A Socioecological Model of Child and Adolescent Development and Preventing, Identifying and Responding to Child Sexual Abuse

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A Socioecological Model of Child and Adolescent Development and Preventing, Identifying and Responding to Child Sexual Abuse: An overview

Drawing on both the areas of healthy Child and Adolescent Development (CAD) broadly, and specifically recognising the risk and protective factors for Child Sexual Abuse (CSA), a socioecological model is provided in **Figure 1**. This model has been developed to assist the Tasmanian Government in responding to the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings. The socioecological model comprises six layers, each containing related variables that intersect to influence CAD. Each layer is briefly summarised below.

Society. Ultimately, CAD is influenced by society-level factors that affect developmental outcomes for children and adolescents, as well as the likelihood of CSA occurring, the potential for prevention, identification and how society responses to abuse. Ideologies, beliefs, values, norms (including those related to social and gender roles), and assumptions—sometimes deeply embedded and based on historical and cultural events—influence many aspects of children and young people's lives by generating standards and expectations about how they should exist in the world. Different groups in society have different levels of power so that some will have a dominating effect, while others are dominated. The results are that not all children and young people have the same opportunities. This social inequality runs right across society and in relation to CSA has important implications throughout the layers of the socioecological model, ranging from access for children and adolescents to a nurturing upbringing through to supporting disclosure and holding abuse perpetrators to account. Children and young people have relatively little influence over their circumstances and the factors that may place them at risk of CSA.

Law and Policy have an indelible role in shaping opportunities and experiences and are the key mechanism by which social inequalities can be reduced. Laws and policies that advance human rights, improve equitable access to social determinants of health, and that result in well-resourced prevention and early intervention approaches are essential for optimum CAD. Politics and ideologies can hamper progress, as can the notion that CSA is a 'policy resistant problem' because of its complexity, and thus the status quo is maintained. However, through the action of civil society, advocacy and strong leadership, key determinants of CAD can be strengthened, and action to reduce risk and increase protective factors relevant to CSA can be prioritised. A combination of universal and targeted laws and policies is essential for reducing the avoidable and

unfair differences in opportunities (inequities) for the healthy development of all children and young people.

Organisations and Institutions. Involvement in sociocultural, faith-based, education and sporting organisations can offer many benefits for CAD. Similarly, out-of-home care, health care services and the youth justice system should help and not harm children and adolescents in their care. However, these settings have been the focus of both the Federal and Tasmanian Commissions into CSA, and there is an urgent need for the creation of safe spaces with rigorous policies and protocol designed to protect children and young people, reassurance that the voices of children and young people are valued and heard, as well as monitoring and intervention. Leadership and organisational culture, which shape assumptions, values, beliefs and norms influence, among other things, how individuals behave when interacting with children, what is understood to be appropriate and inappropriate behaviour, and how children's wellbeing and safety should be prioritised.

Community. Communities offer children and young people opportunities to form trusting relationships, develop a sense of identity and belonging, to feel safe and to be valued contributors to building community cohesion. Communities offer places to make friends and develop skills, and for recreation and to enjoy green space. Communities with high collective efficacy, intergenerational closure and social networks are less likely to be settings for CSA. As mentioned above, not all children and adolescents in all communities have the same opportunities. In this way, the community—as well as the other downstream layers in the model: 'relationships' and 'individual' factors—act as mediators for optimal CAD, while upstream factors—such as those that relate to policy, law and society—can drive the way for change.

Relationships are central to healthy CAD and for the prevention of CSA. A large body of evidence describes the essential role that the maternal-child relationship and healthy family functioning play in influencing the wellbeing of children and adolescents. As children grow, peers, friends, mentors, educators and social networks become increasingly important for optimum development. Among factors that may decrease the likelihood of a child being sexually abused are access to supportive and trustworthy adults, supportive peers, and strong community or cultural connections.

Individuals. Much of the research on CSA highlights individual attributes that elevate risk—age, disability, sex, gender, ethnicity, developmental stage and the intersectionality thereof. This somewhat shifts the focus of addressing the problem of CSA to individuals, rather than looking to society, law and policy, and organisations and institutions to lead the way. Rather than focusing on the negative CAD outcomes and risk of CSA associated with individual attributes, a strength-based approach such as that developed by First Nations Peoples holds promise. Aboriginal cultural, belief and

kinships systems that focus on Aboriginal ways of knowing, learning and healing can foster potential.

Ultimately for healthy CAD there must be a socioecological response that encompasses all that makes up the child or adolescent's ecosystem: society, law and policy, organisations and institutions, communities and relationships.

Artwork created by young people with disability and shows interpretations in the art of their experiences of engaging with child safety services and living in out-of-home care environments. A colourful painting with a many dots, wavy lines and swirls. Two hand-drawn people one is smiling while the other is pushing, what appears to be thumb tacks, into them while lying down

Creative submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Introduction

This report provides an analysis of how the development of children and young people is contingent upon interacting biological and environmental/contextual factors including family, community, sociocultural, economic, political and legal influences, and the services and structures that surround them. This analysis has informed the development of a socioecological model of harm minimisation, and provides guidance on the role that interventions may play in the identification, prevention and/or disclosure of Child Sexual Abuse (CSA) in Tasmania.

The socioecological model illustrates the importance of networks of people and structures that surround a child or adolescent, safeguarding their wellbeing and sense of agency, and supporting their optimal development.

A Socioecological Model of Child and Adolescent Development and Preventing, Identifying and Responding to Child Sexual Abuse

Socioecological models are a useful tool for summarising the ecology of determinants that surround particular social, health or wellbeing issues. Ecological systems models were first developed by the psychologist, Urie Bronfenbrenner. Bronfenbrenner's model depicts four systems—the microsystem, mesosystem, exo-system and macrosystem—which are embedded into a chronosystem representing the space in which children develop into young people and grow into adulthood.[1]

Drawing on both the areas of healthy Child and Adolescent Development (CAD) broadly, and specifically recognising the risk and protective factors for Child Sexual Abuse (CSA), a socioecological model is provided in **Figure 1**.

In the model shown in Figure 1, the microsystem includes two layers: the **individual** and **relationships**. The exosystem includes the **community**, and **organisations and institutions**, and the macrosystem includes **law and policy,** and broader **societal** factors. Many socioecological models include an outer layer known as the chronosystem. This refers to the system of time which has an impact on the interactions between the various layers. The chronosystem includes the ongoing change in knowledge, skills, events and societal values over time. As history progresses and cultures become more invested in children and young people, the way society responds to CSA can shift in the direction of greater protection and support, and more appropriate responses.[2]

It is important to recognise the space between the microsystem and the next layer, the exosystem: the mesosystem, which represents the merging of the two layers. It also shows that society, as a key feature of the macrosystem, has a deterministic affect at all layers of the socioecological model. Hence, we commence our discussion of the model with this outermost layer. For each layer, general information and risk and protective factors related to CAD are presented, followed by risk and protective factors specifically related to CSA.

The approach taken in developing the model

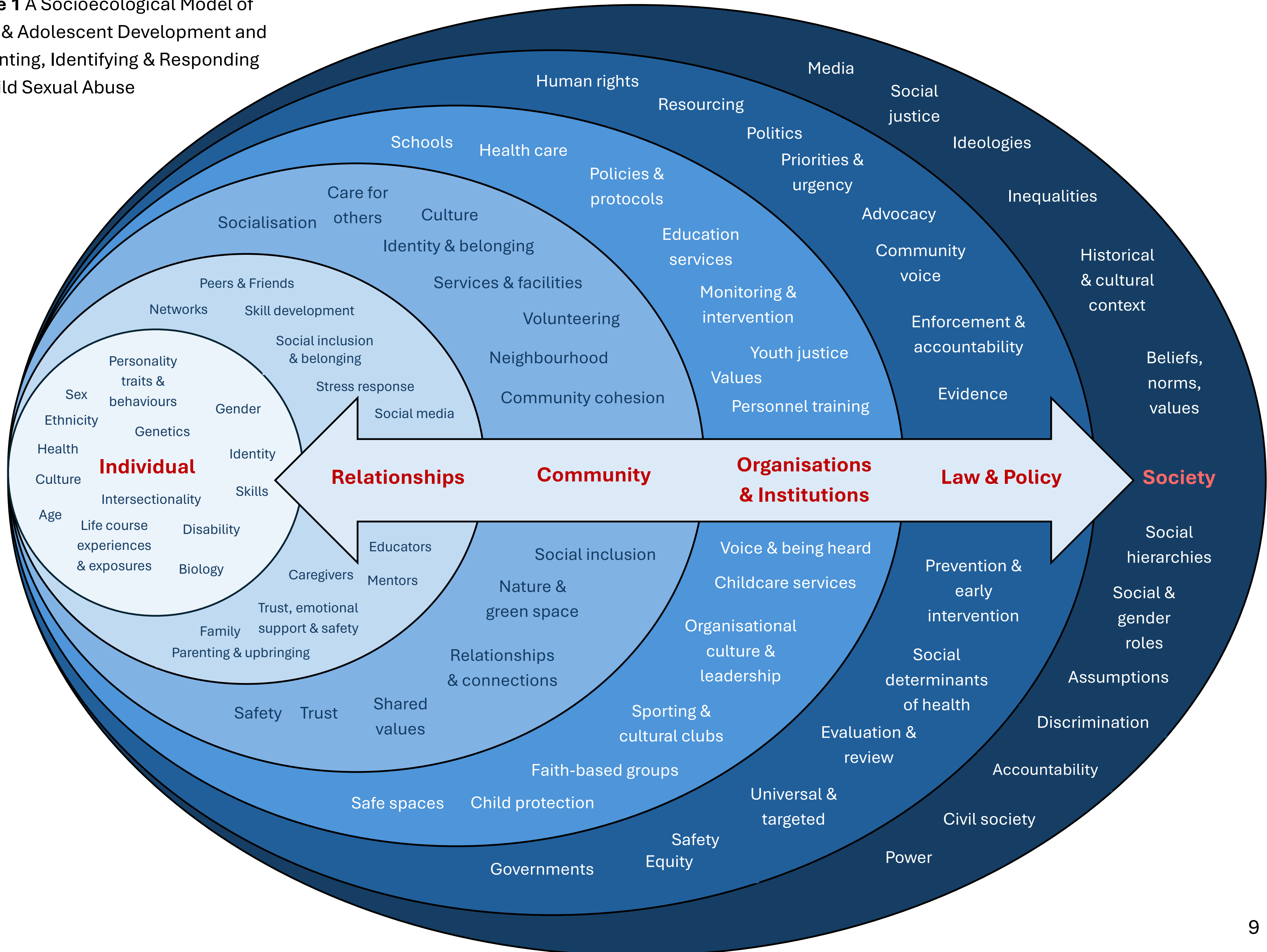
A rapid review of the literature was carried out to inform the content of each layer of the model. The CSA-related data provided in the tables are not intended to match or duplicate the detailed evidence available through reports associated with the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual

Abuse in Institutional Settings and the Royal Commission into Institutional Responses to Child Sexual Abuse. Rather, the tables provide examples of how the variables of each layer of the socioecological model relate specifically to CSA.

In terms of definitions, we refer to the final report of the Tasmanian Commission. The term 'perpetrator' is included here as it is commonly used in the research literature as well as the Tasmanian Government's Keeping Children Safe and Rebuilding Trust Response to the Final Report of the Commission of Inquiry. Further evidence specifically related perpetrators is available through the reports of the Tasmanian Commission and the Royal Commission.

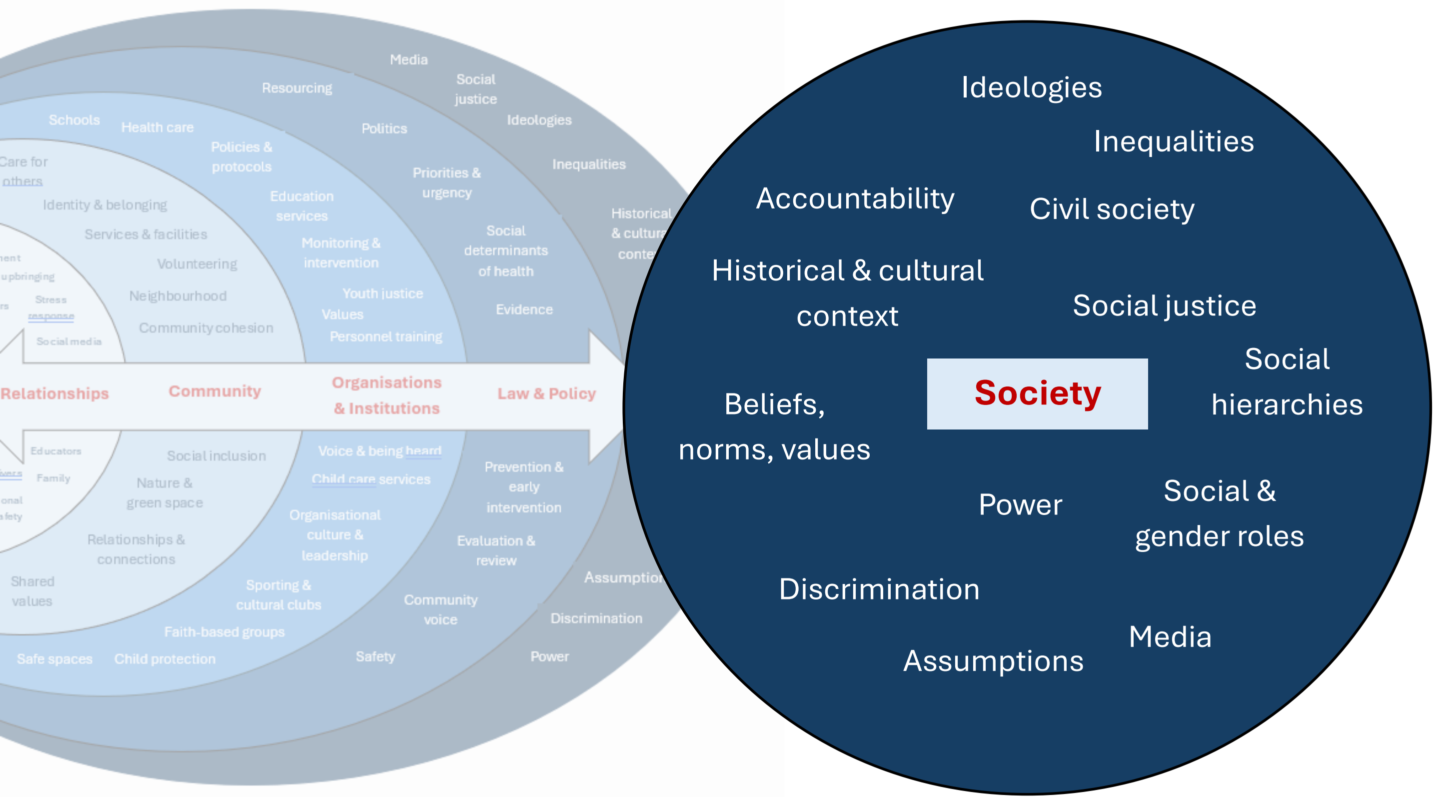
The research on CSA risk and protective factors suffers from several methodological limitations.[3] Perhaps most significant are issues related to the limited generalisability of study findings. There is an overall lack of empirical research in this area due to the difficulty of studying the phenomenon. None-the-less, there are a number of studies that can be drawn upon. The socioecological model has been developed within a short timeframe. The model would benefit from a peer review process and stakeholder engagement on its appropriateness for the Tasmanian context. In line with Recommendation 19.5 made by the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, it should be informed by the voices of children and young people and adult victim-survivors of child sexual abuse.[4]

Figure 1 A Socioecological Model of Child & Adolescent Development and Preventing, Identifying & Responding to Child Sexual Abuse



Society

Societal factors include ideologies, beliefs, norms, values and assumptions that have a structural effect on CAD by producing social systems that ultimately determine what is and isn't possible. Society-related factors shape policy and law, organisations and institutions, community and relationships.



The effects of **social ideologies, values and norms** related to identities, gender, social class, ethnicity and race have a powerful effect on CAD. **Social and cultural norms, beliefs and values** are consciously and unconsciously promulgated through social institutions and policies, setting up **social hierarchies** that can lead to acceptance or **discrimination** and equality or **inequality**.

A socially just, democratic, **civil society** is essential for optimum CAD.[5] Civil society can provide valuable real-life perspectives on the factors that are essential for healthy CAD and play an important role in challenging power imbalances.

A study into the **social beliefs and norms** about factors that shape CAD, found that society advocates deeply held views that can be harmful to optimum development, for

example: 'The family is private and should be protected from interference by government.' This widely held view promotes that 'normal' families know what is best for their own children and that they are able to solve their own challenges—and that only 'abnormal' families need help. Another example is the view that 'Caring work is not real work.' This view promulgates the social norm that it is the role of families, particularly women, to provide care. The **media** plays a major role in this portrayal.[6] Researchers argue that such views prevent progress in favour of optimum CAD develop. To counter this 'current state of play', McKenzie and Millar [7] advocate for action on systemic forces that would help shift current systems and generate improved outcome for all children and adolescents. These include **accountable**, high quality, proactive child development systems, and governments holding responsibility for the whole. All five action areas proposed by McKenzie and Millar [7] are shown in **Figure 2**.

Figure 2 Five categories of deep systemic forces that would help shift the current systems and generate improved outcomes for all Australian children.

Social beliefs, norms and values are generated within **historical and cultural contexts** and are maintained or may be advanced by dominant **ideologies**. For example, Australia has a long history of violence, **discrimination** and racism against First Nations

people and while some important steps towards reconciliation have been made, racism continues to surface. Ore [8] reported how racism continues to contribute to unsubstantiated child protection reports against First Nations families. Similarly, Krakouer [9] argues that "the continuities between past and present child welfare practices demonstrate that systemic racism is an ongoing feature of Australian child protection and out-of-home care systems which drives overrepresentation."

