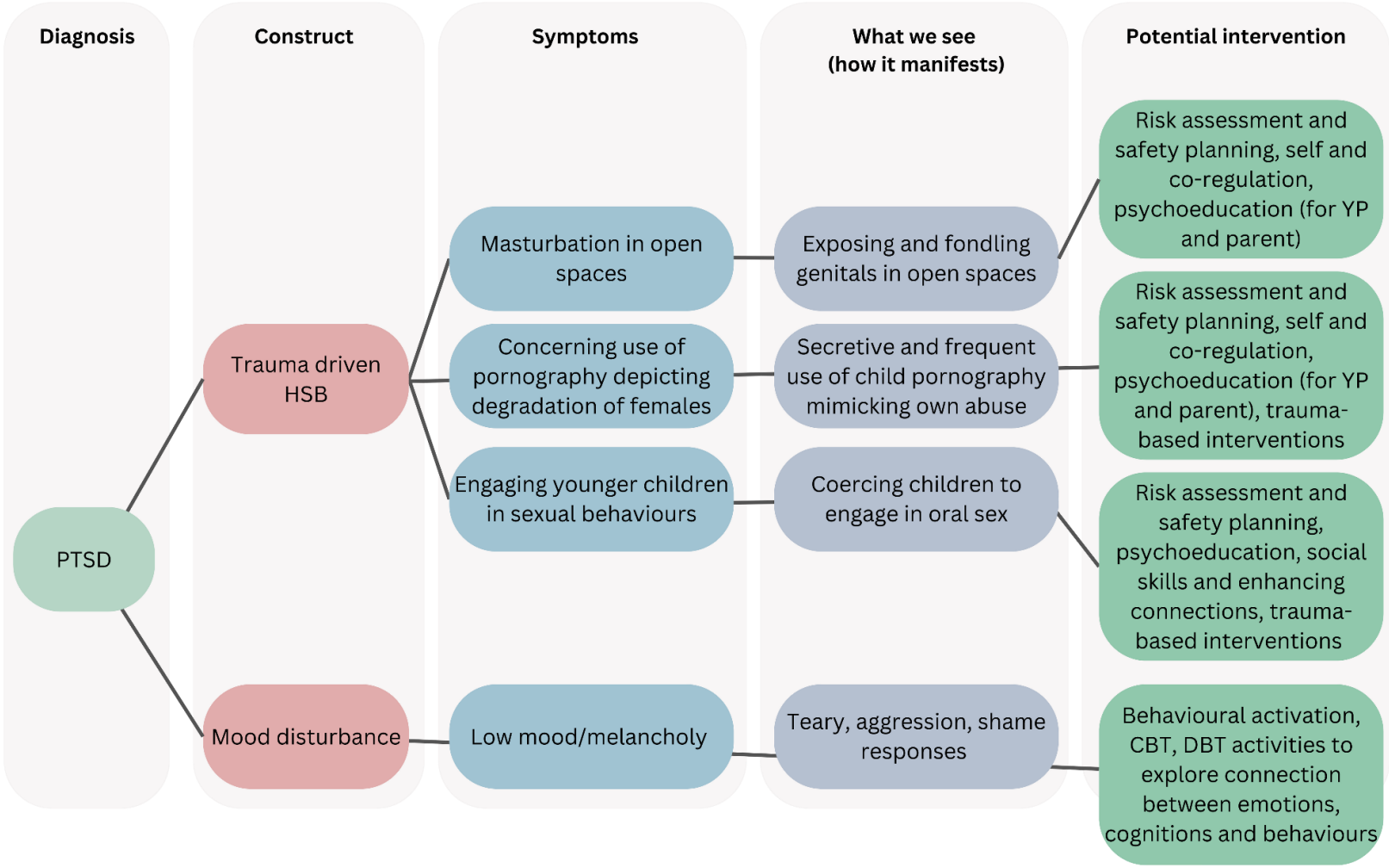
Each area should be examined in detail to understand how the behaviour or concern has developed. Through a trauma informed lens, we can begin to understand the complex interplay between the child or young person's past experiences and relationships, and how these influence their interactions with others in their world.

Therapists using this approach must be agile, highly skilled, adaptive, work within a relationship-based context, be prepared for the longer term, but maintain boundaries, be heavily supported within a robust clinical and therapeutic supervision context and trained in multiple modalities.

Figure 5 is an example of this approach in practice. Taking the elements from a comprehensive layered assessment, breaking these down to their simplest form, and then matching to the most efficacious treatment approach, goal, and activity for that individual.

Figure 5.

