

# Sexual Health and Sexuality Education Needs Assessment of Young People in Care in Ireland (SENYPIC)

## The Perspectives of Key Service-Providers: A Qualitative Analysis

Abbey Hyde, Deirdre Fullerton, Caroline McKeown,  
Laura Dunne, Maria Lohan, and Geraldine Macdonald

REPORT NO. 3

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#### **About the HSE Crisis Pregnancy Programme**

The HSE Crisis Pregnancy Programme is a national programme tasked with developing and implementing a national strategy to address the issue of crisis pregnancy in Ireland. Formerly the Crisis Pregnancy Agency, on the 1st of January 2010 the crisis pregnancy functions, as set out in the Crisis Pregnancy Agency (Establishment) Order 2001, became legally vested with the HSE through the Health (Miscellaneous Provisions) Act 2009 and the Crisis Pregnancy Agency became known as the HSE Crisis Pregnancy Programme (the Programme). The Programme sits within the national office of Health Promotion & Improvement, situated in the Health and Wellbeing Division of the HSE. The Programme works towards the achievement of three mandates

1. A reduction in the number of crisis pregnancies by the provision of education, advice and contraceptive services.
2. A reduction in the number of women with crisis pregnancies who opt for abortion by offering services and supports which make other options more attractive.
3. The provision of counselling services, medical services and such other health services for the purpose of providing support after crisis pregnancy, as may be deemed appropriate by the Crisis Pregnancy Programme.

#### **About the Child & Family Agency (Tusla)**

On the 1st of January 2014 the Child and Family Agency became an independent legal entity, comprising HSE Children & Family Services, the Family Support Agency and the National Educational Welfare Board, as well as incorporating some psychological services and a range of services responding to domestic, sexual and gender based violence.

The Child and Family Agency is now the dedicated State agency responsible for improving wellbeing and outcomes for children. It represents the most comprehensive reform of child protection, early intervention and family support services ever undertaken in Ireland.

The Agency operates under the Child and Family Agency Act 2013, a progressive piece of legislation with children at its heart, and families viewed as the foundation of a strong healthy community where children can flourish. Partnership and co-operation in the delivery of seamless services to children and families are also central to the Act.

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## Table of Contents

Introduction.	1
Section 1 Background, literature review and methodology.	3
Section 2 Whose responsibility is sexual health and meeting the RSE needs of YPIC?	15
Section 3 Bureaucracy: care plans, policies and legislation in relation to the sexual health needs of YPIC.	24
Section 4 Doing RSE and promoting sexual health.	34
Section 5 Sexual health needs of specific groups of YPIC, and of post-care service-users.	53
Section 6 Training and support of staff.	58
Section 7 Summary and conclusion to Report No. 3.	62
References.	65
Appendix 1 Topic guide for interviews with professionals/service-providers.	70

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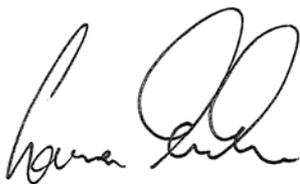
## FOREWORD

I welcome this research and the findings in relation to the Sexual Health and Educational Needs of Children in Care. Tusla - Child and Family Agency has a huge responsibility towards young people in care and our work must reflect the highest standard and best practices. The needs of young people in care must be at the heart of all our decisions and planning. It is within this context that I acknowledge that as an organisation we have work to do to ensure that the developmental needs of young people in care in the context of their sexual health must be given due consideration.

This research was undertaken with the intention of ensuring that the views and voices of the children and young people we serve are heard and captured in a manner that allows the organisation to plan and develop services in response to their needs. It also provided opportunities for our staff and staff in partner organisations to identify the skills they have and skills they require in order to meet the needs of children and young people. The underpinning requirement of the research was to identify ways in which all services could improve and strengthen their capacity to respond to children and young people in care. The reports and, particularly, the composite report identifies work that needs to be taken forward by Tusla both in relation to the education of young people and also, and most importantly, to their need to have safe, loving and stable relationships. The findings serve to highlight the need to consider children and young people holistically when planning for their care.

Tusla with our partners in the HSE Crisis Pregnancy Programme will work together to ensure that any improvements that are required to support and guide children and young people in their sexual development will be met and commitment will be given to ensuring that they are supported in a manner that meets their needs. A robust action plan will be developed to respond to individual actions and the Child and Family Agency are committed to implementation.

Tusla would like to thank all those who contributed to the work on this research, all the researchers, representatives from Tusla and representatives from the HSE Crisis Pregnancy Programme.



*Cormac Quinlan*  
*Director of Policy and Strategy*

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# INTRODUCTION

## by the Head of the HSE Crisis Pregnancy Programme

The *Sexual Health and Sexuality Education Needs Assessment of Young People in Care in Ireland (SENYPIC)* programme of research was commissioned in late 2011 by the HSE Crisis Pregnancy Programme, in partnership with the Child and Family Agency (Tusla).<sup>1</sup> The intention was to document the sexual health and sexual health education and information needs of young people in residential care and foster care from a range of different perspectives.

This is the third report in the programme entitled, '*Report No. 3: The Perspectives of Key Service Providers: A Qualitative Analysis*'. This report presents findings gathered by way of in-depth interviews with 22 service-providers engaged in direct or indirect provision of Relationships and Sexuality Education (RSE) or sexual healthcare to young people in care.

The findings build on Reports No. 1 and No. 2. The report sets out that while many service-providers support the provision of comprehensive RSE to young people in care, many report issues relating to the legal and policy situation that cross-cuts their work, creating uncertainty about how to approach both RSE and the delivery of sexual healthcare. Organisational legacy issues and a lack of workable and pragmatic guidelines were perceived to be key barriers.

Regarding the needs of young people in care, there was agreement across the sample that young people in care have particular needs in terms of sexual health and RSE. Young people in care were considered to have lower levels of maturity and lower levels of life skills compared to their peers and the sexual health and RSE needs related to the lack of consistency and stability in many of their lives. There was consensus that young people in residential care were deemed to have the greatest level of need and that current provision of RSE and sexual healthcare varied within and across settings.

The results from this report identify clear gaps around RSE provision; insufficient training opportunities for service providers; lack of guidelines and policies to support RSE and sexual healthcare delivery and low levels of clarity relating to key legislative and policy change. These findings have been carefully considered by the Crisis Pregnancy Programme and the Child and Family Agency and both organisations have committed to delivering on these actions over the coming years.

I would like to thank the 22 service-providers working with young people in care who took the time from their busy schedules to participate in the in-depth interviews.

I would like to thank the researchers from the School of Nursing, Midwifery and Health Systems, University College Dublin; the School of Nursing and Midwifery, Queen's University Belfast; the School of Sociology, Social Policy and Social Work also at Queen's University; and

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Insights Health and Social Research, Derry. The Principal Investigator for this project was Professor Abbey Hyde, School of Nursing, Midwifery and Health Systems, UCD.

I would like to thank the Project Steering Group for their time, expertise and ongoing support to this study. I would like to thank Dr. Caroline Cullen, Siobhan Mughan, Donal McCormack, Margy Dyas and Barbara Kane-Round.

I would also like to thank Maeve O'Brien, Research & Policy Officer in the Crisis Pregnancy Programme for her commitment to this project and for working closely with the research team to manage this important project to completion and publication, and to Marzena Sekular for her hard work and support throughout the process.

*Helen Deely*

*Head of the HSE Crisis Pregnancy Programme*

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## About the Authors

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### **Acknowledgements:**

The authors wish to convey their sincere gratitude to the service-providers who willingly gave up their time to be interviewed for the foregoing study. They would also like to thank Dr Maria Healy and Ms Frances Howlin for contribution to this component of the overall study. During the course of the research, the SENYPIC programme of research was supported by a Steering Group and an Advisory Group who provided invaluable expertise throughout. The authors express their sincere thanks to these groups, and to the HSE Crisis Pregnancy Programme in conjunction with the Child and Family Agency (Tusla, formerly the HSE Children and Family Services) for funding the research. In addition, we are grateful to Jenny Bulbulia, Barrister-at-Law, and to Suzanne Phelan, Child Welfare Consultant, for reviewing components of this report.

*The views expressed in this report are those of the authors and do not necessarily reflect the views or policies of the sponsors.*

## Abbreviations used in this report

CIC	Children in care
CPP	Crisis Pregnancy Programme
HSE	Health Service Executive
LAYP	Looked after young people (used in England, Wales and Northern Ireland)
LGBT	Lesbian gay bisexual transgender
RSE	Relationships and sexuality education
SENYPIC	Sexual Health and Sexuality Education Needs Assessment of Young People in Care in the Republic of Ireland
YPIC	Young people in care (used in the Republic of Ireland)

## Terminology used in the report\*

**Birth child:** The biological child of a parent.

**Birth parent:** The biological parent of a child.

**Care leaver:** Person who was formerly in state care (foster or residential) for a period of time before the age of 18 years.

**Care plan:** Is an agreed written plan, drawn up by the child and family social worker, in accordance with the *Child Care (Placement of Children in Foster Care) Regulations 1995 (Part III, Article 11)* and *Child Care (Placement of Children with Relatives) Regulations 1995 (Part III, Article 11)*, in consultation with the child, his or her family and all those involved with his or her care, for the current and future care of the child, that is designed to meet his or her needs. It establishes short, medium and long term goals for the child and identifies the services required to attain these.

**Children in care:** Children who have been received into the care of the Child & Family Agency either by agreement with their parent/s or guardian/s or by court order, are referred to as being 'in care'.

**Children in foster care:** Children in the care of the Child & Family Agency who are placed with approved foster carers in accordance with the *Child Care (Placement of Children in Foster Care) Regulations, 1995* and the *Child Care (Placement of Children with Relatives) Regulations, 1995*.

\* This section references terminology used in the *National Standards for Foster Care*, Department of Health and Children, 2003 and the *National Standards for Residential Centres*, Department of Health and Children, 2001. Responsibilities for the care of young people with care orders previously lay with the regional health boards. Since 2014, responsibilities lie with the Child & Family Agency. Aspects of the terminology have been changed to reflect this.

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**Children in residential care:** Children in the care of the Child and Family Agency who are placed in residential care in accordance with the Child Care, (Placement of Children in Residential Care Regulations, 1995)

**Crisis Pregnancy:** Legislation defines a crisis pregnancy as ‘a pregnancy which is neither planned nor desired by the women concerned and which represents a personal crisis for her’. This definition is understood to include experiences of women for whom a planned pregnancy develops into a crisis over time due to a change in circumstances.

**Foster carer/Foster parent:** These terms are used interchangeably throughout the report to refer to a person approved by the Child & Family Agency, having completed a process of assessment and being placed on the Child & Family Agency’s panel of approved foster carers, to care for children in the Child & Family Agency in accordance with the *Child Care (Placement of Children in Foster Care) Regulations, 1995* and the *Child Care (Placement of Children with Relatives) Regulations, 1995* for the purpose of these Standards.

**Key worker:** is a nominated staff member that is appointed based on their suitability to oversee the care of the young person. This person has various tasks such as advocating for and with the young person, supporting them in care planning and child in care reviews, supporting them in family access, attending to their specialist needs. (*This is not an exhaustive list*).

**Link worker:** Is the social worker assigned by the Child & Family Agency to be primarily responsible for the support and supervision of foster carers.

**Relative foster care/Relative care:** These terms are used interchangeably throughout the report to refer to a foster care provided by a relative or friend of a child who have completed a process of assessment and approval as relative foster carers or who have agreed to undergo such a process.

**Relative carer:** is a person who is a friend or relative of a child and who is taking care of that child on behalf of, and by agreement with the Child & Family Agency having completed or, having agreed to undertake, a process of assessment and approval as a relative foster carer. The term ‘relative’ includes:

- A person who is a blood relative to a child;
- A person who is a spouse or partner of such a relative;
- A person who has acted in *loco parentis* in relation to the child;
- A person with whom the child or the child’s family has had a relationship prior to the child’s admission to care.

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**Residential care:** Residential care can be provided by a statutory, voluntary or private provider. The purpose of residential care is to provide a safe, nurturing environment for individual children and young people who cannot live at home or in an alternative family environment. It aims to meet in a planned way the physical, educational, emotional, spiritual, health and social needs of each child.

**Residential centre:** The *Child Care Act 1991* defines a residential centre as ‘any home or institution for the residential care of children in the care of the Child & Family Agency or other children who are not receiving adequate care and protection’.

**Service-provider:** A person or organisation whose formal role is to provide a social, health, or educational service to private citizens or to the general public. The particular service provided may be funded privately or publicly.

**Young people in care (YPIC):** For the purpose of this study the term ‘young people in care’, is used to describe a heterogeneous group of young people living with foster carers, relative carers or in residential care settings.

# Introduction

This report focuses on a qualitative analysis of the sexual health and sexuality education needs of young people in care (YPIC) from the perspective of 22 service-providers occupying positions in social and healthcare services in Ireland with which YPIC interface. It is the third in a series of reports (Fullerton et al. 2015a, 2015b; Hyde et al. 2015a, 2015b), each of which presents a discrete component of a wider study of the sexual health and sexuality education needs assessment of young people in care in Ireland (SENYPIC). The findings of all five reports are amalgamated in a composite report of the findings that outlines each phase of the study and integrates the overall results (Hyde et al. 2015c).

## *Structure of the report*

This report is structured around seven sections. In Section 1, the focus is on the current status of knowledge in relation to the following:

- Available empirical evidence of service-providers' role in sexual healthcare<sup>1</sup> provision to YPIC;
- Expert opinion on the issue;
- The social and legal context of sexual health provision in Ireland.

Section 1 also sets out the aim and objectives of this report and describes the methodology employed.

In Section 2, the first of the 'Findings' sections, against a general consensus that YPIC have particular needs over and above those not in care, the emphasis is on the question of whom participants contend ought to be responsible for providing RSE to young people in care. The issues covered here include participants' insights into some perceived problems with professionals' role in current delivery. In Section 3, the issue of bureaucracy mediating the delivery of sexual healthcare to YPIC is analysed. Participants' views of and experiences relating to the formal structures and procedures involved in sexual healthcare delivery are captured, including their views on the impact of national guidelines in this regard. In Section 4, the perspectives of service providers on what they propose underpins good quality RSE

<sup>1</sup> The term 'sexual healthcare' used throughout the reports refers to the broad spectrum of sexual health provision and relationship and sexuality education, where not otherwise specified.

for young people in care become the focus of attention. It is through an analysis of what participants believe makes for good sexual healthcare for YPIC that the needs of this group are unpacked. The substance of this section is participants' views on the multi-dimensional nature of sexual health needs of YPIC, and on the delivery of sexuality education. Moving on to Section 5, the sexual health needs of specific groups of YPIC, namely, those who identify themselves as lesbian, gay, bisexual or transgender (LGBT), or have a disability are considered. The needs of those availing themselves of post-care services are also examined. In the final findings section, Section 6, participants' perspectives on the training and support needs of staff delivering sexual healthcare to YPIC are considered. A conclusion to Report No. 3 is given in Section 7.

# Section 1

## Background, literature review and methodology

In this section, we consider what is known already about the sexual health and sexuality education needs of YPIC from the perspectives of professionals engaged in service delivery to this group.<sup>2</sup>

Although the key focus of this report is the assessment by service-providers of the sexual health and sexuality education needs of YPIC, one of the objectives of the study was to identify the support needs of key staff in meeting these needs; thus, the scope of the review extends to existing literature on the role of key professionals in the provision of sexual healthcare to this user group, whether in foster or residential care.

Since this is the first study of its kind in Ireland, with little extant nationally-specific knowledge on which to build, this review includes related literature from other social locations with relevance to the topic. The social and legal context of RSE and sexual healthcare delivery to young people in Ireland is also explored, since this featured indirectly in some items of the e-survey relating to policies and procedures (this will be detailed further on).