Another common **ideology** underpinning 'solutions' to many social, health and wellbeing problems, is to turn to the market to 'work things out.' For example, in Australia education, health, aged care, disability, incarceration, and numerous other services and system parts, are delivered by the competitive market. McKenzie and Millar [7] argue that this has led to lack of access to education, health and community services for families. Further, even if people can afford these services, access is limited by waitlists and location; disadvantage due to location is being perpetuated and when the 'market fails' no one is held to account.

Societal Factors and CSA

Society-level factors can foster "a social climate that does not tolerate CSA and has a widespread structural influence that permeates down to community-level perceptions, influencing behaviour and responses at the relationships and individual system levels."[10]

There is an overall paucity of empirical research on CSA, particularly in relation to society-level structural factors [11], however in the table below are some examples of risk and protective factors at the level of society that **may** be associated with CSA.

Society Factors	CSA Risk and Protective Factors
Ideologies, values & norms	• Studies have highlighted the role of deeply embedded patriarchal ideologies and gendered expectations as shaping the context for the ongoing problem of CSA.[12] • Blame for CSA has historically been attributed to non-offending mothers, at least in part, by reason of complicity or negligence.[13] • Regulatory stances over time reflect the 'myth' that online risks to children are inevitable by the "hegemony of a cyberlibertarian ideology."[14] • Breyer and MacPhee [15] found that political and religious conservativism were inversely related to child abuse rates. • Religious ideologies are implicated in CSA in a variety of ways e.g. resigned suffering in silence, the sense that children are

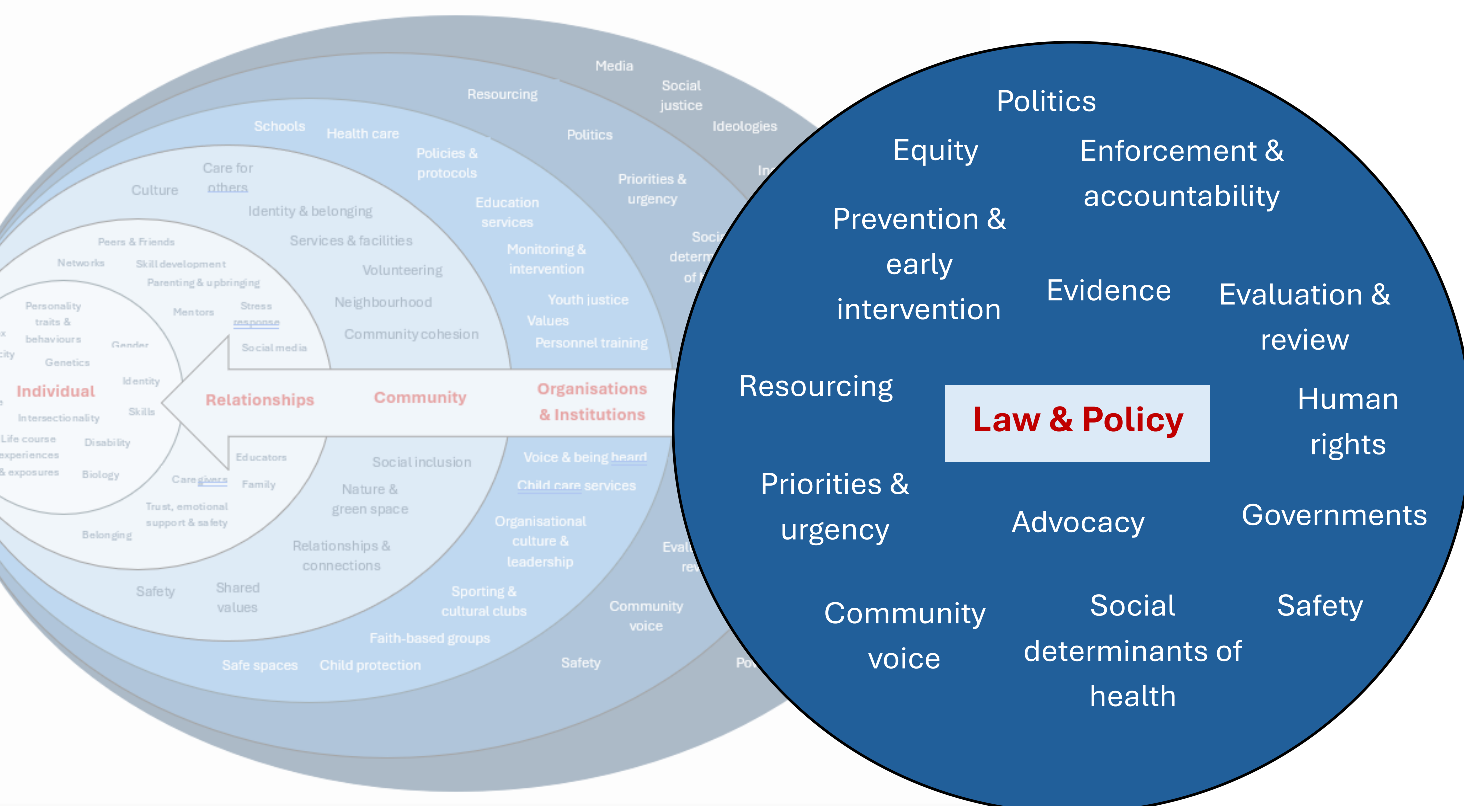
	at fault for their victimization through having committed sins in this or a previous life, promoting premature forgiveness without accompanying child protection, and enhancing abusers' ability to claim a right to children's bodies. • Haug [16] argues that neoliberal ideology promotes "normalcy of power of people over other people", and that market forces and the relinquishing of ethically based preventative measures has driven the trade in human beings and child pornography.
Power	• Social hierarchies are ubiquitous across cultures, such that some individuals enjoy better access to scarce resources, living conditions or influence than others.[17] • The World Health Organisation, in its definition of CSA, states that sexual abuse is associated with the fact that children do not fully comprehend and are unable to give informed consent to these activities and that adults are in a position of responsibility, power, and trust.[18] • Power is a crucial concept, from both the psychological and the sociological perspective, in understanding CSA in the coach–athlete relationship. Power imbalances favour coaches, which enables them to abuse athletes without athletes or bystanders being able to recognize or address the problem.[19]
Assumptions & Myths	• Common assumptions about CSA relate to minimisations or exaggerations of the extent of harm and abuse, diffusions of perpetrator blame, and perpetrator stereotypes.[20] • Incorrect assumptions (myths) are used to deny or justify the sexual exploitation of children.[20] • Stereotyped beliefs related to CSA persist in the disciplines of psychology, in the media, and in the courts.[20] • Studies have found that there may be different opinions on whether a behaviour, in a particular context, is abusive or exploitative and demonstrate inconsistencies in social norms pertaining to CSA.[21] • Based on cultural assumptions about sexuality and aggression, offending by females is mostly portrayed as unthinkable, and CSA is mainly marked as a male problem.[22]
Gender inequality	• Gender inequality has been recognised as a societal level risk factor for CSA.[23]

	• A patriarchal society promotes the notion of men as powerful, which contributes to all elements of the child's ecosystem, impacting how families are supported, how curriculum is taught, and how the child is supported and protected. Challenging patriarchy and misogyny within the macrosystem may serve to impact CSA both directly and indirectly.[2] • There is an emphasis within some sports on power and aggression. This normalisation of violence is likely supported by "prevailing narratives of compulsory heterosexuality and hegemonic masculinity in the world of sports."[3]
Disability	• There exists a common social perception that persons with disabilities are dependent and require their lives to be controlled by 'able others' as well as a belief that these individuals are 'too delayed' to be sexual. Moving beyond a binary of able/disabled, and recognizing value in all individuals could shift how children and young people are included, and serve to reduce the high CSA rates of individuals with disabilities.[2, 24]
Consent & Victim Blaming	• Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings [4] noted evidence of problematic attitudes towards consent and relationships among Tasmanian children and young people, which is particularly relevant to harmful sexual behaviours between children. • CSA victims may face disbelief, blame, and refusals of help rather than offers of assistance when they turn to formal and informal system, which may impact an individual's likelihood of reporting and their own beliefs of themselves, ultimately impacting their recovery.[2]
Media	• Media and popular culture impact how CSA is portrayed and understood at a broader cultural level.[2] • Communication research has demonstrated that media coverage of CSA is often severely flawed and includes sensationalism and voyeurism, the spreading of sexual abuse myths, the demonizing of perpetrators, the stereotyping of victims and neglect of prevention and therapy.[25]

	• Sensationalist, stereotyping or otherwise biased media coverage of CSA can harm survivors and is detrimental to solution-oriented action.[25]

Law and Policy

The next layer in the socioecological model includes laws and policies formulated and implemented by **local, state and federal governments**, as well as **international treaties**. Laws and policies set out rules, social expectations and principles for action, determining social boundaries for citizens. Law and policy have an indelible role in shaping opportunities and experiences for CAD, which can have both positive and negative consequences. For example, laws can help ensure that all children and adolescents receive an education. However, laws and policies can also constrain access to important **social determinants** of quality education, such as adequate income and transport, which—if insufficient—can have a negative effect on a child's ability to access the education that will best meet their needs. The effectiveness of laws and policies is very much contingent on the pervasiveness of underlying principles such as **human rights**, **equity** and **universalism**.



