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Residential Care Practitioners' Knowledge, Training and Insights into Child Sexual Exploitation

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Abstract

This article considers practitioner training, knowledge, and perceptions in relation to child sexual exploitation (CSE) of young people in residential care. CSE is a complex phenomenon, and frontline practitioners need and deserve adequate education and training about its nature, characteristics and impacts, in order to identify and manage incidents, act in the best interests of the young people in their care and engage with criminal justice and other social systems. Internationally, little research has been conducted into CSE and professional practice generally, including in this context of heightened risk. We report the results of a quantitative survey of residential care practitioners from Queensland, Australia. Key findings include: the lack of pre-service and in-service training; the desire for further training; priority areas for development of accurate knowledge; and insights into systemic features that facilitate and impede optimal responses to CSE. Results have implications for diverse settings in Australia and elsewhere internationally.

Keywords: Child sexual exploitation; residential care; out of home care; practitioners; knowledge; professional education.

Introduction

Child Sexual Exploitation

Child sexual exploitation (CSE) is generally understood as involving the coercion of children into sexual activity in return for something of value (Gatwiri et al., 2020; Greeson et al., 2019; Laird et al., 2020; Mooney, 2022; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017). The defining feature of CSE is its transactional nature; the sexual abuse of the child (whether done in person or online) involves abusive acts done in exchange for something of value to the child. The object of value may be financial, but it may also have any other character such that it is perceived by the child as possessing value. The matter comprising the transactional subject of the CSE may involve gifts; provision of alcohol or drugs; provision of other things related to the child's safety or security such as food, shelter, or protection; and it may also involve the provision of privilege or opportunity. The benefit may also accrue to the perpetrator, or to another person (UK Department for Education, 2017). Due to its characteristics, CSE is an important type of child sexual abuse (CSA) (Mathews & Collin-Vezina, 2019), while being distinct from other types of CSA by the element of transaction for value. CSE properly understood is not simply a

synonymous term for either CSA, or for online sexual victimisation or other types of sexual violence such as image-based sexual abuse.

Contemporary Understanding of CSE

The acts constituting CSE have historically been interpreted as "child prostitution," with this misrepresentation conceiving of the children and young people involved as criminal offenders or perpetrators of anti-social behaviour (Hallett, 2016). The impact on the child or young person was seen to be mitigated by the material or intangible gain of the activity, which also contained an implicit acceptance of the child's ability to consent to sexual acts regardless of their age (Alderson & Ireland, 2020), and the circumstances. Understandings in this setting have generally evolved in recent years, moving from a perception of such acts as child prostitution, to an appreciation of them as involving CSE. This has been influenced by practice frameworks developed in the UK (Hallett, 2023), findings from the Australian Royal Commission (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017), and the discovery and recognition of CSE in its online form (Laird et al., 2022). Even still, contemporary difficulties remain, since sexually exploited children and young people may often be perceived as engaging in "risk taking" or "problematic' sexual behaviours" (Hallett, 2023); this somewhat euphemistic conception – while an advance from the perception of CSE being equivalent to promiscuity or prostitution - will often be inaccurate and harmful, given the criminal and damaging nature of CSE.

Current representations of CSE are founded on a "grooming" model (Hallett, 2023). The grooming process is widely perceived to occur, primarily online, when a perpetrator (who could be an adult or a peer), targets a victim, and develops a relationship with them to sexually exploit them (Gatwiri et al., 2020). The child or young person may believe the relationship is normal, when it is, in fact, abusive, involving manipulation, bribery or threats of violence (Gatwiri et al. 2020). A child or young person sexually exploited in a situation portrayed by the perpetrator as a "relationship" may induce them to believe they have given consent, even when they are either under the age of legal consent (Alderson & Ireland, 2020), or when their ostensible consent is negated because it is neither genuinely full, free, and voluntary. Much CSE does occur in situations of grooming, but such grooming situations are not the exclusive context for sexual exploitation. It is important to recognise the broader context in which CSE occurs and the typical lived experience of sexually exploited children and young people (Phoenix & Davidson, 2019). CSE commonly occurs alongside childhood trauma, instability, disconnection, poverty, homelessness and substance use (Gatwiri et al., 2020; Hallett, 2023). A child or young person may exchange sex for their own survival to meet essential needs that have rarely been met by family, or alternate care and welfare systems (Hallett, 2023).

Research into the prevalence of CSE is still in its infancy (Allroggen et al., 2017; Timmerman & Schreuder, 2014). However, existing evidence suggest it is a significant problem. In Australia, for example, the Royal Commission into Institutional Child Sexual Abuse (2016) reported that children and young people living in residential care described alarming rates of CSE. This concern was reflected in specific recommendations; 12.14 and 12.15 to prevent and respond to CSE (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a). The concerning prevalence of this problem is also reflected in international law and policy commitments to its prevention.