### *Empirical evidence on service providers' role in sexual healthcare provision to young people in care*

No empirical research was located nationally that illuminates, from the perspective of service-providers themselves, their role in delivering sexual healthcare to YPIC. A very limited amount of knowledge on the topic is found in UK and US research (Chase *et al.* 2006, Knight *et al.* 2006, Constantine *et al.* 2009). The UK research was a Department of Health-funded study on teenage pregnancy among young people in and leaving care. This study included interviews with 78 service-providers whose role brought them in contact with YPIC (Chase *et al.* 2006 Knight *et al.* 2006). The focus of these interviews was to investigate the experiences, roles and responsibilities of these professionals in preventing pregnancy and supporting YPIC and young care leavers who were parenting. Findings indicated that many participants identified the need for integrated responsibility among professionals and families for ensuring positive sexual health outcomes and support for the young people involved. However, participants cautioned that responsibility may become diffused and diluted, with the needs of young people

<sup>2</sup> Since Report No. 1 of the SENYPIC study (Fullerton *et al.* 2015a) focuses on an e-survey of the perspectives of service-providers, 22 of whom were interviewed for the qualitative study being presented here, the main thrust of this background and literature review also appears in Report No. 1.

overlooked. In addition, the importance of consistency in the sexual health message imparted was emphasised by some professionals.

The US research on the topic was a study reported by Constantine *et al.* (2009) that aimed to assess the need for and the provision of sex education and reproductive health services among young people in foster care and those leaving care in three California counties. Included among the sample were 94 professionals providing services to these young people and their views were sought via interviews, focus groups and an online questionnaire. Findings indicated that lack of clarity around policies and roles, as well as concerns about liability and confidentiality, constituted barriers in addressing the sexual health needs of the young people. Similar to concerns raised in the UK study referred to above (Chase *et al.* 2006, Knight 2006), division of responsibility across a range of professionals was another perceived challenge. Additional barriers to sexual healthcare provision included a lack of training in adolescent sexuality and diverse religious and moral beliefs that impacted on sexual health messages.

Other studies provide some information about service-provider perspectives on providing sexual healthcare to YPIC, though indirectly, insofar as they have a related but not an immediate focus on the topic. For example, there is now a substantial body of knowledge on service-providers' role in the delivery of sexual healthcare to adolescents as a broad category (Tavrow 2010, Sanders *et al.* 2011), but the focus of these studies tends to be generic and not specific to YPIC. Other literature that provides some insights into the sexual health needs and provision of sexual healthcare to YPIC is the slowly-emerging body of work from the UK that reports on the topic from the perspective of young people themselves (Bundle 2002; Billings *et al.* 2007; Dale 2009, 2011). Bundle's (2002) study of 11 young people in a residential care setting in England attempted to clarify what participants viewed (broadly) as important in the area of health information. Indeed, while sex education and information about STIs were among the health information needs identified by study participants, the study did not reveal any information as to whom young people believed should provide this information.

Among the other emerging work from the UK on YPIC with an emphasis on sexual health, the two studies with aims and methodologies closest to the overall SENYPIC study are those of Billings *et al.* (2007), based in an English context, and Dale (2009, 2011), conducted in Scotland. In the case of both studies, because data were gathered from young people themselves, perspectives on sexual healthcare provision are limited to the service-users. While the literature review contained within SENYPIC Report No. 5 (Hyde *et al.* 2015c) will detail what this research tells us about the views of and experiences with these services from the perspectives of young care leavers, some findings from the Billings *et al.* and Dale studies relevant to this report are selectively reviewed here because they provide some insights into service providers' perspectives.

Billings *et al.* (2007) found, based on six focus groups with twenty 15-20 year-old YPIC, that participants reported diverse experiences and a range of views on sexual health provision. Among these was that 'friendly, supportive and approachable members of staff' (p22) appeared to have considerable influence over service-use. Of particular importance to participants was the issue of trust and confidentiality in sexual healthcare encounters. As well as in-school nurse services, preferences were also expressed for out-of-school services, indicating the importance of providing access to a range of service-providers. Among the study's recommendations was the provision of 'specialist training in the particular issues and circumstances faced by looked-after children . . . for those who provide sex and relationships information' (p.46). Also recommended was the establishment of 'long-term relationships with health professionals . . . given the transience described by young people as characterising their relationships with social workers and other professionals', and that service-providers should ' . . . make every effort to adopt a non-judgemental attitude and be empathetic towards the emotional needs of this population group' (p.47).

In the second UK study (specifically in the Fife region of Scotland) that attempted to capture the sexual health needs of YPIC (Dale 2009, 2011), participation was confined to ten YPIC. A scoping study of services was conducted, but service-providers' perspectives did not form part of either the report on the scoping study or the qualitative analysis. Nonetheless, it did emerge from the young participants interviewed that while the most commonly reported source of sexual health knowledge was school, other (unspecified) workers and carers were identified by some participants as having a role (Dale 2009). Additionally, Dale noted that those who acquired information from parents or a parental figure held this input in high regard, and she concluded that:

*Receiving sexual health knowledge from a range of sources appeared to be extremely valued by the respondents, stressing the importance for all people who work with, and care for, LAYP [looked-after young people] to discuss these issues with them. Since LAYP maybe more likely to miss out on schooling, and therefore sex and relationships education, this further emphasises the need for input to come from other people around them.*

(Dale 2009, p. 31)

She surmises that for young people who experience frequent shifts between placements, discussions about sensitive sexual health matters with their service-provider may be compromised in view of the disruptions to the relationship.

One other UK study that casts some small light on the role of service-providers in sexual health delivery to YPIC is Hill and Watkins' (2003) retrospective documentary analysis of the health records of all children in the care of the Southampton City Council who had attended a minimum of two statutory health assessments by the paediatric services over a three-year

period. The records of 49 children were included in the study, over half of whom were aged 10-15 years. The analysis indicated that in the case of teenagers, issues relating to sexual and reproductive health were recorded in just three instances on a single occasion in each of the following areas: contraception, antenatal care, and sexually transmitted diseases. The researchers acknowledge that the records may not reflect the actual number of discussions between service-providers and the young person as the latter may have requested that certain information not be recorded.

### **Formal acknowledgement of service-providers' role in sexual healthcare provision to YPIC**

There is a general consensus of expert opinion nationally and internationally that health and social care professionals have a role in providing sexual healthcare to YPIC (Eastern Region Health Board 2005; Department of Health 2009; Welsh Assembly Government 2003). This role is manifested in the *National Standards for Children's Residential Centres* (Government of Ireland 2001) and by national bodies in both the UK (National Institute for Health and Care Excellence 2013) and the USA (see Diamant Robertson (2013) for the latest national legislative developments on this issue the USA). The UK government recommends the inclusion of 'specialist training modules on sex and relationships in the new training and qualifications framework for foster and residential carers, making clear children and young people in care's heightened risk of early sex and pregnancy' (p.28) (Department for Education and Skills (UK) 2006).

In Ireland, the inclusion of sexuality education in care planning offers the most focused and formal way of acknowledging that there is a responsibility on the part of professionals to provide sexuality education to a young person in care. In the *National Standards for Children's Residential Centres* (Government of Ireland 2001), it is proposed that a care plan 'names a staff member responsible for giving appropriate guidance dependent on age and developmental stage on . . . physical and sexual development [and] sexual health and sexually transmitted diseases . . .' (pp. 29-30) (In practice, though, a Child & Family Agency (2014) report indicated that while written care plans were found to be in place for the vast majority (86.8%) of children in care nationally, in a minority of situations, particularly where children were being fostered by their relatives, the requirement for a care plan had not been observed).

### **The social and legal context of sexual health provision in an Irish context**

Figures for the number of YPIC in Ireland in 2014 indicate a national total of 6,490, most of whom (nearly 93%) were in foster care, with a lower proportion (just over 5%) in some type of residential care, and almost 2% in an 'other' care setting (Child & Family Agency 2014). Of the 6,014 in foster care, a sizeable minority (31%) were in foster care with relatives, with the remainder (69%) in general foster care. The types of residential care also varied: of the 354 young people in residential care, most (338 young people, or 95.5% of this cohort) were

in general residential care, with the remaining 4.5% living either in special care units or in high-support units (Child & Family Agency 2014). In addition, at the end of 2013, 1,093 young adults who were formerly in care were receiving after-care services, that is, support up to the age of 21 years (with a proposal to extend this to 23 years (Department of Children and Youth Affairs, 2014)). After-care is governed by the Child Care Act 1991 and provides that the Child and Family Agency may assist a person if he or she is deemed to be in need of support after leaving care.

With regard to the social and legal context in which social and healthcare service-providers work in Ireland, what emerges from literature is an unclear situation with regard to sexual health delivery and education. An issue that has been highlighted in existing reports on the situation in Ireland (Eastern Region Health Board, 2005) is the lack of guidelines for health and social care professionals regarding the anomaly between the age of consent for intercourse (17 years) (*Criminal Law (Sexual Offences) Act, 2006*)<sup>3</sup> and age of independent consent for medical treatment (16 years) (*The Non-Fatal Offences Against the Person Act 1997*), including hormonally-based contraception and STI testing. In the 2005 strategy document of the then entitled Eastern Region Health Board, it was highlighted that social services have particular responsibilities and challenges regarding sexual health in acting in *loco parentis* for YPIC. It was also observed that 'few [health] boards actually provide written legal guidance for health and social care professionals . . . Health and social care professionals require clarification about what services they can or cannot offer within the legal framework' (Eastern Region Health Board 2005, p.49).

In 2013, the HSE published a *National Consent Policy* that serves as a guideline for health and social care professionals. Such a resource offered some clarification as the legal framework, and child protection issues that cross-cuts it, are indeed complex: *The Non-Fatal Offences Against the Person Act 1997* of Ireland allows persons over the age of 16 years to consent to medical treatment without parental permission, but it has been noted that it does not offer guidelines as to whether medical treatment can be refused (Roche 2010). To address this issue the *HSE National Consent Policy (2013)* proposes that:

*...in cases where an individual between the age of 16 and 18 refuses a treatment of service, in general such refusal should be respected in the same way as for adults. However, if the refusal relates to life sustaining treatment, or other decisions which may have profound, irreversible consequences for him or her, reasonable efforts must be made to discuss the young person's refusal with all the relevant parties, including the involvement of the HSE Advocacy services and/or a third party mediator where appropriate, in an attempt to reach consensus. Failing agreement, an application should be made to the High Court to adjudicate on the refusal (HSE National Consent Policy, 2013 p.55).*

3 It should be noted that the data collection for the SENYPIC study preceded the publication of the Criminal Law (Sexual Offences) Bill, 2015.

Prior to the *HSE National Consent Policy* there was no national guideline on the latitude, if any, for professional discretion about whether to provide treatment without parental consent to children under the age of 16. The Policy suggests that where a child seeks to make a decision in the absence of parental involvement or consent the best practice is to encourage and advise the child to communicate with and involve his or her parents/legal guardians. The guideline state that it is only in exceptional circumstances that health and social care interventions would be provided without such consent. In such exceptional circumstances an objective assessment is required in relation to the rights and best interest of the child as to:

- Whether the minor has sufficient maturity to understand the information relevant to making the decision and to appreciate its potential consequences;
- Whether the minor's views are stable and a true reflection of his or her core values and beliefs, taking into account his or her physical and mental health and any other factors that affect his or her ability to exercise independent judgement;
- The nature, purpose and usefulness of the treatment or social care intervention;
- The risks and benefits involved in the treatment or social care intervention, and
- Any other specific welfare, protection or public health considerations, in respect of which relevant guidance and protocols such as the 2011 Children First: National Guidelines for the Protection and Welfare of Children (or any other equivalent replacement document) must be applied.

(HSE National Consent Policy, 2013 p. 53)

The guidelines also note that in any circumstance where a child is considered to be in an emergency life-threatening situation parental/legal guardian consent may be dispensed with, as under the doctrine of necessity, the welfare of the child will be the paramount consideration (HSE National Consent Policy, 2013 p. 58).

It has been noted, however, that some medical practitioners in Ireland use UK guidelines, known as the Fraser Guidelines (McMahon *et al.* 2010), arising from a judgement in the High Court there in 1983 in which criteria were determined to establish whether a child, regardless of age, was capable of giving valid consent to medical treatment in particular circumstances (Wheeler 2006). In 1985, the House of Lords approved the criteria, which came to be known as the test for Gillick competence by virtue of a case brought by Mrs Victoria Gillick, in which she contested the health provision guidelines that permitted her daughters under the age of 16 years to receive information on contraception without her knowledge. The term 'Gillick competence' bestows the legal capacity to consent to medical treatment and examinations to those under 16 years if they are deemed to have understood the nature of the advice and demonstrate enough maturity to evaluate the risks and implications of the proposed treatment. Lord Fraser noted that:

*. . . . As a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances.*

(Gillick v Western Norfolk and Wisbech Area Health Authority and another [1985] 3 AER 402)

Thus, the capacity to consent is captured in Gillick competence, a term erroneously used interchangeably with that of 'Fraser Guidelines', which refers to the guidelines used in the case of children receiving contraceptive information and services that invoke the Gillick test (Wheeler 2006).

Possible moves in the direction of Gillick competence, or the concept of a "mature minor", as a basis for determining consent are to be found in a report produced by the Law Reform Commission (2011) which contains a Draft Health (Children and Consent to Health Care Treatment) Bill 2011 (Law Reform Commission – Children and the Law: Medical treatment (LRC 103-2011)). In relation to healthcare and treatment (including access to contraception) involving persons under 16 years of age, the Draft Bill echoes the tenets of Gillick competence and invokes discourses of children's rights that take into account the increasing maturity of those under 16 years to consent to, or refuse, healthcare and treatment. However, at the time of writing, the Law Reform Commission's Draft Bill remains merely a recommendation and has not been translated into a legislative reform. Currently, therefore, Gillick competency or the concept of a "mature minor" does not form part of the law in Ireland. The HSE National Consent Policy notes however that Gillick and similar cases that have addressed this issue in other jurisdictions may be of "persuasive authority" if this issue was to come before an Irish court in the absence of legislative reform (page 52).

A few months preceding data collection for the present study was the document *Children First: National Guidance for the Protection and Welfare of Children* (Department of Children and Youth Affairs 2011) was published. This document is a revised version of the earlier guidance set out in 1999 (Department of Health and Children). In it, how child abuse is defined and recognised is outlined, as is the basis for reporting concerns, standard reporting procedures, as well as protocols in managing suspected abuse or neglect. The document states:

*7.16.2 For the purposes of criminal law, the age of consent to sexual activity is 17 years. This means, for example, that a sexual relationship between two 16-year-olds who are boyfriend and girlfriend is illegal, although it might not be regarded as constituting 'child sexual abuse' . . .*

*7.16.3 In cases where abuse is not suspected or alleged but the boy or girl is underage, consultation must be held between the HSE [Health Service Executive] and An Garda Síochána, and all aspects of the case will be examined. Both agencies must acknowledge the sensitivity required in order to facilitate vulnerable young people in availing of all necessary services, while at the same time satisfying relevant legal requirements (p.51).*

While the first edition of the *Children First* (1999) document drew attention to non-abusive sexual activity involving an adult and an underage person (eg. between a 16 year old and an 18 year old) as an illegal activity, it also proposed that 'the decision to initiate child protection action in such cases is a matter for professional judgement and each case should be considered individually.' The scope for such professional judgement, however, did not feature in the 2011 edition of *Children First*.

*Children First* references Section 176 of the *Criminal Justice Act (2006)* dealing with the criminal charge of 'reckless endangerment of children', an offence that carries the penalty of a fine (no upper limit) and/or imprisonment for a term not exceeding 10 years. The Act states that:

*A person, having authority or control over a child or abuser, who intentionally or recklessly endangers a child by –*

*a) causing or permitting any child to be placed or left in a situation which creates a substantial risk to the child of being a victim of serious harm or sexual abuse, or*

*b) failing to take reasonable steps to protect a child from such a risk while knowing that the child is in such a situation, is guilty of an offence.*

*Section 176, Criminal Justice Act, 2006)*

The Children First Act, 2015 was enacted after data for this study were collected. The majority of its provisions await commencement. This Act provides that persons who are mandated to make reports under the Act to the Child and Family Agency shall not be required to make a report in regard to underage sexual activity where one of the young persons is aged between 15 and 17 and the other is not more than two years older than them. Importantly, this allowance for non-disclosure is only available where the mandated person knows or believes that there is no material difference in capacity or maturity between the two parties and the child has made known their view that they do not wish a report to be made. However, if the child discloses that he/she is being harmed, has been harmed, or is at risk of being harmed then a report must be made at the earliest opportunity. This allowance for non-reporting of underage sexual activity may only apply where the relationship between the parties is not intimidatory or exploitative of either party. This echoes a similar provision in the Criminal Law (Sexual Offences) Bill, 2015. It should be noted that the Criminal Law (Sexual Offences) Bill, 2015 is not yet law and may be subject to further amendment.

