Young People's Perceptions of Sexual Assault in Residential Care: "It Does Happen a Lot"

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Abstract

The Australian Royal Commission into Institutional Responses to Child Sexual Abuse uncovered significant levels of child sexual abuse within a wide range of youth serving institutions including residential care. This paper reports on findings from a study completed for the Royal Commission that sought to better understand young people's perception of safety in residential care; particularly in relation to sexual harassment and assault. Qualitative interviews were conducted with 27 young people aged between 13 and 21 years who were or had recently been in residential care in three Australian states. Participants were asked to consider a series of vignettes describing various levels and types of sexual assault and harassment. During these interviews the young people in this study voluntarily reported on the prevalence and nature of sexual assault and harassment, perpetrated by workers, individuals outside of residential care, and peers within residential care. Sexual assault and harassment were most often discussed in heteronormative and gendered ways with young men seen as perpetrators and protectors, and young women seen as being vulnerable. Further, it was evident from this study, that there were varying responses to these situations from workers within the residential care facilities. This research demonstrates a need for further investment into provide safe ways for young people to speak about sexual abuse and harassment in residential care and to further worker training in understanding, addressing and preventing sexual abuse and harassment.

Keywords: Sexual assault, residual care, peer sexual assault, sexual harassment, Out of Home Care,

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Interest in institutional child sexual abuse (ICSA) has increased significantly, largely due to the recognition brought to the issue through public inquiries and civil litigation. These investigations have demonstrated widespread abuse of children and young people who are in the care of adults, other than their adults, who have responsibility for their care. In Australia, the Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) examined a wide range of institutions that provide services to children including educational, sporting, religious, childcare, and residential facilities. Whilst much of the abuse examined throughout the Royal Commission was historical, there was evidence that children and young people in a range of institutional settings were still at risk of harm: either by staff or by young people themselves. To better understand the contemporary experiences of young people a series of research projects were commissioned to consider risks and young people's perceptions of how adults and institutions were keeping them safe. The voices of these children and young people currently or recently in OOHC complement the voices of survivors of historical abuse that have brought attention to the consequences of failing to adequately care for the safety of children and young people and the mismanagement of ICSA.

In the last decade, Australia has seen a large increase in the prevalence of children and young people in out-of-home care (OOHC). There were 46,500 children or young people in OOHC at 30 June 2016, a rate of 8.6 per 1000 children in Australia (AIHW, 2017, p. 47). There is increasing recognition that the number of children in OOHC has placed pressure on systems in terms of providing appropriate placements, staff, and oversight (AIHW, 2017; RCIRCSA, 2016). Residential care is defined as a form of OOHC where "Care is provided in a residential facility, where children are supported by paid staff"

(AIHW, 2018, p.43). This is different to foster care and kinship care, which is family based. Residential care is usually only availed for those children and young people who have complex needs that cannot be met in a family setting (AIHW, 2017).

Previous research has demonstrated that historically children and young people in residential care have been exposed to significant levels of sexual violence perpetrated by staff, volunteers, and peers (Davis, 2015; Middleton et al., 2014). Further studies show that children and young people in care continue to experience disproportionate vulnerability to sexual violence by individuals both within and external to care systems (Allroggen, Rau, Ohlert, & Fegert, 2017; Euser, Alink, Tharner, van Ijzendoorn, & Bakermans-Kranenburg, 2013). Whilst historically institutions may have been more likely to ignore, minimise and cover up the sexual exploitation of children and young people, there continues to be questions as to the adequacy of organisations in both addressing and preventing the sexual harm of children in care (Alink, Euser, Bakermans-Kranenburg, & van Ijzendoorn, 2014; Harnett, 1997; Mayer, 2012).