Example of treatment matching following components-based analysis of areas of concern



Targeted intervention specifically on the development and maintenance of their harmful sexual behaviour

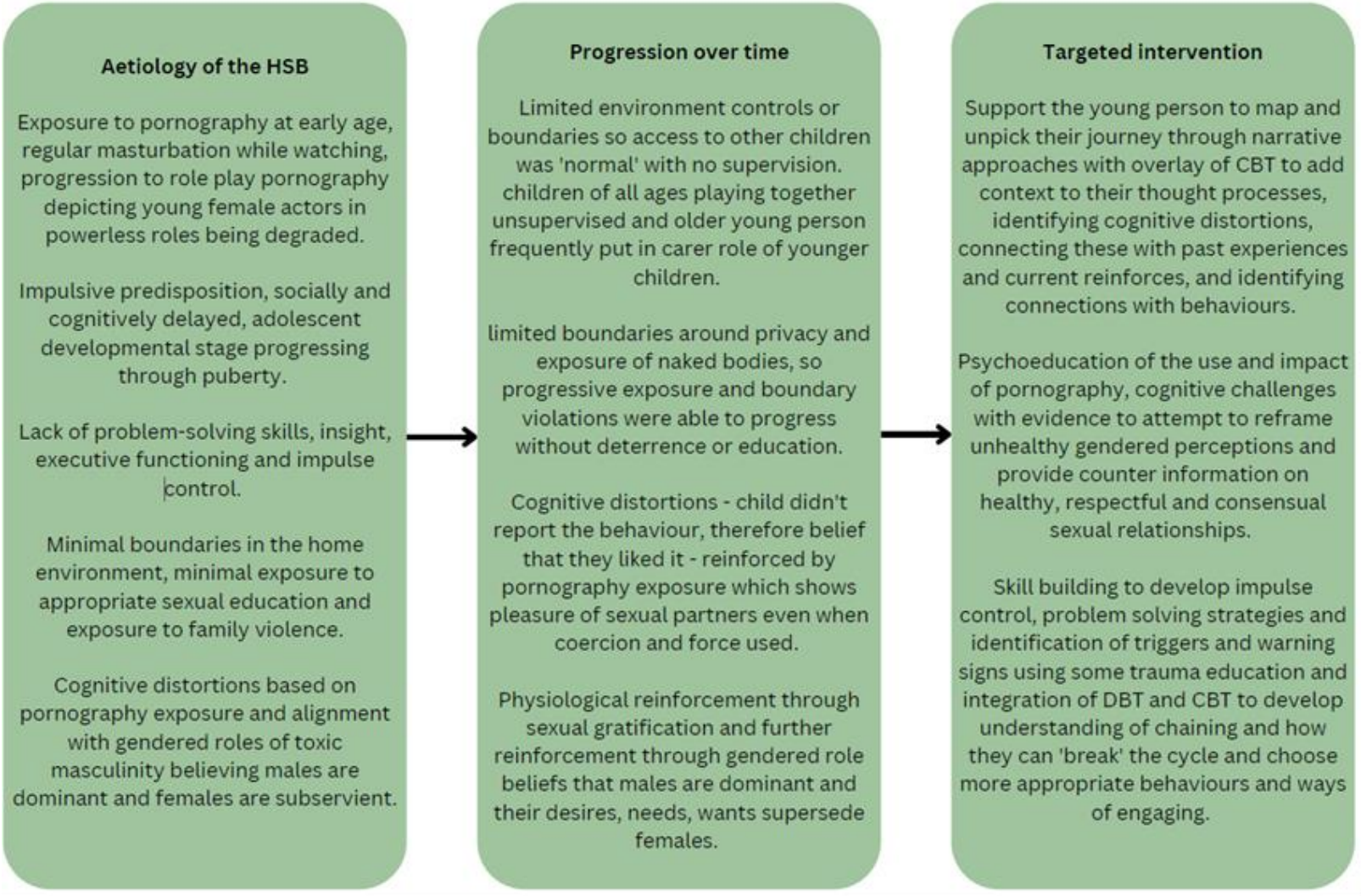
Whilst this may seem counterintuitive, not all young people who have displayed HSB will require more than targeted psychoeducation and behavioural re-direction from their caregivers to cease their behaviour. However, some young people will require more intensive and prolonged therapeutic work to address why and how their sexual behaviour progressed to HSB, how it was maintained, and how they can develop healthier ways of engaging in intimate relationships.

