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UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

To demonstrate the need for assessment and treatment services to assist children and young people presenting harmful sexual behaviours.

Emily O' Callaghan

CARL Research Project

In collaboration with

Action Learning Group Cork

Name of student(s):	Emily O Callaghan
Name of civil society organisation/community group:	Action Learning Group Cork
Name of community group liaison person:	Kathy D'Arcy
Academic supervisor(s):	Dr. Katharina Swirak
Name and year of course:	MA Criminology
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What is Community-Academic Research Links?

Community Academic Research Links (CARL) is a community engagement initiative provided by University College Cork to support the research needs of community and voluntary groups/ Civil Society Organisations (CSOs). These groups can be grass roots groups, single issue temporary groups, but also structured community organisations. Research for the CSO is carried out free of financial cost by student researchers.

CARL seeks to:

- provide civil society with knowledge and skills through research and education;
- provide their services on an affordable basis;
- promote and support public access to and influence on science and technology;
- create equitable and supportive partnerships with civil society organisations;
- enhance understanding among policymakers and education and research institutions of the research and education needs of civil society, and
- enhance the transferrable skills and knowledge of students, community representatives and researchers (www.livingknowledge.org).

What is a CSO?

We define CSOs as groups who are non-governmental, non-profit, not representing commercial interests, and/or pursuing a common purpose in the public interest. These groups include: trade unions, NGOs, professional associations, charities, grass-roots organisations, organisations that involve citizens in local and municipal life, churches and religious committees, and so on.

Why is this report on the UCC website?

The research agreement between the CSO, student and CARL/University states that the results of the study must be made public through the publication of the final research report on the CARL (UCC) website. CARL is committed to open access, and the free and public dissemination of research results.

How do I reference this report?

Author (year) *Dissertation/Project Title*, [online], Community-Academic Research Links/University College Cork, Ireland, Available from: http://www.ucc.ie/en/scishop/completed/ [Accessed on: date].

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Notwithstanding the contributions by the University and its staff, the University gives no warranty as to the accuracy of the project report or the suitability of any material contained in it for either general or specific purposes. It will be for the Client Group, or users, to ensure that any outcome from the project meets safety and other requirements. The Client Group agrees not to hold the University responsible in respect of any use of the project results. Notwithstanding this disclaimer, it is a matter of record that many student projects have been completed to a very high standard and to the satisfaction of the Client Group.

University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

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Author:	Emily O' Callaghan
Qualification:	Master's of Criminology
Institution:	University College Cork
Discipline:	Criminology
Dept:	Department of Sociology
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Head of Dept:	Dr. Orla Lynch/ Dr. Niamh Hourigan
Supervisor:	Dr. Katharina Swirak

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Declaration

This thesis is the work of Emily O' Callaghan and has not been submitted for another degree, either at University College Cork or elsewhere.

Sign:……..

Print Name:……..

Date:……

Abstract

The issues surrounding harmful sexual behaviours in children and young people is a relatively new issue facing health services in Ireland. This present study was designed to highlight the need for treatment and assessment services for children and young people presenting harmful sexual behaviours in the Southern Region (Cork/Kerry). The Action Learning Group Cork through the CARL initiative proposed this research, with the sole purpose to demonstrate the need for these services. Minimal research existed within this area, therefore minimal resources were available.

Information and evidence for this research study was gathered by a literature review and qualitative research, in the form of an interview process with professionals working in the field of harmful sexual behaviour with children and young people. In total 4 professionals shared their views and experiences in dealing with these behaviours.

Upon examination of the findings, the research and evidence from the interviews were supportive in demonstrating the need for these services. Additionally, this research highlighted the uncertainty that remains around this area within Ireland and what other factors such as digital natives, intellectual disabilities and resilience played in these behaviours. This research allows for future investigations into this area that will benefit these services.

Overview of Chapters:

Chapter one:

This chapter provides an introduction of the current research topic. It outlines what areas that this research will cover (what is harmful sexual behaviour (HSB), its origins, services etc.), the rationale and aims of the research and the main research questions.

Chapter Two:

Chapter two will outline the overall design of this research study. This includes the methodology of the study, ethical considerations, data collection and analysis, the challenges and limitations of the study and the conclusion of the methodology.

Chapter Three:

Chapter three analyses relevant literature from both a national and an international context. This section will look at the definitions and understanding of HSB and defining the problem. It will also outline the potential pathways into such behaviour as outlined in relevant literature, such as HSB within the context of gender and social media, and what possible contributing factors they have upon behaviours. Additionally, this chapter will consider historical views on HSB. The

chapter will also look at relevant research conducted in other jurisdictions and what treatments are provided in Ireland and abroad. Finally, the age of criminality and how that plays a role in treating young people and children and the recent discussions about how services that deal with children and young people expand beyond 18, up to 25 years and how this can impact the treatment of HSB will be mentioned.

Chapter Four:

Chapter four will consist of a review of the most successful assessment models and treatments that have been used internationally and their relevance in treating HSB. It will look at the AIM2 assessment model, the Brook's Traffic Light Tool and when it is necessary to treat these young people.

Chapter Five:

Chapter five will summarise the relevant findings from the interviews and literature. Information for this section will derive from interviews with professionals who work with these young people. The information from all sources will be compared to provide a strong evidence for the need of these services.

Chapter Six:

Chapter six will be the conclusion and discussion of all the relevant information that has been gathered within this study. This section will layout the important findings and provide a strong argument to conclude the research. Recommendations will also be provided for future research within this area.

Chapter One: Introduction to the Research Topic of Harmful Sexual Behaviours

1.1 Introduction:

This chapter will look at research topic and commence by introducing the topics that formed this study such as CARL, the Action Learning Group Cork (ALG). It will also provide an overview of the relevant research for HSB, what services are available in Ireland and abroad, and what roles do external sources such as the media, play in these behaviours. The rationale and aims of the research will be examined and finally the main research questions that formulated this study will be outlined. This provides the reader with a brief overview of the research topic.

1.2 CARL and Action Learning Group Cork

CARL is a Community Academic Research Links initiative within UCC, which provides independent research to Civil Society Organisations such as ALG Cork. The aims of this initiative are to promote research within the local community and to empower those groups with limited resources to carry out research. Additionally, it provides the students of UCC with collaborative work and working with partnerships and participation in research. For this study, CARL is supporting the ALG with research that they hope to be undertaken to demonstrate the need for assessment and treatment services for children and young people presenting HSB.

The ALG are the Action Learning Group Cork, made up of members from various services across Cork City such as TUSLA. Current members of the ALG work in preexisting jobs alongside their work in the ALG. Its main aim is to provide tangible solutions to challenges and issues within an organisational context. Members of this group are made up of approximately 8-10 people who meet roughly six times within a ten-month period to discuss the challenges. The external facilitator acts as a catalyst, supporting the process and enabling the skills development and learning of set members.

1.3 Background to Research:

This research began at the request of the Action Learning Group Cork (ALG) in the context of CARL. The context of this study is based upon the research into the need to provide a service to children and young people who present HSB in the Southern region. To commence this research, the basic understanding of the terminology of the term 'child' or young person and 'harmful sexual behaviour' is very important to clarify and outline. The United Nations Convention of the Rights of the Child (UNCRC) states that a child is 'anyone under the age of 18 years of age' (Childrensrights.ie, 2010). The Children's First Act (2015) shares a similar definition where they state, 'a child being a person under the age of 18 years, (Children First, 2.1.2). However, one of the most coherent definitions of HSB comes from the National Society for the Prevention of Cruelty against Children (NSPCC). The NSPCC describes these abnormal sexual behaviours as 'sexually explicit words and phrases,

inappropriate touching, using sexual violence or threats or full penetrative sex with adults or other young children' (NSPCC.org.uk, 2017).

These problematic behaviours can be difficult to define, as their understanding can be less clear-cut than other behaviours such as healthy and harmful behaviours (National Children's Home, 1992). What is understood as healthy and age appropriate developmental behaviours, are clarified amongst many assessment tools, one being the "Traffic Light Tool". Brook, a well renowned sexual health wellbeing service for those under 25 years within the UK, utilises this tool in understanding if behaviours are harmful or not (brook.org.uk, 2017). It is used by various professionals to recognise a healthy or unhealthy behaviour by, utilising the symbolic colours of green/amber/red. This assessment tool will be further discussed within Chapter 4. Many behaviours can be understood as age appropriate and developmentally healthy, but some actions can be taken to an extreme level, such as sexual preoccupation where it takes over the youth's life (Carson, 2006). Such behaviours may also be a one-off offence and not repeated such as inappropriate touching in a naïve and clumsy manner (Carson, 2006). Some problematic behaviour may also originate from peer pressure rather than the individual's need to participate in such behaviours (Carson, 2006). The behaviours that are believed to be outside the norm or inappropriate are provided with attention and an immediate response by professionals.

Arguably, society and our culture can have a possible impact upon what children and young people anticipate or understand about sex and sexuality (NSPCC.org.uk, 2017). What young people view on television, interact with on the internet and in other media outlets, can reinforce these ideas. This can result in young people and children emulating these ideas and understand them to be acceptable behaviours, which can result in harming others (NSPCC.org.uk, 2017). The widespread use of the internet and the role of social media can also provide a possible explanation to some of these behaviours, and can portray these behaviours as socially acceptable. With the idea that these sexual behaviours are ordinary and typical, some young people and children can become involved in harmful habitual behaviours of a sexual nature (NSPCC.org.uk, 2017).

The topic of sexually inappropriate behaviours becomes significant, in the context of the current emphasis of early intervention and prevention. In research conducted across Greater Manchester (Henniker & Foster, 2000), it was discovered that in over a quarter of cases young people charged with sexual offences had not been subject to any form of assessment. Therefore, with our youthful population becoming more sexualized and experimental, services and treatments are more important than ever, and this research will provide further evidence to show this.

This notion is mirrored in the Irish Government study, 'Better Outcomes, Better Future' Report that the Government's Strategy for Growth (2014-2020). It highlights the issues that there is clear international evidence to show that investing in

children during their early years play a positive role for individuals and society. Ensuring the best possible outcomes such as prevention and intervention for children and young people, is an important element in the economic planning of the country. To reduce future offending or eliminate any possible offending, assessments and services are of high priority to prevent such cases.

1.4 Rationale:

The rationale for undertaking this research study is to demonstrate the great need to provide a service within the Southern Region, for young people and children presenting HSB. Currently, there are minimal to no resources for these issues according to the Action for Learning Group (ALG). The Department for Children and Youth Affairs (DCYA) provide help to young people in a general sense with support from agencies such as TUSLA and the Health Service Executive (HSE) in areas such as child protection and welfare. However, as highlighted by the ALG, minimal to no services specifically work with young people and children presenting HSB. The benefits of similar services are evident in other treatment services in the UK such as the Greater Manchester Area Project, where positive results have been seen in their treatment and assessment models. Further evidence of this will be seen in Chapter 4.

1.5 Aims of Research:

The overall aim of this research is to demonstrate the need for these services in the Southern region. This study will be supported by ALG Cork who are optimistic this research will provide a solid framework to highlight the need for these services. This will be demonstrated by researching into the understanding of HSB, successful treatments, and the multiple variables that potentially lead to these behaviours such as social media and its impact upon children and young people. Interviews with professionals within the relevant field will provide expert knowledge and primary insight into the current situation and how services are dealing with these issues. Further research will examine relevant research already conducted in other geographical areas such as the UK and Australia. In addition, to provide a strong argument for the need of these services, in depth research will be completed into models of treatments and interventions that have proven to help youths in similar situations. Models and interventions such as the AIM2 model and the Traffic Light Tool will be discussed in more detail in Chapter 4.

1.6 Research Questions:

The following RQs will be explored throughout this dissertation

1. How can HSB be understood and contextualised?

2. Is there a need to provide a service for children who display HSB within the

Cork area?

3. What types of services nationally and internationally have shown success in treating children with similar behaviour?

4. What are some best practice examples of interventions with children and young people wo display HSB?

1.7 Conclusion

This chapter introduced the topic of this research study by outlining the background of research such as key definitions, the understanding of these behaviours and why services are required. The rationale and aims outlined the reasoning behind why this research is being undertook. The need for these services is evident, and so this research aims to provide a solid foundation to highlight such issues. Finally, the research questions that were outlined provided a basis for what questions will be answered throughout this study. They summarise the main aims that will be achieved through an in-depth literature review and data collection via interviews. These research questions encompass the important areas that need to be investigated

further.

Chapter Two: Methodology

2.1 Introduction

Children and young people are one of the most vulnerable members of our society (NSPCC, 2017) and as a result, every effort to ensure their safety and well-being should be a priority. For that reason, the main aim of this project is to demonstrate the need for a service in the Southern Region of Ireland, providing professional help to those children and young people who present HSB. This chapter will provide an understanding of how the aims of the project will be completed and how the project design intends to meet the aforementioned aims. This will begin with the methodology, the research design, data analysis, ethical considerations, the challenges, and limitations of the study and finally it will conclude with a summation of the chapter.

2.2 Methodology

Children and young people are recognised to be one of the most vulnerable groups within society, and with a statutory responsibility to ensure their well-being and safety, professionalism is essential in providing these children and young people with the best treatments and services (NSPCC.org.uk, 2017). Therefore, the aim of

this research study is to demonstrate the need for services to provide these children and young people presenting HSB, with treatment and protection. The overall purpose of this chapter is to outline the epistemology of this study, how this study was designed and what was done to gather and analyse information. This chapter will conclude with the ethical considerations of this study and the limitations and challenges that met during the research process.

2.3 Community-based participatory research

A core concept of this research study is the community-based participatory research (CBR) as this approach is central to the CARL initiative. This CBR formulates the partnership between UCC, ALG and myself, the researcher. This process involves the participating partners providing input into the pathways of research and furthermore, into the decision making and ownership. This CBR allows for participation and interaction between both the researcher and the participants, where the outcome is for engaging research and allows for the exploration of perceptions and knowledge of all participants (Cornwall & Jewkes, 1995). The main aim of CBR is to facilitate the interaction with participants and to gain primary expert knowledge and understanding of key issues. This research study is in collaboration with ALG Cork as part of the CARL initiative. This research was completed with a thorough literature review and interview process. Furthermore, a collaborative practise within CBR involved the working together of separate agencies that together, designed and initiate a research question, however, the main research was conducted by the researcher (Cornwall & Jewkes, 1995). This

collaboration began when the researcher approached the CARL director. From there, a meeting was organised between the CARL representative, the researcher, the supervisor, and a representative from the ALG Cork.

This meeting involved the consultation and agreement between the researcher and representative of ALG Cork, of the aims, objectives, collection of data analysis and outcomes of the research study. This meeting ensured all parties shared the same outlook and that any issues were dealt with prior to the commencement of the research. The advantage of this meeting was the experience and expertise that the representative from ALG could provide to the researcher. The collaboration between the representative of the ALG and the researcher was positive throughout this study. Communication was key and all parties involved were responsive to the needs of others. The positive experience throughout the research was due to the mutual understanding and motivation to ensure the best outcome for the research.

2.4 Research Methods

Research methods are the techniques involved within a study that collect, investigate and analyse data (Bryman, 2012). This research study selected a semi-structured interview process to carry out the data collection. A semi-structured interview process allowed for deeper exploration within a topic and a more flexible approach. A list of questions were decided upon between the researcher and their supervisor. These questions were formulated from uncertainties arising from the literature and questions brought up at the meeting with the ALG. Uncertainties such

as what treatments work? Do we have enough services within Ireland? What are the origins of these behaviours and can they be prevented? Once all questions were studied and structured, a copy went to the ALG to ensure that all areas would be covered. Once agreement from all parties was received, the questions were finalised and ready for interviews (appendix 1). The nature of the semi structured interview allowed for great flexibility and for a 'latitude in asking further questions in response to what are understood and seen as significant replies for the research' (Bryman, 2012:9). The development of the interview questions and the interview process was in line with the participatory research approach. Once interview questions were finalised, the interview process began. Initially, 8 people were emailed (appendix 2) and asked to participate, however, only 4 participants responded. These participants were professionals who worked with these children and young people. Their knowledge and experience were paramount to this research. Two of these interviews were based in Dublin and the remaining two were based within the services in Cork. Each participant was provided with an information sheet (appendix 3) and a consent form to sign (appendix 4) prior to interviewing to ensure full knowledge of their participation. These forms were taken from the UCC template and re-written for the suitability of this study (ucc.ie, 2015). Each interview lasted approximately one hour, and was recorded via a recording device. On completion of the interviews, each interview was transcribed (see appendices 5,6,7,8). These interviews were grouped into themes, such as the need for services, treatments and proactive versus reactive responses.

2.5 Qualitative Research

A qualitative methodology was used for this research study. Its aim was to explore the attitudes, knowledge and beliefs of the participants when interviewed. Their beliefs of the services currently within Ireland and their views upon the need for such services within the Southern Region. Such research allows the researcher to investigate the attitudes, experiences and beliefs of such participants which is central to the outcome of this study (Flick, 2006). One criticism of this type of research is that qualitative research does not 'measure and quantify the social phenomenon' (Flick, 2006;12). However, as this research aims to understand the experiences and attitudes of the 'social world', quantitative research would not be suitable (Flick, 2006).

2.6 Data Analysis

Data was gathered for this study through interviews and literature review. Interviews were conducted with professionals and members of agencies who work within the relevant field of HSB. The data collected was recorded and analysed, and relevant information that was provided was utilised to strengthen the research. The theoretical framework of this project is child sexual development and what is normal and abnormal within the category of sexual development amongst children and young people. Models such as Finkelhor's (1984) Four Precondition Model will be explored and additionally, how specificity theory explains HSB. This provides the

reader with an understanding of what is normal and what is abnormal and when assessment and treatment is required for children and young people displaying these HSB.

2.7 Ethical Considerations

Due to the nature if this study involving the interview process with participants and asking about experiences and attitudes towards their work, ethical approval from the researcher's tutor was sufficient. This was due to the interviews not involving any direct or indirect contact with the service users. An ethical form was filled out prior to the commencement of the study and provided to the research tutor (appendix 9). The successful approval of this study by the research tutor allowed the researcher to compile information sheets and consent forms that were utilised within the interview process. The forms explained and outlined the aims of the research study to the participants, to ensure full knowledge prior to their acceptance of participation. Informed consent is paramount in ensuring that the research study is being carried out to the highest ethical standard (Bryman, 2012). In addition, prior to the commencement of each interview, participants were once again provided with the information sheet and requested to sign the consent form. This was important as it informs all participants of the confidentiality of their participation and how the researcher plans to share the findings and information provided. All these ethical considerations are important in all forms of research

conducted (Carey, 2009). This provided the participant with full informed consent to the use of the data they provided during the analyse phase of the research.

2.8 Challenges and Limitations

The initial organisation of gathering interview participants seemed achievable. As the researcher, one such challenge I encountered was the acceptance of participants for the interview process. I was eager to send out emails to all professionals that were deemed suitable for to interview. These professionals were decided upon with the help of members of the ALG. Emails were sent to these individuals; however, it was challenging to receive any acceptance from willing participants. This was due to the level of their workload and summer holidays. However, to those who did accept my proposal, information sheets and consent forms were provided. My supervisor provided immense support throughout this process.

Another such limitation of this study was the unobtainable perspective of the service users. To obtain these experiences and attitudes of the service users would have been immensely beneficial to this research. However, ethical issues arose and time limits for ethical approval made this impossible. This is an area that could be explored in future research within this area.

2.9 Conclusion

The aim of this chapter was to outline the intended way the researcher aimed to approach and conduct this study. The layout of the data collection was outlined as so to highlight the effort that went into such collection. Furthermore, it demonstrated the benefits of a qualitative data collection as opposed to quantitative, and its suitability to this study. Additionally, the ethical considerations and data analysis provide a good perspective as to the difficulty to research some areas and how unfortunately, ethical approval would not cover the interviewing of service users. To conclude, the practicalities of this study were considered and the challenges and limitations were outlined for future research.

Chapter Three: Literature Review

3.1 Introduction:

HSB by children and young people initially emerged as an issue of major concern in the UK in the early 1990's (Erooga & Masson, 2006). This in turn, initiated the emergence of the National Children's Home 1992 which was the first national strategy in the UK, to address the challenge of providing a service to children and young people displaying HSB (Erooga & Masson, 2006). This behaviour was not a rare phenomenon and an urgent response was required, to establish policies and an adequate service within the professional community to begin to understand the complexities of HSB. To comprehend what is normal sexual behaviour is not clearcut, as our sexual development is achieved through a complex interplay of 'anatomical, physiological, developmental and psychological factors within the context of family, society and culture and is furthermore, central to one's identity' (Neiki & Stewart, 1991). The current lack of comparable services and accessible recording systems to further understand these complex issues, across both UK and Ireland, make it difficult to capture an accurate referral rate and in-depth understanding of the scale of children and young people who require these services. This introductory chapter provides a literature review and a general over view of the key definitions, the pathways into such behaviour as well as important related issues such as gender in relation to HSB, the impact of the internet and the media and historical approaches to the behaviour.

3.2 Definition of "Children and young people"

To grasp the understanding of this research, it's important to comprehend the implied meaning of the terms 'young people' and 'children'. The United Nations Convention of the Rights of the Child (UNCRC) states that 'a child is anyone who is under the age of 18 years of age' (UNCRC, Article 1, 2010). The definition for children and young people can alter with circumstances, especially with the changes such as demographic, financial, economic, and socio-cultural settings (United Nations Youth, 2007). However, the terms used within this research for 'children and young people' will serve the same meaning as the legal definition of 'child' as stated above by the UNCRC. By understanding this term, policies, laws, and services will be more clearly understood.

3.3 Harmful Sexual Behaviour:

A wide range of terms and phrases have been developed to describe children and young people who present HSB. Such terms have included 'juvenile sex offender', 'young abuser' and 'adolescent perpetrator' (nspcc.org.uk, 2017). The misuse of such imprecise and vague descriptions can result in the misunderstanding of these behaviours and labelling them inappropriately (nspcc.org.uk, 2017). The development of shared and relevant terms is important, as it enables clear communication between professionals, and allows the accurate and fair assessment of children, young people and their behaviours (nspcc.org.uk, 2017). The

terminology that is widely accepted by statutory agencies and those who provide services directly to such children and young people is 'harmful sexual behaviours' (Ashurst, 2014). This expression is understood to eliminate the possibility of labelling the child and to eradicate the stigma that is related to these behaviours (Ashurst, 2014). Furthermore, this expression focuses more on the behaviour, rather than the child, which in turn allows acknowledgement of any developmental issues such as social, personal, emotional, or sexual (Hackett, 2014). The term also provides the potential for the child and young person to change their behaviours (Hackett, 2014). However, the most coherent definition of HSB is by Palmer (1995) where it believes that this behaviour by children and young people who engage in any form of sexual activity with another individual, display this by having power over the victim with age, emotional maturity, gender, physical strength, and intellect (Palmer, 1995). Importantly, this understanding of HSB also includes the victim within this relationship suffering a betrayal of trust (Palmer, 1995).

In addition to this definition, the National Service for the Prevention of Cruelty against Children (NSPCC) describes such HSB as children and young people utilising 'sexually explicit words and phrases, inappropriate touching, using sexual violence or threats or full penetrative sex with adults or other children and young people' (nspcc.org.uk, 2017). This definition goes further in its explanation of HSB as it includes threats and the use of inappropriate phrases. As mentioned above, it's difficult to have one clear definition of HSB that can include all factors. Definitions include multiple factors and both physical contact behaviour such as masturbation,

touching and penetration, and non-contact behaviour such as grooming, threats, sexting and the use of media applications within phones to record, bully or record images.