A further piece of legislation that came into operation on 1st August 2012 (this was towards the end of the data gathering period for the service-provider study) that also impacts on the issue of the reporting of non-abusive underage sex is the *Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012*. This Act provides that it is an offence to fail to disclose to An Garda Síochána, without reasonable excuse, solid information concerning certain serious criminal offences committed against a child or vulnerable adult. Such serious offences include underage sexual activity as defined in the *Criminal Law (Sexual Offences) Act, 2006* which sets out the age of consent for sexual activity. What might constitute a reasonable excuse for non-disclosure is set out in the Act which provides that designated professions and prescribed persons may defend themselves against prosecution for not disclosing information to an Garda Síochána about an offence committed against a child (under 18 years), if they have formed a view, based on their professional opinion, that it should not be disclosed in the best interest of the health and wellbeing of the child. The Act also provides as a defence that such information may be withheld if that is the expressed wish of a young person who is over the age of 14. If under the age of 14, a parent may express the wish that the information is not reported except in circumstances where the alleged perpetrator of the serious offence is a family member. The obligations to report under this Act and the Children First Act, 2015 (when commenced) are separate and distinct from one another and reporting obligations should be considered under both pieces of law.

Another recent legal development has been an amendment to the Irish Constitution (Article 42A of the Irish Constitution) following a referendum in November 2012 enshrining the rights of the child specifically within the Constitution, expanding the latitude for the adoption of children in state care and providing for children to have a greater voice in decisions about their adoption, guardianship or custody in line with their age and maturity. The Constitutional Amendment was signed into law on 28th April, 2015

### Summary of what is known already about the topic

As is the case with other aspects of research on the sexual health and sexuality education needs of YPIC in Ireland, little is known about the perspectives of key service-providers on what the needs of this group are in this regard or how they believe they might be addressed. Expert opinion and policy documents broadly share the view that service providers ought to have a central role in meeting the sex education and sexual health needs of YPIC. However, this is an area rich in expert opinion and poor in empirical data about the substance of the role that professionals actually or potentially provide. What little research that is available about service provision of sexual health and sexuality education to YPIC is, for the most part, empirically weak because the focus of studies has tended to be directed elsewhere, resulting in sexual health and/or service providers' role in sexual health delivery to this group being glossed over. In relation to the social and legal context in which the provision of sexual healthcare occurs, the situation in Ireland is very complex and rapidly changing.

The e-survey detailed in Report No. 1 was the first step to addressing the lack of knowledge about service-provider perspectives on the RSE and sexual health needs of YPIC in Ireland; the present report (No. 3) builds on this knowledge.

### Objectives of Report No. 3<sup>4</sup>

- To reliably describe the sexual health and sexuality education needs of young people in care from the perspective of key stakeholders and service-providers.
- To identify the support needs of key staff with a central role in the provision of sexual health and sexuality education to young people in care.

### Methodology

The methodology for this component of the study was influenced by the outcome of an earlier phase of the SENYPIC programme of research, namely an e-survey of service-providers whose role potentially placed them in positions of being knowledgeable about the sexual health needs of young people in care (Fullerton et al. 2015a). A request was made to those responding to the e-survey to voluntarily supply their contact details should they wish to participate in a further phase of the study that involved being interviewed by a member of the research team to facilitate a more detailed analysis of the topic. There were two reasons why follow-up interviews were deemed to be necessary for a select number of e-survey respondents: (1) to undertake a mapping study of existing relevant services; (2) to gain a more in-depth understanding of service-providers' perspectives on the sexual health needs of young people in care and what supports were required to facilitate service provision. The current report is only concerned with the latter, as the former is reported in SENYPIC Report No. 2 (Fullerton et al. 2015b).

The original proposal was to undertake post e-survey interviews with ten service-providers; however, the e-survey responses indicated that sexual healthcare work with YPIC mediated a range of settings with input from a variety of professionals and organisations (Fullerton et al. 2015a). In order to capture the diversity of perspectives, the sample size was increased from ten to 22 participants<sup>5</sup>. This number allowed data to be saturated, that is, to reach a point where new incoming data were not adding anything particularly novel to the overall analysis, but rather were confirming emerging patterns. The rationale behind selecting the 22 in question was the centrality of their position in understanding the sexual health of YPIC, a strategy referred to as purposeful sampling. Participants were engaged in both direct service-provision (delivering the sex education and sexual healthcare) and indirect provision (such as delivering training to staff or in a supervisory capacity). The sample included those working in the following areas: social work, social care, counselling, project work, outreach services, health promotion, nursing, youth work, health work and education. The types of services/organisations in which these participants worked included: staff training in health promotion,

4 The objectives for the entire SENYPIC programme of research are presented in Report No. 1 (Fullerton et al. 2015a), and again in the final report in the series, Report No. 6 (Hyde et al. 2015c).

5 The descriptive mapping study (Fullerton et al. 2015b) involved details provided by these 22 participants, as well as an additional 12 participants.

youth organisations/youth cafes, addiction support, sexual health services, psychological and counselling services, residential care, advocacy, after-care, fostering and homeless/housing support.

Prior to the in-depth interviews, potential participants were sent an information sheet detailing the study. All apart from three interviews were conducted by telephone. Permission was obtained prior to commencing the interview for it to be audio recorded, and all participants agreed to this. The duration of the interviews ranged from 30 minutes to 1.5 hours, with most lasting approximately one hour. Interviews were later transcribed in preparation for analysis. A semi-structured topic guide (see Appendix 1) was developed to structure the interviews; this was developed from the emergent themes in the literature, and from the e-survey findings. As interviews progressed, some previously unforeseen issues were identified and all interviewers were requested to include such issues in future interviews. This is consistent with an inductive style of research. Interviews for this component of the SENYPIC programme of research were conducted in the spring and summer of 2012.

### **Ethical considerations**

Prior to commencing any field work, a submission to the Research Ethics Committee at UCD for ethical clearance for the study was approved. All data are held according to UCD's data protection policy.

Informed consent was obtained from all participants prior to interview. Participants were guaranteed that they would not be identified in any written reports of the study; for this reason, precise job titles of participants are not always given throughout this report in order to ensure that the identity of participants is concealed.

Some service provider accounts in this report indicate underage sex among YPIC whom these professionals had encountered in their professional role. The principal investigator, also the designated person (DP) responsible for reporting child protection concerns, was satisfied that from these accounts there were no reasonable grounds for concern that a child or children might currently be at risk of physical, sexual or emotional abuse and/or neglect, satisfying obligations under *Children First 2011*. In addition, after proper consideration of data, there were no reporting obligations required with reference to the *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012*. Exactly how service-providers followed up cases of underage sex and how these were investigated were not always clear from data, and determining this was beyond the scope and remit of the research.

### **Data analysis**

The data analysis technique used resembled a strategy developed by Bogdan and Biklen (2007) referred to as modified analytical induction (MAI). It involved comparing whole narratives with each other, rather than slicing data into segments from the outset, as occurs

in some types of qualitative data analysis. In this study, it involved taking the first whole transcript, paraphrasing the voice of the participant (raw data) and processing that through the researcher's repertoire of scholarly discourses (derived from literature) in order to make sense of it. Particularly telling segments of data that most represented important points were retained. From this very first account, tentative hypotheses began to be developed about what was happening on the ground in relation to the topic under investigation. The substance of each subsequent transcript was folded into the emerging picture so that the whole account was filled out, accommodating both similar and new insights. The analysis continued until all transcripts had been analysed and incorporated into the overall account, with pertinent quotations included in order to provide direct empirical evidence to support points where appropriate.

While some core issues and perspectives tended to be shared across the whole sample, others were common only to those occupying similar roles, and sub-patterns began to manifest themselves. Diversity was sought and built in to explanations by giving a sense of the empirical scope of a finding (the level of corroboration or difference from a broad pattern).

In practice, later interviews tended to add little to the emerging account, or only altered particular components of the whole picture as the analysis became saturated. This type of strategy ensured that aspects of data that contradicted the broad pattern were accommodated, but with their scope and strength acknowledged in the text.

The initial stages of the data analysis also informed the ongoing data-collection: Issues that looked promising in the analysis but were confined to just one or two participants were explored further in subsequent interviews.

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## Section 2

# Whose responsibility is sexual health and meeting the RSE needs of YPIC?

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### Introduction

In this section, the focus is on whose responsibility it is to meet the sexual healthcare needs of YPIC, against a general consensus among participants that YPIC do indeed have particular sexual healthcare needs compared to young people not in care. One recurring theme regarding responsibility for sexual health provision was to consider the role of those in positions most close to the young person, particularly the role of the key social care worker in the case of those in residential care. This issue is explored here, as well as some critical perspectives from participants about the limits of the social care worker's role. Participants' experiences of and perspectives on the provision of RSE for young people in care by external service-providers is also considered. A problem identified by several participants was that YPIC are required to interface with multiple professionals regarding sexual healthcare, and the repercussions of this are explored. Finally, the role of foster carers in relation to RSE is considered. It is important to remember that the findings in this report are based on a relatively small number of in-depth interviews with service-providers and are not intended to be generalisable to this population.

### Overview of the sexual health needs of YPIC and current provision of sexual healthcare

Although with an acknowledgement that there was diversity within the broad category of YPIC, there was agreement across the sample that YPIC do indeed have particular needs in terms of sexual health and RSE. This was because they were considered to be more likely to have lower levels of maturity, to engage in risky behaviours and to have experienced greater social instability compared to those not in care. The potential for lack of consistency in their lives and unstable and multiple placements were also identified as issues in this regard. Young people in residential care were deemed to be those with the greatest need.

Views about the extent to which RSE was occurring for YPIC varied. Participants reported having a limited awareness of how much sexuality education young people in foster care were receiving as this was left largely to foster carers and schools. As one principal social worker and team leader noted, 'In foster care where there are no issues coming up, it might not come on the radar at all'. That participant was of the view that the situation was different in relation to residential care, believing that most key workers do sessions on sexual health. However, this was not the impression that social care workers and other participants gave from their experiences. Indeed, a haphazard picture emerged of sexuality education provision in residential care settings. Some social care workers reported that little or no sexuality education was occurring for young people in residential care, while others reported a very good standard of sexual healthcare in such settings.

At a wider level, it was noted that the extent to which RSE was conducted in residential settings was dependent on the commitment of individual staff members who had an interest in delivering it. One area in particular where RSE was reported to be a low priority was in residential centres where residents' behaviour was challenging. Managing crises on a daily basis reportedly took priority over the longer-term preventive work that characterises much sexuality education. In such settings, RSE was described by one participant as 'non-existent'. The lack of policies in relation to sexual health was one obstacle to achieving consistency in RSE delivery in residential settings (This is considered further in Section 3).

As a general point, it was noted by one professional that the standard of care, including sexual healthcare, delivered to young people in care should be at least the same as the standard normatively provided to young people living with their own biological families. Her key point was that if, as a society, we project the message that the care provided by official authorities or foster carers to YPIC is superior to that potentially offered by their (birth) family members, then society needs to live up to this.

### **RSE provision by those with whom the young person has a close relationship**

Although a number of participants indicated that responsibility for sexuality education was a shared one, involving schools and health professionals, several participants identified the role of the key worker as a central source of RSE for young people in residential care. For children in foster care, foster carers were considered to be well placed to undertake the role, though with the support of professionals such as the link worker. It was noted that some children in foster care had a good relationship with their birth parents and these also had a role in their sexual health.

Whatever the type of care order or placement type (foster or residential), the dominant perspective across interviews was captured in the view that a young person responds 'more positively to sex education when it is delivered by somebody they know, trust and have a good enough relationship with'. Another participant summed this up as follows:

*The best person to do this with is someone you are close to, and someone you can be relaxed and open up with, not someone who goes off, so it's very hard. They need to know that they can trust you.*

Openness and accessibility on the part of the service-provider were also seen as key factors in the provision of ongoing RSE.

*They'll come to me with an [sexual health] issue on a casual basis because I'll be very open about it. This access is very important.*

In this regard, daily, rather than intermittent, contact between the young person and their key worker was identified as important by a number of interviewees. It was generally acknowledged that social workers' presence was transient and confined to visits, and for this reason they would not be best placed to deliver sexuality education. In addition, it was acknowledged that social workers simply would not have the time to engage in sexuality education, given the range of other duties demanded of their role. A principal social worker, however, did see opportunities for direct sexual health promotion by social workers during visits, or at opportune moments with the young person, such as while in the car or while undertaking activities. In particular, where the young person had experienced multiple placements, the social worker became the person with whom he or she had the most consistent relationship.

Others (particularly those not in a social worker role) were inclined towards the view that the social worker's role was to identify individuals who ought to be responsible for delivering RSE. Furthermore, the importance of the social work department being informed about any planned sexual healthcare was conveyed. It was acknowledged that while the key worker was well placed to know the young person's needs best, he or she nonetheless required the support of health professionals for information and relied on sexual health trainers for skills' acquisition. While it was recognised that time and resources were very limited in the current economic climate, the commitment of managers to support the up-skilling of social care workers in sexual health was also reported (staff training is considered in Section 6).

The notion that the person delivering sexuality education should be favourably disposed to the role was also raised, as not all staff were considered to be equally suitable. It was noted in Section 1 that Billings et al. (2007) recommended that a concerted effort be made to convey a non-judgemental approach when providing sexual healthcare to YPIC, and this was echoed in the narrative of a sexual health counsellor that follows. She asserted that at the core of choosing staff to deliver RSE ought to be the needs of the young person and the need for a non-judgemental approach.

*And I would imagine there would be some social care workers who wouldn't ever be suitable, or it wouldn't be appropriate for them to deliver the programme, put it that*

*way . . . none of us are in a position to change somebody's values and beliefs, but we can educate them and let them see how it might harm a young person to openly express that [homophobic] view.*

What the selective process of identifying 'suitable' staff to deliver sexuality education highlights is the complexity in determining which values and attitudes about sexuality are appropriate at any given time and in any given society. The 'right' values and attitudes to permeate any sexuality education programme are not universally agreed. Those with highly conservative views rooted in religious values are likely to find liberal attitudes inappropriate, while those with more liberal perspectives are likely to find conservative views paternalistic and judgemental. However, within the current politico-legal framework in Ireland, the discourse of liberal values rooted in secular enlightenment ideals emphasising reason over divine authority (Mills 2002) are dominant and formally supported by equality legislation (*Equal Status Act 2000*).

While the sexual health counsellor from the previous quotation reported that priority should be afforded to the needs of the young person in selecting staff members to deliver sexuality education, she also made reference to the need to protect staff themselves when making such decisions. Some staff, she reported, were themselves vulnerable to the distress of being exposed to accounts of sexual abuse or exploitation experienced by YPIC, particularly where the latter may not recognise this as abuse\*. She indicated that both she and a clinical psychologist had made themselves available for staff de-briefing in instances where staff distress was experienced. Because sexuality education was a key part of the work of particular centres dealing with people with sexuality-related trauma, she reported that staff who were sensitive to becoming affected themselves by sensitive cases were normally not deployed there.

Even where social care staff were willing and suitable to undertake RSE, it was noted that in some residential centres, the immediate daily grind of crisis management took precedence over sexuality education that focused on longer-term benefits. Particular time-periods were deemed to be unsuitable for RSE or any sexual health promotion such as the 'chaotic phase' when day-to-day routines became unstable. Similarly, in the case of foster care, other issues were often foregrounded – 'Bigger needs, like where will the young person stay tonight if the placement is breaking down'.

