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Title page

Using sexual health and safety education to protect against child sexual abuse in residential care – the LINC model

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Using sexual health and safety education to protect against child sexual abuse in residential care – the LINC model

Abstract

Background

Children and young people living in residential care are vulnerable to sexual abuse and there is scant evidence about what sexuality education could help address this vulnerability. This paper explores the impact of the *Power to Kids: Respecting Sexual Safety* program, which involved capacity-building workers to have "brave conversations" with children and young people in residential care.

Method

The aim of the study was to capture the perceptions of workers about: changes in their skill and confidence levels in relation to having brave conversations with children and young people; and the impact of those conversations on children and young people. A mixed-methods study was

undertaken, involving multiple sets of interviews with 27 workers associated with four residential houses.

Results

The qualitative and quantitative data analysis showed that workers perceived the impact of the capacity-building and brave conversations as strengthening protective factors available to children and young people vulnerable to sexual abuse.

Conclusion

The research revealed the "LINC model" as a viable approach to capacity-building workers to educate children and young people in residential care about sexual health and safety. Workers perceived the enhancement of the following protective factors: stronger safe relationships; greater comfort disclosing abuse; and improved knowledge of normal versus harmful sexual behaviour.

Introduction

Children and young people living in out-of-home care are vulnerable to being sexually abused (Royal Commission, 2016). This vulnerability arises because these children are likely to have experienced child maltreatment, poverty, parental mental health issues, domestic violence and compromised caregiving. These adverse childhood experiences can lead to current experiences of mental health issues, difficulties at school, drug and alcohol use, teenage pregnancy, sexual assault, harmful sexual behaviours and dating violence (McLean, Price-Robertson & Robinson, 2011). The vulnerability highlights the need to prioritise sexual health and safety education initiatives, particularly in light of the fact that children in residential care are often disengaged from school and may not receive prevention education provided in that context (Dale & Fife, 2009).

Current approaches to sexual health and safety education in residential care

There is scant literature about evidence-informed practice for sexual health and safety education with children and young people in residential care (small group houses supported by employed workers). In the international evidence, it appears that the majority of programs utilise a classroom-style delivery of a curriculum over multiple days to groups of young people (Ahren et al., 2014; Messey Combs, Aparicio, Prince, Grinnell-Davis, Marra, Faulkner, 2019; Green, Oman, Lu & Clements-Nolle, 2017; Lindroth, 2014; Scotti et al., 1996; and Slonim-Nevo et al., 1996). Other less-common interventions adopt approaches including: mentor-mentee (Mezey, Robinson, Gillard, Mantovani, Meyer, White & Bonell, 2017); one-on-one counselling (Dale, Watson, Adair & Humphris, 2016); one-off group sessions (Schmiege et al., 2009); and education provision by health personnel (Hyde et al., 2016).

The educative content of the interventions appears to vary greatly. Some have very specific content and objectives, such as teen pregnancy prevention or reduction of HIV risk. Other interventions are much broader, addressing multidimensional elements of relationships and sexuality. A small number of studies address trauma-related experiences of children and how that may influence risk-taking

and decision-making in sex and relationships (Messey Combs et al., 2019; Green et al., 2017; Hyde et al., 2016).

Recent literature emerging from the US indicates that children and young people living in residential care may benefit from receiving sexual health and safety education through one-on-one conversations with their workers (Faulkner, Borcyk, Sevillano, Doerge, Nulu & Wasim, 2019). Faulkner and Schergen (2016) have developed a model of "brave conversations" whereby workers have trauma- and evidence-informed conversations with children and young people over the course of the day as opportunities arise. The brave conversations model does not appear to have been evaluated but the evaluation of a similar model that involved capacity-building workers to communicate with young people in residential care about sexual health issues indicated that the knowledge of workers increased, as did the frequency of communication between workers and young people (Colarossi, Dean, Stevens, Ackeifi & Noonan, 2019).

This interest in supporting one-on-one sexual health and safety conversations between workers and young people is echoed in the UK. In Scotland it has been recommended that workers have conversations with children in their care about sexual health and safety issues as part of their role as "public parent" (Nixon, Elliott & Henderson, 2019). Consequently, social workers have been training residential workers to have discussions with children they care for about sexual health and safety although this does not appear to have been trialled and evaluated to date (Nixon et al., 2019).

