MacKillop Family Services

THE UNIVERSITY OF MELBOURNE

Power to Kids: Respecting Sexual Safety

Evaluation Report

20 July 2020

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Glossary

HSB – 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).

CSE – 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).

DV – Dating violence is domestic violence in the context of young people's dating relationships. It is behaviour by a young person towards a partner that is physically abusive, sexually abusive, emotionally or psychologically abusive, financially abusive, threatening, coercive, or that in any other way controls or dominates the partner (Royal Commission into Family Violence, 2016).

Exit – sexual safety response to exit child sexual exploitation

Brave conversations – discussions initiated by carers with children and young people about sexual health and safety issues

Champion – residential carer coached by the Sexual Health Nurse (Educator) to support implementation

Sanctuary Model – The Sanctuary Model is a whole-of-organisation approach to working with traumatised children, young people and families to establish safety and an understanding of how past adversity can continue to have an impact throughout life. It recognises that trauma has an impact not only on the people who have experienced it, but also on the staff who work with them and on organisations as a whole. MacKillop Family Services is the Australia accredited Sanctuary provider.

Executive summary

Background

Children and young people living in out of home care are at significant risk of experiencing harmful sexual behaviour, child sexual exploitation and dating violence. Primary prevention efforts are required that focus on respectful relationships and sexuality education, and secondary interventions should focus on reducing risk factors and enhancing protective factors. Further, tertiary prevention efforts need to involve assisting young people to exit exploitation and providing therapeutic responses for victims of sexual violence and for young people who carry out the violence.

Aim

The aim of the *Power to Kids: Respecting Sexual Safety* project was to co-design, implement and evaluate strategies to prevent and intervene early in harmful sexual behaviour, child sexual exploitation and dating violence in residential care.

Program

The *Power to Kids: Respecting Sexual Safety* program is made up of three prevention strategies.

Prevention Strategy 1 is the Whole-of-house respectful relationships and sexuality education and its core components are: train and coach workers and carers in whole-of-house approach, including recognising and responding to Harmful Sexual Behaviour (HSB) and Child Sexual Exploitation (CSE), as well as Dating Violence (DV); and educate children & young people about respectful relationships and sexual health and safety.

Prevention Strategy 2 is the Missing from home strategy and its components are: establish practice partnerships between each child or young person and their residential carers (involving social media) to counter grooming; assertively engage children and young people using safety planning and social media or phone to stay in touch especially when missing from home; and work consistently with Enhanced Response Model & Sexual Exploitation Protocol.

Prevention Strategy 3 is the Sexual safety response and its components are: early identification, safety planning, advocacy and therapeutic treatment for HSB and DV; proactively support exit strategies for CSE, including strengthening relationships with family of origin; and joining-up of MacKillop workers with local HSB, DV & CSE professionals and local frontline police.

Work was undertaken in the early stages of the project to include Therapeutic Life Story Work (TLSW), a deep-dive process that offers children and young people a better understanding of how their history can influence any current challenging behaviours.

Method

An action research method was adopted to guide the research with four MacKillop Family Services (MacKillop) residential houses. Eight evaluation interviews were conducted with children and young people and 20 interviews were carried out with MacKillop staff. Further, 10 feedback sessions were collected through group interviews with champions. A pre and post survey was carried out with 60 workers in the first wave and 34 workers in the second wave including residential carers, clinical staff and management staff.

Results

The qualitative data indicated positive shifts on each outcome measure. The data indicated that:

- children and young people were at decreased risk of HSB, CSE and DV
- children and young people were missing from home less often
- safe relationships with carers were enhanced
- children and young people's knowledge, skills and attitudes about sexual health and safety improved
- workers were identifying HSB, CSE, DV and ensuring advocacy, exit and treatment
- workers were undertaking safety planning with children and young people for HSB, CSE and DV
- workers had increased knowledge about HSB, CSE and DV
- workers had increased self-efficacy responding to HSB, CSE and DV

The survey data showed that residential carers exhibited slightly less knowledge of child sexual abuse, child sexual exploitation, harmful sexual behaviour and sexual and reproductive health compared to managers and clinical staff; however, improvement between the two time points was observed across all three groups.

Discussion

The qualitative and quantitative results of the evaluation appear to indicate that the *Power to Kids: Respecting Sexual Safety* program is promising to effectively prevent and respond to harmful sexual behaviour, child sexual exploitation and dating violence. In terms of outcomes, the qualitative evidence suggests that the program was successful in decreasing risk levels associate with HSB, CSE and DV. Part of the reduction in risk levels for HSB, CSE and DV related to the improved ability of carers to identify the three forms of sexual abuse and to seek an appropriate response swiftly and using appropriate language. This increase in knowledge and subsequent help-seeking by carers demonstrates how the three prevention strategies worked simultaneously and were mutually constitutive.

The responses sought by carers when HSB, CSE or DV were identified involved collaboration with MacKillop practitioners, DHHS workers, police and HSB treatment services. Establishing strong relationships with local sexual exploitation practice leaders and HSB treatment service clinicians were important in responding to young people at risk of CSE and HSB. This need for multiagency collaboration is no surprise and has been recognised as important to countering child sexual abuse for at least the past two decades. It is essential that agencies work together using a trauma-

informed approach to intervene in HSB, CSE and DV, and to provide pathways for young people out of abuse into pro-social lives.

The evaluation revealed some evidence that young people were missing less as a result of the program. Carers and workers suggested that the reduction in going missing did not relate to the program's smart phones and staying in touch by text or social media, but rather to the improved relationships between carers and young people. The improvement of relationships between carers and young people appeared to emerge from the new appreciation amongst carers of the factors that contribute to sexual exploitation and sexualised behaviours and a shift in their practice from focusing on boundaries and rules to a relationship-based approach.

Relationships were also enhanced through the 'brave conversations' initiated by carers with children and young people about sexual health and safety issues. The brave conversations were successful in boosting the knowledge of children and young people about sexual health and safety issues. Put simply, the education model used capitalised on existing relationships of young people and carers and upskilled carers' knowledge and confidence in sexual health and safety. As a result, these relationships were strengthened further, allowing for young people to want to stay home and stay safe.

In terms of implementation, the role of the Sexual Health Nurse (Educator) was fundamental to implementation and development of *Prevention Strategy 1*. Before the Sexual Health Nurse (Educator) was appointed, the implementation was slow and ill-defined. Further, the Sexual Health Nurse (Educator) identified the brave conversations model (Faulkner & Schegren, 2016) in the international literature and contributed significantly to reworking *Prevention Strategy 1*. The brave conversations were underpinned by evidence about sexual health and safety, delivered by the Sexual Health Nurse (Educator) through the champions to the carers. This process of knowledge translation was very successful, and the knowledge of workers increased about a range of sexual health and safety topics.

It is striking in the *Power to Kids: Respecting Sexual Safety* trial that the confidence and self-efficacy of carers to have evidence-informed conversations with children and young people about topics that previously were avoided improved significantly. This increased comfort and confidence, combined with the whole-of-house approach, meant that carers were not avoiding conversations that traditionally were thought to be inappropriate. Further, it is noted that a trauma-informed, relationship-based prevention approach appears to work well for children and young people living in residential care.

Findings and recommendations

Overall program

Finding	Recommendation
The program appears promising in preventing and intervening early in HSB, CSE and DV	The program is upscaled across MacKillop residential care and made available to other community service organisations

Prevention Strategy 1: Whole-of-house respectful relationships and sexuality education strategy

Finding	Recommendation
The Sexual Health Nurse (Educator) role was fundamental to the implementation of the program	The Sexual Health Nurse (Educator) role is funded to undertake all aspects of Prevention strategy 1 across residential care
The Champion's model worked well in the implementation of Power to Kids: Respecting Sexual Safety program	The Champions model is retained, with the Sexual Health Nurse (Educator) coaching the champions who then coach carers and two champions are trained for each house to address the situation where a champion leaves a house or is moved unexpectedly
Carers confidence and self-efficacy in talking about sexual health and safety issues with children and young people improves through the brave conversation model	All carers are upskilled in having brave conversations about sexual health and safety and have those conversations with children and young people
Carers need a strong authorising environment to help them to feel comfortable and confident in having sexual health and safety conversations with children and young people	Strong leadership is provided by senior management to create an authorising environment to support brave conversations

Prevention Strategy 2: Missing from home strategy

Finding	Recommendation
Providing phones to young people provided carers with an opportunity to have conversations about the safe use of technology	Carers should use the provision of phones to young people as an opportunity to initiate a conversation about the safe use of technology and the importance of staying in touch when away from the home
The quality of relationships between carers and young people improved through the brave conversations model and this protected them from going missing	Further initiatives should be trialled and evaluated to improve relationships between carers and young people

Prevention Strategy 3: Sexual safety response

Finding	Recommendation
Prevention Strategy 3 was more difficult to implement with children and young people who were not case managed by MacKillop	Communication is improved with DHHS case managers working with young people for whom case management is not contracted to MacKillop to improve responsiveness and timely decision-making
Prevention Strategy 3 worked best when carers identified HSB, CSE and DV and made a referral to MacKillop clinicians, and when clinicians informed carers on the steps that were taken	Strong emphasis is placed on assisting staff to identify the red flags associated with HSB, CSE and DV, and a process is put in place to ensure clinicians feed back to carers the response that was taken to address the HSB, CSE or DV

Evaluation

Finding	Recommendation
The brave conversations model appeared to be a promising approach to respectful relationships and sexuality education for children and young people living in residential care	Further action research should be commissioned to confirm the success of respectful relationships and sexuality education using a relationship-based approach
The relationships between carers and children and young people were enhanced through the program and this appeared to be protective against HSB, CSE and DV	A scale is included to measure improvement in relationships between carers and young people to explore this outcome more fully
The MacKillop monitoring data and Critical Incident Report data could not easily provide a meaningful picture of the rates children and young people were missing from home	A system is established to monitor the rates of children and young people going missing and to detail how long they are spending away from the house home for what purpose

Multiagency working

Finding	Recommendation
Exit practice targeting CSE worked best when accompanied by disruptive policing	Further collaborative initiatives focusing on intervening in CSE, including disruptive policing and therapeutic outreach, should be trialled and evaluated

See full list of Findings and Recommendations on page 68

Limitations

A major limitation of this project is that children and young people were not sufficiently engaged in the co-design process. The research team made significant attempts to engage with young care leavers and with children and young people in the houses, but engagement was limited. We did employ a young care leaver researcher to assist with engaging children and young people in the houses and this resulted in eight interviews. However, the data was often disjointed and conversational, making it difficult to draw conclusions from.

A further limitation of this evaluation was that, although we set out to survey children and young people before and after the intervention, it became clear that there would be very few young people who were in the pilot houses at the beginning and at the end of the pilot due to the movement of young people in residential care. Also, due to the difficulty of engaging some of the young people in the research, the sample size would have been so small that it would have been difficult to make generalisations. The survey with workers also presented challenges as many of the staff surveyed at the beginning of the pilot, including those associated with the fifth house, were not in the same roles at the end of the pilot. This meant that the group who undertook the post survey was different to the group that undertook the pre survey. It was also difficult to get responses to the post survey, which meant that the number of participants was almost half.

It was also necessary to abandon the content analysis of Critical Incident Reports and other MacKillop monitoring data which was to be used to measure the rates of children and young people going missing. On advice from the Evaluation Sub-Group Committee, it was decided that the data would not provide a meaningful picture of the rates of young people missing from home.

It was also difficult to determine with certainty how the program impacted the residential care environment because of its multisystem approach, as well as the complexity of the residential care space. There were multiple programs operating in the houses as part of everyday residential care service delivery and those programs may have had an impact on the children and young people and their sexual health and safety. Further, the crisis-driven nature of residential care meant that sometimes the prevention work associated with the pilot was not practiced or was delayed until the situation was resolved. This meant that there may not have always been a consistent focus on the prevention work and that 'dosage' was affected. It is also difficult to ascertain which components of the three prevention strategies were impactful as it became clear that they were mutually constitutive and related to one another in multifaceted way.

Background

Children and young people in out-of-home care are at significantly increased risk of being victimised through **harmful sexual behaviour (HSB)** and **child sexual exploitation (CSE)** (Royal Commission into Institutional Responses to Child Sexual Abuse, 2016; Commission for Children and Young People, 2015). Harmful sexual behaviour is sexual behaviour carried out by children and young people that is developmentally inappropriate and may be abusive towards self or others (McKibbin, Humphreys & Hamilton, 2017), whereas 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 (Hackett, Holmes, & Branigan, 2016). Further, both forms of child sexual abuse are linked to domestic and family violence (Hackett et al., 2013) and certain types of harmful sexual behaviour and sexual exploitation can constitute **dating violence (DV)** (Allardyce, 2018). Dating violence is intimate partner violence carried out in the context of teen dating relationships. It can involve physical, sexual, emotional and financial abuse (WHO, 2012). Both harmful sexual behaviour and child sexual exploitation are forms of child sexual abuse (World Health Organisation, 2006). Sexualised dating violence is a form of harmful sexual behaviour and can, therefore, also be considered a form of child sexual abuse.

There is little prevalence data about harmful sexual behaviour, however the available evidence suggests that a substantial proportion of child sexual abuse is perpetrated by other children and young people. For example, in the USA, Finkelhor, Ormrod, and Chaffin (2009) reported that approximately 35% of cases with victims 0-18 years were perpetrated by other children and young people and for cases with victims 0-12 years, this rose to 50%. In Australia, Boyd and Bromfield (2006) presented police data revealing that 9-16% of sexual abuse was committed by other children & young people. A large UK population study involving 2,275 young people carried out by Radford, Corral, Bassett, Howat, and Collishaw (2011) found that two-thirds of young people reporting contact child sexual abuse identified the abuse as carried out by other children and young people. Although there is no reliable data about the prevalence of child sexual exploitation as a form of child sexual abuse, global meta-analyses indicate that approximately 10-20% of girls and 5-10% of boys are victims of child sexual abuse broadly defined on a spectrum from unwanted touching to rape (Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). Intimate partner violence impacts one in three women globally (WHO, 2013). A meta-analysis of dating violence prevalence rates indicated that one in five young people between the ages of 13 and 18 experience physical dating violence and one in 10 experience sexual dating violence (Wincentak, Connolly & Card, 2017).

As at 30 June 2017 there were 45,756 children and young people living in out of home care. Approximately 6% of those children and young people were living in residential care settings (Australian Institute of Health and Welfare, 2019). A disproportionate 33% of child sexual abuse reports to statutory child protection related to those children and young people living in residential care (Royal Commission, 2016). Further, children and young people from Aboriginal and/or Torres Strait Islander backgrounds and children living with a disability were overrepresented in the data (Australian Institute of Health and Welfare, 2019).

Thus, in Victoria, Australia and globally, child sexual abuse is a problem of significant proportions, particularly in residential out of home care settings. Yet there is a paucity of research identifying effective ways to prevent child sexual abuse specifically in these settings and an urgent need to develop, trial and evaluate new approaches anchored in the best available evidence (Commission for Children and Young People, 2015; Royal Commission, 2016).

Methodology

Aim

The **aim** of the research was to co-design, implement and evaluate strategies to prevent and intervene early to target harmful sexual behaviour, child sexual exploitation and dating violence in residential care.

Method

The **key research questions** informing the project were:

I. What are the components of a promising prevention program targeting harmful sexual behaviour, child sexual exploitation and dating violence in residential care settings?

II. What implementation issues arose during the pilot and how were they resolved?

III. What impacts did the program have to prevent and interven early in harmful sexual behaviour, child sexual exploitation and dating violence?

Research design

The research was guided by the Knowledge to Action Process set out by Graham and Tetroe (2009). The process is circular and involves several stages, including: identifying problem and reviewing evidence; adapting knowledge to local context; assessing barriers to knowledge use; selecting, tailoring and implementing interventions; and monitoring, sustaining and evaluating knowledge use.

The evaluation adopted both a process and outcomes approach (Royse, Thyer & Padgett, 2016). The process aspect of the evaluation focused on implementing the program, the barriers that emerged and how they were overcome. The outcomes evaluation focused on whether key outcomes were achieved that demonstrate the effectiveness of the program.

This report outlines the research associated with the process and outcomes evaluation, rather than the whole action research process. It focuses on the second two research questions outlined above (ii & iii). For papers associated with the broader action research please see: McKibbin, 2017; McKibbin, Halfpenny & Humphreys, 2019; McKibbin & Humphreys, 2019). Please see Appendix A for a detailed evaluation plan. The evaluation plan appended indicates that several of the outcome measures would be assessed on the basis of case file data collected by MacKillop. This strategy was abandoned on advice from the Expert Advisory Evaluation Sub-committee as the data available did not help paint a useful picture of the outcome measures. It was decided that only qualitative interview data and survey data would be used to measure outcomes and that only qualitative interview data would be used to gather insights about the implementation process.

Sampling

Four MacKillop residential houses were chosen by MacKillop's child andfamily services directors. One of the houses was in a region in which another research project was being carried out and, as a result, was taken out of the pilot. A different house was then chosen to be part of the pilot in another region. This meant that pre survey data was collected from five houses whereas post survey data was collected from four house.

Children and young people, carers and MacKillop staff associated with the four houses were recruited into the research. The qualitative sample: included eight children and young people; Mackillop staff including one Sexual Health Nurse (Educator); six carers/champions; five house supervisors; six case managers; one therapeutic practitioner; three principal practitioners; three coordinator and managers; and two directors. The children and young people lived in the four pilot houses and were between the ages of 10 and 17. The quantitative sample included 60 workers (residential carers, clinicians and managers) in the first wave of data collection and 34 in the second. The carers were mostly full-time workers who worked regularly in one of the houses as part of a stable team, and the house supervisors held a leadership role in each of the homes. The case managers had a coordinating role and communicated regularly with children and young people, parents, carers and care teams. Therapeutic and principal practitioners were highly skilled clinicians who assisted carers to work using a trauma-informed approach, and coordinators, managers and directors held operational roles relating to the overall management of the homes.

Data collection

Children and young people participated in a semi-structured interview lasting between 30 minutes and one hour. The interviews were designed to engage children and young people in the project and to capture their reflections. The interview schedule (see Appendix B) was co-designed with a care leaver researcher with lived experience of the residential care system. The interviews were carried out by the care leaver researcher alone or together with the lead researcher. Children and young people received a $50 voucher as an honorarium in appreciation of their time.

Four of the carers, who acted as champions for the program, participated in 10 thirty-minute group interviews (See Appendix C). These group interviews were carried out each fortnight during the course of the pilot. They were designed to capture any feedback about how the champions were translating knowledge on the fortnightly topics to their team and to capture evidence of brave conversations held with children or young people during that fortnight. These feedback sessions had a focus on *Prevention Strategy 1*, the whole-of-house sexuality education.

