Children with harmful sexual behaviours

Life is relationships

Terms of Reference

Scope of the inquiry

What institutions and governments should do to:

- **better protect** children
- achieve **best practice** in the reporting of, and responding to reports of child sexual abuse
- address, or alleviate the impact of, past and future child sexual abuse, including, in particular, in ensuring **justice for victims**.

Three Pillars

- Private sessions
- Public Hearings
- Policy and research

During our five-year inquiry:

At 1st December 2017

- **16,953 people** contacted us who were within our Terms of Reference
- we heard from **7,981 survivors** of child sexual abuse in **8,013 private sessions**
- we also received **1,344 written accounts**
- we have referred **2,562 matters to police**.
- private sessions were held in:
  - every capital city
  - 25 regional locations
  - 62* correctional facilities.

Reports

- **Final Report has 17 volumes plus 189 recommendations**
- **Three other final reports:**
    - **Criminal Justice Report**
    - **Working with Children's Checks**
    - **Redress and Civil Litigation**
- **All together 409 recommendations**

Volume 9: Advocacy, support and therapeutic treatment services
9 recommendations
Volume 10: Children with harmful sexual behaviours
7 recommendations

Public hearings

Key facts

- **57** public hearings, spanning 11 locations – in every state in Australia.
- **444** public sittings days, with **1,302** witnesses.
- **3,574** notices to produce resulting in more than **1.2 million** documents.
- **134** institutions examined in case studies.

Policy and research

At a glance

Policy

- **11** issues papers, **621** submissions
- **5** consultation papers, **410** published submissions
- **7** public roundtables, **28** private roundtables
- **44** Commissioner-led community forums
- **9** consultations with young people

Research

- **59*** published research reports

What we heard in private sessions

Survivor as at 1st December 2017

Of the **7,981** survivors of abuse we heard about in private sessions:

- **63.6%** were male
- **14.9%** identified as Aboriginal and/or Torres Strait Islander
- **4.2%** had disability at the time of the abuse
- the average age at the time of their private session was **52 years**
- the average age at the time of first abuse was **10.4 years**.

What we heard in private sessions

Duration of abuse, as at 31st May 2017

In private sessions, 74.3% of survivors talked about the duration of the abuse:

Of these:

- **2.2** years on average
- **14.4 %** of female victims and **8.9 %** of male victims experienced abuse for between **6** and **10** years
- **3.9%** of female victims and **1.0%** of male victims said the abuse went on for more than 10 years.
- Into adulthood and next generation

What we heard in private sessions

Frequency of abuse, as at 31st May 2017

In private sessions, **92.3%** of survivors talked about the frequency of the abuse:

Of these:

- **85.0%** told us they experienced abuse multiple times
- **20.8 %** told us they experienced abuse on one occasion.

What we heard in private sessions

Number of perpetrators

Of all survivors we heard from in private sessions:

- **62.7%** said they were sexually abused by a single perpetrator
- **36.3%** described abuse by multiple perpetrators:
  - of these, **49.9%** said that this abuse occurred within a single institution

We heard about **3,489 institutions** where we were told that child sexual abuse had occurred

From Private sessions

- About 1 in 6 survivors disclosed sexual abuse by other children
- 62% male, 38% female
- 86% were abused by a male child
- duration, severity and impact similar to adult perpetrator
- Contemporary data suggests an increasing problem

Common features of perpetrator roles

From private sessions

Survivors identified features of the institutional roles the perpetrators were in, including:

- **unsupervised**, one-to-one access to child
- **intimate care**, greater level of physical contact
- ability to **influence** or **control** aspects of the child's life e.g. academic grades
- spiritual or **moral authority** over child
- **prestige**, afforded greater **trust**
- opportunities to become **close** with child/family
- **specialist expertise** such as medical
- responsibility for **younger children**

How and why child sexual abuse occurs

Factors that contribute to children's harmful sexual behaviours

Children with harmful sexual behaviours may have difficulty socialising with peers and have poor impulse control. They may have difficulty understanding social norms.