It is evident that there is limited evidence about trauma-informed sexual health and safety interventions targeting children and young people living in residential care that focus on upskilling workers to have educative conversations, particularly in the Australian context. The aim of this paper is to present findings about how workers perceived the impact of their capacity-building to have brave conversations about sexual health and safety issues as part of the *Power to Kids: Respecting Sexual Safety* project.

Method

Power to Kids: Respecting Sexual Safety program

The *Power to Kids: Respecting Sexual Safety* program was co-designed through a partnership between a Victorian community sector organisation and University of Melbourne. It consists of three prevention strategies: Whole-of-house respectful relationships and sexuality education; a Missing from home strategy; and a Sexual safety response (McKibbin, Halfpenny & Humphreys, 2019**)**. The overall aim of the program is to prevent and intervene early in three forms of child sexual abuse (CSA): harmful sexual behaviour; child sexual exploitation; and sexualised dating violence. Harmful sexual behaviour is behaviour expressed by children and young people under the age of 18 years old that is developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult (Hackett, Holmes, & Branigan, 2016). Child sexual exploitation is adult-perpetrated sexual abuse that involves a child or young person receiving goods, money, power or attention in exchange for sexual activity. Often the exploitation involves a period of grooming and the victim can think that he or she is in a boyfriend or girlfriend relationship with the perpetrator (Hackett, Holmes, & Branigan, 2016). Sexualised dating violence is sexual assault in the

context of young people's dating relationships. It can be technology-facilitated or involve coercing an intimate partner into sexual activity that they do not consent to (De La Rue, Polanin, Espelage & Pigott, 2017).

This paper focuses on the first prevention strategy, which involved a sexual health nurse educator educating residential worker "champions" about 10 topics: *Rights of children and young people; Gender stereotypes and diversity; Sexual health; Normal and problematic sexual behaviour; Respectful relationships and love; Consent and age; Grooming and abuse; Disclosure and informed friend; Online sexual safety; and Pornography and representation* (see Figure 1). Champions then shared their new knowledge with other workers. A further step involved the sexual health nurse educator coaching workers about how to have brave conversations (Faulkner & Schergen, 2016) with children and young people in their care about the topics as opportunities arose over the course of each day.

Insert Figure 1 here

Two models for brave conversations were used: TALK and CARE. TALK stands for: Take the initiative; Ask the child what they think or feel; Let them know the facts and range of beliefs; and Keep the conversation going (Faulkner & Schergen, 2016). CARE stands for: Consent; Age; Respect; and Equality (uncited). The first model is to assist workers in conversations, while the second is to assist young people to assess their safety in any situation involving an intimate partner.

Research question

The research questions informing this study were: (1) How do workers perceive change in their skill and confidence levels in relation to having brave sexual health and safety conversations with children and young people in residential care? and (2) How do workers perceive the impact of those conversations on children and young people?

Research design

The co-design and trial of the *Power to Kids: Respecting Sexual Safety* program was guided by the Knowledge to Action Process set out by Graham and Tetroe (2009). This study reported in this paper used a mixed-methods approach (Royse, Thyer & Padgett, 2016).

Sampling

The sample for the study reported in this paper included workers associated with four residential houses chosen to be part of the research by the organisation's senior managers. Qualitative interview data and quantitative survey data were collected to answer the research question. The qualitative sample included the following workers: one sexual health nurse; four residential carer champions; five house supervisors; six case managers; one therapeutic practitioner; three principal practitioners; three coordinators/managers; and two directors (N=27). The quantitative sample included 60 workers (all categories) in the first wave of data collection and 34 in the second.

Data collection

Semi-structured interviews were undertaken with workers. The interviews lasted between 30 minutes and one hour and were designed to capture the reflections of the workers about the program. The champions participated in 10 thirty-minute group interviews designed to capture feedback about brave conversations with children or young people.