House supervisors, case managers, therapeutic practitioners, coordinators and principal practitioners participated in a thirty-minute interview, and managers and directors participated in a thirty-minute group interview. The house supervisors and case managers were asked about how the program was impacting the dynamics in the house and with the families of origin. They were also asked about any changes in occurrences of children and young people missing from home. This line of questioning had a particular focus on *Prevention Strategy 2*, the missing from home strategy. The group interview with the managers and directors had a focus on the barriers that emerged through the pilot and how they could be overcome as the program was upscaled across other MacKillop residential homes. They also explored system advocacy issues that emerged during the pilot and the question of organisational readiness was addressed (see Appendix D).

Sixty participants in the first wave and 34 participants in the second wave – including those in each of the categories of MacKillop workers – undertook a pre and post survey. The survey was designed to capture: comfort levels about sexuality; confidence in talking about sexual health and safety issues; knowledge about sexual health; and knowledge about harmful sexual behaviour, child sexual exploitation and dating violence (see Appendix E). The participants were not provided an honorarium as it was considered that taking part in the evaluation was part of their everyday work.

Data analysis

The qualitative data was analysed using a combination of thematic analysis (Charmaz, 2014) and content analysis (Liamputtong, 2013). The thematic analysis was inductive and involved a process of initial, focused and analytical coding. Initial coding involved attributing short phrases to each meaningful statement in the interview transcript and focused coding involved grouping those statements together. Analytical coding provided a set of themes that constitute answers to the research questions. Data relating to the implementation of the program was analysed in this way.

Content analysis involved locating in the data particular content about the designated outcome measures. The outcome measures were:

- children and young people are at decreased risk of HSB, CSE and DV
- children and young people are missing from the home less often and safe relationships are enhanced
- children and young people's knowledge, skills and attitudes about sexual health and safety improve
- workers are identifying HSB, CSE, DV and ensuring advocacy, exit and treatment
- workers are undertaking safety planning with children and young people for HSB, CSE and DV
- workers have increased knowledge about HSB, CSE and DV
- workers have increased self-efficacy responding to HSB, CSE and DV

The survey measured knowledge of different topics such as child sexual abuse, including harmful sexual behaviour and child sexual exploitation as well as how comfortable people feel communicating about sex. Quantitative data analysis was undertaken using SPSS version 26. Frequency tables, cross tabulation tables, Chi square statistics and one-way ANOVAs were conducted to understand data patterns both within and between the two time points. Sixty people participated in the study during the first time-point data collection, and 34 in the second. Most of the participants were residential carers (67% and 68% in time 1 and time 2, respectively) and majority of participants were females (68%, measured during time 2 only).

Participants in the time 1 survey came from five pilot houses in metro Melbourne. Participants were divided into three groups for data analysis: residential carers (including house supervisors) clinicians (principal practitioners, case managers, and therapeutic practitioners) and managers (area managers, coordinators and directors).

Ethical issues

There were significant ethical issues associated with this research, particularly in relation to children and young people. One potential risk for children and young people included feeling compelled to participate owing to their dependent relationship with MacKillop. Another risk involved the possibility that children and young people would feel distressed by the content or make a disclosure of child sexual abuse victimisation or of carrying out harmful sexual behaviour. Such a disclosure could expose children and young people to intervention from judicial agencies including Victoria Police.

Ethics clearance to undertake the project was sought and obtained through: the University of Melbourne Human Research Ethics Committee (ID - 1748824) and the MacKillop Family Services Ethics Committee.

To address the issue of children and young people feeling obligated to participate, careful attention was paid to the issue of informed consent. Permission was sought from the Secretary of the Department of Health and Human Services, the legal guardian of the children and young people, and the Minister for Children and Families in line with current state government policy. Informed consent was also sought from children and young people themselves. The final decision to participate was made by each child or young person.

In considering whether a child or young person should be invited to participate and could give informed consent, the researcher collaborated with relevant case managers, house supervisors, carers and biological parents where possible to form a professional judgement. Considerations that informed the professional judgement in relation to children between the ages of 10-12 years included:

- Degree of stability in the child's placement
- Level of risk
- Capacity of child to understand the research
- Presence of intellectual disability
- Presence of any coercion or pressure from peers or workers to either participate or not to participate

Young people between the ages of 13 and 18 were judged to be 'mature minors' and able to consent in terms of the following factors:

- Engagement with the nurse, researcher and carers indicative of maturity, insight and stability
- Degree of understanding of the information presented in the Plain Language Statement and Consent Form
- Ability to discuss consent as meaning that permission to do something is given but that it can be retracted at any time
- Ability to discuss the right of children and young people in out of home care to participate in decision-making that will affect them

The risk to children and young people relating to the possibility that difficult feelings or memories could be triggered by talking about sexual health and safety in residential care settings and the risk that experiences of sexual abuse victimisation or of carrying out harmful sexual behaviour could be disclosed were addressed through the development of distress and disclosure protocols based on the work of Moore, McArthur, Roche, Death and Tilbury (2016). These protocols were developed to guide the researcher's response should a child become distressed or disclose abuse, however this did not occur through the course of the pilot (see Appendix F and G).

Adopting an empowerment approach

The children and young people in this study were conceived as experts in their life experiences of living in residential care and of possibly experiencing harmful sexual behaviour, child sexual exploitation or dating violence, as either those carrying out the abuse or being victims of the abuse. This way of viewing children and young people was important because the research was framed in terms of the rights of children and young people, according to the Convention of the Rights of the Child (Unicef (1989) Convention on the Rights of the Child. Retrieved from https://www.unicef.org/child-rights-convention).

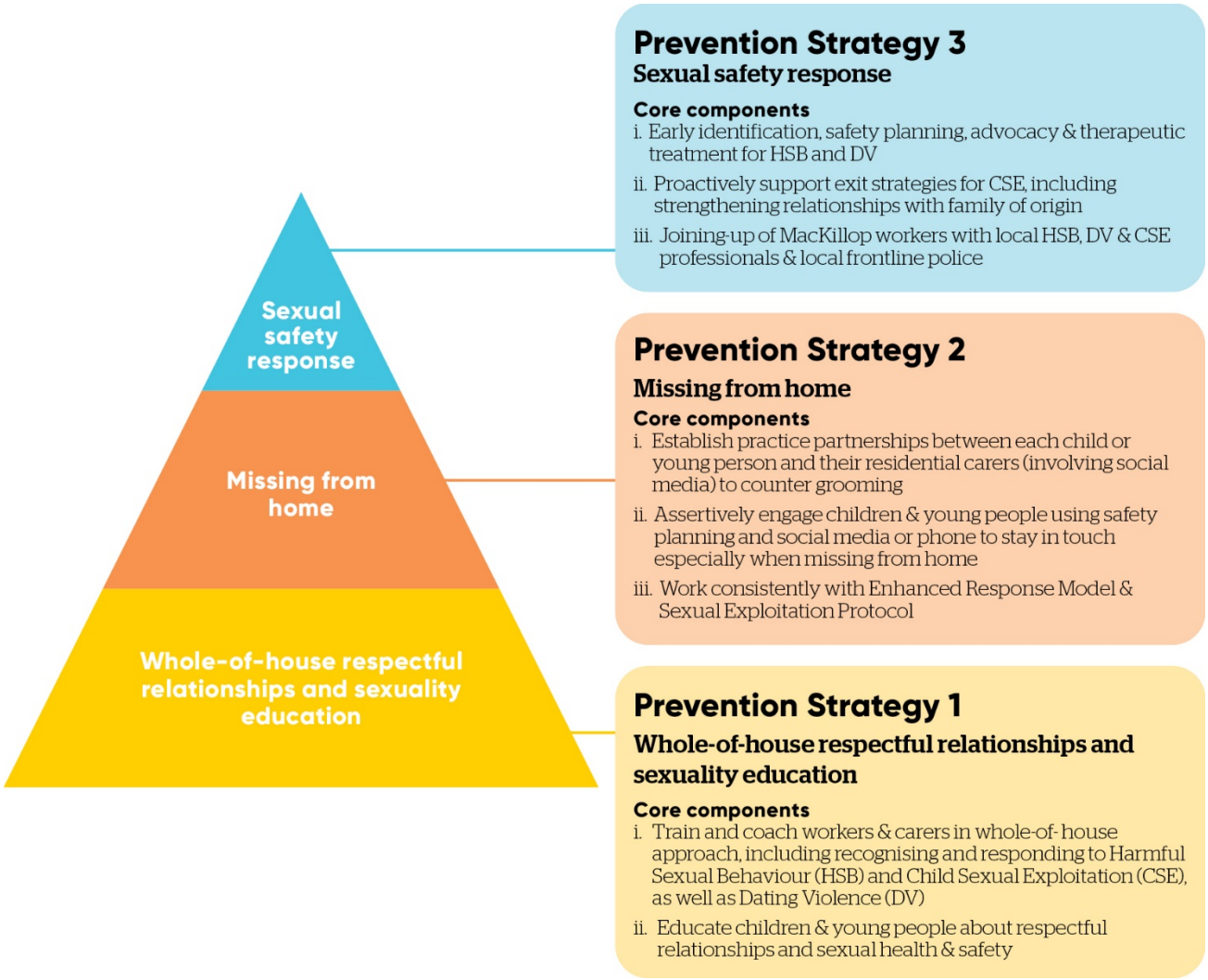
Consequently, the young people in this study were approached as consultants to the research process. It was hoped that the young people would experience this approach as empowering and that it would potentially have a positive effect. The group of young people interviewed in this study had a range of adverse childhood experiences. It was considered that many of the young people generally had not been given the opportunity to speak in an authoritative way about their life experiences. The interviews were conceptualised as an opportunity for vulnerable young people to take up the speaking position of expert about their sexual health and safety needs.

The program – Three prevention strategies

Power to Kids: Respecting Sexual Safety is a program made up of three prevention strategies that were trailed in four MacKillop Family Services (MacKillop) residential homes. The strategies were co-designed through: undertaking focus groups with residential care workers and case managers; consulting with an Expert Advisory Group; and applying the best available scholarly and policy evidence synthesised in a systematic scoping review (McKibbin, 2017).

The three prevention strategies included: *Whole-of-house respectful relationships and sexuality education*; a *Missing from home strategy*; and a *Sexual safety response* (see Fig 1).

Figure 1: Three prevention strategies and their components



Workers were trained in each of the three prevention strategies so that they had knowledge and skills to take part in the implementation of the program. Their practice was further developed through regular coaching by a Sexual Health Nurse (Educator) and MacKillop specialist clinicians (see Appendix H for program logic).

Prevention Strategy 1 – Whole-of-house respectful relationships and sexuality education

The whole-of-house respectful relationships and sexuality education strategy comprised four components: a whole-of-house approach; fortnightly topic education; brave conversations; and Sexual Health Nurse (Educator) consultations. This prevention education strategy was considered necessary to the program in addition to the implementation of the Respectful Relationships whole-of-school approach across Victorian schools (Victorian Government Department of Education of Training, 2015), as well as the delivery of sexuality education in schools through the *Catching On Early: Sexuality education for Victorian primary schools* (Victorian Government, 2013a); and *Catching On Later: Sexuality education for secondary students* (Victorian Government, 2013b) curriculums. This was because many children and young people living in residential care are disengaged from school and may miss out on information about what constitutes respectful relationships and sexual health and safety (Commission for Children and Young People, 2015).

The Respectful Relationships 'whole-school approach' was adopted into a 'whole-of-house approach,' whereby attitudes and behaviours associated with respectful relationships become part of the culture of the house. This approach meant that children and young people learn not only from activities and conversations with carers, but from the behaviours that are modelled by carers and by being part of a system that endorses respectful relationships and equality (Hyde et al., 2016; Our Watch, 2015). Further, the model required carers to recognise, analyse and work on their own values, beliefs and behaviours in order to create an environment that fostered respect, consent and equality.

The prevention education was structured around 10 topics, which were delivered on a fortnightly basis. The 10 topics were identified by the research team as topics that relate to HSB, CSE or DV. The 10 topics were:

1. Rights of children and young people
2. Gender stereotypes and diversity
3. Sexual health
4. Normal and problematic sexual behaviour
5. Respectful relationships and love
6. Consent and age
7. Grooming and abuse
8. Disclosure and informed friends
9. Online sexual safety
10. Pornography

An evidence-based resource was developed to inform the fortnightly education. The resource outlines each topic in detail and sets out what carers should know and what children and young people should know. Further, links are provided to tools and resources for carers, children and young people to build knowledge and skills.

A coaching approach was adopted to ensure that workers understood and implemented the content of the resource. In consultation with all the staff involved in the pilot, the champions model was proposed, whereby one carer in each house was chosen to be trained in the content and subsequently transmitted the information to the rest of the residential care team at the house.

The champion was selected by identifying a staff member that was interested in the content and being a *Power to kids: Respecting Sexual Safety* program leader in the home. Champions attended one two-hour meeting each fortnight led by the Sexual Health Nurse (Educator). Each champion's meeting covered one of the 10 topic areas and included what carers should know, what children should know, activities, posters and real scenarios to have carers explore how they would have conversations with children and young people about that topic. Further, each fortnightly meeting covered advice on how to implement the whole-of-house approach, including the modelling of gender equality and problematising of representations of gender and sexuality in pornography, and links with the Sanctuary Model as relevant to each topic. MacKillop residential house teams meet fortnightly and the champions used 30 minutes of the meeting time to communicate the fortnightly topic coaching to the rest of the team. Champions were responsible for making the education resources available in the house, including putting posters up in the home.

Champions were coached in how to have 'brave conversations' about the 10 sexual health and safety topics. The term 'brave conversations' was based on the work of Faulkner and Schergen (2016), which sets out a trauma-informed approach to sexuality education with vulnerable children and young people. The approach stipulates that there is no 'one big sex education talk' and that carers need to capitalise on situations that happen regularly with children in order to have conversations about sexuality and respectful relationships. In this way, discussions about sexuality and relationships are normalised so that children learn from the things happening around them in daily life.

Two models for brave conversations were implemented as part of the pilot: one for carers to know how to engage in conversations with young people; and one to guide children and young people in decision making. The model for carers to engage with young people uses the acronym TALK, which stands for:

Take the initiative
Ask the child what they think or feel
Let them know the facts and range of beliefs
Keep the conversation going

(Faulkner & Schergen, 2016)

This model provided carers with a simple method to have a conversation about any subject and follows a trauma-informed approach whereby the focus is on: a child or young person's feelings/values about a topic; fact-based education without shame; and empowerment of children and young people to make their own decisions in a safe way.

The model that teaches children and young people decision making and critical thinking is CARE, which stands for:

Consent
Age
Respect
Equality

This model provides a quick check-in to ensure that when in a situation with a partner, children and young people can assess if they are safe or if they need to stop or change what they are doing to ensure that there is consent, the age is appropriate, there is respect and there is equality. The researchers were not able to identify an appropriate reference for this model and came across CARE through word of mouth.

In addition to these two models, carers were coached in using a variety of educational resources appropriate for the ages of the clients in the homes, including: matching activities; YouTube videos; posters; quizzes; worksheets; and websites and apps. When using the resources, staff were coached to use the CARE model to guide children and young people on how to make decisions in different situations and to always consider the importance of context.

A further component of the first prevention strategy involved the Sexual Health Nurse (Educator) visiting the pilot homes and attending team meetings to support the implementation of the program. The Sexual Health Nurse (Educator) visited each house once per month and attended one team meeting per house per month. The purpose of these visits was to provide continuous coaching, stay updated on the children and young people in the home and their behaviours, engage with clients personally when possible and build a strong relationship with staff in the home. If a carer determined a situation where a child would benefit from a nurse consult, this option was available so that the nurse could engage with the child directly.

Prevention Strategy 2 – Missing from home strategy

The *Missing from home strategy* is a secondary prevention initiative that involves targeting the risk factor of children and young people missing from home or placement. A key early indicator of CSE is when a child or young person goes missing from home (running away or being missing from placement) (Jackson, 2014). 'Push and 'pull' factors are considered to contribute to the motivation behind running away or being missing from home. In residential care, push factors include: a lot of conflict in the house; peers acting aggressively; and not being able to see friends and family freely. Pull factors associated with grooming including: the promise of love and affection; and drugs or alcohol (Beckett, 2011).

The missing from home strategy works alongside the Sexual Exploitation Protocol, which is a collaborative approach to addressing CSE by Victoria Police, Child Protection and providers of out of home care. The focus of this collaborative practice is to disrupt adult perpetrators of sexual exploitation and provide an appropriate policing response to children and young people who go missing from care. By contrast, the Missing from home strategy involves enhancing the quality of relationships between carers and children and young people, and supporting them to stay in touch at all times they are away from the home. A significant protective factor against going missing from placement is a strong relationship with carers (McKibbin, 2017).

The *Missing from home strategy* involved establishing 'practice partnerships' between young people in the homes and residential care workers to counter missing from placement. Each child or young person was allocated a key worker and a number of sub-workers to promote connection at all times of the day or night. Smart phones were provided to children and young people who were considered able to use them appropriately. Children and young people needed to sign an agreement that they would use the phone for the purpose of staying in touch with carers and with other safe people in their lives. By providing access to smart phones, the young person and the staff worked together to stay in touch over the course of the day and night using text messages or social media. House Facebook pages were established to encourage children and young people to check in with staff on an alternative platform.

The strategy also involved workers and children and young people working together to develop safety plans to strengthen protective factors in the young person's life, like spending time with appropriate friends and family. Further, carers carried out extensive pro-social activities with children and young people to help keep them engaged with the house.

Prevention Strategy 3 – Sexual safety response

The *Sexual safety response* is an early intervention strategy designed to identify HSB, CSE and DV as early as possible and to provide a therapeutic response. In terms of HSB, workers were trained to work with a schema developed by Hackett, Holmes and Branigan's (2016), which sets out characteristics of normal, inappropriate, problematic, abusive and violent sexual behaviours carried out by children and young people. Further, MacKillop workers and carers were upskilled about how to undertake safety planning and risk management in relation to HSB, drawing on the Victorian Best Interest Case Practice guidelines, *Working with adolescents with sexually abusive behaviour and their families* (Pratt & Miller, 2012). Carers were also supported to forge close working relationships with their local sexually abusive behaviour treatment services so that they could ring the intake worker and discuss particular cases that were concerning them. Practitioners from these services agreed to liaise directly with houses and families to establish strong relationships and referral pathways, and to expedite high risk cases of HSB. They also agreed to work flexibly around appointment times owing to the dynamic nature of residential care. Carers were also encouraged to participate in therapeutic treatment, which takes an ecological approach to the child or young person in recognition that problems like HSB emerge from systems around a young person, not just from their bio-psychological state.