A useful way to conceptualise HSB, is to view it as falling into three broad categories; normal, problematic, and abusive (McGrath, 2010). Normal behaviour includes playing 'doctor', kissing, flirting and the use of inappropriate language (McGrath, 2010). Understanding what is deemed developmentally 'normal, problematic and abusive' within age ranges (such as 0-5 years) within the context of such behaviours, will be outlined in more detail in the treatments chapter. The NSPCC (2017) states that it is important to distinguish between what is deemed 'problematic' behaviour and what is 'abusive' behaviour. The term 'problematic behaviour' is seen as behaviour that does not involve obvious victimisation of others but can be developmentally disruptive and can also result in suffering, rejection or additionally, increase victimisation of the child displaying the behaviour (Hackett, Holmes & Brannigan 2016). These problematic behaviours are sexual behaviour problems when they involve sexual body parts that are developmentally inappropriate or possibly harmful to the child or others (Hackett et al., 2016). Such behaviours vary from problematic self-stimulation and nonintrusive behaviours, to sexual interactions with other children that include more explicit behaviours such as sex play, and aggressive sexual behaviours (Hackett et al., 2016).

Circumstances where these types of behaviours appear to have originated from include traumatic experiences, where symptoms can originate from sexual abuse (Hackett, et al., 2016). These behaviours may be termed 'sexually reactive' (Hackett, et al., 2016). Such behaviours are more frequently related with young people who are in the pre-adolescent age range (ages 9-13 years approximately). In the context of 'abusive behaviour', Hackett et al., (2016) describe these behaviours as involving some component of coercion or manipulation by the young person, and a power imbalance that means the victim cannot give their informed consent. In turn, this type of behaviour has potential to cause physical or emotional harm to its victims.

It is important for these definitions to be set out in a clear and coherent manner. This allows equality within all cases and consistency within services, research, interventions and practises. The issues of labelling and the differences amongst the age groups for classification of intervention, definition of behaviours and alternative services provided need to be addressed in both policy making and in the professional arena (nspcc.org.uk, 2017). With such minimal research in Ireland surrounding this issue, setting a solid foundation of definitions and terms is imperative to provide a clear understanding in this research. The inconsistency in terminology highlights the confusion amongst professionals (Staiger, 2005). Moreover, the inconsistency of the terminology is not surprising given that there is no international minimum age at which a person can be held criminally responsible, which will be discussed further below.

3.4 The Origin of Harmful Sexual Behaviours, treatment and its various cultural perspectives

To gain a better understanding of the current practice amongst those who display HSB, it is helpful to look at how frameworks and interventions have developed overtime and internationally within a historical and socio-political context. In the past, children and young people who displayed HSB endured social exclusion and societal denial (Jones, 2010). The United States was one of the first countries to address this issue that was increasing within its communities. The initial assessments that were implemented were treatment programmes that were aimed towards what they were known as 'juvenile sex offenders' (Jones, 2010). Soon after, this label developed to working with young people and children who were labelled as having 'sexual behaviour problems' (Jones, 2010). This reduced the stigma around labelling and addressed the issues and not the individual. In comparison to the U.S., Europe was slow to acknowledge this growing issue as a problem. This is still reflective of today, with minimal services and treatments across Europe for addressing this serious phenomenon.

However, overtime, treatments and services began to expand within the U.S. Dr. Lewis Doshay documented adolescents who were responsible for committing sexual offences. In 1928, he began a 6-year study amongst 256 juveniles who were responsible for sexual delinquency cases (Doshay, 1943). His results brought to light crucial findings. He showed that there were low levels of recidivism in relation to

'sexual offending' by adolescents but recorded high rates of other non-sexual offending. This suggests that most of the 'offenders' who were convicted of sexually harming others would not be reconvicted for further sexually harming in adulthood (Doshay, 1943). This report was known as the 'Doshay report', which led to other studies being conducted within the U.S. (Atcheson & Williams, 1954). However, treatment programmes were not established on a major national scale until the early 1980's when there was a greater understanding and recognition of all forms of sexual abuse and exploitation amongst young people and children (Jones, 2010).

As stated above, European countries were slower in developing any services for these behaviours amongst young people, in comparison to U.S. Within Europe, the UK was the first European country to start tackling these issues. From a comparative sociopolitical perspective, records and statistics show that there was a close link between social welfare models, and comprehending and actively reacting to these complex social problems amongst young people (Pringle, 1998). Pringle (1998) believed that countries within Europe who adopted the Anglo-Saxon model, reacted faster in comparison to countries with a Northern Europe or corporatist conservative model of social welfare. This was evident in the development of treatments and services for young people and children presenting HSB (Jones, 2010).

The UK is currently one of the leading countries in Europe in its development of services for these young people and children. In 1992, the UK health services began

to assess the development of these services, which lead to the publication of the notary report 'The Report Committee of Enquiry into children and young people who sexually abuse other children' (NCH, 1992). The acknowledgement of these issues was a poignant moment for the development of service provisions. This report was responding to a survey of 'Treatment facilities for young sexual abusers' (NCH, 1992) which was described as painting 'a gloomy picture of the understanding of these areas' (Calder, 1997:1). A major criticism of the report was centred around the fact that the work was predominantly based upon adult sexual offenders and did not acknowledge children and young people who abuse (Jones, 2010). By learning from these mistakes, the UK began to investigate further into the need for services.

In 2003, Hackett and Mason shared the reports of a two-year study into the service provisions for young people and children. Their results saw that around 200 services existed for HSB, however, they were generic more than specialist (Hackett & Mason, 2003). They did however state that the work and services within the UK were more sophisticated and professional in comparison to other European countries (Hackett

& Mason, 2003). In addition to this, the UK Children's Commissioner reported to the UNCRC that there was a severe lack of service provisions and support for these young people and children, and that the response was inconsistent and the needs of the child were not being met (UK Children's Commissioner Report to UNCRC,

2008). This began the overhaul within the service provisions in the UK and began the initiative that was required to set up better services.

Despite the major developments within the UK, many Northern European countries were still reluctant to accept these issues as a social problem, even into the 1990's (Jones, 2010). In Denmark, the first Danish treatment facility did not open until 2003 due to professionals and NGO's gaining more knowledge about the issues and finally accepting it as a social problem (Jones, 2010). Additionally, within Australia, data on children who display HSB is minimal and due to non-disclosure, what may be large numbers of offences have been going undetected (O'Brien, 2010). The provision of community based services is also limited within Australia, due to its geographical vastness. They are challenged by the financial and logistical demands of such services to the nation's largest states and territories (O' Brien, 2010). The mapping of Australia's socio-geographic disadvantages reveals that 52% of the localities with consistently high indicators of social disadvantage are rural (O'Brien, 2010) showing that there is a grave need for therapeutic approaches to rural, suburban and Indigenous populations.

Similarly, within Ireland, minimal effort existed in dealing with these issues. Until recently, the idea of a child sexually abusing was one of shock and disgust to most people (McGrath, 2010). It was understood as a 'taboo' subject. It is only since the 1980s and early 1990s that Irish society began to see the need for services as it was now a real phenomenon. With the acceptance of such behaviours existing within our society, a major rise was seen in cases of suspected abuse being referred to the

child protection services that were operated by the Health Service Executive (HSE). This number increased from 88 cases in 1984, to over 1,000 cases by 1989 (McGrath, 2010). These numbers only continued to double and Ireland's services were not equipped with the appropriate therapies and interventions in dealing with these numbers. Currently, the bulk of services for children and young people who present HSB are in the Dublin area. We should learn from our history and view this issue as it needs to be addressed, with care and appropriate services.

3.5 Treatment Services in Ireland for Harmful Sexual Behaviours

As stated before, services that provide assessment and help to young people and children presenting HSB is under resourced within Ireland. The need to develop a national strategy for assessment and treatment services for HSB, has been recognised by the Ferns Report (2005), the Joint Oireachtas Report on Child Protection (2006), and is supported by the HSE Working Group in response to the Ferns Report (tusla.ie, 2015). The approach towards the treatment for those who have abused and present HSB, has improved and is now believed to be of immense significance to the prevention of child sexual abuse. Additionally, it is viewed in several countries as being a public health issue which is a view Irish services need to share (tusla.ie, 2015).

On average, the HSE receives 2,500 reports annually, of child sexual abuse (tusla.ie, 2015). Not only is there a major impact of sexual abuse upon its victims, the State also sees the impact that sexual abuse has upon services within Ireland, such as medical treatment for survivors, mental health needs, psychiatric admissions, social work interventions, placement of children in care, investigation, the prison service and community supervision (tusla.ie, 2015). Currently in Ireland, the HSE provides services to children and their families through social work, psychology and mental health services. They also fund the Dublin North Side Inter-Agency Project (NIAP), the Dublin South Side Inter-Agency Treatment Team (SIATT), and the ATHRU Multidisciplinary inter-agency service based in Galway which all provide specialist services (tusla.ie, 2015). Services such as NIAP in Dublin, provide assessments with the AIM2 model and ongoing individual work, however more support is required (NIAP, 2009). This approach is of huge benefit to the individuals involved, however, there are not enough services to meet the needs. This also demonstrates that there are no services available within the Southern Region. The HSE also refers a small number of children for specialist residential treatment care to the U.K. where their behaviours have been deemed untreatable within the Irish services.

The HSE established a working group to consider the demands for services in dealing with these behaviours. Some of the leading professionals in Ireland provided their expertise and joined the Working Group (2007), and collectively with the HSE, drew up a report for the treatment services for people presenting HSB. Their report recommended the following:

- Four HSE Areas should establish teams, one for children and adolescents and one for adults - with links to each LHO to ensure local access to services, and links to referring services, child protection services, the Gardaí, Probation and the Prison Service.
- A core and cluster model should be applied with core dedicated staff. These services should be integrated within generic mainstream services where sexually abusive behaviour is not separated from other needs of the client and where assessment and treatment are provided in the context of the person's individual family, community and work life.
- Assessment and treatment services should be integrated with the wider delivery system, including child protection services and the criminal justice services
- Children with sexual behavioural problems should, where possible, be assisted by key workers at a primary care level.
- Young people and adults should be seen in the context of their own families and their own social networks
- The welfare and the safety of children should be the paramount concern for services.

Sourced on www.tusla.ie (2015)

This report was consequently recommended by the Expert Advisory Group for Children's Services, a group established by the CEO of the HSE. The Joint Oireachtas Report on Child Protection (2006) identified the need for these treatment and assessment services and in 2008, it was highlighted in a report by the National

Organisation for the Treatment of Offenders (NOTA, December 2008) (tusla.ie, 2015). These recommendations from the report are an issue for the HSE to consider, in the context of the planning and delivery of a full range of services for adults, children and families (tusla.ie, 2015).

3.6 Deviance and age of criminal responsibility

As stated above, the lack of consistency with the terminology of HSB amongst children and young people can cause confusion amongst professionals. The age of criminal responsibility ranges from the age of 6 to the age of 18 years depending on where the offence was committed. For example, some countries such as Australia and Switzerland have set the age of criminal responsibility to 7 years old, where other countries such as Chile and Denmark have set their age of criminal responsibility to 15 and 16 years (UNICEF, 2002). These varying age groups have likely contributed to the language used in relation to children who engage in this problematic sexual behaviour (Curwen & Costin, 2007). An example of this could be using such terms as 'molesting', 'abuse' and 'recidivism' can connote an element of criminal activity that many find it difficult to understand to be related to a child (Curwen & Costin, 2007).

When looking at young people and children who display HSB, various issues arise and need clarification. Within Ireland, during October 2006, under the Children Act 2001, the age of criminal responsibility was effectively raised from 7 to 12 years old (dcya.gov.ie, 2017). However, an exception is made for 10 and 11-year-olds who are

charged with very serious offences, such as unlawful killing, a rape offence or aggravated sexual assault (dcya.gov.ie, 2017). In addition to this, the Director of Public Prosecutions must provide their consent for any child under the age of 14 years to be charged within Ireland. In comparison to these laws, as stated above, a child/young person is deemed as anyone under the age of 18 years (dcya.gov.ie, 2017). Therein lies the basis for two issues that require policy decisions and clarification. Firstly, the term HSB is criminal by definition and yet the age for criminal responsibility within in Ireland is 12 years old (Ashurst, 2014). Secondly, the research and therapy/services/interventions provided for these HSB make age distinctions, for example distinguishing those under 12 years olds from those who are 12 to 18 years (Ashurst, 2014). These two groups are regularly distinguished within research, literature, intervention models and systems of practise. Therefore, distinguishing between these two age groups can be a prescriptive factor in determining whether a child or young person must enter the criminal justice system or whether they enter the child-protection services.

McGrath (2010) agrees that specialist services and responses are under resourced nationwide. The Ferns 5 Report was commissioned with advising the HSE on the strategic direction and level of need for services in treating these behaviours (Mc Grath, 2010). They completed the report in 2007 and these committees are still reviewing the recommendations towards effecting the appropriate national implementation (McGrath, 2010). However, interestingly, recent discussions within

the Irish Penal Reform Trust surrounding the age of juvenile crime, has seen a suggestion to raise the age a juvenile is considered and convicted as an adult, from 18 to 25 years (iprt.ie, 2015). The reason for this is maturity and development (iprt.ie, 2015). In Ireland, once some juvenile turns 18 years, they are considered an adult and lose all access to services to rehabilitate such as the Garda Youth Diversion

Project which is a successful community based initiative for juvenile offenders (iprt.ie, 2015). Other countries have already taken this approach to juvenile offending, such as Croatia where juveniles aged 18 to 21 years at the time of offending, fall within the scope of the Croatian Juvenile Courts Act (CJCA) and specialised juvenile courts (iprt.ie, 2015). This allows the Croatian courts to apply special juvenile sanctions including special obligations, intensified supervision, and juvenile imprisonment. The reasoning for these measures are aimed to improve the offender's life perspectives by bringing structure and responsibility into their daily life (iprt.ie, 2015). Croatia is not the only country with this approach, Germany, Austria and the Netherlands have also taken a more 'juvenile' approach for those up to the ages of 21/25 years. The reasoning for this, is due to maturity and development within these age groups.

A strong body of scientific research shows that the human brain and maturity continue to develop beyond adolescence and into one's mid-twenties (iprt.ie, 2015). This can be understood that young people into their twenties can have a lower capacity for self-regulation (iprt.ie. 2015). This coincides with the research conducted by Johnson, Blum and Giedd (2009), where it was shown that many parts

of the brain do not mature and fully develop until the mid-twenties in numerous individuals. In turn, this has a direct impact upon their behaviours and this factor should not be ignored when considering their offences and providing treatment. In addition to this, developmental differences amongst young people can also put them at risk of harm. Dahl (2004) compared the gap between early increases in sensation seeking and later development of emotional and behavioural controls as 'starting the engines without a skilled driver'. Such evidence only highlights the need for a more considered approach to young offenders. However, what would this mean for those who display HSB?

No literature exists as to how this will impact those who exhibit HSB. However, it would provide those up to the age of 25years with a chance to change their ways and, depending on the severity of the behaviour, provide them with continuous treatments until they have developed and matured. By taking away services for these young people at 18 years, their chances are reduced to re-integrate back into their communities. A restorative justice approach in dealing these young people have shown significant positive outcomes in terms of reducing re-offending rates, creating safer communities for everyone involved (iprt.ie, 2015). This is an approach that should be considered by the Irish Criminal Justice System, to rehabilitate rather than convict young people.

3.7 Digital natives and Harmful Sexual Behaviour

The emergence of the Internet has provided opportunities for young people and even children to access and generate all possible information without the mediation of adults (Stanley, Barter, Wood, Agthtaie, Larkins, Lanau & Overlien, 2016). Increasingly, children and young people are harmed by simply utilising the internet and online outlets. This in turn, has provided children and young people easier access to material that was previously subject to greater control and regulation (Stanley et al, 2016). Sexual images such as pornography, are one type of information that is being accessed regularly by young people and children, and hand-held devices are the key medium that connects young people with this type of information. Furthermore, it connects their private information into public knowledge (Stanley et al, 2016).

Additionally, smart phones allow both anonymous and private access to this material and has the potential for it to be widely distributed, eradicating privacy and intimacy (Stanley, et al., 2016). Online HSB can take various forms such as coercion, 'revenge' porn, sexting, viewing intimate material such as images of child abuse and grooming with the intent to contact and use inappropriate behaviours. Stanley et al. (2016) believes that as the widespread nature of young people's exposure to pornography becomes more evident, research has also developed that examines the impact of pornography on young people's behaviour and attitudes. This research by Stanley et al., (2016) highlights the relationship between young people and children who view pornography, and those who present sexually aggressive attitudes or behaviours (Stanley et al. 2016). Although some of these

studies have been carried out on offender populations, others have involved young people in the general population. This research builds on this study by highlighting how external factors such as the internet, impact on young peoples' and children's' developmental behaviours. There is minimal research to show how frequent such harmful behaviours occurs online, but is has been recognised by specialist services as an increasing area of growth

(Palmer, 2015).

This exposure to pornography has been shown to play a factor in triggering HSB amongst children and young people. Evidence of this can be seen in research conducted by Knight, Ronis and Zakireh (2009). Their research identified that early exposure to pornography increases the sexual risk for harmful behaviour. Similarly, Loding in (2006) found that this exposure to pornography and inappropriate images of nudity prior to age 10, was significantly higher amongst those young people who displayed HSB in comparison to those who did not display these behaviours. The freedom of surfing the internet and lack of boundaries by parents may be a causal link (Allardyce et al., 2017). A major study that was conducted in 2012 by the UK Safer

Internet Center where research was carried out amongst year 9 (age 13-14) and year 6 (age 10-11) pupils in a school, due to the concerns that children of these age groups were becoming more sexualised and exposed to explicit content on the internet. The results from this research brought many issues to light (Phippen, 2012). Firstly, how 'sexting' was highly prevalent and seen as 'mundane' amongst children of these age groups. Sexting is defined within the South West grid for Learning Resources as 'the use of technology to share personal sexual content'

(swgfl.org.uk, 2012). Many of these young people did not view 'sexting' as a major issue and admitted to sharing topless/naked photos of themselves online with their friends. In addition to this, some children admitted to sharing images of themselves online, performing a sexual act. Secondly, that online activity was a common daily routine for these age groups. And finally, that the exposure to online pornography was a frequent past time amongst the male pupils within the year 9 class. It showed that 33% of these children used their phones to access porn and more than 60% viewed pornography within their familial home.

The normalisation and the sexualisation of young people and children has become a major issue within our society (Phippen & Brennan, 2016). It can be argued that young people and children are becoming desensitised to such sexual activity and therefore consider it more acceptable (Phippen & Brennan, 2016). Evidence of this was seen in the research by the UK Safer Internet Center, where 2/3 of male pupils disagreed that porn was exploitative and that they believed that numerous acts they watch can be emulated within a sexual relationship (Phippen, 2012). Technology facilitates the legitimisation, mainstreaming and even normalisation of these concerning views and behaviours amongst young people (Phippen & Brennan, 2016).

We increasingly live within a society where there are various factors that complicate the development of children and young people. These complex aspects of adolescent development include intimate relationships and healthy sexuality online (Allardyce et al, 2017). Some online activity sees a small minority of young people

actively seeking involvement within technology mediated sexual offending (Allardyce et al., 2017). However, there is the understanding that suggests that not all young people who watch online pornography develop behavioural difficulties. In an interview conducted with a primary clinical psychologist, it was stated that 'viewing pornography has become habitual to all young people, especially males. To say that all young people and children who watch porn commit sexual harm, is not accurate'.

Furthermore, the National Audit Office (2010) report showed that on average, 11 to 16-year olds spend 2.5 hours a day online and younger children are also becoming frequent users.

In addition to this, adult concerns for adolescent and children sexual behaviours can result in normal online behaviour becoming problematic and criminalised (Allardyce et al., 2017). This can lead to considerable confusion amongst carers, parents, professionals, and legislators about sexual experimentation amongst young people. It becomes hard for them to understand where online sexual experimentation ends and sexual exploitation online begins (Allardyce et al., 2017). Despite this, such behaviours can significantly influence both attitudes and interactions that children and young people have with others (Allardyce, 2017), as a society and carers for young people and children, we need to learn how to fully understand these differences, and not hinder healthy developmental sexual behaviour.

3.8 Females who exhibit Harmful Sexual Behaviours

Although work has continued to develop with children and young people who display HSB, uncertainty and anxiety remains around working with young women and girls who display such behaviours (Scott & Telford, 2006). Furthermore, there has been much uncertainty around the possible need for different assessments and interventions for girls and boys (discussed in Chapter 4). A study conducted in Greater Manchester by AIM and the Lucy Faithful Foundation found, that professionals were less confident and experienced in dealing with girls and young women presenting HSB (Ashfield, Bradshaw and Henniker, 2004). As societal beliefs play a major role in our development, it may also play a part in how we treat others as Vick, Mc Roy and Mathews (2002) comment; *'*Societal beliefs about females and in particular young females, sexual behaviours and the nature of sexually abusive behaviour are more likely to have limited the advancement of research and the treatment of this population' (2002; 19). Scott and Telford (2006) believe that the development of identity for girls is largely reliant upon their relationships and connections with others. Girls demonstrate the need to fit in with their peers and to seek approval. Boys on the other hand, value autonomy and achievement in developing their identities (Scott & Telford, 2006). Blues, Moffat and Telford (1999), found this to be true as one of the major differences between female and male service users, as females sought other's approval which positively affected the girls' ability to develop victim empathy.

Findings are still consistent in showing that girls who sexually abuse are much more likely to have been sexually abused themselves (Scott & Telford, 2006). In a study by

Mathews, Hunter and Vuz (1997) it was seen that 77% of girls who sexually abused had themselves been victims of sexual abuse. In contrast to this, O' Callaghan and Print (1994) saw that 30-50% of boys were themselves victims of abuse however, it is not appropriate to consider experiences of sexual abuse as a pre-condition to displaying HSB (Scott & Telford, 2006). Although some positive changes have been seen in professional's attitudes to the behaviours of these girls, perceptions are still often extreme, to the minimization and over-reaction (Scott & Telford, 2006). Therefore, a different approach in treating these females is required to ensure minimal bias and warped perceptions.

3.9 Finkelhor's Four Preconditions Model

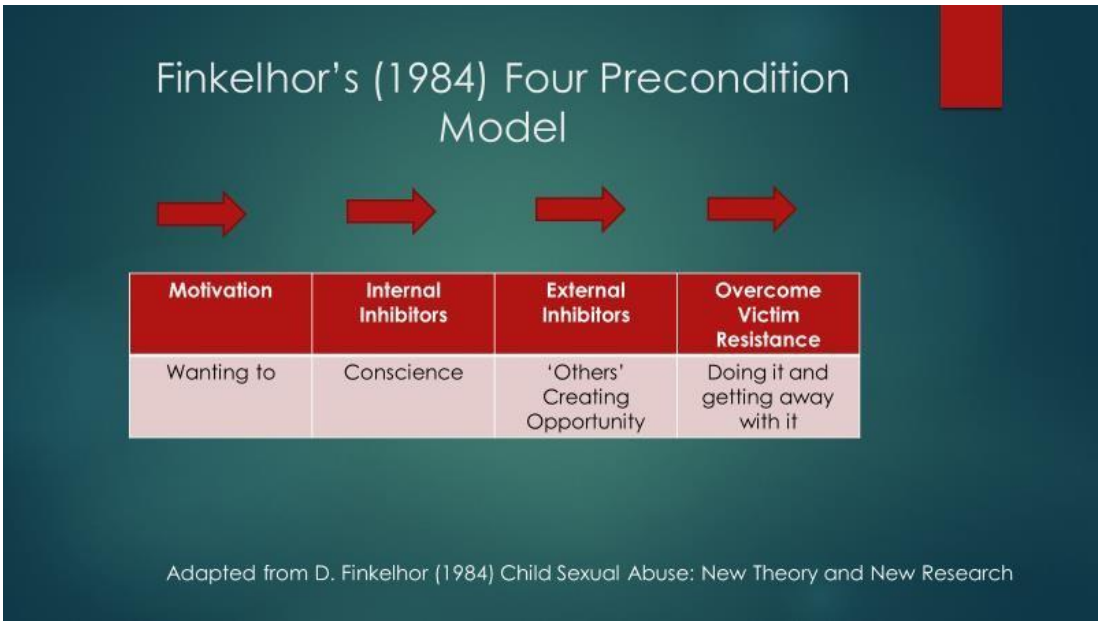
To gain a deeper understanding of HSB, it is important to reflect upon models and theories that attempt to understand these behaviours. David Finkelhor (1984) saw his four Traumagenic's Model become a useful theoretical base in understanding HSB. His aim was to formulate a model that would address both the intra-perpetrator and situational aspects of sexual abusive behaviours and how it relates to familial and nonfamilial incidents (Howells, 1995). An important question that he considered, was why did this behaviour arose in children and young people? (McGrath, 2010). Finkelhor's model amounts to the suggestion that four preconditions must be met before sexual abuse can occur within the child (Howells, 1995). Thus, it is a theory about the necessary conditions for abuse. The four preconditions are motivation to sexually abuse, overcoming internal inhibitors, overcoming external inhibitors, and overcoming the resistance of the child (Howells, 1995). Such behaviours arise from various underlying issues such as a way of

seeking intimacy, seeking power/control over others or a distraction from other worries (McGrath, 2010). These behaviours can also be a way in which the child or young person seeks to communicate a message that is yet not understood, or attempting to understand feelings they cannot comprehend (McGrath, 2010).