International Law and Policy

The United Nations Convention on the Rights of the Child 1989 (United Nations, 1989) contains several articles supporting the prevention and response to CSE. As relevant here, Article 19 requires States Parties (countries that have agreed to be bound by the convention) to take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of violence and exploitation, including sexual abuse, while in the care of parents or legal guardians. These protective measures should include programs to support those who have the care of the child, and to prevent, identify, report, investigate, and treat instances of exploitation. Article 25 recognises the right of a child who has been placed in care to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement. Moreover, Article 20 recognises that a child who is temporarily deprived of his or her family environment shall be entitled to special protection and assistance. Other international instruments, such as the Council of Europe Convention on the Protection of Children Against Sexual Exploitation and Sexual Abuse (the Lanzarote Convention), also recognise sexual exploitation as a priority issue (Council of Europe, 2007). Article 5 of the Lanzarote Convention requires States Parties to build awareness of children's rights in those working with children, and in particular to train practitioners to ensure they have adequate knowledge of sexual exploitation and sexual abuse of children and are able to identify these experiences.

International policy documents, including the International Classification of Violence against Children (United Nations Children's Fund, 2023), now clearly recognise sexual exploitation as a distinct manifestation of sexual abuse, characterised by its exploitative nature. The UN Sustainable Development Goals Target 16.2 aims to end abuse, exploitation, trafficking and all forms of violence against children, and requires governments to report on their efforts to do so (United Nations, 2015). Taken

together, these international instruments and policies evince a recognition that nations and organisations have a responsibility to undertake concerted efforts to recognise and respond to CSE, including through systemic efforts and development of professional awareness and capacities.

The Residential Care Context, and the Professional Practitioner Context

Residential care is defined as a placement in a residential building where staff are employed on a 24-hour roster to care for children (AIHW, 2020). Apart from a minority of privately resourced units, these placements are largely government funded, and administered by nongovernment providers (McNamara & Wall, 2023). Residential care in Australia has predominantly been utilised for children aged 13-18 years of age (McNamara & Wall, 2023), who cannot be placed in family-based placements due to their complex needs and behaviours (Moore et al., 2017). However, substantial numbers of younger children are also in residential care in some jurisdictions. For example, in Queensland, 31% of children in residential care are under 12 years of age (Department of Child Safety, Seniors and Disability Services, 2024). Staff retention and issues of training and support are continual challenges for the sector (McNamara & Wall, 2023). Some evidence suggests CSE is a growing concern in this setting. In Queensland, complaints have increased about the sexual exploitation of young people in residential care settings (Queensland Family and Child Commission, 2024).

Employers of Australian residential care practitioners currently require minimal vocational qualifications, and accordingly many practitioners may not have been equipped by their education and training with suitable skills and knowledge. Despite the vulnerability of children living in residential care to CSE, there is no requirement for these practitioners to receive specialised pre-service or in-service training about CSE. Organisations that provide residential care services assume responsibility for training and providing their frontline practitioners with the skills to protect the children in their care from CSE on an ad hoc, rather than mandatory basis.

Existing Research into Residential Care Practitioner Training: Evidence Gaps

Research into professional practice in relation to CSE is in its infancy. Recent reviews indicate major gaps in evidence about important domains of professional practice and systemic responses (Gatwiri, et al., 2020; Hurst, 2021; McKibbin, 2017; Mooney, 2022). In particular, little evidence exists about: the level of professional training provided to a broad spectrum of practitioners who work with children involved in CSE; practitioners' self-reported satisfaction with this training; practitioners' knowledge of key dimensions of CSE; and practitioners' view about systemic facilitators and barriers to sound responses to CSE.

As shown by research in related fields (Mathews et al., 2006, Mathews et al., 2009; Mathews et al., 2017), professional training is important to equip practitioners in this context of CSE with the knowledge they require to fulfil their professional roles, and professionals can provide important information about systemic barriers to optimal responses. Informed by adult learning theory, professional education is premised on a theory of change in which education and training is essential to build accurate knowledge about complex core concepts, develop prosocial attitudes enabling appropriate responses to challenging individuals and situations, and expand personal and professional skills and capacities to perform key tasks (Knowles et al., 2011; Mukhalalati & Taylor, 2019; Sargeant et al., 2018).

Alongside this general lack of research into professional practice in relation to CSE, both generally and in Australia, there has been little empirical research with residential care practitioners. Several small qualitative studies have been conducted, in relation to statutory child protection practitioner views of challenges and optimal practices in responding to CSE (Hallett, 2023), and ways in which these practitioners believe CSE occurs, as well as its perceived characteristics (Hallett, 2025). However, no quantitative studies have been conducted of residential care practitioners' training about CSE, their views about the adequacy of their training, their knowledge of CSE, and their insights into systemic impediments to good practice. These evidence gaps are concerning. Residential care practitioners deserve to be adequately prepared to fulfil their professional role in responding to CSE, and their professional and therapeutic role when dealing with children suspected or known to have experienced CSE. Children and youth in out of home care have been found to be at heightened risk of CSE, and to themselves have recommended that staff in residential care be better education about CSE and have improved interpersonal skills to deal with it (Dierkhising et al., 2020).