The *Prevention Strategy 3: Sexual safety response* involved senior MacKillop practitioners working therapeutically with children to exit them from exploitation. The *Exit practice* was framed around the *Child sexual exploitation: A child protection guide for assessing, preventing and responding* (Victorian Government, 2017), and involved stages of information gathering, analysis and planning, actions, and reviewing assessments, outcomes, plans and actions. The *Exit practice* involved carers identifying red flags for CSE, like a young person going missing and coming home with gifts. The carer would then alert the MacKillop case manager and therapeutic or principal practitioner who would coordinate a detailed case review into the young person. This was followed by risk management and safety planning, including consideration of whether a circuit breaker (such as admission to Secure Welfare Service or moving away from the immediate area for a period of time) was required to assist the disruption of the young person's attachment to the perpetrator.

Strategies were explored to strengthen the relationships between young people and their families of origin and to support them to re-enter education or to undertake other pro-social activities that they are passionate about. All of these interventions were conducted in accordance with the Sexual Exploitation Protocol, including engaging with Victoria Police and the Department of Health and Human Service's sexual exploitation practice leaders.

Finally, the *Prevention Strategy 3: Sexual safety response* delivered a therapeutic response to children and young people experiencing dating violence as either victims or those carrying out the violence, or both. Dating violence was identified by carers or the case manager and a referral was made to the MacKillop principal and therapeutic practitioners. The practitioners then developed a dating violence response plan. Therapeutic work was medium-term and involved psycho-education and relational work. It was carried out in an informal, outreach capacity rather than in formal therapeutic meetings.

Life Story Work

At the beginning of the pilot, Therapeutic Life Story Work (Rose, 2012) was included as part of the program but was not continued due to the limited uptake by children and young people caused by placement movement in the pilot homes; the appropriateness of the young people to commence at the time; and young people not consenting their involvement. The Therapeutic life Story Work focus was expanded beyond the *Power to Kids: Respecting Sexual Safety* project pilot and will be evaluated separately.

Implementation

The program was implemented according to the implementation science approach set out by Fixsen, Naoom, Blase, Friedman and Wallace (2005). The approach involves six stages and is iterative. The action research method enabled for an iterative and 'learning system' approach to be taken towards implementation, within the framework of implementation science. This meant that we could try something to see if it worked and, if not, try something else. For example, the role of the Sexual Health Nurse (Educator) and the coaching model of delivery shifted during the early stages of the pilot in response to feedback from staff involved in the project.

Stage 1: Exploration

The first stage was *exploration*, which involved consultations and meetings between the research team and carers, managers and directors involved with residential care at MacKillop. It also involved meetings with key stakeholders in policy and practice settings, including the sexual exploitation practice leaders in the Department of Health and Human Services and practitioners from sexually abusive behaviour treatment services. An Expert Advisory Group was established, whose membership included key academics in the field, senior policy-makers and practitioners from government agencies and not-for profit organisations, and representatives from Victoria Police. This group met twice a year for two years, and an evaluation sub-group met twice during the course of the pilot. This stage corresponded with the co-design of the three prevention strategies. Significant efforts were made to engage children and young people in the design of the program but these were not successful.

Stage 2: Installation

The second stage of implementation was *installation*, which involved developing the resources necessary to underpin the program, including the resource for carers and the practice guide. Further, it involved adapting current Mackillop policy and practice documents to account for the new focus on HSB, CSE and DV, such as Behaviour Support Plans.

The Sexual Health Nurse (Educator) was recruited during this phase to support the implementation out of *Prevention Strategy 1: Whole of House Respectful relationships and sexuality education*. Further, reporting documents were developed to assist with ascertaining whether prevention strategies were being delivered by staff.

Stage 3: Initial implementation

The *initial implementation* stage involved training and upskilling workers and carers on the ten topics of prevention education, and how to deliver the prevention strategies. Further, a *Power to Kids: Respecting Sexual Safety* operations group was established to drive the full implementation. This group was made up of house supervisors, case managers, coordinators, managers and directors associated with the four pilot residential homes. This group met fortnightly through the course of the implementation.

Stage 4: Full implementation

This stage marked the implementation of the champion's model and the beginning of the 31-week trial. For this period, all practice and procedures associated with the three prevention strategies were carried out by the relevant workers. Strong leadership was provided by the MacKillop CEO and senior MacKillop operations, policy and clinical staff, and coaching was delivered by the Sexual Health Nurse (Educator). The champion's model, suggested by a case manager involved in the project, emerged as the best way to coach carers and transfer knowledge from the Sexual Health Nurse (Educator) to the carers in the homes. Initially, the Sexual Health Nurse (Educator) was coaching all of the staff in each house but this proved to be an inefficient method as often there were not very many staff members present at any one time and crises often took priority over the nurse visits.

Stage 5: Innovation

The fifth stage was *innovation,* which captured the changes that were made to the program throughout the pilot as issues were responded to during implementation. For example, issues arose relating to the role of the Sexual Health Nurse (Educator) in the program and also to how the activities and resources were presented to children and young people. It is anticipated further innovation will occur as the program is upscaled across MacKillop residential care services.

Stage 6: Sustainability

The sixth stage of implementation is *sustainability*, and it remains to be seen whether the program can be successfully upscaled. Sustainability issues relate to how the pilot homes continue to deliver the program and how it can be upscaled to all MacKillop residential homes in Victoria and New South Wales. Ongoing evaluation and monitoring will be necessary to ensure that the program is delivered with fidelity and tailored to different policy and practice settings.

Results

The results of the evaluation of the *Power to Kids: Respecting Sexual Safety* program will be reported in three sections: outcomes; implementation; and survey data. The outcomes section reports the content analysis of the qualitative interview data; and the implementation section reports the thematic analysis of the interview data on process-type issues that emerged over the course of the pilot and how they were resolved. The survey section will report the results of the pre and post survey data and draw conclusions about workers' knowledge and comfort about sexual health and safety.

Outcomes

This section reports the content analysis of the qualitative interview data. It is set out around the key outcomes that the project aimed to achieve through the implementation of the *Power to Kids: Respecting Sexual Safety* program.

The outcomes sought through the project were:

- children and young people are at decreased risk of HSB, CSE and DV
- children and young people are missing from the home less often and safe relationships are enhanced
- children and young people's knowledge, skills and attitudes about sexual health and safety improve
- workers are identifying HSB, CSE, DV and ensuring advocacy, exit and treatment
- workers are undertaking safety planning with children and young people for HSB, CSE and DV
- workers have increased knowledge about HSB, CSE and DV
- workers have increased self-efficacy responding to HSB, CSE and DV

Children and young people are at decreased risk of HSB, CSE and DV

The qualitative data indicates the program was successful in decreasing the risk of HSB, CSE and DV for some children and young people. The decrease in risk of HSB was discussed by workers in eight interviews. One worker described how the program had created a space in which young people were able to disclose HSB to staff in order to seek help:

> *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)

Along with creating an environment where children and young people understand what HSB is and feel comfortable to disclose, workers discussed how safety planning was reducing risk in the house. In terms of managing HSB in one house, a worker said:

> *We have additional support now [with the HSB] so it's line of sight at all times. We just try and keep the two [young people] separate. If they are engaging together it's in non-contact games like playing outside - but it's like basketball not football, things like that. We just try and stay away from the contact side of things. We have [Champion] as well in the house that did [activities] like My Body, My Say and My Body, My Rules, No Means No! - she read those books to them and … we've got things on the walls now about what's appropriate touch and what's consent.* (House Supervisor)

There is also some evidence that children and young people are at decreased risk from CSE, and this outcome was identified in four interviews. During the pilot, one boy received a nude cartoon when playing an online game. Workers identified this as a red flag for grooming and responded swiftly:

> *What happened was - is that [child] was on the game and he got a request from someone and apparently - I have no idea how it works but apparently somehow in the request they included a nude cartoon. The carer saw it, so he was like: "Don't accept it"; just point blank: "Hey that's not okay." And [child] didn't. Afterwards, they had some conversations around safety on the internet and not accepting people you don't knows friend requests. [Carer conveyed message that] - there are out there [people] who don't have the best intentions for kids.* (Champion)

Workers also identified that one girl who had experienced a very high level of risk through sexual exploitation saw a decrease in her risk level through the course of the pilot owing to her re-engaging with education. This kind of engagement with pro-social activities was key to the Exit practice associated with *Strategy 3*. The worker said:

> *…the most promising initiative we've seen from her is following up with her education. So she's decided she's going to re-engage at school; she's always been enrolled, just never attended. So she's gone through and kind of done her orientation which she organised herself. She cancelled once and then called up herself and re-scheduled and attended.* (Case Manager)

However, workers also discussed how the risk posed by CSE may decrease at times of intensive intervention, like during circuit breakers, but quickly increase again:

> *I felt every time we have done a circuit breaker; she has formed better relationships with the carers and usually for a while she'll stay home directly after. I feel like we always eventually end up in the same position again, due to numerous factors like her mental health, her substance use, her attachments and stuff like that.* (Case Manager)

A decreased risk of dating violence was noted in four interviews. Workers talked about the case of a young person who was abusive towards the girl he was dating. A worker recalled:

> *[The young person] had come to me and was saying some really aggressive not nice things about his partner . . . that started a conversation with me and him about equality and power in relationships and I directed him to look at the poster that we have up on the wall . . . Since then [we] have seen him be a little bit more understanding and the way they speak to each other is a bit more settled.* (Champion)

Another worker talked about how the outreach-oriented therapeutic response delivered through the *Power to Kids: Respecting Sexual Safety* program worked well for a girl who was experiencing dating violence. The worker described how the girl came to realise that the behaviour carried out by her partner was abusive and how this impacted her:

> *[Girl] wasn't aware - like she knew that [boy] was being violent but she didn't see [it] as dating violence or anything different. She kind of felt it was almost like it was normal for her. I think having that time out and someone caring and taking her out for coffee and walking with her and just listening to her, it was good timing for her because she then had a baby and actually didn't talk to [boy] for a good period of time and doesn't seem to now, from what I see, put up with as much from [boy].*(House Supervisor)

Overall, there is some evidence that children and young people are at decreased risk as a result of the *Power to Kids: Respecting Sexual Safety* program. However, the risk levels associated with sexual exploitation appear to be more dynamic than those associated with HSB and DV suggesting that reducing CSE risk is more difficult than that associated with the other two forms of child sexual abuse.

Children and young people are missing from the home less often and safe relationships are enhanced

There is evidence that the *Power to Kids: Respecting Sexual Safety* program contributed to young people going missing less from the home; their relationships with workers improved; and they were staying in touch with workers when they are away from the home.

Six interviews indicated that young people are missing less from the home. One worker talked about how a girl participating in the pilot is missing from home less:

> *All in all, if we look at the rate of absconding last year to this year, it has significantly improved, which is good. Even though she does still abscond at times and last year we were missing her for weeks at a time, whereas two weeks ago she went missing for three days and that hadn't happened in so long that we were like, something must be going on and we were quite concerned. So I definitely think she's been staying home a lot more.* (Case Manager)

Another worker recalled how, although a girl is still going missing from the house, it is less than previously:

> *When she was missing it used to be for really long periods of time, like no contact whatsoever and I think no-one could really kind of manage her. I would say like it's improved; she's still missing every other night, I would say, which is obviously not fantastic, but we're I guess learning how to work with that and be better [at helping her] than what we knew how to do in the past.* (Case Manager)

One of the observations made by workers in nine interviews was that, even if young people were still missing from home sometimes, the quality of the relationship between the young people and the workers had significantly improved over the course of the pilot.

> *I think before [the program] we were a lot more - it's about boundaries and rules. We just lived with that and realising it takes a while to go oh actually, yes, it's about boundaries and rules but not for this. 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 approach when they returned it was really helpful. It wasn't a solution [to the running away] but actually you could see that there was a definite benefit for the relationship with the carers.* (Therapeutic Practitioner)

This new "softness" was echoed in the observation of a case manager 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, we've learned about the push and pull factors for sexual exploitation even on a case management level. Their response when they're returning is a lot more caring and just trying to get that care across, and spend one-on-one time with them.* (Case manager)

In 12 interviews workers talked about how they were using text messaging, phone calls or social media to stay in touch with young people when they were away from the home. Some young people were very receptive to staying in touch, while others would only stay in touch with particular carers. One worker recalled:

> *[Girl's staying in touch] depends on a lot of things; like the state that she's in, who she's with, what staff are at the house, whether or not she wants to stay in contact with them. We do find with the staff member she's got good rapport with, yes, she is checking in, she's saying hi, and if she doesn't like them very much, then they won't hear from her at all.* (Case Manager)

Social media was used by some carers and young people to stay in touch but not others, depending on the preference of the young person. One carer talked about Facebook as a good communication tool:

> *We have [girl] on Facebook as well, which we've found is a very useful tool for finding out what's going on with her . . . it's like the modern-day journal. When they're feeling emotional, that's what is represented on the Facebook page. If they're feeling in a good mood, or a good head space, that's usually also represented.* (Champion)

However, carers also reported that young people preferred not to communicate with carers via social media as they wanted to keep their social media use private. One carer said:

> *Our young person blocked the page that we made months and months ago because they thought we were spying on them. They didn't see it as a you can connect with us through this way. They were like yeah, then you can see everything that I do so no thanks.* (Champion)

Overall, there was evidence that young people were missing less as a result of the program. This seemed to have arisen not so much from the smart phones and staying in touch by text or social media, but as a result of the improved relationships between carers and young people. There was a new appreciation amongst carers of the factors that contribute to sexual exploitation and a shift in their practice from focusing on boundaries and rules to a relationship-based approach.

Children and young people's knowledge, skills and attitudes about sexual health and safety improved

The interview data suggests that children and young people's knowledge and attitudes about sexual health and safety issues improved over the course of the *Power to Kids: Respecting Sexual Safety* program. Their skills improved in some instances but in others there emerged a disjunction between what young people knew about sexual health and safety and the way they behaved. That is, children and young people did not always apply their knowledge to their own situations.

The improvement of children and young people's knowledge and attitudes about sexual health and safety was identified in 28 interviews. Knowledge appeared to increase across a wide range of topics, including: contraception; puberty; conception; impacts of pornography; grooming; consent; and respectful relationships. One worker recalled doing an activity with a boy about puberty:

> *We did two activities with [boy] on puberty, and they were really positive. [Boy] was very surprised to learn that he would be quite a lot younger than what he excepted when he'd be having changes with his body. He [already] knew quite a bit about male puberty, but learnt a lot about female puberty, which was interesting for him to learn, and staff also took away something from it.* (Champion)

Another worker recalled how another boy learned about how babies grow inside the mother's womb:

> *Then we continued talking and started to talk about babies and stuff. [Boy] had said to me, what's the - what's a rare amount of babies to carry? I know twins are kind of normal, but above that? I had said to him, well actually there was a woman who had octuplets. He was like, woah, how did it not kill her? I was like, I'm sure it was uncomfortable and squished her organs. He's like, what do you mean, squished her organs? I was like, oh well sometimes the babies can push against the mum's organs. It led to a really natural conversation about menstruation cycles, and that the babies are in an - amniotic, is it? - sac, and that protects the baby and feeds the baby, and protects the mum's organs. He stayed really engaged and really curious the whole time, and that was completely natural and opportunistic. So, he now knows how babies are made and how they survive in the mother's stomach (sic).* (Champion)

It was also evident that young people's knowledge about pornography and its impacts on sexual expectations in relationships improved. One worker said:

> *It's been a progression around the understanding of the effects of pornography and its excessive uses. So I've had conversations with I think two of the young people that same two that signed up for the OPPO phones and had an open discussion surrounding the negative implications of porn. The youngest of the young people was the one relaying the majority of information so he had already known all about it. He understands that it impacts the lens and the understanding of relationships and the dynamic between the male and the female. We touched on topics of consent and how pornography is basically an illusion and he totally understood all that. In his words he says pornography cooks your brain and it's very silly to expect that from your partner.* (Champion)

The attitudes of children and young people about gender and sexuality also appeared to improve over the course of the pilot. One worker described conversations with children about gender stereotypes associated with colours and jewellery:

> *One of the conversations that came off from that was that [boy] had just gotten his ears pierced. It's like, one of the other kids said, oh that could be considered like a girly thing to do. Then they kind of discussed how girls and boys can wear jewellery, girls and boys can kind of wear whatever clothes they want, do whatever hobbies they want and have any job roles. Then [boys] both identified that they liked pink and purple, so then they kind of had a conversation around that it's okay that anyone can like any colour and that it doesn't have to be - it can be any gender.* (Champion)

This shift towards more gender-equal attitudes was also reflected in a conversation a worker had with a teenage boy about victim-blaming attitudes and boys as bystanders. The worker said:

> *We had a carer take a young person who's a 14-year-old male on a drive. While they were driving, the young person pointed to a woman - it was dark outside - who was alone and she was walking in exercise gear and the young person said: "I don't know why females go out at night. It's dangerous." The worker took that opportunity and had a conversation with that young person about how all people should feel safe to go out at all times, regardless of whether or not it's dark. And as men, it's their responsibility to call out other men or friends who are men who are making women feel uncomfortable. That young person really took that in and had a think about it, which I thought was really beautiful.* (Champion)

Interviews with young people also revealed their knowledge about sexual health and safety issues. One boy articulated very clearly that an adult male giving a teenage girl cigarettes in exchange for sex is unacceptable. When asked what was wrong with the scenario the boy said:

> *Okay, so there's an under-18 who smokes. Giving minors smokes, minors drinks. Age, sex difference. I don't know, everything [is wrong about the scenario]... Just the age... Not a 15 and a 30-year-old, no.* (Young person)

A boy, when asked how he would describe a scenario about a boy posting a nude picture of his ex-girlfriend online, said: "I'd call it family violence, or just violence." Another boy, when asked about the scenario, said: "The boy is wrong because he shouldn't have posted the nude photo on Facebook and called her a S-L-U-T."