Quantitative data collection included a survey comprised of 67 questions that covered participants' knowledge of CSA and sexual and reproductive health, as well as workers' self-efficacy in delivering sexual interventions and their level of comfort in communicating about sexual issues. Knowledge of CSA was measured using the Child Sexual Abuse Knowledge Questionnaire (Goodman-Delahunty, Martschuk & Cossins, 2017). Knowledge of harmful sexual behaviour and child sexual exploitation and knowledge of sexual health and safety were assessed using two scales developed for this study by two of the authors: the Knowledge of Harmful Sexual Behaviour and Child Sexual Exploitation Scale (McKibbin & Bornemisza, unpublished) and the Knowledge of Sexual and Reproductive Health Scale (Bornemisza & McKibbin, unpublished). Level of comfort communicating about sex was measured by the Sexual Communication Comfort Scale (Miller & Byers, 2008 with language modified from client to young person to better fit the program context); and self-reported self-efficacy regarding delivering interventions about sexual health and safety by the Sexual Intervention Self-Efficacy Questionnaire (Miller & Byers, 2008).

Data analysis

The qualitative data was analysed according to Grounded Theory (Charmaz, 2014). The analysis was inductive and involved a process of initial, focused and analytical coding. Initial coding attributed short phrases to each meaningful statement in the interview transcript, while focused coding grouped those statements together. Analytical coding provided a set of themes that constituted an answer to the research question.

Quantitative data analysis was undertaken using SPSS version 26 (IBM Corp., 2019). Frequency tables, cross tabulation tables, means tables, t-tests, and z-tests were conducted to understand data patterns both within and between the two time points. Variables were checked for normality using the Shapiro–Wilk test.

Ethics

Although the study reported here does not report on the involvement of children and young people in the research, there were significant ethical issues to consider in relation to children and young people being involved in sexual health and safety brave conversations. One potential risk involved the possibility that children and young people would feel distressed by the content of the program due to past trauma, or make a disclosure of CSA victimisation or of carrying out harmful sexual behaviour. Such disclosures could expose children and young people to intervention from judicial agencies. Permission was sought from the University of Melbourne ethics committee (ID: 1748824), the organisation's ethics committee and the Secretary of the Department of Health and Human Services. The risk of distress and disclosure was addressed through the development of distress and disclosure protocols.

Results

The qualitative and quantitative data analysis indicated a connection between the capacity-building of workers to have brave conversations and the strengthening of three key protective factors against harmful sexual behaviour, child sexual exploitation and sexualised dating violence. Four themes emerged through the qualitative data analysis: ***L****earning about sexual health and safety through capacity-building*; ***I****nitiating brave conversations with children and young people*; **N***urturing caring relationships with children and young people*; and ***C****hildren and young people are more protected against child sexual abuse*. The results from the quantitative data are provided under the relevant theme.

The LINC model

Emerging out of the data analysis, the authors propose the LINC model (see Figure 2). The LINC model draws together the findings of this study and represents workers' perceptions about the process through which the vulnerability of children and young people living in residential care to CSA can be addressed through brave conversations and the corresponding strengthening of three protective factors: stronger safe relationships; comfort making disclosures; and knowledge of normal versus harmful sexual behaviours.

Insert Figure 2 here

Learning about sexual health and safety through capacity-building

Workers learned about the 10 sexual health and safety topics through a process whereby the sexual health nurse educator coached four champions who then "cascaded" their knowledge to other workers in their teams. The sexual health nurse educator then supported workers to have brave conversations. Twenty-four interviews referred to the importance of this process. Workers reported increased knowledge about topics such as: normal versus harmful sexual behaviours; gender and diversity; and child sexual exploitation. One worker recalled how the project had improved knowledge about normal child sexual development, which had led to a more measured response to issues around children's sexual behaviours:

> *I remember before there used to be lots of overreaction, but having the [Power to Kids: Respecting Sexual Safety] project come in and everyone started to talk about "well kids have a sexuality" . . .[and] when you talk about age-appropriate behaviours you have to be talking about what age they're at and expect different things.* (Therapeutic practitioner)

Further, there appeared to be improvement in understanding of children and young people's use of pornography and its impacts. One champion recalled how they assumed an 11-year-old boy was too young to be watching pornography but soon discovered differently:

> *We thought we didn't want to have the [pornography] conversation with [11-year-old boy] . . . We thought that he wouldn't be searching those websites, porn websites, and as a team we thought we'd be exposing [boy to idea of porn]. But then yesterday we were searching the web history and there was searches for porn.* (Champion)

