Practice Paper

Child sexual abuse

Introduction

The consideration and assessment of child sexual abuse requires the application of a clear practice framework with particular knowledge of the dynamics of child sexual abuse, key features that heighten risk, barriers that may impact upon gathering information and appropriate case planning.

Departmental officers require an understanding regarding the subtle and potentially devastating emotional impact sexual abuse may have upon a child.

Understanding the dynamics and the key features of child sexual abuse can assist departmental officers to apply a risk analysis framework, assess safety and develop case plans with more confidence.

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Definition of child sexual abuse

Child sexual abuse occurs when a male or female adult, or a more powerful child or adolescent (including a sibling), uses power to involve a child in sexual activity. Sexual abuse can be physical, verbal or emotional. The resulting harm can be physical, emotional or psychological.

Secrecy, misuse of power and the distortion of adult-child relationships are key factors in the sexual abuse of children. Sexual abuse can include:

- kissing or holding a child in a sexual manner;
- flashing or exposing a sexual body part to a child;
- spying on children in bathrooms or bedrooms;
- speaking to children about graphic sexual matters;
- obscene phone calls, remarks or e-mails to a child;
- fondling of a child's body in a sexual manner;
- persistent intrusion of a child's privacy;
- penetration of the vagina or anus - digital, penile or other object;
- rape;
- oral sex;
- showing pornographic films, magazines, photographs or internet websites to a child;
- having a child pose or perform in a sexual manner;
- forcing a child to watch a sexual act;
- child prostitution; and
- use of the Internet to lure children for sexual purposes.

Overview of child sexual abuse

Key principles

It is important that departmental officers have a sound knowledge base in relation to child sexual abuse. Given the subtle and often hidden nature of child sexual abuse, the following key principles should be considered when assessing and providing intervention in relation to child sexual abuse matters:

- every child has a right to safety and protection;

- children are unlikely to make false disclosures and more often will under report or deny an incident of child sexual abuse. Children and young people have been observed to deny sexual abuse even where physical evidence is available to confirm abuse has occurred;
- physical indicators are not conclusive and their absence does not negate the accuracy or reliability of the disclosure;
- child sexual abuse impacts upon emotional development and may distort normal sexual development in children. When development is interrupted children may experience difficulty in deciphering normal sexual development from a sexual abuse experience;
- child sexual abuse is often hidden and generally embedded in secrecy. The relationship is perpetuated by a power imbalance and may include coercive behaviour or threats to harm the child, parent, family or others (including pets);
- most child sexual abuse is perpetrated by someone known to the child and family, including parents, defacto partners, siblings, immediate extended family and friends;
- a child is never responsible for the incident; and
- child sexual abuse often occurs within the context of neglect or a lack of parent/carer supervision.

Normal sexual development

Departmental officers should possess knowledge in relation to child development and child sexual development. A broad knowledge regarding milestones and developmental phases can help to determine whether information received constitutes a child protection or safety matter. Knowledge of sexual development, its impact and presentation may also assist departmental officers to plan and ensure appropriate service provision.

Below is a guide to 'normal sexual development'. The list is not exhaustive and should only provide prompts regarding behavioural milestones.

Ages 0 - 5
- children at this age have intense curiosity about nearly everything, including their bodies;
- sexual self-stimulation, or masturbation, normally begins during infancy and continues throughout development as both a self-soothing and an exciting behaviour;
- by pre-school age, children usually know masturbation occurs in private;
- in addition to their own bodies, children at this age are also curious about others' bodies. Their curiosity may lead them to try to look or touch others' genitalia. This is exploratory looking and touching is typically accompanied by giggling and amusement rather than behaviour of a coercive nature;
- when clear limits are set, children take redirection easily;
- before the age of three, children have not developed a sense of permanency about their bodies, so boys may be worried that they may lose their penis when they observe girls don't have one, and girls may worry because they don't have one; and
- preschoolers are not usually concerned with modesty and may enjoy being naked.

Ages 6 - 10
- children this age begin to seek information about sex and look for books and diagrams that explain their own organs and functions;
- curiosity about sexuality at this age takes the form of playing games such as 'I'll show you mine if you show me yours';
- masturbation continues in private;

- boys at this age become interested in sex words and dirty jokes/toilet humour;
- they may hear about sexual matters from their friends and repeat the words they hear even if they don't understand the meaning of the words/actions;
- limited interest in others may be evident in 6 - 10 year olds;
- interest in children's own and others' bodies continues during this time, particularly if changes in their bodies begin to occur;
- feelings of needing privacy emerge at this age; and
- sex play may include kissing games, teasing and pretending to be married.

Ages 11 - 12 (preadolescence)
- masturbation continues during pubescence;
- preadolescents are focused on establishing relationships with peers;
- some preadolescents engage in sexual activity with peers, including kissing and fondling; and
- preadolescents may imitate sexual behaviours that they have seen or heard about.

Adolescence
- masturbation continues throughout adolescence;
- adolescents discuss sex and sexuality with their peers and begin to recognise themselves as sexual beings;
- most adolescents tend to engage in serial monogamy;
- changes in mood;
- adolescents become increasingly independent of their parents, preferring to develop and maintain peer and romantic relationships;
- some adolescents engage in varying degrees of sexual activity with peers of a similar age;
- sexual behaviour is not risky or resulting in sexual misuse, and is not associated with behaviours such as drinking, smoking, and anti-social behaviour (Daniel, Wassel & Gilligan, 1999);
- sexual interests are not deviant; and
- adolescents will often be aroused by various stimuli.

Incidence of child sexual abuse

Research figures on the incidence of child sexual abuse have varied, with reasons for this variance attributed to actual changes in incidence, the definitions of abuse, the methodology of the research, and the population being evaluated (for example, clinical versus non-clinical). In the 1990s, American studies found that one in five girls, and one in ten boys may be sexually abused in childhood (Finklehor, 1994). National incidence figures for Australia were not available at that time.

In more recent research, the incidence figures for the United States have indicated that child sexual abuse has declined over the past decade (Jones & Finkelhor, 2003). A recent Australian survey of 1,784 adults (Dunne, Purdie, Cook, Boyle, & Najman, 2003) found that up to one in every 25 males (4%) reported unwanted, attempted or completed penetration (oral and/or anal) and one in every six (16%) experienced non-penetrative sexual encounters. One in eight females (12%) reported unwanted, attempted or completed penetrative acts and one in three (33%) non-penetrative acts. The incidence of non-penetrative acts was shown to have declined only for males over the past decade.

Critics of this research, however, indicated that the study did not include those who were institutionalised or lived disadvantaged or non-mainstream lives (Stanley & Kovacs, 2004). Furthermore, they highlighted that the wording of the questions in the survey for example, unwanted [act] ... may have led to a lower rate of reported exposure to sexual acts in those under the age of consent, than questions which asked generally if they had experienced the acts named in the research. Given the link between sexual abuse and later difficulties, it is likely that the estimates are lower than that which may otherwise be found. They do however, highlight that large numbers of the adult population report experiencing abuse as a young person.