In general, as applied to practitioners in connected professions such as education (Walsh et al., 2008; Walsh et al., 2022), and nursing (Fraser et al., 2010), it is known that a number of factors influence the effectiveness of practitioners' actual practice. Factors influencing effective responses to child sexual abuse more generally include characteristics of the child's situation, such as the frequency and severity of the child's injuries and behaviour (Walsh et al., 2008). Most significantly for this article, research suggests practitioners' appropriate responses are influenced by the extent, nature, and recency of their training in

recognising abuse (Hawkins & McCallum, 2001). Numerous studies have found practitioners reported being underprepared by training about indicators of abuse and reporting processes, including Australian studies of nurses (Fraser et al., 2010; Mathews et al., 2008) and teachers (Mathews et al., 2009; Mathews, 2011; Walsh et al., 2008). Accordingly, there is a need for staff across the organisation to have a high level of knowledge to underpin core competencies, as is the case across professions dealing with CSE (Mathews & Collin-Vézina, 2016).

These evidence gaps and the regulatory context show that it is necessary to generate evidence of the current state of practitioners' training and knowledge about CSE. It is also important to understand practitioners' insights about systemic features in this context which can facilitate or impede practice, which may further illuminate specific education and practice needs. Such evidence can inform organisational efforts to develop and enhance professional development and better equip practitioners to fulfil their roles in this context.

Research Aims

Informed by current evidence and gaps in knowledge, this study aimed to generate descriptive evidence about several key domains of residential care practitioners' professional development experience, capacity, needs, and practice insights. In summary, the survey was designed to advance understanding of these practitioners': (1) experience of pre-service and in-service training about CSE; (2) self-rated estimation of the adequacy of the training; (3) desire for further training; (4) levels of knowledge, and knowledge gaps, among about the nature, characteristics, and risk factors for CSE; (5) practice-based insights into systemic impediments to effective practice.

Research Questions

Overall, this study considered the following research questions:

1. What is the extent of pre-service and in-service training practitioners have received about child sexual exploitation?
2. What is the level of self-reported satisfaction with this training?
3. Do staff desire further training?
4. What is the current level of practitioners' knowledge about key features of child sexual exploitation?
5. What do practitioners perceive about systemic features that facilitate or impede effective responses to child sexual exploitation?

In relation to these questions, we hypothesised that: (1) There are substantial gaps in practitioners' pre-service training about CSE, and moderate gaps in practitioners' in-service training about CSE; (2) Practitioners would report low - moderate levels of satisfaction with their training; (3) Practitioners would express a moderate desire for further training; (4) There are important gaps in knowledge about key features of child sexual exploitation; and (5) Practitioners would provide valuable insights into systemic features that both facilitate and impede effective responses to CSE.

Methods

The methodology was informed by a similar study of Queensland nurses' training and knowledge (Mathews, 2008), and a similar study of primary school teachers conducted in Queensland, New South Wales, and Western Australia (Fraser et al., 2010; Mathews et al., 2006; Mathews, 2011). We used a quantitative survey methodology which is appropriate for exploring a phenomenon in a general population of interest by measuring a set of variables across the relevant population (de Vaus, 2014; Dillman et al., 2014).

The study employed a cross-sectional survey design, capturing practitioners' responses to a questionnaire at one point in time, providing a descriptive and statistical snapshot of their self-reported training, knowledge and perceptions related to important topics in CSE. The cross-sectional survey was conducted online with a sample of consenting participants, drawn from a purposive sample of eligible State-wide practitioners. This sample is of sufficient size to conduct the required analysis (Dillman et al., 2014; Salkind & Frey, 2019).

Survey Instrumentation / Measures

No existing survey instrument had been designed for this specific context, and accordingly the research team developed the *Practitioner Survey on Child Sexual Exploitation: Training, Knowledge and Insights* for the purpose of this research. This survey instrument contained five sections: demographics; job details; education/training about CSE (including self-rated adequacy); knowledge of CSE; and practice insights.

The section on education and training captured information about whether the participant had ever had training about CSE in pre-service and post-service, and if so, its duration (number of hours). In each case, we also asked about their self-rated adequacy of the training, using a 5-point Likert-type scale in answer to the question "How satisfied were you with the training?" (responses were 1 = Extremely dissatisfied; 2 = Somewhat dissatisfied; 3 =Neither satisfied nor dissatisfied; 4 = Moderately satisfied; 5 = Extremely satisfied). This section also included one item which asked participants whether they would like to receive any further training about CSE.

The section on knowledge of CSE contained a range of questions about CSE, including about its definition, nature and prevalence; perpetrators, grooming strategies, indicators and risk factors; and associated impacts and common behaviours of exploited youth that affect practitioner engagement. Questions about the definition of the more general concept of child sexual abuse, and its nature and prevalence, were included to further illuminate participant knowledge and the capacity to differentiate between the two experiences.

All questions had response options provided, from which the participant selected the correct response. For five questions, there was only one correct answer option from the answer options provided. Some of the questions were multiple choice, with more than one correct response, so that for each respective question there was a single correct answer (whether involving a single or multiple correct response options). For several questions with lists of answer options, all answer options provided were correct. For several other questions with lists of answer options, some options were correct and some were incorrect. This approach enabled us to generate a comprehensive understanding of areas where practitioners were more or less knowledgeable, and to identify common misunderstandings which may affect practice. It enabled generation of results about the proportion of participants who provided a correct answer to each of the 13 questions, and results about an aggregate knowledge score summing all correct answer options provided with a possible maximum of 60.