Evidence indicates that it was not only the knowledge and attitudes of children and young people which improved over the course of the pilot but also their skills in relation to sexual health and safety. One worker described how a girl learnt about condoms through the project and then asked staff for them:

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

Another worker recalled how impressed she was with the critical engagement girls in the house had with music videos. She said:

> *When they got up and out of bed they were watching it [MTV] and they were saying it looks almost like porn, like what they're wearing. I was really surprised actually because it was quite insightful the way they were talking about it. They were just saying I think it's a bad influence for younger kids, that you should respect yourself and that it's not classy. If a boy was with you because of how you looked then that would be wrong and they should want to be with you for you and all these positive things.* (Champion)

These same girls also displayed skills around identifying grooming and being an informed friend who can seek help on behalf of someone who is being abused. A worker recalled:

> *One striking thing that came out of it was that the girls mentioned to the carers that they should be talking to one of the other girls in the house, about [grooming] because they think that she's being groomed by her uncle . . . the girls seemed concerned about this relationship with the uncle and mentioned that to the carers, which is also really good in terms of telling a trusted adult and the previous topic, which was disclosure and informed friends.* (Sexual Health Nurse (Educator))

Although there appears to have been an increase in knowledge, attitudes and skills amongst the children and young people involved in the pilot, there were instances where young people appeared to have knowledge about sexual health and safety but did not apply that knowledge to their own situation. One worker said:

> *[Girl] definitely picks up all of the information and retains it. But then it's really hard to - she doesn't necessarily apply it - and it's really hard to tell how much of it she has really taken on board, because she is very good at telling you what you want to hear. If you try and have one of these conversations, she will just recite what she's been taught, with no real depth.* (Champion)

This reflection was echoed by the Sexual Health Nurse (Educator) who stated:

> *The thing that I've seen [is] a disconnect between [young people's] knowledge and their actions. So a lot of knowledge about healthy relationships, for example, and then when we have had a look at their relationships, how there's that disconnect between what they know is good for them, or the good thing to do, and how they're behaving in their relationships and how they are allowing their partners to behave with them.* (Sexual Health Nurse (Educator))

Overall, it is evident that the knowledge, attitudes and skills of children and young people about sexual health and safety issues improved over the course of the pilot. However, there appeared to be, at times, a disconnect between what the young people knew and the actions that they would take in their lives.

Workers have increased knowledge about HSB, CSE and DV

Like the children and young people, the workers demonstrated improved knowledge about HSB, CSE and DV. In particular, workers reported increased knowledge about various topics, including: sexual health, disclosure of sexual abuse; respectful relationships; gender stereotype; grooming; normal sexual behaviour; and pornography.

Learning about grooming and sexual exploitation was mentioned in six interviews. One worker described how carers and case managers had achieved a new sense of awareness about grooming through the course of the project. She said:

> *The education around sexual exploitation or around consent and things like that [has had an impact]. Or, obviously there's been quite a bit of training rolled out with RSS as well and I think, yeah, I feel like [knowledge about sexual exploitation and consent] has probably shifted. Especially [for] some of the new staff in the team . . . We always knew that the young people are being exploited but whether or not [staff] were aware of the grooming aspect and things beforehand. I think there's - I guess it's just their knowledge has grown around that side of things.* (Coordinator)

Another worker talked about how they had noticed a change in the language that carers were using around child sexual exploitation. She said:

> *I've got another example of language, I notice staff were using "prostitution" but now it's actually made reference that no, it's "sexual exploitation." So just educating and supporting them around language, and how that's delivered, I've seen a shift in that.* (Area Manager)

Workers' knowledge about normal and harmful sexual behaviour was identified in five interviews. A Therapeutic Practitioner, when asked about what had changed through the *Power to Kids: Respecting Sexual Safety* project, responded with: "Everything." He went on to describe how the increase in knowledge about children's normal sexual development had led to improvements in responding to children with sexual behaviour issues:

> *I remember before there used to be lots of overreaction [to sexualised behaviours], but having the project come in and everyone started to talk about - well kids have a sexuality; actually this isn't what normal child development is like, and actually these are - when you talk about age-appropriate behaviours you have to be talking about what age they're at and expect different things.* (Therapeutic Practitioner)

A champion reinforced this increase of workers' knowledge about children and young people's sexual behaviours. She said:

> *I think you mentioned the age appropriate development thing. I think that was really, really helpful, especially when we had some younger kids in the house, for all of the staff members to be familiar with what the appropriate developmental behaviours are. Because [as] you said it creates way less franticness when there's something that's uncomfortable to deal with that happens. Staff weren't overreacting to it and that just created a much more - a much better response and much better educational [response]* (Champion)

There appeared to be a significant improvement in workers' understanding of children and young people's use of pornography and its impacts. Although this was only identified in three interviews, the qualitative data was particularly rich. For example, a 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 [boy] - our house is quite a young house as you know, so [boy] is the oldest, he's 11. We thought that he wouldn't be searching those websites, porn websites, and as a team we discussed not having the conversation with [boy], because we didn't want to - 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 websites on YouTube, obviously we can't pin it to [boy] straightaway but the next under him is seven. We're presuming it is [boy] that has been using those inappropriate websites.* (Champion)

Workers also reported being upskilled about gender stereotypes, and this was identified in three interviews. One champion described how the Sexual Health Nurse (Educator) taught the team about the victim-blaming attitude that underpins the judgement of a girl going out dressed in clothes such as a short skirt and the importance of not shaming young people. The champion recalled:

> *We were talking about a young girl leaving the house and what she was wearing and how we would approach that. You know, originally my approach was, you know, what you're wearing is not appropriate for you to be going out of the house at this time of night. But then, [Sexual Health Nurse (Educator)] said, you know, she kind of informed us that it actually doesn't make a difference what the young people are wearing, it's not even about the clothes . . . I really took from the conversation in the team meeting and I would definitely change the way that I would work with a young person; or a young girl or a young male; leaving the house, because before this I would have said something completely different.* (Champion)

Overall, it is evident from the qualitative data that the knowledge of workers increased about a range of sexual health and safety topics. It appears that there was a particular boost in awareness about children's normal sexual development and an evidence-informed shift away from victim-blaming language associated with sexual exploitation and an adoption of trauma-informed sexuality education principles.

Workers have increased self-efficacy responding to HSB, CSE and DV

The qualitative evidence demonstrates very strongly that workers experienced improved comfort and confidence in addressing sexual health and safety issues with children and young people. This appeared to be supported by the resources provided through the *Power to Kids: Respecting Sexual Safety* program, such as the coaching of the champions by the Sexual Health Nurse (Educator) and the written resources about the ten sexual health and safety topics. It also appeared to be supported through the 'brave conversation' model, which became essential to guiding conversations between children and young people and their workers.

An increase in comfort and confidence was identified in 15 interviews. Workers described the way that the project had enabled them to deal with sexual health and safety issues in an evidence-informed way. They were able to manage conversations that previously they would have avoided or referred to a senior clinician. One worker said:

> *I think a lot of the – in the past, certain [sexual health and safety] conversations would come up and staff would put the conversation on hold so that they could consult with someone, because they weren't sure. Whereas now, the conversations are just flowing. They're not putting it on hold, they're just confident enough to have the conversation. Yeah. Which is great.* (Champion)

Another worker reflected:

> *I guess, the words that are involved and kids disclosing whatever they would like to disclose in terms of sex and masturbation and those kind of touchy subjects that would be I guess, we go back - we rewind a couple of years in residential care and it wouldn't be something that staff would be comfortable in talking to a young person about. We would be referring to leaflets and it could be even we don't talk about that – it is not an appropriate conversation. Whereas now, we're at a space where it's not inappropriate, you know.* (House Supervisor)

Still another worker reflected:

> *I think the project has given staff a lot of confidence to face issues that they probably would be a bit weary of facing before. I think there was a lot of oh, can we talk about that with a young person? Is that appropriate? Then this project came along and it's like yeah, of course we can talk about sex with that young person, like they need to know and this is what an STI is. Let me come into the doctors with you if you're not comfortable and let's just talk about it. It's made it - like it's open and it is what it is and it's life and you need to learn it. Whereas I think before it was like oh, maybe they need to be referred to someone else and it's like well no, you need to capture that conversation now. Like they might not talk to someone else ever again.* (House Supervisor)

Workers attributed this increase in comfort and confidence to the support provided by the resources associated with the program, as well as the whole-of-house approach to respectful relationships and sexuality education. When asked about what had led to the increase in confidence, a champion said:

> *The education definitely and the resources I would say. Knowing what you're talking about because you went over all the information. So I think that's definitely [the main source of] confidence would be knowledge.* (Champion)

It appeared that the carers adopted the whole-of-house approach, which created a culture of gender equity in the houses. The Sexual Health Nurse (Educator) recalled:

> *I've been really impressed with the carers in terms of their - the way that they work in the house in terms of gender equality and modelling behaviours - I've been really impressed with how they behave in terms of the culture and the environment of the house for the young people. So I don't think I have seen one instance of carers or the home being in a way that isn't a reflection of the messages that we're trying to send.* (Sexual Health Nurse (Educator))

Another champion talked about how the culture of the house had changed through the whole-of-house approach:

> *Definitely has changed. I think like I was saying before, it's just a lot more open around the topics around sex, and a lot more - less judgment, less shame and everyone is just a lot more open to have those conversations, which is really good.* (Champion)

The implementation of the whole-of-house respectful relationships and sexuality education, informed by the 'brave conversation' TALK model, led to powerful conversations between carers and young people. This was identified in 15 interviews.

Brave conversations were held across a wide range of sexual health topics, including: pornography; contraception; grooming; LGBTIQ relationships; cycle of violence; and the pornification of culture. One champion recounted a carer having a brave conversation about sexual health:

> *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. She just, even though they were giggling and laughing about it, she tried to be like, it's a really serious issue though. She 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. They seemed to engage with it well, even though they were also laughing and joking around about it.* (Champion)

Another champion described a conversation about the impacts of pornography on young people:

> *I go I know it's a sort of normal thing to grow up and to be sexually curious and to be interested in these sort of things, but then that was the segue into the negative impacts of excessive porn use and to be wary of the type of material that you are watching as well. He proudly showed me it. He didn't hide from it. He's like oh, look what I've got. I've got this. You can download stuff and blah, blah, blah and I'm like be careful not to download anything especially on the new phones because it was again, at the signing of those contracts.* (Champion)

Still another champion recalled a conversation with a girl about pornography. She said:

> *[Girl] came to the office and was talking to me about a virus on her phone, and she said I think I got it from looking at porn. So then we started talking about the effects of porn and she was very understanding of the negative effects of porn. But what I found interesting - and it was really helpful to have the posters - was she said it's worse for men than it is for girls. So I was able to use the poster to show that - well to clarify to her that, yes, it's more common for men to watch porn but I used that brain poster to show her that the effects are actually on your brain. It's the same effects for boys and girls depending on how you use it and what you're watching, which was a really good conversation to have.* (Champion)

Overall, the qualitative evidence indicates strongly that the confidence and comfort of carers increased markedly over the course of the program. Workers reported how carers were having 'brave conversations' about sexual health and safety issues as opportunities arose over the course of the day.

Workers are identifying HSB, CSE, DV, undertaking safety planning and ensuring advocacy, exit and treatment

The qualitative evidence demonstrated that worker's identification of HSB, CSE and DV improved over the course of the program. Workers put the knowledge about red flags for each of the forms of abuse into practice through this process of identification. Once HSB, CSE or DV had been identified, safety planning was undertaken and practitioners were able to undertake *Exit practice* with sexually exploited young people and provide a therapeutic response to those carrying out HSB or living with DV.

Improved identification was noted in 13 interviews. One champion recalled being alert to signs of sexual exploitation, such as going missing and spending time with older people using drugs. The champion said:

> *We were having a conversation and [girl] disclosed that . . . when she runs away she hangs around with 19-year-olds and they do the D word, I asked - kind of played dumb and I said, what's the D word and she's like, oh they do drugs. Then just kind of having a conversation with her asking her, did they ever offer her drugs. Obviously saying that she's not safe when she's with people who are doing drugs and 19-year-olds. I wanted to further the conversation but she kind of shuts it down when you start getting a bit more into detail. So I think that's another follow up conversation for me, just around grooming. Because I think that she could be at risk with - obviously she's at risk if she's absconding and hanging around with 19-year-olds who are doing drugs, because she's only 11 years old.* (Champion)

Another Champion noted the increased attention of staff to red flags of harmful sexual behaviour and sexual exploitation:

> *With the harmful sexual behaviour, [I'm] actually seeing a lot more of our staff are noting red flags and are making a lot more effort to pay attention to red flags of that behaviour, or signs of sexual exploitation with our young people, which has been really awesome because then we've been able to get safety measures put in place a lot quicker than what we would have before the program.* (Champion)

The improved identification of HSB, CSE and DV enabled carers to undertake safety planning in the homes about the different types of abuse. A Therapeutic Practitioner described the process of identifying problematic sexual behaviour and using the safety planning tool in response:

> *So one [time] [the kids are] pulling down their pants because that's what kids do, but then another time they're actually wanting to spend time alone with another kid and then it's like oh what's going on there. Breaking it down and trying to make sense of what's going on or how best to respond, I think it would have been a lot more difficult to try and do that without lots of the education and the [safety planning] tool, and looking across the different domains, the individual and house level.* (Therapeutic Practitioner)

Along with safety planning, carers and practitioners were able to mobilise a therapeutic response for children and young people with harmful sexual behaviour. This was discussed in 13 interviews. For problematic sexual behaviour, workers applied a psycho-education approach:

> *With the problem [of] sexual behaviour we had our young person who is 11, kiss, it was another young person in the house who came to staff and disclosed that [young person] had kissed him on the lips. Basically then we discussed it at reflective practice and we just talked to them both individually . . . [We reassured them that] if they ever needed to come to talk to staff that they could, but not shaming them, and just being sensitive around the topic. But we haven't had anything else since, there was just that instance.* (Champion)

For more serious cases of harmful sexual behaviour, workers supported young people to receive treatment through specialist services. One Principal Practitioner said:

> *Then they've also been very supportive of his weekly appointments at the [HSB service] where he's been having an assessment and the [HSB service] therapist came to reflective practice to talk a bit more about the [treatment] program and his role and his initial impressions of that young person and what the plans would be and what that would look like and to kind of try and integrate that work with what the carers were doing to support that young person in the house and also because in initially he was quite reticent to attend those appointments and it was around strategy through engagement. He's been going very regularly, just with a little recent hiccup for other reasons, but that's been really positive bringing [everyone] together.* (Principal Practitioner)

Carers and practitioners also responded to red flags for sexual exploitation through the implementation of the *Power to Kids: Respecting Sexual Safety Exit practice*. This was noted in eight interviews. One Principal Practitioner described the collaboration between case managers and police to provide a rapid disruption response when a girl was being exploited:

> *The communication is privileged, if you like, between police, CP and MacKillop [workers]. So, there's no setting list to one side, it's like, right, we need to act. So, I would say there's the rapid response. That would be an example of what I've seen happening . . . the planning around the disruption then getting her into Secure - it's all happening more.* (Principal Practitioner)

Another aspect of the *Exit practice* was carried out by the Principal Practitioners: supporting young people to engage with their families of origin. One Principal Practitioner described assisting a young person to connect with her mother, which acted as a protective factor against sexual exploitation. She said:

> *But certainly we know anecdotally for this young person that there's a lot of ruptures that need to repair in their relationship, but [we know] when there's been a rupture and she's not spending time with [her] mum so much, that she's more likely to be sexually exploited and there's been a range of persons of interest. So I guess for us, just trying to re-establish that connection is really important.* (Principal Practitioner)

It was not only the principal practitioners who were undertaking the *Exit practice*, the carers experienced a sense of increased confidence to communicate directly with police and advocate for a response to CSE. One manager recalled:

> *And I think that, throughout this [Power to Kids: Respecting Sexual Safety] training, it's almost given our staff more confidence to do this agitation themselves, rather than just ringing up and giving information to police, passing it on to a case manager, and then the expectation being that, the coordinators, or higher management would follow this stuff up. The staff actually feel skilled and equipped with this knowledge, to be able to agitate for a police response themselves and often they are doing that and they are actually getting really good results.* (Area Manager)

A therapeutic response to dating violence was also practiced by workers. One house supervisor recounted how the DV practitioner had engaged a victim of DV creatively, although the boy using violence would not engage with the clinician:

> *What went well, I think [therapist] took [girl] out so it wasn't like this sit down let's chat. He was very open about - they would go for walks and they'd go get coffee and it was very informal. I think that approach really worked with [girl] who – [girl] wasn't aware - like she knew that [boy] was being violent but she didn't see as dating violence or anything different. She kind of felt it was almost like it was normal for her. I think having that time out and someone caring and taking her out for coffee and walking with her and just listening to her.* (House Supervisor)

Overall, there is significant evidence that workers were able to better identify HSB, CSE and DV through the program. This improved identification enabled carers to engage practitioners and case managers in a therapeutic response to the three forms of abuse.

Implementation

This section outlines the qualitative data about the implementation issues that arose during the course of the pilot. There were some process issues that worked well and others that required the delivery of the program to be adjusted during the pilot. Implementation issues will be addressed for each of the prevention strategies.

Prevention Strategy 1: Whole-of-house respectful relationships and sexuality education

The champion's model underpinning the delivery of the whole-of-house sexuality and respectful relationships education worked well. The translation of knowledge from the Sexual Health Nurse (Educator) to the champions, and the champions to the other residential staff was successful. The Sexual Health Nurse (Educator) noted how the champions' ability to speak clearly about the topics to their colleagues increased over the course of the pilot:

> *I will say the champions also - because they have more responsibility in terms of being the ones to take the information back to the houses - I've seen them gain confidence too. When I've been at the team meetings, in terms of them learning and then going to the team meeting and telling [the other staff] - feeding back the information, from how it was four months ago - how they were four months ago to now, they've developed much more fluency around the topics and a lot - I think less apprehension about talking about different things with the other staff.* (Sexual Health Nurse (Educator))

The champions were taken seriously by the other staff members, who did not have difficulty understanding the material being conveyed. One House Supervisor reported:

> *They do take it seriously and I guess the champion himself is a good presenter and is able to reiterate the information quite well, has really helped. So there's no lost communication - it's never been the case that we don't understand. It's always been the case that we understand what that champion is talking about.* (House Supervisor)

Mangers and house supervisors liked the champions model because it took pressure off them and their already busy schedules. They also noted the importance of champions self-selecting. One manager reflected:

> *I think the champions for us have been the saving grace and, I think, especially without the champions model if this had fallen to coordinators to implement solely on their own, I don't think the effectiveness would have been there. I think the people who were the champions have selected that role for themselves because they have a genuine interest and a passion in the program and they're doing a fantastic job of making it their own and that's not just with the staff it's also with the kids as well, so I think the champions model worked really well.* (Area Manager)

Despite the success of the champion's model in the first prevention strategy, the delivery was not without its challenges. At times it was difficult to engage young people with the resources, and this was noted in 11 interviews. For some workers it was difficult to get the young people to take the material seriously. One champion reported:

> *It's actually quite difficult to get them together to be able to have these conversations with them. Also, to have that conversation with them without them making sort of smart remarks and, you know, taking it as a joke, I suppose. Just feeding off each other's behaviour. That's something that I think we would have found challenging in the last couple of weeks.* (Champion)

Another champion talked about the challenge of the children and young people not being in the home much to do the activities with:

> *A big obstacle is kids not being home. See because [boy] goes to school and we don't really want to overwhelm him with these activities in that little gap we have to engage with him around dinner time. [Girl] is out of the home a lot. When she does come home, she's often not in a very good mood, so you want to have a lovely conversation with her and not, again, overwhelm her with stuff. [Another boy], out of the home a lot and when he is home, like I've said, does not like engaging with this information.* (Champion)

The Sexual Health Nurse (Educator) reflected how it was easier to do group activities with younger children, whereas it was better to do activities individually with teenagers:

> *Also - this is also a big difference between the children and young people - is that the children actually work quite well in groups and the young people, due to shame, due to competitiveness, it has to be one on one.* (Sexual Health Nurse (Educator))

One young person suggested that children and young people were not expected to engage with the material too frequently as this may become annoying. She said:

> *I feel like it shouldn't be too frequent because I feel like the young kids will start to get annoyed of it or get disengaged and not want to do it because it'll become like [a chore]. Yeah, like something they feel that they have to do all the time. This has to be something that you want to do if you really [want] to engage and you really want to learn, so it can't be too frequent. I feel like maybe every once in two months or maybe whenever another young kid comes [into the house] or something like that.* (Young person)

Another major challenge that emerged in the implementation of the education strategy was that, on one occasion, a young person became disturbed by the material. A Case Manager recalled an incident where a young person became very distressed when doing an activity about sexual assault:

> *It first began when [girl] was engaging in the activity that was around consent and rape and recently, prior to her completing the activity, she disclosed that she had been sexually assaulted by a partner previously. When she was doing the activity, she became quite heightened and she was crying and that sort of lasted throughout the whole duration of the night and carers having to console her in her bedroom. It wasn't just…she was upset -she cried and that was it -, it seemed to have impacted her for hours and hours.* (Case Manager)

This event raised a major issue for the project as it was understood by everyone involved in the pilot that triggering young people in this way was not an acceptable outcome. The researchers, clinicians and case manager collaborated to overcome this issue and to minimise the chances of another young person being traumatised.