In 90 per cent of child sexual abuse cases, the perpetrator is known to the child (Finkelhor, 1994).

Sexual abuse of children with a disability is higher than the rate of children with no disability. In a large epidemiological study (Sullivan & Knutson, 2000), children with a disability were 3.14 times more likely to experience sexual abuse than those without a disability. Although research shows that children are more likely to be abused by a perpetrator (irrespective of age or gender) within their immediate or extended family or close social group, this study found, however, that children with a disability were more likely to be sexually abused by an extra-familial perpetrator (59%). Such findings highlight the need for scrutiny of extended family or social networks in cases where sexual abuse of children or young people with a disability is suspected.

The Department of Child Safety statistics for 2002-03 indicate that out of 12,203 cases with a substantiated outcome, 610 (5.0%) were in relation to child sexual abuse. Of these 610 cases, 89 per cent of the children subjected to sexual abuse were aged 14 years and under. Statistics for 2003-04 indicate that out of 12,741 cases with a substantiated outcome, 825 (6.5%) were in relation to child sexual abuse. Of these, 90.3 per cent of the children subjected to substantiated sexual abuse were aged 14 years and under.

It is important to note that the Crime and Misconduct Commission (2004) Inquiry and associated reviews or audits have subsequently identified that departmental statistics, like convictions through the criminal justice system, grossly under-represent the incidence of child sexual abuse. As such, it is essential that departmental officers seek support in such cases through their team leaders, senior practitioners and the department's Sexual Abuse Counselling Service (SACS) to access resources, develop and maintain skills in conducting assessments in child sexual abuse cases, in order to increase the strength of their assessments and to provide greater opportunity to identify or support young people to disclose sexual abuse.

Indicators of child sexual abuse

The indicators of child sexual abuse are most commonly observed in sexualised behaviour or trauma symptoms. Indicators may be subtle and are often attributed to other concerns or problems that the child may be experiencing, particularly in families where other forms of abuse are present. These indicators may be present without an actual disclosure or specific allegation of sexual abuse, including:

- sexual activity is unexpected for the child's developmental level;
- the children involved have unequal power physically, emotionally or intellectually, or have different roles (for example, one child is babysitting the other). Additionally, unexpected or unusual sexual knowledge by one child may pose a power difference to another;
- use of force, coercion or intimidation;
- a pattern of events, circumstances or behaviours appear focused on keeping secrets; and
- behaviour appears compulsive or obsessive, and is not easily redirected and may interrupt normal developmental tasks and functions.

More specifically, indicators can be grouped into physical and behavioural indicators, including:

Physical indicators:

- bruising, bleeding, swelling, tears or cuts on genitals or anus;
- an unusual vaginal odour or discharge;
- torn, stained, or bloody clothing, especially underwear;
- pain or itching in genital area, difficulty going to the bathroom, walking or sitting;
- sexually transmitted disease, especially in a preadolescent child; and
- pregnancy.

Behavioural indicators - sexual:

- masturbates a) publicly b) excessively in private c) causing self-injury;
- promiscuity;
- sexual pre-maturity;
- sexual behaviour that is unexpected/developmentally inappropriate;
- stealing sexual items including, underwear, tampons, pads;
- suicide attempt or fire lighting incident at location where sexual abuse is alleged to have taken place;
- placing objects in genitals; and
- children may engage in any of these behaviours by themselves, with other children/adolescents or adults, or in groups.

Emotional indicators -sudden changes such as:

- anxiety;
- arousal (easily startled, overly fearful or overly watchful);
- change in mood;
- depression;
- emotionless;
- fear of particular situations, persons or things;
- hopelessness/helplessness;
- hyper-activity;
- intense fear;
- lack of concentration;
- lethargy, listless;
- memory problems;
- nightmares, difficulty sleeping, fear of the dark; and
- smearing of faeces or blood in alleged location of sexual abuse.

Behavioural indicators - general:

- aggressiveness;
- avoidance of people or places;
- bed-wetting;
- detachment;
- drug/alcohol or inhalant use;

- vagueness;
- eating problems – difficulty swallowing, loss of or increase in eating;
- oppositional and defiant;
- physical pain (for example, body aches, frequent tummy aches, genital discomfort);
- re-experiences vivid flashbacks, dreams;
- school refusal;
- school-work problems;
- self defeating statements;
- self harm behaviour;
- sleeping problems;
- social problems;
- isolating;
- withdrawing;
- conflict with peers;
- stealing;
- suicidal ideation;
- running away from residence;
- tantrum behaviour;
- truancy; and
- toilet training problems.

The presence of any of these indicators should not be considered in isolation. There may a number of explanations, aside from child sexual abuse, to account for some behavioural presentations. Departmental officers should consider other possible explanations, such as developmental delay and disability, other abuse types and cultural considerations, and should also attempt to gather as much 'pre-abuse' functioning information in order to accurately consider the presenting behaviour.

Pre-abuse functioning may include consideration of the following:
- temperament;
- attachment;
- cognitive development;
- emotional development;
- mental health history;
- psychological development; and
- psycho-social development.

Aside from general indicators, it is important that departmental officers possess additional conceptual knowledge in relation to the following:
- grooming;
- coercion;
- attachment; and
- post traumatic stress disorder.

Knowledge regarding these concepts is important as they have strong links to indicators of child sexual abuse, and they highlight the additional subtleties of child sexual abuse.

Grooming

Grooming considers the process by which perpetrators engage with children/youth and adults in order to enable offending to occur. The grooming processes used vary among perpetrators and may depend on the relationship a perpetrator has with a family, the victim or the parents, the perpetrator's age and how well the family is functioning.

For extra-familial (outside of the family) perpetrators, the grooming process is usually subtle with a relationship developed over a period of time prior to offending. Some extra-familial perpetrators may be keenly rehearsed and have well-developed engagement skills, resulting in the child and family developing 'trust'. It is not unusual for these individuals (usually adults and usually, but not always, male) to be described as 'likeable' and 'good with children'.

The relationship developed with children and families promotes a sense of friendship and kindness and often involves activities that are shared and 'fun'. Some extra-familial perpetrators target children who appear more vulnerable, for example, those who are lonely, lack parent/carer support or supervision, are unassertive or who have difficulties that make them more vulnerable (sometimes due to parent/carer neglect, disability, or other forms of abuse). Others may seek to join a family by establishing a relationship with a single mother in order to gain access to a child to abuse. Some others may use sporting, church, or leisure activities to gain access and establish relationships with children who they may abuse.