Workers reported that as they were educated about topics like child sexual exploitation and gender norms, their use of language changed. One champion reflected how engaged workers were with the material on gender norms and how they began to challenge traditional constructions of gender. They said:

> *I think staff's language has changed around certain topics especially, and even with challenging young people on gender norms . . . So even challenging them when they would say oh this is a boy's colour and this is a girl's colour, and having discussions about well anyone can like any colour.* (Champion)

This shift in language amongst workers was also observed by a manager who noticed that they had begun to use appropriate language around child sexual exploitation:

> *I notice staff were using "prostitution" but now it's "sexual exploitation." So just educating and supporting them around language . . . I've seen a shift in that*. (Area Manager)

The perception of the workers about improved knowledge was supported by the survey data. A trend towards improved understanding of children and young people's sexual health and safety was demonstrated in the quantitative questionnaires. Comparison of the wave one and wave two data showed some indication of increased knowledge on scales of relevance: the Child Sexual Abuse Knowledge Questionnaire (Goodman-Delahunty, Martschuk, & Cossins, 2017); the Knowledge of Sexual and Reproductive Health Scale (McKibbin & Bornemisza, unpublished); and the Knowledge of Harmful Sexual Behaviour and Child Sexual Exploitation Scale (Bornemisza & McKibbin, unpublished).

In terms of the first scale, participant knowledge around CSA increased between the two data collection points: time 1 (M = 3.05, SD = .75) and time 2 (M = 3.31[1], SD = .77), albeit this change was not significant $t(87) = -1.57$, p = .119. This non-significant trend was driven by all but one item of the questionnaire.

Likewise, in terms of the second scale, participant knowledge of sexual and reproductive health showed a trend towards increased understanding between the two time points of data collection: time 1 (M = 1.17, SD = .11) and time 2 (M = 1.14[2], SD = .10), $t(85) = 1.19$, p = .237. Knowledge of the following item significantly improved by the second data collection point: *Menstrual blood is discharged from the urethra* (time 1: M = 1.39, SD = .49 and time 2: M = 1.18[3], SD = .39, $t(88) = 2.18$, p = .032). The number of "don't know" responses also decreased by the second wave from 65 to 19, which together with the slight increase in correct responses further indicates a trend towards increased knowledge.

[1] Measured on a 5-point Likert scale (1-5) where higher scores indicated more knowledge.
[2] Note: in this scale, smaller mean indicated increased understanding, range of mean score could fall between 1-2.
[3] Note: in this scale, smaller mean indicated increased understanding, range of mean score could fall between 1-2.

The third scale, although not demonstrating a significant increase of worker knowledge, by the second wave of data collection (time 1: *M* = 1.22, *SD* = .10 and time 2: *M* = 1.19[4], *SD* = .09, *t*(85) = 1.51, *p* = .135), responses on two items about harmful sexual behaviour did suggest worker knowledge significantly improved in these areas. These two items were the following: *All young people who sexually abuse children continue abusing children as adults.* (time 1: *M* = 1.32, *SD* = .47 and time 2: *M* = 1.12[5], *SD* = .33, *t*(92) = 2.19, *p* = .031) and *A 13-year-old acting out sexualised behaviour on a 6-year-old is normal sexual behaviour.* (time 1: *M* = 1.12, *SD* = .32 and time 2: *M* = 1.00[6], *SD* = .00, *t*(92) = 2.10, *p* = .039). This improved knowledge is neatly demonstrated by the second statement that all respondents correctly answered in the second wave, but not in the first.

Overall, qualitative data demonstrated that workers perceived an improvement in knowledge about sexual health and safety issues through the coaching of champions and the dissemination of that knowledge to other workers. Quantitative data demonstrated that workers' self-perceived knowledge about sexual health and safety issues trended towards more knowledge by the second data collection point, although these changes were not statistically significant.