Finally, in relation to practitioner insights, we asked participants for their views about systemic features that both facilitate and impede optimal responses to CSE, focusing on collaborative relationships with a selection of four key agencies (police, child safety, education, and health). These features were premised on a desire to understand the relative importance of collaborative working relationships with other key sectors in responding to CSE, and the extent of difficulties with different agencies perceived by participants based on their experience. Participants were also asked to rank the four response options in order of salience. We also asked practitioners if they thought the frequency of CSE was increasing, and if so, why, using a list of response options.

The survey instrument was carefully designed in a co-design process between the academic researchers and the industry partner team members through an iterative consultation process. The instrument draws on approaches and principles successfully adopted in previously administered surveys with diverse groups of practitioners about practitioner demographics, training and knowledge in similar fields (Fraser et al., 2010; Mathews et al., 2006; Mathews et al., 2008) and was informed by a review of contemporary social science evidence about CSE.

Sample and Recruitment

This quantitative survey was conducted with a purposive sample of residential care practitioners in Queensland from Integrated Family and Youth Services Limited (IFYS). This sample was selected because of its participants' ability to provide information about the research topics of interest. IFYS is a large organisation which delivers a range of specialist support and intervention programs for children, young people, and families across Queensland, and employs approximately 800 frontline practitioners State-wide. IFYS staff come from a range of backgrounds and are likely to have varied levels of professional knowledge about CSE. The sample was not restricted only to those who worked directly on a daily basis with children and young people, and could include managerial staff who have also worked in a practitioner role. IFYS employs a Principal Advisor (Child Sexual Exploitation), whose role includes the development of workforce capacity to identify and respond to CSE. In a co-design process with the research team, IFYS identified key research questions of interest that underpin this research, namely the identification of practitioner knowledge and training needs, and understanding practitioners' perceptions of systemic barriers and facilitators to optimal responses.

Participation was anonymous, confidential, and voluntary. Participant recruitment was undertaken using the IFYS internal staff database. Initial awareness-raising of the survey was achieved through internal communications to staff via an internal staff intranet. This was followed two weeks later by an approach email inviting participation in the survey, with information about its nature and purpose, and a Participant Information Sheet and Consent Form. Ethical approval was obtained from the Queensland University of Technology Human Research Ethics Committee (#7464, 16 July 2023). Approval to conduct the research was also obtained from IFYS on 3rd July 2023.

Data Collection and Collation

The survey was made available to participants over a nine-week period from 13 October to 2023 to 16 December 2023. We administered the survey using the secure online platform Qualtrics. The Qualtrics software enables efficient, anonymised and confidential participation at a time convenient to participants and different modalities (i.e., desktop computer, laptop, or mobile phone) to suit participant needs. Individuals who were willing to participate registered their signed consent through an initial screen on the Qualtrics survey platform before commencing the interview. The survey took an average of 10-15 minutes to complete, and responses were automatically recorded through the online software. Data were extracted from Qualtrics into a Microsoft Access database and imported into STATA (Version 17) for management, cleaning and analysis.

Data Analyses

The analyses presented here are descriptive statistics, providing data that are practically useful in understanding training exposure and needs within this sector. To summarise the data frequencies, percentages were presented and for scores mean, standard deviation (SD) and range were presented.

Results

Practitioners returned 84 completed questionnaires. Most respondents were female (83%), and the mean age was 39.7 years. This sample was representative of the practitioner population in Queensland, since these features closely reflect the workforce profile. In 2023 when the survey was undertaken, of 807 total employees, the workforce composition by gender was 76.5% female in management roles, and 70.9% female in non-management roles (IFYS, 2023). The majority of participants were frontline practitioners and their managers, although a small number were administrative staff. In addition, 60% of IFYS employees are educated to diploma/degree level, while 15% hold a certificate between levels 1-4; this reflected the educational profile of the sample, of whom 79.75% were educated to diploma or degree level or higher, 15.48% hold a certificate between 1-4, 3.57% hold a Senior Secondary Certificate of Education, and 1.19% selected other.

Presence, Duration and Self-reported Adequacy of Pre-service Training About CSE

Overall, only one in four participants (25%) had received pre-service training about CSE, with this training being of varying duration, and with two thirds (66.7%) being either highly satisfied or moderately satisfied with this training. Three in four participants (75%) had not received any pre-service training. Results are shown in Table 1.

