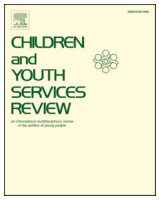
Children and Youth Services Review 186 (2026) 109030

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth



Contextual safeguarding against harmful sexual behaviour and child sexual exploitation: a narrative review of Australian public inquiries into residential care

Kenny Kor

Social Work, School of Social Sciences, University of Wollongong, Australia

ARTICLE INFO

Keywords:
Child sexual exploitation
Harmful sexual behaviour
Out-of-home care
Residential care

ABSTRACT

In Australia, the Royal Commission into Institutional Responses to Child Sexual Abuse revealed the pervasiveness of harmful sexual behaviour and child sexual exploitation in contemporary residential care, as well as the profound impacts these have had on victim-survivors. Other public inquiries in Australia also demonstrated that children and young people in residential care are particularly vulnerable to being sexually harmed by other children and young people with whom they co-resided, or to being sexually exploited by adults in the community. Using a contextual safeguarding lens, this narrative review aimed to address the question, "what contextual factors within residential care systems place children and young people at risk of harmful sexual behaviour and child sexual exploitation?" Public inquiry reports published between 2005 and 2024 were retrieved through systematic search results across three data sources: an academic database, an online repository for non-government reports and the websites of Commissioners for Children and Young People across the Australian states and territories. In total, 17 reports were included in the review, and four contextual factors were synthesised through thematic analysis: (a) inappropriate placement matching; (b) ill-equipped workforce; (c) fractured reporting systems; and (d) disempowering practices. These four contextual factors highlight the challenge of implementing inquiry recommendations without first acknowledging that harmful sexual behaviour and child sexual exploitation are forms of social harm partly driven by systemic inadequacy. This underscores the need for a shift in perspective, from focusing solely on individual risks to improving the policy and practice contexts that shape the experiences of children and young people in residential care.

1. Introduction

Decades of evidence reveals that children and young people in residential care, including formerly institutional care, have endured alarming rates of sexual abuse by adults (Fernandez et al., 2017; The Royal Commission, 2017b). This continued focus on sexual abuse by adults, while important, has drawn attention away from other forms of sexual harm within residential care such as harmful sexual behaviour (HSB) by children and young people (Timmerman & Schreuder, 2014). HSB has been defined differently across countries and settings, reflecting the diverse range of behaviours and contexts in which they occur (Hunt et al., 2024). In Australia, Hackett's (2019) definition is most widely used, describing HSB as:

> "Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person, or adult" (Hackett et al., 2019, p. 13).

There is growing consensus that children and young people who displayed HSB should be treated differently from adult perpetrators because of their developmental capacity (Hackett et al., 2019). Accordingly, non-stigmatising terms that separate the behaviour from their emerging identity, such as "children and young people who displayed HSB" are used in this review (Hackett et al., 2019).

In Australia, the Royal Commission into Institutional Responses to Child Sexual Abuse brought to light the concern of HSB in residential care. The Royal Commission spoke with nearly 7000 victim-survivors, of which nearly one in six (16.4%) disclosed sexual abuse by another child and 63% said it occurred in Out-of-Home Care (OoHC) (The Royal Commission, 2017a). Internationally, a Dutch study found that more than half (57%) of the child sexual abuse reports in residential care involved sexual harm committed by another young person within the

E-mail address: kennyk@uow.edu.au.

https://doi.org/10.1016/j.childyouth.2026.109030
Received 20 September 2025; Received in revised form 5 May 2026; Accepted 5 May 2026
Available online 8 May 2026

same facility (Euser et al., 2013). Although not a direct causation, research consistently demonstrated that many children and young people who displayed HSB have experienced sexual harm themselves (Seto & Lalumière, 2010) and were exposed to domestic and family violence (Ogilvie et al., 2022), and pornography (McKibbin et al., 2017).

Child sexual exploitation (CSE) is another significant concern in residential care (Gatwiri et al., 2020; McKibbin, 2017), especially when children and young people spend unauthorised time away from care (CCYP, 2021; Harris et al., 2025). Globally, varying definitions of CSE complicate efforts to measure its prevalence and develop consistent prevention strategies (Laird et al., 2023). Laird et al., (2023)'s review of international literature demonstrates that CSE is:

> "an abusive act where an individual or group takes advantage of a power imbalance, to use, force, coerce and/or deceive a child or young person into completed or attempted sexual activity, on or offline; (a) by the solicitation or actual exchange of unmet needs or wants of the child/young person; and/or (b) for the economic or social advantage of the perpetrator of facilitator; (c) irrespective of consent or who initiates the contact" (Laird, et al., 2023, p. 2255).

The Royal Commission found that CSE in residential care was predominantly carried out by adults in the community who "took advantage of children and young people's need to feel as if they are cared for, their desire to have things bought for them or their naivety about relationships" (The Royal Commission, 2017b, p. 211). Research has shown that a history of child abuse, neglect, and domestic violence is common among children and young people who have been sexually exploited (Hallett et al., 2019). An Irish study found that children and young people in residential care are particularly vulnerable to being targeted by predatory adults due to the absence of trusting relationships with residential care staff, which is often linked with frequent staff turnover and insufficient staff training on identifying and responding to CSE (Canning et al., 2024). Similarly, a Northern Ireland study found that children and young people in residential care face a heightened risk of CSE when their needs for connection, inclusion, and healing from past abuse are not adequately met within the care environment (Roache & McSherry, 2021).

Online CSE is a fast-growing concern, with a 45% increase of reports to the Australian Centre to Counter Child Exploitation in 2023–2024 (Australian Federal Police, 2024). Preventing predatory access to children and young people in residential care via the internet and social media is challenging especially when residential care staff rely solely on monitoring young people's online activities (Roache & McSherry, 2021). Actively listening to children and young people's lived experiences in care, cultivating trust in their relationships with residential care staff and involving them in shaping safeguarding practices against CSE are paramount (Hallett, 2016; Lefevre et al., 2017).

1.1. Harmful sexual behaviour and child sexual exploitation

Prevalence studies on HSB and CSE specific to residential care are needed to understand the scale of the problem. Population-based studies consistently shows that a substantial proportion of child sexual abuse is committed by other children and adolescents. For example, the Australian Maltreatment Study, which surveyed 8503 individuals aged 16 and above, found that half of the sexual abuse incidents were committed by adolescents (Mathews et al., 2024). Similarly, Gewirtz-Meydan and Finkelhor (2020) interviewed 13,052 participants aged 10–17 along with caregivers of children aged 0–9 and reported that over 70% of child sexual abuse was committed by other children and young people. HSB is predominately committed by males against females (Gewirtz-Meydan & Finkelhor, 2020; Mathews et al., 2024). Most young people referred to community-based HSB treatment programs were aged between 13 and 16 (Cale et al., 2025; Hackett et al., 2013).

In relation to CSE, Laird et al. (2023) reported that up to 5% of children and young people worldwide were affected. Younger children from ages 8–11 were increasingly being identified as victims, particularly in online environments (Coy et al., 2017). Although girls are more frequently victimised by CSE, Cockbain et al. (2017) conducted a large-scale study in the UK involving 9042 users of a specialist CSE support service and found that one-third of the users were boys. Being in residential care is often identified as a risk factor for HSB and CSE (Coy et al., 2017; Gatwiri et al., 2020; McKibbin, 2017), partly due to the complex trauma histories that many children and young people in residential care carry, making them more vulnerable to engage in or be targeted for harmful behaviours. Other contextual factors in residential care can also minimise their physical, emotional, and sexual safety including care instability, inadequate staff supervision, and limited access to respectful relationships and sexuality education (Canning et al., 2024; Gatwiri et al., 2020; McKibbin, 2017; Roache & McSherry, 2021).

This review focuses on HSB and CSE because both issues have been identified as significant concerns in numerous public inquiries into residential care in Australia. HSB and CSE being considered together in this review is also supported by research showing that children and young people affected by both forms of harm share similar vulnerabilities, thereby requiring similar safeguarding practices (Hallett et al., 2019). However, it is important to clarify that these two concerns should not be conflated. While crossover can occur, for instance, a young person coercing another to 'trade' sex for money or goods; not all children and young people displaying HSB are also engaging in CSE. Most HSB appeared to have occurred impulsively rather than in a pre-meditated manner, and some without involving another child, solicitation, or deception (The Royal Commission, 2017a). Each behaviour must be understood and assessed within its broader developmental and environmental contexts (Hackett et al. 2019). Equally important is recognising that victim-survivors of CSE should not be misinterpreted as displaying HSB.

1.2. Residential care

In Australia, residential care is a type of statutory OoHC that provides alternative care for "children aged under 18 years who are unable to live with their families due to child safety concerns" (Australian Institute of Health & Welfare [AIHW], 2025). Across Australia, each residential care placement typically accommodates up to four children and young people, with round-the-clock support from paid staff in a community-based dwelling. Residential care is intended for older children and adolescents, although children under the age of 5 are increasingly being placed in residential care. For example, in Western Australia, nearly 5% of children in residential care were under the age of 5 (AIHW, 2025). In some cases, younger children are placed in residential care because they are part of a sibling group. However, a troubling trend has emerged in which young children are being placed in residential care solely due to the shortage of kinship and foster care placements (CCYP, 2015).