The effectiveness of law and policy making, and of implementation is shaped by many factors. Policy making has been described as a complex **political** process from which outcomes may 'emerge', which are not always **evidence-informed**.[26] Following its implementation, policy effectiveness and the measurement thereof may be impacted by

the level of **resourcing**, time, variables in the implementing environment, the complexity of the problem, **enforcement and accountability**, monitoring and **evaluation** approaches and **review**.[27]

Citizen engagement and **community voice** in the policy development process has multiple benefits. For example, engaging young people in the policy formulation and implementation process will help ensure they feel that their views and needs are being included and respected, thus enhancing a sense of self-awareness and identity, as well as trust in systems and adherence to laws and norms. Connecting with peers through active engagement allows young people to build social capital, an important competency for joint actions.[28] Civil society plays a key role in highlighting **priorities** and matters of law and policy **urgency**, through **advocacy**.

Australia is a signatory to a number of international human rights treaties including the Convention on the Rights of the Child. The United Nations Convention on the Rights of the Child is an international **human rights** treaty which sets out the civil, political, economic, social, health and cultural rights of children 0-18 years. The Convention articulates specific minimum standards and rights for children and is intended to be a guide for establishing and monitoring laws and policies concerning the welfare of children. It is the role of society, including government and non-government institutions, civil society and all those who participate in it, to ensure the rights of the child are upheld, thus that all children are given opportunities for a safe, healthy and quality life. Another important human rights treaty that Australia is party to is the Convention on the Rights of Persons with Disabilities.

Figure 3 Item 19 of the Convention on the Rights of the Child states: Governments must protect children from violence, abuse and being neglected by anyone who looks after them.

Laws and policies are administered by different levels of government. Local governments often deliver a range of services to families. State and Territory governments deliver **universal and targeted services**, and **primary prevention and early intervention** initiatives. They are responsible for the statutory child protection systems, including the support provided to children and young people in out-of-home care, community **safety**, and police and justice systems. The Australian Government delivers **universal** services to help families raise their children, along with a range of **targeted** early intervention approaches. They play a central role in delivering supports and services related to the **social determinants of health** including the provision of income and family support payments, a universal health system, employment services, family relationship and addiction services, and the family law system. In addition, the Australian Government provides support for key services through the States and Territories such as hospitals, schools, housing and disability services. The Australian Government also funds and delivers a range of services for families at higher risk of disadvantage including those in First Nations communities.[29]

Law and Policy Factors and CSA

In the table below are some examples of risk and protective factors related to law and policy that **may** be associated with CSA.

Law and Policy Factors	CSA Risk and Protective Factors
CSA: a crime	• Australian and State/Territory laws outline what constitutes the crime of CSA. • The Royal Commission into Institutional Responses to Child Sexual Abuse made 85 recommendations for reform of the criminal justice system to ensure justice for victims of CSA.[30] • Existing CSA laws (at the time of the Royal Commission) have been widely regarded as ineffectual in achieving their underlying policy objective.[30]
Convention on the Rights of the Child	• Three decades after the adoption of the Convention, CSA remains a serious, persistent, and evolving global issue.[31]
CSA and policy resistance	• Researchers point out that CSA is a 'policy resistant problem' because it is complex, poorly understood, and engendering of emotional and defensive responses.[32]
Prevention	• Despite a decade of concerted effort and policy investment, preventing CSA before it occurs remains a

	fraught endeavour largely because a comprehensive, integrated and shared framework for the primary prevention of CSA does not yet exist. Quadara [33] argues that "…it is not clear to me that there is a shared understanding across key actors of the concept of primary prevention itself, how different prevention initiatives are – or should be – articulating together, or how to achieve sustainable, whole of population and societal change." • Given the strong evidence that young adolescence represents the riskiest period for perpetrating sexual harm against younger children, researchers recommend taking a life-course developmental approach to the primary prevention of CSA, that includes health education curricula for young adolescents covering acceptance of sexual diversity, improved communication between partners, and modelling of sexual activities within a framework of mutual respect and affection between partners.[34] • Most current efforts to address CSA are reactive criminal justice interventions focused on the identification, prosecution, punishment, and subsequent control of perpetrators, and most prevention programs are designed to help potential victims to protect themselves from abuse.[34]
Social determinants of health	• CSA is regarded by some researchers as a life-course social determinant of adult health because of the long-term consequences for health and wellbeing.[35] • Social determinants such as low income, inadequate education, insecure housing, and other social conditions increase the risk of child abuse and neglect.[36] • The risk of CSA increases when parents struggle to balance work and family, experience long commutes and end up with little time to positively interact with and monitor their children.[36]
Disclosure and Reporting	• There is moderate evidence that adopting state mandates for CSA prevention education may increase disclosures and reporting of CSA by school-based sources.[37] • Improvements to the criminal justice system is seen as being critical to enhancing disclosure of CSA, e.g. ensuring

	justice will be served and law enforcement believing the victim's report.[38]
Schools	• A qualitative study in the US found that state laws and policies aimed at preventing CSA by school employees contained numerous loopholes which would allow offenders to escape prosecution and offend again.[39]
Evaluation of effectiveness	• Despite decades of legislative action for CSA prevention across the US, only a few studies have assessed the effects of these policies.[40]

Organisations and Institutions

This layer of the socioecological model is concerned with the organisations and institutions that children and adolescents encounter and engage with throughout their development. These include educational institutions (childcare, schools), recreation, cultural and sporting clubs, health and wellbeing services, and faith-based groups. For some, child protection services and the youth justice system may also make up this collective. The 'organisations and institutions' layer includes the staff and volunteers that work within these settings. Factors within this layer interact closely with relationship factors.

Most children and adolescents go to **school**, and preceding that, many also attend **childcare** or early years **education services**, which range from in-home services through to centre-based day care. Quality childcare can help children to build their confidence and discover their identity.[41] High quality early childhood (0-5 years) education and care programs can be particularly beneficial for reducing inequities in development outcomes for children from more disadvantaged socioeconomic backgrounds and unstable circumstances.[41, 42] Children and adolescents' experiences in education settings are shaped, not only by the quality of the staff and volunteers they engage with in these settings, but also directly and indirectly by the

resources allocated to deliver these services (including teacher resourcing and ongoing support), the delivery of education services that are inclusive for diverse needs, the accessibility of these services, community cohesion and school-community partnerships, the school community's perceived role in relation to social wellbeing more broadly, and the community culture related to school retention and achievement.

Sporting, cultural and other community organisations can provide children and young people with positive opportunities for health, wellbeing, personal and social development. Through memberships of such organisations, children and young people can learn how to trust others and develop values related to competition, cooperation, respect for others, legitimate expression of talent and an acceptance of rule-governed behaviour. The benefits of participation may include increased self-esteem and a stronger sense of attachment to and involvement with others.[43]

Children and young people may also participate in other institutions and organisations such as those of a **faith-based, religious or spiritual** nature. Engagement with these organisations can be beneficial [44] but, similarly to sporting or other community organisation membership, such benefit is largely contingent on organisational attributes including, **leadership** qualities, the **knowledge and skills** of staff and volunteers, policies and procedures, **monitoring and intervention**, and a focus on continual improvement in terms of good governance, quality experiences and stakeholder engagement. The overall **organisational culture** is key to ensuring children and young people feel **safe,** that they feel as though they have a **voice**, and have constructive development and positive social experiences. Staff and volunteers associated with organisations and institutions must follow best practice guidelines to identity and prevent behaviour that may be harmful to children (e.g. Child Safe Practices, Sport Integrity Australia 2021). Maintaining a child safe culture requires ongoing effort, the implementation of accountability mechanisms and continuous improvement.