Following on from assessment and consideration for the broad domains of treatment, some will need a targeted approach. Drawing on principals of Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), Narrative Therapy, and a range of other techniques to unpack this complex issue within a strong therapeutic relationship is often effective and can help the young person:

- Better understand the etiology of their behaviour – identifying where the idea came from, what facilitated its occurrence
- Un-pack and develop a greater understanding/reflection of how the behaviour evolved each time (if it was repeated – by bringing our awareness to the patterns and progression, young people can be better prepared for future triggers)
- Highlight any cognitive distortions, core beliefs and potential origins of these (e.g., child sexual abuse, physical abuse, exposure to family violence, gendered roles)
- To understand why and what they did was abusive (where it involves another child) – bringing in concepts of respect, rights and responsibility
- Reduce denial, and increase responsibility for their behaviour, previously and into the future
- Understand sexual abuse dynamics and general sex education
- To identify and target thoughts, feelings and beliefs that continue to maintain their HSB
- To build victim awareness and empathy (where there is another child involved)
- Identify triggers and early warning signs of their behaviours and come up with alternative behaviours and activities

The figure below provides an example of how this components-based approach is contextualised to the specific targeted treatment of HSB and how you would map the aetiology of the HSB, how it progressed and was maintained over time, with targeted interventions to achieve the above.

Figure 6.
Aetiology of HSB



Putting It All Together

This table outlines the process of transitioning from assessment information to treatment planning for children and young people displaying HSB. It highlights key domains of information, explaining what each domain can tell us about the behaviour. The table also identifies likely sources of this information, including professionals and systems involved in the child's life, and suggests treatment considerations or interventions that may be linked to each domain.

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
Developmental and Contextual Factors				
Child's developmental capacity	*Cognitive development* – relates to intellectual capacity, creativity, ability to interact with others and the world around, memory, plan, process complex thoughts etc. *Language development* – sometimes included within cognitive development (although discrete), relates to the development of language, ability to communicate with others, developing both expressive and receptive language.	This information tells us more about the child's capacity; what may have contributed to the HSB developing and what considerations or adaptations/ approaches we may need to take in treatment. For example, if a child has a cognitive developmental delay, this may have contributed to both their lack of understanding of boundaries and consent but may also be critical in treatment. I.e., if they can be given structured psychoeducation and scaffolding to learn about	Most of the information for this domain will come from parents and caregivers, teachers, and your general observations. It requires information about the child's general functioning in a range of areas and against same age peers. It is likely that this behaviour would be gathered in a thorough assessment, from review of allied health and medical reports, school reports, or from case file history and care plans if the child is in OOHC.	If various developmental delays have contributed to the development of and maintenance of HSB, then resolution or adjustment of expectations to be more in line with developmental age rather than chronological age is critical. For many this will include behaviour social skills training, psychoeducation that is supported by visual cues and tangible reminders such as posters and simple infographic pictorial task sheets. Parental/ caregiver involvement and translation

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	Social/ emotional development – is closely related to one's experience of relationships with others, where they learn to understand and regulate their own emotions, understand emotions of others, develop empathy and general emotional intelligence. *Physical/ biological development* – includes physical changes in the child such as growing in height, weight and strength, development of fine and gross motor skills and abilities related to capacity to self-care. In puberty this includes changes to the child's internal and external sex organs coupled with changes to physiological reactions and hormone changes.	boundaries and consent could they change behaviour. Or does their developmental cognitive capacity limit their capacity for future learning and therefore potential for change.		of learnings from therapy into other environments will also be critical here to ensure knowledge translation. For some children and young people with developmental delays, targeted psychoeducation on why the behaviour was not safe, how it caused harm, and how to behave more appropriately and respectfully with peers into the future is adequate to overcome some of these capacity issues. Unfortunately for some, cognitive delays may be such that learning new skills or managing impulse is challenging and treatment responses may need to include strict supervision to ensure safety, regular in situ prompting to make safe choices when interacting with others etc. Those with social and emotional delays will require targeted intervention to build

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	Sexual development – beginning from birth including both physical development to internal and external sex organs, and changes in hormones and physiological responses to stimuli; and emotional attitudes, beliefs and interest in sexual activities, intimacy, and exploration.			emotional literacy, understanding of experience of emotions, emotional expression, and regulation. This should then extend into developing a better understanding of emotional experiences of others.
Predisposing contextual factors	*Child abuse and neglect experiences* – a range of adverse experiences are known to co-exist with HSB. Notably experiences of child sexual abuse, family and domestic violence and physical abuse. *Problematic socialisation of sexual behaviour* – this can include an overtly sexualised home environment, exposure to pornography and child abuse material and other forms of violent sexual imagery that leads to a normalisation of sexual behaviour despite	This information reveals contextual information about experiences that may have influenced the child to develop HSB and other concerning behaviours. It also highlights early targets for intervention; if these issues are not resolved then the behaviour may continue to persist even with targeted intervention.	This information may not be known overtly when you begin to work with or assess a child or young person. Whilst there may be some information in case file history, reports, or referral information much of this information will come out through the assessment process asking caregivers questions and also throughout the therapeutic process as the child or young person begins to share their experiences.	Child abuse and neglect experiences can result in trauma related symptoms. It is critical to ensure that such symptoms are assessed thoroughly and resolved alongside targeted focus on HSB. Interventions such as EMDR, TFCBT etc have been evidenced as effective treatment approaches for children and young people who have PTSD or trauma related symptoms. Psychoeducation alongside behavioural and environmental changes may