Finkelhor believed the 'motivation' to abuse may be due to the victim meeting some emotional or sexual need. This belief is acknowledged by Butcher and Webster (2012) and Hackett, et al., (2016) where HSB in young people were understood to have originated from a traumatic event and the child displaying their emotional distress through their actions. Cognitive distortions were understood to be overcoming internal inhibitions which went against acting on that inappropriate motivation. This is where the young person has self-serving distortions of attitudes or beliefs that the victim is believed as consenting to or responsible for their own abuse (Finkelhor, 1984). Overcoming external impediments refers to committing the sexually abusive act. In practical terms, this means gaining the opportunity to have access to the potential victim in a scenario where the abuse is possible (Finkelhor, 1984). And finally, overcoming the victim's possible resistance to these advances is not a simple issue and can relate to various complex factors involving personality traits. This is reflective of abusive behaviours in children, where it can cause grave harm to others including themselves. Finkelhor's model provides a level of understanding the dynamics of the abuser in addition to the abuse process (Erooga & Masson, 2006). His model bridges the gap between psychological and sociological interpretations of sexual abuse and this highly influential

conceptualisation of sexual abuse has found its way into many major publications and practise guidelines within the field of sexual abuse. An example of his model can be seen in figure 1 below.

Figure 1.



3.10 Multi-Faceted Aetiology of Harmful Sexual Behaviours

While research is limited within this area of HSB amongst young people and children, it has consistently found that HSB can emerge from an amalgamation of multidetermining variables rather than from any single causal factor (Butcher & Webster, 2012). The Association for the Treatment of Sexual Abusers USA (ATSA) identified a range of factors contributing to HSB within their review that was published in the Report on the Task Force on Children with Sexual Behaviour Problems (2006). Such factors included were family, social, economic and developmental factors identified by Friedrich, Davies, Feher, & Wright (2001) prior sexual abuse experiences (Friedrich, 1993) physical abuse, neglect, poor parenting practices, exposure to sexually explicit media, living in a highly sexualized environment, and exposure to family violence (Friedrich et al.,, 2001). In addition to this research, Langstrom, Grann &Lichtenstein (2002) identified that heredity may also play a contributing factor. Bonner, Walker, Berliner, Bard and Silovsky (2005) found that the more intense a child's sexual behaviour, the more likely they are to have co-morbid mental health, social and family problems.

Neglect and maltreatment experienced within the family environment is a core influence on a child's development, influencing their attachment and sexuality (Hawkes, 2009). This can result in the disorganisation or disorientated attachment during infancy, and a diminished capacity to contain emotions and to reflect upon them. This results in the child or young person adopting externalised coercive coping strategies to manage relationships and regulate their emotions (Hawkes, 2009). After an experience of sexual victimisation, these strategies can take on a

sexual character (Hawkes, 2009). Hawkes (2009) draws on attachment theory to explain how neglect and maltreatment by parents or caregivers may result in the child being sexually abused and how this experience can act as a precursor to developing HSB in preadolescent boys. This does not suggest that all children who were abused will continue to sexually harm others, but it can understand the roots of those who present HSB. Such attachments to caregivers, serve as an emotional safeguard and provide a template for the child to learn and explore their physical and emotional world (Hawkes, 2009). Attachment and sexuality are closely related as they both involve sensory experiences of taste, sound, touch and smell. They also require emotional, affective and behavioural skills to communicate and understand others (Hawkes, 2009). Therefore, the relationship with parents and caregivers is crucial to the development of the child.

Given the aetiological link between a child's experience of abuse in the form of physical, emotional, sexual, exposure to domestic violence or neglect, and problem sexual behaviour, nation states who have approved the International Convention, are obliged to provide programs of rehabilitation, based on a thorough assessment undertaken at 'the highest attainable standard'. The New South Wales (NSW) Standards for Statutory Out-of Home Care (The Children's Guardian, 2010) acknowledges that "children and young people with unmet mental health, social or emotional needs are particularly vulnerable to placement breakdown" and that they "often have poor health status and a fragmented treatment history". Children and young people who are frequently within the care system, often do not have

family members who are able or available to care or support them in terms of their rights when professionals and agencies do not meet the minimum standards of care and ethical practice that is their right under the International Convention (The Children's Guardian, 2010).

In addition to developmental and attachment issues, adolescence and puberty are known to be a significant time of physical and emotional change and sexual development in young people and children (Allardyce et al., 2017). It is a poignant moment within their lives as it becomes an important stage within their sexual development. Their sexual identity, intimacy skills and lifestyles are not fully formed in addition to their perspective taking skills and reading social situations (Allardyce et al., 2017). This knowledge is imperative in social settings, yet young people and children must make mistakes to begin to learn these skills (Allardyce, et al, 2017). In more recent years, sexual knowledge is gathered from various sources such as television, film, media, the internet etc. It is argued this stage is when sexual urges are at their most urgent, but are also least controlled with minimal experience (Allardyce, et al., 2017). This can begin the pathway to HSB. Issues in relation to sexual experimentation can arise, even for the most experienced and rational minded young person (Allardyce et al. 2017). Sexual choices can become impaired and irrational by the lack of consequential thinking and immense urge for sensation seeking.

For many of these young people, HSB is simply a continuum of problematic and inappropriate behaviour within their pre-adolescence years (Allardyce et al 2017). Up to half of sexual abuse amongst these adolescents have involved siblings and close family relatives (Allardyce & Yates, 2012). The family unit plays a monumental role within the pathway to HSB. The family environment is not just the context for the emergence of these behaviours, but the setting for where the abusive behaviour began. Sibling sexual abuse is the most common form of intra-familial sexual abuse, and often goes unidentified (Monohan, 2010). It is estimated that half of all adolescents that have committed HSB offences include siblings (Shaw, 1999). Parents are a key factor within the recognition and treatment of such behaviours and the distress caused to families is worsened if the victim of the child is within the immediate family (Hackett et al., 2016). The sexual abuse that occurs amongst siblings often occurs over an extended period and is likely to be more penetrative when compared to extra-familial HSB (O'Brien, 1991).

As previously stated, even the most logical young person and child can find themselves making the wrong decisions, however, for those with developmental delay and learning disabilities, it can become more of a significant issue. In recent years, children and young people have been exposed to increasing amounts of sexual information at an early age. They are being confronted by complex sexual and social dilemmas before they have the intellectual and emotional maturity to cope (Durham, 2010). With adolescents and the onset of puberty representing a peak time for sexual offending due to a change in hormones and social settings

(Hackett, 2014). With such an important issue at hand, it is imperative that models/theories and research are advanced to help in addressing these issues, for all ages, and bring forth the need for services within the Southern Region.

3.11 Resilience

The term 'resilience' currently constitutes to be one of the most important and challenging concepts within developmental psychology (Von Eye & Schuster, 2000). The resilience theories provide an important yet neglected framework in understanding children and young people and HSB. There are various children who experience traumatic events within their lives, yet, do not behave in a harmful and aggressive manner. Some children have protective mechanisms that can contribute to their resilient outcome when faced with opposition in their lives. However, those who do not possess such attributes, find themselves displaying behaviours of an inappropriate nature, simply a way of coping (Hackett, 2006).

There are many factors that that can be understood to inhibit such achievements amongst children and young people. Factors such as psychopathology and risk factors are known to be the cornerstone upon which the child welfare services and mental health systems have built their frameworks upon (Hackett, 2006). Various studies by Luthar (1999), Cicchetti & Rogosch (1996) and Hammen (2003) have continued to demonstrate that a proportion of children and young people who experience high levels of trauma, neglect, abuse and loss, continue to defy the odds

and demonstrate a positive outcome at different developmental levels (Hackett, 2006). Therefore, the major focus of such research is to identify these resilient and protective factors that these young people develop. Treatments and interventions are focused upon helping the young person try to understand their behaviours and why they committed such acts. By understanding the resilience of those who do not display HSB, professionals can apply these factors in treating those who do abuse (Hackett, 2006).

Resilience is a dynamic process rather than a personality characteristic possessed by some more than others (Hackett, 2006). Resilience is known to be socially driven, and therefore, this factor is important for professionals to understand when treating these children and young people. Resilience can also be understood as the adjustment of the child's psychological and emotion state in dealing with traumatic and troubling issues (Hackett, 2006). It can relate to a young person's relative resistance to psychological risk factors. It is influenced and enhanced by various factors, such as positive peer influence, positive sense of self, internal handle on control and a sense of personal power (Hackett, 2006). By enhancing these factors to those who display HSB, it can aid in developing coping mechanisms for those who utilize abuse as an outlet both emotionally and psychologically. This in turn provides them with the tools and coping mechanisms to deal with their issues.

These coping skills and resources are learned not only through teaching, but through experience (Hackett, 2006). Such skills are key in a child or young person

building up their social tools required to cope when dealing with adversity. It is a common human adaptational outcome, and is not a product of a process or characteristic (Hackett, 2006). As Maston (2001) said, 'resilience is ordinary magic'. Children and young people who display HSB demonstrate non-resilient outcomes, however, resilience provides an optimistic framework for intervention and at the heart of such interventions is resilience enhancing practise. Building such resilient interventions into our framework helps to focus on the strengths of the individual and how they can build upon these strengths in addressing their issues (Hackett, 2006). The adoption of such positives can help professionals adopt a fresh mind set towards those who abuse, leading them to consider the strengths of the individual rather than the problems or failures (Hackett, 2006). This notion is very true for the treatments of those who sexually harm.

3.12 Conclusion:

This chapter has reflected upon the various research and literature pieces that have attempted to understand HSB in children and young people. From the various literature, it is obvious to see that HSB amongst children and young people is a serious issue that does not have much support in addressing. This chapter has shown that not only is Ireland minimal in its service provisions, it also has no statistical records and is not being addressed adequately. We know that females require different approaches to treatment. In addition to this, the literature has shown how important the individual is, and not the behaviour. We must learn from our mistakes and avoid all labelling as this only accelerates the issues. Models and

theories have been postulated to enhance our knowledge about these issues and how we can recognise any risks and attempt to understand the complexities surrounding these behaviours. By building upon their, we simply make them better people. By taking a step back, and recognising the immense needs of these children and young people, it becomes more obvious how we are failing in our service to provide the children and young people of Ireland with adequate care and services. It is their basic human right to care and treatment, are we really achieving this in Ireland? It is evident, that this is a complex matter, however, the evidence within the UK of their relative successes in their practises, highlight the lack of attention we are bringing to our services within Ireland.

Chapter Four: Assessments and Treatments

4.1 Introduction

This chapter will focus on the need for interventions and treatments, and how successful these frameworks have been. In recent years, many professionals have learned more about the nature and extent of HSB amongst children and young people, and what constitutes good assessment and intervention approaches for both the child and their families. Despite the increasing evidence on the scale, nature and complexity of the problem, service provisions across the UK and Ireland

remain relatively un coordinated. However, with those services that are available, some show levels of good practice (Hackett et al., 2016). The United Nations Convention on the Rights of the Child (1989) declares that every child has the right to assessment by a professional, ably qualified person to undertake this task (Article 25). Additionally, the UNCRC (1989) states that all responses by professionals should be comprehensive and should promote the child's sense of dignity and worth which in turn will reinforce the child's respect for human rights. A human rights approach to responding to children and young people who display sexual behaviour requires the government, its agencies and professionals to not only ensure protection of the child, but to ensure assistance is provided in overcoming any physical or psychological condition that impairs their well-being (Butcher & Webster, 2006). The time is right to progress these approaches, which will give it impetus shape and focus within the

UK and Irish child welfare, criminal justice and health and education systems.

4.2 The importance of the right's based approach to intervention

As articulated above, the UNCRC (1989) states that all children and young people have undisputable human rights to special care, assistance, and protection. The Human Rights of Children, Article 25.2 of the Universal Declaration of Human Rights (1948) proclaims that children are entitled to special care, assistance, and protection. In keeping with this ideology, the United Nations, through the International Convention on the Rights of the Child (1989) announced its vision for children, asserting that, along with other rights, each child has the right to protection from abuse. It states that each child and young person has the right to

mental health care services 'as is necessary for their well-being' and have access to the opportunities for rehabilitation at 'the highest attainable standard' (ICRC, 1989). This is to provide accurate assessment and effective evidence-based treatment in a manner that builds the child's sense of dignity and worth. A human rights centred approach to assessment requires all professionals to recognise, reflect upon, and respond to children's sexual behaviours in a manner that prioritises the dignity of the child by identifying who should assess and what should be considered in the assessment of children's sexual behaviour (Butcher & Webster, 2012).

The ICRC (1989) believes so strongly in children's special rights due to their vulnerability in comparison to the power of adults in positions of authority (Butcher & Webster, 2012). Given the complex nature and uniqueness of each child and young person, a psychosexual assessment of the child must recognise the differences in their mental states and personal needs, reflect upon the entirety of the child (e.g. where they live), and identify responses that will not only reduce the risk of harm to the child and others but consider their needs as a person (Butcher & Webster, 2012).

In addition to this, all responses that are recommended within the International Red Cross (2007) children's rights, are to follow a comprehensive assessment that promotes the child's sense of dignity and worth, reinforcing the child's respect for the human rights and the fundamental freedoms of others, and promotes the child's integration in society. This is paramount to the child as to regain a 'normal' and accepted way of life is important to integrate back into society (Butcher &

Webster, 2012). Where children and young people have committed harmful or inappropriate sexual behaviours, there is a professional consensus that there should be a holistic and therapeutic approach to addressing their needs (Durham, 2010). This approach acknowledges the wider social context of these HSB and recognises that these children and young people may have experienced various forms of abuse,

oppression, and other difficulties within their lives (Durham, 2010). Addressing these factors alongside more specific sexualised offences, is a key component of the therapeutic response.

Grant and Ludeberg (2009) provide an extensive list of factors found to damagingly impact upon the sexual development of children and young people. These factors include "sexual/physical abuse, neglect, medical and health problems, mental health issues, behavioural disorders, learning/intellectual disabilities, social deficits, high levels of family stress, lack of age-appropriate sexual information, disrupted parentchild relationships, exposure to highly sexualised material/information, etc." (Grant & Lundeberg, 2009, pt.1. p.5). A rights centred approach in dealing with such HSB, is consistent with codes of ethics that require professionals to conduct assessments in a manner that communicates to the child and their value as individuals (Butcher & Webster, 2012). Butcher & Webster (2012) believe that there are two aspects in which psychosexual assessments should promote a child's sense of dignity and worth: the quality of interaction between the child and the professional and the recommendations drawn from the assessment. This rights

centred approach to assessment, as suggested by Butcher & Webster (2012), prioritises the need for professionals to communicate to each child that they are valued. By focusing on the child's uniqueness and through the quality of interpersonal interaction between the professional and the child, this relationship can be achieved.

It is believed that both human rights and therapeutic action are anchored in the reliable empathically centred "spirit of enquiry" (Lichtenberg, Lachmann, & Fossage, 2002). That in turn can lead to the creation of a profound experience for the child and young person, to be seen, understood, and cared by someone (Fosshage, 2006). The professional's most beneficial response to the child's implicit and explicit communications, during a time of vulnerability, can assure the child that they are being recognised and valued (Bacal, 1998). In addition, the professional's engagement with the child can help assert their worth and make the child feel entitled to the care and attention that they are receiving, through empathic atonement, confrontation, support, self-disclosure, validation, and invalidation (Butcher & Webster, 2012).

Even in instances where a child is resistant to the approaches of clinicians, the way a child is spoken to, their views being valued and the manner within which they are informed about the processes they are experiencing, provides a sense of worth and dignity to the child (Butcher & Webster, 2012). In addition, the explanations and responses to any questions the child may have, communicates the belief of the child's worth in the eyes of the professional and provides the child with authority

over their own issue and a responsibility in the management of their behaviours (Butcher & Webster, 2012). The selection of psychometric instruments and forms of therapy needs to be executed in a careful manner. It is not only in terms of relevance for the child's developmental level but, more importantly, that the instruments selected do not cause distress to the child (ATSA, 2006). For example, phallometric treatment is not appropriate for use with children and adolescent's due to the invasive nature of the procedure, amongst other reasons (Butcher & Webster, 2012).

4.3 The child centred approach to intervention

As expected, children are often not voluntary participants in these assessment process (Butcher & Webster, 2012). The need for an assessment is typically recognised by an adult rather than the child. Therefore, there is a strong potential for the assessment to be experienced by the child as a coercive and potentially humiliating. This results in the responsibility falling upon the professionals who are in direct contact with these children to reinforce their dignity and sense of worth (Butcher & Webster, 2012). The rights centred approach identifies that there may be some level of invasiveness and intrusiveness within their assessments. Therefore, huge responsibility lays on the professionals to ensure that the rights of each child undergoing this approach are respected. In addition, the professional should recommend specific responses that go beyond the aim of eliminating problem sexual behaviour (Butcher & Webster, 2012). These recommendations

should include the promotion of the child's awareness of the rights of vulnerable others and to ensure that, by the end of their program of rehabilitation, the child feels they have an equal place in society (Butcher & Webster, 2012). Finally, the professional should ensure that they facilitate the child's integration in the community in a manner that allows them to fully participate in all aspects of life that is normal for children (Butcher & Webster, 2012).

Intervention and case planning in relation to contact with other vulnerable children is of major significance when a child has engaged in HSB (Pratt &Miller, 2010). Further care needs to be provided to those who have been in contact with the child. These groups would include siblings, fellow students at school/day-care/nursery, sporting activities, clubs etc. (Pratt & Miller, 2010). Butcher & Webster (2012) suggest that it may be necessary to impose sanctions upon the child to reduce opportunities to engage in behaviours that cause harm, depending on their progression through the treatment and the severity of their cases. However, despite this, it must be achieved with minimal intrusion while guaranteeing community safety and complying with the rights and dignity of the child (Butcher & Webster, 2012). Safety strategies should be closely monitored with a view to restoring the normal degree of contact between the child and their re-integration back into community (Butcher & Webster, 2012).

The purpose of a psychosexual assessment is to clarify and assess the individual qualities of the child's personality and the patterns of their behaviour (Butcher & Webster, 2012). This is to make decisions about future responses which can be

tailored to the specific needs of the child. Given the limitation of research within this area of HSB amongst children and young people, a single treatment of choice has not emerged (Bacal, 2011). This places a greater onus upon the professionals to consider the various treatment approaches that are available to children and which is best suited. Additional recommendations about future treatment should not only consider the most appropriate treatment approach or intervention, but also the most appropriate professional to treat the child. Bacal (2011) argues that Specificity Theory suggests that therapeutic progress is made within the relational context of the professional and the child. This is comprised by the operation of a unique, complex, and reciprocal relational system (Bacal, 2011). Munschauer (2006) adds to this argument further by explaining that Specificity Theory is premised upon the recognition that each person's relationship is unique and, therefore, every therapeutic relationship is unique. Specificity theory 'calls attention to the importance of improving the therapeutic fit between the child's particular therapeutic needs and the professional's capacity to respond to them' (Bacal, 2007, p.125).

As highlighted above, children who engage in HSB typically need to address a range of complex psychological issues. A child's right to treatment at the highest standard is respected if they are matched to professionals that fit their personality and identified needs. The ATSA Task Force (2006) noted that the behaviour and status of children can alter over time as the children are in a process of development and maturation, and that their circumstances and the social environment can also

briefly change. Consequently, the validity of any clinical assessment must be considered time-limited. "Good child assessment reports often include explicit statements to guard against inappropriate use of the report long after its validity has expired'. (ATSA, 2006, p.12)

4.4 The Evolution of treatments in United Kingdom

A key milestone within the emergence of treatments and assessments for treating children and young people with HSB began in the UK with the Committee of Enquiry into Children and young people who Sexually Abuse Other Children (NCH, 1992). It was one of the first reports to highlight that children and young people in the UK, who presented HSB were a cause for concern. In 1992, this report made numerous recommendations in relation to the assessment of these young people and children. The recommendations suggested that abusive behaviour should not be looked at in isolation. However, the strengths and positive qualities of the young person should be looked at and considered during these assessments (Matthew & Allardyce, 2014). Other recommendations for assessment included a degree of acceptance of responsibility by the young person for their behaviour, considerations into their family background and if there was any abuse within their childhood. This report also encouraged research into other areas of this field and it showed that children and young people presenting HSB were responsible for one quarter of convictions for sexual offences against victims of all ages (Vizard, et al., 2007). Since this enquiry, there have been improvements to the assessments and services provided to these young people.

Subsequently, assessment practices and recommendations for best practice have developed significantly. Most importantly, assessment practices have developed from an assessment approach that mirrored treatment for adult sex offenders, to models that are more suited to the needs of young people and children (Matthew & Allardyce, 2014). Research, such as a study by Prentky and Righthand (2003), have consistently shown that the period of adolescence, is a turbulent time and one of dramatic change in a young person's life across various areas such as personality, sexual experimentation etc. Research into this area highlights the importance how not to apply adult sex offender models to the models that assess and treat young people. The adult model is simply not suited in treating adolescents. However, despite advancements, there is still no universal UK policy which unifies and orients professional responses as to which system a child or young person should enter, the Child Protection System or the Criminal Justice System (Prentky & Righthand, 2003). This is also reflected in the responses to services and treatments provided to these young people as varied and inconsistent (Hackett, 2014). In an assessment conducted in 2003 that rated local services and responding agencies across the UK, 42% of these agencies were rated as either inadequate or entirely unsatisfactory (Hackett, Masson & Philips, 2003). These agencies varied from private to public voluntary sectors and statutory sectors such as health and social services (Matthew & Allardyce, 2014).

Such assessment services are accessible through community, in custody and residential settings but there is no national agreement in place that guides the

nature of assessments or prescribing by whom they should be conducted (Matthews & Allardyce, 2014).

The establishment of the Home Office National Group on Sexual Violence Against Children and Vulnerable Adults in the wake of the Savile case, and the high-profile cases of child sexual exploitation and online abuse, present an opportunity to forge a better approach to the issue of HSB displayed by children and young people (NSPCC, 2016). These treatments and frameworks support local work with children and young people and their families, who have displayed such behaviours, by delivering and developing clear policies and procedures, and by refreshing local practice guidelines and assessment tools (NSPCC, 2016).

4.5 When to Treat Harmful Sexual Behaviour

Where a concern may exist regarding HSB by children or young people, it is important that such behaviours and incidents are looked at within a holistic context and that the correct assessment and responses reflect the appropriate intervention (Mathew, 2011). This includes the need to actively consider whether the child or young person

displaying the behaviour need safeguarding themselves (www.safeguardingpeterborough.org.uk). As stated before, there is major importance in identifying if the behaviour is healthy/normal; i.e. is the behaviour healthy given age and context within which it has taken place. Additionally, was this behaviour

inappropriate and likely to become harmful? Unlike in the adult field, there are no empirically validated or definitive assessment instruments currently available for children and young people who display these behaviours (Mathew, 2011). Providing high-quality services for these young people and children is essential for child protection. By helping and intervening upon these behaviours as early as possible, other children, along with the children in question, may be protected from further harmful behaviours (Ashurst, 2014). Therefore, treatments are paramount for a successful intervention. Many exist such as Brook's Traffic Light Tool and the AIM2 assessment tool. To define what is appropriate and what is inappropriate behaviour can be difficult and this is where these two assessment tools come into practise.