An approach was adopted whereby the Case Manager consulted with the carers and other members of the care team about each activity before presenting it to the girl who had disclosed sexual assault. Focus was also placed on creating a safe space before any activity was attempted with any child or young person or staff member in the pilot. The Principal Practitioner involved with the girl who disclosed her trauma noted how well the feedback about the triggering was taken on board by the research and operations teams:

> *Well the thing that comes to mind is my appreciation of the fact that you incorporated feedback from the project as it was given to you on the way, and I was pleasantly surprised by [the fact that the feedback] was going to be implemented in the scaled-up version of the project. This seemed to acknowledge some of the feedback that came from [house with triggered girl] particularly about the way that activities were going to be delivered and the respect, I guess, for where the workers, the carers were at, as well in terms of how they would deliver the information.* (Principal Practitioner)

Young people also provided comment on the first prevention strategy. One young person described how she and her co-resident did not like the posters and activities associated with the program displayed in the common areas of the house because they made the home feel like an institution. She said:

> *If you think about it, anybody that lives at home wouldn't have posters around, like sexual health and everything all over their walls or anything. If anything, it would be like the parents' job to teach them and stuff like that, and I feel like that should be the same in residential care, like have somebody come out and actually teach us about it. Because we learn a lot more from someone actually speaking to us than just reading posters and stuff like that, if that makes sense?* (Young person)

This same young person felt strongly about being talked to about sexual health and safety issues by a carer of the same gender. She said:

> *I would not want to see any male carer about anything like this, because it's really uncomfortable for me. I think it would be uncomfortable for a lot of other young children. If it was like a male worker, a male carer talking to a male child, yeah, that would make sense. But if it's different genders, it's uncomfortable.* (Young person)

This sentiment was echoed by a champion who reported that male workers were anxious about having conversations about sexual health and safety with girls but that this anxiety was ameliorated somewhat through support from the Sexual Health Nurse (Educator):

> *I think a lot of the male staff members were very anxious to have those kinds of conversations with females, so talking to [Sexual Health Nurse (Educator)] and other female staff members and having those conversations I think reduced their anxiety around speaking to the opposite gendered people.* (Champion)

Based on interviews with the Champions, other children and young people expressed the preference to engage with a champion, close worker or the Sexual Health Nurse (Educator). One champion described how the young people in her house really enjoyed having the Sexual Health Nurse (Educator) around to talk to about sensitive issues:

> *I think the kids have really liked having [Sexual Health Nurse (Educator)] there as an expert, and I know that it has actually helped facilitate a lot of conversations. When [Sexual Health Nurse (Educator)] is there staff can be like: "Oh so what is a uterus?" And create that conversation that might not normally happen. I think the kids feel more comfortable talking to her directly sometimes than talking to some of us. So it's been really good having her there.* (Champion)

Another challenge that arose for the implementation of the first prevention strategy pointed to the importance of stable staffing teams. Champions found it harder to carry out their knowledge translation work when there was a lot of movement in the staffing group. One champion commented:

> *It's just in the past fortnight, or month, I've done four or five inductions for new casuals. It's - yeah, it's always changing. We've just had few people go on holidays, come back. Now there's about to be another two of our full-timers on holiday, so that'll be other casuals constantly coming in. Yeah, it makes it a little harder. Especially when they don't have the rapport with the kids, you know? The first time they're in the home, and the kids certainly don't react to new faces in a very friendly manner, at all, ever. Ever.* (Champion)

Overall, the implementation of the first prevention strategy through the champion's model worked well and the knowledge translation from the Sexual Health Nurse (Educator) through the champions to the carers was successful. Some challenges that emerged for the delivery of the strategy involved the "triggering" of a young person who had been sexually assaulted in the past, as well as the challenge of working in an environment where staff were moved at short notice to other houses, particularly if those staff were champions for the program. Young people expressed a strong preference for talking to workers of the same gender, or to the Sexual Health Nurse (Educator) or champion.

Prevention Strategy 2: Missing from home strategy

Prevention Strategy Two: Missing from home strategy faced a number of implementation challenges, primarily in relation to concerns about safety. In the first instance, workers were concerned about providing young people with smart phones because it was considered that young people may use the phones to have contact with perpetrators of sexual exploitation. However, the research team rationalised that young people generally already have access to phones provided by MacKillop and that perpetrators also give phones to young people during the process of grooming. Workers reflected how the phones worked differently to how they anticipated. One Coordinator said:

> *It's worked differently than what I would have expected. We were all pretty concerned about giving the young people the phones because it was like, oh, we're making it easier for them. Or, you know, are they going to keep them? Sell them? We've had some issues with them, but I think having the contract worked really well because then when the young person did sell his phone, it was - he didn't kick up a fuss. Didn't get another one because it was according to the contract. But then [girl], that we were really worried about giving her a phone, she's held on to it. The whole time. It got damaged once and it wasn't her fault, so that worked well.* (Coordinator)

Young people did misuse the phones or use them creatively to get around the phone agreement. One young person had two phones: one from the RSS program and one from somewhere else. She used the RSS phone in accordance with the phone agreement but then used the other phone to make contact with potentially unsafe people. A worker reflected:

> *Then what we're finding with that one person [at risk of sexual exploitation] that we are quite worried about in that sense, she's devious in how she gets around in terms of like having two different phones or changing her SIMs and things like that. But I guess it's still that statement in her mind of where the boundary is and this phone I can use to do these things and that phone I can use to do those things, and still having that in her mind, where subconsciously she's being told this is unsafe behaviour. So that's why she's like trying to circumvent that but it's still in the back of her mind that what's she's doing in that sense is not condoned, it's not safe.* (Case Manager)

By the end of the pilot, champions reported that most of the smart phones distributed through the project had been lost or broken, and that the phones were not an impactful part of the program. One champion said:

> *The phones really didn't impact the project at all. It didn't make a difference if it was that phone, a different phone, not a smartphone. It didn't really impact. Yeah, [our phones] have been sold. I think too we've had kids that don't have the Oppo phone and kids that do have the Oppo phone and there was no real difference. They didn't engage more because they had the phone. They didn't contact us anymore because they had that specific phone. It was pretty even across.* (Champion)

However, one young person did feel like the phone he received had made an impact on his staying in touch with workers. He said in response to being asked if the phones were helpful:

> *Yeah . . . [the phone helps to] keep in contact with the resi, yeah, and I contact - keep in contact with everyone, let them know my location, so they know where I am and that I'm safe. Because I won't leave the house unless I'm telling people where I'm going. Like the resi, I call them, yeah, I'm on the train, call mate, yeah. Call a couple of my good mates, oh yeah, I'm on the train. I'm going to - this is where I'll be at this time of day, I'm going to [unclear] at this time. Yeah. So if anything does happen, they know where I am. They know they can just come there, straight away. They know if I don't answer my phone, like three, four calls, they know there's something going on, because I usually answer first call - first or second call.*

Despite the misuse of smart phones, the focus on the phones appears to have had an impact on the carers in raising their awareness about staying in touch with young people when they are away from the house, and doing this in a thoughtful and creative way. One worker described how the care team was collaborating around one girl at risk of sexual exploitation to produce text messages that would assist to increase her levels of safety. She said:

> *What we've been doing over the past fortnight and it's actually an agenda [item] from the care team, that we form a script that's attached to her behavioural support plan within the next two weeks around specific messages to send to her, because generally she won't reply or she won't answer a call if it feel scripted. Like if it's hi [girl's name], please stay safe, you need to be home by this time, she won't respond because she thinks it's so generic, it's not personal and stuff like that. So we've been quite creative in what we message her and I know the carers are always putting their name in it, like hey it's me, [worker's name], I'm on till nine, I'm hoping to cook you dinner, can you please come home so we can catch up.* (Case Manager)

Some young people had strong feelings about the *Missing from home strategy*. One young person questioned the premise of the strategy that children go missing because they are being sexually exploited. He said:

> *Kids are leaving the house and going places because they're not allowed to have their friends over, they're not allowed to have programs where they see kids all the time. They're getting their little programs, but they're not really doing anything.* (Young person)

In general, young people were keen to receive a new smart phone. One boy talked about "harassing the shit" out of the champion to get him one of the smart phones. Young people also spoke strongly about not wanting social media contact with carers. They expressed the view that social media platforms are their private business. One boy said:

> *I don't reckon social media is really - it's sort of confidential. That's why I changed my name on Facebook several times, because I don't like the workers looking on my Facebook, it's private what I post. I've got my personal life compared to the resi. I've got obviously my life around the resi, everything included, but when I leave the house it's [my space].* (Young person)

This sentiment was supported by the reflections of workers, who reported that young people did not want to engage with carers through social media.

Overall, the implementation issues associated with the second prevention strategy related to the concerns that workers had about providing new smart phones to young people at risk of sexual exploitation and the damaging and misuse of the phones by young people. A further issue was that young people preferred not to communicate with carers through social media but were generally happy to communicate by text message or phone call.

Although the second prevention strategy did not work in the way intended, it does appear that it functioned to increase carers' focus on using technology to stay in touch with children and young people when they were away from the home. It also appears that, although the smart phones did not seem to influence the level of children and young people going missing from the home, the strengthened relationships between carers and young people did have an impact. That is, going missing from the home did appear to be reduced as protective relationships with carers were enhanced.

Prevention Strategy 3: Sexual safety response

A number of implementation issues arose in relation to the *Prevention Strategy Three: Sexual safety response* – the third prevention strategy. These issues can be understood in terms of both barriers and facilitators. A facilitator of the strategy involved the development of strong service partnerships, whereas barriers emerged relating to the contracting arrangement of children and young people, as well as the need to embed the strategy more fully in MacKillop practice.

In terms of the facilitator, workers talked about the strengthened relationships with harmful sexual behaviour treatment services, as well as the importance of good relationships with the sexual exploitation practice leaders and local police. A Therapeutic Practitioner recalled the importance of getting to meet a clinician from the local HSB treatment service:

> *It also helped us get an understanding [HSB-treatment-wise] and just really early on - getting them just to come in and sit down with you I think it was at the time. Oh let's meet and greet. It just makes things easier. You've got a face [at the HSB treatment service] so we know them and they've told us what they do and then I remember them when something happens, and it's not just a cold ding, ding, hello out of the blue. Trying to figure out who to go to. It makes a big difference to know who your service partners are.* (Therapeutic Practitioner)

Workers also talked about the importance of being able to communicate with the Sexual Exploitation Practice Leader, although this appeared to be working well in some areas but not in others. A Coordinator recalled:

> *We had a young person that was living in [region 1] but was linked to the [region 2] and she was engaged with a lot of other young people at risk of sexual exploitation, so we had a lot to do with [region 2] at that time. This was like a year or so ago. So, the sexual exploitation practice leader from [region 2] was really heavily involved and it's what we weren't used to [in region 1]. Like, they were coming to care team meetings. They were advocating for placement changes or contact. They were very, very active. Completely different to what we see in [region 1]. Or, active in a different level I suppose. Yeah, they were very much on the ground level. Very, very active.* (Coordinator)

It also became clear that workers were developing their relationships with police and feeling more empowered to disagree with policing decisions and advocate for an alternative response. One worker said:

> *Again it comes back to knowledge. Their knowledge. I think that knowledge is power to them, and before they would ring up, they didn't feel confident enough to go back to a police officer, and say actually, that's inaccurate. They didn't feel that they had the support or the skills or the knowledge to be able to disagree with the police officer, so I think they're doing it quite respectfully, but for me that's a pretty big change.* (Manager)

The program appeared to strengthen the relationship with local police to a certain extent, although this aspect of the prevention strategy was not fully developed in the pilot. One Practitioner said:

> *It was a really positive meeting [with] four of us from MacKillop…the director and the case manager, the resi coordinator and myself as principal practitioner. Look, it was a great conversation and even though some of the issues for the current four young people in that house [were not discussed]… [we hoped that the meeting would lead to] not butting up against the police so much. We had a great conversation about building those partnerships so that when there will inevitably be a change of the composition of the young people in the house, we've got all this in place and it becomes a regular routine thing that MacKillop and the police will go out to the house together, have conversations with young people as part of their orientation into the home and the neighbourhood so that they have that positive experience with police.* (Principal Practitioner).

A barrier emerged for the timely undertaking of the *Exit practice*. One MacKillop Principal Practitioner described how the *Exit practice* could be hampered when the case management responsibility for children was not contracted to MacKillop Case Managers. She said:

> *There were barriers around the kids that were not contracted to MacKillop, so when they were contracted with the Department [of Health and Human Services] - and still are - there are still these same barriers in place. It was very dependent on how proactive and active the child protection worker or Departmental case manager is as to whether things were followed up in a very timely manner and if red flag meetings were called or even if you got responses.* (Principal Practitioner)

One Case Manager put this down to differing conceptions of risk and other processes within the Department of Health and Human Services. She said:

> *I think that sometimes it can be a differing opinion and what we classify as risk in comparison to the risk that others sit with. I think that it would be the exact same here internally in different Case Managers sitting with different risks and that kind of thing. I feel like with [girl] being so high risk, like we've always done everything and anything that we can with the exit strategy and sometimes I find that it can be quite a lot quicker if we do it. Whereas with the Department, because of their own restrictions, like we were trying to source a Harbouring Notice for [Girl] last year and I reckon it took maybe three or four months, so it can be quite timely due to their own restrictions.* (Case Manager)

Another process issue that emerged during the pilot related to the need to embed the *Sexual safety response* more fully into MacKillop policy and practice. For example, the Consult Referral Form that was designed to trigger a response to HSB, CSE or DV did not appear to be used as it was intended and workers were confused about its use.

One Principal Practitioner said:

> *I was going to try and catch up with [Case Manager] before this phone call to try and understand from her whether they think that a Consult Form would be coming to her rather than me or whether that should be coming from [Case Manager] to me or whether it's from [House Supervisor]]. I suspect it's not really knowing - and I know it's been very clear about what the lines of communication and accountability are, but I suspect it's just that it's a form that doesn't get filled in.* (Principal Practitioner]

However, a Therapeutic Practitioner had a different experience and found the Consult Referral Form helpful in coordinating practice. He said;

> *I actually really enjoyed having the Consult Form because it did give lots of structure to responding to it. I've got a pet peeve of - I have one conversation with the House Supervisor and then I'll have another conversation with the Case Manager, and then another conversation with a Carer, another conversation with a kid, and all of a sudden you've got 10 different versions and 10 actions to do. But having that helped to well let's just group together and let's fill this form in together…it helped us develop a common understanding of what was going on. In relation to the harmful sexual behaviours that were quite concerning that was really, really helpful.* (Therapeutic Practitioner)

At the same time, though, House Supervisors did not feel clear about what action had been taken by practitioners as a result of the Consult Referral Forms. One House Supervisor felt that the action taken was not swift enough and that the response to the request for a consult did not carry enough momentum:

> *This program was put there to help us put an intervention in rather than, we've got a [clinician], we can sit down and talk about it all day long. But the speed of the [clinician] is not at the speed of how fast this [harmful sexual behaviour is] happening in the home I feel that we lack that kind of momentum to get up and do a referral at all costs. Because even though we've got a clinician, that clinician can't solve everything, because nobody can solve everything. It's about what steps are we taking, what we feel, what services we give them and how do we action that and what time - and what timeframe are we actioning that. It was just all about getting the consult form done and sending it straight to the clinician and that was it.* (House Supervisor)

There was consensus amongst the Principal Practitioners that the processes involved in the third prevention strategy needed to be more fully ingrained. One of them said:

> *[The third prevention strategy has] got to be more visible, more - almost like - just part and parcel of the - yeah, of the framework around the houses and it's like anything…it's always going to be a work in progress but something about - yes, the naming of [the third prevention strategy], the key elements of it, right this is - that holds that anxiety, that's what we do here. The sort of processes, information flow, communication.* (Principal Practitioner)

With the third prevention strategy there was also confusion about the role of the case manager versus the role of the principal practitioner and who is best placed to have oversight of the strategy, particularly the *Exit practice*. A Case Manager said in response to being asked about who should manage the *Exit practice* of a particular young person:

> *I would say, more than anyone, myself and whoever she's contracted to at the Department at the time, mainly because she was living in our other therapeutic home and I was case managing her there…since April 2018. So I've worked with her for probably good 15, 16 months and I've done all of that [Exit strategy] over time, alongside police and the Department.*

The Principal Practitioners agreed that they needed to develop a greater understanding of the Sexual safety response and that this would be undertaken as part of upscaling the program across all of MacKillop's residential care homes. A Principal Practitioner noted:

> *But I think what we need to do as a matter of priority is …have a shared, clear role and priority for the [Principal Practitioner] in [the third prevention strategy]. I know for me and we know each situation will be slightly different, but I need my to-do template…adapted from what's worked, but we make it up-scaled…So we do need to do that, I think, so that when we're ready to go, we've kind of got a step one, step two, step three to be doing.* (Principal Practitioner)

Overall, the process issues that confronted the implementation of the third prevention strategy related to the value of strong service partnerships to facilitate the strategy. Barriers to the smooth implementation of the strategy involved the difficulty of receiving a timely response from DHHS when children and young people are contracted to the Department. A further barrier related to the need for greater organisational readiness to deliver the Sexual safety response. It is evident that the practice associated with the third prevention strategy was being carried out but that this was occurring in a less organised way then was intended by the research team.