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	developmental capacity, consent, and respect in relationships. *Attachment and dysregulation* – many sexual behaviours and HSB develop because of soothing behaviours, lack of capacity for self-regulation or adaptive mechanisms for regulation and attempts by a child to connect with another individual through sexual behaviour.			be required to resolve issues and HSB that has developed or been maintained by exposure to sexual imagery, or sexual environments. HSB is unlikely to desist if drivers of those behaviours remain. For example, if the child still readily engages in viewing of pornography, (regardless of type) then efforts to reduce HSB may be fraught as they are still experiencing gratification from sexual activity. Attachment based behaviours often co-occur with experiences of complex trauma, separation from parents and early childhood abuse experiences. Attachment disruptions are often difficult to treat, require long term therapy and a longer-term care relationship to provide reparation. Treatment options such as DDP or play based therapies

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
				may be suitable here within a dyadic therapeutic experience. As with social and emotional capacity deficits above, for those children with HSB that is at least in part fuelled by the need to self sooth, and poor self-regulation – treatment targeting these is crucial. In addition, activities such as mindfulness, other and co regulation activities, body movement and sensory immersion are sometimes helpful to provide regulation and more adaptive soothing.
Broader contextual factors	*Social context* – social setting or situational circumstances around a person. *Cultural and religious context* – a child's cultural and religious identification is crucial in understanding the broader context of HSB. Shared beliefs, values,	This information can offer valuable insights into understanding an individual's beliefs, likely experiences and behaviour more broadly. This information also helps us to gain a more comprehensive understanding of an	This information may also not be known overtly when you begin to work with or assess a child or young person. This information will likely become known through the assessment process asking caregivers questions and also throughout the therapeutic process as the	Frequently, efforts to address identified issues in these areas extend beyond individual interventions with the child or young person. Instead, referrals for supplementary supports may be of benefit, such as participation in structured group social activities,

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	customs, history, stories, and language shape identity, influencing how a child perceives the world and interacts with others. Cultural and religious perspectives on gender, development, sexuality, and diversity can affect a child's understanding of sexual behaviour and influence the responses of those around them. *Environmental context* – the physical environment and space within which a behaviour occurs. This may also extend to the physical environment the child or young person lives, engages in community, works, or learns. *Parental/ carer capacity* – the ability of the parent or caregiver to effectively meet the needs of the child and provide a safe, nurturing,	individual's motivations and challenges. Together, this facilitates a deeper understanding of how the behaviours of concern may have evolved, what meaning and significance they may hold for the individual or their community, what treatment and supports may be most effective, and the existing strengths the client possesses.	child or young person begins to share their experiences. Information relating to parent/carer capacity and motivation may be provided by other professional working with the child (teachers, case manager) and gleaned from your observations.	mentoring, or community-based programs. Enhancing family functioning and circumstances through various supports may also be valuable; for instance, parenting education and support, access to healthcare services, and legal advocacy. Consideration of the specific needs of the parent/ caregiver may also be of use here, including mental health support or family and domestic violence services.

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	and supportive environment for their growth and development. This encompasses parenting skills, emotional stability, social supports, resources, and resilience. Understanding parental capacity helps determine the level of support and intervention required to address concerning behaviours and promote positive outcomes for the child's overall development.			
Connection – within predisposing	The Social Emotional Wellbeing Framework (SEWB) notes seven determinants of health that are relevant here: *Connection to body and behaviours* Diet and exercise *Connection to mind and emotions* Beyond mental health to include culture bound	Although particularly important for Aboriginal and Torres Strait Islander children and families, this domain is critical for understanding and guiding treatment for all children and families. It provides an overall picture of a child or young person's wellbeing and health, showing how their experiences, behaviours, and context influence their	Information relating to this domain will come from various sources. The child, immediate and extended family, important community members and cultural elders may all be keepers of this information. Some of this information may be garnered at the point of referral, though much will become known through the assessment process.	Treatment considerations span both within individual interventions and beyond these. Interventions should consider focus on fostering connections with family, history, and the development of healthy relationships with significant others. Reconnecting with family and community plays a critical role in healing, promoting