4.6 Brook's Traffic Light Tool

During a visit to Australia, Brook's Chief Executive, Simon Blake, visited True Relationships & Reproductive Health (formerly Family Planning Queensland) and discussed the traffic light guide they had developed. He was inspired by this innovative and successful project and was keen to bring back the model to the UK (brook.org.uk, 2012).

Brook's well renowned sexual behaviours traffic light tool, supports professionals working with children and young people, by helping them to identify and respond appropriately to sexual behaviours (brook.org.uk, 2012). This tool uses a traffic light system which assists professionals in categorising the sexual behaviours of young people. By categorising these behaviours as green, amber or red, professionals

across different agencies can work to the same criteria when making decisions in treating children and young people with a unified approach (brook.org.uk. 2012). Indicative behaviours have age specific groups starting at 0-5 years, 5-9 years, 9-13 years and 13-17 years (brook.org.uk, 2012). This is designed to help those working with children and young people identify the response to sexual behaviour that is likely to be most appropriate as adolescents have developed and matured more in comparison to those of the 0-5 age groups. An example of this tool can be seen in appendix 10.

In circumstances where practitioners have reason to believe that HSB may be taking place, they make a referral to a contact centre or police if deemed necessary to prevent a crime or the destruction of evidence (brook.org.uk, 2012). Once the traffic light tool has been utilised in the correct manner and completed, practitioners decide from there, about whether or not the behaviour identified can be categorised as green (safe/healthy), amber (potential to be outside of safe and healthy development for that age group) or red (behaviours that are undeniably outside of safe/healthy development) (brook.org.uk, 2012). Where the behaviour appears to be inappropriate and likely to become harmful, practitioners make a referral to a contact centre using a standard referral form (brook.org.uk, 2012). The behaviour causing harm, its frequency, the age of the individual displaying the behaviours and the information, if accessible, of the victims must be clearly identified within the referral form (brook.org.uk, 2012). Any further information that is available surrounding the impact upon the child targeted, the extent of

consent and any indications of remorse is also included within the referral. This information is important as it can help in the analysis of any potential patterns of problematic behaviour if further assessments are required later (brook.org.uk, 2012).

4.7 AIM2 Assessment Model

The AIM2 assessment tool is a UK derived initial assessment process that helps to determine the level of supervision needed for adolescent sexual offenders. The original AIM Initial Assessment model was based on Morrison's (2000) adaptation of work by Ryan (1999). It was to develop a scale of responses ranging from early community based intervention with low risk cases, to intensive work with the most high-risk individuals who displayed HSB, often in out-of-home settings (Ryan, 1999). This model was introduced in 2001 across Greater Manchester services. It provided a collective inter-agency and holistic model for the initial assessment of young people who displayed HSB (aimproject.org.uk, 2017). This model supported practitioners matching information gathered during the assessment process. The AIM2 assessment framework and procedures was designed to support professionals in the assessment of children and young people who displayed HSB and or committed a sexual assault (nscb.org.uk, 2014). This framework is currently the most recent preliminary risk tool that is in use within the UK. The assessment model offers an evidence-based tool that can be ustilised in understanding and comprehending the suitable level of supervision that is needed for these young

people and their therapeutic needs (cycj.org.uk, 2017). It has recently been updated to incorporate use for girls and young people with learning difficulties.

From the outset, this framework established a clear vision and strategic partnership objectives that connected individual agencies legislative requirement and core business (Morrison & Henniker, 2006). Both the assessment tools and training within this framework emphasizes the degree to which professionals existing knowledge and skills can be effectively transferred into this specific area. Practice procedures stress that good practice is anchored within the knowledge of child development, protection, attachment and cognitive behavioural principles (Morrison & Henniker, 2006). This framework is not a service provider to which agencies refer children and young people for treatment. By focusing responses around a specialist resource would not only fail in addressing the level of demand, but also, result in unnecessary delays in providing suitable service provisions (Morrison & Henniker, 2006). This framework adopts a joint approach of concepts from two assessment approaches, which is essential for the development of effective practice. These assessment approaches include the concepts of the 'Framework for the Assessment of Children in Need and their Families' used by Children's Social Care and other agencies, as well as the 'Asset' framework used by Youth Offending Teams (nscb.org.uk, 2014). These concepts from both frameworks are proposed to fit within the timescales agreed by the criminal justice and child welfare systems in the UK (nscb.org.uk, 2014).

The AIM2 initial assessment model is the first stage in gathering and analysing information (nscb.org.uk, 2014). This assessment model understands the importance of parents and family support for the child or young person throughout their assessment. Therefore, the framework of the AIM2 model adopts a holistic approach when assessing the young person and their immediate family networks. This framework provides a model to assist all professionals within agencies or services, who have contact with children and young people, to conduct an initial assessment

to:

- Identify potential risk of re-offending
- In child protection terms identify risk to either the young person or their actual or potential victim(s)
- Identify the young person's needs
- Assess the young person's motivation and capacity to engage in services and plans
- Identify the capacity of the parents or carers to support the young person
- Suggest priorities for initial response
- Consider referral into the public protection system

Sourced on (www.nscb.org.uk, 2014)

In assessing the distinction between behaviours, for example those that are believed as experimental in nature and behaviours that are abusive, the assessors

consider the notions of consent, power, equality and authority (nscb.org.uk, 2014). This is important as to ensure the holistic and non-judgmental approach to the individuals.

Some circumstances may not allow for the child or young person to remain living with their family during the assessment or treatment process as they may be considered a risk to other children in the household. The model does not make decisions for assessors but will support decision-making by focusing on strengths and concerns. The model contains levels of responses linked to the strengths, concerns and complexities in each young person's situation. An example of the continuum for strengths can be seen in appendix 11.

The AIM2 assessment tool makes the deliberate use of the terms 'strengths' and 'concerns' rather than the use of 'risks' (Morrison & Henniker, 2006). Language can be immensely impactful and can shape a professional's response, therefore making the language used by professionals important (Morrison & Henniker, 2006). In contrast, the use of these terms facilitates a more differentiated approach and multilayered understanding of the child's developed behaviour. This means that not all uncertainties can be eliminated and that risks need to be communicated between agencies and frameworks that emphasis an understanding rather than a risk management approach (Morrison & Henniker, 2006).

As previously mentioned, the involvement of family members and carers in this framework is important for its success. Their involvement within this process cannot be over stated. The distress that is caused to families when their child sexual harms is inexplicable and is worsened if the child has harm another member of their family. Between a third to a half of HSB perpetrated by young people and children involve close family members (Beckett, 2006). Careful assessment of family strengths needs and dynamics are essential if siblings are to co-habit in a safe environment. In some cases, siblings may need to be separated, however, where possible, reunion may be a goal but the safety of the victim remains paramount (Hackett et al., 2016). Hackett (2004) suggest that attention should be given to identifying and laying a solid foundation to build upon family strengths, and not just focus on the risks and deficits. Secondary post traumatic response may occur for parents when they find out their child has perpetrated these acts (Hackett et al., 2016). A study conducted by Duane, Carr, Cherry, McGrath and O'Shea (2002) saw that parents of a young male who had sexually harmed, uncovered a process of shock, confusion and self-blame. They found that these are common reactions to parents and that they can undermine their parenting skills. Hence, it is very important to involve the parents and family members in the treatment as it provides them with resources and coping skills that in turn will be beneficial for their children.

4.8 Female centred interventions

As mentioned before, the number of females who sexually harm is much less than males. In addition to this, there is minimal research within the area of females who sexually harm. Current literature reflects a consensus that there is a tendency to minimise or under respond to HSB displayed by girls (Hackett, et al., 2016). The assessment frameworks that have been mentioned above, have been predominantly based upon professional understanding of boys. Within the UK a service called the Barnardo's Taith Service provides assessment and intervention to young people and children and their families who are experiencing issues of HSB. In addition to these services, it also has a service specifically for girls who HSB which is funded by the Big

Lottery (Hackett, et al., 2016). This study aims to develop and standardise assessment tools and interventions for young girls who display HSB (Hackett, et al., 2016). It identifies the needs, to reduce risk and enable these young girls to move towards healthy adult relationships. The referral rate into this service has increased since it started in 2010. It has risen from 8% to 29% in 2014.

There is a tendency to view girls who display HSB as being the 'victims' yet boys are seen as the 'perpetrator' (Hackett, et al., 2016). On referral, the girls experiences of victimisation are given more precedence in comparison to boys (Hackett, et al.,

2016). Research that has been conducted within this Barnardo's Taith Service in relation to young girls and young women displaying HSB has shown that there needs to be a difference in assessment and intervention approaches depending on the gender (Hackett, et al., 2016). Furthermore, it highlighted the variations from professionals within the systems and support offered depending on the gender of the child.

4.9 School based Interventions

As this research has seen, the majority of training and clinical practice has been developed to aid professionals and practitioners in their management and understanding of dealing with HSB. Research has been written predominantly for those who work with these children and young people in youth work or youth services, however, there is little written in relation to those who work closest with these children, teachers. There has been little to no research specifically focused on teachers dealing with sexually harmful children, despite the increased awareness of sexual harassment within the school settings. In a 2010 poll conducted by YouGov in the UK, 29% of 16-18 year old girls experienced unwanted sexual touch at school. These findings are congruent with the results of Allardyce et al., (2017) where it was seen that at least a third of cases of HSB involved peer to peer sexual exploitation. Therefore, teachers are a significant part of a child's network and should be involved within the management of such behaviours amongst their students.

The AIM assessment tool agrees that all networks within the child's and young person's life should receive training and support in understanding these HSB and to be a part of the programme that works to help these children take control and change their behaviour (Carson, 2006). Early intervention is key and when any belief of HSB is recognised, appropriate action should be taken or a referral should be made. The responses of the pupil and their victims are also important factors to consider when evaluating seriousness and risks. School staff can feel deskilled and disempowered when dealing with children and young people with HSB (Carson, 2006). Their lack of confidence in evaluating these behaviours can be a cause for concern but with adequate training, their confidence will increase within their assertion and decision making (Carson, 2006). If these teachers are supported and involved in planning, they can work on significantly reducing sexual behavioural problems within the school environment and even more importantly, before they escalate. It is inevitable the important role within which the school staff in this area of work play (Carson, 2006).

4.10 Conclusion

This chapter has highlighted many significant issues in relation to treatments and assessments for the children and young people. A failure to recognise and respond in an efficient manner to these specific needs of the child or young person, can in turn, fail to recognise their dignity and worth by ignoring who they are as a unique person (Butcher & Webster, 2012). Furthermore, the formulaic imposition of a prescribed set of interventions is likely to further compromise the child's mental

health, social well-being, and human rights (Butcher & Webster, 2012). Specific descriptions of what problems a child may have, not only guide clinicians toward the appropriate recommendations for responses and treatments, it can also offer some understanding about whether action is required to protect other children (Butcher & Webster, 2012). The best interest of the child is paramount in the treatment process and care and professionalism should be adhered to at all times. There are various treatments and assessment tools available, however, it's how they are executed is of the utmost importance. For a child to reap the benefits of the treatment, respect, care and a non-judgemental approach is essential. This chapter has not only highlighted the models and frameworks that have shown success in their use, but it has also shown that each child male/female, need the treatments to be suitable to their needs. These treatments are not an umbrella approach to all HSB. Each individual child requires understanding and acknowledgement from the

professionals that their own specific needs are met, without judgement or prejudice.

Additionally, prevention is always better than cure, and a more in-depth look into schooling and their education around HSB could be key in preventing these behaviours from arising in many children.

Chapter Five: Results and Findings

5.1 Introduction

Within this chapter, the main findings from the research and interviews that were conducted, will be analysed and categorised into 5 main themes. Participants were asked questions surrounding their knowledge of HSB and their experiences in dealing with these behaviours. These interviews were recorded and subsequently transcribed to analyse and to compare/contrast to other research findings. Questions asked included:

Experience:

- Their interpretation of the term 'harmful sexual behaviours'.
- Their dealings with children who presented these behaviours.
- What makes these children pursue these behaviours?
- Do you feel the current response is enough in tackling these issues?

Why?

- Why would these children commit these behaviours? underlying issues?

- Does the impact of the media play a factor in these behaviours?
- Has the normalisation of sexual behaviours impact the way children understand what is normal and what is not?
- Are these people aware of their behaviours?

Who?

- Are there members of any certain socio-economic backgrounds that display these behaviours more frequently?
- Any age groups more likely to commit these behaviours?
- Are the children willing to make a change to their behaviours?

Policies/Services

- Would you see much recidivism?
- What services/therapies are most successful?
- What services are currently available?
- How can these behaviours be prevented? School education etc?
- What would the benefits of having a service in the Southern Region be?

The five main themes covered are:

1. The Evolution of HSB services within Ireland
2. Impact of Media and Technology
3. Treatments
4. Proactive rather than reactive responses
5. The Need for A Service within the Cork/Kerry Region

All names and identifying material have been anonymised to protect participant's identity. A table below provides a brief introduction to the participants and their professional profile and experience:

Participants	Role	Years of Experience
Interview 1	Social Worker and Currently in Social Work Education	15+ Years
Interview 2	Co-Ordinator of Children's Residential Services	40+ Years
Interview 3	Clinical Psychologist	26+ Years
Interview 4	Principal Social Worker	20+ Years

5.2 The Evolution of HSB Services within Ireland.

From the interviews with the participants, a common theme showed that this service is relatively new within Ireland, and very localised. This contrasts well with the literature that shows in general throughout Europe, the response to these needs for young people and children has been minimal and under resourced (Mc Grath, 2010; Jones, 2010). Such services are paramount in addressing these issues in an appropriate manner and within the best interest for the child. Interview #1 agrees with this when they refer to an incident where a young person was required to leave the country due to the inadequate services within Ireland; "*we were left with suggesting that the young person leave the jurisdiction to get an*

intervention…….I want to promise that this would never happen again…..I wondered would there be benefits to have a specialised residential treatment programme in Ireland, just one for the entire country".

The lack of services within Ireland only further highlights the great need to provide a better service to these young people and children within Ireland, instead of sending them overseas to deal with their issues. Ireland has been slow to expand its services to other areas such as within the Southern Region. To be under resourced in a country where these issues are evident is not acceptable. Interview #3 also agrees with this by stating that "*it's very unrealistic and we have a lot to do with very few resources".* Progress is being made within Ireland to improve these services, however, more needs to be done. Interview #1 stated a very poignant phrase when speaking about the Irish response to these issues, it was said that "*It would allow for less of an Irish solution to an Irish problem*" in addition, interview #2 shares a similar outlook upon the services provided within Ireland when asked how are these behaviours been addressed within Ireland; "*It's not… It's been a shunted problem, it's how we are being treated. We are much happier to have it dealt with in another country it seems"*. As a country, it is obvious that we need to realise there is an issue that needs to be addressed in a professional manner, with the best services for these young people. To evolve as a country, we need to accept these issues and build a solid foundation within our services across a wide framework within various areas of the country. The stigma surrounding this issue needs to be addressed and eliminated as history has shown that society's view of a child sexually abusing, was one of shock and disgust (Mc Grath, 2010). And in some way,

you could say that today, that view is still shared. The issues are being given to another country to deal with when we have no other options for an individual. Interview #2 also shares this opinion of the views of HSB in Ireland when they said that '*I think to take the taboo off it would get people talking about it, would be a benefit of the service, so that people don't fear that. And ultimately, you'd see a reduction in HSB and crimes. That would be the long term'.*

Interview #4 further accentuates the lack of action taken within Ireland when asked is the current response sufficient within Ireland "*No, there is a vision certainly, but we are no way near bringing that vision to life I suppose at the heart of it, that young people who present with HSB, wherever they are in Ireland will be able to access a service locally, that is age appropriate and is appropriate to their needs. And they are not able to do that yet. No, it is not anywhere near developed enough yet, there's a vision, its slow, progressing*". The acceptance of these behaviours within the health care system and beyond has shown to be beneficial. As mentioned above in the literature review, we have seen a significant increase in referrals to the child protection services from the mid 1980's (Mc Grath, 2010). The acceptance is one step in the right direction, however, now we must act in a productive manner, like these professionals hope to do for future treatments.

As mentioned before, the majority of services are located in Dublin, this is not acceptable. As a whole, the country should provide our children and young people in all corners of the country, with the services they deserve. The evidence is clear to

see, these professionals with expert experience, all agree that Ireland has not evolved in the manner it should to respond to such a major issue amongst children and young people. To once again refer to Interview #1, we need to stop having an "*Irish solution to an Irish problem*". This statement encompasses the issues around the lack of services so well.

5.3 Successful Treatments

As outlined within the previous chapters, treatment for such behaviours is paramount and ensuring the most suited is chosen for each intervention and assessment is key for a successful outcome. At such a vulnerable age, these young people and children require the best care and service that can be offered. As stated above, insufficient services across the country do not help the situation at hand, however, the continuous training and progression in treatment and assessment within this area can only have further beneficial outcomes (Mc Grath, 2010).

Within the majority of the interviews, most participants agreed that the AIM2 framework model is one of the best assessment tools to utilise. Interview #4 said that "*We are very fond of the AIM2 because its holistic and it looks at all the different domains in the young person's life. So, we like that, and it also has predictive tools for teenagers, there are some that are developed at all research levels. We do use this in our general assessments*". In agreement, interview #3

stated that "*it certainly is a good tool and a robust tool……. the AIM2 because it is holistic, because it is also strength based, as its coming from a 'how can we build up the resilience and barriers to protect' we like that, are not focusing on all the negative risky behaviours that maybe going on. And that is one of the things we do like about it'.* It appears that this framework, focuses on the person and is more holisitic in its approach. With HSB being an inevitable personal issue, this assessment tool is clearly tried and tested amongst these professionals. This also agrees with the literature where the AIM2 assessment tool is utilised in various services across the world (aimproject.org.uk, 2017). This model has only been in use since 2001 and has shown to have many beneficial outcomes amongst those who use it. It is vital to ensure that the most suitable therapeutic needs of the child are met in every case and this framework has evidence of this, even from our interviewed professionals.

However, interestingly interview #3 stated a very important comment about how such an assessment tool is utilised, "*So the AIM2 framework is a tool for a wider comprehensive assessment. What I am seeing though is throughout the country within these services, is that they say 'oh we are doing an AIM2 assessment' and they almost call it an AIM2 assessment as a report heading. And I'm like no, you must use your own clinical judgement. Because it is a tool, it is not the end all be all".* This comment was found to be extremely important, as by simply using this framework to treat young people and children is not enough. Adequate training is vital to ensure this framework and other assessment tools are utilised within the

manner they are created for. Treatments and interventions with young people is a delicate matter and should be approached in a professional manner. Therefore, these tools should be utilised in the manner that they are intended and not as the '*be all and end all*'. This statement agrees with Hackett, et al., (2016) where adequate training is vital and a suggestion to constantly re-visit training by all professionals would ensure that services and its members are all on the same page and are using these models in the best possible manner.

This country is fortunate to have many experienced professionals within this field, who provide expert advise and knowledge surrounding this area. Having spoken to only four of these professionals, it was evident to see their passion and knowledge in relation to these issues. Their practical knowledge and experience is priceless in going forward to improve all services both new and current. This is important, as adequate training prevents the issues around the idea of HSB being a 'taboo subject', such that interview #2 said that "*Adults response to children who do have HSB is extremely anxious….that it can leave the youngster with a lot of guilt…..that is not the way in which to correct behavioural trajectory….And that is a worry as I have a worry as how our services tend to look at these children and see them at a loss without actually developing what might have happened to ensure that it does not happen again".* Once again, adequate training and a positive outlook is imperative for all professionals dealing with these behaviours. Judgemental and inexperienced approaches to these issues will only hinder the growth and development of the child. This coincides with the literature by Butcher and Webster

(2012) where emphasis is put upon the training of professionals in dealing with this matter.

Additionally, all participants shared the same view, that treatments within Ireland need to be able to cater for all young people and children, on all areas of the 'harm spectrum'. Interview #1 spoke about how they dealt with young people who were deemed 'higher on the harm spectrum' and spoke of how the inadequate service within Ireland failed that young person "*Perhaps the youngsters in the cases may well have been at the higher end of the harm spectrum, none the less I feel we should have dealt with those young people within our community. I feel it would be safer to have them in their community rather than pushing them to the other side".* The issue of sending our children to another country is once again reflected upon. Which shows, that this is a serious matter to consider by the health officials in Ireland. This response is clearly not working and furthermore, it is costly and unnecessary.

Another area that was highlighted by each participant, was how not only is the treatment important for the child or young person, it is vital for their family and carers to receive the tools to cope with such an ordeal. By providing their primary carers with the knowledge and information on how to deal with such HSB, you are providing the child with a supportive and understanding environment. This was seen in the comment by interview #3 where they stated that "*We require the parents to take part or we won't work with them, we have to have parent or carer*

participation and it is absolutely crucial….we have to have the parents involved as they have to go through their own journey, they go through their stages of grief, so it's absolutely crucial". This assessment tool helps to carefully assess the strengths and dynamics of a family unit. By doing this, when faced with this issue, families can work together to overcome the obstacles and distress this issue has caused. By laying a solid foundation, it prevents any cracks in their unified state. This is reflective of the research by Hackett (2004) where a solid family foundation is an essential part of a successful treatment. Parents and carers are just as important to treat as the child, once again our services need to ensure that this is adhered to and not diminished.

Additionally, females and those with I.D. are being treated with the same approach to males. However, as seen within the literature, different approaches are vital for these groups. All of the participants spoke predominantly of males with HSB. Not much information was available for females who come to their services as the numbers are minimal, but they exist. This is concerning as there is a tendency to see the females as the 'victims' and therefore, may not be treated correctly (Hackett, et al., 2016). It is an area that needs more thorough research and the commencement of record keeping. It is inexplicable to think that within this country, minimal statistical evidence exists of HSB amongst young people and children. This opinion was shared by interview #3 when they said that "*So, all they (health services) are tracking is, this a child who is being referred for physical abuse, emotional abuse, sexual abuse, but there is not a category for a sexual behaviour profile. So, we have*

no way of knowing. TUSLA nor the guards are tracking systematically what are the ages of alleged offenders connected to any accusation of sexual abuse. So, we have no way of cross referencing this".

Addressing and treating HSB is not an easy task, however, it is extremely achievable. With professional training and adequate funding to provide sufficient services, this issue can be dealt with in a professional and safe manner. Successes with the AIM2 model framework is evident, and as a country, we need to ensure that we utilise this in the correct manner, and ensure suitability to all that are treated. The welfare of the child and young person is paramount, this should be reflected within these essential services that are required nationally.

5.4 Proactive rather than reactive responses

A common theme that linked between the research and interviews was that as a country, we need to be more proactive in preventing these issues from arising initially rather than reactive, and trying to solve the problem as it happens. Not only are these services minimal, but so is the education provided to children at a young age, about healthy emotional and sexual relationships. All participants agree that the onus should not just be on the services to provide a response to these HSB, but more responsibility should be upon parents to spend more time with their children in explaining sexuality and what is healthy and not healthy. Furthermore, the education system also need to address these issues within their curriculum by establishing an open-minded approach to each child's sexual understanding and

educate them on life skills. Teachers are the first port of contact for children and young people for a vast duration of their lives. They get to know many on a personal level and to utilise this relationship would be incredibly beneficial as a preventative measure. Additionally, by training teachers to observe and recognise HSB before they excel, would be an invaluable preventative measure. This approach was also shared by interview #3 where they stated that "*I think we have to do more earlier, and I think it needs to be logical and coherent throughout the education system*".