Similar themes run through other settings that young people encounter, including the **youth justice** system. Cavanagh [45] argues that to maximize adolescents' potential and reduce their likelihood of further involvement in crime, juvenile justice policy must recognize developmental science so as to provide meaningful opportunities for youth to acquire the skills necessary to prepare for adulthood. Youth in detention do better if the system is focused on the rights of the child, takes a therapeutic approach, is focused on rehabilitation and breaking the cycle of offending to create generational change.[46]

Health care services play a central role in healthy CAD. Medical practitioners are often the link in the community identifying children at risk and coordinating care across health and social care sectors. Within the frame of a trustful relationship, health care professionals can help children and young people to deal with health and wellbeing

concerns, and navigate life's challenges.[47] Health care services can have an adverse impact on development and wellbeing, if health professionals don't validate patient's experience of hardship and trauma. Trauma-informed education and training within health care institutions is critical.[48]

For a range of reasons, some children and young people are unable to live with their biological family and as such encounter the **child protection** system. Child and adolescent experiences with the child protection system can have a significant and lasting impact on development, health and wellbeing. A recent Australian study found that placement stability, as well as placement type, carer wellbeing and support can contribute to emotional, cognitive and physical health development.[49]

Organisational and Institutional Factors and CSA

CSA can occur anywhere, however, children can be at greater risk in organisational and institutional settings, such as those related to education, sport, culture and religion.[11] Cultural (e.g. leadership and organisational culture), operational (e.g. day-to-day practices) and environmental (e.g. the physical space) factors within organisations and institutions can all affect the likelihood of children being sexually abused and the prospect that abuse will be identified, reported and responded to appropriately. Both the Royal Commission and the Tasmania Commission of Inquiry Report provide substantial evidence relating to the role organisational and institutional factors and CSA.

The table below sets out a range of examples of risk and protective factors related to organisations and institutions that **may** be associated with CSA.

Organisational/Institutional Factors	CSA Risk and Protective Factors
Education services	• Schools have been found to be a common setting for institutional CSA.[50] • CSA at preschools is difficult to detect and sometimes children are too young to be able to tell with their own words what they have been through.[22] • School settings have been shown to decrease self-blame and increase reporting but there is little evidence to show how schools have reduced CSA victimisation.[51]
Sporting organisations	• Sporting organisations provide environments conducive to CSA including power imbalances,

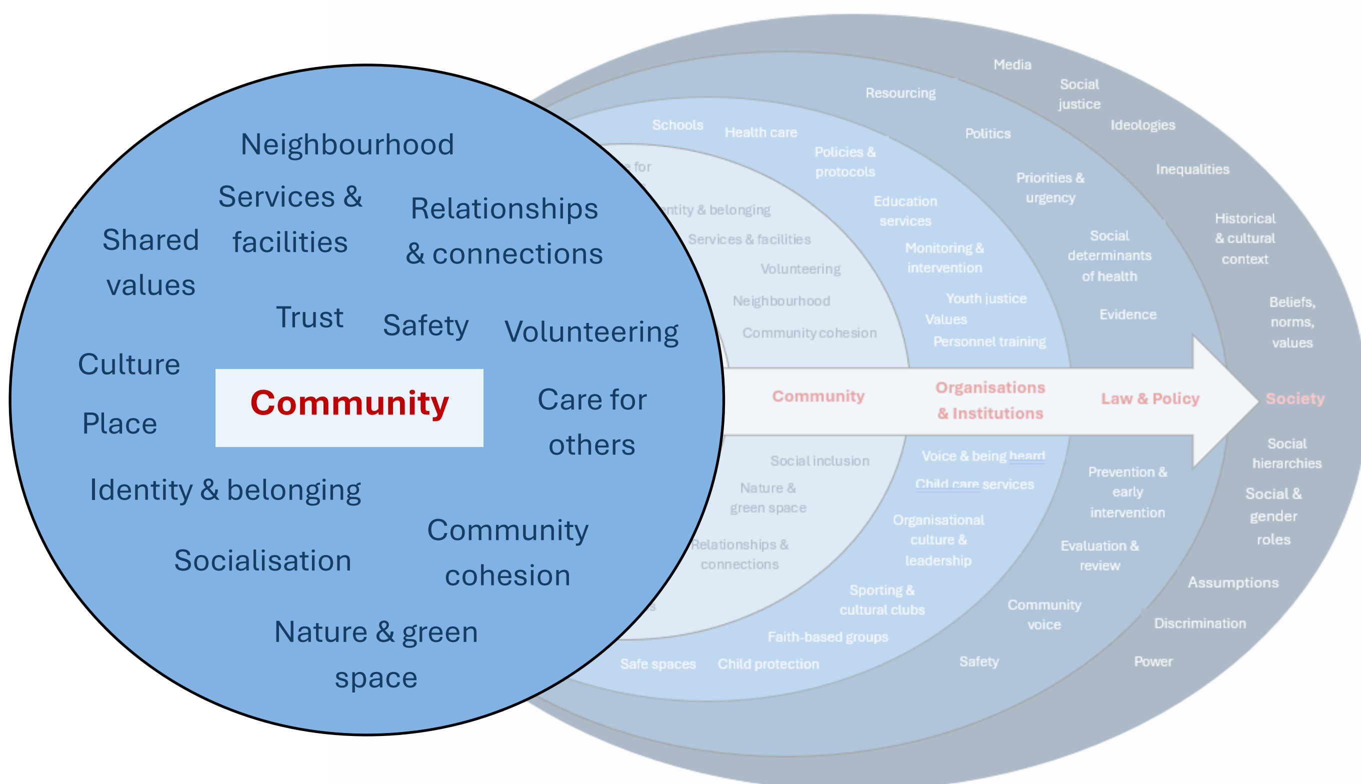
	isolation and conformity to dominant values in sport (e.g. children are often encouraged to sacrifice their own identities for 'the good of the team', which may make it difficult for children to stand up for themselves).[52] • It is generally assumed that the true extent of sexual abuse in sports is much greater than research shows due to chronic under-reporting.[3, 52] • Sports organisations have historically maintained a 'culture of silence', which may be a reason why many female athletes do not report their sexual victimisation.[3, 53]
Faith-based organisations	• Particular risk factors with regard to CSA in churches and other religious or faith-based organisations relate to the authority conferred on leaders (such as priests), which allows them to act without fear of repercussions and gives them direct access to children.[3] • The sexual abuse 'problem' that churches face not only concerns the incidence of abuse, but also the lack of an appropriate response when abuse is identified.[3] • Perpetrators, religious traditions, religious tenets and religious leaders have been found to use religion perversely as a tool for corruption, exploitation, shaming, secrecy, and isolation.[54] • Churches have made significant attempts to prevent child sexual abuse through policy change, education and situational prevention.[3]
Youth justice system	• A history of sexual abuse is the most salient predictor of recidivism for young female offenders.[55] • Youth are at higher risk of sexual assault and victimization while in custody than adult inmates.[52] • Risk factors for CSA for youth in custody include: prior history of assault, non-heterosexual experiences of violence, gang membership, and length of time in custody (with reductions in

	supervision and monitoring by staff over time).[56]
Child protection system	• Children in out-of-home care are more vulnerable to CSA as they are often younger, are more likely to have a disability, to have experienced prior maltreatment, or to have a history of trauma and mental illness.[3, 57] • Children in residential care are at particular risk of both carrying out harmful sexual behaviour and being victims of CSA.[32] • Studies suggest that half of the sexual abuse of children in out-of-home care is carried out by other children, who are predominantly male.[58] • Victims and children who engage in sexually harmful behaviour in care are likely to have been victims of sexual abuse.[58] • Little is known about what out-of-home care placements can do to effectively support young people who are at risk of being sexually abused.[32, 58] • First Nations children are more likely to experience abuse and maltreatment in out-of-home care because they are over-represented in the child protection system. Aboriginal children are often placed with non-Aboriginal families and are therefore dislocated from culture, and experience frequent placement moves.[11] • The National Royal Commission reported that children in care who had regular visits from their Child Safety Officer were less likely to be sexually abused than children who were not visited regularly.[3]
Health care services	• Despite awareness of the problem of child sexual abuse in health care services, there has been some resistance to creating protocols to address it.[3] • The risk of CSA in health care settings is linked to contributing environmental factors (such as isolated hospital units and difficulty in supervising patient play areas), situational

	factors (such as heavy sedation and a lack of supervision for patients waiting for X-rays or scans) and critical policies (such as not providing optional chaperones for patients during sexually invasive procedures).[59, 60]
Organisational culture & policies and protocols	• Organisational culture plays a key role in insulating perpetrators of CSA and third-party observers that might otherwise act to intervene.[61] • Higgins [62] criticizes organisations that focus mostly on screening out ‘bad people’. Instead the research advocates for organisational leaders to take a strong stand, and introduce policies and practices that focuses on situational factors: reducing opportunities to offend; increasing the chances of getting caught; reducing the ‘pay-offs’ of offending; and making excuses for adults’ inappropriate behaviour less plausible.[62]

Community

Communities are social units that share common characteristics related to **place, culture**, **identity,** values, interests or other attributes. Communities can play a key role in socialisation, identity formation, and create a sense of **belonging** and **safety**, as well as access to **services, facilities** and resources that can support CAD.