Compared to foster care, children and young people in residential care often experience poorer physical and mental health, and more entrenched behavioural and learning difficulties (Leloux-Opmeer et al., 2017; Leloux-Opmeer et al., 2016). Critical incidents threatening children's safety and well-being are disproportionately high in residential care (VAGO, 2014), which often leads to placement instability, where children and young people are frequently moved between different placements. An Australian study found that young people in residential care were more likely to experience placement disruptions compared to those in foster or kinship care (Wulczyn & Chen, 2017).

This collective evidence points to a paradox: despite poorer outcomes and persistent instability, children and young people with complex trauma and needs continue to be placed in residential care (Kor & McNamara, 2021). In response to the paradox, therapeutic models of care have been introduced in Australian residential care, with promising, albeit limited results (Verso-DHS, 2011). Crucially, HSB and CSE remain significant concerns. This study aims to review evidence of

Australian public inquiries into residential care, using a contextual safeguarding lens to elicit contextual factors associated with HSB and CSE.

1.3. Public inquiry

Public inquiries bring together experts by virtue of either their profession, representation, or lived experience "to fact-find, hold actors to account or develop policy lessons" (Stark, 2019, p. 397). Across Australia and other comparable countries, public inquiries, ranging from high-profile royal commissions to other independent reviews have been used by governments and independent organisations to examine the scale, causes, and consequences of complex and entrenched social issues (Swain, 2014; Wright, 2017). In Australia, since the late 20th century, abuse in institutions and contemporary OoHC has become a common focal point of public inquiries (Swain, 2014), often catalysed by victim-survivors' activism following media exposure of abuse and cover-ups (Sköld, 2015). This type of inquiries was typically testimonial-oriented, drawing on victim-survivors' lived experience as a primary source of evidence (Swain, 2014). It aims to bear witness to the pain inflicted upon victim-survivors and seek justice by making recommendations for redressing the harms they endured (Wright, 2017).

Recent public inquiries in Australia have also repositioned trauma as social harm, bringing to light how government policies and institutional practices marginalised victim-survivors and failed to provide protection and justice (McPhillips et al., 2020). The recognition that trauma is social harm reorientates the focus from individual responsibilisation to systemic failures. Contextual Safeguarding is therefore an appropriate lens to review the evidence gathered through public inquiries as it sharpens the gaze on the context and how it enables or reduces harm.

1.4. Contextual safeguarding

Developed by Carlene Firmin in the UK (Firmin, 2020), contextual safeguarding is an approach to addressing extra-familial risks and harms (e.g., HSB). It "seeks to identify and assess and, where appropriate, intervene with all of the social spaces associated with young people's experiences of harm" (Firmin, 2018, p. 179). Firmin et al. (2022) demonstrated that young people's experiences of safety are shaped not by interactions between young people alone but by their interactions with the contexts surrounding them. Context therefore refers to the diverse environments and systems (e.g., residential care) in which young people are embedded and with which they interact (Firmin & Rayment-McHugh, 2020). Firmin (2020) argued that child protection and justice systems have traditionally been designed to address the risk of harm within the family or to the individual young person, rather than focusing on the broader contexts associated with the harm. This approach not only limits to addressing individual or familial harms alone but also diminishes the system's capacity to create safety for young people who experience overlapping victimisation and perpetration in the *contexts* where harm occurs (Firmin, 2020). Using a contextual safeguarding lens therefore provides a route to widen the focus from locating risk within individuals to understanding how contexts facilitate, enable, or fail to challenge harmful behaviour or practice in extra-familiar settings. Without this shift, Firmin (2020) argued, we "shut down routes to protection" (p. 52). Informed by this perspective, this review seeks to address the question, "what contextual factors within residential care systems place children and young people at risk of HSB and CSE?"

2. Methodology

2.1. Narrative review

Using a narrative review approach, this review draws on evidence from public inquiries to explore contextual factors within residential care systems that may have placed children and young people at risk of HSB and CSE. Narrative review is considered a legitimate form of scholarship that aims to assemble evidence to investigate complex questions that cannot be sufficiently addressed by a single empirical study (Baumeister & Leary, 1997). Narrative review is commonly used in medical science research (Baethge et al., 2019) and more recently social science research on sexual harm (e.g., Lateef & Jenney, 2021). The rigour of a narrative review can be enhanced by employing a systematic approach to searching and sorting the literature, as well as applying explicit inclusion and exclusion criteria to select relevant studies to address the research question (Byrne, 2016). Accordingly, this review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Page et al., 2021) (see Fig. 1).

The inclusion criteria included public inquiries that were specific to residential care, contained primary findings and which were published in the past two decades, between 2005 and 2024. In order to maintain the independence of the findings, government reports such as those published by statutory child protection departments were excluded, so were literature reviews and other reports that do not contain primary findings. Public inquiries addressing broader OoHC systems were also excluded to ensure the analysis is specific to residential care. One exception was made for the Royal Commission report on HSB. This report was included because it was the first public inquiry to dedicate an entire volume to the issue, reflecting the significant attention and comprehensive findings it received.

2.2. Search strategy and selection

Public inquiry reports are grey literature. Accordingly, the search strategy combined website search engines and an academic database. The Informit database was chosen to conduct the initial search because of its wide coverage of humanities and social sciences literature. The search terms *"residential care" AND "review" OR "commission" OR "inquiry" NOT "aged care"* were used to conduct the search in March 2025. This search identified 28 results.

The Analysis and Policy Observatory (APO) was then used to search for the grey literature. APO is an open access platform in Australia that hosts reports published by government and non-government organisations. The search term *"residential care for children and young people"* was used to conduct the search in March 2025 via its digital repository webpage, yielding 49 results.

Additionally, the websites of Commissioners for Children and Young People across the states and territories were searched. Where available, the term *"residential care"* was entered into the site's search engine to locate and sort relevant reports. For the Office of the Children's Commissioner Northern Territory and the NSW Office of the Children's Guardian, where no search engines were available, hand searches were conducted instead. These combined search methods identified nine reports.

In total, 86 reports were identified. After removing duplicates, 80 remained for initial screening. Where abstracts were not part of the report, the executive summaries or tables of contents were screened instead. Following this initial screening, 19 reports were assessed for eligibility. Two were excluded, bringing the final number of reports included in this review to 17. Fig. 1 presents the PRISMA flow diagram for the selection process.

2.3. Data analysis

Firstly, key characteristics of the selected inquiries were extracted into a table to summarise their primary objectives and inquiry methods (see Table 1). Following which, the selected inquiry reports were imported into NVivo12 for coding. Thematic analysis (Braun & Clarke, 2022) was employed. Guided by the research question, "what contextual factors within residential care systems place children and young people at risk of HSB and CSE?". Initial coding was done semantically (e.g., young people felt unheard) and gradually moved towards latent coding