Within Ireland, there is currently no module dedicated to sexual behaviours, relationships etc. Interview #3 speaks about our current education system and about the inadequate education provided, "*My current understanding of what our education offers is a 'stay safe programme' which really doesn't get into inappropriate sexual touches…… we have to realise that we are in 2017, social media and what kids are seeing are different to when it was even 10 years ago".* Similarly, interview #2 spoke about the insecurity of speaking about such issues within schools, "*There has been a history of difficulty where it has been suggested that schools look at sex education with youngsters, that they felt uncomfortable or that they didn't like it".* Interview #4 agrees "*that the school can give you the facts, but it cannot give you the values and what your wanting young people to apply to their sexual behaviours and to their values".*

To refer to a previous statement by interview #1 about "*an Irish solution to and Irish problem*", this view is shared by interview #3 in the context of education. They said

that "*maybe I do think that the religious history of Ireland influences education and has been a barrier and people obviously want to protect their children and not give them too much too soon. But I can certainly tell you, they are learning a lot, an awful lot earlier in age than any of us ever thought. And in light of that we need our education system to be better prepared to help that*". This statement agrees with the work of Carson (2006) where it was shown that by empowering children with knowledge, they in turn become more confident and 'equipped' in dealing with situations. We need to evolve with each generation and accept that our children are becoming more sexualised at a younger age. We need to empower and support those within the education system to take charge of outlining societal values. And we need to do this without any bias.

In addition to schooling, parents are a vital figure in these preventative measures. Interview #3 speaks of the lack of education children are getting from their parents "*…very few of our clients have had adequate conversations themselves with their children about sex education and relationships….. we can't count on parents to give it and parents are anxious about it and they really dread it and so how can we work more together around that"*. At this point, asking parents to teach their children about these values and behaviours is a little late, as with prior knowledge, it could be argued that maybe these behaviours could have been avoided with the adequate information. Parent's approach these issues with caution and anxiety, and in turn, may not ever explain them to their children. This is a cause for concern. However, they cannot be forced to do so. This is where our education system

comes into practise for these issues. As to educate children and provide understanding and development, is priceless for their personal growth and confidence (Carson, 2006).

For such curious children and young people, a foundation of understanding and a place to go and ask questions is essential in a healthy understanding of societal norms. Both schools and parents need to provide more support, transferable skills and open mindedness to their pupils and children in helping them to understand what can be the most difficult times of their lives and provide them with support and answers.

5.5 The Impact of Media and Digital Natives

The issues surrounding online activity, the media and technology have never been more under the spotlight as they are now. With young people and children owning smart phones and having access to more explicit material than ever, questions have been raised as to whether this has led to this 'sexual revolution' and has made the attitude towards sex more normalised amongst these young people and children. Research has shown that indeed, young people understand sexualised acts that they view on pornographic websites to be 'normal' (Phippen, 2012). These questions were out forward to the participants to explore their views on the matter.

Interview #1 stated that "*repeatedly it does transpire that there is, I would have a professional concern, that what young people seeing porn, is how they interpret relationships".* This is reflective of the research completed by Phippen (2012) where young people, predominantly males, believed that what they saw in porn is what occurs during intimate relationships. However, there has been no evidence to show that there has been a rise in cases of HSB amongst young people since the emergence of smartphones and internet access. Interview #1 goes onto say that "*children as young as 7/8 years are exposed to porn, I think we need to be realistic in the sense that there are lots of children exposed to porn, we have issues around consent but a lot of young people do that. That they don't go on to sexually harm people, like the cat is out of the bag, for censorship of the internet in this country would be impossible to control the access to the internet*". Similarly, interview #4 echoes this statement where it was said that "*it was around 91%, possibly 96% of the Irish studies, show that they have access to or viewed pornography and we don't have 91% or 96% within our service having committed sexual offences. So, pornography in itself is not causal to SHB but some kids maybe more vulnerable to what they do with that information*".

However, once again, it highlights the importance of what education the child receives from a young age either from their parents or schools. Through this education they can differentiate what is normal and what is not. Interview #3 shared similar view on this when it was said that "…*more importantly it has the*

potential for some young people as they can't differentiate between what's real and what's media. And they begin to think that the way that the people are treating each other in these pornographic clips or videos is normal….they don't understand that there is a vast difference in that". Once again, education and preventative measures can have a major impact in how these young people interpret pornography and other inappropriate material. This is also reflective of the work by Phippen and Brennan (2016) where these behaviours are becoming more 'normalised' through the media and internet.

Interestingly in interview #4, the approach to pornography is looked upon in a more critical manner, "*essentially, what is its role amongst young people and what we are coming down to is, is it that accessing porn causes the interest? Or the accessing of the porn is expressing that behaviour? It's very hard to distinguish"* however, it once again came around to the similar conclusion that lack of information for children is part of how they misinterpret these images "*the research was quite interesting was the role of parents. It was if you have no other source of information other than porn it can be problematic so they were making a point that parents should talk to the young people*".

In conclusion, access to various media outlets and online pornography can in some ways potentially spark an interest in some young children. However, not all of these young people will continue on to behave inappropriately. Stopping young people and children from accessing these materials is not an option, therefore, we

approach the issue with education and preventative measures. Once again, it is with the power of knowledge and information by parents and education providers that these behaviours can be prevented.

5.6 The Need for a Service within the Southern Region

The need for a service such as this for young people and children within any area of the world, is essential. Its value is priceless and by providing such services, we are providing children and young people with a chance to change and progress in a positive way within their lives. All the literature has nothing but positive views upon these services, as their only outcome is beneficial when completed in a professional and educated manner. This view is reflective of all participants opinions on providing a service to the Southern Region.

Interview #3 stated strongly that "*it's so important to be able to do this work*". This work within the Southern Region requires the appropriate level of training and professionals to make this service a success for all those involved. A solid progression in this professional field would be a step in the right direction to add further services to other parts of the country. Interview #1 said that "*a service provision to that young person who has harmed, it would prevent further abuse from happening. It would also, stop the cycle of abuse happening, so it's a preventative measure first and foremost……I also think that having a service would allow for not only assessment, that there is over reliance on assessment yet there is*

not intervention, no follow through. Not accepting that something has happened. This would allow for

intervention".

Interview #2 uses a powerful statement by saying "*The service needs to wrap around them (children and young people). That's what it would be benefiting".* This statement encompasses the simple requirement that services need to provide. By "*wrapping around them",* services in turn can change and stop the cycle of these behaviours. This view is also reflected in interview #1, "*having a dedicated team, you'd have a suite of dedicated staff that would not see the taboo and would work with additional needs, this is a specific sexual need that needs to be addressed. It would have a dedicated service for the victims' families"*. They then go onto explain how by not having a current service in the Southern Region has impacted their current practise, "*The difficulty of having a service where there isn't a dedicated core team, it's an addendum to our current practise".* The strain upon services currently is evident and this should not be ignored. By providing the Southern Region with a service to help HSB, would be reduce the current strain on services, and provide the children and young people with what they deserve and what they are entitled to.

Engaging with children and young people with sexual aggression continues to be a complex and challenging area (Hackett, 2006). This is true and reflective within these services, however, by continuing to establish solid frameworks and

interventions and providing more services to more areas across Ireland, only positive outcomes can result from this. The aim is to be part of the solution and not shy away from the problem.

5.7 Conclusion

This chapter served its purpose of highlighting various themes within the context of HSB by examining the interviews and the literature. These themes were categorised into headings to provide a clear approach. With the help of the participants providing their experiences and expert knowledge within the area of HSB, many issues were brought to the fore and this information was immensely valuable. The findings showed that more proactive responses are required within external resources e.g. schools. Furthermore, both the literature and participants highlighted that not all social media is bad and a more careful approach to this is essential in assessing HSB. Treatments were also discussed and findings showed to have an overall agreement on successful treatments that have been utilised and proven to work. Finally, the need for services within the Cork/Kerry Region was further accentuated by the attitudes and views of the participants. Overall, the findings provided instrumental evidence to further endorse the literature. A more in-depth discussion of these themes will be discussed in the closing chapter 6.

Chapter 6: Conclusion and Recommendations

6.1 Introduction

HSB is a growing concern throughout the country, and is an issue that is vital in addressing for the safeguarding of our children and young people. This study has sought to demonstrate the needs for services for children and young people presenting HSB. Previous chapters introduced the concept of HSB, provided a comprehensive description of the methodology utilised, analysed the literature and explored some of the key findings that emerged through this research study. This chapter will provide a discussion and summation of some the key findings from the

literature and collected data. These conclusions will outline how successful this study has been in demonstrating its main aim. In addition to this, recommendations will be made for future research to highlight any areas requiring further examination.

6.2 Need for Services

This research set out to demonstrate the need for services in the Cork/Kerry Region, for children and young people displaying HSB.

Having conducted a thorough literature review and interviewing professionals within the relevant field, there were a number of key findings. Above all, the immense need for a service to be provided in the Cork/Kerry region is apparent. All four participants within the interviews agreed that the services within Ireland are under resourced and that more services are vital to ensure a high standard of care for these children and young people. This finding is consistent with the literature that shows that more services are needed on an international level to keep a high standard of care which in turn, can help in reducing such behaviours from occurring (Hackett, et al., 2016; Mc Grath, 2010; NSPCC, 2016). Both the literature and the voices from the participants agreed that these vulnerable children and young people greatly need these services to reduce re-offending and to ensure healthy development for the future of the child. Many participants spoke about how such services impact these young people in a positive way and more importantly, it would stop certain young people being sent overseas to be treated. The taboo

surrounding this sensitive issue would be eradicated with a dedicated team who would in turn provide invaluable treatment. The needs for these services is undeniable.

6.3 Proactive Responses

Another key finding was in relation to education and how schools should be more involved in the prevention and education of these behaviours. The literature emphasised the lack of education that schools are providing with sex education and sexual behaviours (Phippen, 2012). This idea was echoed in the attitudes of the participants, all four believed there was a lack of relevant sex education within our schools. Furthermore, they agreed with the literature when stating that teachers and schools are the first port of call for these young people and that these institutions would play a major role in reducing such HSB from occurring with the correct education. In response to this, curriculums would need to be changed and furthermore, the attitude of the Irish schooling system would also need to change around such issues being raised within schools.

6.4 Availability of Research

One such finding that became more evident as the research progressed, was the lack of statistical evidence of HSB surrounding gender/ethnicity/offending/recidivism/I.D. To provide services of the highest

standard and knowledge surrounding these areas is paramount to ensure each service provides suitable and adequate treatments. The lack of such data both nationally and internationally was quite alarming. Not only can data provide those within these services with more knowledge on the issue, it can lay a solid foundation to ensure all treatments and assessments undertaken are fully equipped and suited for each individual. The level of importance for more research and data recording is unapparelled and more attention and structure should be outlined for each service.

6.5 Digital Natives

Another finding that was interesting was the role that media and the internet played in the context of HSB. Having conducted the literature review, an attitude was formulated that these factors would have a significant impact upon HSB. However, few participants highlighted that it was not online pornography and social media that created these behaviours, it was in fact how the young person interpreted this information was a contributing factor towards displaying HSB. Additionally, participants downplayed the idea that digital natives were a major influence towards HSB. This was an unsuspecting finding, however, very relevant to consider for future research. This once again, highlights the need for more education for children and young people in schools as learning what's healthy/unhealthy behaviours and answering any questions they have, is key in prevention.

6.6 Treatments

Finally, the findings in relation to the treatments and interventions coincided with the literature, which was anticipated. Participants all agreed that AIM2 was a highly successful model to utilise within the services. However, one such participant stressed that it only be utilised as a tool and not the answer to the issues. Literature also agrees with the success of the AIM2 assessment model (NSPCC, 2016; Hackett, et al., 2016) and how when utilised in its intended manner, can provide immense help in treatment and intervention of the young person. Once again, the structure and suitability for each individual case is of the highest importance and should be a consistent practise within all services. Knowledge is key within this area.

6.7 Conclusion

It was clear from the research that HSB is an issue that requires more attention. With the lack of specialised services for such behaviours, causes much concern for the health and well-being of these children and young people. The main issue lies with the lack of services and this research has demonstrated that such services are imperative in dealing with these issues not just for the child involved, but also for society and its victims. Not only must we accept we are not providing the basics for these young people, we must see that is not just a simple behaviour, it is a

behaviour that has various underlying issues, issues that need addressing ever before such behaviours arise.

6.8 Recommendations

Whilst the amount of research in the area of HSB is growing, various areas are still vital to consider. One main area is in relation to data recording and how our services need to initiate a system where information such as gender/ethnicity and other diversities need to be recorded as such information can provide services with more knowledge around the cause of these behaviours and how to treat them further. Additionally, more emphasis needs to be put upon the health services in Ireland, to not only provide services within the Cork/Kerry Region, but in all regions of Ireland. Finally, the standpoint from service users would be of immense benefit to future research to gain further insight into the causes and best treatments of HSB.

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Appendix 1

Experience

1. Can you tell me about your professional background (education/training) and your role and responsibilities your professional role?
2. Have you come across the term 'harmful sexual behaviour' before? If so, how would you define or describe it?
3. Have you dealt with any children and young people displaying these harmful sexual behaviours in your professional practice? If so, can you tell me more about these particular behaviours?
4. Based upon your professional experience, why do you think these children and young people display these behaviours?
5. Would you and your colleagues see these children mainly as victims of their own circumstances or as perpetrators of a wrongful act?
6. How were these children brought to your attention? (Referral/Agencies?)
7. Within your role, how have you tried to address these behaviours?
8. Did you feel these responses were appropriate or sufficient? If not, do you feel there is better way in which to respond?

Why

1. From your professional experience, what are some of the underlying issues that these children and young people present with? (e.g. early childhood trauma, isolation, mental development, poverty?)

2. How do you feel the impact of the media and/or social media have impacted the attitude of sexual behaviour amongst these children and young people today? Do you feel it plays a role in why these behaviours occur?
3. Do you think that a certain 'normalisation' of sexual behaviour amongst young people and children has an impact upon how they practise their sexual behaviour? If so, why is this?
4. In your experience, do you believe that these young people are aware of their harmful sexual behaviours?

Who

1. Based on the children and young people you work with, do you believe that there are members of a certain socio-economic/educational backgrounds that display these behaviours more frequently?
2. Are there any age groups that you understand to display these behaviours more frequently?
3. As a result of this, do you think these children and young people are generally willing to make changes to their behaviours?

Policies, Services, institutions

1. How many youths would you see on a weekly basis coming to you with these behaviours?
2. From your experience, what services/therapies would provide successful and effective care for these children and young people?
3. What would be the benefits of having a specific service dedicated to these young people?

4. Have you received any feedback or opinions from the children and young people displaying these behaviours on what they feel might be beneficial for them?
5. Currently, what services are provided to these young people and how effective are they?
6. How do you believe these behaviours can be prevented in children and young people?
7. Would you agree that parents/carers of these young people require support also? If so, what types of support/how?
8. Do the policies within Ireland do enough for these young people? The laws against child abuse are strict, how can we shine a light to improve the current policies within Ireland to deal with such an intense matter?

Appendix 2

To (insert name)

My name is Emily O' Callaghan and I am emailing you in connection to request an interview with you.

I am an MA Criminology student in University College Cork, currently completing my dissertation. My dissertation is based upon highlighting the needs for services for children and young people who display harmful sexual behaviour. I am working with CARL within the university and I am completing this piece of research for Action for Learning Cork to help them put forward completed research that will help them to require such a service within the Southern area.

I was hoping, if it was possible, to interview you around the area of this topic. Your experience and profession would enable me to gain a further insight into first hand experiences in your research/experience/educational background which would provide invaluable information for this research.

If you are interested, please let me know via email. My phone number is 0838366187 if needed. In addition, my supervisor is Dr. Katharina Swirak of the Sociology department within UCC. Myself or Katharina would be more than happy to answer any questions you have surrounding this interview. If you accept to take part in the interview, an information sheet will be provided to you to ensure your full informed participation. The interview will last a maximum of 1 hour on a date and time that would suit you best.

I look forward to your response,

Kind Regards,

Emily O Callaghan

Appendix 3

INFORMATION SHEET



Purpose of the Study. As part of the requirements for MA Criminology at UCC, I am required to carry out a research study. The study is concerned with the investigation for the need for services to assist young people presenting harmful sexual behaviours.

What will the study involve? The study will involve an interview process that will last no longer than one hour. Interviewees will be professionals who work/worked with such young people who display these behaviours or have knowledge surrounding these issues. The questions asked will surround the need for such services in relation to combating these issues amongst young people who display these behaviours and the point of view of the interviewee such as the attitudes towards such behaviours and the treatment of these young people, how policies may need to change and the what needs of these young people are and how can they be met.

Why have you been asked to take part? You have been asked because of the nature of your profession that relates deeply to the topic of the research. Your point of view and opinion is paramount within this study to gain more information surrounding the needs and understanding these issues in further detail.

Do you have to take part? No, you do not have to take part. This interview is voluntary and if you feel uncomfortable or unsure, you may withdraw at any time even after agreeing to participate or during the duration of the interview. You will be asked to sign a consent form prior to participation, you will also get to keep a signed copy of this consent form and the information sheet. You have a right to withdraw within two weeks of participation and can also ask to have the data you provided destroyed. This is to allow for afterthought on your behalf.

Will your participation in the study be kept confidential? Yes, your participation will be kept confidential, however absolute confidentiality is not always possible. Your participation will be kept anonymous and any personal comments or clues to your identity will be kept anonymous within my thesis. All efforts will be made to ensure anonymity and confidentiality within this study for all participants.

What will happen to the information which you give? The data will be kept confidential for the duration of the study, available only to me and my research supervisor. It will be securely stored within a securely locked cabinet within the Sociology Department on the UCC Campus. On completion of the project, they will be retained for minimum of a further ten years and then will be destroyed. All electronic data collected will be destroyed after transcripts will be written up.

What will happen to the results? The results will be presented in the thesis. They will be seen by my supervisor, a second marker and the external examiner. In addition, the Action for Learning Group in Cork will also have access to the results

as I am working with them for this study. The thesis may be read by future students on the course. The study may also be published in a research journal.

What are the possible disadvantages of taking part? I don't envisage any negative consequences for you in taking part. It is possible that talking about your experience and scenarios within your profession may cause some distress, however, all efforts to avoid this will be made.

What if there is a problem? At the end of the procedure, I will discuss with you how you found the experience and how you are feeling. If you subsequently feel distressed, you should contact myself, my supervisor (Dr. Katharina Swirak) or the head of the department of Criminology (Dr. Orla Lynch) within UCC.

Who has reviewed this study? Approval must be given by the Social Research Ethics Committee of UCC before studies like this can take place.

Any further queries? If you need any further information, you can contact me: Emily O Callaghan, 083-8366187, 107577371@umail.ucc.ie.

In addition, you may contact my supervisor Dr. Katharina Swirak on the email address k.swirak@ucc.ie

If you agree to take part in the study, please sign the consent form overleaf.

Appendix 4

CONSENT FORM



This consent form is designed with qualitative research in mind. Where quantitative methods are used, issues such as quotations and audio-recording do not arise.

I……agree to participate in Emily O Callaghan's research study.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I give permission for my interview with Emily O' Callaghan to be audio-recorded and subsequently written up in transcripts.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box:)

I agree to quotation/publication of extracts from my interview ☐

I do not agree to quotation/publication of extracts from my interview ☐

Signed:……. Date: ……..

PRINT NAME: …….

Appendix 5

Interview #1

Q: Can you tell me about your professional background and your role and responsibilities within your professional role?

A: I am an accredited social worker with Cru. I've worked in practise for about 15 years before moving into social work education.

Q: Have you ever come across the term 'harmful sexual behaviour' and if so, how would you define this term/describe it?

A: Yes, I have, for a lot of my service I worked in a child assessment unit where children would have made allegations of a sexual nature against somebody, and it would be our duty to assess the veracity of those allegations based upon the child's account. So, we would use HSB within that context as an allegation against a young person as opposed to an adult and that when there is a level of coercion, a power differential between the alleged and the alleged victim, which used sexual harm when it's a penetrative behaviour, coercion, threat, power differentials, an age differential and a developmental differential and there was an absence of consent with one of the parties. So, we could call something sexual harmful if there was no coercion but of there was an age differential, so kind of assault. We would use the term inappropriate sexual behaviour or inappropriate sexualised behaviour when

there was behaviour amongst young children that used harmful sexual behaviour when it's kind of a teenage/older adolescent rather than younger child.

Q: So, it would be more a predominant term used for adolescents than young children?

A: Yes, it would depend, in general, within my practise we would use harmful sexual behaviour with, you know, teenagers, we would use inappropriate sexual behaviour for those of a younger age. It would be, there would be some level of discussion around what we would label it. Whether we would label it as HSB depending on the nature of the alleged behaviour, the duration of the behaviour. Again, taking in all the other factors we discussed, there would be a discussion around that, but we would also look at more recently at Hackett's traffic light tool, of the breakdown of what is within in the normal range, what is within the amber range that's is somewhat normal and then the final one is what is what's harmful. I guess the most important thing I would notice would be that I worked with victims, or alleged victims, so your always mindful that an allegation of HSB, that is still a young person, that they are still in their formative development, that they are, yano, that it is possible that they do not have a sexual interest in children and that this is a product of adverse childhood experiences that they have had. Other dysfunctional issues that have arisen for them. So, we use the term HSB to differentiate from SB by an adult, but we would also differentiate it from inappropriate play or child's play, because its distinct. Now that has been a transition over time, at one time in my practice we would have used inappropriate sexualised behaviour almost until

the person was 18 years, when I started in my work it has changed, so we changed it to inappropriate sexual behaviour and then it was in only the last 4/5 years that we only make the distinction between the two. Occasionally in the early days when we used ISB we might have gone and said sexually abusive behaviour, then again, the difficulty with the language and what you call it is that children, it isn't so much the younger group, but in terms of working at a systemic level, you're working now not only with, the alleged victim and you are working with the parents. And sometimes working with the parents they find it difficult to accept that it happened, and being supportive and safeguarding role. The word abusive can be very difficult for parents to hear. Even when you say ISB is easier to hear to take on board and perceive rather than HSB or harmful, that it can feel, because obviously parents feel that it's my fault, so you're working with parents so you need to be careful of the language. And yet you do have to state that it did cause harm because on the other side, at a systemic level, I work with the victim and also the victim's parents. So, working with them to say yano, yes this happened to your child, however we are not calling it sexual abuse, we are calling it something else, that can be distressing for the parents, so calling it HSB at least it gives a good balance for the victim and the person who has committed the behaviour. I think it is an issuative process, as more info comes out. I've read research recently, from Vizard or something, and they talked about the impact of the victim, it doesn't matter the age of the child, the assailant, and the impact upon them is their emotional response, and that it doesn't matter, that it's the violation that's happened to them and it's how they respond to the violation, and how they recover from that. But we would see it as

vitally important in terms of the potential to change the behaviour and passions when they are adolescents, when they still are forming.

Q: So how we these children/young people brought to your attention? Referral/through and agency?