### **The provision of RSE by external service-providers**

While the dominant view was that the key social care workers should be the main source of sexuality education for young people, there was also a minority view that RSE should be delivered by professionals from outside the organisation. One social care worker favoured this practice because she believed that the education conveyed by social care workers may be 'diluted'. She also felt that the social care worker would need to be privy to the substance of any RSE delivered by an external provider in order to be in a position to manage any traumatic repercussions that may later emerge.

*I think an external person coming in would be more effective and I think the social care worker to act as a support and sort of play on the relationship that they have with the young person in sort of encouraging them . . . Whereas I think if the social care worker delivers it on the unit it just becomes diluted. I think it would be more effective to come from an external stranger so to speak. I think they [social care worker] would have to have some type of knowledge about what was being delivered because then when the external person leaves, or whatever was said in the session could trigger bad memories, again they [YPIC] could go into crisis. And at that point then the social worker would need to know how best to respond to manage the situation.*

Sharing the content of a sexuality education session, though, was not something that all professionals working parallel to social care workers were in a position to do. One psychologist who engaged in sexual healthcare with YPIC indicated that a good deal of the substance of what was discussed between herself and the young person would not be shared with the rest of the care team 'unless there was an issue of risk'.

*Young people will come in and tell you they are sexually active and they're terrified that the care worker will find out. If they are over age there's nothing we can do, we have a confidentiality. If they are underage we have to look at the ethical dilemmas.*

The management of information in relation to underage non-abusive sexual activity will be considered further in Section 3.

### **Sexual healthcare as part of the jurisdiction of multiple professionals**

In relation to identifying who had a responsibility for the sexual healthcare and RSE needs of young people in care, the fact that often there were multiple service-providers involved was raised as an issue of concern. Young people who had experienced multiple placements were considered most likely to fall between two stools when it came to RSE delivery. Returning to education or changing employment during the years of economic boom was also believed to contribute to rapid staff turnover, exacerbating the problem. While acknowledging that some children in care are not affected in this way if they experience a stable placement, one participant noted the challenges for those who experienced a lack of continuity in care.

*If they [young people] are coming and going and there is no continuity nobody knows exactly what they have done before, what came before and what does it come after, so that can be difficult.*

Reflecting on the time when she worked in residential care another participant recalled how sexuality education was never undertaken because of the assumption that some other professional would deliver it. Lack of clarity about whose role RSE was a key problem.

*There was always that bit about, it is the social worker's job, or you assume the social worker was doing it or you assume the teacher in school was doing it.*

A separate issue to emerge relating to the multiplicity of service-providers involved was that several stakeholders could be privy to the intimate lives of the young person. The difficulty for the young person of so many professionals having access to such sensitive and personal documented information about themselves was acknowledged as follows:

*There's also the thing about over the years so many professionals knowing so much about them, which is hard on the young person too – here's another new one, new member of staff – she's going to be reading my files. There's a privacy things there too. It's very hard on the young person . . . Breakdown in staff is difficult for them. I have come across people who have had 25 or 30 social workers and whatnot over their life.*

A social worker noted that even a simple request for a paracetamol for menstrual pain may be documented in a log book and open to staff as well as Health Information and Quality Authority (HIQA) personnel to read, something that she considered difficult for a 13- or 14-year-old. While acknowledging that residential managers were required to record such events, she contrasted this with the situation for a girl in her family home who might just inform her mother that she was taking paracetamol from the medicine chest.

An additional factor raised was the complexity created for those in residential care by the layers of stakeholders that those requiring a sexual health intervention would have to negotiate. One service manager gave as an example the multiple professionals involved in a young person in care accessing contraception or emergency contraception, even where they were over 16 years of age. She compared this with the less complicated process for those not in care.

*I think it is a little bit more difficult when they are in care because there are so many people who have a say. If a young person who is 16 wants to get the morning-after pill or wants to go on the pill or wants to get the bar [contraceptive implant] in, then they have to discuss that with their key worker who will discuss it with the manager of the unit who will discuss it with the child care manager, do you know what I mean? If a young person at home wants the bar [contraceptive implant] in they will talk to their mother about it or they come in and get it.*

The participant went on to clarify that her criticism was not directed in any way at those at the front line of caring, who in her experience were not 'unreasonable', but rather to make the point that, 'it is always easier to talk to one person than it is to know if you talk to one person, then six people are going to be aware of the conversation'. She was of the view that once individuals reach 16 years, they should have the right to make decisions about safer sex themselves, and that when they reach 17 years, their position should be no different to that of

young people in general. She also shared her observation that while the legal implications of young people in general of 15 years seeking emergency contraception were no different from those of YPIC, the former 'could probably chance it', that is, had a higher chance of informally circumventing the legal system by claiming that they were older than their years. This perspective was shared by a social worker who noted that 'in an ordinary family if a teenage girl needed the morning-after pill they could access it by parents through the GP'. She also noted that the need for young people in care to have access to their medical card number to avail themselves of free GP services sometimes led to social care staff wondering whether or not they were permitted to sanction this type of sexual health intervention, particularly if the young person was under the age of 16. She referred to decisions by GPs to prescribe emergency contraception to underage minors without the knowledge of the social worker as a practice sometimes met with pragmatic relief.

*We often find out that the doctor did give the 14-year-old the morning-after pill and sometimes we're nearly glad that that happens without our knowledge because it can become, well, it would have to go through the social worker and all that.*

Another participant noted that, for reasons of confidentiality, she and a nurse on a multidisciplinary team were the only team members privy to a 17-year-old resident being taken for STI screening. When other team members later learnt of the clinic visit she described them as being 'very angry that they hadn't been told'. It should be noted that in a study by Billings et al. (2007), reviewed in Section 1, YPIC highlighted the importance of trust and confidentiality in encounters with healthcare providers. Data in the present study suggest that maintaining confidentiality may be problematic in a professional jurisdiction in which multiple providers are involved.

The relatively weak relationship of a multiplicity of professionals to the young person was also deemed by another participant to compromise a key 'protective factor' in sexual health, namely strong parenting. In the quotation that follows, the participant asserted that parents are in a position to impart their knowledge and values to their child in a very clear and definitive way, which is more problematic for service providers.

*One of the key protective factors for children, regardless of type of risk behaviour, is their parents. As a general rule permissive parenting leads to more unwanted behaviours in young people. When a professional does it [delivers sexuality education] it is in the way of giving choices but I think when a parent does it they should be saying, 'You are not to have sex'... not wishy-washy messages. Parents need to make it clear to 15-year-olds that they are not able to take on rights and responsibilities of adulthood until they are able. For children in care and the kids that don't get that stricter parenting fare worse.*

*Interviewer: Do you think that parental figures for children in care should be giving the strong message: 'Don't do it?'*

*In no uncertain terms . . . but it's very difficult for care staff on a Saturday afternoon shift to talk to young people about having sex. I do think that it should be a message from society that it is not okay for 16-year-olds to have sex.*

In justifying his perspective, the participant's canvassing of an abstinence message did not appear to be based on a Christian Right perspective, as is the case with many of the North American sexual abstinence programmes (Calterone Williams 2011). Rather, a developmental approach was invoked, that is, a recognition that teenagers are in a development phase and are not yet adults. His contention was that young people in care need unequivocal guidance through their teenage years rather than individualistic self-direction until they are mature enough to make decisions for themselves.

### **The role of foster carers in RSE and sexual health provision**

The compromised position of foster carers in delivering strong sexual health messages as they might in the case of birth children was raised by a sexual health trainer. Her view was that foster carers may have particular difficulties around sexuality education and may be less confident about conveying their values and attitudes 'because they are in that kind of mid-way place'. This, the participant contended, was complicated because of the lack of 'statutory or standard guidelines on the type of support foster carers should get in relation to sexuality education'. Another participant, an outreach worker dealing with children at risk of losing a home placement, indicated that part of his role was to assess sexuality education needs and how they are being met. He commented that foster carers had requested that he or his colleagues deliver the required sexuality education.

*We would ask the foster parents, 'Have you had the conversation around sexual health?' and they would say, 'No, I can't do it, they won't listen to me. Would you mind doing it?' And we would say, 'No problem at all', and we would do that piece with them.*

For all YPIC, it was proposed that a consistent, planned approach to sexuality education that knitted well together was the best approach, and that early sexuality education should be built on what has been covered previously. However, the sense from data overall was that the ideal of a consistent, joined-up approach is not happening uniformly on the ground.

### **Key points: Section 2**

- There was a general consensus among participants that YPIC have particular sexual health and RSE needs compared to young people who are not in care.
- The extent to which sexual healthcare and RSE were being delivered to YPIC was believed to vary both within and across care settings.
- While a range of service-providers were acknowledged as having a role to play in meeting the sexual health and RSE needs of YPIC, those with the closest and most continuous

relationship to the young person were favoured for the role. This was deemed to be the foster carer in the case of young people in foster care, and the key social care worker for those in residential care.

- Limits to the roles of social workers and social care workers were acknowledged, and a willingness to undertake the role was considered to be important.
- A minority view within the sample of participants was that external stakeholders specialising in sexual health should be the key providers of sexual healthcare and RSE; however, views were divided on how much information about the young person's sexual health should be shared between external staff and social care workers (in the case of young people in residential care), in light of considerations around confidentiality.
- A dominant view across the sample was that the number of people involved in the lives of YPIC and with a stake in their sexual healthcare, contributed to their difficulties and was at variance with their need for consistency.
- For children in foster care, foster carers were acknowledged as having a role in RSE.

## Section 3

# Bureaucracy: care plans, policies and legislation in relation to the sexual health needs of YPIC

### Introduction

In this section, participants' perspectives on bureaucratic practices and structures that mediate how the sexual health needs of YPIC are managed are considered. Starting with the local level of care plans, participants' views on organisational policies around sexual health through to national guidelines and legislation on child protection are captured. How plans, policies and guidelines (or the absence of these) were seen to impact on their work in sexual healthcare provision with young people and on meeting the latter's sexual health and RSE needs will be illuminated. As will become clear from the accounts of some participants, the context in which service-providers were working at the time of data-gathering preceded the enactment of the Children First Act 2015.

### Care plans

As indicated in Section 1, the provision of sexuality education, for those in residential care at least, has formal support by its inclusion in the *National Standards for Children's Residential Centres* (Government of Ireland 2001). These standards charge a named staff member with specific responsibility for imparting 'appropriate guidance on . . . physical and sexual development [and] sexual health and sexually transmitted diseases . . .' (pp.29-30). In the case of the present study, the inclusion of sexual health in care planning in this way found favour with a number of participants. However, a social worker noted that sexual health was not specifically identified as a 'named' area, but rather in theory was captured during child care reviews under the various components of health such as physical, psychological and social well-being. A greater emphasis, she reported, was placed on general health, immunisation, dental health, and the possession of a medical card. The lack of explicit detail about which aspects of sexual health (if any) had been covered was also borne out by a project worker who admitted finding it 'hard to know how much they [new service-users] have covered without looking into their background forensically'. He acknowledged that while care plans covering

'health' tended to be forwarded to the service site by social workers, it was nonetheless difficult 'to ascertain whether [new service-users] have had any kind of specific sexual health training'. It has been noted by researchers in Britain (as indicated in Section 1) that the absence of assessment information about young people in care may not mean that discussions did not occur, simply that they were not recorded (Hill and Watkins 2003). That Hill and Watkins found very little evidence of recording of sexual healthcare in case notes among a sample of young people in England suggests that the issues raised by service-providers in the present study about the recording of sexual health issues for young people in care are not unique to Ireland.

Nonetheless, the lack of a formal acknowledgement of sexuality education as an integral component of a young person's care plan and the reliance on individual staff members, having an interest in RSE, to deliver sexuality education was raised by a sexuality education trainer.

*I mean that is a significant barrier, that it is not recognised as being an integral need to the young person and just part of the curriculum and part of the care plan . . . So the workers didn't feel supported even if they had a personal wish to do it.*

Another participant also reported that in her previous experience of working in residential care there were no protocols that ensured that sexuality education was part of the plan. The result of this, she observed, was that 'for young teenage girls and boys, their sex education needs were never identified'. She was of the view that this state of affairs had not changed in recent times because service-users with whom she currently engaged in an after-care setting indicated that they had not received sexuality education.

*And my experience of working with the residential staff was that it was an area that, a taboo area, they didn't want to get into it. It was the elephant in the room and no one wanted to sit down, even though people knew they were engaging in risky behaviour. I don't think it has changed because they [current service-users] would say that they didn't get any sex ed. But I think when they are in care it definitely should be part of their care plan.*

Another noted that ideally, both parents and social workers ought to be made aware of sexual healthcare within care plans.

*Ideally involve their parents, ideally involve their social workers, we have to involve their social worker to let them know, particularly if they are on a care order, but certainly inform the parents of what is happening where you can.*

The inclusion of a range of stakeholders in sexual healthcare planning (as part of a care plan) for a young person in care was, however, potentially problematic because of the presence of the young person at childcare reviews. In considering the sensitivities around sexuality, one social worker questioned the inclusion of sexual health in joint planning.

*Does the child want that [sexual health] mentioned in the middle of a meeting, because the child attends the reviews? It could be embarrassing for the young person. You have the team leader who chairs it, you have the social worker, you've maybe foster carers or if in residential care residential care staff, you've the young person there. You might have child psychiatry people there.*

This social worker's concern about openly raising the issue of sexuality in the presence of the young person may be well-founded in view of existing evidence that embarrassment is indeed a feature of communications about sexuality between children and adults (Hyde et al. 2010, Turnbull et al. 2011).

### Organisational policies

The sexual healthcare needs of YPIC may potentially be recognised at a level above individual care plans, namely incorporated into regional and national organisational policy. The extent to which organisational or local policies (or, more usually, the absence of these) impacted on sexual healthcare delivered by professionals interfacing with children in care was a strong feature of participants' accounts. Two sexual health trainers indicated that they saw a role for themselves in encouraging and supporting organisations to develop guidelines around sexuality education. In the absence of such policies, these trainers noted that frontline workers were delivering sexuality education in isolation.

*None of the workers who have come to our training . . . have said that their organisation had a sexual health policy or a sexual education policy . . . I shouldn't be so generalising, but some of the workers didn't feel supported to do it.*

*And sometimes they [staff] work pretty much on their own so we are trying to encourage them to have a policy within the centre.*

In addition, two psychologists expressed the view that in their position within a multi-disciplinary team, their intention was to develop such a policy but a lack of time prevented them from doing so. The slow development of policies appeared to exacerbate a sense of uncertainty and fear among staff about how to approach sexual health with service-users. In the following quotations, an openness to discussing sexual health needs and a clear policy that offered staff a degree of protection to engage in sexuality education without fear of censure was advocated<sup>7</sup>:

*That's where the problem is – there needs to be policies and procedures, but nobody is going to grasp that nettle. You have individual clinics – a lot of things going on on the ground, but we need to have staff protected. We need to have a mature conversation about this. It's one of those subjects that does not get discussed.*

<sup>7</sup> To recapitulate, interviews were conducted in the period prior to the enactment of the Children First Act 2015, which provided some further clarity on the issue of non-abusive sex between those aged 15 years and over.

*I think the only barrier that stands out, and what I know from working with people, is definitely the lack of policy or a lack of formal structures that they work with to guide them . . . listening to very highly skilled professionals saying, we are doing this work and that work around human development, around sexual development and information. So ok what happens if this, and we propose a legal scenario, and then they look at us. And well, who is being sued? You or your centre? So we have to try and get them into that mind that it is the centre that is responsible overall, so definitely I would say if every centre had a very clear path and policy that guided and supported their staff in working with young people. I know it can be too rigid, but certainly there should be certain guiding points . . . independent supervision, I think there is a huge gap in that that is not provided.*

One participant recounted how seven years previously, attempts were made by some people in the organisation in which she worked to develop a policy on sexuality education, but there was a sense that prescribing a set of sexuality education practices as policy would open an oppositional debate and actually be counterproductive if anti-sex education sentiment came out stronger. In view of this, the plan failed to progress and it was decided that undertaking sexuality education would rest with individuals in an informal way. Nonetheless, there was an expectation that each young person entering care would have an individualised sexuality education programme that met his or her needs, and its delivery rested with the individual manager. While raising concerns over the lack of standardisation, she simultaneously acknowledged the level of flexibility that an 'open' approach (that is, an approach free from being bound by policy) affords. Her concern was that a policy designed to meet sexual health needs in general might limit the scope an educator had in tailoring RSE to specific cases. Her ambivalence is captured in the following quotation.