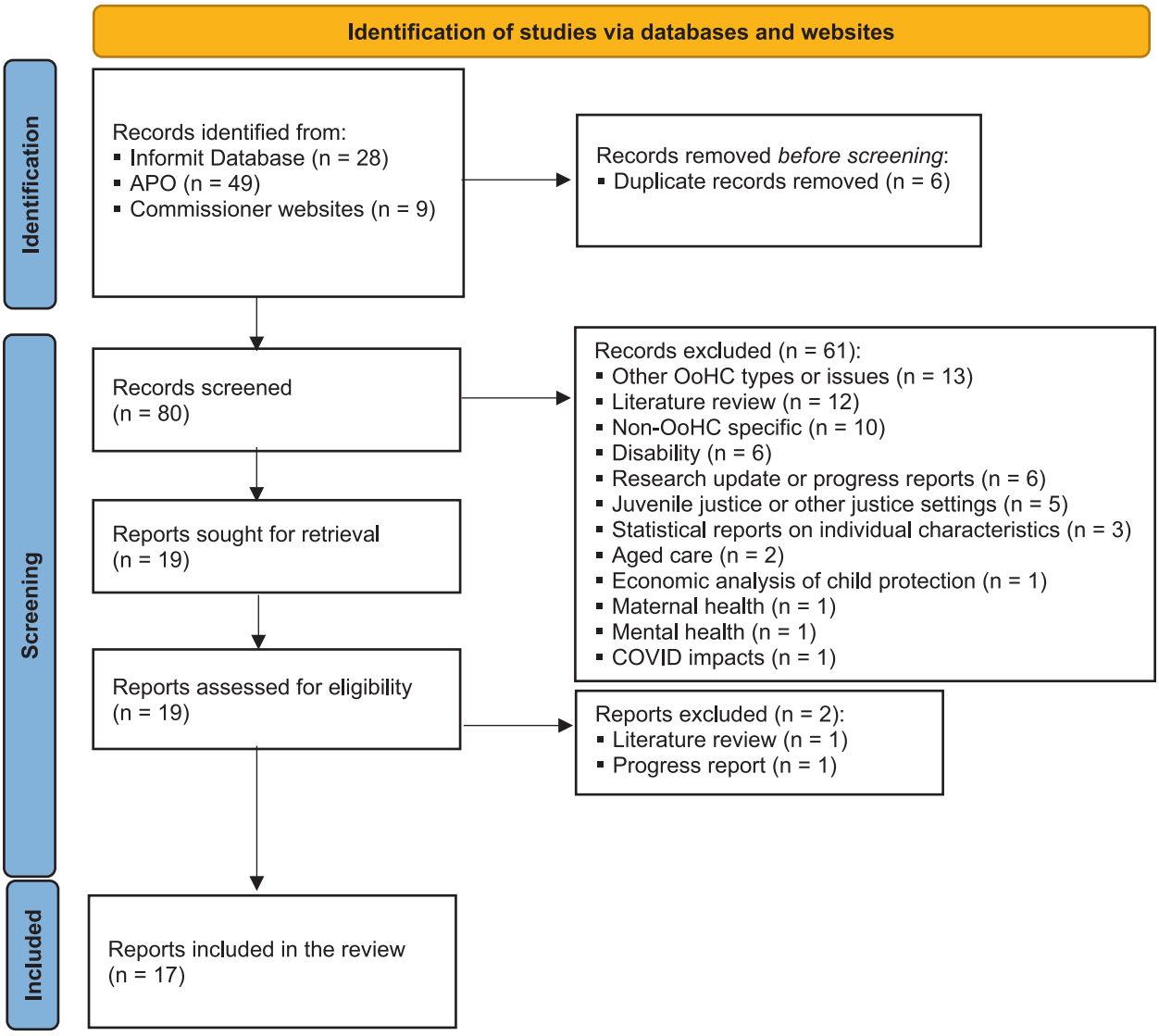


Fig. 1. PRISMA chart.

(e.g., disempowering practices) as the analysis deepened through familiarisation and iterative coding of the data (Braun & Clarke, 2022). Related codes were then merged and reorganised into four themes that capture the essence of the findings (Braun & Clarke, 2022).

3. Findings

As shown in Table 1, a total of 17 public inquiry reports were included in the review spreading across Northern Territory ($n = 1$), Queensland ($n = 7$), South Australia ($n = 1$), Victoria ($n = 5$), Western Australia ($n = 1$) and two reports from the Royal Commission. These inquiries used a range of methods to collect evidence, from reviewing case files and policy documents ($n = 8$), conducting site visits ($n = 3$), consulting with key stakeholders ($n = 7$) to eliciting the views of children and young people directly through surveys, interviews or focus groups ($n = 15$). Analysis across these inquiry reports was synthesised into four contextual factors: (1) inappropriate placement matching; (2) ill-equipped workforce; (3) fractured reporting systems; and (4) disempowering practices.

3.1. Inappropriate placement matching

Across all 15 inquiries that asked children and young people about their lived experience in residential care, many reported physical and sexual violations by co-residents (CCYP, 2015; CCYPWA, 2021; CCYPCG, 2008, 2012; Moore et al., 2016; The Royal Commission 2017a; VO, 2020). HSB ranging from inappropriate touching to sexual violence committed by and against co-residents were reported (CCYP, 2015; CCYPWA, 2021; Moore et al., 2016; The Royal Commission 2017a; VO, 2020). Children and young people were also reportedly 'recruited' by co-residents into criminal and sexual exploitations (CCYP, 2015; CCYP, 2021; OGCYP, 2019; VO, 2020).

Inquiries consistently revealed that inappropriate placement matching was one of the key reasons that led to children and young people feeling unsafe and experiencing harms both within and outside of residential care (CCYP, 2015; CCYPWA, 2021; Moore et al., 2016; OGCYP, 2019; QFCC, 2018, 2023, 2024; The Royal Commission 2017a; VAGO, 2014; VO, 2020).

Multiple inquiries documented numerous cases where residential care staff voiced safety concerns about placing young people displaying HSB with younger or other vulnerable children such as those with a disability or a known history of sexual abuse (CCYP, 2015; VO, 2020). In some instances, these concerns were expressed by young people themselves who worried about their own behaviour. For instance, the inquiry in Western Australia found in their file review that a young person:

Table 1
Characteristics of inquiry reports.

Jurisdiction	Year of publication	Inquiry/report author	Inquiry report included in the review	Objectives	Primary inquiry methods
Commonwealth of Australia	2016	Moore. T., McArthur. M., Roche. S., Death. J., & Tilbury., C.	Safe and sound: Exploring the safety of young people in residential care	Commissioned by the Royal Commission to explore (a) what does safety mean to CYP in residential care; (b) their safety concerns in residential care and (c) their views on prevention and response	• Interviews: 27 CYP (aged 10–20) who had lived in residential care for more than 3 months
	2017	The Royal Commission into Institutional Responses to Child Sexual Abuse (The Royal Commission)	Final report Vol. 10: Children with harmful sexual behaviours	Investigated the scale, nature, cause, and response to child sexual abuse in institutions	• Private sessions: 8,846 • Public hearings: 57 • Public & private roundtables: 35
Northern Territory	2024	Office of the Children's Commissioner (OCC)	Residential care in the Northern Territory: Monitoring Report	Evaluated the new Intensive Therapeutic Residential Care (ITRC)	• Site Visits: 9 ITRC homes in Darwin & Katherine • Interviews: 10 CYP in ITRC • Reviews of agency records
Queensland	2008	Commission for Children and Young People and Child Guardian (CCYPCG)	Views of young people in residential care Queensland	Explored CYP's satisfaction with residential care, the child safety system, and the Community Visitor program	• Survey: 94 CYP (aged 4–17) in residential care
	2012		Views of young people in residential care survey – Responding to trauma and attachment needs in residential care: What young people's perceptions tell us about how well we're doing in Queensland	Explored CYP's relationships with staff and the sanctuary care environment	• Survey: 211 CYP (aged 6–17)
	2013		Views of young people in residential care survey – Young people's views about the support and advocacy provided by Community Visitors in residential care	Assessed the effectiveness of the Community Visitor Program	• Survey: 239 CYP and 50 carers
	2018	Queensland Family and Child Commission (QFCC)	Young people's perspectives of residential care including police call-outs	Explored CYP's perspectives of police call-outs in residential care	• Workshops: 11 CYP (aged 18—23) who had recently transitioned from residential care to independent living
	2022		The decision to place an Aboriginal and Torres Strait Islander child or young person in residential care	Examined the implementation of the Child Placement Principle	• Analysis of legislation, policy and practice documents • Case file reviews • Stakeholder discussions
	2023		"I was raised by a checklist"	Explored CYP's lived experience in residential care	• Workshops: 11 CYP (aged 18—23)
	2024		"Treat us like humans"	Gathered CYP's ideas about the improvements needed for the residential care system	• Workshops:73 CYP living in or recently transitioned from residential care
South Australia	2019	Office of the Guardian for Children and Young People (OGCYP)	What matters to us	Explored CYP's views of the Child and Young Person's Visitor Program	• Interviews: 6 CYP (aged 15—25) who were either living in or previously lived in residential care.
Victoria	2014	Victorian Auditor-General's Office (VAGO)	Residential care services for children	Examined whether residential care was meeting CYP's needs and whether there was effective oversight.	• Site visits: 7 • Focus groups: 3 (aged 16 & 18 – 21) who were living or had recently left residential care • Case files reviews: 28 • Interviews: Departmental staff
	2015	Commission for Children and Young People (CCYP)	"…as a good parent would…"	Examined the adequacy of service and system response to CYP who experienced sexual abuse or sexual exploitation whilst residing in residential care	• Site visits: 21 • Case file reviews: 166 • Interviews: 34 Departmental staff, 21 residential care service staff and young people • Public submissions
	2016	Victorian Auditor-General's Office (VAGO)	Follow up of residential care services for children	Assessed the extent to which the Department had actioned on the recommendations made from the 2014 audit	• Reviewed the responses and submissions provided by the Department
	2020	Victorian Ombudsman (VO)	Investigation into complaints about assaults of five children living in Child Protection residential care units	Investigated residential care safety and response following four young people and one adult reported physical and sexual assaults in residential care	• Case file reviews: 5 • Interviews: 5 victim-survivors and 11 witnesses • Policy reviews • Submissions from the services involved

(*continued on next page*)

Table 1 (*continued*)

Jurisdiction	Year of publication	Inquiry/report author	Inquiry report included in the review	Objectives	Primary inquiry methods
	2021	Commission for Children and Young People (CCYP)	Out of sight	Investigated the scale, cause, and harm of CYP going or being at risk of absent or missing from residential care	• Interviews: 13 CYP (aged 13–19) • Consultations: 89 stakeholders • Case file reviews: 12 • Quantitative analysis of 337 incident reports, OOHC and relevant police data
Western Australia	2021	Commissioner for Children and Young People (CCYPWA)	Independent review into the Department of Communities' policies and practices in the placement of children with harmful sexual behaviours in residential care settings	Investigated systemic responses to HSB following a young person spoke out in the media about her experience of harm by another young person in residential care	• Departmental policy reviews: 55 • Case file reviews: 2 • Interviews: 2 • Submissions: 6 • Consultations: 47 stakeholders

Note: CYP = Children and Young People.