Children with harmful sexual behaviour may have had adverse experiences, including:

- **trauma**, **neglect** and **sexual and physical abuse***
- exposure to **family violence**
- exposure to **pornography** and other sexual activity.

Institutional environments

Key factors that enable child sexual abuse in institutions

- **cultural** – leadership, values, beliefs and norms influence how children's wellbeing and safety is prioritised
- **operational** – governance, internal structure, practices including recruitment and screening of staff and volunteers
- **environmental** – characteristics of physical and online spaces that offer access to adult perpetrators and children with harmful sexual behaviours to access victims.

Institutional cultures: HSB

- encouragement of sexualised behaviours
- physical and emotional abuse and neglect
- bullying and initiation rituals
- hierarchical structures where children held power over other children
- lack of supervision of children
- lack of understanding of children's sexual development and of harmful sexual behaviours
- inadequate provision of sex education to support healthy behaviours

Problematic Institutional responses

- not identifying that harmful sexual behaviours were occurring
- minimising the harmfulness of the sexual behaviours rather than recognising them as serious matters requiring intervention
- inadequate institutional policies and procedures for handling complaints about children engaging in harmful sexual behaviours
- not communicating with affected parties, including parents of the child engaging in the harmful sexual behaviours and the parents of the victim/s
- excluding the victim/s from the institution.

What influences a child's vulnerability to sexual abuse

All children can be at risk in an institution

Research has identified factors that influence a child's vulnerability to sexual abuse include:

- **gender**, **age** and **developmental** stage
- prior experience of **maltreatment**
- **disability**, and the nature of that disability
- **family** characteristics and circumstances
- the **nature of involvement** in institutional settings
- other factors – **physical** characteristics, social **isolation**, level of understanding of sexual behaviour and **personal safety**, sexual orientation, high achievement and **self-esteem, cultural**

Disclosure: what we heard in private sessions

Key facts, as at 31st May 2017

- Survivors told us, it took, on average, **23.9 years to disclose** the sexual abuse they experienced as a child.
- For **10.3%** of survivors, speaking to the Royal Commission was the **first time they had spoken to anyone** about the abuse.
- Meaningful disclosure
- Adults may disclose in any service!
- Child, adult, parent

Disclosure: what we heard in private sessions

- Many disclosures occurred over many years
- Full story unfolded over time
- Often no action resulted
- Delayed reporting, delayed response
- Criminal justice processes took many years
- Redress responses also slow

In general

Factors that prevent, delay or disrupt disclosure

- age and developmental stage: <6 less likely
- disability
- gender
- family dynamics
- Community or cultural expectations
- religious beliefs
- Broader societal beliefs, attitudes, stigma
- racism and discrimination

Who children tell first?

From PS:

- 35.6% told their parents, especially their mother
- 38.3% told someone in authority in the institution in which the abuse occurred
- 19.7% had told police or someone in authority outside the institution

From research

- almost 60 per cent said they would turn to a friend
- 55 per cent said they would turn to their mother
- 34 per cent said they would turn to their father (this was more commonly reported by males)
- Adolescents more likely to tell peers and no-one else

Belief and disbelief

- Attitudes towards children
- False allegations (rare, more likely non-disclosure)
- Lack of understanding about impact and memory
- Myths and misconceptions about children with a disability
- Prioritising adults over children

Supporting disclosure

For children

To support disclosure, children need:

- access to **safe adults**
- **opportunities** to raise and discuss concerns
- **information** about sexual abuse and access to sexual abuse prevention programs
- to learn how to provide **peer support**
- appropriate **tools to communicate** abuse including what to say, how to approach someone, role play

Supporting disclosure

For children (youth consultation)

To support disclosure, children need:

- Long term supportive trusting relationships
- ‘Genuine’ person
- Someone who takes an interest in you and talks to you like a real person
- education for us and our parents including examples for boys
- practical ‘how to’ training

Ways to identify child sexual abuse

Sources other than the victim's disclosure

These include:

- disclosure by **another victim** or the **perpetrator**
- **witnesses** who see the abuse or other evidence
- **physical evidence** such as an injury, a sexually-transmitted infection or ill health
- **other evidence** such as child sexual exploitation material
- Any noticeable change in the child (40% nil)
- **recognising non-verbal or behavioural clues that a child has been sexually abused**
- Suicide attempts and DSH in young children

Ways to identify child sexual abuse

- Despite sometimes very clear disclosure, other potential victims were not identified
- Institutions failed to see the level of risk
- Even families failed to identify other children at risk

Initial reactions to disclosure often prevented other children from disclosing

Other children easily overlooked

Taking ‘no’ as the answer despite evidence to the contrary

Personal barriers

Factors that prevent, delay or disrupt disclosure

Victims and survivors may experience:

- feelings of **shame, embarrassment, guilt and self blame**
- **fear** of not being believed, especially with female perpetrators
- fear of being **stigmatised or viewed differently,** especially being labelled as a potential perpetrator
- uncertainty about what is abusive
- difficulty **communicating** their experience of abuse
- misunderstanding or poor response to disclosure
- sexual identity, masculinity, homophobia, virginity
- consequences for self, family (what parent will do)
- confidentiality
- cultural taboos
- Disclosure could be very dangerous

Personal barriers

Factors that prevent or delay disclosure

These factors can be so strong they prevent disclosure even when

- asked directly about CSA
- applying for redress
- hearing other's stories
- seeing the perpetrator prosecuted
- having therapy

Institutional barriers to disclosure

Governance and leadership that:

- prioritises **reputation**, **prestige** or **loyalty** to the institution above children's safety
- features strong personal **relationships** between **adults** within institutions, or conflicts of interest for individuals in institutions.
- allows **widespread** sexual abuse, physical punishment, violence and retribution.
- codes of silence and secrecy

Common factors across institutions include:

- not following **policies** and **procedures**, or not having any in place
- inadequate **avenues for disclosure** and poor institutional responses to sexual abuse or related behaviours, such as bullying
- inadequate **recordkeeping** and information sharing.
- lack of training addressing abuse within institutions.

Disclosure

- The impacts of disclosure on a victim depend greatly on the response of the person to whom they are disclosing.
- Evidence suggests that dismissive, disbelieving, hostile, non-protective or non-supportive responses from others can increase the risk of negative outcomes.[201]
- Negative responses may in turn deter further disclosure and result in feelings of isolation and distress.[202]
- Poor responses by others to disclosure may further traumatise victims,[203] leading to ‘secondary wounding’.[204]
- Impacts Volume 3, Chapter 2, page 50

The need for change

Barriers to effective service responses

Service system responsiveness is limited by:

- the inconsistent **level of knowledge** about how to recognise and respond to survivors' needs
- ad hoc **availability of expertise** to work with trauma
- inconsistent **practice standards**
- limited **professional development** and staff support opportunities
- **funding** and staff capacity constraints
- complex policy settings and **limited collaboration** within and between service systems.
- Service system is fragmented and difficult to navigate

A responsive service system

Principles for service system reform

A service system that is responsive to victims' and survivors' needs:

- understands how child sexual abuse can **affect** people and shape their support needs
- provides relevant services as part of a **cohesive systems approach**
- **supports staff** to work safely, efficiently and effectively
- ensures services are **trauma-informed**, **collaborative, available**, **accessible**, **acceptable** and **high quality**
- includes **Aboriginal healing approaches**

System Response

- Education and training
- Service environment and culture
- Understand disclosure, bearing of witness
- Trauma informed, competent care
- Safe, collaborative journeys through service systems
- Proactive staff support system

Outcomes: Children with HSB

- Research: low rate of recurrence of the behaviours
- Studies show average recidivism rates for harmful sexual behaviours that reach a criminal threshold range from 3 per cent to 14 per cent.
- This challenges a common assumption that children who commit sexual offences will inevitably become adult sex offenders.
- In addition, we heard of therapeutic interventions that can reduce recidivism.