Table 1

Presence, Duration and Self-Reported Adequacy of Pre-Service Training About CSE (N = 84, n, %)

Presence of pre-service formal training		
Yes	21	25%
No	63	75%
Pre-service formal training duration		
≥ 2 hours	1	4.8%
3 to 6 hours	8	38.1%
7 to 9 hours or a day	-	-
More than a day	6	28.6%
Full time study	1	4.8%
Cannot remember	5	23.8%
Satisfaction/adequacy with pre-service training		
Highly satisfied	5	23.8%
Moderately satisfied	9	42.9%
Neither satisfied nor dissatisfied	6	28.6%
Dissatisfied	1	4.8%
Highly dissatisfied	-	-

Presence, Duration and Self-Reported Adequacy of In-Service Training About CSE

Overall, slightly more than half (55.9%) had received in-service training about CSE, with this training typically lasting either a day or 7-9 hours, and with the vast majority (93.6%) being either highly satisfied or moderately satisfied with this training. However, nearly half of all participants had not received in-service training. Results are shown in Table 2.

Table 2

Presence, Duration and Self-Reported Adequacy of In-Service Training About CSE (N = 84, n, %)

Presence of in-service formal training		
Yes	47	55.9%
No	37	44.1%
In-service formal training duration*		
≥ 2 hours	8	18.2%
3 to 6 hours	4	9.1%
7 to 9 hours or a day	8	18.2%
More than a day	24	54.6%
Satisfaction/adequacy with in-service training		
Highly satisfied	31	65.9%
Moderately satisfied	13	27.7%
Neither satisfied nor dissatisfied	2	4.3%
Dissatisfied	1	2.1%
Highly dissatisfied	-	-

Note: * Three participants did not respond.

Desire for Further Training About CSE

All participants who attended in-service training about CSE (n = 47) were asked if they had a desire for any further training. Of these participants, 85.1% (n = 40) responded that they would like further training, 6.4% (n = 3) said they would not, and 8.5% (n = 4) were unsure.

Knowledge About CSE

Definition, nature and prevalence of CSE. Overall, participants demonstrated sound knowledge of definitions of CSE and CSA, although one in five (22.5%) and one in three (35.7%) participants respectively did not know the correct definition of these concepts. Knowledge of prevalence of these two experiences was similar for CSE, but far lower for CSA. Practitioners demonstrated very high knowledge of the types of things of value that can be involved in CSE, with nearly all correctly identifying all relevant items. However, only one in five practitioners (19.1%) correctly answered the item about what is required to give consent to sexual acts. Results are in Table 3.

Table 3

Accuracy of Practitioner Knowledge About CSE and CSA Definitions and Prevalence (N = 84, n, %)

CSE definition*		
Yes	62	77.5%
No	18	22.5%
Things of value that can be involved in CSE (Multiple response)		
Money or gifts	84	100%
Drugs or alcohol	83	98.8%
Food	83	98.8%
Housing	83	98.8%
Protection	83	98.8%
Employment	82	97.6%
Privilege or opportunity	83	98.8%
Aggregate knowledge (things of value in CSE), mean, SD (range)	**84**	**6.9, 0.6 (2-7)**
CSE prevalence in Australia§		
Yes	64	78.1%
No	18	21.9%
CSA definition*		
Yes	54	64.3%
No	30	35.7%
CSA prevalence in Australia#		
Yes	17	20.5%
No	66	79.5%
Nature of consent to sexual acts		
Yes	16	19.1%
No	68	80.9%

Notes: * Four participants did not respond. The item wording and response options appear in the Appendix. § Two participants did not respond. The item wording and response options appear in the Appendix. # One participant did not respond. The item wording and response options appear in the Appendix.

Perpetrators, grooming strategies, indicators and risk factors of CSE. Overall, participants demonstrated very high knowledge of which individuals can perpetrate CSE, with nearly all correctly identifying all relevant responses. Similarly, nearly all practitioners demonstrated excellent knowledge of in-person CSE grooming strategies, and of online grooming strategies. Knowledge of indicators of CSE was also high, although one indicator (school absences) was infrequently identified (22.0%). However, in relation to CSE risk factors, lower knowledge was evident, with several common risk factors being less often identified: for example, child gender, body image problems, single-parent families, and poor school performance. Results are in Table 4.

Table 4

Accuracy of Practitioner Knowledge About CSE Perpetrators, Grooming Strategies, Risk Factors and Indicators (N = 84, n, %)