Initiating brave conversations with children and young people

Workers began to initiate brave conversations with children and young people on a daily basis, with the support of the sexual health nurse educator. This theme was noted in 15 interviews. Brave conversations were initiated about a range of sexual health and safety topics as teachable moments emerged over the course of the day. One worker described a conversation with a boy about pornography as they were driving in the car:

> *Just in the car on the way home, [worker] spoke to [boy] and basically said that it was normal for an 11 year old to be curious about sex but that porn doesn't display a real image of what sex life really is and how it can be quite degrading towards women.* (Champion)

Another worker talked about a brave conversation she had observed a colleague having around women's sexual health issues. She said:

> *One of our staff members had a conversation with the girls about vaginal health, something to do with yeast came up and they started looking up images on the internet of vagina infections basically. [Worker] was trying to explain to them what's healthy and what's not healthy - women always get discharge, but if it starts to smell, or if it starts to look a funny colour you need to go to the doctor.* (Champion)

Still another worker recalled a conversation with a boy with harmful sexual behaviour who was new to the house about age, respect and consent:

[4] Note: in this scale, smaller mean indicated increased understanding, range of mean score could fall between 1-2.
[5] Note: in this scale, smaller mean indicated increased understanding, range of mean score could fall between 1-2.
[6] Note: in this scale, smaller mean indicated increased understanding, range of mean score could fall between 1-2.

> *[Boy] started to notice the [Power to Kids: Respecting Sexual Safety] posters and stuff around the house. He said to me before he left for school - he was standing by the office and he said: "What's with all the posters about sex in the house?" So I just said to him it's because we run the Respecting Sexual Safety Program and I explained to him what it is. When I explained to him that part of it is learning about consent his response was well, I know about consent and he kind of laughed. I laughed and used the [CARE] framework back. I said to him well you learn about consent in relation to age and respect and equality as well and he kind of looked at me, and I said don't worry you'll get used to me talking to you about it a lot.* (Champion)

In terms of quantitative data, the Sexual Communication Comfort Scale (Miller & Byers, 2008) was used to evaluate workers' level of confidence and comfort regarding different sexual topics. No shift was observable on this scale between the two time points of data collection. The lack of shift can likely be explained by the fact that this validated scale only vaguely mapped onto the ten key topics addressed in the coaching and did not reflect the brave conversation model of intervention at all.

Workers reported significantly increased levels of skills and comfort in discussing sexuality issues for young people by the end of the program. Using the modified language within the Sexual Intervention Self-Efficacy Questionnaire (Miller & Byers, 2008). This questionnaire measured three types of self-efficacies: comfort and bias self-efficacy, measuring participants' self-reported level of comfort and bias towards responding to young people's sexual concerns; skill self-efficacy, measuring participants' self-reported level of skill to use appropriate techniques and interventions responding to young people's sexual concerns; and information self-efficacy, measuring participants' self-reported level of knowledge translation and teaching skills to educate young people about sexual issues and concerns. Item-level investigation of this scale revealed increased levels of self-efficacy on every item of this questionnaire.

Workers' self-reported levels of self-efficacy in delivering interventions about sexuality was also measured. Self-efficacy has been linked to better performance (Pajares & Johnson, 1994) due to feeling capable of doing well and has been found to be predictive of behaviour change (Skelly, et al., 1995). The authors considered improvement in workers' self-efficacy would foster their willingness to engage in brave conversations.

There was a significant improvement in workers' perception of their skill self-efficacy in the second wave of data collection (M = 4.68, SD = .60) compared to the first wave (M = 4.11[7], SD = .85), $t(89)$ = -3.45, p = .001. Improvement in workers' comfort and bias self-efficacy was also significant at the end of the intervention (M = 4.80, SD = .62) compared to the start of it (M = 4.47[8], SD = .69), $t(87)$ = -2.19, p = .031. The change in participants' information self-efficacy between the two time points suggested a trend towards improvement, although it was not-significant (time 1: M = 4.56, SD = .87 and time 2: M = 4.89[9], SD = .66, $t(90)$ = -1.91, p = .059).

[7] Measured on a 6-point Likert scale (1-6) where higher scores indicated higher levels of self-efficacy.
[8] Measured on a 6-point Likert scale (1-6) where higher scores indicated higher levels of self-efficacy.
[9] Measured on a 6-point Likert scale (1-6) where higher scores indicated higher levels of self-efficacy.