> 'repeatedly expressed concerns to staff about his sexual urges and the safety of younger children who were living in the same residential care home as him…These were recorded in his case file and included the following: "[he] feels urges towards other residents occasionally and one in particular…[he] didn't understand why DCP (the Department) would put him in a house with younger people…[he] is crying for help and no one in the house cares about him anymore."' (CCYPWA, 2021, p. 14)

However, inquiries found that some of these concerns were ignored by the statutory departments, often until repeated incidents of sexual harm occurred in the residential care placement (CCYP, 2015; CCYPWA, 2021; VO, 2020). Placement matching decisions were found to have been driven by operational needs rather than children's need for safety (CCYP, 2015; VAGO, 2014; VO, 2020). Bed availability in residential care dictated some of the placement matching decisions, with residential care service providers reporting feeling "pressured" by the statutory department to accept referrals or risk losing funding (CCYP, 2015; VO, 2020).

Furthermore, placement matching decisions were often made with limited and dated information (CCYPWA, 2021; The Royal Commission, 2017a; VO, 2020). In some cases, the lack of understanding of HSB led to minimisation, resulting in under-reporting of HSB and thereby missing critical information for placement matching assessments (CCYP, 2015; CCYPWA, 2021; The Royal Commission 2017a; VO, 2020). The inquiries in Victoria raised a specific concern that the statutory department might have deliberately withheld information, preventing residential care services from properly assessing and considering the placement requests they received from the department (CCYP, 2015; VO, 2020). Several inquiries also found an apparent lack of transparency in both residential care services and the statutory department regarding the ways in which placement matching assessments and decisions were made (CCYP, 2015; CCYPWA, 2021; VO, 2020).

The Victorian Ombudsman (2020) noted that poor placement matching did not always imply a deliberate disregard for child safety. The lack of available options in kinship or foster care was often attributed to the pressure within the residential care sector to accept children and young people in urgent need of a placement, even when there were safety concerns about placing them with other vulnerable children (CCYP, 2015, 2021; CCYPWA, 2021; VAGO, 2014). The Victorian Auditor-General (2014) revealed that, in part, this issue stemmed from the funding structure of residential care services. Departmental funding for residential care was primarily structured around a 4-bed placement model, supported by one or two staff members at a time. When additional needs arose that required one-on-one placements, the demand for placements quickly exceeded supply because what was available were four-bed placements, not single or double placements. To address this shortfall, the statutory department often purchased additional placements from agencies to meet the service demand (VAGO, 2014). As a cost-control measure, young people were sometimes moved between placements to either make room for others who needed more intensive support or to optimise the 4-bed capacity in another placement (VAGO, 2014). In many such instances, residential care services would accept placement referrals on the proviso of additional funding from the department to increase staffing to support the children. Ironically, the funds for these additional placements and staffing were often redirected from budgets initially allocated for other essential services, such as health, education, and Aboriginal workforce capacity building (CCYP, 2015; VAGO, 2014).

Inquiries also found that children and young people were often moved between placements with very little time and support to prepare for placement transition (CCYP, 2015; VO, 2020). Likewise, residential care staff found themselves ill-equipped to support children and young people through placement transition, both for the young person who was moving into the placement and those who were already in the placement (CCYP, 2015). Young people said they needed "warnings" to help them prepare for new placement or new resident moving into their placement (Moore et al., 2016; OGCYP, 2019). Poor placement matching and planning prior to placement move contributed to placement instability, which, in turn, diminished young people's sense of safety and connection with the placement. Young people described leaving the placement unauthorised to avoid their co-residents in search of safety and connection from elsewhere (CCYP, 2021). The Victorian Ombudsmen (2020) and the Out of Sight inquiries in Victoria (CCYP, 2021) detailed extensive evidence of young people experiencing or were at risk of a range of sexual harms including CSE while spending unauthorised time away from care.

> "I would go into the city and try and go home with men because I didn't feel safe around those 3 girls… I would [call the carers and] say, 'Hey I'm in the city on Bourke Street.' Then I would turn my phone off and go home with an older man." (A young person, aged 19; CCYP, 2021, p. 107 & 282)

Poor placement matching also contributed to negative peer dynamics within a residential care placement where children and young people would trigger one another or being "pressured" by peers into engaging in harmful behaviours (CCYP, 2015, 2021; OGCYP, 2019; QFCC, 2018; VO, 2020).

> "Peer pressure made it hard. It could be going out to drink or smoking something. Every bad thing you could think of they would try and pressure you into, especially if you are young. I got peer pressured so bad. With drugs and alcohol and illegal shit, I feel like it

all comes from being in resi." (Young person, aged 18, CCYP, 2021, p. 235)

3.2. Ill-equipped workforce

Relationships with residential care staff determine the care experience of children and young people. Across inquiries, children and young people in residential care clearly expressed the need for adults to provide consistent and responsive care that can safeguard their safety and wellbeing (CCYP, 2021; Moore et al., 2016; OCC, 2024). However, many young people reported that residential care staff did not always respond adequately to HSB disclosures or when they left the placement unauthorised (CCYP, 2021; VO, 2020; CCYPWA 2021). Children and young people wanted adults to ask them if they were being harmed rather than expecting them to disclose (Moore et al., 2016). Children and young people felt they could not disclose HSB to residential care staff or their statutory caseworkers because they feared that they would get into trouble or that they would not be believed (Moore et al., 2016; OGCYP, 2019). These fears are not unfounded; for many children and young people, despite multiple disclosures of sexual harm to residential care staff and the statutory departments, they were either not believed (VO, 2020), had their disclosures minimised, or were blamed for the harm they endured (CCYPWA, 2021; Moore et al., 2016).

A lack of safeguarding practices following disclosures was evident across multiple inquiries. For example, The CCYP inquiry found that in many instances, no critical incident reports were made following disclosures of HSB; neither was there any review or update on the safety plan of the children involved, there was also no evidence of consultation with departmental staff and no referrals made for the children to receive counselling (CCYP, 2015). In cases where investigations took place following disclosures of HSB, children and young people were not provided information about the outcomes, and be reassured that they would be kept safe or provided with counselling support (CCYP, 2015; VO, 2020). In circumstances when allegations were proven, there was no record that the victim-survivors were given information about their legal rights (CCYP, 2015; Moore et al. 2016; The Royal Commission, 2017a). Neither were they provided with adequate acknowledgement and assistance (CCYP, 2015; OGCYP, 2019; The Royal Commission 2017a).

In cases where children and young people left placements unauthorised, many recalled mixed responses from residential care staff. These ranged from lacking genuine attempts to locate them to encouraging them to return by calling and texting them and their friends, conducting outreach, and utilising afterhours services to collect them (CCYP, 2021). Inquiries found that, in most cases, residential care staff were over-reliant on police intervention and in some instances, residential staff refused to collect young people from the street because it was too "far away" (CCYP, 2015; QFCC, 2018; QFCC, 2023, 2024), or due to having only one staff member on duty (VAGO, 2014). In some of these cases, young people were left on the street without any safeguarding support and were reportedly sexually exploited by others in the community (CCYP, 2015). Return-to-care conversations that aim to rebuild connection with the young person and gather information about what occurred during unauthorised time away from care did not occur consistently because staff did not always have the relationship required to engage young people in return-to-care conversations (CCYP, 2021).

Residential care staff identified that heavy workloads and administrative burdens limited their capacity to provide more attuned and tailored care (CCYP, 2021). High staff turnover also led to a heavy reliance on a casualised workforce (CCYP, 2015, 2021; QFCC, 2024; VAGO, 2014), resulting in a high volume of staff rotating through each residential care placement (CCYP, 2015, 2021). This, in turn, affected staff's ability to establish and sustain stable relationships with children and young people.

Insufficient support to residential care staff was also reported across multiple inquiries. For example, residential care staff in Victoria reported that they could not access specialist training on how they should adequately respond to HSB (CCYP, 2015, 2021). In Western Australia where specialist training was offered, agencies found it difficult to release staff to complete training due to staff shortage (CCYPWA, 2021). Residential care staff also revealed that they lacked day-to-day practical support from specialist staff; with many reporting that they did not have reflective practice supervision or critical incident debriefing for extended periods of time (CCYP, 2015; CCYPWA, 2021; QFCC, 2024).

Inquiries also found that staff were particularly ill-equipped to work with children and young people who had a disability or identified as LGBTQI+ (CCYP, 2015; VO, 2020). For example, the Victorian Ombudsman (2020) heard testimonies from two young people, one identified as transgender and another as non-binary, experiencing sexual harm from co-residents. Staff were reportedly unable to protect their safety, with further evidence of violating their right to express their sexual identities (VO, 2020). For example, a young person who identified as female was denied access to her dresses and dolls (VO, 2020). In another example, a young person who identified as same-sex attracted was persistently ostracised by his co-residents; he reported that the staff gave him little protection which led to him spending unauthorised time away from care.