Although it is known that young people in care have increased vulnerability, rates of sexual assault in care are not known, and current data lacks reliability (RCIRCSA, 2016). This is due to several factors including under-reporting, differing definitions of ICSA, mismanagement or misidentification of disclosures, difference in recording practices including mis recording disclosure of sexual assault that occurred prior to entering care, and differences between Church and nongovernment providers of care and government providers of care. From the data available across Australian jurisdictions, the Royal Commission found that 5% of children and young people in OOHC were in residential care but 33% of complaints about sexual assault came from children or young people in residential care (RCIRCSA, 2016, p. 5). This compares to 39% of complaints coming from the 41% of children in foster care (RCIRCSA, 2016, p. 5). Despite accounting for 49% of children in

OOHC, kinship care only accounted for 20% of complaints (RCIRCSA, 2016, p. 5). Relevant contemporary complaints of sexual abuse included both peer-to-peer sexual assault and sexual assault by workers (RCIRCSA, 2016; South et al., 2015).

Research indicates that peer to peer, or child to child, sexual assault in OOHC has been a focus of literature and policy development (Euser et al., 2013; Font, 2015; South et al., 2015). Policies generally target improving caregiver capacity to manage sexualised behaviours and working directly with children with problem sexual behaviours to address these behaviours. This research largely generalised OOHC to include foster care, kinship care, and residential care (South et al., 2015). Although the research in this area is limited, evidence was provided to the Royal Commission that in Victoria, in 31% of sexual assault cases reported in residential care facilities, the assailant was another child (RCIRCSA, 2016, p. 38). Children who demonstrate problem sexual behaviours, including the abuse of peers, most often come from backgrounds of complex trauma which often includes family breakdown and CSA (Amy et al., 2008; Euser et al., 2013; Malvaso & Delfabbro, 2015; RCIRCSA, 2016).

Critiques of the management of sexualised behaviours or peer-to-peer violence in residential care facilities raise concerns with: the accessibility of reporting mechanisms within the facilities, the necessary skill involved for workers in dealing with behaviours, the potential to destabilise placements, the placement and management of children and young people with problem sexual behaviours in residential care, organisational and staff ability to cope with their behaviours, and the effectiveness of policies to address peer-to-peer sexual violence (South et al., 2015). Addressing peer-to-peer sexual violence relies on multiple approaches including pre-screening workers thoroughly, training workers appropriately, and creating environments and procedures where sexual violence can be more easily detected and

meaningfully addressed (Allroggen et al., 2017; Euser et al., 2013; Kopfensteiner, 1990; Milne & Collin-Vézina, 2014).

Since the 1980s there has been increased recognition of the need for highly trained and skilled workers to address sexual harassment or sexual violence in residential care (Euser et al., 2013; Harnett, 1997; Zelechoski et al., 2013). Worker relatability, reliability, and accessibility to young people in care are recognised as mitigating factors against violence in general, sexual violence in particular, and in limiting the negative consequences of resulting harm where violence of any type does occur (Authoers, 2018; van Lieshout, Mevissen, van Breukelen, Jonker, & Ruiter, 2016). As McLean (2015) and others have pointed out, aggressive and violent behaviours by residents are a major cause of workplace stress for staff, and contribute to worker turnover, burnout, and job dissatisfaction. The Royal Commission found that high worker turnover continues to impact on the capacity for the OOHC industry to address sexual violence in residential care as it disrupts or prevents the formation of safe relationships between residents and carers and disrupts carer skill development and training (RCIRCSA, 2016).

Despite working closely with vulnerable children, the residential care sector seldom require specific pre-service training, and set only minimal training or qualifications requirements for workers (Hansen & Ainsworth, 2015; Smith, 2017). Criminal history checks to screen for previous offences are mandatory across Australia. Residential care work has been referred to as "professional parenting" and an emphasis placed on worker availability and personality fit, rather than qualification (Bastiaanssen et al., 2014, p. 227). Courses are available to support the training of workers in residential care, however trained and skilled professionals are unlikely to pursue this course of employment in favour of professionally recognised and higher paying positions (Seti, 2008). These issues are not unique to Australia with international research recognising that safety, including safety from

sexual harms, is a key issue of concern (Green, 2005; Green, et al, 2002; Milne & Collin-Vézina, 2014).