Socialisation is an important part of CAD. While during the early years (0-3 years), socialisation tends to largely take place in the family with limited experiences in community settings, as children progress into adolescence and youth, socialisation is increasingly shaped by the wider community.[63] For some children, **connection** to community is intertwined with **culture** as well as family, and the **natural environment**, from the very beginning.[64]

Community is essential to quality outcomes for children. Community can provide a supportive and inclusive environment that helps children grow their social-emotional skills and feel a sense of **belonging**. A community can provide opportunities to develop meaningful relationships and friendships, a sense of **identity** and learning. When children have a sense of belonging and feel safe, secure and supported, they have the confidence to play, explore and learn.[65]

Children and young people who are connected to communities learn to live interdependently with others, be decision-makers and have influence. The ability to participate in different communities—a central element of citizenship—helps young children and adolescents to respond to diversity and become socially responsible.[65]

Community can encompass the **place** where children and adolescents live. The 'liveability' of a **neighbourhood**—with access to affordable housing, with facilities (e.g. playgrounds), services (e.g. library), and social infrastructure (e.g. schools) accessible by public transport, walking, and cycling—have implications for CAD.[66] **Services** that connect with communities are more likely to be welcoming, inclusive, and connected to the culture.[65] An important element of place for CAD is access to the **natural environment** and **green space**.[67]

High levels of neighbourhood social capital and collective efficacy (i.e. shared expectations, residential monitoring of children's behaviour and intervention if necessary) have been linked to healthy CAD and behavioural outcomes, including in communities with fewer financial and educational resources.[66] High residential mobility, vacant housing, neighbourhood violence and crime, on the other hand, can serve as a risk factor for poor youth outcomes.[63, 68]

Communities provide opportunities for active participation in society through activities such as **volunteering**. Volunteering and mentoring can enable youth to contribute a protective resource to their community. Young people can be an asset for building community social capital and fostering a caring outlook for other community members.[63]

Community Factors and CSA

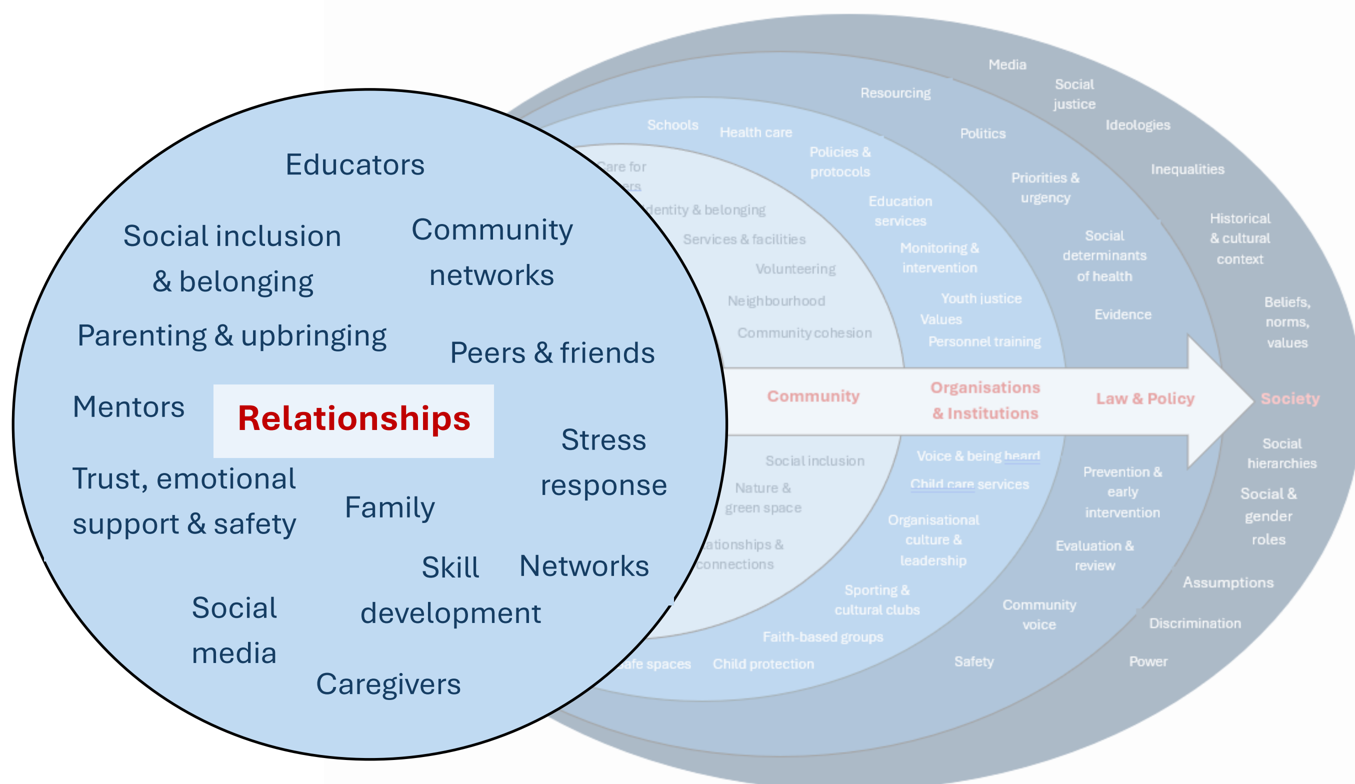
In the table below are a range of examples of risk and protective factors related to community that **may** be associated with CSA.

Community Factors	CSA Risk and Protective Factors
Socialisation	• Children who engage with others in the broader community with an interest in their wellbeing are more likely to be noticed when they are in danger and have networks of support to draw upon when they feel unsafe.[65]
Culture	• Culture is related to CSA through numerous mechanisms including immigration status, language competence, child and family anxieties and fears, disclosure hesitations,

	expectations, sources of support, and reactions of others.[54] • Other factors include how CSA is understood, attitudes towards sexuality and openness to discussing sex-related issues, and traditional gender roles.[54] • Immigration-related stress has been identified as a risk factor for CSA in a number of ethnic groups.[69]
Place-related factors	• Concentrated neighbourhood disadvantage including high poverty and residential instability, high unemployment rates, high density of alcohol outlets, community violence, and poor social connections have been associated with elevated rates of CSA.[70]
Housing	• One study found that a large number of times a respondent reported moving house while growing up was significantly related to increased risk of CSA.[71] • Other housing-related risk factors identified in the literature include being homeless and living in overcrowded housing.[58, 72]
Out-of-home care	• According to the National Royal Commission, maintaining positive connections with family, community and culture may be protective against CSA in out-of-home care.[4]
Community violence	• Community violence has been identified as a risk factor for CSA.[58, 73, 74]
Community cohesion	• Neighbourhoods higher in collective efficacy (i.e. a shared belief in capabilities), intergenerational closure (i.e. the extent to which parents know the neighbourhood's children), social cohesion and social networks, and lower in disorder (e.g. neighbourhood vandalism) have been found to have lower levels of CSA.[75]
Volunteering	• Advocacy and volunteering activities including speaking out about abuse and working with victims' rights organisations can help some CSA victims in their recovery.[76]

Relationships

This layer of the socioecological model describes the relationships and social connections a child/adolescent has with key individuals, who have a significant impact on their development—including **family** members, **friends**, **peers** and **social networks**. The layering of nurturing and supportive relationships throughout CAD enriches self-perception, self-image and life skills.[77]



Parents, caregivers and the extended **family** play a significant role in CAD. Sensitive and responsive caregiving is essential for the healthy neurological, physical and psychological development of a child and to reduce unhealthy **stress responses**.[77, 78] A child's development is shaped by the nature of their relationship or attachment with their primary caregiver during infancy. A consistently responsive and nurturing relationship between the child and their caregiver encourages a secure attachment and facilitates the development of future relationships throughout the child's life, while providing a safe foundation for learning. Children are born with a range of attachment behaviours that seek **safety** in supportive others, and parenting style is central to establishing these attachment behaviours, increasing positive feelings and minimising stress and defensive states, and in the long term is essential for overall health and

wellbeing outcomes in later life.[79] Parental warmth and guidance are key aspects of parenting by which caregivers shape child social, emotional and behavioural development, with low levels of parental warmth being associated with negative child outcomes.[51] A large body of evidence describes the essential role that the maternal-child relationship and healthy family functioning plays in influencing the wellbeing of children and adolescents.[80-83]

Through **caregivers** in the household setting children and adolescents access social determinants of health and wellbeing, including education, nutrition-including breastfeeding, income for daily living needs, housing, gender norms, faith or religious beliefs, safety, healthcare, transport and cultural connection. CAD outcomes follow a social gradient such that the further along the socioeconomic spectrum toward greater access to socioeconomic and cultural resources, the better the outcomes.[84, 85]

Where parents' lives are unstable, chaotic or antisocial, children may experience conditions that promote toxic stress risk processes. Young people experiencing community and school instability and lacking stable personal relationships are more likely to use drugs and become involved in antisocial behaviours.[63]

For most youth, the **family** remains the primary arena of social influence and security. Families influence adolescents through socialization processes that make them capable of participating in interpersonal relationships.[86]