Intra-familial perpetrators include those who offend against a biological relative or those who have been involved in the family for some time before they began to offend, and did not join the family specifically for the purpose of offending. The pattern of engagement (grooming) process that occurs where a family member offends is usually different in nature than that which is observed by individuals outside of the family. In families, opportunities to offend come with having direct access to children and relationships where touch and displays of affection are usually appropriate. As such, this type of grooming can be difficult to identify and separate from non-abusive affection until the behaviour/s themselves become more intrusive and clear.

Grooming is a subtle process and given the entwined role of secrecy and coercion that may at times occur without detection or suspicion. It is important that departmental officers gather as much information as possible and look for clues in relation to the nature of the relationship between the alleged perpetrator and child. It is important that the length of time between the development of the relationship with the non-offending parent, and allegations concerning the time when the offending commenced be considered in cases where the perpetrator is not a biological parent but is involved in a caretaking role.

Grooming may include the following (Van Dam, 2001):
- taking the child to places that are unlikely to be supervised – parks, beach, secluded areas or a place of business, or taking long drives alone in the car, usually making opportunities to exclude other members of the family, including the non-offending parent;
- an alleged perpetrator specifically and deliberately choosing hobbies or interests that appeal to and interest children. The selection appears unusual given the relationship or type of activity chosen. The departmental officer may identify incongruous behaviour or consider the type of activity to be inappropriate;
- an alleged perpetrator showing a keen interest in what a child looks like. The perpetrator may also give enticements or rewards such as money or gifts. Clothing and jewellery may also be given as 'gifts' with a special request to wear the outfit, for example, when next they meet. It is also useful to explore the presence of attitudes which indicate that they see the child as mature for their age, physically, mentally and emotionally;

- an alleged perpetrator becoming the child's 'confidante';
- an alleged perpetrator not disciplining the child they are abusing – the young person may be seen as a parent/carer 'favourite';
- an alleged perpetrator working to win the trust of the child and those who have responsibility for the child's care, education and well being, for example, by being extremely helpful or charming;
- an alleged perpetrator encouraging the non-offending parent to go out to work, or to participate in social activities or hobbies outside of the home to provide opportunities to offend;
- an alleged perpetrator targeting families where non-offending parents have reduced capacity to monitor at home, for example, substance use issues, mental or physical health issues or otherwise stressful lives;
- an alleged perpetrator telling the child that their relationship is special and should be kept secret;
- an alleged perpetrator restricting a child's social opportunities and support so they become emotionally dependent on perpetrator;
- a perpetrator using desensitisation to touch as a means to build up to offending – seemingly innocent behaviours which result in the reduction of discomfort in the child and possibly the parent, who attributes this as an appropriately developing affection, for example, tickling, wrestling and piggybacks;
- a perpetrator using desensitisation to language, for example, telling a child they look 'sexy' rather than 'pretty' or encouraging sexual conversations;
- a perpetrator desensitising other family members by encouraging values which erode normal sexual boundaries, for example, by encouraging nudity and lack of privacy in the home or use of pornography;
- where youth or other children are involved as perpetrators, making efforts to spend more time in the interpersonal space of the child or young person than is usual; and
- a sibling or other young person taking over parenting or caregiving roles in order to gain access to a young person, either from inside or outside of the family.

The internet has been increasingly used in the grooming of children to sexual abuse them. This may include perpetrators making contact with children they do not know via the internet. Additionally, children may be exposed to pornographic images downloaded by perpetrators in their home as a means of desensitising them to or normalising child/adult sexual contact. Additionally, a parent may offer a child to perpetrators by sending images/descriptions over the internet.

Coercion

Coercive behaviour results when patterns of controlling behaviours result in social isolation, silencing, increased fear and anxiety, low self esteem, increased distress or numbing to emotional or physical harm. Examples include physical and emotional trickery, bribery, threats of harm or loss of power or safety. Coercion involves a power imbalance between the perpetrator and the child. Power imbalances may relate to age, intellectual ability, knowledge, experience and gender. Children are taught to respect and obey adults, and that adults are wiser and have authority over them. Coercion can also be more forceful, involving intimidation by the perpetrator's physical size and strength or use of physical force.

Examples of coercive behaviour include:
- withholding the child's normal rights, for example, denying them contact with friends or removal of pocket money or treats if they don't comply;

- setting the child up so the other parent sees the child as deceitful or unreliable to undermine the child's credibility if the child discloses the abuse;
- making the child feel directly responsible for the abuse, for example, they were flirting, led the perpetrator on, kept coming around, or making them feel indirectly responsible, for example, 'Your mother won't give me sex';
- encouraging the child in other forbidden activities such as drinking and truanting, so they cannot disclose the sexual abuse without fear of consequences for the other forbidden activity;
- the child may be told that what they do together should be kept a secret or some negative event will occur (for example, messages perpetrators tell their victims that their parent/s may be hurt, their pets may be killed, mum may become very upset, the family will break up, they will get into trouble/be sent away, no-one will believe them or they deserved it);
- there may be direct threats to the child's physical safety if they disclose, for example, that the perpetrator will kill them, beat them up, or implied threats, for example, standing in visual range when a parent asks if anything has occurred;
- there may be threats to the child's emotional safety, for example, the perpetrator won't love them or look after them any more, they won't be special any more or others will blame them; and
- the young person may be expected or feel obligated to participate in sexual abuse activities by virtue of favours provided (the offending parent taking their side over the non-offending parent or receiving special privileges or gifts).

In the build up to and during offending, the perpetrator usually uses a combination of grooming and coercion to enable offending and to maintain secrecy about the behaviour. Irrespective of the nature of perpetrator behaviour to enable them to abuse, the effects on victims, and the non-offending family members can range from subtle (and often undetectable to those involved) to dramatic changes in behaviour. Additionally, the use of grooming or coercion may also influence the manner in which a non-offending parent may act protectively, even after abuse is suspected, disclosed, or discovered.

Attachment

Attachment is the deep and enduring connection established between a child and the parent in the first several years of life. It profoundly influences every component of the human condition – mind, body, emotions, relationships and values. Attachment is not something that parents do to their children, rather, it is something that children and parents create together in an ongoing, reciprocal relationship (Levy & Orlans, 1998:1).

Attachment theory defines children's relationships with their parents as a biologically based bond, an instinctual connection. Ainsworth (1985) originally framed attachment as evidence in patterns of behaviour. Crittenden (1995) expanded this perception by viewing attachment behaviour as reflecting the utilisation of an information processing style where the evaluation and integration of relational data can occur in either an accurate or a biased manner.

At least four broad categories of children's attachment behaviour have been identified. These include secure, insecure-coercive, insecure-defended and insecure-disorganised (Friedrich, 2002).

A securely attached child has an internal working model of parents as being consistent, supportive in times of stress, attuned to their needs, reciprocal to the children and committed to the relationship (Friedrich, 2002).