Research Approach

Young people in vulnerable situations have important insights into their lives and make credible and worthwhile research participants (Hill, 2006; Moore, Noble-Carr, et al., 2016). The centrality of children and young people's voices is embedded in the United Nations Convention on the Rights of the Child and is becoming of increasing importance to researchers working in areas that impact on the lives of children (Bird, Culley, & Lakhanpaul, 2013; Clavering & McLaughlin, 2010). Despite increased awareness of their need for involvement, there is often hesitancy to ask children and young people who have experienced trauma or increased vulnerability to engage with research processes. Whilst caution is warranted, failing to adequately engage young people meaningfully quickly results in the marginalisation of their perspectives, needs and desires, and does not recognise their autonomy and empowerment (Clavering & McLaughlin, 2010; Monks et al., 2015). The need to involve children and young people in research goes beyond viewing them as objects of the research to engaging them in determining how research should be conducted (Hill, 2006; Moore, Noble-Carr, et al., 2016).

Consistent with the principle that children and young people have a right to have a say in decisions that impact on them, this research sought to create spaces where these voices were valued (Bessant, 2004; Moore, Saunders, & McArthur, 2011). Building on work previously conducted for the Royal Commission into Institutional Responses to Child Sexual Abuse (Moore, McArthur, Roche, Death & Tilbury, 2016), the present study explored children's perspectives of safety in residential care through qualitative interviews. This project emerged from a larger study of children and young people's perspectives of safety in a broader range of settings (see Moore et al, 2016). At the request of young people in this

wider study, this project was developed to specifically consider children and young people's perspectives of safety in residential care. In addition to having children and young people as participants, the project formed a reference group of children and young people in care to consult with in regards to research questions, research tools, and themes that emerged from the research.

Method

Participants

Twenty-seven children and young people aged between 10 and 21 years were interviewed regarding their perspectives of safety in residential care. Eighteen of these participants were male and nine were female. Three participants identified as being from culturally or linguistically diverse backgrounds. Six young people identified as being Aboriginal or Torres Strait Islander. Participants were recruited into the study if they had lived in residential care for more than three months, were aged between 10 and 22, and were currently or had been in residential care less than three years prior to the study. Participants were excluded from the study if they were currently involved in court proceedings related to sexual assault as the victim or perpetrator, or they had recently experienced a traumatic life event that may impact on their emotional ability to participate.

Of the 27 participants, only the older participants (5 female and 8 male) are the focus the data presented in this article (n = 13), as these participants shared the most direct experiences of sexual assault. Overall, younger children (10-12 years; n = 14) had been in residential care between 3 and 18 months and experienced relative stability in placements. These children reported limited experiences of physical or sexual abuse whilst in residential care, although they had experienced these types of abuse in their family of origin or foster care. Older residents (13-21 years; n = 13) had been in care on average for more than two years, with only one participant being in care for less than 12 months. These participants

experienced less stable placements and were more likely to report exposure to sexual and physical violence by peers in OOHC, which resulted in multiple moves to alternative care arrangements. The young people are identified with the acronym YAM or YAW for young adolescent man/woman in the age range of 13-16 years. The acronym YW or YM are used for young woman/man 17 years old or above.

Recruitment

Recruitment or participation followed a consistent format in all three Australian jurisdictions, a. Statutory child protection authorities identified potential service providers from which participants may be recruited. Either the research team or the statutory child protection agency worked with the service provider to ensure the research met internal ethics requirement. Lists of potential participants were created by non-government service providers and refered to statutory bodies for approval. Relevant case workers were then contacted within statutory bodies to ensure the young people were eligible to participate based on the selection criteria. Non-government service providers then distributed information to potential participants to gauge their interest in participating. Participants were offered a $30 (AU) gift voucher for participation. This was given to the participant on attendance at the beginning of the interview and was not conditional on completion of the interview.