A: So, they would be referred, they would be a bi-product of a referral to our services from those who were sexually harmed or who had made allegations of sexual abuse of sexual harm. So, they would be named or identified within that. Traditionally, we would have asked for an opinion or a response from the person who made the allegations and if the young person admitted the behaviour, that we might have had to put the child, the alleged victim into an assessment process. If there was an admission. So, between 25/30% of our referrals each year relate to a young person and of that, the vast majority be male. Your talking, in one year, there was only one female, teenager against whom the allegations were made. You're never talking more than 5 to us in a year, where a teenager alleged was a female, all of them were male. In one sense, I think SA is a gendered form of child abuse, whereas more females are abused and more assailants are male. Now, there is also a possibility that there is under reporting of allegations of female abuses, Sharon Lambert has done some research in that. So that's how we identify them. One of the difficulties we encountered was that while there was limited therapeutic support for victims after the SA, there was nothing at all for the young person, so what happened was that I had been active on two social parties as a social worker and I was looking to how we could develop services for young people who SH to np

avail. We got so close. Funding was to no avail. There was hopes for funding in 2006/7 rising out of the Fern's report commission. Then the recession hit and there was no funding available. So, in recent years in 2011/12/13 I was asked to do a review of a young person who had sexually harmed along with a principal clinical psychologist and the concern was that the young person would need, that there was no facility in Ireland that could conduct, support this young person. So, we were asked by the court the review and examine the young person. And part of that review we met with the residential staff, and we were left with suggesting that the young person leave the jurisdiction to get an intervention, and at that time, I would have contacted one of the more senior managers and said look really, I want to promise that this would never happen again where I can't understand, I wondered would there be benefits to have a specialised residential treatment programme in Ireland, just one for the entire country. And at the time the manager who I spoke with, heard it. And said its probably unlikely that we will get any funding for it and that trying to locate a unit within the country, you could encounter difficulties with communities that they didn't want this unit within this area, however it did start up a conversation that kept going. One residential unit in this area suddenly became a defacto because they ended up taking young males, the staff got training, somewhat becoming, what came out of that was that staff started to say I actually with support, I can actually work with these young people. That the taboo was gone. They decided to form an Action for learning group to look at ways how we could get community resources so from a bottoms up reporting, myself and other staff member within the unit got it off, she had worked in a child assessment unit for years and had been working consistently and got training herself in the area and

we have been working and looking a developing and looking at community based services and creating a bank of staff that are trained in the area and that can carry out initial assessments, and interventions for young people.

Arguably there will always be 1/2 cases where they will need more intense intervention and may need to leave the jurisdiction. But that community based resources, based assessment units can work for lots. Once they are identified. And once their families are supportive of their intervention. So thats how I became involved in the ALG and pushed it along the line.

Q: From your professional experience in dealing with these children/young people what are the underlying issues that these children present?

A: With SH I would argue that it is one of the most class-less forms of child abuse. In that my experience that SA can be found in all strata. And that those who engage on SB come from all strata so I wouldn't relate it to socio-economic status, what I would relate it to, that there are a number of factors, that the myth is that those who dissipate in such behaviour has been a victim themselves. For me that isn't the case, it can be a factor I think that there are a lot more adverse childhood experiences, those who carry out the abuse, do the ACE scoring and go from there. Family dysfunction, domestic violence, exposure to poor family boundaries, sexual boundaries, that there are a number of other factors I would see, parenting attachment issues and if attachment is sometimes present in blended family systems, step siblings, can be about power and again around attachment. And again, around the absence of pro social skills. Sometimes, we almost have this

stereotype of the teenage boy who was socially isolated, who didn't have friends, peers, sports, who may have had some additional learning needs, or almost very academic, isolated, who didn't have opportunities to engage in normal sexual developmental practices with a peer in a non-coercive space. And the then some other of the additional training I've had in that breaking that stereotype, there is also an increasing sexualised society in that you have young people who end up talking about sexual contacts with experience being with someone within their family, much younger, that they would be babysitting or something, so I suppose the environmental factors their own life history, they may have been abused themselves, but they also may have been exposed to other things and then their own personalities come into it. Some young people who sexually harm, will have sexual interest in children. Not all of them would. Absence of pro social skills and poor self-esteem and understanding of consent, what that means, looks like.

Q: Do you think that the social media, the internet the use of smart phones etc impact upon these behaviours?

A: Based upon the training, the children as young as 7/8 are exposed to porn, I think we need to be realistic in the sense that there are lots of children are exposed to porn, lots of them are looking at porn a lot, we have issues around consent but a lot of young people do that. That they don't go on to sexually harm people, like that cat is out of the bag, for censorship of the internet in this country would be impossible to control the access to the internet, given the periferation of the introduction of smart phones certainly, its more around having conversations with young people.

So, it certainly is, repeatedly it does transpire that there is, I would have a professional concern, that what young people seeing porn, is how they interpret relationships to be an academic concern that we don't over simply it to say its due to an over exposure. Where its over simplified. From a practices POV I can see that I suppose the training I have, hearing from another worker saying that every single fella she's met, that it was habitual use of pornography. So, you can't just over simplify it, yet we can't deny it either.

Q: Have you seen an increase in children/young people coming forward with HSB since the introduction of smart phones etc?

A: Historically I've looked at the figures and I've been working with groups. And it was 20/30% of referrals to us, so it has been pretty standard and steady, for me, I have been within the two working groups and between them I have seen that a lot of our referrals have been young people. Within our family agency, we have a responsibility for those u18 so we need to use, we have moral/legal obligation to provide services, and in the old Children First 1999, they refer to peer abuse and they say that a third of allegations so this is 1999, research shows that one third. Before the explosion of smart phones etc. so in 2011 when they reviewed peer abuse, they removed a third and said a high proportion. They softened the language. So be honest, I think it's been consistent. Which would take it away from smart phones being the only issue. The thing is if we say childhood adversity, poor boundaries, they have been there before the internet was ever there, what I think you have is the type of abuse. I think the issue of the internet relates to people in

penetrative sexual behaviour at a younger age in comparison to times before and also, I suppose issues of consent and what is understood to be kind of, the regare what is sexual relationship between peers.

Q: What benefits would you believe come from having a treatment service in the Southern Region?

A: At the moment, vast areas of the country have no services at all. So, you have, if a child has made an allegation, and the young person has admitted it, or the process of investigation has found to have done it, a service provision to that young person who has harmed, it would prevent further abuse from happening. It would also, stop the cycle of abuse happening, so it's a preventative measure first and foremost. Secondly, having a dedicated team, you'd have a suite of dedicated staff that would not see the taboo and would work with additionally needs, this is a specific sexual need that needs to be addressed. It would have a dedicated service for the victims' families. Argue that when an allegation is made by their child, that the onus is on them. That their child needs to prove the allegation. At the moment, there is nothing for the adolescent that abused, all they have to say it that they did not do it. And it goes the garda route and rarely there is a prosecution and then they don't see, whereas if there was a service there would be an intervention happening. I also think that having a service would allow for not only assessment, that there is over reliance on assessment yet there is not intervention, no follow through. Not accepting that something has happened. This would allow for intervention. I did training on the GLM, having done this is highlights right what have we done, how can we re-educate and support and safeguard. It would build up

a capacity to safeguard. Decreasing sexual harm. The difficulty of having a service where there isn't a dedicated core team, it's an addendum to our current practise. What we know that is there repeatedly mentioned a burden being put on the services of additional work. Could be problematic for the sustainability of services. We also know, it can work. If it's not additional work to their work loads, it is a part of their workload, it provides them with additional piece of work that is a specialised area. Something new, the models being used across the country that have allowed people to work for half a day or whatever with those people. I think an issue that always comes up is that infrastructure, this area is a big area and that is made of urban rural. The work we look at is a hybrid of units and those in the capital and services in the west, it's so rural, they don't do individual work they only do group, we need to look at having a hybrid. You would have time in a rural area that some of the practitioners have raised concern that they go to the training and know someone else on the group. They hang around after and develop anti-social behaviour. In Dublin, they know each other too. Work through it, they set boundaries. For me, a dedicated service, a small team, multi-disciplinary team, layer two, staff that could come in and support and do individual assessment. It would allow for less of an Irish solution to an Irish problem, and expect putting a child on a plane and sending them to another jurisdiction will work, the young people that come back, have lost their base in Ireland. They have lost their support and safeguard. Coming back putting the at risk with an absence of support. So, having a mature response to this issue.

Q: Do you believe the policies and laws need to be altered and changed?

A: So, we have had the introduction of the new sex offences act this year, which has strengthened the legislation around child abuse, grooming and public indecency. I would argue that criminal and sexual crimes against children are played out in court,

I think for children, I think the burden of proofs is difficult. Then when it comes to people who sexually harm, the amount of kids that go to court is quite low because the sexual harm can happen within the family and family members don't, whether its parents or aunts/uncles don't necessarily criminalise their son who has sexual harmed their child. I would argue that there should be a better policy to better work with the Gardaí within the family agency and that I think that sometimes, before I was in practise that some guards emphasise criminal route when you know there wasn't going to be a case. My views have changed in 18/24 months. Due to the training, I have received. Refers to case* allegation was made within a family. The person received treatment within a service up the country the case never went to court. When the sibling became an adult, reported to the guards, and it went to court and the alleged was criminalised and given a sentence. The argument was that if that had been investigated at 16 years old that the young person may have gone to prison/Oberstown but arguably got a non-custodial sentence, or tried in the children's court or be cautioned. Could have received something from the JLO. So now perhaps there should be an investigation as the person admitted it at the time and had received services also, and there has been no report since then of further offences. I think we need to look at how, do we criminalise young people and give

them a criminal record that may impact them in adult life, or do we not do that but then, have potential to resurrect down the line, it's such a complex area, you need to balance parents needs and wants. The child's, the offenders needs also. In terms of policies, I think it's so complex. Some of the areas I'd like to research are the complexities of siblings' abuse. Most policies involve the siblings to have no contact with alleged abused while investigations go on. So, families are torn apart, which causes difficulties. Family trauma with the expectation on parents arbitrarily that its ok to live or not ok to live with them. A lot of work and more support to families too. Asking them to break up, when they themselves are going through a grief process. I have encountered situations where young people, could be going to the same school as the alleged victim, and that can cause difficulty in a rural area. You're stuck, how do you safeguard all the privacy and everybody else's risk management. It can lead to exclusion and very complex. We have a strong policy against who the allegation is made, but they have to be informed of all the processes. We are weak on collaborative work with families and expectations. CAO of TULSA We can't eradicate risk. We will always have risk.

I welcomed that. In the sense that there seems to be a position within the media a sense of eradication of risk and no burden on all social workers. It's a class less act. Never been known to social work. Complete shock. Cannot correlate with other antisocial behaviours. guards have never encountered. More policies need to be developed.

Appendix 6

Interview #2

Q: Give a summary of your professional background/education.

A: Currently I am the co-Ordinator for the children's residential services for Cork and Kerry. My background is, 40 years ago, I started to work with the homeless in cork city and in the 90's I did child care. So, I worked in child care residential and child care community settings. And I subsequently went on to become a manager of particular units and went on to become manager of more units including special care and high support and mainstream care. So, my main background would be social care and social work, and working directly with youngsters and supervising and supporting staff to work with youngsters with significant needs.

Q: Have you come across the term 'HSB' and if so how would you describe it?

A: Difficult as you say. Clearly what is says, that it is harmful as opposed to explorative or normative or even a bit silly. It usually has a harmful element to it. To either to person doing it or towards the person they are targeting the behaviour to. So, its harming.

Q: Based upon your professional experience, what is your understanding of why these children display these behaviours?

A: Why? Ok, the aetiology. Myriad possible potential sources and roots. In some ways and meanings, like all behaviours, it's to meet a need, funnily enough when I work with these people I try to get them to go back to where this need might be. The need is fine sometimes the behaviour might be the problem, but needs are universal, we can't avoid them, they are human nature. It's a condition, what might the needs be, the needs might as well be as simple of some gratification, not being gratified in other ways. It might be compensatory, some loss or maybe hurt maybe a response to hurt, maybe aggressive. It can be a myriad, it could be gaps in development gaps in affection and attachment, disruption, bereavement, exposure to grave promiscuous or pornography. The why is a big thing.

Q: Within your role you've dealt with these behaviours and young people. How have these behaviours and issues been addressed within the local area by agencies services etc?

A: It's not… It's been a shunted problem, it's how we are being treated. We are much happier to have it dealt with in another country it seems. There is a parallel, the reason I became interested in a local response, as we had local responses before but they started and then they stopped. I think there was a problem the way they put it together. I think it was called the Carraig project which in the early 2000's. It was the HSE or even pre HSE or even the Southern Health Board. And it was set up to work with problematic or HSB but the criteria was that the person engaging within the service had to admit the wrong doing before any commencement, and low and behold. They got very few referrals coming in. whereas we have more intelligence from others within the country that you never go looking for that. You don't help someone with issues by shaming them. You know, there was that. That started and stopped. And I have worked in centres with youngsters you have had HSB. In a number of occasions, they have been sent to a number of places within the UK, that was my motivating to be involved in the local Munster project. When children are already disadvantaged, maybe from their family or education, poverty, or all series of economic and social factors. They are then sent out from a small community where they are form, to the UK for 18-24 months to a programme, loosing local supports, coming back, usually with a UK accent and how is this risk reduced? You are meant to build people up to stop the behaviours, not break it down. That was the history, I worked in those areas. In a

variety of residential areas where that was done. Perhaps the youngsters in the cases may well have been at the higher end of the harm spectrum, none the less I feel we should have dealt with those young people within our community. I feel it would be safer to have them in their community rather than pushing them to the other side.

Q: Have you found that there is any definable group within society e.g. social class, age group, gender etc that display these behaviours more frequently?

A: No, it's completely across the board. The thing that is unusual is, that when we meet the youngsters in care, we have 24 hours and a microscopic view, which we see more if it. I suspect there are plenty of places that we don't get a look in to it though.

Q: Do you feel that the use of smart phones and the growth of the internet has impacted upon these behaviours? such as is known the 'sexual revolution'? Worked as a catalyst per say?

A: I liked the phrase of 'sexual revolution' as they thought the 60's was the age of the sexual revolution, but they were wrong. Now it's the revolution through the internet, through their phones. There is a greater amount of it. The media is unbridled as to what they show, and what messages they show. Simply there is

much more of it, there is fairly a real issue that people need to address. It is not censored, it is not watched it's probably not talked about in many places. Which is a real problem as it is how people can regulate themselves. The images that they can be subjected to, I can see how phones and porn and images can make a bigger impression, because they do, they do. It's a big challenge to deal with and I don't know how we are going to do that.

Q: And have you seen any increased number of referrals since this 'revolution'?

A; I have seen an increase, I have chaired for about a decade centre of admissions committee so the referrals are made to residential care are made through me, so we normally have an over view of these things. So em, it's a common, but it's not an epidemic. It's an increase but I wouldn't call it epidemic proportions. It has slightly increased and maybe the internet etc has impacted upon it but I can say for sure.

Q: For those young people coming through your service, do the understand what they have done?

A: I think they do, I think children are very intelligent and very resilient. They may not tell you but I think that they know. But I'm not sure that they've done. But sometimes they don't know what they are doing here about that. They will get treatment and worked with in a family environment as well. I'm pretty sure most

youngsters believe they are being moved into care on foot of HSB as its punitive, I think if I was pulled out of my home and community and sent somewhere else in the country and I was kept and I could only get home under strict supervision then undergo treatment, I would feel it would be a little more punishing. I think they experience somewhat like that, I can't be sure. I imagine if I was in their place I would see it like that. They know that they have upset the social norm. I think they do deep down. Significantly, it happens in males, not just males but females too (which is very much a taboo area and we don't know very much about it) but it can happen in the teens, pre-teens. It can happen before that 11/12 into the teens, and at that stage, cognitive development is pretty good. And they know how the world works so yes, they do.

Q: Do you see a lot of repeating offenders?

A: Again, I talk from experiences as by the time the youngster is referred to us they are watched like hawks. I can say that, probably maybe the worst breach we had was one poor youngster who was in a social situation, who be friended a girl and who got probably over energetic in their affections towards each other, but nothing too extreme. Adults response to children who do have HSB is extremely anxious. And so anxious that it can leave the youngster with a lot of guilt. Maybe that what prevails for them. But again, that is not the way in which to correct behavioural trajectory. Which can result, in certain circumstances to perpetuation. And that is a worry as I have a worry as how our services tend to look at these children and see

them at a loss without actually developing what might have happened to ensure that it does not happen again. I mean they still have all the needs, the human needs that we all have and they have to be met, but I can do it in a way that does not harm. I think we try to do that, but I think the watching and the anxiety watching doesn't help.

Q: Prevention is better than cure, however, do you believe schools should have more education and developmental training in this area and dealing with it?

A: Yes, absolutely I believe so, there should be some informed teaching and education centres that probably do that. There has been a history of difficulty where it has been suggested that schools look at sex education with youngsters, that they felt uncomfortable or that they didn't like it. Something in the curriculum or something like that. Look sensible education or something like that and an open field to youngsters to discuss this, prior to it coming into the time where actions are more likely to be pursued. They should have some sort of an idea that this is what is coming up. I mean I have young relations who can talk about those things and they are safeguarded by being clued in and knowledgeable about it. I think I did the training with Carl Carson, I did the AIM2 training with her which is a great reference, which it resembles a traffic light with red amber green stages. Many people are surprised or arch their eyebrows with many of the green behaviours, the green behaviours are the normal ones, the ones we shouldn't get upset about. But some people get a little touchy about this and it's a taboo subject, which what

makes it so interesting. But AIM2 I thought was excellent and they should have that within the school curriculum.

Its easily transferable and kids will understand it.

Q: Do you feel these assessment models and intervention frameworks need to be renewed quite often as perceptions of sexual behaviours can change?

A: What we find, and I am not surprised by this. There is a whole array of criteria for adjudicating what we would be problematic or HSB and I think that true of individuals. But it doesn't help if we don't have some categories that spill into each other, then how the heck can we identify if there is a problem and two, of response or intervention that can help. So, it's difficult, the cloud and the shadow if the taboo area is the most defining aspect, I think, I mean the issues from the Ferns 5 report and the way they are rolling that out. There are struggles there too. Issues with social views and culturally and where you grow up. All might have a different threshold and that might define the degree of harm. Because the harm is the harm that you feel or experience.

Q: From your experience, what services or therapies would be most beneficial if such a service would be rolled out?

A: I did training in the GLM, I like it. I like it because its humanist, because it sees the individual and the individual dealing with many influences and if they did get into a pattern of behaviour it is probably due to an area in their lives that they need to address and build up. You do address the HSB and you control the risks as much as you can and you do your supervision as much as you can, but you build up all the other aspects. As change comes from within. You cannot change people's behaviour by being punitive or with extra sanction, it doesn't generally work. What works is when you have an insight into their behaviour and help to see a new way. There are other models that suit other behaviours. Some can be harder to access.

Q: What would be the benefits of having a HSB service dedicated to children and young people in cork?

A: Probably, many fold. I think there should be some of an educative aspect to this. You've mentioned schools but I feel there is other fora within which it would benefit from more discussion about this and take away the taboo surrounding this issue. I think the benefit of this service, from the people I know who provide these services in Dublin, who have come down here to help us get the service off the ground have done so on partnership basis, and have realised that these services are an add on to the child to the family to the community of helpers wherever they might be, so that's in residential care or foster care or in the community or another setting that's fine. The service needs to wrap around them. That's what it would be benefiting. We would get away from the idea that, I remember we worked in a time

where we were getting a string of referrals predominantly to do with children of HSB and some people around got the idea that it would be good to set up a centre exclusively for these behaviours, and I did not like that one little bit. Not at all, this is a behaviour one of a series of different behaviours, one that we must deal with. And there is no point in grouping everyone together almost colonising those who have HSB. It's one manifestation of a difficulty in life. I don't think of specialising were helpful. So, I think to take the taboo off it would get people talking about it, would be a benefit of the service, so that people don't fear that. And ultimately, you'd see a reduction in HSB and crimes. That would be the long term.

Q: How do you think these behaviours can be prevented?

A: care, care for these children within the family settings can be a safe plan to do it. If you can take away the horror. And say simply, look this is what they were doing its not great for him or for others if we do nothing about it, can we support you in dealing with it rather than going in and giving them instruction on what to do about it, what they have to do. And get them to see what they have to do. You have to win over people and it can be prevented. You can only do proper prevention with a supportive and informed approach, and you have to engage the person involved within this, honestly and meaningfully over time.

Q: DO you feel policies and laws within Ireland need to be renewed, do we need to change them or renew them?

A: It is clear for adult abuses, I don't think it's simple. It will have to be looked at to some degree. Laws are made for the adults and rationales amongst us. I think children and individuals who are involved in HSB are involved due to individual circumstances, I think making laws for that is difficult. I think that the judiciary has looked upon cases where it has dealt with HSB in young people and they have decided not to prosecute even though they could. Because they don't think it'll be helpful. But they do accept that it is not black and white it's not simple. So, I think rather than push or promote further legislation in that regard, maybe education should be the thrust of it. And leave the law to those it applies to.

Appendix 7

Interview #3

Q: Can you provide me with a brief summary of your professional and educational background?

A: I qualified as a clinical psychologist in 1991 in California Pepper dime. I went straight into work with specialist treatment foster care CA and was a part of the

founding team. As we were all beginning to learn how to treat children with alleged sexual behaviour and I was a part of that. Moved to Ireland in 1994 because of my background went straight into St Louise's Unit which was the child sexual abuse validation centres in Ireland at the time. I was there for 22 years thereabouts. In this role, I would have done child sexual abuse assessments and coordinated that on the management team and then 1998 restarted what was the 2nd group therapy in Ireland at the time, so we began SIATT which was an interagency initiative that helped the governance the children's hospital of Crumlin and St. Louise's unit. However, when I changed my post to TUSLA, it did create a bit of a pondering about what to do with clinical governance. Could I hold it as I was not placed in the hospital so it leads to what we wanted for many years but it took my departure to make it finally happen. TUSLA took governance of what was formally known as SIATT. And around 9 months ago I started with TUSLA in the position of professional principal clinical psychologist and I am one of the co national managers for TUSLA's new SHB service. So, I co-manage that with my colleague Judy Mc Carthy who is the principal social worker and we have a total, including ourselves, of 4 WTE posts to set up a national service. So, it's very unrealistic and we have a lot to do with very few resources. But certainly, we will be submitting for additional WTE's to support us. So, a lot of experience in assessment and treatment of u18's primarily the group of adolescents but we also have St. Louise's SHBS who we do limited work with the u12 population. So, the CSB the child sexual behaviour and then we have the adolescents who sexually harmed as well. Other background would have been my working with NOTA. NOTA came to Ireland in 1999. It is a UK based charity but has an international membership and international branches. So, Joan Cherry and

myself set up the Irish branch in 1999 and I would have been vice chair of the for 5 years and an additional

3 years after that before I stepped back from NOTA, and I am about to step back into NOTA.

Q: How would you define HSB?

A: To make it harmful it has to be unwanted or forced. Or in the absence of appropriate consent. They would have to be the main 3 differentials.

Q: What would the behaviours that you most commonly deal with?

A: It varies, because we have primarily dealt with contact, so the safest term to use would be contact for HSB. What is interesting is that it is not about the behaviour, the behaviour has very little to do with the assessment or the treatment it's a wider context.

Q: Why do these children and you people commit these behaviours?