CSE perpetrators (Multiple response)		
A parent	83	98.8%
An institutional authority figure (e.g., teacher; residential care provider)	84	100%
An individual adolescent	82	97.6%
A group of adolescents	82	97.6%
An individual adult	83	98.8%
A group of adults	83	98.8%
A criminal gang	83	98.8%
An unknown person online	82	97.6%
A friend	83	98.8%
A peer in out-of-home care	82	97.6%
An unknown person offline	81	96.4%
Aggregate knowledge (CSE perpetrators), mean, SD (range)	**84**	**10, 1.1 (1-11)**
In-person CSE grooming strategies (Multiple response)		
Psychological manipulation e.g., flattering the child, boosting their self-esteem	84	100%
Promises to provide things of value	83	98.8%
Promising or providing access to parties, alcohol and drugs	83	98.8%
Isolating child from family and parents	83	98.8%
Gradual gaining of trust over time	83	98.8%
Aggregate knowledge (in-person grooming strategies), mean, SD (range)	**84**	**4.9; 0.3 (3-5)**
Online CSE grooming strategies (Multiple response)		
Psychological manipulation e.g., flattering the child, boosting their self-esteem	84	100%
Promises to become the child's boyfriend	82	97.6%
Exchange of jokes and innocuous content, gradually escalating to sexual content	82	97.6%
Making the sexual acts seem normal	83	98.8%
Aggression, e.g., threats to distribute online images	83	98.8%
Financial promises	84	100%
Financial threats	81	96.4%
Threats to harm themselves if the child does not do as they are asked	81	96.4%
Aggregate knowledge (online grooming strategies), mean, SD (range)	**84**	**7.8, 0.5 (4-8)**
CSE risk factors (Multiple response)		
Childhood sexual abuse	84	100%
Poverty	77	91.7%
Single-parent families	60	71.4%
Engagement in risky sexual behaviour	78	92.8%
Poor school performance	59	70.2%
Child gender	54	64.3%
Instability in out-of-home care placement	78	92.9%
The child having body image problems	66	78.6%
The child being in out-of-home care	75	89.3%
Aggregate knowledge (risk factors): mean, SD (range)	**84**	**7.5, 1.9 (2-9)**
Indicators of CSE (Multiple response)		
Sudden possession of money or objects without any clear explanation	80	96.4%
Frequent association with people the child does not know, who the child has no clear reason to be with	82	98.8%
Absences from home, especially at night	82	98.8%
Absences from school	69	22.0%
Aggregate knowledge (indicators), mean, SD (range)	**84**	**3.7, 0.7 (0-4)**

Associated impacts, and behaviours affecting practitioner engagement. Overall, participants demonstrated very high knowledge of the impacts of CSE on adolescents, with over 90% correctly identifying each outcome. Participants also demonstrated very high knowledge of the common behaviours characteristics of young people who have experienced CSE can affect engagement with residential care practitioners, with over 90% correctly identifying each outcome. Results are in Table 5.

Table 5

Accuracy of Practitioner Knowledge About CSE Impacts on Behaviour and Effects on Practitioner Engagement (N = 84, n, %)

Impacts of CSE on adolescents (Multiple response)		
Cognitive distortions about sex	82	97.6%
Aggression	81	96.4%
Alcohol and drug use / dependence	83	98.8%
Health risk behaviours e.g., self-harm, suicidal thoughts	84	100%
Mental health problems e.g., anxiety, depression	84	100%
Criminal offending	78	92.8%
Aggregate knowledge (impacts), mean, SD (range)	**84**	**5.9, 0.6 (2-6)**
Common behaviours of exploited youth that affect practitioner engagement (Multiple response)		
Resisting practitioner efforts to help	80	95.2%
Going missing / running away	82	97.6%
Identifying with the perpetrators	79	94.1%
Protection of the perpetrator	79	94.1%
Mistrust of practitioners	80	95.2%
Aggregate knowledge (behaviours), mean, SD (range)	**84**	**4.8, 0.8 (1-5)**

Practitioner Insights into Systemic Facilitators and Challenges

Participants indicated the importance of collaborative working relationships with other key sectors in responding to CSE. Notably, nearly half (46.6%) ranked effective interagency working with police as the most important facilitator to good responses to CSE, with a further one in four (23.3%) indicating effective collaboration with education personnel as the most important facilitator. Similarly, two in five participants (40.6%) ranked challenges in working with police as the most important impediment to good responses to CSE, with a further one in four (27.5%) indicating challenges in supportive relationships with the Department of Chid Safety was the most important impediment. Results are in Table 6.

Table 6

Ranking of Systemic Characteristics That Facilitate and Impede Responses to CSE

Systemic Characteristics	Ranking			
	1	2	3	4
Facilitators (N = 73)*	n, %	n, %	n, %	n, %
Cooperative relationships with Department of Child Safety	12 16.4%	26 35.6%	14 19.2%	21 28.8%
Effective interagency working with police	34 46.6%	15 20.5%	13 17.8%	11 15.1%
Effective interagency working with health personnel	10 13.7%	22 30.1%	27 36.9%	14 19.2%
Effective interagency working with education personnel	17 23.3%	10 13.7%	19 26.0%	27 36.9%
Challenges (N = 69) §				
Challenges in cooperative relationships with Department of Child Safety	19 27.5%	25 36.2%	14 20.3%	11 15.9%
Challenges in effective interagency working with police	28 40.6%	20 28.9%	10 14.5%	11 15.9%
Challenges in effective interagency working with health personnel	7 10.1%	18 26.1%	25 36.2%	19 27.5%
Challenges in effective interagency working with education personnel	15 21.7%	6 8.7%	20 28.9%	28 40.6%

Note: * 11 participants did not respond. § 15 participants did not respond.

Perceptions About Whether CSE is Becoming More Common

Overall, a substantial majority of four in five practitioners (79.3%; n = 65) indicated they thought CSE was becoming more common, with a further one in five (19.5%; n = 16) saying they did not know. Among those who said yes, the three most prominent reasons offered were the availability and impact of technology (100%), poverty, homelessness or socioeconomic strain (82.8%), and general sexualisation of society (73.4%). Results are in Table 7.