Procedure

Face to face interviews were conducted with all participants either individually or in pairs. These interviews took between 45 and 90 minutes. The researchers were acutely aware of the sensitivity of the area being discussed and so interviews were structured to:

a) Provide choice and control over what participants discussed and how the discussion proceeded;

b) consider hypothetical situations rather than to disclose their own experiences of a lack of safety or harm;

c) begin by identifying concerns they believed were present for young people in residential care, rather than being presented with a set of issues to discuss;

d) propose recommendations for the Royal Commission that they believed would lead to positive change. In one part of the interview young people wrote their own messages or were asked to provide one-line recommendations which we would pass directly to the Royal Commission as part of our report [Author 2017].

Gaining meaningful consent from vulnerable participants was considered paramount in this project. A detailed consent process was implemented with each participant. Participants were also offered multiple opportunities to postpone or end the interviews with check-ins built into the interview process. This was done to ensure the emotional safety and well-being of young people (see Moore et al, 2016 for more detail). For a detailed description of the consent process followed with young people please see Moore et al, 2016).

Participants were not asked directly about their experiences of inappropriate or violent sexual behaviours in care, rather, after first being invited to discuss what they thought the safety issues were, participants were asked to reflect on a number of vignettes with varying types of behaviours by other residents or staff of residential units. Vignettes have been shown to be an effective approach to meaningfully engaging young people in sensitive research (Bradbury-Jones, Taylor and Herber, 2014; Keefe and Andrews, 2015). Some of the situations described in the vignettes were obviously describing acts of sexual assault, other vignettes displayed behaviours that may lead to young people feeling uncomfortable. An extract from the lengthy interview guide is appended. Participants rated the behaviours in the vignettes on a matrix of how likely they were to occur and how 'bad' it would be if they did

occur. Participants were also contacted by the interviewer within three days of the interview to ensure that they were feeling comfortable about the interview they had participated in and if they had any further questions.

Interviews were transcribed, and themes developed using a grounded theory approach and indictive coding in order to draw themes from the research data. Researchers also wrote short journal entries and engaged with other team members to reflect on the interview and coding process. Transcripts of interviews were managed in NVIVO. Multiple members of the research team independently coded the research interviews closely and compared analysis and codes. Coded material was discussed amongst the wider research team. This approach to qualitative data analysis is well supported in literature (Punch, 2013; Silverman, 2011). Themes that developed from the interview material were also discussed with a panel of young people in residential care to provide an opportunity for their feedback on the research findings. The study received approval from the Australian Catholic University's Human Ethics Committee [Approval 2015 225H] and ratified by partner universities. Researchers worked closely with child protection agencies (who provided organisational approval) in the three participating jurisdictions (these agencies have been de-identified to protect the identities of participants).

Results

Gendered Vulnerability

The young people in this study were clear that the risk of sexual violence exists in residential care facilities and reported that it was something that they managed themselves. Most of this violence was perceived to be in the context of peer relationships.

> *YAW2: It does happen a lot. There is a lot of times that other residents will try to pressure you into doing things you don't want to, whether that be go*

out, do drugs, get drunk, have sex and it does happen, it does happen a hell of a lot in resi[1].

YAM2: I've come across sexual harassment in resis between young people. This one guy I lived with, as soon as there was a girl in the house, if he couldn't get with them, he would make their lives a living hell until he could.

Q: What sorts of things would he do?

YAM2: Throw mugs at them. Glue their door shut. Break glass in front of their door while they're sleeping. All sorts of stuff.

Young people in this study talked about how they saw vulnerability to sexual violence as different for males and females describing how young women being perceived as more vulnerable to assaults by peers and by workers than young men.