*If we draw attention to it and the whole thing gets rubbished then it might put a complete stop to sex education or sex education that actually meets the needs of the young people we are working with. I really struggle whether or not it should be in writing or not. That at the other side there is no obligation then on anyone to deliver it and you are down to hoping that the professionals responsible will actually see it as necessary and go on and do it.*

### **The limitations of guidelines and policies**

Creating policies on sexual health was not seen as a panacea; a worker in a residential setting was of the opinion that even if sexual health policies were in place, crisis management of emerging situations would take precedence over a policy to deliver quality sexuality education.

*You can have a policy and procedure but more times than not when the unit is in crisis or when the young person is in crisis, policy and procedures sort of just go out the window and it is just containment and keeping them safe and everything else sorted.*

A further issue noted by a few interviewees was that the absence of local policies was particularly complex where the organisation had a Catholic ethos, and words like 'fear' and the need to 'be very careful' were used in relation to delivering sexuality education at such locations.

*I work for a Catholic organisation and we can't hand out condoms here. We have to be very careful talking about contraception and things like that . . . But up to 18 you have to be very very careful. Any organisation you have to be very careful. I work for a Catholic organisation – you have to be discreet about it.*

Another participant similarly noted that there continued to be a legacy from the epoch when the care services were managed by religious orders with conservative views on sexuality.

*When I started in the service it was a voluntary service managed by a religious order. Now a few years later it became part of the HSE. But the religious influence was certainly there then. I would say, and people may not be comfortable admitting it, but there is still an element of influence amongst staff who were working then and still working, they would say, 'there is no way we could say that years ago' . . . And there was enormous fear of would individuals get into trouble for giving certain messages in sex education programmes or even doing it in the first place.*

That participant went on to recall an incident within the previous ten years when a social care worker who was a single woman was advised not to discuss her pregnancy with the young people.

### **The impact of national guidelines and national discourses relevant to YPIC**

In relation to national guidelines that impact on the sexual health needs of YPIC, just one participant referred (loosely) to those of the Health Information and Quality Authority (HIQA) and several others referred to the *Children First* (2011) guidelines. A number referred to child protection discourses broadly without naming any report. In relation to HIQA, one participant indicated that she was reviewing the standards proposed by the Authority and welcomed their anticipated extension to all residential settings in view of their 'personal centred focus'.

There were mixed views about the impact of national child protection policies on sexual health and the delivery of sexuality education. One participant suggested that the new climate of child protection facilitated the delivery of sexuality education and the duty to protect children could be invoked as the justification for providing sexuality education to young people.

*I certainly wouldn't see the attitudes of the powers that be as a barrier: I am more than happy to justify everything I do and to be honest I would think in this new climate of child*

*protection and safety I would be amazed if anyone spoke out and said, 'Young people should not have sex education.'*

This participant's argument was that young people were more likely to protect themselves if they were furnished with information. She held strong views that the discourse of child protection mandated professionals working with young people to impart information about sexual safety in the interest of the young person's welfare. She foregrounded the duty to care, and held the view that not providing information to young people (under 17) would constitute negligence. In this regard, she invoked particular guidelines that she believed were used by medical professionals.<sup>8</sup>

*My attitude is I think it is negligent not to give young people basic information that would keep them safe, bottom line. And I think that is certainly what other professionals, medics included, I mean there is a lot to be said for the rule that it is about if the young person is going to do it anyway then give them the information to keep them safe . . . And I don't think anyone could stand over denying young people information that would allow them to protect themselves . . . I think their credibility in terms of child protection and working in the best interest of children, they would just find themselves in the gutter.*

The participant went to suggest that professionals who may have been reluctant to engage in sexuality education until the more recent period would be committing 'career suicide' and endangering their credibility by not undertaking it in the present climate. This participant highlighted professional judgement as the core to protecting young people and did not draw attention to how she might manage information about underage non-abusive sexual activity.

Not all participants were of the view that child protection guidelines were singularly helpful. One participant, a health professional working with younger people, was of the view that reporting all instances of underage non-abusive sex potentially problematised the position of professionals because there were multiple ways in which risk could be defined. Moreover, in his experience the social services system simply would not be able to process the number of referrals if all instances that could be defined as risky were reported. He revealed that he had reported a number of instances of underage non-abusive sex in the past and found that there was no follow-up of such cases because the resources were not available to investigate them. He also elaborated on the 'grey areas' that cross-cut professional practice, and the manner in which this exposed professionals who may have information about a 'risky' practice (like underage non-abusive sex) yet did not report it. At the same time, he asserted, professionals sometimes make poor decisions, so leaving decision-making to the discretion of professionals could be problematic and leave them exposed. The alternative of mandatory reporting on the basis of rigid rules (in this case chronological age) alone, he contended, was problematic.

*You get into grey areas: The problem is that people can use their judgement really badly. When you hear about children in care and children at risk, there is an assumption that*

<sup>8</sup> As indicated in Section 1, McMahon et al. (2010) noted that some medical practitioners in Ireland use UK guidelines based on the Gillick case, although these guidelines do not have established legal validity in Ireland.

*something should have been done differently . . . yet the Minister is going to the stage of mandatory reporting<sup>9</sup> so that if someone is having sex at 16 years and 360 days they should be reported but if they are having sex 6 days later that's fine, and that kind of black and white system makes no sense . . . I would not like to be the professional trying to explain publically why the issue of two 15 year-olds having sex isn't a risk – we all know that it is a risk, but whether or not the way to deal with it through a mandatory reporting system is the issue. . .*

Additional complexities that mandatory reporting brings, he noted, relate to professional confidentiality. He was of the view that mandatory reporting could impede professional practice and hinder health assessments (gathering data from the individual to arrive at a professional 'diagnosis').

*If we were to say to young people, 'Every risk that you tell us about we have to report to the social worker, even if you don't have one already,' they're not going to tell us a thing. We can no longer give a guarantee of confidentiality.*

He reported being aware of another organisation that dealt with risk behaviours where staff had had to resort to the principle of 'Don't ask; don't tell,' because, he relayed, many of their clients were underage and engaged in risk behaviours that were illegal. Reporting all instances, he indicated, would impede the clinical work of the organisation. The result, he contended, was treating young people therapeutically (non-invasive or non-medical interventions) without having first asked directly if they had engaged in the risk behaviour; that they attended the organisation implicitly confirmed that they had engaged in the behaviour. His fear was that the same principle would apply to sexual health, impeding a social and clinical history-taking that allows professionals to plan care/interventions. Since good practice proposes the systematic and purposeful gathering of information in order to identify the best course of action for a particular service-user, avoiding history-taking is at variance with the tenets of professional assessment for health and social care workers (Turney *et al.* 2011). A few participants noted how uncertainty about managing sensitive information around sexuality impeded workers in their role.

*For some of the workers . . . most of it is about fear: Should they be handling this? Is this allowed?*

*Well I think staff are afraid to discuss sex with children because they may face disciplinary proceedings.*

*I think staff are afraid of going into areas where they don't feel confident or safe or who feel they don't want to be discussing sex with teenage boys in case it's seen as overstepping a mark.*

<sup>9</sup> The participant's comments here reflect earlier drafts of the Children First Act 2015 during its development and proposals that ultimately did not transpire.

Another participant similarly described a lack of clarity around how to approach the reporting of underage sex, reflecting the uncertainty at that time period prior to the enactment of the Children First Act 2015. This section of the Act, when commenced, will bring greater clarity as it sets out the circumstances in which underage sexual activity must be reported and, importantly, the circumstances in which it may not be necessary to report. In the description that follows, she revealed that she made professional judgements based on a careful history and thorough assessment and adopted a 'harm reduction' approach. Her account suggested that she reported underage sexual activity in cases where she deemed that there was a level of domination or a risk of harm to one of the parties. In other instances, her approach was reportedly pragmatic and safer sex was prioritised.

*If a 17-year-old comes to me and says they are having sex with a 16-year-old girl – now if a boy came to me and said he was having sex with a girl under 15 my concern would go up, but most of the boys if they are 17 the girl is 16 or 15, or the boy and the girl are both under age, so legally they are in a grey area. Look, what do I do if a boy comes in – he's 16, she's 15 and he's having sex with her? I don't know who she is. I ask a bit about what they're doing. I ask about whether he's harmful or abusive. Is it normal teenage fumbling or experimentation? If a boy came to me and I was concerned about how he was treating the girl, I would take it further, but if this was normal teenage sexual activity, I would be more concerned about – is he being safe? Is he using birth control? Is he using a condom? And take that harm-reduction approach instead.*

The same participant went on to indicate that for her, the psychological needs of the service-users took priority over the risk of professional censure for not reporting. Her decision not to report underage sex would be taken in 'the best interest of the young person concerned'<sup>10</sup>. However, her narrative also revealed her understanding that her professional decision constituted a risk, but one that she was prepared to defend if required.

*It's a difficult area and I have to tread a fine line because if they are having any sort of sex with a girl who is under 17 they do need to be able to talk about it. Legally, it's thin ice to skate on and other youth workers struggle with this as well . . . Maybe I should be more anxious about where I stand legally, but I suppose I tend to take the approach: look, this boy needs to talk about it, me saying anything is not going to stop him having any kind of sexual relationship – he's either going to talk about it and seek advice and seek help or he's not, and my role is to give advice, and God forbid if it comes up to bite me legally, I'll just have to do my best to stand over it and explain it as being in the best interest of the young person concerned. I suppose I take that risk.*

Noting that the national guidelines were becoming 'tighter and tighter', she criticised the *Children First* guidelines on the grounds that they were overly rigid: 'It's almost the reverse of muddy – some would say it's too black and white'.

<sup>10</sup> In some cases, such in this one, it appeared that service-providers did not comply with *Children First* guidance where underage sexual activity was reportedly known to them. It was not always possible to determine from data whether such service-providers were in fact HSE Child and Family Social Services (now Tusla) employees during the time at which the events they recounted occurred.

Uncertainty about whether the proposed course of action was legally and procedurally acceptable was also reported to delay decisions about accessing sexual health. A principal social worker, for example, reported that on some occasions a young person's query about accessing contraception required the service-provider to consult with others about guidelines and policies, and the young person may have had to wait a week for an answer. In one instance, she reported that on some occasions a young person's query about accessing contraception required the service-provider to consult with others about guidelines and policies, and the young person may have had to wait a week for an answer. Participant went on to describe the anxiety among social workers in situations where they were pulled between child protection obligations and preventing YPIC from becoming pregnant or getting an STI. She also referred to what she viewed as the contradictions and tensions within the system, describing the need for greater accountability, which she felt was a positive move, and the increased bureaucracy, which she viewed as 'nearly immobilising social workers on these areas [sexual health] because you don't have a clear guideline'. The fear of an inspection by the Health Information and Quality Authority (HIQA) might raise questions about some actions of social workers such as enabling a young person to access condoms, she added.

The complexity of the situation was described as a 'minefield' for those under 16 years attempting to access sexual health services, since consent of biological parents was required for medical treatment for these young people in voluntary care. The knowledge that young people under 16 years could be putting themselves at risk by engaging in unsafe sex because staff felt that they were not at liberty to facilitate making condoms available was reported by one participant as causing disquiet among social care staff. One of the needs for those over 16 years, identified by one participant, was for the young person to be empowered to take charge of their own sexual health: to take initiative in making a doctor's appointment and to become proactive about the routines associated with using contraception.

There were also service-providers who indicated that they continued with their work without engaging in much introspection about guidelines and therefore did not feel that their work was affected by them.

*Certainly they [policies] have never impacted in terms of we have not been able to work because of them, so that it is not a difficulty from that point of view. I wouldn't say I have read them all to the extent that I would know them well enough to say anything else about them really. I mean I have read the regulations and whatever obviously but it has never been a huge issue.*

The lack of a public discourse that acknowledges early adolescent sexual activity was also raised. In the following quotation, the participant reported her perception that early sexual activity is harmful (a view consistently supported in empirical literature), yet in the interests of child protection she advocated a public recognition that some early adolescents are sexually active and a dialogue as to why this is the case.

*I think there does need to be a discussion at national level . . . First of all an acknowledgement that young people are sexually active. It doesn't have to be the norm. There are lots of problems associated with early sexual behaviour and I think there needs to be an understanding of why it is happening . . . My personal opinion, it is really not safe or not healthy for 12 and 13 year olds to be sexually active in that way. And it is happening because there isn't the discussion, because there isn't the debate, because it is almost assumed that it doesn't happen. I think sex education on the whole can be left too late.*

A participant working in a rural area noted that young people who were sexually active were not in a position to protect themselves because of the cost of condoms and the difficulty in accessing sexual health services for those in rural areas.

Before leaving Section 3, it is worth noting a wider political issue that may well have an indirect impact on the sexual health of YPIC, namely the disincentive to stay in education by the provision of State allowances to those on training programmes such as Solas (previously FÁS) courses. One participant noted that no incentive was in place to enable working-class teenagers to complete their secondary schooling. Given the association between poor educational attainment and teenage pregnancy (Baird and Porter 2011), this may well have an indirect effect on sexual health among YPIC.

### **Key points: Section 3**

- Participants believed that the sexual health needs of YPIC should be documented in their care plan, as this would facilitate implementing sexual healthcare; participants' accounts suggest that this is not consistently practised currently.
- The perceived absence of organisational policies governing how sexuality education should be approached was viewed as problematic and impacted negatively on meeting sexual health needs at local level; a minority view was that the absence of local policy in this regard facilitated flexibility for those delivering RSE.
- There were mixed views on the extent to which the national guidance (*Children First 2011*) facilitated the sexual health and RSE needs of YPIC; how to interpret 'risk' and making judgements about what sensitive information to report formally was perceived as problematic for some participants. This was particularly the case in relation to non-abusive sexual activity, although participants' views in this regard reflected the time period when the interviews were conducted, which was prior to the enactment of the Children First Act 2015.

## Section 4

# Doing RSE and promoting sexual health

### Introduction

In this section the focus is on service-providers' perspectives on *doing* RSE and promoting sexual health for YPIC. In teasing out service-providers' educational practices and teaching strategies, the sexual health needs of YPIC are revealed most clearly. Before unpacking the various dimensions of these needs, participants' sense of the multi-dimensional nature of the sexual health needs of YPIC is presented, including the need to learn social and emotional skills and to apply these to everyday life as well the need for factual sexuality education. It is important that the finer details of sexual health work are captured in order to acknowledge the contribution of those delivering this and to make visible the sometimes taken-for-granted yet highly skilled work that sexuality education involves. In addition, participants' perspectives on modes of delivery of sexuality education – whether through group or individual sessions – is also considered. The challenges that some participants have experienced using group work with YPIC will be outlined. Attention then focuses to some additional challenges for service-providers in maintaining the sexual health of young people in residential care: these include managing boundaries between safety and privacy; achieving consistency in house rules and dealing with the complex needs of young people in residential care.

### The multi-dimensional nature of sexual health needs of YPIC

A range of factors were identified as being important to meeting the sexual health needs of YPIC, and participants highlighted practices and techniques that they used in their everyday work or that they believed constituted good practice. Among these factors were a positive and meaningful relationship between professional and young person, sound knowledge and a confidence to deliver this and a non-judgemental approach. These attributes are captured in the following quotation by a sexual health counsellor experienced in delivering RSE to YPIC.

*I would say first of all a professional with the ability to develop positive and meaningful connections with young people. Knowledge is crucial -you have to know what you are talking about – but you can know what you are talking about and not be able to impart that knowledge, not be able to deliver the information. Because either you can't develop relationships with young people or because your own attitudinal stuff gets in the way.*

*So I would say you have to have the knowledge, you have to have the ability to connect with young people. You need to keep your own attitudes in check so you need to have the ability to be fairly neutral.*

A number of participants referred to the myriad of sexual health needs of YPIC in terms of 'pieces', reflecting the multi-dimensional nature of sexuality. The need for a holistic approach is illustrated in the following quotation, where the range of components of sexuality education normatively expected to be met within the family environment is identified.