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	disorders and importance of positive emotions, self-confidence and experiencing of joy rather than just the absence of a disorder *Connection to family and kinship* Family and group relationship, kinship attachment systems of reciprocity and caring gender and age roles *Connection to community* Social inclusion and relationships, community cohesion *Connection to culture* Cultural expressions, knowledge and identity *Connection to country* Belonging to country Yearning to heal country *Connection to ancestors* Knowledge and belief systems, cultural healing	connection to others and the world. This information highlights both strengths and areas requiring targeted attention. These connections are often inter-related as well, requiring balance and purposeful focus when one is off to ensure others do not slip as priorities change.	Understanding and knowledge of this information will also continue to develop and evolve across the intervention process, as trust and connection builds between the child, young person and their family and the practitioner/ agency. In gathering information about this domain it is essential to use culturally appropriate, respectful, and trauma informed methods. Taking the time to establish meaningful relationships and foster open communication and deeper understanding is crucial, as is understanding that some of this information may be considered deeply personal or sacred and should only be shared with permission.	belonging and emotional well-being. Encouraging self-determination and community control is key, as engaging with others and seeking support fosters empowerment and resilience. Opportunities for learning about and participating in cultural expression and knowledge should be emphasized, helping individuals strengthen their identity and find healing through cultural reconnection. Returning to Country is also a powerful intervention, as spending time on country can heal the mind, body, and spirit, and re-establish ties with ancestral lands. This holistic approach is often intertwined with mindfulness practices that enable peace and balance, helping individuals regulate emotions and

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
				connect with the present moment. The expression of spirituality, whether through traditional practices, ceremonies, or personal reflection, can also be vital. Supporting individuals in exploring and expressing their spirituality fosters deep healing and aligns with culturally appropriate therapeutic approaches. These interventions create a pathway to healing that respects and uplifts cultural and spiritual identities. For Aboriginal and Torres Strait Islander children and families, accessing culturally safe supports and interventions can be achieved by engaging with cultural Elders connected to their family. Elders provide culturally specific guidance, support truth-telling, and

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
				facilitate connections with culturally appropriate agencies and healers. Aboriginal Community Controlled Organisations (ACCOs) are also vital sources of support, offering access to traditional healing practices, culturally safe mental health services, and assistance in integrating traditional diets, sports, and activities like hunting into treatment.
Factors related directly to the behaviour/s				
Acute contextual factors	*Access and opportunity* The availability to environments or unsupervised situations that provide the means or change to engage in the behaviour. *Secrecy* Deliberate concealment of the behaviour from others *Emulation*	These factors provide insights as to why and how HSB may have emerged, have been reinforced, and persist. Understanding these factors can help to inform plans to enhance safety, identify precursors to the behaviours, and tailor responses to the behaviour and the issues fuelling them.	This information is likely to come from caregivers, case workers, or other individuals who may have witnessed the behaviour (i.e., teachers) during the assessment process. Additional information can be gathered via interview or use of questionnaire based tools.	Addressing these factors requires individual interventions, safety planning, and caregiver education and skill building. Helping the child distinguish healthy from unhealthy sexual behaviours for their developmental stage, while equipping them with adaptive coping and self-soothing strategies, can reduce acute contextual

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	The imitation of observed behaviours – from peers, adults or media. *Soothing* Use of the behaviour to soothe emotional distress. *Play and exploration* Behaviours occurring through curiosity or exploratory play. *Safety* The presence or absence of safety surrounding the child.		Historical information may be captured in documentation, such as case files, medical letters or reviews, documents from allied health professionals, or legal documents.	risks. Overcoming barriers to open and honest communication between children and caregivers is also crucial. Caregiver education and skill development are also key to reducing these factors by supporting effective safety planning and implementation. Understanding the factors contributing to the behaviour and learning supportive, therapeutic responses enable caregivers to implement safety strategies effectively. This may include setting clear house rules to minimise risk, promoting respectful and safe behaviour, and ensuring appropriate supervision.
Behaviour	*Who* The child or children who were involved with the behaviour.	Understanding this 'core' information about the behaviour of concern provides a starting point for its assessment, serving as a	Information about current behaviours is likely to come from caregivers, case workers, others who have witnessed the behaviour (i.e.,	This information is a key indicator of the baseline behaviour that requires intervention. It provides the foundation for measuring