Table 7

*Practitioners' Perceived Reasons for CSE Becoming More Common (N = 64, n, %)**

Lack of parental supervision of children and youth	44	68.8%
Availability and impact of technology	64	100%
Sexualisation of society generally	47	73.4%
Online pornography and its effects on offenders	44	68.8%
Poverty, homelessness or socioeconomic strain	53	82.8%
Drug addiction or alcohol addiction	46	71.9%
Family breakdown	46	71.9%
Offenders being less likely to have healthy sexual relationships	37	57.8%
Other	5	7.8%

Note: * 1 participant did not respond.

Discussion

Overall, this study contributes new insights in relation to residential care practitioners' self-reported training, knowledge about CSE, and insights into systemic impediments and challenges. Several main themes emerged.

Self-Reported Training, Adequacy, and Desire for Further Education

In relation to the training component of our survey, we found three key themes, which generally confirmed our first hypothesis. First, and consistent with this hypothesis, we found that there are very substantial gaps in practitioners' pre-service training about CSE, with only one in four receiving any pre-service training. This notable finding suggests a major gap in pre-service curriculum in relevant courses of study at university or similar institutions. However, we also found substantial gaps in practitioners' in-service training, with little more than half having received any such exposure. This finding was somewhat concerning, but may be explained by the range of backgrounds from which practitioners enter this role, as well as the generally brief length of employment to date, and the recent developments in training in this particular organisation which may not yet have permeated through the entire organisation. Here we can note that practitioners' in-service training could have included training experienced within or beyond this specific organisation, although it is likely that a not insubstantial proportion would have received in-service training as delivered by the organisation, especially those who reported that their training duration was more than one day. The in-service training being progressively administered is formally endorsed as continuing professional development, and includes content about CSE in the international and Australian context, and material supporting skill development in how to identify children or young people at risk of CSE. Tools and techniques are introduced to support staff to engage with young people at risk of CSE and to develop an understanding of how to support them. Participants also receive practice tools and materials to develop their ability to prevent, identify, and respond to CSE.

Second, we found that overall, practitioners reported high or very high levels of satisfaction with their training. This was particularly evident for those who received in-service training, where the vast majority (93.6%) was highly or moderately satisfied with it; and even a majority (66.7%) of those with pre-service training were generally satisfied or moderately satisfied with it. This generally disproved our hypothesis that practitioners would report low - moderate levels of satisfaction with their training. This is an important finding, since it suggests an authentic engagement with the subject matter and that even relatively brief exposure to pedagogical content can provide salient information, build individual and collective capacity, and have positive effects on dispositions towards children and youth in these circumstances.

Third, confirming our hypothesis, we found a very high desire for further training, even among those who had already received in-service training, with 85% desiring further training. This encouraging finding reflects the typical ethic of committed professionals in professions serving children and youth, their commitment to the children they serve, and their desire to enhance social justice. It also indicates that further substantial gains can be made to the professionalisation of the workforce by providing follow-up training, or a series of progressively advanced training, to these practitioners. Finally, although we did not ask where the participants had received their in-service training, it is plausible that many of them would have received it through the organisation, and to this extent it indicates the training provided in this organisation is well-received.

Knowledge about CSE

In relation to the knowledge component of our survey, we found that generally, practitioners had very sound knowledge in relation to three broad domains assessed, namely, the definition, nature and prevalence of CSE; perpetrators, grooming strategies, indicators and risk factors; and associated impacts and behaviours on exploited youth which are likely to affect practitioner engagement. In particular, practitioners demonstrated excellent knowledge of things of value involved in CSE; perpetrators and grooming strategies both in person and online and impacts of CSE on adolescents and their effect on practitioner engagement. These findings partly disproved our hypothesis that there would be important gaps in knowledge about key features of child sexual exploitation. The overall knowledge levels are somewhat incongruent with the low levels of training characteristics of the sample; however, they may be explained by these participants – including those without the formal in-service training - having a combination of practical experience, exposure to knowledgeable colleagues, and being employed in an organisation which may have a healthy culture of general awareness-raising about this setting. However, we did find some significant gaps in knowledge, which confirmed our hypothesis and is consistent with the low levels of formal training. Most notably, practitioners were less knowledgeable about: the correct definitions of CSE and CSA; the nature of consent to sexual acts; and risk factors for CSE. Generating knowledge about these foundational concepts and facts is important to develop the workforce and inform their practice, and should be attainable.

Practitioner Insights

In relation to the practitioner insights component of our survey, we found practitioners considered the most salient impediment and facilitator to successful responses to CSE to be effective cooperative relationships with police and the Department of Child Safety. CSE is a complex phenomenon which intrinsically involves multiple sectors spanning child protection, law enforcement, education and health. Results indicate practitioners most urgently need police and child protection to be effective collaborators with them in order to best prevent, interrupt and respond to instances of CSE. This finding highlights that there may be a need to enhance communication and collaboration between agencies, to identify specific barriers to capacity and operational efficacy so that they may collectively provide consistent and protective responses as an integrated whole. This is especially important, given that we found practitioners also generally considered CSE to be becoming more common. The key drivers suggested by practitioners may not reflect causal connections, but nevertheless their concern about the impacts of technology (which enables constant and immediate access to children and youth, as well as normalising sexual behaviour (including commercial sexual behaviour) through pornography) are relevant given contemporary debates and legal developments about youth access to online social media. Similarly, practitioner concerns about the impact of social determinants such as poverty and financial strain suggest associations between widening social and economic inequality and heightened risk for CSE.