Q: I want to ask [YAM1] is it the same or is it different for you, in terms of the ways that you think about risks of sexual assault in resi care? <Long pause> or do you not?

YAM1: I don't even think about it. In our particular household and stuff, I don't really think about that. Because I just know that it's not going to happen. Even if it does, I'm probably going to be first line of defence, so to speak, until a youth worker comes.

For this young man, his own vulnerability to sexual violence was not an obvious consideration, rather, if he was to consider vulnerability to sexual violence his focus was on protecting the young women in the house – being the first line of defence. This sentiment was reflected by other participants:

[1] Resi is an abbreviated term used by young people to refer to residential care

> *YAM3: I guess guys don't feel like they're going to be attacked by probably a guy in a sexual way. They may feel physically intimidated but not in a sexual way and girls probably don't feel the same way with a girl worker. But if you have a male worker with a female young person then the young person may feel intimidated by that or unsafe and they may think that sexual tension is there.*

Interestingly, in the following exchange, this same young man spoke about interactions with a male peer that made him feel uncomfortable:

> *YAM3: I'm trying to think, like I know gay's not insulting, but it's rude to insult. He kept trying to convince me to do stuff with him. That was in the early days of me being in care and I really didn't feel comfortable.*
> *Q: How old were you then?*
> *YAM3: Twelve and a half so it was still quite young.*
> *Q: How did you manage that situation?*
> *YAM3: I kept saying no and kept trying to put distance between him so I spent a lot of my time in my room and that then. If he was in the lounge room I'd be in my room or I'd be outside. I just tried to avoid him as much as possible. Turns out he was also doing it to other people that lived in the house and eventually he went up to a nine-year-old and started bugging him. The nine-year-old went to the worker and then DHS had to investigate it which is what I probably should have done. But being that young I kind of just went, "I don't know what to do I'm getting out of here".*

It is evident in this exchange that the young man dealt with sexual harassment from a peer but did not clearly frame it as such and this inhibited disclosure.

As in other studies on peer violence in residential care, it is evident that young women often assumed responsibility for assessing and managing their risk of sexual violence (Euser et al., 2013; Milne & Collin-Vézina, 2014).

> *YAW1: My friend's parents didn't agree with me moving in here because there was two guys. They thought something like, for example, sexual abuse*

could happen. But obviously it hasn't. We're really good friends. So that's why I've let my guard down a lot with the boys. But I think it could be a major impact because something could happen, then they wouldn't tell the youth worker because they'd be scared of getting them in trouble or something like that.

Q: Do you think it was a legitimate concern of your friend's parents?

YAW1: Yeah. It was a legitimate concern that they had, that one of them were going to hurt me, either physically or sexually. And I would tell them - bit by bit, once I got used to the boys, bit by bit, I'd tell the parents that it's fine. They're not going to do it. They're really good guys…

The gendered threat from peers was integrated into this young women's perspective of entering a residential unit. In addition, the young woman took a role in assuring the adults in her life that she was able to identify and assess the potential for physical and sexual violence. In this example, the young woman internalised responsibility for assessing the risk of other residents and did so over time in order to ensure her own safety and allay the fears of other adults in her life.

Sexual assault by staff

Although vulnerability to sexual violence by peers was more frequently raised by young people in this study, the risk of sexual assault from workers was also acknowledged, with perceptions of risk and incidence varying between participants,

YAW3: … *I've heard occasional tales that they're working with young people and it's not something you hear that often. So, I don't know the likelihood of it happening.*

YW2: No, I was sexually abused by a worker. It hasn't happened anymore because he's not allowed to work at that unit until he gets investigated

further and there's been a few workers that have actually lost their jobs for sexually assaulting kids.

YAW2: I can speak on behalf of a friend, her mental state at her mother's wasn't the best. She was abused a lot physically and verbally, she got put in resi and it took her out of that situation but she was put into the temptation of the drugs and everything in resi. She was sexually abused in resi by one of the workers and it wasn't safe for her either way.