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	What A description of what the behaviour involved. *Where* The environment/s the behaviour has occurred in. *When* When the behaviour has occurred. Initial behaviours and subsequent if known.	foundation for gathering the in-depth details required for deeper layers of evaluation. Knowing who is involved, what the behaviour looks like, and where and when it does or does not occur sets the initial parameters for the assessment. This helps guide the exploration 'within' these factors and offers early insights into where the behaviour may fall on the Layered Continuum.	teachers), incident or mandatory report documentation, legal records, and possibly the child themselves. This information may be captured at the point of referral and during the assessment process. Historical information may be captured in case files, medical letters or reviews, documents from allied health professionals, or legal documents.	progress and evaluating intervention activities. Addressing these factors requires individual interventions, safety planning, and caregiver education and skill building.
Pattern	*All behaviours* When considering pattern, consider all HSB if multiple have occurred. *Frequency* How often are the behaviours occurring? *Escalation*	Information about the pattern of the behaviour allows for a more nuanced assessment and response. Knowing the frequency of the behaviour helps to distinguish between isolated incidents and persistent problems, while also identifying events, circumstances, and environments that increase	This information is likely to come from caregivers, caseworkers, others who have witnessed the behaviour (i.e., teachers), incident or mandatory report documentation, and possibly the child themselves. Some of this information may be available at the point of referral, though it is most	Information about pattern is helpful in tailoring interventions to the child's needs. Behaviours that are frequent, escalating, and/or involving other children may require more urgent or intensive intervention than those that are occasional, stable, and/or solitary.

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	Are the behaviours worsening over time? *Involving others* Are the behaviours solitary or involve other children?	the likelihood of the behaviour occurring. Understanding whether the behaviour is escalating, decreasing, or remaining stable over time informs the urgency and severity of the issue. Knowing whether other children are involved in the behaviour informs its severity, the urgency and type of responses required, and the necessary safety planning. Monitoring of pattern information may also indicate whether current responses or interventions are effective.	likely that most detail will be captured within the assessment process. Additional information may become as engagement progresses, if additional behaviours occur or as patterns change/reduce. Historical information may be captured in case files, medical letters or reviews, documents from allied health professionals, or legal documents.	
Persistence	*Without understanding* Behaviour persisting due to deficits in the child's understanding of the behaviour being inappropriate or harmful *With secrecy*	Information about the persistence of the behaviour allows for further fine tuning of the assessment and planned intervention response.	This information is likely to come from caregivers, caseworkers, others who have witnessed the behaviour (i.e., teachers), incident or mandatory report documentation.	Behaviours that persist can benefit from individual, caregiver, and safety planning intervention considerations that include: *Education*

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	Behaviours that persist with the child attempting to conceal them. *With intervention* Behaviours that are persisting despite intervention responses	Persistence of a behaviour informs upon its severity and may contribute to our understanding of the needs of the child, and the risks associated with the behaviour. Persistence without the child understanding the that they behaviour is inappropriate or harmful may indicate neurodevelopmental challenges, a lack of appropriate sexual education, trauma experiences, or exposure to sexualised environments. Persistence with secrecy may indicate intentionality to the behaviour, an understanding that the behaviour is not appropriate and/or causes harm, impulse control issues, difficulties with empathy, and a desire not to be 'found out'. Behaviours that persist with	Some of this information may be available at the point of referral, though it is most likely that most detail will be captured within the assessment process and as the intervention progresses. Your interactions and observations of the child across sessions can also add information relating to the understanding the child holds about their behaviours and any secrecy entwined with them.	The child may benefit from education on healthy sexual behaviours for their stage of development. The care giver may require targeted education and support to foster their responses to the child and support of their learning. *Safety planning and supervision* Proportionate safety planning and supervision is essential to monitor and reduce persistent behaviours. *Need for multidisciplinary support* Persistent behaviours may benefit from the support of a team of professionals to provide a comprehensive and holistic support network. *Placement considerations* Persistent behaviours, particularly those involving other children, may benefit

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
		secrecy are usually considered at the 'upper end' of severity. In the context of active intervention, persistence of the behaviour can indicate the effectiveness of the intervention plan and activities.		from an evaluation of the child's care arrangement to determine whether it provides the support and stability and required. *Re-valuation of the case formulation and treatment plan*. Review may identify a need to adjust the case formulation or intervention plan to improve effectiveness.
Consent	Power, control, coercion and respect. Capacity through understanding and experience.	Information regarding consent can help us better understand a child's developmental understanding, intent, underlying drivers to the behaviour, and level of associated risk. Young children often lack a developed concept of consent, so the lack of this in relation to a behaviour may not be overly concerning.	This information may come from caregivers, caseworkers, others who have witnessed the behaviour (i.e., teachers), incident or mandatory report documentation. Some of this information may be available at the point of referral, though it is most likely that most detail will be captured within the assessment process and through your clinical	Addressing concerns related to consent may involve a combination of individual interventions, safety planning, and caregiver education and skill development. *Individual interventions* Depending on the broader clinical context, interventions such as targeted education, activities increasing self awareness, impulse control, emotional