A child with an insecure attachment has experienced caregiving which is unpredictable, not available or not appropriate to the situation. This may be linked to inconsistent parenting practices, parenting which is not responsive to the physical, psychological or emotional needs of the child, or reduced commitment to parenting (Friedrich, 2002). Beeghly and Cicchetti (1994) found that maltreated children are significantly more likely to be insecurely attached than securely attached.

Children with a defended attachment learn that interactions with parents are consistently aversive. Coercive or resistantly attached children often originate from families where the care giving is characterised by intrusiveness and inconsistency. According to Main (1995) children with a disorganised attachment do not demonstrate a coherent attachment strategy and their behaviour is often described as contradictory and incomplete. Interactions with the parents are quite inconsistent and unintegrated, often the result of multi-generational maltreatment (Main, 1995).

The central features of attachment include a secure base, commitment and being in tune, and reciprocity, with the child (Friedrich, 2002).

Alexander (1992) identified three aspects of insecure attachment that was evident in families of sexually abused children – rejection, role reversal, and the multi-generational transmission of unresolved trauma. These attachment difficulties can be used as a guide for interviewing the parents of molested children and adolescents. Inquiries should be made about aspects of the child that the parent/s dislike/hate or whether the parent relies on the child for emotional or relational/sexual gratification. Knowledge about the parents' own abuse history and whether they have taken steps to resolve it contribute to the prognosis.

Research indicates that the quality of the parent-child relationship, more than any other variable, defines a sexually abused child's ability to change and rebound from victimization (Friedrich, 2002). Shapiro and Levendosky (1999) found that attachment mitigates the effects of sexual abuse and subsequent psychological distress. Therefore, understanding the child's attachment style, and quality of the child's attachment to the parent/s can provide an understanding of the child's symptoms and allow case workers to cater treatment recommendations to the child's needs. It must be stressed, however, that until a child is in a safe environment (for example, not exposed to the risk of further sexual victimization) they are less likely to recover from their experiences of abuse. Departmental officers must ensure that children are not exposed to further risk, via the removal of the perpetrator in the first instance, where required, and the removal of the child if a parent is unwilling to consider the ongoing risk, or supports the perpetrator.

Post traumatic stress disorder

Children may experience several distressing reactions including anxiety, fear and depression following major emotional and physical upheavals such as childhood sexual abuse. As a result of the abuse, they may suffer from Post Traumatic Stress Disorder (PTSD), which may persist over long periods of time. These children may present with the following:

- repetitive, intrusive thoughts and recollections about the abuse;
- vivid flashbacks;
- sleep disturbances brought about by fear of the dark, nightmares and waking throughout the night;
- separation difficulties;
- anger and irritability;
- difficulty talking to peers and parents;
- difficulties in concentrating, especially at school;
- memory problems in mastering new skills and remembering old skills;

- incessant alertness to possible dangers in the environment;
- a sense of fragility of life (pessimism, loss of faith, feeling that the future is foreshortened);
- changed priorities (for example, not planning ahead);
- fears associated with specific aspects of the abuse;
- avoidance of situations associated with specific aspects of the abuse;
- depression (notably in adolescents);
- suicidal thoughts; and
- panic attacks.

These behaviours may result in children being diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) even though physiologically they are likely to be quite different from other children who arrive at that diagnosis in a non-traumatic pathway (Friedrich, 2002). It is important to recognise the symptomatology of PTSD and keep the association between these and the diagnosis of ADHD in mind when working with children who have been sexually abused.

Profile of a sexual perpetrator

Any person, any age and either gender can perpetrate child sexual abuse. Males are identified primarily in the community as perpetrators, however, there is no exclusion for women or girls. Parents, siblings and other young relatives are equally capable of perpetrating child sexual abuse and should not be discounted or overlooked when assessing for child sexual abuse. Despite attempts to develop typologies of sexual perpetrators, researchers have been unable to develop reliable and valid profiles. This is likely to be because sexual offending relies on an interaction of factors that involve the perpetrator and the circumstances to be suitable for offending and vulnerability in the child/parent/family system to be present.

Careful consideration needs to be given when allegations are made about females as co-perpetrators with their male partners. A decision by a departmental officer that a female may have been coerced into the behaviour should not be made without sufficient information to back up such a finding. When gathering information, it is important to identify if the mother was a participant or observer in any of the abuse incidents, whether the child believes she knew of, or facilitated, specific incidents of abuse, whether she engaged in sexually abusive acts with or without the partner, or if she may have taken a leading role in the offending.

It is important to consider that it is difficult to identify the real recidivism rates because of:
- the nature of the behaviour and the associated fears or victims' lack of understanding about what is happening (see also section on barriers to disclosure);
- the lack of disclosure by victims or those responsible for their protection (usually non-offending parents/carers or other family members);
- the different sex offender populations being studied; and
- difficulties in actually measuring recidivism because of a lack of consensus on how recidivism is recorded, defined, and other methodological considerations.

In a recent study of sexual offenders within the Australian population, recidivism for sexual abuse has been conservatively estimated to range between 2 and 16% (Lievore, 2003). Treatment was considered to have, overall, a small effect on recidivism but it was observed that the treatment for child sexual abuse perpetrators was more effective than for sexual assault perpetrators. The study, which concurs with experts who work within the field of sexual perpetrators, advocates that the assessment of risk of sexual perpetrators is integral to reduce the likelihood of recidivism. In achieving such a reduction, children and families in general will be spared the experience and aftermath of sexual victimisation.

Impact of child sexual abuse

As well as knowledge regarding the indicators of child sexual abuse, it is equally important to possess an understanding of the impact child sexual abuse may have upon a child. When considering departmental intervention it is important to possess knowledge, not only regarding the particular details of an incident, but also knowledge regarding the emotional and psychological impact child sexual abuse may have upon a child and the possible resulting behaviour. This assists departmental officers to tailor ongoing intervention and develop case plans that reflect childrens' safety needs and protective factors. Distinguishing between ongoing safety needs and protective factors ensures ongoing intervention meets both of these domains. Diminishing future risk of sexual abuse only addresses part of the issue. Protective factors may have been resolved (for example, the alleged perpetrator was removed from the home or a child protection order was sought), however, ongoing safety needs may be apparent given the impact of the abuse and resulting 'at risk' behaviour (for example, suicidal, self- injurious behaviour, substance abuse or prostitution). Protective factors need to be seen, however, as assertive behaviours by the non-offending parent. They need to provide clear statements that they believe the child's disclosure, that they are clear that the relationship with the alleged perpetrator will not be continued or favoured with the child's needs sacrificed, even when reunification is a possibility at some point in the future.

It is important to note that not all children who experience sexual abuse are traumatised, and that the impact they experience will relate to their individual resilience and the level of support they experience in their nuclear and extended family, as well as their community. Given that victim studies have identified a high level of under-reporting of sexual abuse, many of those who have experienced sexual abuse will go on to lead rewarding lives. Furthermore, there is no evidence to suggest that those who are adversely affected by sexual abuse will have ongoing problems throughout their life. Some may experience difficulties at different stages of their lives, requiring more support at these times. This highlights the need for careful assessments of children or youth who experience sexual abuse to ensure that, after their safety needs are met as a priority, any planned intervention targets their specific needs.