Developmental psychologists have emphasized the increasing developmental significance of **friendships** across childhood and adolescence, and the importance of friendship stability and quality. Whereas friends in early childhood mainly provide companionship and fun, adolescent friendships also start fulfilling other needs for **trust**, intimacy, and **emotional support** [87]. Friendships become increasing important as children develop into adolescents.[68, 88] Quality friendships have been linked with positive developmental outcomes and mental health among adolescents, and may protect against the negative effects of adverse experiences, such as peer victimization and internalizing behaviours [81, 87]. Poor quality adolescent friendships (e.g. those low in supportiveness) are associated with multiple negative outcomes, including incidence of loneliness, depression, and decreases in achievement in school and work settings.[89] Adolescents may be a time for exploring romantic or sexual relationships. Variations in qualities of dating and romantic relationships are associated with psychosocial development during adolescence.[89]

Important relationships are also developed in the **wider community** as children and adolescents engage with **educators**, **mentors**, sporting clubs and other community organisation, forming a sense of **social inclusion**. Early years education and progression through school settings provide opportunities to gain academic knowledge, life skills, support and mentoring, and social and emotional development.[90] Schools

are a place where children and adolescents develop an image of who they are and want to be. A clear and stable identify makes people more confident and reflective.[80, 91]. Children and young people develop coping **skills**, adaptability and their stress responses through a range of other 'non-school' educational settings and experiences.[92, 93] Involvement in extracurricular activities at school and community-based organisations can facilitate CAD in ways that will lead to greater community and civic involvement in adulthood.[94]

Relationship Factors and CSA

This layer of the socioecological model recognises the ways in which relationships influence the risk of CSA. Quadara [70] developed a conceptual map of how different groups of relationships are implicated in CSA. The model identifies three major relationship groups: Intra-familial relationships (e.g. family, friends of family), extra-familial relationships (e.g. relationships based on care, supervision or authority) and impersonal relationships (e.g. connections made through social media). These relationships include those that may protective or conversely increase the risk of experiencing CSA, as well as those who can support disclosure processes in adverse circumstances.

In the table below are some examples of risk and protective factors related to relationships that **may** be associated with CSA.

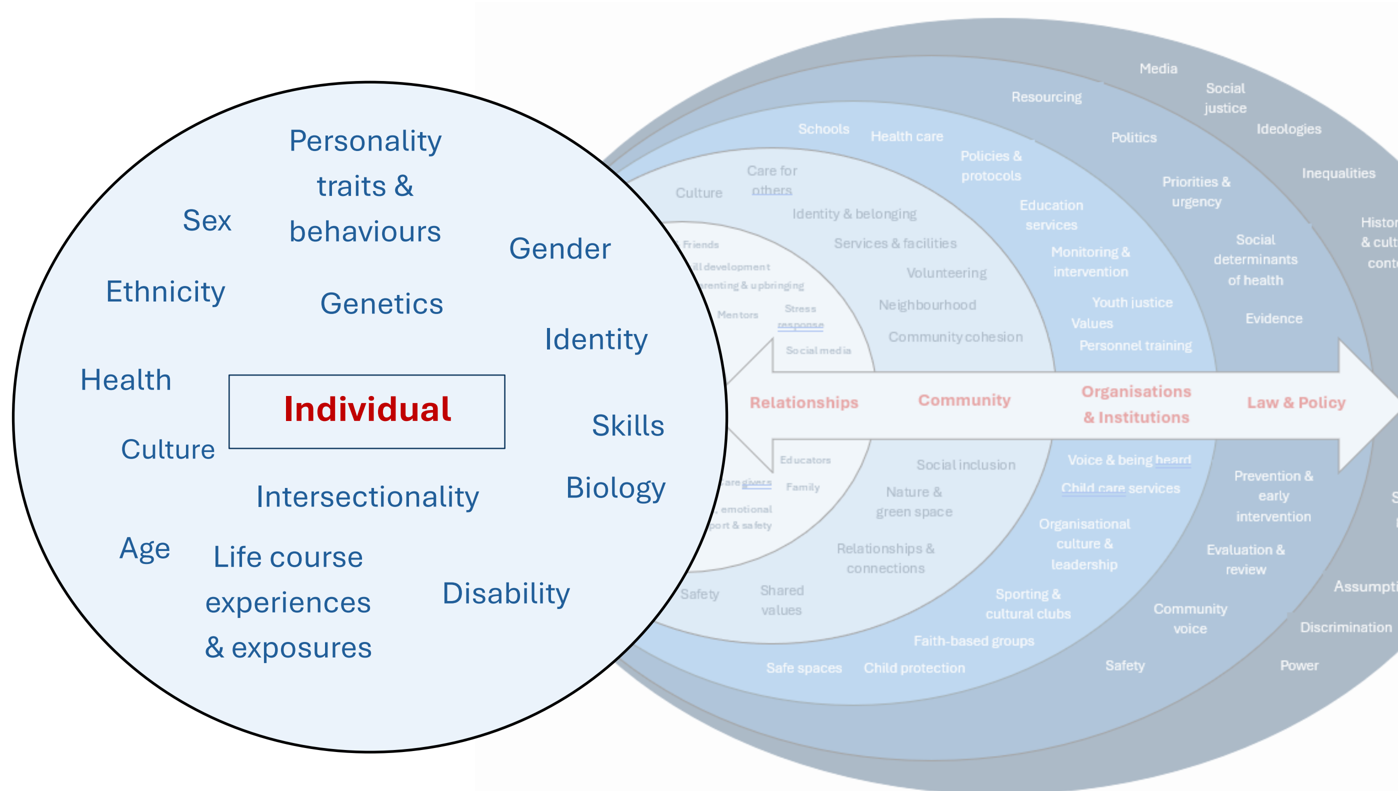
Relationship Factors	CSA Risk and Protective Factors
Families and caregivers	• Risk may increase for children from broken homes, low socioeconomic status, parents with mental illness, parental history of abuse, substance abuse, and legal problems.[3, 11, 51, 58, 70, 95] • A meta-analysis undertaken by Assink, van der Put [95] report a large number of family-related variables that may increase risk of CSA, including young maternal age, conservative sexual/family values of parents, strong religious affiliation and low parental competence. • Most CSA is perpetrated by individuals well known to the victim.[10, 51] Familiarity, trust and authority become key facilitators of CSA.[10] • Mathews, Finkelhor [96] found that the second most common perpetrator classes are parents/caregivers (after

	other known adolescents) in the home followed by other known adults and other unknown adults. • The domestic setting is the most common place for CSA to occur.[10] • Divorce and remarriage are considered risk factors for sexual abuse as many adult perpetrators are stepfathers.[97] • Exposure to family violence has also been identified as a common risk factor in the development of sexual violence among adolescents. Male victims of sexual abuse are more likely to sexually victimize others if they have witnessed family violence.[98] • Stability in terms of a connected and supportive family environment, without frequent changes of caregiver and/or housing and education are associated with greater assurance and ameliorate the effects of sexual maltreatment.[99]
Friendships and Peers	• Not doing well socially in primary school, having few friends, and being dissatisfied with social life as a teenager is associated with an increased risk of CSA.[71] • Children with few friends or close relationships, have no one to confide in, lack confidence and have low self-esteem are at increased risk.[58] • Non-romantic adolescent peers have been found to be common perpetrators of CSA.[96] • Among factors that may decrease the likelihood of a child being sexually abused are access to supportive and trustworthy adults, supportive peers, and strong community or cultural connections.(6)
Educators & services staff	• Education services staff are typically well positioned to support CSA prevention, recognise signs and symptoms of abuse, respond to allegations and disclosures, report to the proper authorities, and provide information on community resources and supports.[2] • Other service staff commonly implicated in reporting CSA are those associated with legal and law enforcement, social services staff, medical and mental health practitioners, child day care workers, and foster care providers.[100]

Online spaces	• Online platforms facilitate access to vulnerable children and increase risk of CSA.[101] • The virtual setting is integral for social interaction and communication, particularly for adolescents and young people, creating copious opportunities for online grooming and sexual exploitations.[10] • A child's frequent use of the internet has been found to increase the risk of CSA.[95]

Individual Factors

The socioecological model places the individual child or adolescent and their identity at the centre of their ecology, while recognising the impact of the multiple surrounding layers of interacting variables. Within this microsystem, different aspects of a person's **identity** overlap and interact, shaping a child's **experiences** and **exposures**, including those related to privilege and empowerment, or, conversely, oppression and discrimination. Due to the **intersecting** nature of an individuals' social identity and characteristics it is important to recognise individual factors that affect CAD in combination rather than in isolation.



At the level of the individual, CAD is shaped by **biological** factors such as **age, sex, health** and **genetics**. Research into sex differences and CAD has established that brain structure and function is not fixed (brain plasticity), and that biological development is a continual process that responds to socialisation.[102] For example, boys are more physically active than girls throughout childhood and sex differences in physical activity continue to widen during childhood, despite the fact that sex hormone levels do not differ between boys and girls from six months of age to puberty. Parenting and social norms are factors likely to amplify the disparity.[103]

Gender and **ethnicity** labels, including stereotypes, also emerge early in the lifecourse and are closely tied to socialisation over time, including the emergence of prejudice and

sexism.[102, 104] **Culture** intersects with **biology** through a range of pathways, including brain organisation and life trajectories. Harkness and Super [105] note that while the basic **skills** of infants and young children may continue towards growth and mastery in similar ways, even in diverse contexts, "with experience and maturity they are shaped to the affordances, constraints, and uses of the cultural environment." In other words, the development of skills and abilities are heavily influenced by the child's social environment.