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
		Older children may hold developed or developing understanding of consent, and the absence of this may hold greater concern in relation to the behaviour. Where information suggests a child has ignored another child's lack of consent and/or distress, and forced, manipulated or coerced a child into a behaviour this can signal concerns about power dynamics, impulse control, or harmful beliefs about relationships and sexuality. Where children have participated in a behaviour mutually and freely, this may indicate behaviours driven by curiosity, exposure to explicit material, trauma re-enactment, or other social influences.	interpretation of the information provided in this process. Your interactions and observations of the child across sessions can also add information relating to the child's developmental understanding and beliefs about their behaviour and others involved.	regulation, and empathy may be useful. Trauma processing and cognitive behavioural strategies can help challenge unhelpful beliefs about consent and support healthier attitudes and behaviours. *Caregiver education* Targeted education can help caregivers develop a stronger understanding of sexual consent and how to support the child in learning and applying these principles in their daily interactions. *Safety planning* The presence of force, coercion, manipulation, or disregard for another child's lack of consent must be carefully assessed within safety planning. Strategies should focus on minimising risks, ensuring appropriate supervision, and reinforcing

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
				respect for boundaries and personal autonomy.
Emotionality	*Expressed objective* Emotions self-reported by the child. *Observed subjective* Subjective interpretation of emotions demonstrated by the child by people who have witnessed the behaviour. *Empathy intersubjective* To what degree the child recognises and responds to the feelings of any other children involved in the behaviour.	A child's emotional response to a behaviour provides valuable insight into motivations, underlying drivers, and associated risk. This information is most useful when considered alongside other contextual factors. *Positive or neutral emotions* If a child displays or reports positive or neutral emotions, the behaviour may stem from curiosity or exploration. However, it can also indicate learned patterns or a lack of awareness that the behaviour is inappropriate. *Emotional distress (i.e., fear, distress, shame, hostility, aggression, emotional numbness/detachment)* The presence of fear, distress, hostility, or	This information may be sourced from those who have witnessed the behaviours and incident reports or case notes. It may also come from the child/ren involved dependent on their developmental capacity and willingness to engage. This information may be available at the time of assessment, though may also become known as the intervention progresses.	Considering a child's emotional responses can provide valuable guidance when planning and tailoring intervention and treatment activities. *Positive or neutral emotions* Children who display positive or neutral emotions may benefit from education and guidance, depending on the broader clinical context. *Emotional distress* Children displaying fear, shame, or distress may benefit from education and guidance, along with targeted intervention activities such as trauma processing, emotional regulation support, or therapy specific to HSB. Children who display hostility, aggression, or

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
		emotional numbness often signals a need for concern. These emotions may suggest the child feels unsafe, recognises the behaviour as inappropriate, or is experiencing a trauma response. Hostility and emotional detachment are particularly concerning and are often linked to higher-severity behaviours.		emotional numbness can be particularly difficult to engage and often require more intensive, structured, and multifaceted interventions.
Subjective experience	Self-reported information relating to: *Sensations* Physical perceptions and feelings experienced by the child when engaged in the behaviour. *Feelings* Emotions experienced by the child about and during the behaviour.	A child's subjective experience provides a window into the emotional and cognitive processes driving the HSB. This information provides added insights into motivations, underlying drivers, and risk associated with the behaviour.	This information is most accurately gathered from the child once they feel comfortable and safe to share it. This may be during the assessment process or as the intervention progresses and therapeutic rapport increases. Caregivers or other adults important to the child may also have insight into information if the child has shared this with them.	This information enables interventions to be further tailored to the child's needs to enhance engagement and outcomes. Although presentations vary widely, some considerations include: *Trauma and adversity* Subjective experiences that suggest experience of trauma or adversity may benefit from trauma informed approaches. E.g., processing trauma experiences and

Domain	Description	What does it tell us	Who is likely to have this information and when will it be gathered/ known?	Treatment suggestions/ considerations
	Thoughts Thoughts and beliefs about the behaviour and those involved held by the child.			developing safe coping strategies. *Emotional regulation* Intense or fluctuating emotions or reliance on inappropriate self-soothing strategies may warrant skills training in emotional regulation. These activities help children to identify, understand and manage their emotional responses effectively. *Underdeveloped or distorted understanding and belief systems* Confusion, poor understanding, or distorted beliefs may benefit from targeted education, or cognitive behavioural techniques. These approaches help to clarify safe personal boundaries and promote healthier thought patterns.

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Appendix A

How to select the right tool – elements to consider when selecting an assessment tool for understanding risk related to harmful sexual behaviours *(adapted from Paton et al. 2024).*

PURPOSE AND EFFICACY

1. Purpose match
Why was the tool developed; for what purpose was it developed.
What setting or context was the tool designed for? (e.g., clinical, forensic, in patient, detention)
What question was the tool designed to answer? (e.g., to track progress, assess risk, assess recidivism, guide treatment)
How does this match, or not, to the purpose of your assessment?