Some children may be coping well but may fear that something must be wrong given they are being required to participate in sexual abuse treatment. For such children, it may be best to support the protective parent/carer by providing accurate information on normal childhood development, including sexual development, and how they can access more specialised treatment if required. In some cases, it may be the parent/carer who needs counselling more than the child who was abused. Referral to appropriate services to support should be made in such cases.

In cases of Aboriginal and Torres Strait Islander children, the impact on the community may be enormous, particularly depending on the individuals involved or suspected of involvement of sexual abuse. Consideration of the particular impacts in Aboriginal and Torres Strait Islander communities and their needs may assist in reducing the impact they experience.

Impacts of child sexual abuse may include:
- no immediate signs of distress or impact, but may present with signs of distress a year or many years later when a trigger event occurs;
- difficulties such as emotional stress, new anxiety, low self worth or behavioural problems;
- feelings of depression, sexualised behaviour, self loathing, aggressiveness and confused thoughts;
- signs that look similar to post traumatic stress disorder such as isolated flashbacks, repetitive play or bedtime problems such as nightmares, sudden changes in wanting to sleep with a parent or carer, or becoming afraid of the dark;

- difficulties in developing trust, intimacy, sexuality and self-determination in adolescence/ adult life;
- difficulty in forming appropriate social and personal relationships – this may be subtle and difficult to detect and includes establishment of boundaries, tolerance of inappropriate or harmful behaviour as they have had no other role models;
- over-achievement 'perfection' or over compliance;
- eating disorders;
- self injurious behaviour;
- suicidal ideation;
- substance abuse;
- poor hygiene, such as difficulty managing menstruation or peculiar behaviour regarding toileting; and
- potential risk for becoming a perpetrator in the future.

It is noteworthy that there is a commonly held belief that many perpetrators of sexual abuse were themselves abused during childhood. The joint Queensland Crime Commission and Police Service (2000) reviewed the literature of the 'sexually abused – sexual abuser hypothesist' (p. 59). They highlighted that studies on convicted sexual perpetrators established sexual abuse histories in a range from 18% to 73%). Difficulties in establishing the true impact of sexual abuse include:

- the benefits some perpetrators may perceive in reporting being sexually abused as a child;
- the fact that sexual abuse is recognised as a vastly under-reported crime and the true extent of the progression from victim to perpetrator cannot be established;
- sexual abuse has differing impacts on victims, with males demonstrating a greater likelihood of becoming perpetrators of sexual abuse; and
- sexual offending has not been established as a consistent behaviour over time. Some individuals may engage in sexualised behaviour as a result of their own abuse, others may begin to offend as juveniles, with others commencing as adults. Individuals in each of these groups may commence or cease inappropriate sexual behaviour or sexual offences without developing a lifelong pattern of offending (Burton, 2000).

Gathering information

In the process of gathering information, the Child Protection System may provide information on agencies or other departments to follow up for information. It is helpful if these are followed up at the earliest possible point. In addition to the Queensland Police Service (QPS), the Department of Corrective Services (DCS) may be able to provide information where there has been a conviction/s in relation to previous sexual abuse by an alleged perpetrator. Information may be obtained through the Director of Child Safety in the Department of Corrective Services or through approaching individual centres/offices directly.

DCS consists of Custodial Corrections and Community Corrections and for the main part they maintain separate records. Relevant information which may assist in the protection of children includes:

- the status of an alleged or known perpetrator and their progress through the system;
- records of incidents/breaches of discipline which may relate to sexual abuse specific risk (for example, their sexual behaviour during incarceration); and
- records of any sexual offence specific program commenced or completed and the Sentence Management Review, if applicable.

For perpetrators who commence a sex offender program, Progress and Exit Reports are likely to be available and these usually detail the relevant risk factors, compliance with the program rules and progress toward meeting the relevant program goals. Some sex offender program Exit Reports also include an assessment of risk which may be helpful in the investigation and assessment. Perpetrators who complete a sex offender program will have completed a Relapse Prevention Plan which, at a minimum, will detail some information about their offending, risk factors, identified coping strategies and social supports.

At times, some alleged sexual offence cases do not proceed through the criminal courts because mental health issues are identified and the alleged perpetrator is found not responsible for the alleged behaviour. In such cases, Queensland Health may be approached for details of any assessments which were undertaken and supplied to the Mental Health Court. It will be up to the discretion of the Queensland Health Chief Executive as to whether they release this information or not. In such cases, such approaches may be facilitated through the Director of Child Safety in Queensland Health.

Additionally, in Family Court proceedings relating to contact and residence, an assessment of an alleged perpetrator or the family may have been conducted. This may provide an additional source of information for the departmental officer.

Where appropriate, the school can be approached for information on any disclosures, sexualised behaviours or other concerns that relate to the notification. In cases involving Aboriginal and Torres Strait Islander children, approaching elders, justice and community groups would be appropriate starting points in obtaining or planning to obtain information on those who may be able to assist.

Investigating child sexual abuse

When conducting the investigation and assessment, there are four assessment areas that are important to cover. The variables which, at a minimum, should be covered, include the following.

Historical or developmental factors:

Family of origin:

- the parent's own experience of instability during childhood;
- the parent's own experience of being parented; and
- exposure to family maltreatment or violence during childhood.

Socialisation experiences outside of the home:

- exposure to non-family violence during childhood.

Social competence:

- educational and academic functioning;
- vocational/occupational functioning;
- interpersonal and relational competence: and
- observable impulsivity in the lifestyle led, including patterns of irresponsibility.

Functioning as a parent:

- attachment histories with their partners and their children/step-children;
- communication and style of interaction within the family;
- disciplinary techniques used – flexibility, appropriateness and contingent to behaviour; and
- the level of supervision and protection of the children within the home. Consider this both before and after allegations have been made.

History of violent behaviour:
- current family violence; and
- history of family violence.

Characteristics of prior violence and maltreatment that enhance risk:
- age at which abuse began;
- number of prior episodes;
- the length of time over which offending is known, or alleged to have occurred;
- frequency and escalation;
- number of victims;
- type of violent behaviours;
- criminal versatility or the range of different types of offending engaged in;
- threatened or actual use of a weapon;
- threats of injury or death;
- severity and physical injury;
- victim gender – although some studies have found a relationship between offending against male victims, studies looking at the association between victim gender and risk are have found mixed results;
- precipitating behaviours and motivations;
- consequences and interventions – responses to date and attitude displayed; and
- biological variables.