A: I have theories as to why they do this, certainly. For the u12 and over 13's they are a very homogenous group there is not difference. In very stereotypical

interpretation, we have had family members whose parents were in the top 2 of financial income working within the financial sector in Ireland. So, we would have the exceptionally wealthy, we have had parents who were a guard, lecturer's professors and then we have families who come in from the local flats and who have generations who have always been within the flats, being a part of the social welfare system within Ireland. So there really and truly is no background or socio-economic status that would inform this. Certainly, we are becoming more aware at who may be at risk, and I use the in-air quotes partly because there is no scientific validity to assess risk for juveniles. So therefore, we use the word rick but there is no science to back up. So, it's a term to be cautious of. But we do have information about who we think would be more of a concern. Often times for the juveniles we take, say the 3-10-year olds may get involved in this because they have been a victim of sexual abuse but that is still relatively a low statistic. What you do see is attachment problems, exposure to sexualised material or language. What is 'normal' in their local play area on the green, who are they talking to, who are they playing with how many truth or dare games get a little too far. Sometimes it happens out of self-masturbatory behaviour at age appropriate, if they discover it feels nice and is comforting and they want to share it. And they don't understand the adult's reaction to this and its turn on essentially and they don't know the rules and boundaries of what's okay and what's not okay. So, you have everything from attachment based problems to where SB maybe a bit more aggressive or abrasive. It may be about power and control rather than self-comfort. Or you have the ones that accidentally find their ways into SB. So, the pathways can be anything on a continuum. With the teenagers who have had no earlier onset of SB typically the

mean age is 15 when we look at the 13-18-year olds, and that would fit with pubertal development. It is usually around 15 when males have their testosterone surge and their impulse control around how much sexual thoughts they are having part of what's going on when they are trying to make healthy decisions. And we also have the cognitive development that's another discussion. So, with a teenager, the vast majority of those who we are working with who are exceptionally limited with their social skills and confidence are fascinated by SB but don't have the confidence to go out there and engage it in age appropriate encounters with their peer group. So, they don't want to look like a fool with their mates. They want to truthfully say something like 'ya I touched a girl's vagina'. They don't need to reveal it was a 4-year-old but they feel like I have stature now I too have done this sexual behaviour. So, it's sometimes that lack of social context social opportunities or social confidence. Then there are other ones that it is more about an added emotional feature where they say that they don't like that child, that child is now getting all the attention I used to get from mom and dad. Ah sure they don't mind, they don't count, they won't remember and you get a lot harsher judgement going into the choice for the behaviour. So again, quite a range of different pathways that they can get into. The more troubling category is the more conduct disorderly profiles. They are at risk of engaging in any type of inappropriate behaviour including further sexual abuse. They are more likely to get into more trouble with the guards with further anti-social behaviours but because of how they are seeing the world and thinking about things the likelihood of them sexually abusing again in a passively aggressive sexual manner or just to spite somebody. So certainly, there are more troubling profiles, more complicated to get them onto a more normal

developmental path. But the vast majority are exceptionally treatable and have a god sexual prognosis and the recidivism research is overwhelmingly in favour of this treatable group that does not want to further cause sexual abuse as an adult but also are at a low risk of doing something as an adult. What might be perceived as a lifetime persistent problem. And hardly any of them are what anyone would call a paedophile. So, to have a sexual attraction to children is a very very small minority of what we might be encountering in our work.

Q: Would you see a lot if u12 year olds coming through your services?

A: not a lot yet but that's more an issue for the system. I know in my various professional hats there would be 5 u12 queries a week around them being involved in SB and assisting in whether if its normal do we need to do something or provide a service. The problem with the system is there is not a centre for all of those children to go to and even our own service at the moment we haven't released our referral forms massively as we only have 4 posts so I don't have an idea of what will come when we formally launch. Within TUSLA's social work department they track the reason for referrals after the child's first admissions of abuse. So, they are tracking is this a child who is being referred for physical abuse, emotional abuse, sexual abuse, but there is not a category for a SB profile. So, we have no way of knowing. TUSLA nor the guards are tracking systematically what are the ages of alleged offenders connected to any accusation of sexual abuse. So, we have no way of cross referencing this. Now within my role within St. Louise's Unit I kept track of those

stats. And certainly, the stats of the referrals rates we were seeing were consistent with research, which were 1/3 of all sexual abuse perpetrated by someone u18. So, then you have to extrapolate from the number of sexual abuse allegations that TUSLA receives over all but we have no way of tracking that. We just know they exist and we know that when you build it, they come. We are very busy trying to establish services around the country as well as responding to clinical need as best we can. We have a very tightly resourced situation.

Q: Have you seen a growth in cases since the introduction of smart phones etc?

A: I'm not sure if we could say that we have seen an increase of sexual behaviour as a result overall from the totality of that stats that we can get our hands on. It is certainly an important feature in the assessment and the treatment. For example, these smart phones and other lovely gadgets that people have in their homes, like play stations games have internet access you know so, you get it anywhere in a variety of ways. But the sneakiness of pornography and the ease of access to free pornography and whether that it accesses to adult images of child images, that's a whole other separate thing. Certainly the young people in our programmes just about all of them have been viewing a fair bit of pornography prior to or during their abusive stage and they would see that as contributory but we also take a look at research within Ireland around access to sexual images just in general, for general young people and I think it was around 91% possibly 96% of the Irish studies, show that they have access to or viewed porn and we don't have 91% or

96% within our service having committed sexual offences. So, porn in itself is not causal to SHB but some kids maybe more vulnerable to what they do with that information. It can certainly increase arousal. But more importantly it has the potential for some young people as they can't differentiate between what's real and what's media. And they begin to think that the way that the people are treating each other in these pornographic clips or videos is normal, and that's what girls like, and oh that's what people do, oh that's how a girl is meant to behave when they are turned on. And they don't understand that there is a vast difference in that. But similarly, the research show that also girls are accessing pornography, the 91-96% were not just males, it included females. So, they are also potentially getting concepts of that, oh that's how a girl is supposed to behave and that's partly because if juveniles have not had a lot of experience in sexual and intimate relationships, how do they know what's normal. And it's not until as we get older that we see, aw ya that's a stint, and we begin to have more of the ability to differentiate what's healthy or unhealthy. And they can often take it in and think 'oh that's what we're meant to be doing'. So, as they are not developmentally ready, it's not so much that they do not have the experience and you have a lot of sexualised material out there, those are challenges. One of my issues is Grand Theft Auto, which has a derogatory view of women and points for killing prostitutes and there is a litany of these shows that have bad name. and we have a lot of people saying, 'oh that's not what the game is about, I don't care about that stuff', and they don't necessarily see or assess how these images can impact how they value women or how I value human life. But then there is also research to say that participation in violent games has nothing to do with violence unless you are a

subtype profile and we know who that subtype profile is. But we have to find out what kind of access can do to this person and their treatment needs.

Q: Do these young people understand what they have done?

A: Certainly, by the time they get to use they do and more often than not they were aware of what they were doing at the time they were doing it. They were just hoping not to get caught. Certainly, where most of these young people have deficits in understanding how someone can be affected by this and the ripples of harm that go out from that particular act. With those who sexually harmed its cognitive distortions and justified thinking. But we all do that I can justify why I might speed down the M50, if you were in an accident where we may have caused the death of a person and to live with that we have to learn a way to cope with that. So, it isn't that all cognitive distortions are bad it's the ones that need to pay attention to are the ones that could make them do this again. So, when you're dealing with do they get 'it', when you're dealing with the parents, the most important questions from them are 'does my son get it' and we work with them on 'what does that mean?'. What is 'it', and we certainly try to help their son to get 'it'. Most of them do get it. Most of them created a situation where they were clueless and didn't understand that they would have affected harm and thought oh well the victim didn't hit or push me away they still sat next to me the next day, they didn't run away from me, they didn't cry so it must not have been that bad. So those type of distortions come and we have to try to help them understand about somebody freezing, somebody

liking you but not liking the behaviour and then they begin to get it. Then when you start to go into serious victim empathy treatments and issues, they are typically quite over whelmed when we are doing that, as some people having sleep disturbance, have anxiety based symptoms as this is the first time they begin to see what they did and how many ways it affected that person let alone that persons family their own family beyond the impact of the sexual abuse itself. Often time we see family fall out we see parents who can't see their sister anymore because my son did this to my niece.

And the losses to the grandparents who don't know what to do, who do they choose. How do I stand by my son and not go to the christening? So, the ramifications of this are so vast any far and the also, as far as consequences not all cases are put through the gardai. A lot of families don't want to do that for a variety of different reasons. But we make sure that all our clients are aware that when the child victim reaches their own age of maturity there is a window where they can go to the guards and make their own complaint. So, this never goes away this keep following them and they don't know when the other shoe will drop. And of course, we say to our clients, if I ever find out you pled not guilty to something, I will have words with you (laughs) and if you are still attached to the programme then you might get expelled. So, we certainly don't want them to do anything further that will add trauma to the victim or the victims' family. We try to in still that this is the price that you pay. That they have to be responsible and do the right thing.

Q: Prevention is better than the cure, do you believe more onus should be upon the parents and schools to educate youngsters?

A: My current understanding of what our education offers is a stay safe programme which really doesn't get into inappropriate sexual touches until they're a little bit older in primary school. And then you have the CSPE programmes within the secondary schools, Now I think we have to realise that we are in 2017, social media and what kids are seeing are different to when it was even 10 years ago and even when you go into my generation. We know our values are changing for example, and I still don't know what to do with this value judgement. One of our boys was talking about his behaviour recently at a disco, and he had 8 girls come up and snog him. And he felt this was completely normal, 8 different snogs with 8 different girls, that he hadn't initiated any of them. And I'm kind of going, oh dear god no, 8? 8? Seriously 8? And my team was watching me have a large reaction to this. But who am I to put my values onto 2017 and it I different. So, coming back to education, I think we have to do more earlier, and I think it needs to be logical and coherent throughout the education system. I really like the programme that they have got in Canada, called the 4th R. Relationships, and they are teaching kids to the equivalent of junior infants all the way up they have a curriculum of the 4th R in every year. It is about teaching consent, respect, physical space solving problems dilemmas, conflict resolution, real life skills. And as they go through them, they do get to gender and dating issues, as in how boys and girls play together. And what's okay when you play together so its addressing bullying, sexual violence, dating violence, and while

they haven't researched this specifically, I think there will be a by-product of resulting in preventing sexual abuse but also earlier reports. And seeing the results, there is a reduction in dating violence etc when they look at those who have had input in these courses and they output. By the time they are in secondary school they are using the media and have classes doing role plays about doing different scenes in dating life. And conflict resolution, and again they are seeing drops in pregnancy. They are seeing so many core fundamental improvements and that to me is really pitching it. And maybe I do think that the religious history of Ireland influences education and has been a barrier and people obviously want to protect their children and not give them too much too soon. But I can certainly tell you, they are learning a lot an awful lot earlier in age than any of us ever thought. And in light of that we need our education system to be better prepared to help that. Because if we don't they are going to be having these conversations and having these exposures and not knowing where to go with it and a lot of parents are particularly resistant in participating themselves in sex education with their kids. And certainly, very few of our clients have had adequate conversations themselves with their children about sex ed. and relationships. As sex ed is not about the anatomy and the body's reproduction, but bearing in mind the young people we are seeing they don't know how to chat up somebody, they don't know how to treat somebody, the don't know how to get into relationships. They don't understand the consequences of cheating and trust, so they need a lot more than the anatomy and reproduction. And we can't count on parents to give it and parents are anxious about it and they really dread it and so how can we work more together around that.

One of the reasons these teenagers sexually abuse is because of their curiosity, I want to know what a G spot is, I've heard about this G stop I want to know where it is, I want to find it confidently with this girl I really fancy. So, if it's that real curiosity, our belief is that have adequate sex ed and have a master's class for our treatment group. Let there be nothing you are left curious about because I will not let that be the reason that they have to go do this again. So, we have some 12 weeks solely on relationships. So, we don't just have sex ed, it's called dating and relationships and we start with friendship skills and dating skills and what type of man you want to be when you're 30 and how you get to be that guy. If you're treating women like this now, how do you get to be him? What's okay what's not okay. So yes, you do need to address that if you want to be helping to prevent further sexual abuse.

Q: Do you get a positive response from these young males?

Q: Absolutely. It would be very rare not to. It would be very pathological if a young person within our programme who truly did not care about anyone else, and would have the nerve to say to me, I don't care I did that, she said it was alright. They are defending it, justifying it. That would be very rare. These kids are here by parental influence, none of our kids are court ordered. They come, we do not have a problem getting young people in our system or into our service. Certainly, our

young people are petrified but once they meet me in the waiting room and see people walk by they go they think ‘oh he’d not a thug, he is like me’ is we are demystifying it even before they come into the room together. And they absolutely love having a place to come and talk as they know what they did has been judged they themselves are not being judged and they have a place where they can come and ask all these questions. And their questions are basic, we always ask them to give us your list of questions and they ask, ‘how do I find the right person?’ ‘how do I know they really love me?’ and you get other things like ‘why do girls go to the bathroom altogether?’ or ‘why do they wear makeup?’. Basic things, they truly don’t understand. But then you’ll have the other ones asking, ‘well how many dates in before we split the bill?’. So practical things so they don’t necessarily have the people in their lives addressing this with them. But similarly, we do a parallel programme with the parents where have them reflect on, well who did you have to talk to, how did that conversation go? What were you thinking, were you going to have that chat with your own kids? Did you have the chat, how did that go? Who had the chat, mommy, daddy? And looking at all that. And they often, when we present the sex ed box from the family planning clinic, you get the female condom, the IUD you name it it’s in the box and we let them see that and then we show that to the lads.as when they are having healthy sexual relations we want them to be safe. And we address STI’s and all that. So, there is so much, they eat it up, they soak it up. As it’s a place they can come and not be judged and ask the questions. And I’m mindful, as you mention working with the boys, I think girls probably have similar questions, and maybe they get little more chats at home because of things like managing their menstrual cycles and what have you and a few other different

chats. But I say for girls how to respect themselves and learn how to say no and that they can say no, and learn about how this isn't how you earn peer points and how people will like me. Matching their images on the internet and sexting problems and what is sexting and what if you're both under 17 and you want to type naughty flirty messages let along photographic images. So, there is a lot to be done to help young people make better choices and be safe.

Q: Are there any models or assessment tools that you use that you feel work quite well?

A: We primarily use AIM2 as the framework. I'm mindful of one of the areas I'm trying to influence at the moment is to do with experience. Our service of the SHBS we advocate for a comprehensive holistic assessment. That assessment includes adequate background information, reports of proper referral information, useful specific information, clinical interviews with and adult relative to the young person, clinical reviews with the young person, a battery of psychometric questionnaires for parent and the young person and then the information is put into the AIM2 framework. So, the AIM2 framework is a tool for a wider comprehensive assessment.

What I am seeing though is throughout the country in these services is that they say, 'oh we are doing an AIM2 assessment' and they almost call it an AIM2 assessment as a report heading. And I'm like no, you must own your clinical judgement. Because it is a tool it is not the end all be all. But it certainly is a good

tool and a robust tool in the opinion of Fern's 5 committee. AIM2 is one of the sanctioned assessment frameworks. There are others that I am not a fan of and have strong negative views on, but the vast majority of what's out there is a good option. But TULSA and Fern's 5 are in the view, that the AIM2 because it is holistic, because it is also strength based, as its coming from a 'how can we build up the resilience and barriers to protect' we like that, are not focusing on all the negative risky behaviours that maybe going on.

And that is one of the things we do like about it.

Q: Have you received any feedback from the young people within your services that they would like to cover?

A: They wouldn't even be thinking about that, all they would be thinking about it why I'm here and I will never do it again. And why must I come here and why am I here so long. So that is not where their thinking is at. We have never asked them the questions about what would have made it easier, or maybe to engage. What we do have is or related to that, is when young people are finished our service they participate in what we refer to as a 'graduation ceremony'. That doesn't mean they are 'cured' it means we are marking the closure of their discharge phase and they have to tie together all the issues that are relevant to them and they present it to the boys group, the parents group, and the clinical team in a large session. And newer boys are petrified of this, and they think oh down the road they will never be able to do that. They know it's coming, there is no escaping it and they do that in

accordance with their own skills and abilities. So, you have everything from pictures drawn to a power point for 45 mins. So, its varied and we let them do it at their abilities. But what they say to us at those times. Is when I get an admission. So, in their graduation dates what a lot of them are saying things such as 'I didn't think I needed to be here, but I can't believe how much I've changed and grown since I was here'. Some of them, a smaller percentage will say 'thank god I was here, because if I wasn't I'd still be doing it'. You get the 'this was the only place I could talk about this stuff' because this is a shameful taboo subject for anyone to talk about and for a teenager, their job is not wanting to talk to their parent's kind of sort of, our job is trying to get to open up the can and get them to talk. But the teenagers try to be independent and who wants to talk about the sexy things with their mommy and daddy. So, they need a place to talk and they certainly find the value. The front end, what the kids say when they do give and admission, is, I'll always ask them 'well what made you decide to tell me that today?' because they've probably already been by a social worker or their mother or father or grandparent and a guard possibly. And they've held this denial denial I didn't do it. And when they give us the admission I'll ask them that and their answer is always in the ball park of 'I knew you could handle it'. So, what I often say in training for people who are out there on the front line beginning to do this work or having a rare case if it comes up, I say 'fake it till you make it'. If you want an admission, they have to think you can handle it. Even if you are sweating, even if you are nervous, you have to be able to say these works about William's bum and Mary's vaginas and boobies and breasts. Call them any simple or clinical name but you have to be able to talk about this. And you have to be able to go there, you have to be able to flip

things to help them to be ok with making an admission. There are a lot of us in the field when dealing with a juvenile in that situation, they are through the roof anxious they are petrified they are worried they may not be able to emigrate to America, they can't become a guard, that they will be kicked out. My mom knows 10% when she finds out 100% she will turf me out I will be homeless. They are so petrified, petrified of it being in the newspapers or it getting out. So, there can be real ramifications around this, so we have to be reassuring that yam this is bad, but it is not the end of the world. We can help you so you can get your life back. But to do that there is a lot of hard work here. There is harm, you know, you've harmed people we can't forget that but we can help you with this. I will often say things to them about especially only when there is a level of admission, but I'll make them aware of two things, 1st do you think that you are the only person to have gotten into this kind of trouble? A lot of them do, a lot of them think that they are an absolute freak. And when they find out they are not alone, they think wow are you serious? You are so not alone, we had to set up a whole national service for you guys, so they like that because teenagers hate to be different. So, you are making them feel that you are not alone. This is bad, but you are not alone. And we got you. And the thing we tell them when they have admitted it how brave they are. Because this is something that is so difficult to own and the fact that you have done that, you are actually helping the victim. Harm is being done, we can't go back, but it's an after the fact way of trying to make up for it a little bit. So, I think it takes a lot of guts to do that. So now you have totally flipped a teenager's head because they thought they were coming into be judged and punished and possibly sent to prison and in fact you say I got you, you're not the only one it takes guts to admit to

what you have done. We will help you and your family get through this. And if you can say things like that and fake it till you make it, the rest will follow. But if they are looking at you like 'you don't know what to do either' they think why should I tell you. And those things help kids enter these services.

Q: What type of services do you provide to the parents?

A: We require the parents to take part or we won't work with them, we have to have parent or carer participation and it is absolutely crucial. If you think about it from a teenager's perspective for a lot of them, for when this comes out their parents go through a rejection phase. I've had moms say I couldn't touch their laundry afterwards. We have had parents who have no had sex since the discovery of the abuse because their own sex life is thinking about what their own son had done. So, there is a huge impact upon parents. For the kids, if we can't get to their parents to make a progress, then they go through the rest of their lives with this canyon between them and their parents and how do you believe I can get my life back on track if you think I haven't made up for this in some way. I've paid the price so my parents will love me again. You have some parents who cannot believe anything as they think my son cannot do the worst of the worst. But that's for us to be addressing as well. So parental involvement is crucial we know from the research that those young people that have had parental involvement in their treatment plan do better. And do better faster. Because they see, my mom brings me here every Wednesday my mom is in my reviews/ she checks in on me when I have had a

tough group session. So, we help them repair the parent/child relationship. The other things going forward is, if the young person needs the support around sexually abusing again who's in their wheel house to help them with this. When they leave us, it's their family so we need their parents to be prepared for if their son comes to them and says they have 'oh ooo' thoughts that's a big bridge for a young person to go and seek help. But it's their families that is their first tier of support so we need the parents to know that this is what they come to you with, that it's not a failure, that it's a success. That they are coming to you saying I need help, and saying 'ok breathe breathe' and I got your back. So, we have to have the parents involved as they have to go through their own journey, they go through their stages of grief, so it's absolutely crucial. In the treatment sense, all we do it balance the parallel work say when the young people are working on victim empathy we don't do that with the parents as the teenagers find it very emotional and we don't want the parents in a dark place when the group is finished. So, when the boys come out of the group, they are able to be emotionally receptive to their sons. But parents will do that while the boys are doing social skills, so you try to balance it.

Q: What benefit would it be to have a service within the Southern Region?

A: It's so important to be able to do this work, while it is specialist it doesn't take specialists to do it. And the SIATT programme and the NIATT programme those were also people, who were coming to work on Wednesday from various

populations. So, you had people coming from social work, residentials, Oberstown they came from all over and pulled together so they were released from their day job to come and give x amount of hours per week to do this. And what the Cork area in particular needs for that to happen is for the sanctioning of the releasing of the staff from their teams. To come out of their existing teams to do this work how many hours a week they are being released. That is the barrier, that is the fundamental piece that if you don't have a team you are back down to one or two people taking care of Cork. That is the most fundamental piece for how you get an initiative actually going is the formalised release and the inter-agency agreement of the framework that provides for the clinical governance and safety and efficacy of the work. Obviously, we are trying for these kids not to do it again and we don't want to make them worse, so it has to be done safely and effectively.

Appendix 8

Interview #4

Q: Can you tell me about yourself and your roles and responsibilities within your profession?

A: I came to where I am after I did a degree in social science and masters in social work within UCC. And the I was launched into Ballyfermot in 1997 to work with children and families in children protection. 5 years working with mostly children in care, then I spent another 6 years as duty team leader and further 6 years on a children and care team and then I went into social work in CPC's and then I came here. Early on, Rhonda had done a presentation and at that time they had a hope and spoke model to get more people to do this, it caught my attention and wet my appetite. So, I pursued this, got agreement from my manager to be released an afternoon a week to do it. That continued for 17 years, essentially, I was being someone who was released to do this work. And at the time this programme was working with boys who had sexually harmed. So then when the post for An Tusla

came up for principal social worker I applied for it and got it. So that's how I got here.

I continued with this programme.

Q: How would you define the term 'HSB'

A: In a nutshell, a harmful sexual behaviour that hurts someone else. Now there is no easy way to define it. We've had a number of young people who have assaulted adults, you have contact and non-contact, we've had young people who had exhibitionist behaviour which can be as harmful, and there is a distinction I think between inappropriate and harmful because I think young people who have sexually inappropriate behaviour would not have a sexually harmful behaviour. There is a range of inappropriate behaviour, but there is a threshold for harmful behaviour.

Q: How would these young people be referred to you?

A: Almost exclusively through social work departments. Occasionally through CAMHS the younger ones but it usually is that way, but it is normally set up that way too.

Q: Do you feel the responses within Ireland currently is sufficient in dealing with these issues?

A: No, there is a vision certainly, but we are no way near bringing that vision to life I suppose at the heart of it, that young people who present with HSB, wherever they are in Ireland will be able to access a service locally, that is age appropriate and is appropriate to their needs. And they are not able to do that yet. No, it is not anywhere near developed enough yet, there's a vision, its slow, progressing.

Q: Is there any common underlying issue that you see amongst these children, socioeconomic etc?

A: It's any kid any family and social setting. It has a range that said we also would say young people don't end with us if everything is going alright, so there can be a range of development issues and needs, or a range of family issues, mental health, addiction, family relationships. We've had a significant number of young people who have experienced bullying and quite significant bullying for whatever reason. There are again, people who have the same characteristics who don't sexually harm but I mean typically you're looking at poorer than average with communicating, regulating emotions, perspective taking, all that. Looking at, the same issues in families where they sexually harm and their parents ask well why didn't they get a car and drive it around the place. Hard to know really. There is a consolation of factors you see, but you see these in families where there would be a different behaviour. They are not predictive factors. But invariably there are issues we work on. Gail Ryan, suggests that parents are causal and that parents have contributed

and hindered growth of empathy or contributed somehow or at the very least, if they change they can really help the young person's treatment.

Q: Do you believe that the rise in internet use and smart phones etc has exasperated these behaviours?