Strengths and Limitations

To our knowledge, this novel study has generated the first quantitative evidence in an Australian setting about residential care practitioners' training in relation to CSE and desire for further training, knowledge of CSE, and insights into systemic facilitators and impediments to dealing with CSE. This evidence sheds new light on this important context and can inform further education design and delivery in this and other sectors. Findings can also inform policy deliberations between relevant agency stakeholders in relation to interagency collaboration, and provide a basis for further research.

Several limitations should be noted. First, the study was limited to practitioners in one State, and was limited to one albeit large organisation. Further, this particular organisation is committed to expanding staff knowledge and improving practice. Accordingly, the current findings are not generalisable to workforces from other organisations providing similar services, or the wider child protection sector. Second, participants may have self-selected based on their interest in the topic; moreover, the sample was relatively small, although missing data was minimal except for the items on systemic facilitators and impediments. Third, the sample included a small number of staff in administrative (n = 11) and managerial positions (n = 12), but results indicated they were similar to the frontline practitioners (n = 54) in meaningful characteristics; for example, their aggregate knowledge score (54.8, and 54.6 respectively) was almost identical to that of the practitioners (55.5%); it is likely that many of these would have worked in frontline capacities at some time.

Conclusion

This novel study has advanced knowledge about residential care practitioners' training about CSE, desire for further training, knowledge about CSE, and insights into systemic impediments and challenges to deal with CSE. Key findings include: the low levels of pre-service and in-service training; the strong desire for further training; priority areas for development of accurate knowledge; and insights into systemic features that facilitate and impede optimal responses to CSE. Improving workforce education about this complex field is an essential condition to facilitate effective professional practice, and individual practitioners need, deserve and desire this education. Organisational efforts to build the capacity of frontline professionals to identify and respond appropriately to CSE, through development and provision of training to improve knowledge about CSE, offer the opportunity to enhance prevention, identification and responses to children and youth who are at risk of CSE, and who have experienced it. Results have implications for diverse settings in Australia and elsewhere internationally, especially those in child welfare, law enforcement, and education settings dealing with children at increased risk for CSE.

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Appendix A

Items and Response Options to Survey Items Regarding Definitions and Prevalence, and Consent

Item on the definition of CSE

Item wording: What is the correct definition of "child sexual exploitation"?

Response options:

- CSE occurs when any adult engages in any kind of sexual activity with a child
- CSE occurs when an adult exploits a relationship of any kind of power, or abuses a position of authority or trust, to coerce, manipulate or deceive a child aged under 18 to engage in sexual activity in exchange for something of value, and/or to obtain for the perpetrator a financial advantage or increased status
- CSE occurs when any person (adult or child) exploits a relationship of any kind of power, or abuses a position of authority or trust, to coerce, manipulate or deceive a child aged under 18 to engage in sexual activity in exchange for something of value, and/or to obtain for the perpetrator a financial advantage or increased status

Item on the prevalence of CSE

Item wording: In Australia, what is the prevalence of child sexual exploitation? ("prevalence" means the percentage of all children who experience it)

- 1.7%
- 2.8%
- 3.6%
- 4.9%
- 6.0%
- It is unknown because research has not established the true prevalence

Item on the definition of CSA

Item wording: What is the correct definition of "child sexual abuse"?

Response options:

- CSA occurs when an adult involves a child aged under 18 in any sexual activity
- CSA occurs when an adult involves a child aged under 16 in any sexual activity
- CSA occurs when an adult involves a child aged under 18 in any sexual act for sexual gratification, where the child either is not cognitively capable of consenting to sexual activity, or the child has cognitive capacity to consent but does not provide full, free, and voluntary consent to the specific acts free of any kind of coercion
- CSA occurs when any person involves a child aged under 18 in any sexual act for sexual gratification, where the child either is not cognitively capable of consenting to sexual activity, or the child has cognitive capacity to consent but does not provide full, free, and voluntary consent to the specific acts free of any kind of coercion

Item on the prevalence of CSA

Item wording: In Australia, what is the prevalence of child sexual abuse? ("prevalence" means the percentage of all children who experience it)

Response options:

- 5.4%
- 10.2%
- 16.6%
- 25.7%
- 28.5%

- It is unknown because research has not established the true prevalence

Item on sexual consent

Item wording: In general, what is required for participation in sexual activity to be genuinely consensual?

Response options:

- No child aged under 18 can ever give true consent to sexual activity
- No child aged under 16 can ever give true consent to sexual activity
- A child may be capable of consenting to sexual activity, but only if the child has full cognitive capacity to understand the nature of the acts, and in fact provides full, free, and voluntary consent to the specific acts that is free of any kind of coercion