Dispositional or personal factors:
- cognitive functioning;
- level of intellectual functioning;
- other cognitive or neurological challenges:
  - problem solving;
  - abstract reasoning and cognitive flexibility;
  - perceptual accuracy;
  - the tendency to make attribute negative motivations for behaviour or perceptions about themselves, others in general and their children in particular;
  - attitudes and beliefs;
  - parent/carer expectations of child behaviour;
  - emotional functioning; and
  - sexual functioning.

Personality functioning:
- attachment style;
- apathy;
- domineering, controlling interpersonal style;
- emotional immaturity;
- empathy;
- external locus of control;
- impulsivity;

- passive-dependency;
- pervasive anger and hostility;
- self-concept and self-esteem;
- personality disorders;
- psychopathy; and
- perceived stress.

Coping responses and internal resources:
- coping skills;
- ability to perceive and access social supports; and
- motivation and readiness for change.

Clinical or symptom factors:
Note: a departmental officer will not make diagnoses on the presence or absence of individual symptoms associated with mental illness, but will consult with relevant health/medical professionals.
- specific symptoms;
- psychotic illness;
- parent/carer psychosis with delusions involving the child;
- command hallucinations or delusions that focus on the child;
- threatening mannerism, posturing;
- grandiosity;
- suspiciousness;
- agitation;
- personality disorders;
- suicidal ideation or behaviours;
- more general patterns of violent thoughts or behaviours;
- parent/carer emotional problems and instability;
- feelings of despair and anguish;
- generalised anger;
- anger and hostility toward others;
- marital anger; and
- substance abuse.

Contextual or situational variables:
Victim factors:
- age;
- gender;
- physical, temperamental, and developmental factors; and
- victim behaviour: for example, sexualised behaviour, difficulties within school or social environments, trouble with authorities/breaking the law, cruelty to animals.

Social and economic factors:
- economic poverty;
- family structure;

- home environment;
- residential stability;
- the cohesiveness of the neighbourhood in which the child lives, for example, good neighbourhood relations which may act as supports for children or non-offending parent/ carer;
- child-parent dyad and interactive factors;
- current family functioning and patterns; and
- social supports.

(Righthand, Kerr, & Drach, 2003)

Although non-offending mothers/parents may take appropriate actions to remove a perpetrator from the home, careful assessment of the reasons for this and the likelihood that this might be sustained should be undertaken. For example, although a mother may remove a perpetrator, they may still accept financial assistance, allow contact with the victim, or act as an intermediary accepting gifts or passing on other messages from a perpetrator. If the child displays fear of the perpetrator, or general fears associated with revictimisation or distortions that view adult-child sexual interactions as acceptable contact, no matter what form, these may continue to affect the child's functioning.

Departmental officers should also consider the role of the non-offending parent or partner. Are there identified 'failure to protect' issues, either now or in the past? It is not uncommon for a number of unsubstantiated findings for neglect to be the precursor to a disclosure or the discovery of sexual abuse. When gathering information it is important to elicit as much history as possible and to consider patterns, relationships and any prior disclosures or events identified by the family. Other information that reveals family patterns and attitudes is a critical clue and may provide useful information regarding the families functioning. For example, identifying a family rule such as 'anything that happens at home stays at home' may unlock other family secrets or views that have not been elicited through other questioning or observation. Given the dynamics of child sexual abuse and the difficulty often found in obtaining disclosures and admissions by perpetrators or non-offending parents, it is critical to look for other points of leverage to establish patterns, behaviour and attitudes that may cultivate or suggest secrecy, isolation and emotional dependence.

Adults and adolescents are uniquely different in their developmental needs, understanding of sexual health and sexual development. Understanding sexual health history and sexual learning, as well as family sexual environment is part of assessing risk and safety factors.

Not all adults who develop new friendships and relationships with children and families are motivated by deviance. However, research suggests that people known to the child and family perpetrate the majority of child sexual abuse and can include parents, siblings, extended family, immediate friends and adults in social roles of authority (for example, youth group leaders or teachers).

Sometimes a perpetrator may seek to offend against children they gain access to through their own intimate relationships. It can be difficult to ascertain how a perpetrator should be classified, for example, did they develop the relationship with the mother to gain access to offend against the children in the future or did they offend after difficulties within their relationships, or their own vulnerability?

It is also important to understand that children who disclose may, once the investigation and assessment has commenced, retract their allegations. This may be as a result of the upheaval created since the investigation and assessment commenced, pressure at observing how others

have been affected, fear that others will (or have) blamed them, an ongoing concern for the alleged perpetrator which may be due to their relationship (familial) or their experience of grooming by the perpetrator. These, and other factors, cannot be underestimated in their influence on children (Rickerby, Valeri, Gleason, & Roesler, 2003). This may however, be a subtle process and difficult to both detect and intervene. Careful consideration of how supportive the non-perpetrating parent/ carer is of the child, is of paramount importance in reducing the likelihood that children may recant.

Working with children

When working with children it is important to have a good grounding in child development. A solid understanding of the issues that are important developmental markers during childhood will assist in preparing for the investigation and assessment and in identifying discrepancies. As such, departmental officers should have a solid understanding of issues such as attachment, normal and abnormal sexual behaviour in childhood and adolescence, the various ways in which victims may present after (or when at risk for) sexual abuse, how disability may affect the presentation of the child or young person, language development, the factors which influence disclosure and the cultural background in which the child is currently living or has previously been raised.

Adolescents affected by sexual abuse may present with a number of challenges. Although they may be more likely to make a disclosure, trusting adults may be highly challenging for them. A willingness to disclose to stop abuse should not be confused with an adolescent's capacity to cope with the challenges that they face, particularly where the non-offending parent does not completely support them or attribute blame to the perpetrator. Family relationships may be so disrupted that emotional and behavioural problems may be more apparent. Coping with the normal sexual developmental issues of this stage in their lives may also provide challenges for the adolescent who has been sexually abused, the parent, other family members and the departmental officer.

The investigation and assessment of sexual abuse can also present great challenges for departmental officers, as in many cases there is little physical evidence to corroborate suspicions or allegations. Additionally, exposure to the effects of sexual abuse can also be difficult to manage, particularly over the long-term. It is important for departmental officers to utilise support from their peers, professional supervisors and other individuals or agencies as appropriate. This may include using the Employee Assistance Program (EAP) available to departmental officers. The contact number is 1300 667 791 (at the date of publication of this paper). Human Resources Branch can be contacted for further information on this service.

Effective supervision, as well as participation in professional development activities, can boost confidence, provide an opportunity to increase skills and reduce the sense of isolation that comes with child protection work.