YAW2 further disclosed to residential workers that she had been sexually assaulted by an ex-partner. The situation in that instance was handled in a satisfactory way with workers supporting and negotiating with the young woman for her safety. Overall this young woman reported positive experiences around discussing sex with workers.

YAW2: Yeah see my workers would always tell us, "If you want to have sex, we can't stop you, but make sure you're safe about it. If you think there's the possibility you're pregnant, you can come to us and we'll work something out." But, they wouldn't tell us things to make guys want to have sex with us, they'd always make sure, "All right make sure you're safe," all that kind of stuff.

Q: Do you think you've had too little or too much sex education I suppose at the resi care? Did you have enough information or not enough?

YAW2: We had enough information and trust with our workers that if something was wrong we could go talk to them.

Developing trusting relationships with workers has also been highlighted as a significant protective factor in prior research (Timmerman & Shreuder 2014; Timmerman Shreuder & Kievitsbosch 2017).

Sexual assault by outside people

One young woman stated that she had been in a residential care unit where the young women were physically and sexually assaulted by a male resident. She then went on to discuss inappropriate relationships with older outside males which led to the use of drugs to perpetrate sexual assault.

> *YAW3: We had one boy who actually physically sexually assaulted some of the girls. But then we also had the outside people, so for example quite a few of the girls ended up, dated guys that were obviously a lot older, because we were easy targets, we literally were, we craved the attention and if they could give us what we needed we did it. I don't think there was one of us who didn't end up dating a guy over 30. … I ended up in hospital with third degree burns, met a guy in there and next thing I know he's rocking up at my resi unit wanting to see me, texted me at 12 o'clock at night that he's next door at the carpark, and it surprised me and it still surprises me to this day, the encouragement I got from one of the staff members, she was fully encouraging it, "Yep go see him. You know, have you got something sexy to wear." It's like she was facilitating it.*

This scenario fails to recognise, and indeed actively promotes, relationships where young people, who are already vulnerable, are at increased risk of being in sexually compromising, exploitative, or abuse situations.

When meaningful supportive relationships are absent, the vulnerabilities of young people are amplified. This is particularly so in a context where heteronormative gender roles are either actively or passively promoted, an area of research that needs substantial development.

> *YAW3: At the time I thought nothing of it, I thought yeah, I'm getting attention from a guy. I thrived on it, because being in resi you literally you*

> *want attention, you want someone to look at you and you think that they think the world of you when really you don't understand but clearly the older guy, there's only one thing they want from you at that time. …. You know thinking back on it now I know it's unsafe but at the time literally I ended up in so many multiple situations which could have been dangerous and it got to one point where he drugged me to try and get what he wanted.*

This young woman identified factors that increase vulnerability for children and young people in residential care: craving attention, poorly trained youth worker(s) who encourage inappropriate relationships, and reliance on peers to manage vulnerable situations. Similar themes have emerged in other studies (Kendrick 2011).

Negative or neglectful experiences were not the only accounts offered by participants.

> *YAW2: They did a police check on one of my exes, like my ex *****, I was 16 and he was 21. They were like, "Okay they shouldn't be dating, but he's not sleeping with her." Because he was driving they're like, "He gets her to her appointments if she doesn't want to go, he's really not that bad."*

In this instance, workers communicated with the young woman, empowered her to make decisions around her relationships, and actively sought to ensure her safety by enabling her to make informed decisions.

Discussion

The young people in this study generally constructed traditional gender roles where females are victims, not perpetrators, and where some males are protectors and other males are perpetrators (Gartner & Sterzing, 2016; Kahn et al., 2011). This dynamic is consistent with heteronormative constructions whereby young women are perceived as vulnerable to male perpetrators and young men resist constructions of victimisation (Javaid 2018).