A: Interestingly, recently I was involved in a presentation about young people and the internet who sexually harm at the St Claire's conference. And it was fascinating. The answer really ends up with who knows, however, there is evidence to show that the vast majority of young people have access to pornography and the vast people are also not sexually harming. So essentially, what is its role amongst young people and what we are coming down to is, is it that accessing porn causes the interest. Or the accessing of the porn is expressing that behaviour. It's very hard to distinguish. I remember reading sure it doesn't really matter what the child is watching, its more around how they are watching it. It's about how a young person understands it as opposed to another young person watching it. So obviously there would be concern if they were skipping school and staying home and watching porn all day. What came out of the research was quite interesting was the role of parents. It was if you have no other source of information other than porn it can be problematic so they were making a point that parents should talk to the young people. Not saying don't watch that you shouldn't be watching that but to provide

an alternative narrative around sex and sexuality relationships as opposed to porn. And for those young people who don't have that narrative they can prove to be more problematic. That aspect of it. The other issue is, does watching porn, if the young person is sexually harming, does the young person, does it escalate the young person's SHB ore quickly, and then, does it tilt, impact on risk assessment. Cu normally if you're seeing a more harmful behaviour you may see more of a risk. But if you are factoring in more pornography what does that do. We are doing a dating and sexuality module at the moment. It was really interesting to see that if you are watching a lot of porn you have that normalising effect you need something more stimulating to be aroused. Its taking more stimulus to be aroused. This wasn't the impact we were looking at but actually, reading about it, it makes sense. So, it has a sense of what does porn really do to young people psychosexual development generally who knows. There is also concern about younger children accessing porn, and there is evidence of younger children accessing porn and the negative impacts of that. But for the teens, it seems, most teens have and do access porn.

Q: For those young people you see, do they understand what they have done?

A: it depends, some young people know immediately, most don't in fairness, some are immediately aware that they crossed the line and the harm it has caused. Some young people are aware that they are in trouble, they are keenly aware that they are in trouble. They are scared their friends will find out, they are feeling bad about it. It's really egocentric. We do apology letters here where the young people write

apology letters to their parents and to the person they've harmed and to their parents. And it's really interesting when they start their drafts of letters because when you go how do you think that has impacted upon your parents, almost universally you get, because of the inconvenience this has caused them to come here,

1 day a week for a group treatment programme. That is the impact that they see.

Now we talk about this to the parents and its funny that this is the extent of the impact this has had. So, they have to understand how people feel as they need to be telling them. And often parents try to conceal cuz they don't want to burden the kid, they want to protect them, they are worried that if they don't get it, or if they do get it that they will feel so bad and harm themselves. They have all of these anxieties. I suppose a lot of parents are trying to conceal their own personal reaction with different degrees of success. And depending on the relation the young person has with their parents often times where there is resent or anger or any issues with attachment it's like any young person not being able to apologise to the parent. He won't initially in relation to the children they have harmed, they are usually not able to give a good account of how that impacted them. It's not always children it can be adults. Sometimes they literally don't know they've never had exposure, they've never had meetings to try find out and to educate themselves about this. Sometimes parents don't have good understating of it. They have extreme negatively about it.

We had a parent who made a comparable about this how it is like 'ethnic cleansing'. If that's the level the parents feel their son's behaviour is at then there is no relationship into the future. If they saw their behaviour as comparable that was

problematic. And then you might have other parents who might go, oh well this was only once or it was curiosity. And sometimes that's a way of coping. We had a mother at one time, and we went over and over the assessment with her and it was like each time was the first time for her hearing it. They are in crisis, and she turned it into what she could cope with. She was able to cope with the accurate information at that stage. And then you have parents thinking that children who sexually harmed, are damaged goods. Then you have parents who see that their son won't be ok. They see it as they got help they are ok. We had someone come in from Victim service one evening to the parents and they said that not every child will be ok. And the parents were devastated because they had so much invested in them being ok. Again, it's understandable. And it's partly to do with our approach, as we put a tilt on it. As we say that they are young people and they are not adults, they have the capacity to grow and change and they made a mistake, this is a behaviour all that sort of stuff. Sometimes parents can develop and idea where someone its less harmful because it was a teenager and not an adult. I go into parents group and say it doesn't make it less harmful whether it's a 16-year-old or a 26-year-old. So, they don't have a great understanding that they've harmed, but they are not alone in that sometimes and it is part of what we do in victim empathy module and what they learn. They find the victim empathy module the hardest, nearly always.

Q: Prevention is better than cure, do you feel there should be more responsibilities upon schools to provide training and development?

A: Interestingly again, I was looking recently at research around this. That the school can give you the facts, but it cannot give you the values and what your wanting young people to apply to their sexual behaviours and to their values. You get a lot of your values from home actually. It was a sex education DVD, I'm sure it's called 'You can talk to me' it was produced by the HSE and it was really interesting. I was watching it with a parent and it was really interesting to watch these young people talk about what they wanted their parents to talk to them. Some had their school talking to the, some had a mixture. It was really interesting as they wanted Mom and Dad to be talking to them about stuff. As well as the school. So, no matter how good or fantastic the bit in school was, it was not enough. We have had parents come into the groups saying if I had only known about this possibility and known about this potential I would be doing a different type of sex ed with my kid. I wouldn't be doing the protection of strangers come to me if someone touches you kind of education. I would have done a more 'if you feel like' yano. This is not ok and if you were troubled by something or worried that you were thinking about that you come to me. And they were like that they would really have liked that included in sex ed. and it's not. Of course, the other problem is, that's its distinctly Irish one it's like we have evolved in a mature way so we will have 'the talk' but of course it's not a talk it's an ongoing discussion from early on. The parents torture themselves and say that they oh I have to have the talk, and here teenagers are

saying they wanted more. Parents thought this is a once in a lifetime thing, and once the conversation finished it was like as if the offer expired and there was no going back to it at all. It was quite interesting seeing that. What fascinates me still, it that this is still the case. We can have ideas that this has evolved and changed but now it's still very much, that people are struggling. Within this context they arrive to us, so we can't talk about normal healthy sexual behaviour and here we are now having to talk about HSB. We do dating sex ed with boys, we also have a blue box with the family planning association. And we have everything in it, contraception's, devices, and anything you can think of, but it's hilarious as I've worked with this a few times with my colleagues and they were horrified saying 'I can't believe you are doing sex ed with parents and teaching them like a granny to suck eggs etc', but they love it. They literally pay attention to everything and are like 'what is that?' 'I've never seen it before' the female condom gives rise to conversation every time we have someone saying, 'oh I know how that works' and it was interesting as she wasn't Irish she was a woman from a new community. And in fact, there are cultural differences around our preferences of contraception as well but it was really interesting seeing the moms and dads absolutely soaking this information up and then feeling more confident. Part of the problem is they think that sure the kids are getting nothing anyway and the info is online or sure they are getting it in school sure what can they possibly learn from me. There's some notion that you should be an expert as a parent around it. Well first you have to say well no none of us are experts, we read the leaflet and we do all of this. But I also think how it is approached, it's all about the parents conveying those values and consent respect communication how you know what's ok what's not ok. All those kind of things,

how you chat up someone, how you know if you fancy someone but not about the level of expertise about STI's or contraception.

Q: Would you see much re offenders?

A: No, would not have people come back through us anyways. But we haven't heard or seen many to date actually we also have a particular profile of a young person, as we are looking at essentially young people who have not have families to support them, who have voluntarily looked-for help, who want to make amends with their families, who will do what's expected of them. They are motivated for treatment and engaged. The ones that we don't see are the ones that are denying or the ones whose family don't take it seriously. I think in way if we can make progress in profiles about these young people it would be interesting.

Q: Are there any frameworks that you feel are very effective in dealing with these issues?

A: We are very fond of the AIM2 because its holistic and it looks at all the different domains in the young person's life. So, we like that, and it also has predictive tools for teenagers, there are some that are developed at all research levels. We do use this in our general assessments.

Q: Would you say we need to keep looking at these frameworks and renewing them as normalised sexual behaviour keeps evolving?

A: We use a traffic light framework too. I was given a rather ambitious task with foster carers in my previous role around sexualised behaviour in children and young people. The first issue was 'well children and young people engage in normal sexualised behaviour what's the problem?' of course a lot of sexualised behaviour is normal. This is not universally accepted. The first point is that oh no children don't sexually engage in these behaviours. we have done training and adapted that where we go we ask them to stand up and move around depending on whether they agree or disagree with a statement such as 'its normal for a child in preschool to masturbate?' so everyone goes into disagree and if you said its normal for these children to touch their genital area and they all move to agree, so the real problem here is the word that's used. But this happens all the time, when we are talking about sex and sexuality, we are talking about values. So, then we are looking at frameworks that look at what's normal/what you should pay attention to/what needs professional help for all the behaviours for all of the age ranges. So, we were looking at Tony

Kavanagh Johnson for the younger age groups and the traffic light framework. There's another one for the 11-13's, but finally, there are a number of frameworks and they are accessible on the internet that you can easily use. The having people think about how they really make these distinctions, as it comes out repeatedly, it is

not the behaviour that causes the concern, there's no use in ringing me telling me this child did x, its utterly meaningless. It doesn't convey any level of concern for how people should be but we still have a tendency to look at how severe the sexual act is the more concerned we get, that's not how you do it. Families can push it and it has nothing to do with the behaviour really. What other think of converse is when other people keep talking about 'risk' and risk assessments. People tend to decide if they have sexual behaviour is more serious. And you're going, well that's not how you determine concern about young people, and neither do you decide concern upon the person they have harmed which it's what we are inclined to do. Maybe the child is upset by this and the experience is awful then they are high risk. They are a whole range of other things. I guess what you see is that, it's not that people don't have any way of judging this we do judge. And if you don't base your judgement on any evidence or research or framework or thinking about it, or you are not testing your ideas with people, then I guess you are doing what you think is right and what you think is concerning and that comes with all behaviour sexual behaviour and HSB. And people say yes, I have accepted this, this is normal for teens to engage in all of these behaviours, just not my teenager. So, once you have teenage kids its very interesting. And also, the different standards you apply for children in care. So, its ok for some children to do it, just not children in care to do it. And if children in care do it then we must notify the guards.

Q: What benefits would it bring to the Southern Region to have a service dedicated to these behaviours?

A: Every region should have this. I do believe cork and Kerry should have it, but I feel everywhere else should have it too. Kids who do need a service like this, should be able to access it. And at the core of it, the point of it is to reduce sexual harm and there is evidence from research that treatment works. So, there's a treatment works reason but there is also absolute devastation for the families. How do they pick up the pieces? And these families should have a service to help them pick up the pieces and help support them and young people should have a service that helps them and their family to reconnect because it destroys families. And those young people who sexually harm are just like every other Irish child, they should be able to achieve succeed participate and get services they need. When they need them. The only response should not be punishment.

Appendix 9

UCC University College Cork, Ireland Coláiste na hOllscoile Corcaigh	**ETHICS APPROVAL FORM** **MA Criminology/MA Sociology**

Introduction

UCC postgraduate research students who are seeking ethical approval should complete this form. Ethical review is required where the methodology proposes to involve:

- direct interaction with human participants for the purpose of data collection using research methods such as questionnaires, interviews, observations, focus groups etc.;
- indirect observation with human participants for example using observation, web surveys etc.;
- access to, or utilisation of, anonymised datasets;

- access to, or utilisation of, data concerning identifiable individuals.

Please add additional relevant notes to convey what you think is pertinent about the ethical aspects of your study.

Application Checklist

This checklist includes all of the items that are required for an application to be deemed complete.

Completed SREC Application Form	Yes / No
Information Sheet(s) / Information Statement - this is what is to be presented to participants	Yes / No
Consent Sheet(s) / Consent	Yes / No
Data Collection Instrument: Psychometric Instruments / Interview Guide / Focus Group Schedule / Survey Questionnaire / etc. included	Yes / No N/A
Copy of permission letters to undertake research from relevant agencies/services included (if available)	Yes / No N/A

APPLICANT(S) DETAILS

Name of UCC applicant(s)	Emily O Callaghan	**Date**	28/04/2017
Department / School / Research Institute / Centre / Unit / College	Sociology/ University College Cork	**Contact No.**	0838366187
Correspondence Address	Adjoining Campus, Askive, Sociology Department, University College Cork, O' Donovan's Road Cork	**Email Address**	107577371@umail.ucc.ie

Name and year of course (students only)	MA Criminology	**Name of supervisor(s)** (students only)	Dr. Katharina Swirak
Is this a resubmission?	Yes / No		

Project working title	The investigation for the need for services to assist young people presenting sexually harmful behaviours.

ETHICAL APPROVAL SELF-EVALUATION

If your answer falls into any of the shaded boxes below, please address each point later on in the application form

		YES	NO
1	Do you consider that this project has significant ethical implications?		X
2	Will you describe the main research procedures to participants in advance, so that they are informed about what to expect?	X	
3	Will participation be voluntary?	X	

4	Will you obtain informed consent in writing from participants?	x	
5	Will you tell participants that they may withdraw from the research at any time and for any reason, and (where relevant) omit questionnaire items / questions to which they do not wish to respond?	x	
6	Will data be treated with full confidentiality / anonymity (as appropriate)?	x	
7	Will data be securely held for a minimum period of ten years after the completion of a research project, in line with the University's *Code of Research Conduct* (2016)?	x	
8	If results are published, will anonymity be maintained and participants not identified? (see Q. 30 below regarding open data considerations, if relevant)	x	
9	Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?	x	
10	Will your project involve deliberately misleading participants in any way?		X
11	Will your participants include children / young persons (under 18 years of age)?		X
12	If yes to question 11, is your research informed by the UCC *Child Protection Policy*? http://www.ucc.ie/en/ocla/policy/		
13	Will your project require you to carry out "relevant work" as defined in the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016?[i]		X
14	Do you require official Garda Vetting through UCC before collecting data from children or vulnerable adults?[ii]		X
15	Will your participants include people with learning or communication difficulties?		X
16	Will your participants include patients / service users / clients?		X
17	Will your participants include people in custody?		X
18	Will your participants include people engaged in illegal activities (e.g. drug taking, illegal Internet behaviour, crime, etc.)?		X
19a	Is there a realistic risk of participants experiencing either physical or psychological distress?		X
19b	Is there a realistic risk of the researcher experiencing either physical or psychological distress?		X
20	If yes to question 19a, has a proposed procedure for linking the participants to an appropriate support, including the name of a contact person, been given? (see Q. 33)	n/a	
21	If yes to question 19b, has a proposed procedure/support structure been identified?	n/a	
22	Are your research participants students with whom you have some current/previous connection (module coordinator, research supervisor, professional tutor, etc.)?		X

23	Will your study participants receive payment / gifts / voucher / etc. for participating in this study?		X

DESCRIPTION OF THE PROJECT

*Ethical review requires that you **reflect** and seek to **anticipate** ethical issues that may arise, rather than reproduce copious text from existing research proposals into these boxes.*

*Entries should be **concise** and relevant to the point / question.*

24. Very brief description of your study (15-25 words max.)
[i.e. This is a qualitative study of primary school teachers' attitudes towards religious teaching using focus groups to collect original data]

This study provides a foundation of research for the setting up of a service to address the needs of young people exhibiting harmful sexual behaviour.

25. What is your study about? (100-200 words max.)

The context of this study is based around investigating the need to provide a service to young people/children who present sexually harmful behaviours. This study will aim to highlight the need for such services that are currently lacking/non-existent within the Cork and surrounding areas. This study will research the success and failures of other countries who utilise similar services in addressing these issues. In addition, research will be done into how these behaviours may arise e.g. social media. The understanding of the origin can help in understanding these behaviours and finding the correct treatment to deal with such issues. From this research review, the need for similar services will be highlighted and set the foundation for the set-up of these services within the Cork and surrounding areas. Furthermore, interviews with professionals will provide additional strength to this argument.

26. What are your research questions?[iii]

5. Is there a need to provide a service for these children who display sexually harmful behaviour within the Cork area?
6. Have similar services nationally and internationally exhibited success in treating children with similar behaviour?
7. What therapies/services would be beneficial to these youths?

27. Brief description and justification of methods and measures to be used (attach questionnaire / interview protocol / discussion guide / etc. for **full** SREC approval. **Not** required for SREC outline approval)

Qualitative data will be used within this study. The methods used to obtain this information and data will be through an interviewing process of professionals. These professionals will be asked questions in relation to their work and knowledge surrounding the research topic. Approximately 6-8 professionals will be contacted via email to request their participation. On arrival, the participants will be provided with an information sheet. They will be asked to read this and once they have read it, they will be asked to sign the consent from if they agree to participate. A recording device will be used within the interview and transcripts will be written up after all interviews are complete. Each participant will be interviewed individually and on separate occasions. Each interview will take an hour maximum to complete. Once the interview is complete, each participant will be debriefed and thanked. In addition, a literature review will be completed for this study. Appropriate literature that will aid in the progression of the study, will be researched, and utilised to provide evidence and a solid foundation to this research.

28. Participants (recruitment methods, number, age, gender, exclusion/inclusion criteria, detail permissions to be sought / secured already)

Participants for this research will consist of professionals within the Social Care Sector E.g. Psychologists, Social Care Workers. There will be approximately 6-8 participants consisting of both males and females and of the ages 18-64 years. They will be recruited via direct email to them or to their organisations and information will be provided surrounding the research and the value of their participation. Once they have agreed to the interview process, an interview date will be set that will accommodate both the interviewer and the interviewee. They will be interviewed individually. Their consent will be sought prior to interviewing to ensure full informed consent surrounding their participation.

29. Concise statement of *anticipated* ethical issues raised by your project. How do you intend to deal with them? Please address *all* items where your answers fell into a shaded box in the self-evaluation above. (350 words max.)

The anticipated ethical issues raised within this project would be minimal. One such issue would be the interviewing of the professionals. This issue would be dealt with by informing the participants in full about the research and the reason for their participation. In addition, consent would be sought from these participants to ensure full informed participation within these interviews. They will be informed that they can leave the interview at any time. Respect for the rights and dignity of the participants will be of the utmost importance.

30. Data:

(a) What type of data will you be storing?

(b) How and where will you store your data?[iv] (provide details for both physical *and* electronic documents).[v]

(c) For how long will you store the data? (A minimum storage period of 10 years is required)

(d) Who will have access to the dataset? (*Sample* prompts: If you plan to make your raw research dataset available publicly as part of the open data movement, please address your protocol here. For collaborative/community-based participatory research, please address issues such as shared ownership of data, publication of findings, etc. If your funder contractually requires you to give them access to the 'raw' dataset, examine relevant implications, including appropriate anonymisation, protocols for secure access to the dataset, etc.).

(e) If you are planning to analyse an existing dataset, please outline how the original consent process allows for your analysis.

a) The data that will be stored will be text files and transcripts. All audio recordings that will be collected will be destroyed once interviews are transcribed verbatim.

b) They will be stored securely within a locked cabinet located in the Askive Building within the Sociology Department in UCC.

c) The datasets will be stored securely for a minimum of ten years.

d) The research supervisor Dr. Katharina Swirak, Dr. Orla Lynch and an external examiner, will have access to the dataset. In addition to this, members of the Action for Learning Group within Cork will also have access to this data, due to their involvement within the study. All participation will be kept anonymous and information will be kept confidential. e) I am not planning to analyse an existing dataset.

36. Declarations

31. Arrangements for informing participants about the nature of the study (cf. Question 3)

Participants will be informed of their participation prior to their interview. An information sheet will be provided to them and once they have read this, they will sign a consent form to ensure full consent and knowledge from each participant. An information sheet will be obtained from the UCC Social ethics website, edited to fit the framework of this study, and provided to each participant. Relevant information sheet will be attached.

32. How you will obtain Informed Consent? (cf. Question 4 - attach relevant form(s))

A consent form will be obtained from the UCC social ethical website, it will be edited to fit the framework of this study. On meeting the participants, and once information sheets have been read, they will be asked to sign a consent form to ensure fully informed participation. They will be informed that their participation is voluntary and that they can leave at any time. Communication will be the centre of the interview at all times, to ensure complete comfort and respect. Relevant form will be attached.

33. Outline of debriefing process (cf. Question 9). If you answered YES to Questions 19a or 19b, give details here. State what you will advise participants to do if they should experience problems (e.g. who to contact for help).

Once the interviews are complete, participants will be thanked and informed of when the data they provided within the interviews will be written up and available to read. They will also be informed that they have two weeks after the interview has been complete to ask for their data to be destroyed. This is to allow for afterthought of the participants.

34. Estimated start date and duration of project

Start date will be April 2017 and the end date will be 1st September 2017.

35. Additional information of relevance to your application

Text here

I/we agree that should there be unexpected ethical issues arising during the course of this study, that I/we will utilise my/our professional/disciplinary code of ethics, and/or notify UCC SREC, where appropriate	Yes / No
I/we have consulted the UCC *Code of Research Conduct* (2016) and believe my/our proposal is in line with its requirements	Yes / No
I/we have consulted the UCC *Child Protection Policy* and believe my/our proposal is in line with its requirements	Yes / No / NA

37. Signatures	
UCC Applicant(s)	**Academic Supervisor / Tutor / Principal Investigator** (where applicable)
Emily O' Callaghan	
Date: 28/04/2017	Date:

Website links and helpful resources

UCC *Child Protection Policy*	https://www.ucc.ie/en/media/support/ocla/policies/UCCChildProtectionPolicyFINAL.pdf
UCC *Code of Research Conduct*	https://www.ucc.ie/en/media/research/researchatucc/documents/UCCCodeofResearchConduct.pdf
Garda Vetting of UCC Staff	https://www.ucc.ie/en/hr/gardavetting/
UCC Student Vetting Policy	https://www.ucc.ie/en/media/studyatucc/undergrads/downloadabledocumentssection/StudentVettingPolicyandProcedure.pdf
IT Support for UCC Researchers	http://www.ucc.ie/en/it/services/research/
EU Commission, Responsible Research and Innovation & H2020 **RRI Tools Website**	https://ec.europa.eu/programmes/horizon2020/en/h2020-section/responsible-research-innovation http://www.rri-tools.eu /

Irish Qualitative Data Archive (IQDA)	https://www.maynoothuniversity.ie/social-sciences-institute/research/iqda
Irish Social Science Data Archive (quantitative datasets)	http://www.ucd.ie/issda/

Electronic data storage

UCC NAS **(Network-Attached Storage)**	http://www.ucc.ie/en/it/services/networkfilestorenas/
UCC Device Encryption Service	http://www.ucc.ie/en/it/services/encryptionlaptop/
UCC Staff IT Services	http://www.ucc.ie/en/it/services/staff/
HEAnet FileSender	http://www.heanet.ie/services/hosting/filesender

Appendix 10



Brook Traffic Light Tool for Sexual Behavoiurs
(https://www.brook.org.uk/brook_tools/traffic/Brook_Traffic_Light_Tool.pdf)

Appendix 11

Continuum of Indicators of Strength

	High Strengths **A**		Medium Strengths **B**		Low Strengths (High Need) **C**
1	Young person has the ability to reflect and understand consequences of offence behaviour	1	Young person has at least one parent/carer who supports and is able to supervise	1	Young person appears not to care what happens
2	Young person is willing to engage in treatment to address abusive behaviour	2	Young person demonstrates remorse for offence (even if not accepting responsibility	2	Young person has poor communication skills
3	Young person has positive plans/goals	3	Parents/carers are healthy and there is no other family trauma or crisis	3	Young person has no support/is rejected by parents/carers
4	Young person has positive talents and interests	4	Parents demonstrate responsible attitudes and skills in family management	4	Young person has been excluded from school/unemployed
5	Young person has good problem solving and negotiation skill	5	Parents/carers have no history of own abuse or abusive experiences are resolved	5	Isolated family
6	Young person has at least one emotional confidant	6	Family has positive social network	6	Absence of support/structured living environment
7	Young person has positive relationships with school or employers	7	Community is neutral towards young person/family	7	Parents/carers unable to supervise
8	Young person has experienced consistent positive care	8		8	Family is enmeshed in unhealthy social network
9	Parents demonstrate good protective attitudes and behaviour	9		9	Family has high levels of stress
10	Family has clear, positive boundaries in place	10		10	History of unresolved significant family abuse
11	Family demonstrate good communication	11		11	Family refuses to engage with professionals
12	Family demonstrate ability to positively process emotional issue	12		12	Domestic abuse in family
13	Family is positive about receiving help	13		13	Community is hostile to young person/family

14	Young person lives in supportive environment	14		14	
15	Network of support and supervision available to young person	15		15	