Siblings who abuse

There has been growing recognition of siblings as child sexual abuse perpetrators, by both the child protection and criminal justice systems. It is important to realise that consideration needs to be given to siblings who may legally be charged (meet the criteria with respect to age) as well as those who are younger. Irrespective of the type of intervention which is undertaken in relation to sibling abuse, the risk and protective factors which are involved in child sexual abuse matters need to be addressed. This is especially important as some research has identified that abuse by siblings may be associated with greater frequency, over longer periods, greater access to victims, younger victims, more intrusive (such as penetrative) acts and a higher incidence of non-sexual behavioural problems (see Cyr, M, Wright, J., McDuff, P. & Perron, A, 2002; Rayment & Nesbitt, 2003). Additionally, although there is little literature on the effects of abuse by children, there are suggestions that victims of abuse by children may experience similar difficulties as victims of sexual

abuse by adolescents or adults (Shaw, Lewis, Loeb, Rosado & Rodriguez, 2002). Children who engage in sexual behaviour against other children were more likely to be siblings than adolescents who offend against children (Shaw, et al 2002).

Maternal support has been identified as a strong predictor of coping in victims of sexual abuse. Cyr, et al (2002) found that children or youth abused by either siblings or step-parents were less likely to receive support from their mothers. Additionally, mothers with a history of problems were less able to support their children after discovery or disclosure of sexual abuse. Such problems included difficulties in family relationships during their childhood, their own experience of sexual abuse, substance abuse or mental health problems.

A lack of maternal support was also associated with a longer duration of difficulties in victims of sexual abuse (Paredes, Leifer & Kilbane, 2001). Furthermore, being a victim of sexual abuse by a male sibling was more strongly associated with trauma symptomology, such as dissociation than abuse by step-fathers (Cyr et al, 2002).

Given the importance of maternal support, particularly in cases of intra-familial abuse, it is important to identify risk and protective factors within the family. Particular consideration should be given to the parent/s willingness to place the needs of the victim above that of the perpetrator. It is not uncommon for parents to want to protect the perpetrator from the stigma and consequences associated with intervention by the criminal justice system. Additionally, they experience high levels of shame and may either passively or actively attempt to thwart departmental investigations. At these times the needs of the victim may be sacrificed in order to maintain family unity and in the efforts that go into supporting the perpetrator. In addition to the facts relating to sibling perpetrators, there is often a greater incidence of family discord and higher levels of acceptance of abuse/enmeshment in the relationships between sibling perpetrators and victims. As victims may be expected to voice few concerns about their exposure to abuse, it is imperative that information is collected from multiple sources. Careful assessment of the family's capacity to monitor siblings should also occur. At a minimum, this should be informed by family strengths, previous history of supervision, the level of distortion in relation to the effects of abuse, potential for risk of recidivism, parent/carer support, parent/carer/extended family history of sexual abuse or other forms of maltreatment, parent/carer functioning and attitude toward, and response to, previous counselling.

Departmental officers are reminded that the best interest of the child must come first through all departmental investigations and assessments and interventions.
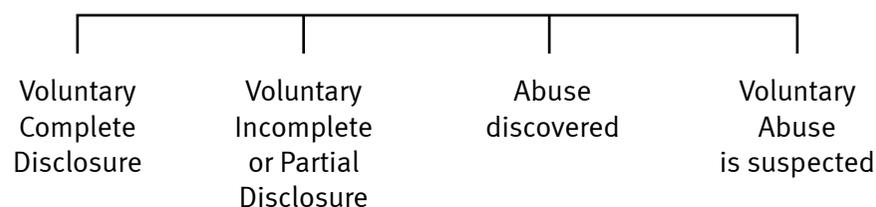
Barriers to disclosure

There are a range of reasons why children and young people do not disclose, even when there is physical evidence or an admission of offending by a perpetrator. An understanding of these barriers will assist departmental officers in their investigations, as they provide a framework within which to collect data to support or refute allegations of abuse during the investigation and assessment process. These include but are not restricted to:

- a victim or other family member feeling fearful, embarrassed, ashamed;
- a lack of skills in language to communicate the abuse;
- a fear of not being believed;
- coercion – afraid of threats made by the perpetrator or a significant other;
- trauma – unable to remember the details of the abuse;
- dissociation during the interview, thereby restricting the departmental officer's capacity to obtain information;
- failure to recognise the activity as abusive;

- cultural considerations;
- not wanting to talk to strangers;
- the gender of interviewer;
- system/community responses – scared about what will happen following the disclosure; and
- lack of maternal support, either explicitly voiced or implied. It is important to note that disclosure is not an all or nothing process.

The following figure illustrates the various ways in which disclosure can occur. Disclosure by children and young people occurs along a continuum and it is not unusual for victims of sexual abuse to be able to clearly relate some incidents in great detail, while others are either not recalled or information is not provided completely, because of the barriers which exist.

The Continuum of Disclosure (Adapted from Lanning, 2002, p.333).

Voluntary Complete Disclosure	Voluntary Incomplete or Partial Disclosure	Abuse discovered	Voluntary Abuse is suspected

At one extreme, disclosure occurs voluntarily by the child or young person. They have told another person of the abuse that they have experienced and are able to relay the details, with varying degrees of complexity and completeness (dependent upon their age and other barriers that may exist). This child or young person can generally be supported to provide detail with little intervention required by the departmental officer or the police. While these children or young people provide a lot of detail, it is still important to conduct the interview in such a manner to ascertain the risk and protective factors which operate, as some of the barriers to disclosure may come into play once others are aware of the allegations.

Voluntary, but incomplete or partial disclosure occurs when the child or young person may be unable or chooses not to reveal the full details of the abuse.

Sometimes abuse comes to light when a perpetrator is observed by another person, through medical examinations due to non-specific complaints of symptoms that are investigated through medical appointments, or when physical evidence such as pictures, videos or blood on underwear are discovered.

Abuse which is suspected, presents the greatest challenge for departmental officers, as the issues which need to be investigated and assessed may be among the most difficult and complex for society to deal with generally, and as such, require sensitive interviews. Investigators must balance the child's reluctance to talk about sexual abuse with the possibility that they were not abused.

Protective behaviours/sexual safety

With the growing emphasis on protecting children from sexual abuse, a variety of interventions have been established to address children and youth, parents, perpetrators, potential perpetrators, and the community in general. Those programs which aim to provide children with information about and or skills to support them to resist advances by potential or actual perpetrators have been collectively termed Protective Behaviour Programs.

A recent survey of sexual abuse prevention programs (Sanderson, 2004) identified core concepts that are generally provided:

- they define sexual abuse;
- they teach children how to resist or refuse overtures; and
- they encourage children to tell their parents or other trusted adults about what happened.

Other concepts that may be taught include:
- children are not to blame for any sexual abuse; and
- perpetrators may be people children know and trust.

Effective child focussed sexual abuse prevention programs were identified to include several characteristics:
- active participation;
- explicit training;
- group training;
- standardised materials;
- were integrated into school curriculum;
- were long rather than short programs;
- included parent/carer involvement; and
- teacher education.

Age, socioeconomic status and self-esteem were also identified as factors that affect a child's capacity to benefit from protective behaviour and other sexual abuse prevention programs.