> "I am gay. So, they [the co-residents] locked me out of the house and the workers didn't do anything about it. I didn't feel safe. I went past the resi every day but to check in. They would sight me and that was it, so then I'd just move on back to wherever I was going…" (Young person, aged 15, CCYP, 2021, p. 106)

In a practice context where residential care staff lacked the resources and capacity to safeguard children and young people, institutionalised measures such as surveillance cameras and alarms were used instead. While younger children in residential care valued these measures (Moore et al., 2016), young people expressed that these measures were intrusive to privacy, making them feel unsafe (CCYP, 2015; CCYPWA, 2021; QFCC, 2024). Other punitive measures also made young people feel they were not treated with respect and dignity. For example, the Victorian inquiry found that in some residential care placements, the entire power source was removed from a child's bedroom as a means of behaviour management (CCYP, 2015). Other institutionalised practices such as having the kitchen cupboards locked (OGCYP, 2019), needing to submit paperwork to seek departmental approvals for having friends over or participating in extra-curricular activities left children and young people feeling stigmatised (CCYP, 2021; QFCC, 2018, 2024). Children and young people who spent authorised time away from care reported that these institutionalised environments gave them very little incentive to stay in placements (CCYP, 2021). Other young people described that they wanted residential care staff and caseworkers to "treat us like humans, not like prisoners" (QFCC, 2024, p. 4).

While many young people reported having trusting relationships with residential care staff (CCYPCG, 2008), they also felt that staff were not always attuned to their need for protection (Moore et al., 2016), especially in the online environment where young people were found posting sexually explicit photographs and videos on social media, and were sexually exploited by adults they met online (CCYP, 2015). In some cases, staff behaviour normalised a sexualised culture (CCYP, 2015). For instance, the CCYP (2015) inquiry raised concerns about a particular residential care unit where a whiteboard in a staff office displayed a sexually suggestive 'quiz' question. While this might have been an isolated incident, multiple inquiries found that children and young people wanted more education about respectful relationships (CCYP, 2015; Moore et al., 2016; QFCC, 2024; The Royal Commission, 2017a).

> "resi don't actually have sex ed. Kids who aren't really in resi usually either have their parents or a family member or school, so there's always more options. In resi, staff don't really want to talk about it. They don't necessarily have family around, and they're either not

attending school or the schools don't do the education. So where is the learning coming from?" (Young Person, aged 17–20; Moore et al., 2016, p. 58).

3.3. Fractured reporting systems

Safeguarding children and young people in residential care against HSB and CSE requires timely and accurate reporting of allegations and critical incidents. However, across multiple inquiries in different jurisdictions, the reporting systems were found to be cumbersome, with incosistent practices between residential care services and the statutory departments (CCYP, 2015; CCYP, 2021; CCYPWA, 2021; The Royal Commission, 2017a; VAGO, 2014). The Commissioners in Victoria and Western Australia themselves experienced significant delays in obtaining the required information from the departments for their inquiries, and some information was never made available (CCYP, 2021; CCYPWA, 2021).

At a systemic level, inquiries found that the statutory reporting systems were unwieldy and uncoordinated, with many residential care and departmental staff citing persistent difficulties in documenting, retrieving, tracking, and sharing information about a child or young person (CCYP, 2015; CCYP, 2021; CCYPWA, 2021). Voluminous case files and critical incident reports were cited as significant burdens for departmental staff to sort, process, review, and evaluate information (CCYP, 2015; CCYP, 2021; CCYPWA, 2021), often resulting in missed opportunities for prevention and early interventions.

The inquiries in Victoria (CCYP, 2015; VAGO, 2014) found that a wide range of behaviours warranting further investigations and safeguarding actions were often reduced to broad categories, rated from "most serious or less serious" (CCYP, 2015) or between "major impact" and "non-major impact" (CCYP, 2021). This broad-brush approach frequently led to misclassification, with allegations of rape, indecent assault, and CSE often incorrectly categorised under the "sexual behaviour" label, which severely hampered safeguarding efforts (CCYP, 2015).

Coupled with delayed reporting, many immediate concerns were not addressed, and no records were available to demonstrate safeguarding actions had been taken. For example, in one incident, a 15-year-old girl disclosed to staff that she had tested positive for pregnancy and was experiencing bleeding and pain (CCYP, 2015). This disclosure and help-seeking behaviour were recorded by staff as "behaviour disruptive". The report was not faxed to the statutory department until three days after the disclosure, and it took another three months before the department reviewed the report and recommended that the young person be supported to seek medical care (CCYP, 2015). The inquiry found no further information in the young person's file to confirm whether she ever received medical or other care in response to the disclosure (CCYP, 2015).

In Victoria, the Critical Incident Management System (CIMS) was the primary reporting platform for cases where a child or young person had gone missing or was absent from their placement. However, the inquiry found that CIMS was an impact-based reporting system, directing staff to report only when the absence had caused harm to the child or young person (CCYP, 2021). This suggests that many instances where harm may have occurred went unreported and unaddressed unless a disclosure was made or hospital admission occurred (CCYP, 2021). Staff also revealed that if a young person was an older adolescent and frequently spent authorised time away from care, they were often considered less vulnerable, as their absence was viewed as a common behavioural pattern. This suggests that the young people who went missing or absent most frequently may have the least documentation about their absences, as the behaviour was normalised and therefore not reported (CCYP, 2021).

At a practice level, the inquiries revealed a range of concerns. The CCYP (2015) found that, in some cases, information about one child was mistakenly recorded in another child's file. Multiple inquiries found that many critical incident reports in the systems were still in draft form (CCYP, 2021) or that a child's information was copied and pasted from one document to another without any specific detail to inform assessment and decision-making (CCYPWA, 2021). In other cases, information about a child or young person was often recorded in a disorderly or point-in-time manner, without chronological order, making it difficult to identify patterns of behaviour and their underlying drivers (CCYP, 2015; CCYP, 2021; CCYPWA, 2021; VAGO, 2014).

In numerous cases, young people's allegations of rape were documented in case notes; however, no further records could be found to determine whether any safeguarding actions were taken by the residential care service or the department; nor was there any information regarding the welfare of the young person (CCYP, 2015). Similarly, the Western Australia inquiry found that, in the case of a young woman who was sexually harmed by a male co-resident, critical information such as her history of sexual abuse and her expressed fear of being raped by the co-resident was not recorded in her safety plan (CCYPWA, 2021).

Role confusion among residential care staff regarding who was responsible for reporting and to whom reports should be made led to numerous delays or omissions (CCYP, 2015; CCYP, 2021; CCYPWA, 2021). These issues also hampered information sharing between the statutory departments, residential care services, and Police in cases where a child or young people would have benefited from timelier and coordinated responses across the different systems (CCYP, 2015; CCYP, 2021; CCYPWA, 2021; The Royal Commission, 2017a; VAGO, 2014).

3.4. Disempowering practices

Inquires also revealed a range of practices that were disempowering to children, young people and their families, reducing the capacity for those around them to safeguard their safety. Firstly, children and young people were not adequately supported to maintain family and cultural connections, driving them away from placement to reconnect with family and culture (CCYP, 2021). Evidence across inquires pointed to many shortcomings in the implementation of The Aboriginal and Torres Strait Islander Child Placement Principle (CCYP, 2015; CCYP, 2021; CCYPCG, 2008; OCC, 2024; QFCC, 2018; 2022; 2023; 2024; VAGO, 2014; 2016; VO, 2020). While the Principle encompasses five interdependent elements—participation, partnership, prevention, connection, and placement, numerous inquiries identified persistent deficiencies. These included a lack of genuine partnerships with Aboriginal families and communities, and ongoing failures in placing children and young people within their kinship and community networks (CCYP, 2015; OCC, 2024; QFCC, 2022; VO, 2020). The persistent shortage of Aboriginal placements resulted in many Aboriginal children being placed in non-Aboriginal care settings; however, many Aboriginal children were left without a cultural plan; and where cultural plans were developed, they were often delayed or lacked specific, actionable steps (CCYP, 2015; CCYP, 2021; OCC, 2024; QFCC, 2018; 2022; 2023; VAGO, 2014; 2016; VO, 2020). Resultingly, many children and young people grew up without knowing their skin names and opportunities to maintain or develop their cultural identities (CCYP, 2015; CCYP, 2021; OCC, 2024; QFCC, 2018; 2022; 2023; VAGO, 2014; VO, 2020).

Children and young people also wanted more support to maintain and strengthen family connections (CCYPCG, 2008; QFCC, 2018; 2024). They cited several key barriers including being placed too far from their families, a lack of practical support such as transport and staff availability, and complex, slow processes for obtaining approval for family contacts (CCYP, 2021; QFCC, 2018; 2023; 2024; VAGO, 2014).