Heteronormativity establishes sexual relationships between males and females as normal and ideal creating hierarchies of relationships and potential violence within them (Hlavka 2014; Javaid 2018). Young women in this study identified seeking out these relationships to have their needs for affection, attention, and increased self-worth validated. This is significant when the ways in which young people's development of their sexuality is taken into consideration (Firmin, Warrington, & Pearce, 2016). Young women in this study were seen as vulnerable to abuse but also encouraged to pursue heteronormative sexual relationships. It is important to state that it is unknown how common it is for staff to encouragement of potentially inappropriate relationships. However, young people in residential care may be yet to develop the skills needed to recognise inappropriate, or exploitative, relationships and so rely on adults to provide quality relationship education that promotes safeguarding (Firmin, 2017).

Findings by the Royal Commission point to the vulnerability of children and young people in OOHC and some of the factors that sustain this vulnerability, including poor staff training, the desire for attention, and overlooking children and young people's victimisation and constructing it as normal sexual development (RCIRCSA, 2016). This has also been recognised in international literature as a key element in understanding and managing young people's vulnerability to sexual violence in residential care settings (Indias, Arruabarrena, & De Paúl 2019). The affirmation of the heterosexual contract in residential care has been examined by Barter (2006), who found that young women pursued relationships with males looking for protection, but who consequently may increase their vulnerability. Such research demonstrates that young women seek assurance and protection from males in ways that leave them vulnerable to harm, but this is not well understood by child protection services (Firmin, 2017; Firmin et al., 2016).

Historically at least, abuse in care facilities has generally included more prevalent victimisation of boys and young men (Blakemore, Herbert, Arney & Parkinson, 2017; Sköld, 2013). This has included abuse by workers, adults external to the care institution, and by peers (Allroggen et al., 2017; Gallagher, 2000; Sköld, 2016). This abuse often happened in large scale residential facilities, such as children's homes or educational facilities that were generally segregated by gender for both carers and residents. The move away from such models of care to smaller, community-based residential care may have increased safety for children, perhaps in particular for boys whose vulnerability should not be overlooked. However, research conducted in the Netherlands found that where CSA does occur in residential care it is now more likely to be with female victims (Euser et al., 2013). This can act to reinforce gendered notions of female vulnerability and of male roles as perpetrator or protector. Whilst greater instances of sexual abuse against young women is reflected in broader literature about sexual victimisation rates, it is not reflective of all sexual abuse in OOHC situations, and care should be taken not to assume that boys are not vulnerable and so do not need to be educated on this vulnerability (Gartner & Sterzing, 2016).

While literature shows that young women, and women in general, carry an additional mental and emotional burden in assessing safety from sexual violence in their daily lives, young women in residential care have already experienced trauma related to the reasons for their removal from their family of origin, have often have experienced instability in placement, and continue to monitor their environment for risk of sexual assault (Ayotte et al., 2017; Hackman, Pember, Wilkerson, Burton, & Usdan, 2017; van der Bruggen & Grubb, 2014). However, little is known about how the internalised acceptance of responsibility for managing risk, combined with instability in residential care placements, may specifically impact young women (Ayotte et al., 2017; Sorsoli, Kia-Keating & Grossman 2008). Despite evidence, here and elsewhere, of residential care impacting differently on young women

compared to young men, there is sparse research on this issue (Ayotte, Lanctôt, & Tourigny, 2017). Additional work by (Moore, McArthur, Death, Roche and Tilbury 2017) discusses young people's perceptions of the availability of workers and their need for qualified and available workers.