Survey data results

The quantitative questionnaire consisted of five scales. Knowledge of Child Sexual Abuse (CSA) was measured using the Child Sexual Abuse Knowledge Questionnaire (Goodman-Delahunty, Martschuk & Cossins, 2017). Knowledge of HSB,CSE and sexual health and safety were assessed using the Knowledge of Harmful Sexual Behaviour and Child Sexual Exploitation Scale and the Knowledge of Sexual and Reproductive Health Scale, both of which were developed for this study by two of the authors.

The level of comfort communicating about sex was measured by the modified language Sexual Communication Comfort Scale (Miller & Byers, 2008). The language of this scale was slightly modified: the word 'client' in each statement was changed to 'young person' to better fit the program context. Lastly, self-reported self-efficacy to deliver sexual health and safety-focused interventions was measured by the Sexual Intervention Self-Efficacy Questionnaire (Miller & Byers, 2008).

Knowledge of child sexual abuse: Participants on average scored in the middle of this scale (M=3.05 on a 1-5 scale), indicating there was room for improvement. Most of the uncertainty exhibited was surrounding this statement: 'Children who are sexually abused display strong emotional reactions afterwards.' On average, clinical and managing staff responded to more questions correctly on child sexual abuse than residential carers. The highest score that carers achieved was the same as lowest score that clinicians/managers attained – that is, carers' best was the clinician/manager's worst.

Knowledge of harmful sexual behaviour and child sexual exploitation: Overall, participants knew more about child sexual exploitation than harmful sexual behaviour. On this scale, all respondents correctly indicated as false the following statement: 'A 12-year-old masturbating in public is normal sexual behaviour'. Most of the uncertainty was surrounding the following statement: 'All young people who sexually abuse children continue abusing children as adults'. Over 30% of respondents chose 'don't know' as the answer. The most frequently incorrectly answered question was: 'Boys are more likely to touch the genitals of a younger child than girls'; over half of the whole sample incorrectly answered this statement.

Knowledge of sexual health and safety: All respondents correctly indicated the following statement as false: 'Lesbians cannot get sexually transmitted diseases'. Most uncertainty and least knowledge was exhibited about the statement: 'Children as young as 10 years can face charges for sexual offences'; 36% of participants chose 'don't know'. There was notable confusion for the residential carers but not for clinicians and managers about the statement: 'Menstrual blood is discharged from the urethra.' Lastly, 56% of all participants did not answer correctly the statement: 'A girl can get pregnant from having sex without a condom while having her period'.

Level of comfort communicating about sex: Overall, clinicians and residential carers showed high levels of comfort and managers slightly less, probably partially due to them having less face-to-face client contact. Participants were most comfortable communicating about 'sexual intercourse with someone of the opposite sex' and least comfortable communicating about 'Engaging in sex with a partner in the presence of others.' Residential carers also found it difficult to talk about "intercourse during the menstrual flow.'

Findings from the first round survey indicated there was room to improve participants' knowledge and skills as mean scores were in the middle ranges for each scale. Residential carers struggled most with answering the knowledge questions correctly; however, some topics were found to be confusing for everyone, especially topics around legal knowledge and abuse trajectory. Findings imply that training and coaching could focus particularly on literacy around harmful sexual behaviour and biological sexual health information for residential carers could also be useful. Overall, more literacy is needed about harmful sexual behaviour than about child sexual exploitation.

In the second round of data collection, 34 participants completed the survey, some were returning participants, whilst others were new workers due to the high turnover of workforce in this sector. Participants came from four houses. In the second round data collection, 68% of participants were residential carers, 18% clinical staff and 6% managing staff. Gender was measured in this wave of data collection and it is likely gender distribution was similar across the first round as well, namely that predominantly more females work in this sector compared to males. During the second round data collection, 68% of respondents were females, 32% males.

Comparison across roles during the second data collection

Similar trends were observed when comparing residential carers, managing and clinical staff during the second data collection point. On the knowledge scales, residential carers still underperformed both clinical and managing staff. On the sexual communication comfort scale, residential carers expressed most comfort and clinical staff the least.

On the self-efficacy scales, the highest comfort/bias self-efficacy was amongst managing staff, followed by residential carers then clinical staff; the highest skill self-efficacy was measured amongst residential carers, closely followed both by managing staff and clinical staff;, and highest information self-efficacy was expressed by clinical workers, followed by managing staff and residential carers.

On the knowledge of harmful sexual behaviour and child sexual exploitation scale, clinical and managing staff performed near identical, followed by the residential carers. Lastly, on the knowledge of sexual and reproductive health scale, management staff performed the highest, residential carers the lowest.

Changes over time

Changes over time were compared across the following two domains: learning about sexual health and safety; and comfort and self-efficacy to develop more nurturing caring relationships.

Learning about sexual health and safety

Participants in the second round data collection showed a trend towards improved understanding of children and young people's sexual health and safety compared to the first round participants. This indication of increased knowledge was based on three knowledge scales.

Participant knowledge around CSA increased between the two data collection points on the Child Sexual Abuse Knowledge Questionnaire:

- first round: M = 3.05, SD = .75
- second round: M = 3.31 , SD = .77
- changes over time: t(87) = -1.57, p = .119

Albeit this change was not significant. All except one item of the questionnaire contributed to this non-significant trend.

A similar small trend towards increased understanding was observed on the Knowledge of Sexual and Reproductive Health Scale between the two data collection points:

- first round: M = 1.17, SD = .11
- second round: M = 1.14 , SD = .10
- changes over time: t(85) = 1.19, p = .237

There was significant change on one item over time; significantly more participants were able to correctly answer the following statement during the second round compared to the first: 'Menstrual blood is discharged from the urethra':

- first round: M = 1.39, SD = .49
- second round: M = 1.18 , SD = .39
- changes over time: t(88) = 2.18, p = .032

Another notable observation is that the number of 'don't know' responses dropped from 65 in the first to 19 in the second round. Taken together, it is likely that knowledge of sexual and reproductive health increased by the second data collection point.

The third knowledge scale was the Knowledge of Harmful Sexual Behaviour and Child Sexual Exploitation Scale. The rate of increased knowledge on this scale over time was small:

- first round: M = 1.22, SD = .10
- second round: M = 1.19 , SD = .09
- changes over time: t(85) = 1.51, p = .135(note a mean score closer to one indicates more knowledge here).

Participants during the second data collection round on two items demonstrated significantly improved knowledge compared to the first time. These were:

1. 'All young people who sexually abuse children continue abusing children as adults. '
    - first round: M = 1.32, SD = .47
    - second round: M = 1.12 , SD = .33
    - changes over time: t(92) = 2.19, p = .031

2. 'A 13-year-old acting out sexualised behaviour on a 6-year-old is normal sexual behaviour.'

- first round: M = 1.12, SD = .32
- second round: : M = 1.00 , SD = .00
- changes over time: t(92) = 2.10, p = .039

This second statement was correctly answered by all participants in the second data collection point but not in the first.

Comfort and self-efficacy to develop more caring relationships:

Level of comfort and confidence around sexual topics was evaluated using the Sexual Communication Comfort Scale. No difference was observed on this scale over time. This scale did not closely map the key topics addressed in the program, which likely contributed to the lack of change found between the two data collection points.

Significantly increased levels of skills and comfort to discuss sexual topics with young people were reported in the second round, compared to the first, as assessed by the modified language Sexual Intervention Self-Efficacy Questionnaire. Every item on this scale showed increased levels of self-efficacy over time. Three subscales were created using this questionnaire:

1. comfort and bias self-efficacy, which measured self-reported levels of comfort and bias towards responding to young people's sexual concerns;
2. skill self-efficacy, which measured self-reported levels of skill around techniques and interventions appropriate to responding to young people's sexual concerns; and
3. information self-efficacy, which measured self-reported skills to educate young people about sexual concerns and issues.

Perception of skill self-efficacy was significantly improved by the end of the program compared to the start:

- First round: M = 4.11 , SD = .85
- Second round: M = 4.68, SD = .60
- Changes over time: t(89) = -3.45, p = .001

Perception of comfort and bias self-efficacy also significantly increased by the second round compared to the first:

- first round: M = 4.47 , SD = .69
- second round: M = 4.80, SD = .62
- changes over time: t(87) = -2.19, p = .031.

Perception of information self-efficacy did not significantly change over time, although a trend in the increased skill direction was observed

- first round: M = 4.56, SD = .87
- second round: M = 4.89 , SD = .66
- changes over time: t(90) = -1.91, p = .059

Overall, although some of the workers did not participate in both the pre and post surveys due to workplace turnover, an improved knowledge and skill trend was observed over time. This increase was small albeit prevalent across all knowledge and skill measures.

The data from the survey indicates that participants' level of comfort discussing sexual topics remained unchanged. However, the qualitative data strongly indicated an improvement in comfort levels. The scale used to measure comfort levels was borrowed from another research project and did not adequately reflect the content of *Power to Kids: Respecting Sexual Safety*.

Lastly, residential carers exhibited slightly less knowledge of child sexual abuse, child sexual exploitation, harmful sexual behaviour and sexual and reproductive health compared to managing and clinical staff; however, small improvements between the two time points was observed across all three groups.

Discussion

Reducing risk

The qualitative and quantitative results of the evaluation indicate that the *Power to Kids: Respecting Sexual Safety* program is promising to effectively prevent and respon to the risk of harmful sexual behaviour, child sexual exploitation and dating violence. In terms of outcomes, the evidence suggests that the program was successful in reducing the level of risk associated with HSB, CSE and DV. However, it appeared that the risk levels associated with sexual exploitation were more dynamic than those associated with HSB and DV in that attempts to exit young people from exploitation had to be made repetitively as they were drawn in and out of exploitative relationships.

This observation about risk levels is in keeping with the evidence base, which indicates that most young people with HSB do not reoffend (Carpentier & Proulx, 2011; Chaffin, 2008), especially if they have received treatment, whereas young people who are sexually exploited often do not recognise themselves as victims and may resist intervention in what they may think of as normal relationships (Gilligan, 2016; McKibbin & Humphreys, 2019).

Part of the reduction in risk levels for HSB, CSE and DV relate to the improved ability of carers to identify the three forms of sexual abuse and to seek an appropriate response, involving collaboration with MacKillop practitioners, DHHS workers, police and HSB treatment services. As a result of increasing carers knowledge to identify risk factors and red flags for HSB, CSE and DV, they were able to respond and seek support more efficiently and quickly, and with the appropriate language.

Stronger relationships

Establishing strong relationships with local sexual exploitation practice leaders and HSB treatment service clinicians appeared to be important to respond to young people at risk of CSE and HSB. This need for multiagency collaboration is no surprise and has been recognised as important to countering child sexual abuse for at least the past two decades (Fargason et al., 1994; Sharp-Jeffs, Coy & Kelly, 2017).

It is essential that agencies work together using a trauma-informed approach to intervene in HSB and CSE and to provide pathways for young people out of abuse into pro-social lives. It was encouraging to see some improvement with local police through the pilot as workers reported feeling incredibly powerless in the face of police when children and young people went missing from the home (McKibbin & Humphreys, 2019). However, this aspect of the pilot was not fully developed and more work is needed to engage with police and to support disruptive policing in relation to perpetrators of CSE.

The evaluation revealed some evidence that young people were missing less as a result of the program. Carers and workers suggested that the reduction in going missing did not relate to the program's smart phones and staying in touch by text or social media, but to the improved relationships between carers and young people. However, young people did appreciate having the smart phones and some did indicate that they were staying in touch more, albeit not using social media as much as phone calls and text messages.

Further, the discussion and agreement that was negotiated with young people upon dispensing the phones did allow for a conversation about the safe use of technology, as well as dangers associated with pornography and grooming. Carers were able to refer back to this conversation and the agreement when young people behaved in ways that contradicted the terms of the agreement.

Although the phones did not appear to be a major contributing factor to young people going missing less, the newly-placed focus for carers on staying in touch with young people may have had an impact. However, maintaining a focus on countering the risk factors of going missing from placement is important as it is a significant indicator of sexual exploitation (Beckett, 2011; Jackson, 2014). Further research could be undertaken to trial other initiatives that support young people not to go missing from the home.

The improvement of relationships between carers and young people appeared to emerge from the new appreciation amongst carers of the factors that contribute to sexual exploitation and sexuaised behaviours; and a shift in their practice from focusing on boundaries and rules to a relationship-based softer approach.

Relationships were also enhanced through the brave conversations initiated by carers with children and young people about sexual health and safety issues. The brave conversations were successful in boosting the knowledge of children and young people about sexual health and safety issues, although there appeared to be a disjunction at times between what they knew and how they behaved. Although the brave conversation model set out by Faulkner and Schergen (2016) does not appear to be evaluated in the peer-reviewed literature, the *Power to Kids: Respecting Sexual Safety* pilot indicates that it is a promising trauma-informed approach to educating children and young people living in residential care about sexual health and safety issues.

Confidence and capability to respond to educative opportunities

The 'brave conversations' were underpinned by evidence about sexual health and safety, delivered by the Sexual Health Nurse (Educator) through the champions to the carers. This process of knowledge translation was very successful, and the knowledge of workers increased on a range of sexual health and safety topics. It appears that there was a particular increase in the awareness of children's normal sexual development and an evidence-informed shift away from victim-blaming and shaming language associated with sexual exploitation and sexual behaviours.

The education model used in this intervention capitalised on existing relationships between young people and carers; and upskilled carers' knowledge and confidence in sexual health and safety. As a result, these relationships were strengthened further, resulting in young people to wanting to stay home and stay safe.

The approach of the *Power to Kids: Respecting Sexual Safety* program to upskill carers to have evidence-informed conversations with children and young people differs significantly from other approaches to sexuality education for this cohort in English-speaking jurisdictions, which tend to involve the delivery of group-based sexual health curricula aimed at reducing teenage pregnancy and sexually transmitted infections (Combs et al, 2016; Green et al, 2017).

In contrast to this group-based delivery, the *Power to Kids: Respecting Sexual Safety* approach involved upskilling workers to have conversations with children and young people about sexual health and safety. This approach parallels some work being done in the UK and US. In the UK, Dale and colleagues (2016) found that a one-on-one approach to sexuality education was successful for an out of home care cohort.

Further UK research carried out by Nixon, Elliot and Henderson (2019) found that carers regularly had discussions with young people about sexual health and safety and that they required further support to increase carers' comfort and confidence levels. In the US, Colarossi and colleagues (2019) developed and evaluated a multisystemic approach to sexual health education for young people in care that involved training workers and embedding sexual health education in policy and practice. Unlike the *Power to Kids: Respecting Sexual Safety* intervention, there did not appear to be a coaching element, but the results from the pilot indicate that intervention is promising.

The *Power to Kids: Respecting Sexual Safety* trial led to significant improvement in the confidence and self-efficacy of carers to have evidence-informed conversations with children and young people about topics that were previously avoided. This increased comfort and confidence, combined with the whole-of-house approach, meant that carers were not shying away from conversations that were previously thought to be inappropriate. Strong leadership was required through the program and senior MacKillop staff members to create a safe place for carers to have these kinds of discussions without feeling vulnerable to accusations of 'inappropriate contact; with children and therefore facing investigation. This need for strong leadership is reflected in recent Respectful Relationships Education in Schools' evaluation research, which pointed to the importance of strong leaders acting as cultural change agents (Kearney et al., 2017).

In terms of implementation, it was evident that from the perspective of the carers and other MacKillop staff, that the champion's model worked well. This approach to implementation, whereby an element of coaching is involved, has been found to be more effective than when practitioners are simply trained or given information (Fixsen et al., 2005).

What may not have come through so strongly in the qualitative data was the significant investment of resources to build the organisational readiness to fully implement the program. It was essential to have the systems in place to support the prevention strategies. For example, case managers needed to understand the complexities of the program so they could communicate with care teams, and managers needed to find funds or space in rosters to enable residential carers to participate in training and coaching sessions. The implementation science approach set out by Fixsen and colleagues (2005) and adopted by the research team placed a good deal of emphasis on program installation and initial implementation phases, creating organisational readiness.

Our evaluation research indicated that further organisational readiness was required to embed the implementation of *Prevention Strategy 3: Sexual safety response*. It appeared that although the practice associated with the strategy was being undertaken, there was confusion about the roles and responsibilities of different workers and of the processes to identify abuse and refer to clinical staff.

Prevention Strategy 3: Sexual safety response needs to be more fully ingrained in organisational policy and practice as the program is implemented across residential care services. This is not necessarily surprising given the complex nature of the environment in residential care services, which is often crisis-driven and in which practitioners are responding to highly traumatised young people with challenging behaviour issues (Bollinger, 2017; Moore, McArthur & Death, 2019).

It was also important that the implementation of the program took an iterative approach. This meant that as issues arose like the 'triggering' of a young person who had been sexually assaulted in the past, the research team could work closely with the operations team to find solutions. This meant that changes to the program were incorporated as various challenges arose. The action research methodology adopted for the program implementation and evaluation (Graham & Tetroe, 2009) enabled for this kind of iterative approach and for strong engagement of the research team with MacKillop workers. This adopting of a 'learning system' approach created an implementation environment where knowledge was generated and shared throughout the pilot, and the researchers were not constructed as experts, but rather as co-learners in the process.