Overall, it was evident that workers began to initiate brave conversations regularly about a wide range of sexual health and safety issues over the course of the day as opportunities arose. Workers perceived that their skills and comfort regarding responding to young people's sexual concerns significantly improved by the end of the intervention. It is likely that workers' significantly increased level of comfort and skill and the trend suggesting increased knowledge contributed to their improved ability to better respond with greater sensitivity to children and young people.

Nurturing caring relationships with children and young people

Workers perceived that the brave conversations between with children and young people generated a new-found "softness" in the quality of their relationships. That is, the quality of the relationships between the workers and the young people improved. This theme was identified in nine interviews. One champion recalled the way that their sense of caring for the children and young people had been enhanced through the brave conversations:

> *Definitely the quality of [how we care] has improved . . . The way we operate and the way we work and the removal of shame and stigma around this sort of stuff in the house is unbelievable.* (Champion)

The enhanced quality of care included a shift in focus away from rules and boundaries to a softer, caring approach. This was evident when young people returned to the house after going missing. A Therapeutic Practitioner observed:

> *I think before we were a lot more - it's about boundaries and rules. [But] actually for that kid, them leaving the house is very fight or flight. They were running away because they couldn't just deal with their emotions and that was their pattern and they needed that softness. When we started to do the softness and the [caring] approach when they returned it was really helpful.* (Therapeutic practitioner)

This sentiment was echoed by another worker who said:

> *Our response when it is a young person who we believe is being sexually exploited - our response when they return has definitely changed. Even when they haven't been in contact or they're being aggressive, because of the education, [our] response when they're returning is a lot more caring and just trying to get that care across.* (Case Manager)

Still another worker commented on how a trusting relationship with a girl at risk of sexual exploitation was enhanced through the brave conversations. He said:

> [Girl] feels safe in talking about what she's doing, where she's going. There's a trust being built [between girl and workers] where she [and workers] make an agreement where she'll have her phone and answer it, and that's been happening. (Manager)

The quantitative questionnaires did not explicitly measure the quality of the relationship between workers and young people. Overall, the qualitative data indicated that relationships children and young people's relationships with workers were enhanced through the process of having brave conversations about sexual health and safety issues.

Children and young people are more protected against child sexual abuse

Workers thought that the brave conversations with children and young people helped to keep children more protected against CSA. In particular, workers identified an increase in the knowledge of children and young people about sexual health and safety issues, as well as an improved comfort around disclosing abuse to workers.

In terms of increased knowledge, one worker observed how the brave conversations had impacted the knowledge of a girl about contraception. She said:

> The conversations that we're having with [girl] are phenomenal . . . Me having that conversation with her about condoms and birth control and her actually just asking me for [condoms], I don't think that would have happened without this project being implemented in the houses. (Champion)

Another worker recalled a conversation with a girl about respectful relationships and applying the CARE model to a new relationship:

> I kind of used the CARE framework when [16 year old girl] did disclose that her partner was 19 . . . and I said, well you're consenting and you're saying that the age difference is not significant or illegal. The main thing that's important is if it's respectful both ways. She said, yes, it is. It's a respectful relationship, and yes, there is an equality in the relationship. No one has more power, which was a really nice conversation to have with her that she was paying attention to those things. (Champion)

Another worker observed how boys in his house had taken on board the notion of consent and were actively seeking the consent of others before touching them. The worker recalled:

> *Considering this fortnight's topic was on consent, both of the young people have taken on my harping on consent. Now I can see them asking for hugs. I can see them asking for fist bumps. I can see them asking to touch my hat or my phone, which is really cool.* (Champion)

The brave conversations about sexual health and safety issues also appeared to create a space in which young people were able to disclose harmful sexual behaviour to staff in order to seek help. A worker said:

> *We had a disclosure around one of the young people that had exposed himself to the other client. Yeah, [the victim] was very forthcoming in telling us what had happened. Six weeks ago, I don't think he would have come forward. Maybe it's the way that we've built our relationship with him, but I think it's also about the brave conversations that we've been having in the meantime so now it's more educating him and now he knows that well, this actually isn't okay and this is what that looks like so I need to tell the staff. So I think that the project has definitely had an influence on him and made him feel comfortable to talk to the staff around what has happened.* (Case Manager)

This was echoed by another worker who said:

> *One thing that I believe the project might have encouraged is the boys to feel comfortable when they know that something isn't right and to disclose that to the staff rather than hiding that from the staff. I think maybe the brave conversations have actually made them feel like "oh no, this isn't something that I need to hide". I can actually have that conversation with the staff and tell them about something that may be happening.* (House supervisor)

The workers perceived that the impact of capacity-building and initiating brave conversations with children and young people left them safer from CSA. Three protective factors were identified to have contributed to this new-found safety: strengthened relationships with workers; increased knowledge about sexual health and safety; and enhanced comfort in disclosing sexual abuse.