*Well again, like that, I suppose when they are in care it is like you are in loco parentis and so in that sense if you are looking at it from the family dynamic it is providing them with all of the education of the academic piece, the skills' piece but also just the human development piece about who they are and what they are and where they are going.*

Another participant, a sexual health trainer, described the needs of YPIC with the analogy of a 'jigsaw'; she noted that service-providers whom she encountered frequently needed support themselves to understand how to integrate 'the pieces of the jigsaw' that went beyond the bio-scientific dimensions of sexuality. The holistic approach was otherwise described as a 'layered process', involving programmes that started with self-esteem, self-confidence and self-awareness', with sexuality and sex education 'worked in'. Another described this as 'tiered', noting that in respect of young people with a relatively stable upbringing, providing factual and scientific information would be acceptable since these teenagers experience normative stable relations played out in their everyday lives through which to process information. For YPIC, however, 'sexual health work needs to be more therapeutic and thought out'.

While emotional and social aspects of personal development are heavily intertwined, they are explored separately below in order to understand them more clearly.

### **The need for personal and emotional development education**

A dominant theme across the interviews was the centrality of emotional issues that YPIC tend to have, though the degree of emotional need was deemed to vary depending on the young person's background. The problems of poor self-esteem, emotional disconnectedness and inability to recognise and express emotions among YPIC were a recurring theme. The problems identified by service-providers here strongly reflect those identified in international literature on the mental health of YPIC (McAuley and Davis 2009).

One participant described the emotional learning that occurs in emotionally healthy and stable contexts as happening covertly and though unconscious approval and disapproval, a phenomenon well established within socialization theory (Handel et al. 2007); however, for those with a history of childhood trauma, she noted, they 'have been denied that "natural" opportunity to learn these things'. In such situations, having missed out on the unconscious

learning of emotional connection through socialisation, her role required that she formally teach emotional consciousness.

*So most of us don't learn these things in a formal way, but for the young people that I work with, very often we do have to teach them in a formal way. So that is the emotional side.*

Other participants also spoke of the need to facilitate those who had experienced emotional deprivation to connect with a spectrum of human emotions. It was noted that for those who had experienced emotional instability, their emotional expression tended to be confined to anger or aggression.

*A whole nurturing factor as well; a lot of them [in care] would be deprived of that from a very young age. Instability can cause them to be aggressive and that . . . is all they know how to express themselves a lot of the time.*

Participants who delivered sexuality education described the process of self-awareness education that is required to enable young people to identify a range of emotions, so that these may be expressed in a safe environment, without the threat of negative responses from those in authority. A sexual health counsellor observed from her own experience the gendered dimension of emotional management, with boys more likely to manifest a range of emotions as anger.

*So in a very basic way they know they have a feeling but they can't say whether it is sadness, whether it is anger. I would say in my experience boys tend to be much more comfortable with anger, so every emotion gets translated into anger. But when you go beyond that a little bit you can see that actually a lot of the time it is frustration or sadness. But they are not emotions that they can name; they are not emotions they are comfortable with. So really a lot of the time it is around basic education around identifying emotions in themselves and then expressing it in a way that is socially acceptable so they don't get themselves into trouble.*

One participant reported that in her experience of working with some girls in care, the need for survival had very often led them to 'have to stay a step ahead of everybody else', causing some of them to become manipulative, with misdirected social skills. She noted that for some manipulation as a mode of survival was carried over to romantic relationships.

While a non-judgemental disposition in sexuality education was generally advocated by participants, there were times when participants felt that the educator needed to take an ethical stance. Enabling a young person to become emotionally sensitive to behaviours considered to be unethical required the educator to take a clear position and to convey this in a transparent way to the young person. This ability to discriminate appropriate from

inappropriate behaviour was considered to be an important part of a young person's emotional development.

*You need to have a value system that says when is something not okay. It's not okay to say to young person, 'It's okay for a 13-year-old to have sex with a 19-year-old.'*

*Now there are some things you don't want to be neutral on: You don't want to be neutral on abuse, you don't want to be neutral on things that ultimately would give the young person the wrong message. So you are not going to be neutral on rape, you are not going to be neutral on abuse, those kind of things.*

One participant, a counselling psychologist, reported that part of her educational role was to help young people understand the characteristics of an abusive relationship, what emotions might mediate it and what an egalitarian relationship should feel like. She did this through consciousness-raising activities with young men. Understanding that one should choose to have sex when one was emotionally ready rather than drift into sexual relationships was the key, according to another participant, as was equipping young people with the social skills to engage in sexual activity safely if they so chose.

Another participant spoke about 'how quickly they [the young women] could fall into a relationship' (and sometimes, she noted, short-lived marriages) without a sensitivity to the signals of abuse, only later to experience domestic violence or other relationship difficulties. She identified emotional reasons for their poor sense of judgement, noting that 'It's the loneliness that they feel to settle for second best in terms of relationships'. Part of her educational role was to try to 'ground' the young women, an endeavour that she experienced as challenging. Another participant, a social worker, spoke about non-Irish national children (not necessarily specifically those in care) being drawn in the sex industry as an issue 'hitting our radar at the minute' and in highlighting this, she conveyed her anxiety about appearing racist. She also acknowledged that Irish girls and young women also were vulnerable in this regard, an observation borne out in UK evidence indicating that young women who have been in public care have an increased risk of becoming involved in sex work (Ubido et al. 2009). It was also suggested by that participant that young men were vulnerable to being 'abused by older females', adding that there 'can be a tendency for that not to be taken as seriously, which is wrong'. The notion that the sexual exploitation of young men may not receive adequate attention has been raised in UK literature (Lillywhite and Skidmore 2006).

The issue of embedding elements of 'formal' emotional and social skills' learning into everyday life will be considered further on.

## The need for social skills' education

One part of the 'jigsaw', and something that was transmitted in a deliberate formal way as well as reinforced through everyday interaction in the social care environment (that is considered later), was a range of social skills as follows:

*Skills in making decisions, skills in being assertive, skills in being able to take no for an answer. Those kind of basic skills for negotiating with other people are really essential.*

Other skills referred to by interviewees were those of listening, asking questions and seeking clarification. These skills are critical in maintaining mutually respectful relations and in negotiating safer sex -conveying consent to sexual advances or signalling sexual boundaries. Indeed, the skills to manage consent were referred to by several participants engaged in front-line RSE. One of these, a psychologist working in a residential centre, described alerting boys to the complexities around consent and the grey area that may arise around interpretations of rape.

*We do a lot around the question of consent and I think they are quite shocked of how easily they could be accused of rape. And that does make them sit up and take notice. Consent is much more complex – how do you know how far to go? Do you stop and ask her every so often? How can you be sure that she is willing to do this? These are the issues to be teased out.*

Another participant also spoke of her attempts to convey the notion that consent is far from straightforward. She noted that its complexity is intensified because the social cues in an environment of abuse and emotional disconnectedness are different from those in a more normative context.

*And even right down to, especially with boys, because they tend to be the ones who are more likely to be prosecuted in a situation like that rather than girls, so we would look right down to the basics: How do you know if somebody is consenting, what are the signs that they are consenting and how would you know if somebody consented but then changed their mind? What are the signals? And again it might seem like a very basic thing but for a lot of young people who have been brought up in difficult environments, that message would have passed them by. And young people who have been sexually abused would be totally confused about that message because they might have protested and they might have said, 'stop', when they were being abused and that message was ignored. I suppose what a lot, well not a lot, but some boys wouldn't understand the idea that some girls might freeze, and in freezing they are not consenting. Just because they don't say no doesn't mean that they are saying yes. So we put a lot of emphasis on that and not just with the boys, we would with girls as well. Giving them the skills to say, I don't want this, why I don't want it and how to let somebody know you don't want it.*

The notion that verbalising 'No' is the only clear signal of refusal has been problematised in academic literature (Kitzinger and Frith 1999), since more subtle cues of refusal (about any social offer) are often used instead within Western cultures. The participant's recognition of this as an area requiring special skills and cultural literacy is supported in literature. The cultural embeddedness of female 'token' resistance as a feature of the 'heterosexual script', where women are expected to display some level of resistance even when sex is expected to take place also needs to be factored in (Livingston et al. 2004).

The same participant also drew attention to another challenge for sexuality educators, namely, to familiarise themselves with rapidly shifting norms of early teen intimacies that differ from those into which educators themselves were socialised.

*And then what we would call the social rules of sexual behaviour, which I would say is very challenging because the rules that we might have grown up by are not the current rules. Things like it wouldn't be that unusual for kids in a city centre to just make eye contact and chat for a few minutes and then their language is unbelievable, like in some groups of kids, 'meeting' means snogging or kissing . . . And in another group young people say 'meeting' is actual penetrative sex. So you have to stay on top, check things out with them, when they say 'meet', what do you mean by 'meet'? So the social rules where we might think, well at least you would have to be going out with someone for a few weeks at least, people might only know each other for a few minutes and not even know their name.*

While these norms pertain to young people in general, the propensity to risk-taking often associated with YPIC make them particularly susceptible in situations of uncertainty. Anecdotal reports suggest that the relatively new social practice of 'meeting', referred to in the quotation above, abounds (in Ireland) in early teens, and while it apparently refers to brief episodes of sexualised kissing fairly indiscriminately among early teens, its meaning and other related practices are largely elusive to those beyond teenage culture. The challenge for educators, alluded to by the participant, is to glean information about the lexicon and intimacy norms of young people, which is 'insider' information and not easily accessible to those outside (adults). It is challenging for adults to decipher and keep abreast of the norms of early teen conduct, a challenge made more difficult by the fact – referred to in the quotation above – that cultural practices vary across groups. Young people essentially exercise the power to self-monitor and regulate these norms of intimacy. The participant observed that acknowledging the occurrence of a social practice (rather than denying that it happens) can be used to teach young people that they have the power to make their own decisions about whether or not to engage in certain behaviours.

Aside from the social skills required to negotiate sexual encounters, several participants referred to the everyday social skills that children in stable environments learn incrementally and initially with support that YPIC may have missed out on. These include routine skills such

as how to buy goods in a shop or how to go about having a haircut. The lack of basic skills, including grocery shopping and cooking, among some YPIC was particularly emphasised by those engaged in after-care services.

*Before coming to the service? The whole independent living piece – being able to cook a meal, being able to manage a budget, being able to hold their own out in the community – that would be huge.*

The transition from group living to independent living was deemed to require high levels of adjustment, where the risks of loneliness and isolation were high. The extent to which links could be maintained with their previous 'home' after leaving care appeared to vary, with one participant reporting that some residential centres allowed return visits while others did not. Those working in after-care indicated that far more time and input is required to prepare young people for life after leaving care. One suggested that preparation for this should start at least 18 months ahead of time. The social skills required to negotiate independent living in the transition to adulthood have been captured in a concept referred to as 'positive youth development' (PYD) and this has been linked to sexual health competency (Gavin et al. 2010). Although no single definition of PYD has emerged, social, behavioural and emotional competencies are key characteristics along with self determination, self-efficacy and a belief in the future. A review by Gavin et al. (2010) of PYD programmes indicated promising results in terms of improvements in sexual and reproductive health, although the authors caution that more research is needed in determining what programme characteristics facilitate positive outcomes.

### **The need to apply social and emotional skills in everyday life**

While the need for YPIC to learn discrete social and emotional skills (listening, reflecting, etc.) either through role play or another educational strategy was recognised as forming part of their RSE, embedding this learning in the real world was also viewed as highly important. One way of integrating social skills (e.g. of questioning, seeking clarification, self-awareness) in ways that may passively yet effectively be imbibed by the young people is described as follows:

*Very often a young person who has got low self-esteem or who is struggling in any way, they might feel 'I can't ask a question because they will think I am stupid,' or 'I am 16 so I have to pretend I know that'. So it is about teaching young people that actually learning is all about asking questions; there is no such thing as a stupid question and we model that on an ongoing basis. You might have social care workers saying, 'God I didn't know that', or 'That is news to me', or 'I know this might seem mad that I don't know this but...' They model asking questions and they make it normal or usual not to know certain stuff, so in doing that, so if an experienced social care worker says, 'I don't know that', then the young person learns it is ok to say you don't know stuff. In a very basic way you are giving them the skills for learning where it is ok to ask questions, it is ok not to know stuff and*

*it is ok to say, 'I have had enough of this for today, I am not in the mood for this today'.  
So the young person learns their own saturation point: I have so much information now I can't actually take in any more today.*

What care workers appear to be doing in deliberately yet subtly weaving good communication skills into their everyday interactions with young people is promoting social skills' learning by immersion and modelling, a notion supported within scholarship on social learning theory (Bandura 1977). As another participant describes this, the unconscious learning of mutually respectful normative rituals of interaction mediates sexuality education (in its broadest sense) in stable family environments through unconscious learning. Without this, she contends, 'school based' (or formal) sexuality education is insufficient.

*So much of the sexual health needs of children in more stable families are met without them even knowing that they are doing sexuality health. Just in the way they relate to each other and the positive affirmation that kids might get, you know, all those bits that build up their self-esteem and their image of themselves, the man or woman, you know all that piece that happens in more stable families. And if that is not happening for those young people who are already disadvantaged, who already have experienced huge gaps in their development in terms of who they are and how valuable they are and what a healthy relationship is, what they can expect and what they should be able to demand in terms of respect and just acceptance and value of themselves. If that is not there then the stuff in school is not enough.*

The application of emotional awareness learning is very well articulated by the following respondent, who described the importance of simply making the young person in care aware that someone else is engaged in sharing with them their thoughts and emotions.

*if the child feels thought about, they are experiencing something, they are experiencing being thought about and that can happen in the most simple way or complex. Even showing interest, it's also important to wonder with the child, to ask with the child. Let's make it explicit that we are holding them in our minds.*

Another participant described the process of embedding social and emotional learning as 'giving them some sort of normality or some kind of sense of what is normal and what is okay.' Interactions in residential centres, according to another participant, should create an environment in which 'people negotiate with one another how they make decisions together'. A care worker currently working in after-care but with considerable experience of residential care similarly promoted role modelling by staff as a social learning strategy, noting that, 'They [those with emotional issues] don't know how to be nice or affectionate towards people. And working on the staff team it's up to us to show by example'.

Yet even if civility and courteousness through interactions were displayed by staff, an obstacle to a young person in residential care practising social and emotional skills, according to one participant, was the reluctance of some social care staff 'to reveal their own lives and relationships.' The relationship was blatantly hierarchal, she observed, insofar as staff were privy to a considerable amount of information about that young person (that we considered in greater detail earlier) but the exchange of personal knowledge was not reciprocal. She noted that the relationships that the young people see played out in residential care are not 'real' relationships, but are professional relationships that are thus very guarded. This impacts on the young person being 'held' emotionally and physically in a reciprocal way, she observed, and drives them to seek 'intimacy and sex as a means of having a close connection, rather than have that sterile environment that you get in residential care'.

One possibility for addressing the limits of hierarchy in relationships that was proposed was to have those leaving care or in after-care mentored by others (a little older) who had formerly been in care and who had shaped their lives positively after leaving care.

It is worth noting the reservations of two psychologist participants who raised issues about the extent to which young people were allowed to develop (or practise) their social skills within residential settings. The first, a psychologist on a multi-disciplinary team, conveyed the view (based on clients of hers from care settings) that relations between social care staff and service-users were excessively authoritarian, with insufficient emphasis on negotiation.