Findings and recommendations

Overall program

Finding	Recommendation
The evaluation found that the three prevention strategies were mutually constitutive	The three strategies should be implemented as part of a single program
The program appears promising in preventing and intervening early in HSB, CSE and DV	The program is upscaled across MacKillop residential care and made available to other community service organisations

Prevention Strategy 1: Whole-of-house respectful relationships and sexuality education strategy

Finding	Recommendation
The Sexual Health Nurse (Educator) role was fundamental to the implementation of the program	The Sexual Health Nurse (Educator) role is funded to undertake all aspects of Prevention Strategy 1 across residential care
The Champion's model worked well in the implementation of Power to Kids: Respecting Sexual Safety program	The Champions model is retained, with the Sexual Health Nurse (Educator) coaching the champions who then coach carers and two champions are trained for each house to address the situation where a champion leaves a house or is moved unexpectedly
Children and young people may become distressed by some of the content, especially if they have been victims of child sexual abuse	A safe space is always created before undertaking activities with carers or children and young people
Carers confidence and self-efficacy in talking about sexual health and safety issues with children and young people improves through the brave conversation model	All carers are upskilled in having brave conversations about sexual health and safety and have those conversations with children and young people
Young people may prefer to be spoken with by a worker of a particular gender or a worker they are close to	Young people's wishes to be spoken to by a particular gender or person, or not to discuss a particular topic, are respected

Finding	Recommendation
Carers and house supervisors are less knowledgeable about sexual health and safety issues than clinicians and managers	Particular focus is placed on improving the knowledge, confidence and skills of carers and house supervisors
Carers need a strong authorising environment to help them to feel comfortable and confident in having sexual health and safety conversations with children and young people	Strong leadership is provided by senior management to create an authorising environment to support brave conversations

Prevention Strategy 2: Missing from home strategy

Finding	Recommendation
Providing phones to young people provided carers with an opportunity to have conversations about the safe use of technology	Carers should use the provision of phones to young people as an opportunity to initiate a conversation about the safe use of technology and the importance of staying in touch when away from the home
Young people did not always want to communicate with carers using social media	Young people provided with phones should be asked how they would prefer to be communicated with by carers – social media, text messages or phone calls
The quality of relationships between carers and young people improved through the brave conversations model and this protected them from going missing	Further initiatives should be trialled and evaluated to improve relationships between carers and young people

Prevention Strategy 3: Sexual safety response

Finding	Recommendation
At times there was confusion about the roles and responsibilities associated with Prevention Strategy 3	Exit practice and therapeutic responses to HSB an DV should be fully embedded across MacKillop and in Child Protection practice
Prevention Strategy 3 was more difficult to implement with children and young people who were not case managed by MacKillop	Communication is improved with DHHS case managers working with young people for whom case management is not contracted to MacKillop to improve responsiveness and timely decision-making
Prevention Strategy 3 worked best when carers identified HSB, CSE and DV and made a referral to MacKillop clinicians, and when clinicians informed carers on the steps that were being taken	Strong emphasis is placed on assisting staff to identify the red flags associated with HSB, CSE and DV, and a process is put in place to ensure clinicians feed back to carers the response that was taken to address the HSB, CSE or DV

Evaluation

Finding	Recommendation
The evaluation did not include monitoring the upscale of the program	Ongoing attention to action research is supported to continue evaluating the three prevention strategies as they are upscaled
The brave conversations model appeared to be a promising approach to respectful relationships and sexuality education for children and young people living in residential care	Further action research should be commissioned to confirm the success of respectful relationships and sexuality education using a relationship-based approach
The Sexual Communication Comfort Scale was not helpful for capturing the increase in the comfort of carers to discuss sexual health and safety issues with children and young people, which was evident from the qualitative data	The use of the Sexual Communication Comfort Scale is ceased, and a new scale is designed, developed and validated to measure the comfort levels of carers having brave conversations

Finding	Recommendation
The relationships between carers and children and young people were enhanced through the program and this appeared to be protective against HSB, CSE and DV	A scale is included to measure improvement in relationships between carers and young people to explore this outcome more fully
The MacKillop monitoring data and Critical Incident Report data could not easily provide a meaningful picture of the rates children and young people were missing from home	A system is established to monitor the rates of children and young people going missing and to detail how long they are spending away from the home for what purpose

Multiagency working

Finding	Recommendation
Exit practice targeting CSE worked best when accompanied by disruptive policing	Further collaborative initiatives focusing on intervening in CSE, including disruptive policing and therapeutic outreach, should be trialled and evaluated
The state-wide therapeutic response to HSB seems to be more fully developed than the therapeutic response to CSE	Sexual assault services or Sexually Abusive Behaviour Treatment Services are funded to develop and deliver therapeutic services to young people who are being sexually exploited including outreach, in addition to the therapeutic treatment service for harmful sexual behaviour

Conclusion

The *Power to Kids: Respecting Sexual Safety* project has been a successful action research initiative that aimed to co-design, implement and evaluate a program to prevent and intervene early to the problems of harmful sexual behaviour, child sexual exploitation and dating violence for children and young people living in residential care.

The findings of the evaluation demonstrate that the program is promising to effectively prevent and respond to these three forms of sexual violence. Of particular interest is the importance of one-on-one relationship-based prevention conversations for this cohort. It is fundamental that Australian federal and state governments invest in innovative initiatives such as *Power to Kids: Respecting Sexual Safety* to protect the children under their care from sexual abuse.

The issue of children missing from placement continues to be a significant issue in residential care. This evaluation found evidence that practice development focused on building relationships between residential care staff and children did assist in addressing this problem. Further researchshould focus on relationship-based prevention for children and young people in out of home care.

Appendix A: Evaluation Measures

Activities	Indicators of success	Data collection methods	Who/when
Prevention Strategy 1 – Whole-of-house respectful relationships and sexuality education	**Process** The training session is delivered to residential staff, case managers and coordinators at four MacKillop pilot houses and in 20 foster care families		
	Outcome At least 70% of workers report an increase in their level of confidence to respond to sexual health and safety issues	Feedback sheet and Sexual Communication Comfort Scale (Millers & Byer, 2008)	Researcher to administer at the end of training session
	Process A whole-of-house respectful relationships and sexuality education is successfully implemented in four pilot houses		
	Outcome Children & young people's knowledge, skills and attitudes about sexual health and safety improve	Interviews with children & young people with embedded Student Knowledge, Attitudes and Skills survey from RREiS Final Report and the Questionnaire on Child Sexual Abuse (Halperin et al., 1996)	Researcher to undertake pre- and post-implementation
	Outcome Workers have increased self-efficacy responding to HSB, CSE and DV	Focus groups with workers and Sexual Intervention Self-Efficacy Questionnaire (Miller & Byers, 2008)	Researcher to undertake pre- and post-implementation
	Outcome Workers have increased knowledge about HSB, CSE and DV	Focus groups with workers and Child Sexual Abuse Knowledge Questionnaire (Goodman-Delahunty, Martschuk, & Cossins, 2017) Knowledge of HSB and CSE scale (under development by research team)	Researcher to undertake pre- and post-implementation

Prevention Strategy 2 – Missing from home strategy	**Process** Missing from home strategy is successfully implemented in four pilot houses		
	Outcome Children & young people are missing from home less often	Analysis of Incident Report and daily data collected by MacKillop residential staff (Verso data)	Researcher to undertake pre- and post-implementation
	Outcome Children & young people are at decreased risk of HSB and CSE	Analysis of Incident Report daily data collected by MacKillop residential staff (The Carer's Phone data)	Researcher to undertake pre- and post-implementation
Prevention Strategy 3 – Sexual safety response	**Process** A sexual health & safety response is successfully implemented in four pilot houses		
	Outcome Workers are identifying HSB and ensuring advocacy and treatment	File analysis of case planning and review documents and day sheets	Researcher to undertake throughout duration of implementation
	Outcome Workers are undertaking safety planning with children & young people	File analysis of case planning and review documents and day sheets	Researcher to undertake throughout duration of implementation

Appendix B: Interviews with children and young people

Engagement questions

Materials: plasticine, putty, paper, connector pens

Approach: My aspect, your aspect; young person as expert in their own life and experience

Thank you for meeting with us today. My name is Gemma and this is Maddie. Maddie used to live in residential care and she is here to help us talk about some work that is being done in your house at the moment. The work is about three things: harmful sexual behaviour; child sexual exploitation; and dating violence. We will explain what these things are as we go and ask you what you think about them.

1. First, we are going to start with three scenarios. Maddie will read them for us and then we will have a talk about who is in the right and who is in the wrong (adapt language to make more appropriate for 10-12 year olds where necessary).

Scenario one

A fourteen-year-old boy makes his eight-year-old sister watch pornography and then acts it out on her. The girl is very upset but her brother says that he will hurt her if she tells their mum.

Scenario two

A 30-year-old man gives a fifteen-year-old young person cigarettes and alcohol in exchange for sex. The young person thinks they are in love with the man and wants to leave their resi home to live with him. The young person often runs away from the home to spend time with the man. Last time the young person was at the man's house he asked the young person to have sex with his brother. She didn't want to, but he said the young person should do it because they love him.

Scenario three

A sixteen-year-old girl and a sixteen-year-old boy are in a relationship. They have sex and take nude photos of each other. The girl meets another boy who she really likes and breaks up with her boyfriend. The ex-boyfriend is very angry and posts the nude photos of the girl on Facebook saying she is a slut.

Who is in the right and who is in the wrong?

1. In our language, we call the first scenario 'harmful sexual behaviour', the second scenario 'child sexual exploitation' and the third scenario 'dating violence.' Is this how you see these scenarios? Do you have other language that you would use to describe what is happening in the scenarios?
2. 3. Do you think you could identify if these things were happening to you or to those around you?
3. If we wanted to help you to be able to recognise these things in your own life or in the lives of those around you, what would be helpful to you? (Exit practice; HSB response; dating violence response – Prevention Strategy 3)

4. If you were experiencing any of these things in your own life, what would you like to happen? Would you want help? What kind of help? Who could be helpful? What would they say? How would they talk to you? (Education-brave conversations – Prevention Strategy 1)
5. With child sexual exploitation, one of the red flags for us is when young people go missing from the house. We are keen to work our ways to stay in touch with young people when they leave the house. Most young people have smart phones these days. Can we use social media to help young people stay in touch with carers so that the young people can let carers know they are safe (or not)? What would that look like? (Missing form home strategy – Prevention Strategy 2)
6. We are interested to know if you would like to be part of a group with other children and young people to learn how to be a young consultant to government and to MacKillop. Maddie did this when she was at Berry Street (Maddie to talk about her experience as a young consultant). If you would like we can set up a time to meet with other young people who are interested in having their voices heard.

Evaluation questions

1. Through the *Power to Kids: Respecting Sexual Safety* program, we have been trying to help children & young people know more about safe relationships and what to do if they are not safe. Can you tell me a bit about what it has been like to talk with the Sexual Health Nurse (Educator)?
2. What did you think about the Charter of Rights for all children & young people living in care (show copy)? (Rights of children & young people)
3. I think that your carer has been talking about safe relationships. Can you tell me a bit about what you think a safe relationship is? (Respectful Relationships & love)
4. It is very sad but lots of children & young people have experienced situations where they are hurt by adults or other children & young people, even people they love. It would be good if you could tell me about what you would do if you found out that one of your friends was being hurt. (Disclosure and informed friend)
5. Sometimes it can be hard or embarrassing to talk about stuff to do with love and sex but it is also really important that children & young people know what is normal and what they are allowed to do. Please could you say something about the rules of age and consent? (Normal sexual development; Age & consent)
6. What about stuff to do with your body like the proper names for your private parts and girls get pregnant? (Sexual health)

Offer break and food

7. One of the things that we really wanted children & young people to learn is about grooming. Grooming is when an adult or more mature young person gives a child or young person a gift, drugs, alcohol, money and makes them get involved in sexual stuff. Is that something that you have learned about and how could that information help keep you safe? (Grooming and abuse)

8. You have been partnered up with Carer to stay in touch using an Oppo phone when you are our of the house. How has that been working out? Do you find it OK to stay in touch using text messages and Facebook?
9. We have talked about what it means to be a girl or a boy and how we are sometimes expected to act like a "girly girl" or a "blokey bloke." What do you think about the idea that girls and boys are equal? (Gender stereotypes and diversity)
10. Sometimes abuse can happen online. This means that children & young people can be using social media like Facebook or Instagram and they can be contacted by abusive adults. How could you recognise a person who is trying to hurt you online? (Online sexual safety)
11. (For 13 years plus) The last thing I am going to ask you about is pornography. It can be hard to talk about but there is so much pornography on the internet now. It can make you think that it is normal for men to hurt women and girls. How has the porn free zone been working out in your house? (Pornography and porn free zones)

Thank you for coming along today. It is great to hear your ideas for this project.

Bear cards to close and contain

Engage children and young people in an opportunity to choose a Bear Card that represents how they are feeling after participating. The participants are welcome to explain why they chose that card. Acknowledge any negative feelings that are shared and support resolution of these feelings with exploration of what helps the child to feel better. Discuss how participants may wish to do a nice activity following their participation in the interview today and provide opportunity for children to share what that activity might be. Ensure any necessary support.

Appendix C: Feedback session questions for Champions

1. Please tell me about your role in the *Power to Kids: Respecting Sexual Safety* project.
2. How is the whole-of-house approach going? Culture, leadership, teaching & learning, community partnerships, support? Sanctuary? Porn-free/non-toxic gender zones?
3. Was *Power to Kids: Respecting Sexual Safety* discussed during reflective practice or at team meeting?
4. How did you pass the info on to other carers and influence them?
5. What was the topic for this fortnight? Was there an activity? Who did the activity?
6. Please describe a BRAVE conversation you have had this fortnight or one that you overheard or were told about. How did the ANSWER model go?
7. Have any consults been requested from Sexual Health Nurse (Educator) this fortnight? Were they helpful?
8. Have any Consult referral Forms been sent to PPs about PSB, CSE or dating violence?
9. Have there been any issues with the Oppo phones?
10. Do you see any impact on the house of the RSS project? Is there any interaction between the strategies? That is, is the education/BRAVE conversations helping with exit or with desistance from PSB or not carrying out dating violence or being a victim of dating violence? Think about individual young people and also carers.

Appendix D: Interview schedule for workers

1. In general terms, how have the prevention strategies been working out in your house/home?
2. Let's talk through each prevention strategy in turn. With the *Whole-of house sexuality and respectful relationships education,* how has this impacted on your **knowledge** of, and **confidence** in responding to, Harmful Sexual Behaviour, Child Sexual Exploitation and Domestic & Family Violence? What about your knowledge and confidence in responding to reproductive health issues like contraception, pregnancy and sexually transmitted diseases?
3. Please tell me a bit about how the whole-of-house approach is structured in your house/home? For example, who is the leader of the approach and how does it fit in with the general routines of life in the house/home?
4. How have the children & young people taken to the education approach? Have you noticed changes is their behaviour or understanding of abuse?
5. What challenges have arisen in the delivery of the whole-of house sexuality and respectful relationship education? How is the Nurse Practitioner and Life Story Work therapist working out?
6. Let's move on to discuss Prevention Strategy 2, the Missing from home strategy. How are the practice partnerships involving social media working out?
7. Have you noticed any change in children & young people being missing from the house/home?
8. What kind of support or contact have you had through the Enhanced Response Model – for example, reporting children & young people as missing and liaising with the Child Sexual Exploitation Practice Leaders.
9. And thinking about Prevention Strategy 3, the Sexual safety response, how are you going with the early identification of Harmful or Problematic Sexual Behaviour?
10. Are you able to get the support and treatment from your local Sexually Abusive Behaviour Treatment Service? How are you getting involved in that treatment as the child or young person's carer or worker?
11. What about supporting exit strategies for children & young people living with sexual exploitation – have you been able to assist any out of the exploitative situation and how have you done this?
12. Is there anything else you want me to know about how the prevention strategies are working out in your house/home?

Interview questions for House Supervisors and Case Managers

1. Please tell me about your role in the *Power to Kids: Respecting Sexual Safety* project?
2. Who is currently in the house and who has moved? (think YP and staff)
3. House supervisors are responsible for *Prevention Strategy 2*, the *Missing from home strategy*. How are the Oppo phones going? Are there ongoing conversations about the purpose of the phone?

4. Are children and young people being partnered with a key worker?
5. Thinking about each child or young person, what is the quality of relationship with their key worker? Do they stay in touch with the key worker?
6. Is social media being used creatively to support young people to stay in touch with the house? Are young people missing less often? Do you have to put in a missing person report if you are in touch with a young person on social media?
7. How is the relationship with the local police going?
8. Are carers and young people engaging in any activities provided by Sexual Health Nurse (Educator)?
9. How is the Champions model of working going? Are other carers picking up how to have BRAVE conversations about the 10 topics?
10. Please give me an example of a BRAVE conversation that you have had or heard happen.
11. Have you made any referrals to the PPs about PSB, CSE or DV?
12. Are the safety plans being used with CYP for PSB, CSE or DV?

Interview questions for PPs and TP

1. Please tell me about your role in the *Power to Kids: Respecting Sexual Safety* project.
2. The principal practitioners are responsible for overseeing *Prevention Strategy 3*. How are the Consult Referral Forms going? Are they being discussed at Client Update Meetings?
3. Is problematic sexual behaviour being identified by carers using the schema and how are you responding to the PSB? Are you liaising with Gatehouse or SECASA?
4. How is the *Exit practice* going? What are the barriers and facilitators for the *Exit practice*? Are you liaising with care teams and the sexual exploitation practice leaders? Any circuit breakers? Family engagement?
5. How is the dating violence therapeutic response going? Is medium-term therapeutic work and psycho-education being undertaken with victims and YP using violence?
6. Are you using the safety plans for PSB, CSE or DV?
7. Can you tell me an example of successful PSB, *Exit* or dating violence practice? Can you tell me an example of what didn't go so well?
8. Is there anything else you want to tell me about how the RSS program is going?

Interview questions for managers and directors

In this focus group we are going to talk about two things: the process of implementing the RSS program and the outcomes that we are seeing from the program. Let's start with outcomes first.

1. Are you seeing any evidence that children and young people's knowledge and skills about sexual health and safety have improved?
2. Are you seeing any evidence that workers (carers, TPs, CMs) are feeling more confident responding to HSB, CSE and DV? Having more brave conversations?

3. Are you seeing any evidence that workers have increased knowledge about HSB, CSE or DV? Having more evidence-informed conversations?
4. Have you noticed any changes in the instances of children and young people going missing from home or the way staff are managing when they are missing? For example, staying in touch more? Has there been any improvement in relationship with local police?
5. What about collaboration with the sexually abusive behaviour treatment services and the management of HSB in the houses?
6. Have you noticed an improvement in exiting children and young people from sexual exploitation? What is working? What needs more attention?
7. What about dating violence – have you noticed workers and young people identifying dating violence more?
8. Thinking about implementation now, how do you think the champions model has worked for *Prevention Strategy 1*? Do we use this model moving into the upscale?
9. Who should have oversight of *Prevention Strategies 2 and 3* moving into the upscale?
10. What barriers emerged over the course of the pilot and how were they resolved?
11. Is MacKillop organisationally ready to upscale the program? If not, what needs to happen to assist readiness? Facilitators of readiness?
12. How could the role of the Sexual Health Nurse (Educator) be used most productively as we upscale?
13. What other issues would you like to raise from the point of managers and directors?

Appendix E: Questionnaire for workers & carers

Name_____

House name _____

Date _____

Role (residential staff/case manager/etc.) _____

Gender _____

Part A - (Source: Goodman-Delahunty, Martschuk, & Cossins, 2017, Child Sexual Abuse Knowledge Questionnaire)

Here are some general statements on child sexual abuse. Do you rather agree or rather disagree with these statements?