Across inquiries, children and young people expressed that they felt they were not listened to (CCYPWA, 2021; CCYPCG, 2008; 2012; Moore et al., 2016; OGCYP, 2019; QFCC, 2018; 2023; 2024; VO, 2020). Inquiries found little evidence that children and young people were involved in their own case planning (CCYPWA, 2021; Moore et al., 2016; QFCC, 2023; 2024; VO, 2020). Children and young people attested that

adults rarely took the time to explain to them how and why decisions were made on their behalf, and they were often the last to be informed about what was happening (CCYPWA, 2021; QFCC, 2024). Furthermore, they were not told what actions, if any, were taken after making disclosures of abuse or the raising of safety concerns (CCYPWA, 2021; OGCYP, 2019). Young people also expressed that adults rarely recognised their capability to openly discuss their concerns about sexual abuse and to advise them on what works best to protect them from harm (Moore et al., 2016).

> "I think workers should rely more on young people. We know what is going on, we know what it's like, we know what works and we know what is going to work … If young people know that workers have learned what to do from us kids I reckon they'd be more like … to go along with it. It makes sense – but I don't think they'd even think about asking us." (Young man, aged 17–20, Moore et al., 2016, p. 57)

Relatedly, inquiries also converged on the finding that there was a pervasive lack of independent oversight of residential care service quality which diminished accountability. While there were well-crafted service guidelines outlining expected service standards, inquiries found that there was a lack of regular and robust monitoring to ensure that the standards were achieved; performance indicators were also too narrowly focused on throughput or individual residential care setting rather than children's experience of safety in care (CCYP, 2015; CCYPWA, 2021). While Ombudsman (e.g., in Victoria) and the statutory departments had the mandate to receive and investigate complaints made by children, young people, and their families in residential care, many of them were not aware of this mechanism (VAGO, 2014; VO, 2020).

Many inquiries pointed to the importance of having an independent advocate for children and young people in residential care (CCYP, 2015; CCYPWA, 2012; Moore et al., 2016; QFCC, 2018; The Royal Commission, 2017a). Where an independent advocate was available, children found that the advocate was trustworthy and felt they could speak with them about issues that they would not have otherwise spoken with adults about (CCYPWA, 2021; CCYPCG, 2008, 2013; OGCYP, 2019). Many children and young people, however, wanted more frequent and longer visits from the independent advocate (Moore et al., 2016; QFCC, 2018; OGCYP, 2019):

> "Your voice can't be heard – how can your voice be heard and say everything you need once a year in an hour?" (OGCYP, 2019, p. 5)

4. Discussion

This review sought to explore how the residential care contexts across Australia might have placed children and young people at risk of HSB and CSE. This exploration is important because identifying contextual factors is the first step towards contextual prevention (Rayment-McHugh et al., 2024). The findings of this review drew specific attention to the need to improve placement matching, enhance the capacity and capability of the workforce, strengthen reporting infrastructure and practice, and elevate the voice of children and young people in residential care. Despite persistent calls from children and young people for better placement matching in residential care, practice and policy attention to this area remains limited (Kor et al., 2023). Research demonstrated that, when matched appropriately, children and young people in residential care can be a source of support, rather than a risk to one another (Moore et al., 2019). As multiple inquiries revealed, the configuration of residential care and the associated funding requirements to optimise occupancy rate generated perceived pressure for residential care services to accept referral despite safety concerns. Addressing this context is crucial, from changing the ways in which residential care services are commissioned, to increasing and sustaining other home-based placement options to reduce the burden on residential care.

The review also points to the need to upskill the workforce in identifying and responding to HSB and CSE more adequately. Research suggested that apart from staff training, establishing a community of practice, led by senior executives to create an authorising environment for frontline workers to develop and embed safeguarding practices into residential care holds promise (McKibbin et al., 2024). Specialist outreach services that provide tangible support (e.g., transport and emergency accommodation) was also valued by young people who spent unauthorised time away from care (Venables, 2023). Crucially, safeguarding responses must be driven by relationship-based practices that meet children and young people's need to feel connected, valued, and respected (Lefevre et al., 2017; McPherson et al., 2025), especially those who have been further marginalised due to disability or their sexual minority identity.

The finding that older adolescents who repeatedly spent authorised time away from care were less likely to be flagged by the system as at risk of harm warrants attention. This practice exemplifies the fallibility of risk assessment identified by Munro (2008) in child protection practice, where a new incident involving an already at-risk child increases the perceived risk only slightly, whereas the same incident involving a child initially regarded as low risk drastically elevate the risk assessment. This constrains responses to new and immediate risks, rather than cumulative harm, thereby marginalising those who have experienced ongoing harm. Recognising this, each piece of risk-related information should be accurately and chronologically documented, and assessed for its immediate and long-term impacts.

The need to elevate the voice of children and young people in care is a recurring finding in this review and previous research (e.g., Bessell, 2011). Powell et al. (2020) illustrated that positioning children as vulnerable who are completely dependent on adults for protection contributed to the tendency for organisations to relegate listening to children to a checklist exercise. A rights-based approach that recognises adults' dual responsibilities to protect and enable participation is required (Powell et al., 2020).

Apart from justice-seeking, public inquiries also aim to take stock of 'lessons learned' and drive forward change. However, this objective of instigating reforms to fundamentally change the status quo is perhaps the most difficult to achieve. Stevens and Gahan (2024) reviewed over 3000 recommendations from 61 reports and inquiries on child protection and youth justice in Australia, spanning a 12-year period from 2010 to 2022. They found that relevant governments publicly responded to just over half of these reports and inquiries. Concomitantly, systemic failures have consistently appeared across all reports and inquiries (Stevens & Gahan, 2024), a finding that is also evident in this review.

Stark and Yates (2021) argued that most public inquiries have limited control over the way in which recommendations are transferred to policy agendas, and the extent to which government commitment and resources are put towards implementations. They attributed this to the misalignment between the three interlinked policy environments: 'the inquiry room', 'the actioning environment', and 'the institutionalising environment' (Stark & Yates, 2021). Extensive public lobbying by advocacy and interest groups is often necessary to instigate policy reforms following public inquiries (Stark & Yates 2021). Creating an independent agency to oversee post-inquiry policy development, liaise with governments, and coordinate service reform would provide the legitimacy and authority needed to support more robust implementation of inquiry recommendations (McPhillips et al., 2020; Stark & Yates, 2021). This approach should be considered for residential care.

Another inherent challenge is that residential care is embedded within numerous service contexts across the human services sector, each with its own service philosophy, mandated requirements, and priorities. Recognising this, evidence of contextual safeguarding points to the need for a cultural shift towards systemic thinking, moving away from a siloed, disconnected service approach to inter-dependent and mutually reinforcing ways of working (Firmin et al., 2024). Recognising child maltreatment as a form of social harm may foster collective

responsibility (Parton, 2019), bringing gatekeepers across sectors together to address the systemic drivers of HSB and CSE and to strengthen safeguarding practices in residential care.

5. Limitations

Although the reports included in this review were identified and retrieved through a systematic search across three data sources, it remains possible that other inquiry reports that would have been relevant to this review was inadvertently excluded. Inquiries into OoHC more broadly might also offer relevant insights; however, they were excluded to allow a more specific focus on residential care. Public inquiry reports are considered grey literature which precludes them from peer review; hence, their scientific rigor cannot be determined. Nevertheless, all 17 inquiries included in this study were undertaken by independent commissions; 15 of which used either surveys, individual interviews, or focus groups to elicit the lived experiences of children and young people, thereby affording the inquiries a degree of creditability and legitimacy. Crucially, this review focused exclusively on the Australian context which limits the generalisability of the findings to other countries. Neither was it the aim of this review to examine the extent to which Australian governments have addressed the issues identified in the inquiries; this will be a topic worthy of examination in future research.

6. Conclusion

In response to the growing concerns about HSB and CSE in residential care, this review applied a contextual safeguarding lens to review the evidence from public inquiries and explored the question, "what contextual factors within residential care systems place children and young people at risk of HSB and CSE?". The findings highlighted the need to improve OoHC options and strengthen placement matching assessments and decisions. It is also critical to equip the workforce to respond more effectively to HSB and CSE. This includes building capacity and ensuring that concerns and incidents are reported in ways that facilitate timely and coordinated responses across different service systems. Equally important is the need to strengthen independent oversight to ensure that residential care and its surrounding service systems partner with children, young people, and families to create a safe and nurturing care environment. Critically, recognising HSB and CSE in residential care as forms of social harm is needed. This shift in perspective broadens the focus from mitigating individual risk factors to improving the broader policy and practice contexts that shape the experiences of children and young people in residential care.

Declaration of competing interest

The author declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

Data will be made available on request.

References

Australian Institute of Health and Welfare [AIHW] (2025). Child Protection. https://www.aihw.gov.au/reports-data/health-welfare-services/child-protection/overview.