There is evidence that sexual assault by workers in OOHC continues to occur and the currency of vulnerability to sexual assault was recognised by the Royal Commission in its final statements and report (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017, 40). Euser et al. (2013) acknowledged that high levels of worker turnover and instability in residential care placements increased the risks of sexual violence for residents in care units. The young people in this study acknowledged the importance of residential care workers being available, well skilled, and open to dealing with issues of sexuality. The experience of this was varied amongst the young people in this study. Those responses that were identified as positive recognised the agency of young people in managing their own sexuality and managing their response when they did experience sexual violence. This is consistent with the work of Firmin, Warrington and Pearce (2016) who identified context as essential in addressing the sexual exploitation of young people. Agency can be supported by acknowledging that young people are learning about how to manage their sexuality and how to manage a range of sexual experiences. The best solutions to managing the vulnerability of young people recognise the context in which harms may occur, or are occurring (Firmin, Warrington and Pearce 2016). Although there were some positive experiences reported in this study, there were also negative experiences where participants continued to feel and be vulnerable to sexual assault by workers. The importance of creating safe spaces and worker relationships has been addressed elsewhere by (Moore *et al.* 2017)

Conclusion

This study demonstrates that young people in residential care are aware of and managing their risk of sexual assault from peers, workers, and outside parties. They are doing so, in environments that are not consistently supporting them as they negotiate these risks. As was identified in the closing statements of the Royal Commission, sexual abuse in care should not be considered an historical issue but continues to be one that confronts care organisations, the state and young people who enter OOHC (RCISRA, 2017). The development of meaningful support networks for young people and the effective management of sexual abuse is essential to address the differing ways in which young people experience vulnerability, abuse, and their capacity to manage their own sexuality. In order to meaningfully support the objective of increased safety in residential care practitioners and policy makers should continue to prioritise worker training, create meaningful reporting mechanisms, create cultures of safety that encourage young people to speak with workers, and provide meaningful education for young people on sexual development and healthy relationships. These are not new recommendations. This study affirms, however, that there remains work to be done and that young people in residential care want and need this work continue in order to improve their safety.

Limitations of the study

The wider study originally aimed to recruit 50 participants. These numbers were not reached despite extending the data collection period. Researchers were not able to recruit young people directly and relied on workers in residential services to inform young people of the project in a way that engaged their interest. This approach may have meant that some potential participants were not informed of the study and the possibility of participation. Due to the smaller number of participants in this study and the nature of qualitative research, the findings of this study are not generalisable to all children and young people in residential care. This research is comparable with other existing evidence, however.

This research did not hear from young people who openly identified as LGBTIQ or gender-diverse. Young people were not asked to identify their sexuality. Whilst it is noted in this paper that responses were heteronormative, there is a gap in literature addressing the voices of young people in care who identify as LGBTIQ and their experiences of sexual assault and harassment. This work cannot be assumed to generalise to that population.

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Appendix

Except from interview schedule with selected scenarios

Give the YP the "scenario" examples and an A3 matrix and ask them to decide (a) from their experience how likely is it that a YP would encounter a scenario like the one presented; (b) if a young person came across the situation, how bad would it be?

For each scenario ask:

- Do you think YP in residential care are at greater risk? Why / not?
- Why did you choose to rank the scenario as you did?
- Are there greater risks for different types of young people?

1. **Jessica** feels uncomfortable because staff are always "checking in" with her. She feels like they don't respect her privacy – coming in to her room, and also knocking on the door when she is in the bathroom.
2. Two of the workers, Craig and Mitch, are always making sexual jokes about one of the female staff, Sarah in front of the boys. **Kelly** feels uncomfortable about it.
3. Denise, one of the workers, often gives the **Jasmine** sex advice and tells her things that she has does to make guys want to have sex with her
4. The boys sometimes dare each other to play truth or dare seeing how far they'll go. **Danny** feels pressured into doing this.
5. **CHRISSIE** has been bullied by other young people. Older boy, Brett, has said that he'll protect Chrissie [Chris] if she does" things" for him. Chrissie [Chris] is worried that it will include sexual stuff but doesn't feel safe
6. There's a worker, Ben, who has been sleeping with one of the girls, **Krystal** in residential care. The other young people think this is a bit dodgy but don't want to tell anyone.