Discussion

The authors propose the LINC model as representing the process through which the vulnerability of children and young people living in residential care to CSA can be addressed through sexual health and safety education communicated through brave conversations and the corresponding strengthening of three protective factors: stronger relationships; comfort making disclosures; and knowledge of normal versus harmful sexual behaviour.

The improvement in the quality of relationships was striking in the study and was not anticipated. A strong relationship with a safe adult carer has been found to be a protective factor against child sexual exploitation (Radford, Allnock & Hynes, 2014). The safe relationship counters the "pull" factors used by adult perpetrators to ensnare a child or young person in exploitation, such as affection, drugs or material goods (Jackson, 2014).

Similarly, the ability to disclose abuse early and to a safe person acts as a protective factor against all forms of child sexual abuse (Morrison, Bruce & Wilson, 2018). Adult perpetrators or young people with harmful sexual behaviours may use grooming techniques to stop their victim from telling anybody about the abuse. Increasing the comfort of potential victims in making disclosures is therefore powerfully protective (McAlinden, 2006).

Furthermore, knowledge of normal versus harmful sexual behaviour has been found to be a protective factor against harmful sexual behaviour (Letourneau, Schaeffer, Bradshaw & Feder, 2017). Young people who have displayed harmful sexual behaviour talk about not understanding the issues around age and consent that play an important role in distinguishing normal sexual behaviour from harmful behaviour so providing this information to the cohort of children and young people in residential care is critical (McKibbin, Humphreys & Hamilton, 2017).

The approach of the *Power to Kids: Respecting Sexual Safety* program to upskill workers to have brave conversations with children and young people resonates with recent work undertaken in the US and UK to capacity build workers to have conversations with children and young people in their care about sexual health and safety issues (Colarossi et al, 2019; Nixon, Elliot & Henderson, 2019). The trauma-informed sexuality education model – brave conversations – developed by Faulkner and Schergen (2016) and embedded in the program explored in this paper, offers a promising approach

to educating vulnerable children and young people about sexual health and safety issues in residential care.

Further, the brave conversations model appears, from the perspective of workers involved in providing residential care, to have the additional impact of keeping them safer from CSA, particularly in the forms of harmful sexual behaviour, child sexual exploitation and sexualised dating violence. Importantly, this form of sexuality education is neither entirely victim nor "perpetrator" focused. The conversations can equally support young people to desist from harmful behaviours as they can support the recognition of abuse victimisation and disclosure. This differentiates the approach from traditional child sexual abuse education which is entirely victim-focused (Assini-Meytin, Fix & Letourneau, 2020).

The quantitative findings demonstrate the importance of improving the knowledge of workers about sexual health and safety issues as the pre-test survey results highlighted that worker knowledge of these issues should not be assumed. A systematic review of 23 papers by Babatsikos (2010) found that the majority of mothers talked to their children about child sexual abuse. However, the information imparted to children was often based on misconceptions about child sexual abuse including the idea that strangers are mostly responsible for perpetration. Like mothers, workers need evidence about sexual health and safety so that brave conversations are underpinned by evidence and not misconceptions.

The survey data indicates that the coaching model adopted for Prevention strategy one was successful in improving the self-efficacy of workers to have brave conversations with children and young people. These conversations were supported by the whole-of-house approach led by the community service organisation, which gave permission for workers to broach topics that they have avoided traditionally as too confronting or as exposing them to accusations of inappropriate workplace behaviour.

Overall, it appears that the capacity-building approach involving coaching workers and supporting them to have brave conversations is a promising approach to sexual health and safety education for the cohort of children and young people living in residential care, particularly if the aim is to increase protective factors against CSA. The promising nature of this kind of relationship-based sexual health and safety education resonates with the work of Moore, McArthur, Death, Tilbury and Roche (2018) who found that the quality of the relationship between workers and young people impacted significantly on young people's sense of safety in residential care.