Baethge, C., Goldbeck-Wood, S., & Mertens, S. (2019). SANRA-a scale for the quality assessment of narrative review articles. *Research Integrity & Peer Review, 4*(5). https://doi.org/10.1186/s41073-019-0064-8

Baumeister, R. F., & Leary, M. R. (1997). Writing narrative literature reviews. *Review of General Psychology, 1*(3), 311–320. https://doi.org/10.1037/1089-2680.1.3.311

Bessell, S. (2011). Participation in decision-making in out-of-home care in Australia: What do young people say? *Children & Youth Services Review, 33*(4), 496–501. https://doi.org/10.1016/j.childyouth.2010.05.006

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.

Byrne, J. A. (2016). Improving the peer review of narrative literature reviews. *Research Integrity and Peer Review, 1*, 12. https://doi.org/10.1186/s41073-016-0019-2

Cale, J., Whitten, T., Perales, F., O'Shannessy, D., & Leclerc, B. (2025). A quasi-experimental evaluation of a specialized treatment service for youth adjudicated for sexual offences in Queensland, Australia. *Journal of Criminal Justice, 99*, Article 102462. https://doi.org/10.1016/j.jcrimjus.2025.102462

Canning, M., Keenan, M., & Breslin, R. (2024). The sexual exploitation of children in the care of the Irish state - Professionals' perspectives. *Child Abuse Review, 33*(6). https://doi.org/10.1002/car.70013

Cockbain, E., Ashby, M., & Brayley, H. (2017). Immaterial boys? A large-scale exploration of gender-based differences in child sexual exploitation service users. *Sexual Abuse, 29*(7), 658–684. https://doi.org/10.1177/1079063215616817

Commission for Children and Young People (2015). "...as a good parent would..." Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care. www.ccyp.vic.gov.au.

Commission for Children and Young People (CCYP). (2021). *Out of sight: Systemic inquiry into children and young people who are absent or missing from residential care*. https://ccyp.vic.gov.au/assets/Publications-inquiries/Out-of-sight-inquiry-report-Web.pdf.

Commission for Children and Young People and Child Guardian (CCYPCG). (2008). *Views of young people in residential care, Queensland 2008*. http://www.ccypcg.qld.gov.au/resources/views/Views-of-children-and-young-people.html.

Commission for Children and Young People and Child Guardian (CCYPCG). (2012). *Views of young people in residential care survey: Responding to trauma and attachment needs in residential care: What young people's perceptions tell us about how well we're doing in Queensland*. https://apo.org.au/node/32139.

Commission for Children and Young People and Child Guardian (CCYPCG) (2013). *Views of young people in residential care survey: Young people's views about the support and advocacy provided by Community Vistors in residential care*. https://apo.org.au/node/34489.

Commissioner for Children and Young People Western Australia (CCYPWA). (2021). *Independent review into the Department of Communities' policies and practices in the placement of children with harmful sexual behaviours in residential care settings*. https://www.ccyp.wa.gov.au/media/2sabhcfy/independent-review-of-department-of-communities-september-2021.pdf.

Coy, M., Sharp-Jeffs, N., & Kelly, L. (2017). *Key messages from research on child sexual exploitation: Social workers*. Centre of expertise on child sexual abuse.

Euser, S., Alink, L. R. A., Tharner, A., van Ijzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2013). The prevalence of child sexual abuse in out-of-home care: A comparison between abuse in residential and in foster care. *Child Maltreatment, 18*(4), 221–231. https://doi.org/10.1177/1077559513489848

Fernandez, E., Lee, J., Foote, W., Blunden, H., McNamara, P., Kovacs, S., & Cornefert, P. (2017). There's More to be Done; "Sorry" is Just a Word': Legacies of Out-of-Home Care in the 20th Century. *Children Australia, 42*(3), 2085. https://doi.org/10.1017/cha.2017.29

Firmin, C. (2018). *Abuse between young people: A contextual approach*. Routledge.

Firmin, C. (2020). *Contextual safeguarding and child protection: Rewriting the rules*. Routledge.

Firmin, C., Lefevre, M., Huegler, N., & Peace, D. (2022). *Safeguarding young people beyond the family home: Responding to extra-familial risks and harms*. Policy Press, 10.51952/9781447367277.

Firmin, C., Lefevre, M., Langhoff, K., & Ruch, G. (2024). A line in the sand: Moving from surface improvement to foundational shifts to develop effective responses to extra-familial risks and harms. *British Journal of Social Work*. https://doi.org/10.1093/bjsw/bcae193

Firmin, C., & Rayment-McHugh, S. (2020). Two roads, one destination: Community and organizational mechanisms for contextualizing child abuse prevention in Australia and the UK. *International Journal on Child Maltreatment: Research, Policy and Practice, 3*(2), 229–247. https://doi.org/10.1007/s42448-020-00049-3

Gatwiri, K., Cameron, N., McPherson, L., & Parmenter, N. (2020). What is known about child sexual exploitation in residential care in Australia? A systematic scoping review. *Children and Youth Services Review, 116*. https://doi.org/10.1016/j.childyouth.2020.105188

Gewirtz-Meydan, A., & Finkelhor, D. (2020). Sexual abuse and assault in a large national sample of children and adolescents. *Child Maltreatment, 25*(2), 203–214. https://doi.org/10.1177/1077559519873975

Hackett, S., Branigan, P., & Holmes, D. (2019). Harmful sexual behaviour framework: an evidence- informed operational framework for children and young people displaying harmful sexual behaviours. https://learning.nspcc.org.uk/media/1657/harmful-sexual-behaviour-framework.pdf.

Hackett, S., Masson, H., Phillips, J., & Balfe, M. (2013). Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child abuse review (Chichester, England: 1992)*, *22*(4), 232–245. 10.1002/car.2246.

Hallett, S. (2016). 'An uncomfortable comfortableness': 'Care', child protection and child sexual exploitation. *British Journal of Social Work, 46*(7), 2137–2152. https://doi.org/10.1093/bjsw/bcv136

Hallett, S., Deerfield, K., & Hudson, K. (2019). The same but different? Exploring the links between gender, trauma, sexual exploitation and harmful sexual behaviours. *Child abuse review (Chichester, England : 1992)*, *28*(6), 442–454. 10.1002/car.2591.

Harris, L., Powell, M. A., Moore, T., Dickson, J., & Ghani, F. (2025). Young people who spend unauthorised time away from care: A scoping review. *Child and Youth Services Review, 170*. https://doi.org/10.1016/j.childyouth.2025.108137

Hunt, G. R., Higgins, D. J., Willis, M. L., & Harris, L. (2024). Scoping review of the definitions used to describe and understand harmful sexual behaviors in children and young people. *Trauma, Violence, & Abuse, 25*(4), 2569–2583. https://doi.org/10.1177/15248380231218294

Kor, K., Fernandez, E., & Spangaro, J. (2023). Placement matching of children and young people within out-of-home residential care: A qualitative analysis. *Health & Social Care in The Community*. https://doi.org/10.1155/2023/7431351

Kor, K., & McNamara, P. (2021). Therapeutic residential care. In E. Fernandez, & P. Delfabbro (Eds.), *Child protection and the care continuum: Theoretical, empirical and practice insights*. Routledge.

Laird, J. J., Klettke, B., Hall, K., & Hallford, D. (2023). Toward a global definition and understanding of child sexual exploitation: The development of a conceptual model. *Trauma, Violence, & Abuse, 24*(4), 2243–2264. https://doi.org/10.1177/15248380221090980

Lateef, R., & Jenney, A. (2021). Understanding sexually victimized male adolescents with sexually abusive behaviors: A narrative review and clinical implications. *Trauma, Violence, & Abuse, 22*(5), 1169–1180. https://doi.org/10.1177/1524838020906558

Lefevre, M., Hickle, K., Luckock, B., & Ruch, G. (2017). Building trust with children and young people at risk of child sexual exploitation: The professional challenge. *The British Journal of Social Work, 47*(8), 2456–2473. https://doi.org/10.1093/bjsw/bcw181

Leloux-Opmeer, H., Kuiper, C., Swaab, H., & Scholte, E. (2017). Children referred to foster care, family-style group care, and residential care: (How) do they differ? *Children & Youth Services Review, 77*, 1–9. https://doi.org/10.1016/j.childyouth.2017.03.018

Leloux-Opmeer, H., Kuiper, C., Swaab, H., & Scholte, E. (2016). Characteristics of children in foster care, family-style group care, and residential care: A scoping review. *Journal of Child & Family Studies, 25*, 2357–2371. https://doi.org/10.1007/s10826-016-0418-5

Mathews, B., Finkelhor, D., Pacella, R., Scott, J. G., Higgins, D. J., Meinck, F., Erskine, H. E., Thomas, H. J., Lawrence, D., Malacova, E., Haslam, D. M., & Collin-Vézina, D. (2024). Child sexual abuse by different classes and types of perpetrator: Prevalence and trends from an Australian national survey. *Child Abuse & Neglect, 147*, Article 106562. https://doi.org/10.1016/j.chiabu.2023.106562

McKibbin, G. (2017). Preventing harmful sexual behaviour and child sexual exploitation for children & young people living in residential care: A scoping review in the Australian context. *Children & Youth Services Review, 82*, 373–382. https://doi.org/10.1016/j.childyouth.2017.10.008