*They tend to be ruled by the rules a bit too much. I think that there should be more flexibility. I think the behavioural management piece can be a little harsh. I know resources are tight, but there is a lot of emphasis on control rather than discipline. They need to be able to make decisions. Even in the most stable backgrounds there are meltdowns. Young people need to be listened to, and there needs to be more counselling skills into training for social care people . . . it needs to be collaborative rather than dictatorial.*

The second psychologist (working in a residential setting) also experienced similar feedback from the boys to whom she delivered sexuality education. She lamented that being in residential care meant that they had limited opportunity to try out new techniques for negotiating relationships to which they were introduced during her group work. Although she acknowledged the positive efforts of residential social care staff in embedding social skills into everyday encounters, some of the feedback that she received from service-users indicated that there were areas for improvement.

*I hope a lot of it [the social skills piece that she teaches] is apparent in their day-to-day work within care: seeing and experiencing positive relationships, seeing different ways in which adults deal with young people, therapeutically in the living environment. I think*

*it has to be done in residential care across the entire setting to give them opportunities to be positively assertive . . . when dealing with staff they will often say 'But there is no point, what's the point in trying to argue my case or raising this particular grievance because it doesn't get anywhere', or 'We'll just be labelled as argumentative', so we are trying to give them experience in this setting of managing themselves.*

To summarise this subsection, the view being expressed by participants is that because for many YPIC, their background was characterised by exposure to violence and/or unequal relationships, re-socialising is required, and modes of interaction that privilege dignity and respect need to replace previous dysfunctional notions of 'normal'. While re-learning mutuality in relations has relevance across their social milieu, it carries over to healthy sexual relations. This type of 'teaching', that might be described as semi-formal, is far less visible and tangible than more formal learning, yet judging by the heavy references to deficits in mutuality and value-orientation in the prior relations of many YPIC (acknowledged in participants' accounts and in academic literature), this type of teaching may have the greatest impact. It is also possibly the most difficult type of teaching to evaluate using well-established pre- and post-intervention measures that dominate social science scholarship because it does not constitute a discrete 'intervention' amenable to measurement. Data presented here also suggest that in some care settings, this type of embedded social learning may need to be strengthened.

Before leaving this subsection, a brief note about 'normality' is required because constructions of 'normal' have been the subject of criticism within social science literature. Normality – derived from the word 'norm' in sociology – refers to the most socially approved patterns of behaviour within any given culture. Socially-approved modes of interactions in contemporary Western cultures privilege civility, mutuality and shared decision-making. This was not always the case historically (Elias 2000). Elias has traced how social etiquette has evolved since the middle ages and how societies have now come to expect humans to have greater self-control over drives and emotions, control over violent outbursts, and to have consideration for others. Notwithstanding that all such rules of social conduct (for example, 'appropriate' voice levels, conversation turn-taking, politeness, negotiation, etc) serve to preserve social order, these interaction practices are widely agreed as being central to a civilised society and to socially-constructed notions of dignity, equality, respect and mutuality.

### **The need for factual sexuality education**

Although a minority regarded the educational needs of YPIC to be no different from those not in care as far as biological (e.g. reproduction and safer sex) and factual (e.g. legal issues, sexual health services, etc) information was concerned, there was still a sense that the former had additional needs in this regard. In view of the tendency for YPIC to have complex needs (e.g. attention difficulties), the capacity of some of them to process the information was raised. One of the psychologist participants observed that some fairly basic biological information was

found to '[go] right over their heads' and the level of detail needed to be modified accordingly. This would appear to be important in light of Dale's (2009, p.30) finding of a gap between the formal knowledge of health professionals and the 'everyday ways of speaking' of service-users as was found in her study of ten young people in care in Scotland (referred to in the literature review earlier).

Assessing exposure to prior knowledge was a factor that cross-cut the approach taken in delivering factual sexuality education and informed the decision as to what content to deliver.

*I think again it depends on what stage they have come into care and what they have already learned. I mean the other thing is whether they have had any sex education before and what that has been. If it has just been the fifth-class talk or the sixth-class talk, that is going to be very different from somebody who has had some education all the way through or a young person who has been in care where there has been ongoing development of their sexual needs or assessing their sexual needs than somebody who has come in at 14 who has never been told anything.*

A few participants suggested that while young people (including those in care) may give the impression that they are well-informed about the scientific facts about sex, this is not always the case. The young person, they reported, may have missed out on this teaching at school, may not have attended to the lesson, or may have been exposed to misinformation through friends. One approach to teaching proposed was to acknowledge that the young person may have information already (this may help affirm their prior knowledge), but not to assume this. The sensitivity required to engage the young person is captured in the following quotation:

*But again you have to be very careful in how you present it. So we would say to young people, rather than something that isolates them or alienates them, like we would never say, 'We are going to do the basics with you', we would say, 'You probably know all this already but let's just do a recap'. And that way then we're giving them permission to sit there and they don't have to feel insulted, they don't have to feel embarrassed if they don't know stuff... I would say certainly we would start with the biological.*

The above examples illuminate how a practice ordinarily constructed as perfunctory (conveying biological 'facts') actually demands a highly skilled approach. A few participants referred to the need for the educator to tailor the level and substance of the educational materials to the needs of the learner, based on his or her past experiences.

*For some young people in care they may not have had the parental supervision that would have protected them from early sexual experiences. So my view would always be if they have had sexual experiences or if they plan on continuing to be sexually active you need to give them a level of information that matches their past or current experiences.*

*You could be talking about children who have been abused or may have abused themselves, so knowing your client is very relevant.*

While age-appropriateness was mentioned as a factor that mediated the factual content of sexuality education, it was not the only guiding factor in delivering sexuality education. Educators were also challenged to attune their educational endeavours by discriminating within an age cohort. This required the careful appraisal of environmental and contextual factors.

*So what you might think wholly inappropriate for a 13-year-old brought up in a protective loving caring environment might actually be crucial for the well being and safety of another 13-year-old in residential care who didn't have that kind of safety and security in their lives . . . even within residential care the information we would give to one 13- or 14-year-old might not necessarily be what another needs.*

In terms of the content of biological information, a participant working in after-care stressed the need for more education around STIs, as in her experience, care leavers tend to 'bury their head in the sands' about the dangers to which they exposed themselves.

If we turn now to other factual information that participants believed that young people in care need, knowledge about the law featured here. Some participants observed from their experience that a high number of teenagers are unaware that the age of consent to penetrative sex is 17 years and often assume that the British age of 16 years also pertains in Ireland. Clarifying the legal age of consent was considered to be important. One participant indicated that since the young people were in the care of the HSE, he felt duty bound to ensure that they had received this information. He also reported that he advised young people that underage non-abusive sex could bring with it legal complications.

*As we say, your girlfriend may like you, but her mam and dad may not like you, but it's them that will bring you to court. We always bring it in as knowing your rights and responsibilities. Because they are in the care of the HSE we're duty bound to do that.*

### **Modes of delivery of sexuality education: group session teaching or individual sessions**

When participants were asked to comment on the mode of delivery of sexuality education, that is, whether group work or individual sessions were used with YPIC, a recurring theme was that the choice was based on an assessment of the situation. This assessment involved taking into account the content to be delivered, the composition of the group and the suitability of individuals to engage with group learning. In some circumstances, a group approach was believed to be feasible, such as in the teaching of biological information, although, as indicated earlier, many other participants believed that even this required individual tailoring.

A psychologist working in residential care reported that very carefully selected groups, where group members were selected on the basis of being compatible with each other, tended to be successful. A principal social worker indicated that she was a 'real believer in group work,' because group members could challenge each other and share information, and challenges to behaviour might come better from a peer. On balance, though, participants were inclined to be unfavourably disposed to group work for sexuality education because of specific factors associated with the young people themselves (such as attention difficulties); specific challenges of group work identified by participants are considered in the next section.

One participant suggested that the idea of professionals 'coming in' to a residential setting for group sexuality education was an imposition, given that in a regular home environment this would never occur.

For several participants the notion of having any 'formal' programme, whether one-to-one or by group was experienced to be less effective than, in the words of one, 'if we are just tipping away at it all the time rather than trying to tick boxes, like we've done this now and it's done'. Ongoing, informal, mainly one-to-one sexuality education 'worked in' to everyday life practices tended to be favoured. Where RSE was of a formal nature, the importance of any programme to be 'home grown', that is culturally appealing to the Irish setting to facilitate young people in identifying easily with the material, was also stressed. Another participant suggested more generalised modes of imparting sexual health messages by putting posters with sexual health messages on the toilet doors in residential settings.

The cautious approach to group work and the need to assess individual vulnerabilities, as well as the readiness of individuals to participate, is illustrated in the following quotation:

*Workers who have developed a relationship, if they know that the young person has sufficient ground in themselves to be able to operate in a group, I think that is when the group comes in. And some of the residential workers are working in groups but to just launch into that without taking into account the individual and where they are at could be difficult, or dangerous in some cases.*

*Again it very much depends on the young person. Some young people thrive on one-to-one contact away from the group and love that type of attention. And then other young people, maybe a little bit of a show off, they will thrive in the group situation and they will want any sort of sessions like that delivered in a group.*

Descriptions of structured, planned one-to-one sessions were sparse across the interviews, as individual sessions appeared to be largely ad hoc. One exception was a series of individual sessions delivered by sexual health counsellor; the usual number of sessions ranged from six to ten and these were supported by informal applied learning referred to earlier. Sessions that she delivered were divided into three areas: biological, social/legal and emotional.

## Challenges of group work with young people in care

As indicated in the previous section, participants took a cautious approach to group work as a mode of delivery of sexuality education. Reasons for this included threats to trust and confidentiality, the sensitive nature of sexuality, distractions and intimidations of group dynamics and the fear of displaying ignorance.

### *Threats to trust and confidentiality*

One participant referred to the difficulties that young people from particular backgrounds might have around establishing trust of other members of the group, particularly those with experience of abuse.

*It depends on the development of the child . . . If you have a child coming from a very abusive background, well that is going to be far more difficult to work in and to build trust issues.*

A few participants drew attention to the pervasive impact of their existing relations on group trust for those in residential settings. Extant knowledge that residents had about one another and underlying tensions in relations, it was contended, could inhibit group members from sharing information.

*So the stuff they have on each other and all the squabbles and the relationships and the conflicts and everything that go on come into the group as well . . . the inter-relationships they already had. They were scared to speak up in front of each other or they were sharing too much information.*

Another raised the issue of vulnerability around disclosure; while she herself could guarantee them confidentiality (though added that she made it clear to group members that they would have to decide themselves whether or not to trust her), she could not offer the same reassurance about peer group members.

*Because it is a vulnerability that the boys have here – if they do disclose anything or even ask a question that the others think is daft there is always the risk that one of them will run out and tell every boy in the centre.*

### *The sensitive nature of sexuality*

The sensitive and personal nature of sexuality was also raised as an impediment to undertaking group work. Revealing personal decisions around sexuality or imparting delicate information in groups was considered to be problematic.

*I mean a group can be a very exposing place so you'd have to know the young people fairly well and they would have to have a really good sense of themselves to operate in a group.*

*If they are in chatting to somebody they have developed a relationship with where it is really based on where they are coming from and what they want and where they can discuss things, they can say, 'I am not ready', or 'I have had sex before and I have decided that is not for me and I want to move in a different direction', It is much easier to talk to one person about than it is to say that in front of three other people.*

A further dimension added was that group members with a history of sexually inappropriate behaviour might become sexually aroused in the context of discussions about sexuality, which participants noted reinforced the importance of understanding each young person's background and needs.

*I would not include a person with a history of inappropriate sexual behaviour in a group session as the substance of the discussion might cause them to become aroused sexually.*

*With under 18s you just have to know your client. There are young people who might get very excited talking about sexual health so you have to be very careful not to be putting yourself out there with the wrong messages. You need to know their background.*

In view of the sensitive nature of sexuality, the impact of group discussions at (regular) school for YPIC was raised by a former school teacher. She identified transience in the lives of YPIC, as well as the teacher's lack of prior knowledge of their individual circumstances as impediments to their safe engagement in group work at school.

*And obviously if children are transient and are not developing that relationship [with teacher and fellow pupils] I would say it could be very difficult, maybe even traumatising for them to be in a group situation where they have to talk about stuff that maybe they have quite difficult experiences that the teacher wouldn't be aware of.*

### ***Distractions and intimidations of group dynamics***

While it was acknowledged that humour can be a positive feature of group work, it was also noted that distractions that emerged from group dynamics such as laughter and joking, as well as inappropriate contributions, could be detrimental to learning.

*I found that the stuff I could have covered in one session on an individual basis, it would nearly take two in a group because there is the laughing, the joking, sometimes inappropriate stuff. They feed off each other.*

*But then trying to manage the dynamics of a big group like that might lessen the effectiveness of the information being delivered. So I would personally say one-to-one would be a better option.*

The increased likelihood of group members to boast about or exaggerate their experiences leading to feelings of inadequacy in others was also raised.

*They are more likely to brag about their sexual experiences or exaggerate their sexual experiences, which in turn makes other people feel inadequate sometimes.*

*Groups can make people worse – it gives people the impression that everybody is doing something when they are not.*

### **Fear of displaying ignorance**

Other disadvantages were the reduced likelihood of group members asking questions for fear of others' negative responses to their ignorance.

*Where the advantages of a group setting would be . . . I would struggle to think of the advantages. You could argue that it saves time, it is efficient, but I think on the whole young people are less likely to ask questions in a group. They are less likely to expose their lack of knowledge.*

*They might leave without knowing something they really wanted to know.*

*In a general sense I would say a little bit of both, and one-to-one is very useful because they allow the person to ask questions they may not do in front of a group.*

## **Additional challenges in maintaining the sexual health of young people in residential care**

It has been noted throughout this report that young people in residential care were deemed to have the greatest needs of all YPIC when it comes to sexual health and sexuality education. However, a number of additional, very specific challenges were highlighted in relation to young people in residential care that impact on sexual health, namely managing boundaries between safety and privacy, consistency in house rules and the complex needs of young people in residential care.

### **Managing boundaries between safety and privacy**

One of the difficulties noted by a number of participants for maintaining the sexual health and safety of young people in residential care was that creating a balance between socially regulating young residents' lives and conceding to them rights to privacy. Physical boundaries in a mixed-sex residential facility were described by one participant where upon young men

and women were segregated into different sides of the house, each side with its own stairs, to countermand heterosexual activity. Residents were not permitted to cross over, and an alarmed fire door separated the sleeping locations. Staff were obliged to monitor possible sexual relations, the participant explained, in view of some residents being under 17 years.

Another issue raised by one participant related to the use of mobile telephones, which were acknowledged as a valued possession for those in care, yet also a source of vulnerability, particularly where such devices were internet enabled. The tendency for vulnerable young people to seek love and relationships through social networking sites, with their often compromised capacity to discriminate between healthy and abusive relationships, was believed to make them particularly exposed. One participant reported that social care workers to whom she was delivering sexual health training had raised the issue of balancing privacy and safety with regard to mobile phone use. She identified the need for guidance for social care workers in this regard.

### *Consistency in house rules*

A sexual health educator noted that one of the issues that was problematic for social care staff to whom she delivered programmes was the inconsistency in 'house rules' (that mediated sexual well-being) in the residential setting. One participant described the varying norms that prevailed within the same residential setting as altering according to staff preferences and levels of acceptance of particular behaviours.

*That is one thing that has come up quite a lot about the inconsistency that young people in care experience, what is acceptable, what isn't. So if one worker is on, this is acceptable, so it is acceptable maybe for young people to be in each other's rooms if one worker is on but it is not acceptable if somebody else is on. Some people, in terms of the sexual practice, like masturbation, some workers would just say to young people, 'That is ok in your own room with the privacy', Others, if they were caught, would be demonised. So there is huge inconsistency around what is allowed and it seems to be based on personal opinion and preference rather than on the young people's entitlement.*

Another reported a similar state of affairs, but with the added complexity of staff conflict about the appropriateness of some house rules. Her perspective was that staff with traditional views about sexuality required education to address their 'old-fashioned' ideas.