How frequently can the tool be used for an individual? How long are the results reliable for? This is important if you wanted to use the assessment tool to track progress or have results contribute to your understanding of risk (e.g., results may only be valid for an acute period of time)

2. Psychometric properties
What is the evidence base of the tool for the intended purpose?
Does the tool reliability do what it says it does? Is it a valid measure of the construct?
Has this been tested? (e.g., if it was designed to measure recidivism risk, has it been evaluated to demonstrate that it does predict recidivism?)

STRUCTURE AND APPROACH

1. Theoretical underpinning
How was the tool created? Was it based on understanding of adult sexual offending or on child and adolescent sexual behaviour?
Who (age and context) was used to inform the normative data?
Does the assessment include an understanding of child development represented in its descriptions, scales, and interpretations?

2. Information sources and methods
Does the tool draw on multiple informants? Is it based on case file history, clinical interview, carer rating, observations, or self-rating? Does this fit for your setting?
Multiple informants should be used wherever possible.
Is it categorical yes/ no, present/ not present ratings, or does it use scales? Are these numerical values added up to give you a 'score' for a domain? Does this make sense?

3. Inclusive of protective, dynamic, and contextual factors
What scales, domains or areas does the assessment look at? How many items of questions are in each and do these make sense?
Does it include areas on contextual considerations and protective factors? How are these understood in the final analysis? Does this fit your purpose?

4. Use of levels of concern
If the tool uses descriptors or levels of concern, how are these determined? Are there clear cut off scores, do these change for different cohorts (e.g., ages of children), how were these cut offs determined (e.g., are they arbitrary or are they based on normative data – if so, what participants where used – do they match your client group?)
What will these levels, or labels be used for in your context? Consider the unintended consequences for a young person of receiving a 'high risk' label on a particular tool.

DIVERSITY OF HSB POPULATION

Given there is significant variability among children and young people who have displayed HSB, any chosen assessment should generally match or represent your intended cohort and include similar variability.

1. Age
Does the assessment tool cover an age range that aligns with your intended age range? Was its development or normative data used to decide on cut off scores representative of children (e.g. under 12 years) or young people (e.g. 12-18 years). Does it consider developmental variations?

2. Gender
Does the assessment tool include considerations for gender differences? Was its development of normative data used to describe cut off scores representative of males, females and gender diverse children and young people? Does this match your intended cohort?

3. Ability
HSB displayed by children and young people with varying ability, can have significantly varied trajectories in terms of how the behaviour developed, the function it serves and what is maintaining it. Assessment tools used on children and young people with diverse abilities such as developmental delays, neuro diversity etc require tools sensitive to this and ones that have included these variations in their development and any cut off scores.

CULTURALLY RESPONSIVE

Understanding how a tool was developed will inform your decision related to cultural safety.

Was the tool developed on appropriate considerations for variations in cultural backgrounds?

Does it include multiple perspectives or only one traditional dominant view (e.g., traditional western beliefs)? If the tool has an evidence base and has been evaluated, did the sample include a diverse representation of cultures and backgrounds?

Does this population match your population?

For those in Australia, a key consideration is the inclusion and consideration of Aboriginal and Torres Strait Islander peoples in the development, evaluation, and use of a tool.

CONTEMPORARY AND EVIDENCE INFORMED

1. Use of language
Does the tool use language that is in line with your organisational policies and frameworks? Does it recognise that children and young people display a range of sexual behaviours and that children's HSB is distinctly different to child sexual abuse perpetrated by adults?

2. Inclusion of Technology Assisted HSB
HSB is readily facilitated and maintained by the online space.

Is technology included in the tools' assessment scales?

This can be an important consideration for both assessment of concern and treatment needs and targets.

3. Considering use and exposure to pornography
Exposure to pornography, especially extreme, violent, and degrading content can be extremely damaging for children and young people.

Does the assessment tool require you to consider exposure and use of pornography? Does it include questions related to the viewing or creating of child sexual abuse material?

USER REQUIREMENTS AND FEASIBILITY

What type of skills and qualifications are required to administer and interpret results of the tool? Who is required to complete the tool?

Does this work for your purpose and setting?

What specific training requirements are there for this tool? Are these onerous, do they take into account prior expertise and experience, or are they inflexible? What are the costs of the training and any registration requirements, is this appropriate within your budget and setting?

Do you have to buy a licence to use the tool, ongoing protocols? Are they restricted or free?

Is the user, training and purchasing requirements of the tool sustainable for your service, organisation, system?

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