McKibbin, G., Humphreys, C., & Hamilton, B. (2017). "Talking about child sexual abuse would have helped me": Young people who sexually abused reflect on preventing harmful sexual behavior. *Child Abuse & Neglect, 70*, 210–221. https://doi.org/10.1016/j.chiabu.2017.06.017

McKibbin, G., Lynch, O., Bornemisza, A., Green, R., & Humphreys, C. (2024). Communities of practice support implementation of power to kids in residential care: The EMBED model. *Child & Family Social Work*. https://doi.org/10.1111/cfs.13243

McPherson, L., Canosa, A., Gilligan, R., Moore, T., Gatwiri, K., Day, K., Mitchell, J., Graham, A., & Anderson, D. (2025). Young people's lived experience of relational practices in therapeutic residential care in Australia. *Children & Youth Services Review, 170*. https://doi.org/10.1016/j.childyouth.2025.108129

McPhillips, K., Salter, M., Roberts-Pedersen, E., & Kezelman, C. (2020). Understanding trauma as a system of psycho-social harm: Contributions from the Australian Royal Commission into child sex abuse. *Child Abuse & Neglect, 99*, Article 104232. https://doi.org/10.1016/j.chiabu.2019.104232

Moore, T., McArthur, M., & Death, J. (2019). Brutal bullies and protective peers: How young people help or hinder each other's safety in residential care. *Residential Treatment for Children & Youth, 37*(2), 108–135. https://doi.org/10.1080/0886571x.2019.1682487

Moore, T., McArthur, M., Roche, S., Death, J., & Tilbury, C. (2016). *Safe and sound: Exploring the safety of young people in residential care*. https://www.childabuseroyalcommission.gov.au/media-releases/research-finds-children-residential-care-feel-unsafe.

Munro, E. (2008). *Effective child protection* (2nd ed.). SAGE.

Office of the Children's Commissioner Northern Territory (OCC) (2024). *Residential care in the Northern Territory: Monitoring Report 2022*. https://occ.nt.gov.au/_resources/documents/occ-publications/other-reports/OCC-FINAL-CASPA-ITRC-Monitoring-Report.pdf.

Office of the Guardian for Children and Young People (OGCYP). (2019). *What matters to us*. https://www.gcyp.sa.gov.au/wordpress/wp-content/uploads/2020/02/2019-09-30-Report-U-Marwitz-What-Matters-to-Us.pdf.

Ogilvie, J., Thomsen, L., Barton, J., Harris, D. A., Rynne, J., & O'Leary, P. (2022). *Adverse childhood experiences among youth who offend: Examining exposure to domestic and family violence for male youth who perpetrate sexual harm and violence (research report, 13/2022)*. *ANROWS*. https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2022/07/30135343/4629-ANROWS-Rynne-Research-Report-2-FA-Accessible_v3.docx.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hrobjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., McGuinness, L. A., Stewart, L. A., Thomas, J., Tricco, A. C., Welch, V. A., Whiting, P., & Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ, 372*, Article n71. https://doi.org/10.1136/bmj.n71

Parton, N. (2019). Child maltreatment as social harm. In *Re-visioning public health approaches for protecting children* (pp. 473–485). 10.1007/978-3-030-05858-6_27.

Powell, M. A., Graham, A., Canosa, A., Anderson, D., Taylor, N., Robinson, S., Moore, T., & Thomas, N. P. (2020). Children and safety in Australian policy: Implications for organisations and practitioners. *Australian Journal of Social Issues, 56*(1), 17–41. https://doi.org/10.1002/ajs4.134

Queensland Family & Child Commission (QFCC). (2018). *Young people's perspectives of residential care, including police call-outs*. https://www.qfcc.qld.gov.au/sites/default/files/2022-06/Young%20people%20s%20perspectives%20on%20residential%20care,%20including%20police%20call-outs.pdf.

Queensland Family & Child Commission (QFCC). (2022). *The decision to place an Aboriginal and Torres Strait Islander child or young person in residential care*. https://www.qfcc.qld.gov.au/sites/default/files/2022-12/The%20decision%20to%20place%20an%20Aboriginal%20and%20Torres%20Strait%20Islander%20child%20and%20young%20person%20in%20residential%20care%20report.PDF.

Queensland Family & Child Commission (QFCC). (2023). *"I was raised by a checklist"*. https://www.qfcc.qld.gov.au/sites/default/files/2023-10/I%20was%20raised%20by%20a%20checklist%20-%20QFCC%20Review%20of%20Residential%20Care.pdf.

Queensland Family & Child Commission (QFCC). (2024). *"Treat us like humans"*. https://www.qfcc.qld.gov.au/sites/default/files/2024-12/Treat%20us%20like%20humans%20-%20Workshops%20with%20young%20people%20living%20in%20residential%20care_0.pdf.

Rayment-McHugh, S., McKillop, N., Adams, D., Higgins, D. J., & Russell, D. H. (2024). Context matters: Conceptualising and operationalising the contextual prevention of child sexual abuse. *Child Abuse Review, 33*(1). https://doi.org/10.1002/car.2859

Roache, M., & McSherry, D. (2021). Understanding and addressing Child Sexual Exploitation (CSE) in residential care in Northern Ireland using a qualitative case study design: The residential social care worker perspective. *Child Abuse & Neglect, 122*, Article 105329. https://doi.org/10.1016/j.chiabu.2021.105329

Seto, M. C., & Lalumière, M. L. (2010). What is so special about male adolescent sexual offending? A review and test of explanations through meta-analysis. *Psychological Bulletin, 136*(4), 526–575. https://doi.org/10.1037/a0019700

Sköld, J. (2015). Apology politics: Transnational features. In J. Sköld, & S. Swain (Eds.), *Apologies and the legacy of abuse of children in 'care'. International perspectives* (pp. 13–26). Palgrave Macmillan.

Stark, A. (2019). Left on the shelf: Explaining the failure of public inquiry recommendations. *Public Administration, 98*(3), 609–624. https://doi.org/10.1111/padm.12630

Stark, A., & Yates, S. (2021). Public inquiries as procedural policy tools. *Policy & Society, 40*(3), 345–361. https://doi.org/10.1080/14494035.2021.1955485

Stevens, E., & Gahan, L. (2024). *Improving the safety and wellbeing of vulnerable children: A consolidation of systemic recommendations and evidence*. https://aifs.gov.au/research/research-reports/improving-safety-and-wellbeing-vulnerable-children.

Swain, S. (2014). *History of Australian inquiries reviewing institutions providing care for children*. https://safeguardingchildren.acu.edu.au/research-and-resources/history-of-australian-inquiries-reviewing-institutions-providing-care-for-children.

The Royal Commission into Insitutional Responses to Child Sexual Abuse (The Royal Commission). (2017a). *Final report Vol. 10: Children with harmful sexual behaviours*. https://www.childabuseroyalcommission.gov.au/final-report.

The Royal Commission into Insitutional Responses to Child Sexual Abuse (The Royal Commission). (2017b). *Final report Vol. 12: Contemporary out-of-home care*. https://www.childabuseroyalcommission.gov.au/final-report.

Timmerman, M. C., & Schreuder, P. R. (2014). Sexual abuse of children and youth in residential care: An international review. *Aggression and Violent Behavior, 19*(6), 715–720. https://doi.org/10.1016/j.avb.2014.09.001

Venables, J. (2023). Features of service delivery that young people in out-of-home care who 'self-place' and stay in unapproved placements value when accessing a specialist support service. *Child and Adolescent Social Work Journal, 42*(1), 95–107. https://doi.org/10.1007/s10560-023-00939-8

Verso & the Department of Human Services Victoria (Verso-DHS). (2011). *Evaluation of the therapeutic residential care pilot programs: Final summary and technical report*. https://dhhs.vic.gov.au/publications.

Victorian Auditor-General's Office (VAGO) (2014). *Residential care for children*. https://www.audit.vic.gov.au/report/residential-care-services-children?section=.

Victorian Auditor-General's Office (VAGO) (2016). *Follow up of residential care services for children* https://www.audit.vic.gov.au/report/follow-residential-care-services-children?section=.

Victorian Ombudsman (VO). (2020). *Investigation into complaints about assaults of five children living in child protection residential care units*. https://www.ombudsman.vic.gov.au/our-impact/investigation-reports/investigation-into-complaints-about-assaults-of-five-children-living-in-child-protection-residential-care-units-1/.

Wright, K. (2017). Remaking collective knowledge: An analysis of the complex and multiple effects of inquiries into historical institutional child abuse. *Child Abuse & Neglect, 74*, 10–22. https://doi.org/10.1016/j.chiabu.2017.08.028

Wulczyn, F., & Chen, L. (2017). *Placement changes among children and young people in out-of-home care. Pathways of Care Longitudinal Study (PoCLS): Outcomes of children and young people. Research Report Number, 8*. https://www.facs.nsw.gov.au/data/assets/pdffile/0009/591669/Researchreport-8-Wulczyn,-F.-and-Chen,-L.-Placement-Changes-Among-Children-and-Young-People-in-Out-of-Home-Care.pdf.