Although there were benefits observed in teaching children protective behaviours, Sanderson (2004) observed that there were many weaknesses observed such as:
- they may not provide children with appropriate sex education and may be inadvertently teaching children that discussing sexuality is taboo;
- they either fail to deal with abuse by a familiar adult or may overemphasise the risk posed by strangers or acquaintances;
- they may present potential abuse situations as involving either a sudden approach or attack, ignoring the concept of grooming (of children and adults) which is an essential tool used by perpetrators to facilitate abuse, even in cases of stranger attacks;
- they may not explain the appropriate use of adult authority – ie to differentiate appropriate versus inappropriate behaviour by those in positions of authority such as parents, teachers, coaches; and
- not emphasising that sexual abuse also includes non-contact offences such as exposure to pornography, exhibitionism or a sexual act with another person.

Child safety and protective factors

In addition to the identification of risk factors that increase the likelihood of recidivism in perpetrators and revictimisation for victims of sexual abuse, it is important to identify protective factors that mitigate against such risk. Such factors involve:
- the identification of parent/carer strengths as well as their vulnerabilities;
- the child/ren's strengths, their needs and the presence of any special needs (for example, disability or emotional issues);
- the parent-child dyad;
- other family members, including extended family and kinship; and
- members of communities, particularly in Aboriginal and Torres Strait Islander communities.

From the family's perspective, it is important to ensure that interventions that are recommended:
- meet their needs;
- are targeted to identify and address the most basic needs before less crucial needs;
- are timed to support families;
- take into account cognitive functioning of the members;
- recognise and monitor progress and compliance, as participation in many interventions are either involuntary or families feel coerced and participate under duress without incorporating the messages or making the associated behavioural changes;
- do not overwhelm them through the engagement of multiple services simultaneously; and
- address the needs of the entire family, including the perpetrator.

For children who attend school, it is important to ascertain what the school knows and what role they may play in supporting and monitoring relevant child sexual abuse cases. Some schools have strong support structures, provide access to regular school-based counselling and are able to play a strong role in augmenting intervention services that are provided to children. They may also provide programs that strengthen the likelihood that children will use school staff as sources of support or to be open to disclosures of sexual abuse.

Community-level responses may also be providing strong protective influences in the lives of families. For example, church, sporting and justice (or other equivalent community) groups in Aboriginal and Torres Strait Islander communities may oversee the protection of children and monitor the family. Such supports, however, should not be relied upon to overcome barriers to protection that exist in families. Instead, they should be seen to provide a boost to existing family strengths. In identifying protective groups, the longevity of the family's contact with such groups and any characteristics of the group themselves which provides evidence for or against their capacity to support the family in protecting children should be considered.

Child-centred contact

The statutory aim of contact reflects the principles of the *Child Protection Act 1999*, section 5. As such, it is important that departmental officers are aware of the risk and protective factors for each child and the family as a unit. In sexual abuse cases it may be important that these factors are identified before a decision about contact is made and written into the case plan. Although this is not an exhaustive list, the following questions may assist.

For supervised family contact:
- Does the child have a clear understanding of their right to terminate contact if they do not feel safe? Have they had the opportunity to identify the people to whom they may express any concerns they have? Have they been provided with the opportunity to practise how they may seek assistance from these people?
- What behaviours by family members may the make child feel unsafe? Is the department aware of behaviours or terms used by a perpetrator during grooming or offending? Are there behaviours or statements made by the non-offending parent that may be distressing to the child? Are behaviours which may be of concern to the child or which the department may view as inappropriate/damaging documented in a case plan?
- Where will contact take place? How will this contribute to the safety of the child/ren?
- Do all the members of the family have a clear understanding of the safety rules? Is there a specific written plan which details the terms and conditions for safe contact that the child and the parents are aware of? Can the rules for safe contact be displayed or made available during contact?

- Do all the family members know what the consequences are for breaking the rules developed to protect the child? Have the consequences been clearly outlined?
- How will the supervisor for contact know when family members are feeling unsafe during contact? What individual indicators can family members use to alert supervisors during contact? Have signals been developed?
- Have the family members developed a team who can be approached to assist in maintaining child safety or parent/carer support? Do family members know who is on this team? How will they tell these individuals when they are feeling unsafe?
- Do all the family members know in what circumstance contact would be terminated or cancelled?
- Are all family members willing to produce a written list of the rules (incorporating risk factors) for safe contact?
- Do all family members demonstrate a capacity to identify the rules spontaneously, taking into account the child's developmental level?
- If the perpetrator is present, have they acknowledged the alleged offending and the potential for further harm (for example, future offending or difficulties that arise due to the child being exposed to them)?

For unsupervised family contact (in addition to the questions above):
- Has the child demonstrated a capacity to assert their needs above those of the parent in situations in which they feel unsafe? Is there a specific written plan which details the terms and conditions for safe contact that the child and the parents are aware of?
- Has the Department recorded a family contact plan in the case plan which includes safe/unsafe behaviours and topics of conversation?
- Are the family able to identify when contact may be distressing for the child and be prepared to terminate the family contact visit if it is in the child's best interest, and are there appropriate arrangements in place should this need to occur?
- Do the adults understand and agree that there may be a need to restrict contact with the alleged or known perpetrator until it is safe (for example, that the child and the perpetrator are able to interact safely and that the other parent identifies the possibility of risk and is willing to monitor)?
- Are the adults prepared not to speak about the allegations?
- Have they complied with rules about this previously?
- Has a plan for post contact debriefing of the child with their parent, case worker or another appropriate person been established?
- Is the child able to demonstrate the safety strategies that have been developed?

For Aboriginal and Torres Strait Islander children, appropriate elder or community representatives are well placed to support the development of contact and safety plans in cases of sexual abuse. It is imperative, however, to identify where conflicts of interest may occur when developing these plans to ensure that children are not placed at risk during contact.

In some cases, parents may be able to identify factors that will increase safety with support from the departmental officer. In other cases, more long-term intervention is required before it may be safe for any form of contact to occur. In many cases it may be essential that the alleged perpetrator has received offence-specific counselling prior to contact being considered. Prior to consideration of contact and reunification, it may be helpful to consider the reunification criteria established by Cedar Cottage, a centre that specialises in working with families who have experienced sexual abuse. These guidelines provide information which may assist in decision making regarding contact and reunification but should not be prioritised over departmental policies and procedures.

Conclusion

Dealing with sexual abuse and its consequences presents a challenge to the department, due to the nature of the behaviour, the context in which it occurs and the complexity of the issues that need to be addressed.

Departmental officers need to be aware of the developmental needs of children to understand appropriate and inappropriate sexual functioning within and outside of families and how to assess the various parts of the system to reduce the opportunity for information to be missed or misconstrued.

Additionally, the challenge is to identify sufficient strengths within individual, family and other systems, which may serve to protect those affected by sexual abuse from revictimisation or further traumatisation.

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