Primary prevention

- outline the difference between developmentally appropriate and harmful sexual behaviours by children in a non-stigmatising way
- give children clear guidance on what sexual behaviours are acceptable, what peer and adult behaviours are wrong, and where they can seek help if they feel unsafe
- take into account gender, age, cultural context and disability.

Secondary prevention

An institutional response to an incident where a child displays harmful sexual behaviour should include:

- monitoring the wellbeing of all children involved – the victim, the child who caused the harm, and any witnesses or other children who have been impacted
- communicating with the children involved, their parents or carers and relevant agencies, including police and child protection where relevant
- documenting events and sharing relevant information with relevant agencies, where necessary and appropriate.

Tertiary prevention

Best practice principles

- A contextual and systemic approach should be used. For interventions to be effective they should take account of a child's whole environment and include family, neighbourhood and community supports.
- Family and carers should be involved. Practitioners should equip the child's family and carers with techniques and strategies so they can play a continuing role in behaviour management and promoting positive change for the child.
- Safety should be established. An overarching safety plan must be agreed on between services, home and school that provides safe and appropriate ways of managing the child's behaviour.
- There should be accountability and responsibility for the harmful sexual behaviours. Therapeutic interventions should assist the child with the harmful sexual behaviours to acknowledge and take responsibility for their behaviours.

Tertiary prevention

Best practice principles

- There should be a focus on behaviour change. The aim should be to guide the child towards understanding appropriate and safe ways to behave, through education which takes account of the child's entire circumstances, including at home and at school.
- Developmentally and cognitively appropriate interventions should be used. They should be tailored to the child's age and developmental stage and accommodate learning and language difficulties, developmental delays, cognitive impairment and other needs resulting from disability.
- The care provided should be trauma-informed. A trauma-informed approach recognises that many children with harmful sexual behaviours have trauma in their background and therefore have complex needs that require a holistic response.
- Therapeutic services and interventions should be culturally safe. In particular, Aboriginal and Torres Strait Islander children and their families may require culturally tailored approaches. Practitioners should consult with cultural experts to ensure interventions are effective.
- Therapeutic interventions should be accessible to all children with harmful sexual behaviours.
- Evaluation, tracking and outcomes

Service Gaps

- inconsistent treatment options for children under the age of 10
- limited or non-existent services for children in out-of-home care in some jurisdictions
- lack of training for staff to work effectively with children with an intellectual impairment, learning difficulties or emotional or behavioural disorders (including conduct disorders), who are over-represented in therapeutic services
- lack of specialist services in regional and remote communities
- lack of expertise in culturally safe services for Aboriginal and Torres Strait Islander children.

Recommendation 10.1

The Australian Government and state and territory governments should ensure the issue of children's harmful sexual behaviours is included in the **national strategy** to prevent child sexual abuse that we have recommended (see Recommendations 6.1 to 6.3).

Harmful sexual behaviours by children should be addressed through each of the following:

- primary prevention strategies to educate family, community members, carers and professionals (including mandatory reporters) about preventing harmful sexual behaviours
- secondary prevention strategies to ensure early intervention when harmful sexual behaviours are developing
- tertiary intervention strategies to address harmful sexual behaviours.

Recommendations 10.2-4

Recommendation 10.2

The Australian Government and state and territory governments should ensure **timely expert assessment is available** for individual children with problematic and harmful sexual behaviours, so they receive appropriate responses, including therapeutic interventions, which match their particular circumstances.

Recommendation 10.3

The Australian Government and state and territory governments should **adequately fund** therapeutic interventions to meet the needs of all children with harmful sexual behaviours. These should be delivered through a network of specialist and generalist therapeutic services. Specialist services should also be adequately resourced to provide expert

support to generalist services.

Recommendation 10.4

State and territory governments should ensure that there are **clear referral pathways**
for children with harmful sexual behaviours to access expert assessment and therapeutic intervention, regardless of whether the child is engaging voluntarily, on the advice of an institution or through their involvement with the child protection or criminal justice systems.