Australia's **First Nations** children and young people are exposed to high levels of adversity, however there are many strengths and protective factors in Aboriginal **cultural**, belief and kinships systems that focus on Aboriginal ways of knowing, learning and healing that can help overcome adversity and foster potential.[106] The Dance of Life model (shown in **Figure 3**) is a multidimensional model of health and wellbeing from the perspective of First Nations peoples that bring together five dimensions of life and development which include: • physical • psychological and emotional • social • spiritual • cultural. Using this model can help develop an understanding of the historical legacy of trauma, powerlessness and grief and the intergenerational impact, to make sense of poor developmental outcomes for Aboriginal children and young people.[106]

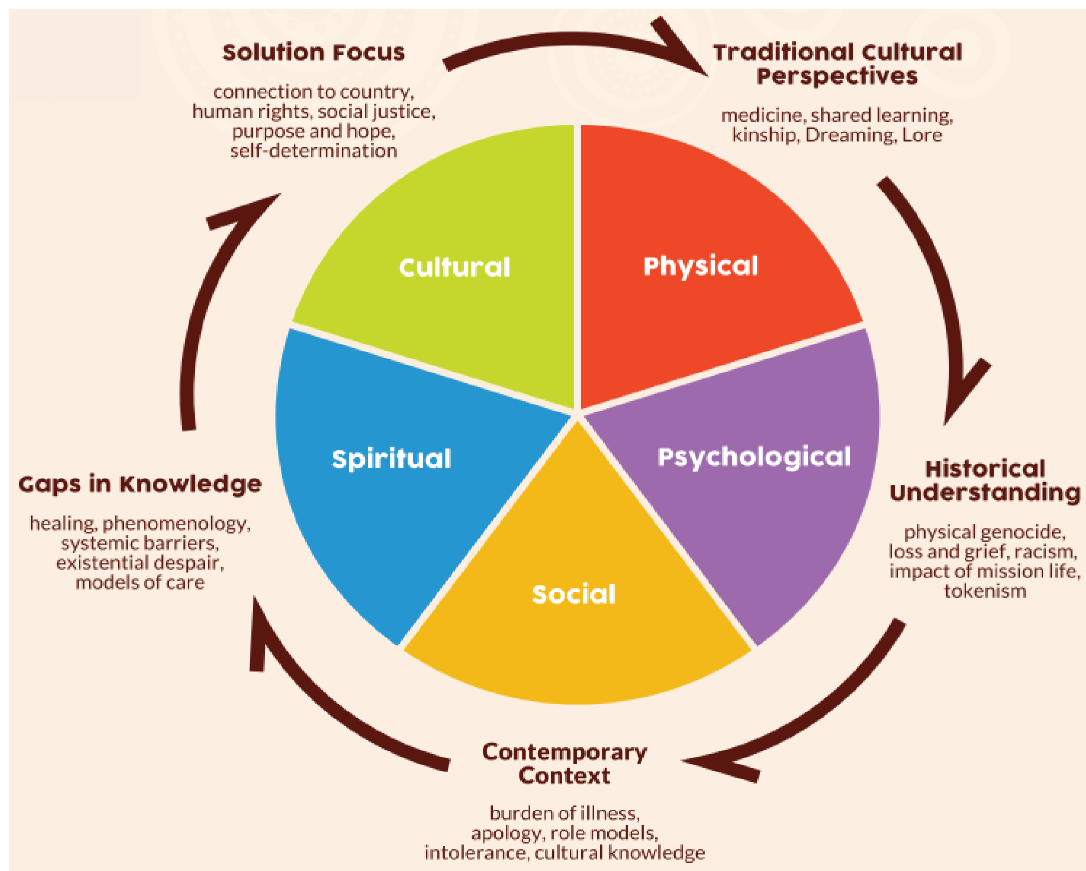


Figure 4 The Dance of Life model [106]

Individual Factors and CSA

CSA is not the result of a single factor, but a complex interaction between many variables. Explanations for why CSA occurs that centre only on individual attributes, risk blaming the victim for the sexual abuse. **CSA is never the fault of the victim**.[11]

In the table below are a range of examples of risk and protective factors associated with individuals that **may** be associated with CSA.

Individual Factors	CSA Risk and Protective Factors
Sex and gender	• Both male and female children are victimised, and experience risk differently.[58, 70, 107] • The majority of victims are female [11, 95, 96, 108, 109] however there is concern that the rates of disclosure for males is low.[2, 3, 11, 110] • The predominant sex of victims in specific settings is affected by the characteristics of the setting.[3] For example, Mathews, Finkelhor [96] found that males were more likely to be victims of CSA by institutional workers than females. Females were more likely to be victims than males when CSA was committed by parents/caregivers in the home, or by other known adults, unknown adults, siblings, other known adolescents (romantic and non-romantic) and other unknown adolescents.[96] • Boys are more at risk of CSA by a non-family member, outside the home, girls by a family member and over a longer duration.[10] • Children and adolescents who identify as LGBTIQ+ and those who do not fit societal expectations of appropriate gender expression may be at increased risk.[2, 11]
Age and developmental stage	• Age at which abuse starts varies according to setting.[3] • Middle childhood (average age 11 years) is the most vulnerable period.[10, 11] • Girls tend to be younger than boys when abused.[10] • As children become teenagers and more aware of their sexuality, they may be at increased risk of abuse if adult perpetrators seek to exploit this development stage.[11]. • For victims, risk of revictimization across the life course is high.[10, 95, 111]

	• It is widely acknowledged that, in order for children to report their experiences of sexual abuse, they must have an anatomically correct vocabulary.[2]
Other biological and personality traits	• Low birth weight, pregnancy or birth complications, child temperament and behaviour and disability are considered individual risk factors for abuse and neglect.[112] • Physical weakness or smaller stature, children who are socially isolated, those who are high achievers, have low self-esteem, and those with limited understanding about sexual behaviour and personal safety may be at increased risk.[2, 11, 58]
Aboriginality	• First Nations children experience sexual abuse at a rate of 2.7 per 1000 children compared to 0.5 per 1000 for non-Aboriginal children. This abuse is underlined by wider social factors related to intergenerational trauma, inequality, racism and poverty.[113] • First Nations children may be more vulnerable to sexual abuse because they encounter circumstances that • place them in institutions with high risk • make it less likely they will be able to disclose or report abuse • make it more likely they will receive an inadequate response to sexual abuse than other children [11].
Ethnicity and migration status	• Children from culturally and linguistically diverse backgrounds also may be more vulnerable to sexual abuse because they encounter circumstances that • place them in institutions with high risk • make it less likely they will be able to disclose or report abuse • make it more likely they will receive an inadequate response to sexual abuse than other children.[11] • Child asylum seekers and refugees, and their families, can have past trauma from their experiences in their countries of origin or during the migration journey that make them more vulnerable to abuse. Past trauma together with a lack of support to communicate in the English language, social isolation and immigration detention may increase the vulnerability of child asylum seekers and refugees.[11] • Racial discrimination and stereotyping make it is possible that a child's race and/or culture may impact how they are supported in CSA prevention and their likelihood of experiencing sexual abuse.[2]

Disability	• Presence of any disability increases the risk of sexual victimisation. [2, 3, 51, 58, 70, 109] • Children with intellectual disability, or communication or behavioural disorders are at particularly higher risk of all forms of abuse.[11] • Due to communication and cognitive delays, children with intellectual disability may not be able to accurately report abuse, and may not be able to dissuade an abuser (e.g., by articulating "no" or "stop").[2] • Children with a disability may be more vulnerable to sexual abuse because they encounter circumstances that • place them in institutions with high risk • make it less likely they will be able to disclose or report abuse • make it more likely they will receive an inadequate response to sexual abuse than other children.[11]
Prior history of maltreatment or mental illness	• Children with a history of prior sexual victimisation or maltreatment (domestic violence, emotional or physical abuse, neglect), and prior history of mental illness are at greater risk.[3, 4, 11, 111] • Maltreatment may lead to a range of emotional, cognitive and psychological effects (e.g. low self-esteem, poor relationships, heightened need for affection, developmental disorders) that can make children more vulnerable to subsequent CSA.[11] • CSA victims often experience mental ill health consequences [111].
Behaviours	• Positive family communication about sexual behaviour, has been found in a number of studies to be associated with improved sexual safety among adolescents.[51] • Victims of CSA are more likely to partake in sexual risk-taking behaviour when they reach adolescence [101]; and may be at increased risk of substance abuse and antisocial behaviour.[114]
Disclosure	• It is estimated that only 10–20% of all CSA cases are reported to the law enforcement and some cases are never disclosed at all.[115] • Reasons for non-disclosure include guilt, fear of family disruption, and self-blame.[115]

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