		Strongly agree 1	Somewhat agree 2	Neutral (neither agree/ disagree) 3	Somewhat disagree 4	Strongly disagree 5
1	Children who are sexually abused display strong emotional reactions afterwards					
2	A child victim of sexual abuse will avoid his or her abuser					
3	Children sometimes make false claims of sexual abuse to get back at an adult					
4	Children aged 7-8 years are easily manipulated to give false reports of sexual abuse					
5	Children are easily coached to make false claims of sexual abuse					
6	A medical examination almost always shows whether or not a child was sexually abused					
7	Repeating questions such as: 'What happened? What else happened?' leads children to make false abuse claims					
8	Child victims of sexual abuse respond in a similar way to the abuse					
9	A sexually abused child typically cries out for help and tries to escape					

Part B – (Source: Miller & Byers, 2008, Sexual Communication Comfort Scale)

Please indicate how you feel about another person talking to you about each of the following topics.

		I feel extremely comfortable about it	I feel comfortable about it	I feel somewhat comfortable about it	I feel neutral about it	I feel somewhat uncomfortable about it	I feel uncomfortable about it	I feel extremely uncomfortable about it
		1	2	3	4	5	6	7
10	Using masturbation as a form of sexual outlet							
11	Mutual masturbation with someone of the opposite sex (an affectionate and tender relationship between the partners is assumed. It is also assumed that there is no danger of a sexually transmitted disease)							
12	Mutual masturbation with someone of the same sex (an affectionate and tender relationship between the partners is assumed. It is also assumed that there is no danger of a sexually transmitted disease)							
13	Sexual intercourse with someone of the opposite sex (an affectionate and tender relationship between the partners is assumed. It is also assumed that there is no danger of a sexually transmitted disease)							

14	Oral-genital stimulation with someone of the opposite sex (an affectionate and tender relationship between the partners is assumed. It is also assumed that there is no danger of a sexually transmitted disease)							
15	Oral genital stimulation with someone of the same sex (an affectionate and tender relationship between the partners is assumed. It is also assumed that there is no danger of a sexually transmitted disease)							
16	Engaging in sex with a partner in the presence of others							
17	Three or more people engaging in intercourse and other sexual activity together							
18	Maintaining more than one sexual relationship at a given time							
19	The woman in a heterosexual relationship being the more aggressive partner at times							
20	Using erotica (erotic literature, pictures, films, live sex shows) to stimulate sexual arousal							
21	Intercourse during the menstrual flow							

Part C – Modified language (Source: Miller & Byers, 2008, Sexual Intervention Self-Efficacy Questionnaire)

The following questionnaire asks about your thoughts and feelings concerning your CURRENT ability to work with sexuality issues. Please indicate the degree to which you agree/disagree with each statement on the following scale:

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
		1	2	3	4	5	6
22	I have very little knowledge of the interventions used to respond to sexual health and safety issues						
23	There are issues related to sexuality that I would not feel comfortable talking to a child or young person about						
24	I am unfamiliar with the techniques used to intervene with children or young people who have sexual concerns/problems						
25	If a child or young person told me that they were having a sexual problem I would refer them to another worker						
26	I am fairly certain that my own biases will not hinder my ability to effectively respond to children & young people who have sexual concerns/problems						
27	I know some techniques that can help young people who are having sexual problems.						
28	I am able to teach children & young people specific skills to deal with their sexual concerns/problems						
29	I think that it would be best to refer a child or young person if they had a sexual concern/problem						
30	I will be able to respond to children & young people with sexual problems even when I don't necessarily agree with their decisions/actions						

31	Sexual dysfunction is something that I do not know how to respond to						
32	I worry that I would seem uncomfortable if a child or young person talked to me about masturbation						
33	I would probably do more harm than good if I tried to work with a child or young person who had a sexual concern/problem.						
	I am confident that I can relay accurate information to children & young people about:						
34	Sexual orientation/identity issues						
35	Sexual violence						
36	Sexual dysfunction and problems						
37	Sexually Transmitted Diseases						
38	Conflict over sexual issues in relationships (e.g. differing sex drive)						
39	Sexual issues in childhood						
40	Childhood/adolescent sexual development						
41	Reproductive health						

Part D - Knowledge about Harmful Sexual Behaviour and Child Sexual Exploitation Scale (Bornemisza & McKibbin, unpublished)

Here are some general statements about Harmful Sexual Behaviour and Child Sexual Exploitation: Are these statements true or false?

Here, children are defined between 0-12 years old, and young people between 13-18 years old.

		True 1	False 2	Don't know 3
42	It is normal for children of all ages to have some sexual feelings.			
43	All young people who sexually abuse children continue abusing children as adults.			
44	Adults showing pornography to young people is part of normal sexual education.			
45	Boys are more likely to touch the genitals of a younger child than girls.			
46	Some adults give children & young people something (like money, alcohol or drugs) in exchange for sex.			
47	Young people who run away from home are not at risk of being used sexually.			
48	In dating relationships between young people, one partner can be used sexually by the other partner.			
49	A 12-year-old masturbating in public is normal sexual behaviour.			
50	Watching sexual images (pornography) is linked with acting out sexually.			
51	Only girls can be used sexually by adult men.			
52	It is OK for someone under 18 years old to be in sexual relationships with an adult five years older if they are in love.			
53	Drinking alcohol increases children and young people's risk of being sexually used.			
54	A 13-year-old acting out sexualised behaviour on a 6-year-old is normal sexual behaviour.			
55	Children and young people who experience domestic & family violence are at risk of being sexually used.			

Part E – Knowledge of sexual and reproductive health scale (McKibbin & Bornemisza, unpublished)

Here are some general statements about safe sexuality and reproductive health: Are these statements true or false?

		True 1	False 2	Don't know 3
56	Equality between partners is important for creating respectful relationships.			
57	Children & young people have the right to have their opinions considered when adults are making decisions about them.			
58	Menstrual blood is discharged from the urethra.			
59	Testicles sit inside the scrotum.			
60	Girls don't get their periods until they are 12.			
61	Conception happens when a sperm meets another sperm.			
62	Lesbians cannot get sexually transmitted diseases (STIs).			
63	People who use condoms are safe from all sexually transmitted diseases (STIs).			
64	Girls can't get pregnant if they are "on the pill".			
65	A girl can get pregnant from having sex without a condom while having her period.			
66	It is illegal for a young person to have sex under the age of 18.			
67	Children as young as 10 years can face charges for sexual offences.			

Appendix F: Disclosure protocol

Adapted from Moore, T., McArthur, M., Roche, S., Death, J., & Tilbury, C. (2016). *Safe and sound: Exploring the safety of young people in residential care.* Melbourne: Institute of Child Protection Studies, Australian Catholic University. Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney.

Disclosure	Questions	Action/s
Disclosure of child sexual abuse victimisation	1. Stop the interview 2. Acknowledge the disclosure 3. Give the child or young person your full attention. • Maintain a calm appearance. • Don't be afraid of saying the "wrong" thing. • Reassure the child or young person it is right to tell. • Accept the child or young person will disclose only what is comfortable and recognise the bravery/strength of the child for talking about something that is difficult. • Let the child or young person take his or her time. • Let the child or young person use his or her own words. • Don't make promises you can't keep. • Tell the child or young person what you plan to do next. • Do not confront the perpetrator. 4. Assess the nature of the abuse - 'Do you mind telling me when this happened?' - 'Is this person still in your life?' - 'Are you still in danger of experiencing abuse?' - 'Have you got help as a result of your harm?' - 'What do you need to keep safe?'	If the abuse has occurred in the past, there is no threat of ongoing abuse AND the young consultant is getting support no action may be required If the abuse has occurred in the past but there has been no action taken and others are at risk, action should be taken through making a report to Victoria Police and Child Protection If the abuse is ongoing, take action in collaboration with young consultant: • ensure that the young consultant is safe and work with them to make arrangements to keep themselves safe • make a report to Victoria Police Negotiate with the young consultant: • whether they would like to be involved in making a report • who they would like to tell so that they can get support and be protected from potential abuse • whether they would like help to get support from a sexual assault service
Disclosure of child sexual abuse perpetration	1. Stop the interview 2. Acknowledge their disclosure 3. Remind them that you have a duty to report concerns for the safety of others	If the abuse has occurred in the past, there is no threat of ongoing abuse AND the young consultant has received treatment for harmful sexual behaviours, no action may be required If the perpetration of child sexual abuse is ongoing, take action: make a report to Victoria Police, refer the young consultant to an adult sex

	4. Assess: - Are you concerned about the imminent safety of others?	offender programs and report the identities of victims to Child Protection
Disclosure of domestic or family violence	1. Stop the interview 2. Acknowledge the disclosure 3. Assess the nature of the abuse - 'Do you mind telling me when this happened?' - 'Is this person still in your life?' - 'Are you still in danger of experiencing abuse?' - 'Have you got help as a result of your harm?' - 'What do you need to keep safe?'	If the abuse has occurred in the past, there is no threat of ongoing abuse AND the young consultant is getting support no action may be required If the abuse has occurred in the past but there has been no action taken and others are at risk, action should be taken through making a report to Victoria Police and Child Protection, and a referral to a domestic violence support service If the abuse is ongoing, take action in collaboration with young consultant: • ensure that the young consultant is safe and work with them to make arrangements to keep themselves safe • make a report to Victoria Police If the abuse is being perpetrated by the young consultant, consider referral to an Adolescent Family Violence program or Men's Referral Service Negotiate with the young consultant: • whether they would like to be involved in making a report • who they would like to tell so that they can get support and be protected from potential abuse • - whether they would like help to get support

Appendix G: Distress protocol

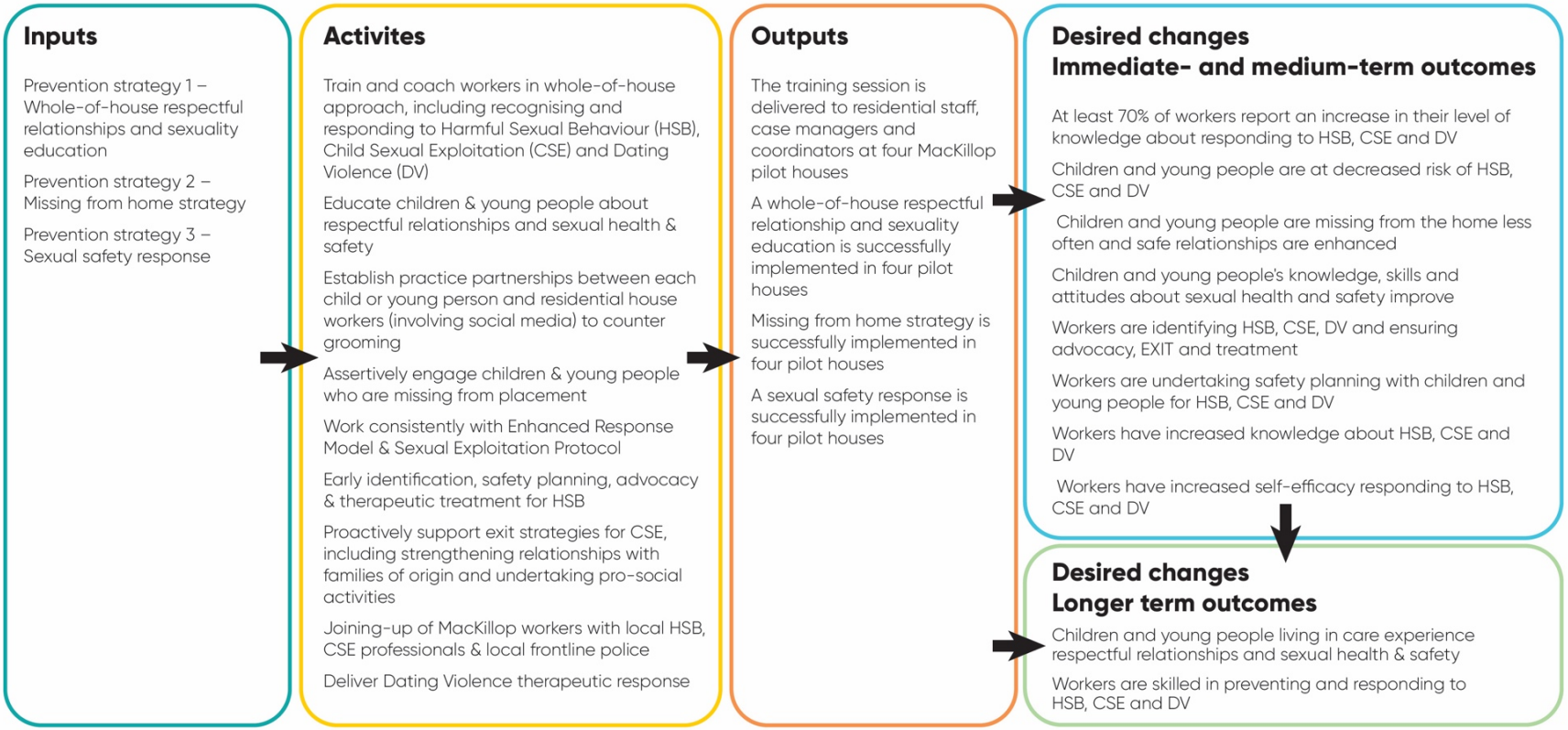
Adapted from Moore, T., McArthur, M., Roche, S., Death, J., & Tilbury, C. (2016). *Safe and sound: Exploring the safety of young people in residential care.* Melbourne: Institute of Child Protection Studies, Australian Catholic University. Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney.

Indications of distress	Questions	Action/s
Display signs of distress or upset (crying, shaky voice) during the interview	1. Stop the interview 2. Acknowledge the emotion 3. Offer support and allow them to 'regroup' 4. Assess their status: - 'What's going on for you?' - 'What feelings are you having?' - 'Do you feel you are able to go about your day?' - 'Do you feel safe?' 5. Offer options: - 'What do you want to do? Did you want to wrap it up here or stop for a bit or keep going?'	IF the young consultant is quite distressed or upset the interview should be halted. 'I'm worried about you. The interview seems to have brought up some tough emotions for you and I want to make sure that you're going to be OK.' 1. Remind the young consultant you have a responsibility to act 2. Identify who to best inform and what other actions might be necessary (in negotiation with young person) 3. Act (support, refer, report) 4. Report situation to Director of Policy and Research 5. Facilitate debrief with Nurse 6. Follow up with a phone call or visit to the young consultant
Indicates that they are thinking of hurting themselves during the interview	1. Stop the interview 2. Express concern 3. Assess situation: - 'What thoughts are you having?' - 'Do you intend to harm yourself?' - 'How do you intend to harm yourself?' - 'When do you intend to harm yourself?' - 'What do you need so that you won't harm yourself?' 4. Determine if the person is in imminent danger to self	1. Identify supports 2. If there is imminent danger remind the young consultant that you have a responsibility to act 3. Identify who to best inform and what other actions might be necessary (in negotiation with young person) 4. Act (support, refer, report) 5. If young consultant is in imminent danger report situation to Crisis Assessment Team 6. Report situation to Director of Policy and Research 7. Facilitate debrief with Nurse
Indicates that they are thinking of hurting others during the interview	1. Stop the interview 2. Express concern 3. Assess situation: - 'What thoughts are you having?' - 'Do you intend to	1. Identify supports 2. If there is imminent danger remind the young person that you have a responsibility to act

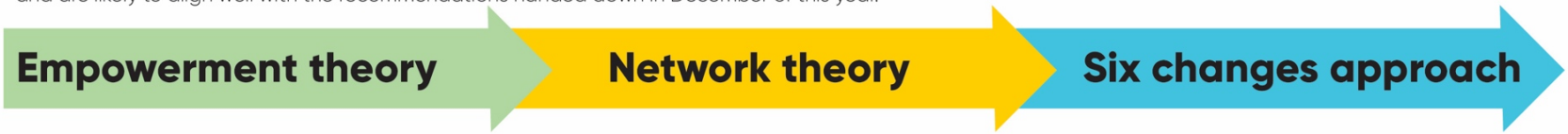
	harm someone else?' - 'How do you intend to harm them?' - 'When do you intend to harm them?' - 'What do you need so that you won't harm them?' 4. Determine if there is imminent danger	3. Identify who to best inform and what other actions might be necessary (in negotiation with young person) 4. Act (support, refer, report) 5. If there is imminent danger report situation to Victoria Police 6. Report situation to Director of Policy and Research 7. Facilitate debrief with Nurse
Indicates that they might be in danger if anyone (or someone in particular) found out about their participation in the research during the interview	1. Stop the interview 2. Assess the danger/threat: - How might you be in danger? - How might the other person find out that you participated? What do you think the other person would do if they found out? 3. Determine if the person is experiencing a safety concern	1. Identify supports. 2. If there is imminent danger remind the young person that you have a responsibility to act 3. Identify who to best inform and what other actions might be necessary (in negotiation with young consultant) 4. Act (support, refer, report). 5. If young consultant is in imminent danger report situation to Victoria Police 6. Report situation to Director of Policy and Research 7. Facilitate debrief with Nurse
Indicates that they have been feeing distressed about the interview or content at one week follow up after the interview	1. Acknowledge the emotion 2. Offer support and allow them to 'regroup' 3. Assess their status: - 'What's going on for you?' - 'What feelings are you having?' - 'Do you feel you are able to go about your day?' - 'Do you feel safe?' 4. Offer options: - 'What do you want to do? Did you want me to talk to your carer or to the nurse? 5. How best can I support you right now?	1. Remind the young consultant you have a responsibility to act 2. Identify who to best inform and what other actions might be necessary (in negotiation with young person) 3. Act (support, refer, report) 4. Report situation to Director of Policy and Research 5. Facilitate debrief with Nurse 6. Follow up with a further phone call or visit to the young consultant within one week or organise for the nurse to follow up in that time frame

Respecting Sexual Safety: Preventing Harmful Sexual Behaviour, Child Sexual Exploitation & Dating Violence for children & young people living in out-of-home care

Objective: To prevent and intervene early in Harmful Sexual Behaviour (HSB), Child Sexual Exploitation (CSE) & Dating Violence for children & young people living in residential care



In terms of the socio-political landscape it is an ideal time to undertake this prevention project. It is absolutely in-keeping with the implementation of the recommendations from the Royal Commission into Family Violence, the Roadmap for Reform and the report by the Commission for Children & Young People entitled: ". . . as a good parent would." Further, the prevention strategies are informed by evidence from the Royal Commission into Institutional Responses to Child Sexual Abuse and are likely to align well with the recommendations handed down in December of this year.



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MacKillop Family Services acknowledges the Traditional Custodians and their Elders in each of the Communities where we work.

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