Recommendation 10.5

Therapeutic intervention for children with harmful sexual behaviours should be based on the following principles:

- a contextual and systemic approach should be used
- family and carers should be involved
- safety should be established
- there should be accountability and responsibility for the harmful sexual behaviours
- there should be a focus on behaviour change
- developmentally and cognitively appropriate interventions should be used
- the care provided should be trauma-informed
- therapeutic services and interventions should be culturally safe
- therapeutic interventions should be accessible to all children with harmful sexual behaviours.

Recommendations 10.6-7

Recommendation 10.6

The Australian Government and state and territory governments should ensure that all services funded to provide therapeutic intervention for children with harmful sexual behaviours provide **professional training and clinical supervision** for their staff.

Recommendation 10.7

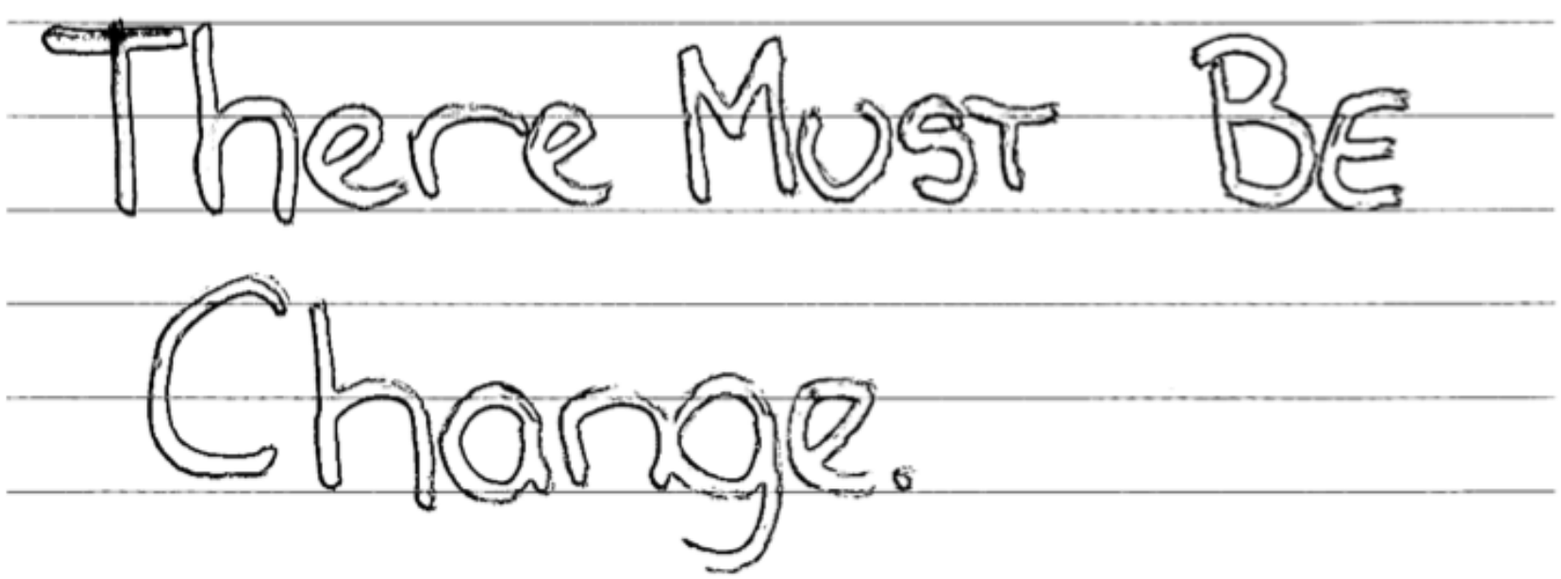
The Australian Government and state and territory governments should fund and support **evaluation** of services providing therapeutic interventions for problematic and harmful sexual behaviours by children.

Foundations for a stronger future

- Creating the right story
- Within strong relationships
- Understanding context
- Through a cultural lens
- Responsive service system
- Trauma informed and competent care
- Compassionate society

- Once upon a time …

My Message to Australia



Royal Commission
into Institutional Responses
to Child Sexual Abuse

Thank you

childabuse**royalcommission**.gov.au