Limitations

There were limitations associated with this study. Of most importance was the difficulty engaging young people in the research and capturing their voices about their experiences of the program in an easily translatable way. The researchers attempted to undertake surveys with children and young people and to interview them about their sexual health and safety knowledge, as well as their responses to the program. It became clear that it would not be possible to do a pre and post survey with children and young people due to changes in placement. Although interviews were undertaken with eight children and young people, they focused on engaging them in the action research and on

their knowledge of CSA, rather than on the impact of the program. They were highly conversational and did not shed light on the LINC model in a meaningful way. Work needs to be done to make sure that the reflections of children and young people are incorporated into any implementation of the LINC model. A further limitation is that the evidence supporting the LINC model is derived through the perceptions of workers, rather than through the perceptions of any other groups involved in the pilot.

Further limitations of the project related to the often chaotic and crisis-driven environment that often characterise residential care. Attention to prevention initiatives wavered in the face of critical events. Also, there were significant changes to staffing groups during the course of the intervention, and children and young people moved around regularly. This meant that the education and coaching were disrupted at times.

The quantitative strand of this study also had limitations. As mentioned above, a more appropriate scale measuring the effect of brave conversations could be developed for future implementations. The lack of control group in the design is also worth noting, it is possible the changes observed were the result of an unmeasured variable and not the intervention. Moreover, future studies should focus on incorporating young people's perspectives as a more integral part of the quantitative evaluation. Lastly, some of the non-significant results might be due to the small sample size of the second wave of data collection (n = 34). Issues hindering data collection in this setting have been discussed above; however, a larger sample size could contribute to more robust quantitative findings in the future.

Conclusion

It is fundamental that the risk of children and young people living in residential care of experiencing sexual abuse, including harmful sexual behaviour, child sexual exploitation and sexualised dating violence, is addressed. Prevention work with this cohort is essential considering their vulnerability and common disengagement from school prevention programs. The LINC model offers an option for educating children and young people about sexual health and safety issues that is promising in strengthening protective factors against CSA. It is not a silver bullet and must be combined with other strategies to disrupt adult perpetrators and to hold them to account, but it does demonstrate the importance of relationship-based prevention education in the residential care space. Spontaneous, regular and nonjudgmental conversations around sexual health and safety normalises this content and leads to the building of trust and safer relationships.

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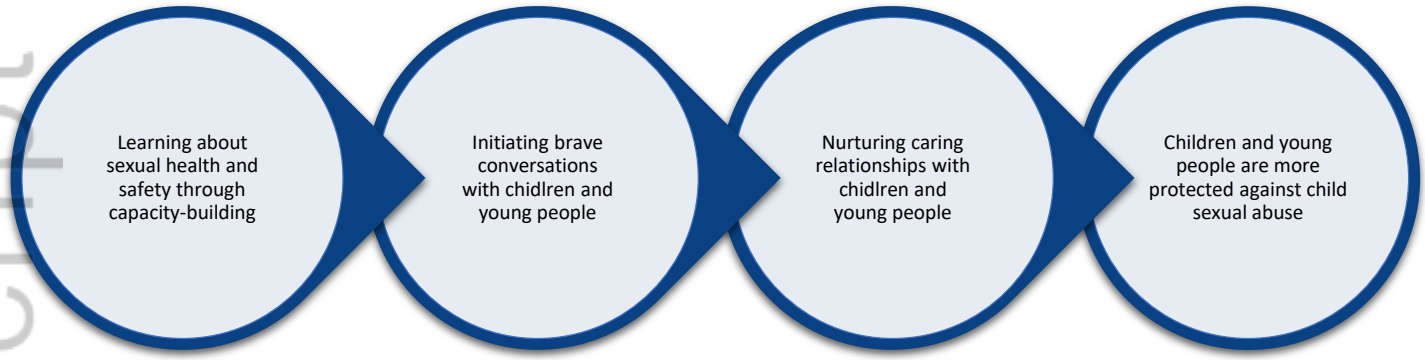
Figure 1: The coaching process

Figure 2: The LINC model



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