*And some of the staff have very old-fashioned ideas. Do you know in hotels the 'Do not disturb' signs? Well we gave some of the boys these signs to put on the door when they were masturbating, and some of the staff went crazy that I was promoting that sort of thing. So education is a big thing.*

Another participant reported that some staff at residential centres had very strong moral perspectives about what behaviours they viewed as appropriate and inappropriate. In her

opinion, if one agrees to work for an organisation, one should agree to present a single consistent message 'or look to working somewhere else'. While she believed that an 'openness' to meeting the sexual health needs of young people in residential care was required of staff irrespective of their own moral opinions, she also held that 'in foster care there might be a set of values' in the home that could limit the freedom of the young person as far as sexual behaviour was concerned. This suggests that a latitude for individual choice of the young person over his or her sexual behaviour was accepted in residential care, safety and legalities notwithstanding, while those in foster care might be expected to fall into line with the prevailing moral norms of the family home in which they lived.

### *The complex needs of young people in residential care*

The difficulty for children in residential care 'slotting in' to RSE at school was raised; their needs were deemed by many to be too complex for school-based education alone to suffice. Their very status of being in residential care suggested that they had a history of behaviours that impeded their living in a family environment. These young people were deemed to have lives dominated by transience, by negative experiences and feelings of not being valued; and this carried over to negativity about education, poor aspirations in life generally, entrapment in a cycle of indiscriminate relationships and a tendency to early parenthood.

*Aspiration is such a protective factor, and for some of those young people their education is being disrupted, their emotions are all over the place.*

*Kind of career and moving on in terms of relationships, they have so many obstacles that aspiration obviously is very difficult. You can see why some young people would want to form a relationship, even if it is destructive, and maybe to become a parent.*

### **Key points: Section 4**

- In addressing the multi-dimensional nature of the sexual health needs, participants highlighted the importance of a positive and meaningful relationship between professional and young person, sound knowledge and a confidence to deliver RSE, and adopting a non-judgemental approach. It was believed that meeting the sexual health needs of young people in care demanded a sophisticated approach on the part of the sexual health provider and required a willingness to undertake the role.
- Participants identified the need, to varying degrees, for young people in care to undertake personal and emotional development in order to address the problems of poor self-esteem, emotional disconnectedness and an inability to recognise and express emotions. These attributes were often lacking among YPIC compared to those not in care, though to varying degrees.
- Participants identified the need for young people in care to be taught social skills to enable and empower them to negotiate relationships and sexual intimacies.

- Participants highlighted the need for YPIC to have positive social skills applied or embedded in everyday social situations; such skills, they reported, are part of a repertoire of competencies needed to negotiate relationships and safer sex.
- Participants identified the need for factual sexuality education around biology and legal matters to be taught to YPIC and tailored to their individual needs.
- Service-provider accounts suggest that while there was a place for group-work as a mode of delivery of RSE to YPIC, it was fraught with difficulties including threats to trust and confidentiality, dealing with the sensitive nature of sexuality in groups, distractions and intimidations of group dynamics and group members' fear of displaying ignorance.
- Additional challenges pertaining to young people in residential care identified by service-providers in maintaining their sexual health included balancing the need to keep young people safe with their need for privacy, achieving consistency in house rules and dealing with the complex needs of young people in residential care.

## Section 5

# Sexual health needs of specific groups of YPIC, and of post-care service-users

### Introduction

YPIC are not a homogeneous group. In this section, the sexual health needs of specific groups of YPIC are considered, including those of LGBT orientations and those with a disability. In addition, the sexual health and RSE needs of young people formerly in care and who avail themselves of after-care services are explored. Finally, attention focuses on specific RSE and sexual health needs relating to young men in care. It should be noted that while some participants acknowledged that ethnicity could impact on sexual health needs of YPIC, very few had experience with young people from ethnic minority groups so gaps in knowledge about these young people continue to exist.

### Sexual orientation and disability cross-cutting sexuality education and RSE needs of YPIC

#### *Sexual orientation cross-cutting sexual health needs of YPIC*

Issues surrounding LGBT orientations for YPIC were raised in several interviews. Participants generally appeared to be aware of the work of organisations such as BeLonG To, an organisation that supports LGBT young people in Ireland, and many reported having referred a young person there.

Nonetheless, challenges associated with dealing with young people of LGBT orientations were identified. The possible difficulties for the young person him or herself were acknowledged, as was the sense that LGBT identities tended to be played out covertly, 'almost hidden away or . . . to the side', and a greater need for awareness about them in residential settings was highlighted. It was suggested that identifying and meeting young people's sexual health needs in this regard required a different 'piece'. A principal social worker suggested that a 'good guide' was required to educate service-providers, particularly in areas such as how to deal with cross-dressing. Currently, she indicated, Google was her source of information. A sexual health trainer proposed that the absence of a policy or guidelines as to how to manage LGBT issues contributed to workers' uncertainty as to how to respond.

*Workers suspect that young people in their care may be LGBT or questioning or exploring . . . and they are looking for some sort of guidance in what they should do to support the young people. But again it usually comes from individuals [workers] looking for support rather than there is some sort of policy or guidelines on how to support young LGBT people who end up in care.*

That participant went on to explain that an acknowledgement of LGBT identities is relatively new in Ireland, and even well-meaning social care workers struggle to deal with it.

*It is fairly recent that it [LGBT] is actually being talked about in education, even in the public domain in Ireland. So for some of the residential care workers sexual health is an area that some of them are uncomfortable with . . . it is alien to them. And to be fair it is not that people aren't trying to do their best, but these are new issues coming up for them and they don't seem to have sufficient support.*

A sexual health need identified by one participant was for homosexuality to be normalised in all sexuality education, and for transgender to be accepted. She referred to the link between suicide among young men and issues associated with sexual orientation.

An observation of another participant relating to LGBT issues, based on his recent experience working with YPIC, was their tendency to shift between heterosexual and same-sex relationships fairly readily. He commented that he was unsure as to whether this signalled a cultural transition at a broad level – in view of greater tolerance of sexual diversity – or whether there was a particular propensity to orientation transitions among those in care. Another participant also described having encountered a young person in her care who experienced transitions across sexual preference: that person initially engaged in a lesbian relationship, then a heterosexual one, and later expressed her identity as bisexual. A review of literature on adolescent sexual orientation in North America (Saewyc 2011) noted that many sexual minority teenagers experience the rejection of families. A Swedish study also found that while maximum sexual preference fluidity occurs in the 25-34 age range, sexual fluidity was linked to living away from family (Ross et al. 2012). Given that YPIC have less close family ties than those in the wider population, one may speculate that they may feel less restricted in engaging in minority sexual practices.

A separate issue was the perceived vulnerability of young men in care engaging in homosexual prostitution. One participant believed that young men in care were associating sexually with older men both to initiate themselves into 'being a gay man' and for financial reasons; it had reportedly been insinuated to her by young men who identified themselves as homosexual that there were 'always ways to make money'.

Finally, the need to educate foster carers about LGBT issues was raised. This point was made at a fairly general level, and service-providers did not elaborate on how this might be achieved.

### **Disability cross-cutting sexual health needs of YPIC**

A few participants noted that some YPIC have mild to moderate learning disabilities and, according to one, social care workers were 'trying to work with that as well'. A few participants referred to the care of those with behavioural difficulties (ADHD, etc) (usually viewed as distinct from disability) creating particular educational challenges.

One issue raised was that sometimes a mild learning disability may not have been diagnosed resulting in the young people bypassing disability services and thus leaving them vulnerable to sexual exploitation.

*I think they can be exploited sexually . . . It is something that we have definitely come across and we actually see that quite a bit that those who have that undiagnosed disability, learning disability, are very vulnerable.*

It was noted that, as a culture, Irish people are not comfortable with seeing those with disabilities as sexual beings and education was required around this, although the participant who conveyed this view did not specify how this might be achieved.

Another participant reported that, where appropriate, particular types of contraception such as the coil or contraceptive implants were more suitable to young women in care who have learning disabilities as these did not demand the daily discipline and need for regular prescriptions required of methods such as oral contraceptives.

### **The sexual education and RSE needs of those in after-care**

From the perspectives of service-providers, there tended to be similarities between the sexual health and RSE needs of YPIC and those attending after-care services. However, the most obvious difference reported was that those in after-care were adults, and empowering them to take control over their fertility and decisions about sexual health was prioritised. Clearly, issues around age of consent to penetrative sex and to medical treatment did not apply to those in after-care. There was a view that those in after-care did have a reasonable level of factual knowledge about sexuality. Barriers to proactive sexual health practices for this group tended to be the use of drugs or alcohol and other risk-taking behaviours.

*They have an okay general understanding of the basics of the sexual health part of it – they would have knowledge of it. They do understand that they should be using condoms but they still engage in risk-taking behaviours like when they are drunk – a few have come with STIs and some of the girls have used emergency contraception.*

One participant reported that a young man who engaged with an after-care service indicated that he did not use condoms because of his view that his sex partner could avail herself of emergency contraception because she had a medical card.

The transience of relationships (both sexual and platonic) was again raised as a feature of the lives of those in after-care services. One participant involved in after-care suggested that service-users 'could all do with more information on relationships – more emphasis on what a normal relationship might be'.

### **The particular sexual health and RSE needs of young men in care**

The heaviest emphasis in the accounts of participants across the sample was on the sexual health needs of young women in care. This is likely to have arisen because of conventional gender roles that place the burden of responsibilities arising from an unplanned pregnancy on women, and on the way in which responsibilities for contraception have tended to be constructed along gender lines (Lohan et al. 2011, Smith et al. 2011). As the interviews unfolded, interviewers questioned participants specifically about the particular needs of young men in relation to the study topic, and a number of gender-specific issues were raised. A dominant perspective here was that young men had often experienced no or poor role models in terms of responsible sexual behaviour and parenting. Many were believed to have witnessed domestic violence from male adults in the home prior to being taken into care, and some had difficulty in dealing with emotions, particularly anger, as a result. One participant described this tendency as follows.

*A young man who has grown up in abusive relationships where the male in the household is behind it, they may need to learn how to manage violence. Domestic abuse is common in their [young men's] lives. These are repeating what they have seen, also all other resources have been exhausted. They don't have the ability to process the issues. Assault is a very primitive reaction, but for some, it's their only way of handling the world.*

The participant also suggested that when these young men enter residential care with strong female carers, they have to learn to respect women. Indeed the issue of developing a respect for women was raised by other participants, as the view was that many had a very poor sense of how to relate to women.

*The attitudes that boys have towards women is not good – they have a very low level of responsibility with regard to pregnancy and that.*

In addition, it was noted that, as is the case for many girls, young men in care tended to 'seem overly sexualised for their age'. It was also noted that in some cases they appeared to have access to pornography. The issue of access to inappropriate material via the internet and 'smart phones' and the negative or unknown implications of these was deemed to be historically new given that their use has proliferated over the past number of years.

### **Key points: Section 5**

- YPIC who identify themselves as LGBT are encountered by service-providers and are deemed to have particular needs. More attention to educating staff in residential care about LGBT issues was called for.
- Gaps in knowledge about YPIC from ethnic minority groups continue to exist.
- Young people with mild levels of learning disability have particular sexual health needs which may bypass disability services creating additional challenges for service-providers.
- The needs of those in after-care centred on becoming empowered to take control over their sexual health and over their general behaviour.
- Young men in care were believed to have specific needs, particularly about how to relate appropriately to women.

## Section 6

# Training and support of staff

### Introduction

In this section, the training and support of staff who interface with YPIC is considered. First, participants' perceptions of staff training are explored, including their views on opportunities and organisational practices in relation to training. The focus then turns to the content of staff educational programmes and participants' views on the extent to which sexuality is addressed within social care courses. The section closes with a brief account of staff willingness and suitability to engage with sexuality training programmes.

### Staff training in sexual healthcare

The need for staff training in sexual healthcare delivery was raised by several participants, and opportunities for staff training appeared patchy. This echoes a perspective in the Eastern Region Health Board's *Sexual Health Strategy (2005)* that 'The lack of standardisation of training programmes particularly for youth workers with clear evaluation and accountability was particularly noteworthy as only a few isolated programmes meet accredited standards' (p.33).

The emerging picture was that training opportunities were not provided in a structured, regular way and were facilitated predominantly where there were managers 'committed' to training staff in RSE delivery. Even for those professionals who were not restricted by line management from availing themselves of sexual health training the opportunities to do so were described as *ad hoc*. A sexual health trainer spoke of the benefits of training a critical mass of staff from the same setting on the same trainer programme, as this helped to change the culture of the organisation to a greater degree. This view was reiterated by a social care worker who had undergone extensive training herself and viewed very positively the fact that a colleague had been sent on the same course.

*They've sent another girl from work on the TRUST<sup>11</sup> course, which is great because for a long time I was on my own. And some of the staff have very old-fashioned ideas. If there is more than one person that they can approach it is better. Once you have enough staff*

11 The TRUST course is a Post-primary teacher-only training course provided by the SPHE support service. The participant may have been referring to the 'Foundation Programme in Sexual Health Promotion' provided by the HSE Health Promotion Department, South.

*trained – you need to have enough staff trained to understand that hormones during adolescence influence their behaviour across the board.*

In expanding on the considerable variation in the sexual health training that staff received across social care settings, a sexual health counsellor noted that where the social care location did not have a focus on sexual health or counselling, it was questionable whether time would be made available for staff training around sexuality health promotion. Of the four centres with which she was involved, the staff at two were very well educated on sexual health issues because of the sexual health or rehabilitation focus of their work; the other two dealt with a range of risk behaviours, and sexual health was not a priority. In the case of the latter, she indicated, it had been 'a while' since she had been involved in a staff training programme and at one in particular, she had had very little engagement in terms of staff training. That sexual health counsellor went on to describe how (apart from at one centre where group training sessions were run more regularly) training sessions tend to be delivered on an ad hoc basis, sometimes in response to the behaviour of a young person at that time. However, she indicated that she was not in a position to impose training on others. Sometimes, she noted, she had been called upon by a centre for advice by individuals and would meet with them to share her expertise. Thus, training sessions with social care workers were not structured – once a year approximately a session might be delivered (depending on the centre) – and attendance was voluntary. At centres where sexual health was not the focus of their work, she deemed that staff discomfort around child sexuality and abuse was one of the reasons for the lack of enthusiasm that some exhibited in relation to further training; these staff, she reported, appeared far more comfortable with their own areas of expertise, e.g. drug or alcohol abuse.

Another participant described two types of training that she had received; one, she reported, used scare tactics (seeing sex as dangerous) and another focused on celebrating sexuality, but when the individual felt ready and in a position to make a positive choice. The programme required her to attend for two days a week over five months, but in her view greatly promoted her ability to engage in sexual health work<sup>12</sup>.

It was also found across the interviews more generally that a lack of resources and staff shortages were key barriers to staff education. Releasing staff to attend courses was a major challenge, and in the current economic climate, the services were deemed to be reactive rather than proactive.

In relation to staff training and education, one of the issues singled out for special attention more than any other was to address staff values and attitudes around sexuality.

*But I do get a sense . . . that not enough time is spent on actually supporting them [front-line staff] around working through their own attitudes and values. And how they actually impact on the service they provide.*

<sup>12</sup> The participant was referring to the 'Foundation Programme in Sexual Health Promotion' provided by the HSE Health Promotion Department, South.

*We really have to be clear about what our values are, and this needs to filter down to residential staff and those staff need to be confident and competent in giving that information and being the bearers of that value system.*

### **Sexuality as a component of education and training programmes for professionals**

The lack of space devoted to sexuality education in the initial training courses for social care workers was also raised. It was believed that the content of such courses addressed theory but did not address sexuality issues in sufficient detail to enable staff to deliver sexuality education.

*If you take attachment, that is a huge part of social care training, attachment theory, all of those types of things, social policy. But yet the things on the ground are substance abuse, sexualised behaviours, sexually aggressive behaviour, all that type of stuff. They are not done in any great detail that would make you confident in going in and saying, 'Ok – I am going to deliver a sex education key session to this young person'.*

*There's still a lot of old fashioned ideas and especially in social care courses. When I did my degree in social care, sexuality was not even mentioned; I think it should be a big part of it.*

There was, however, one participant with a qualification in social work who reported having covered the issues of HIV/AIDS in detail in his social work training by virtue of having a lecturer with a particular interest in the topic. However, he was of the view that some social care workers do not receive this input, and other participant data corroborated this view. The importance of self-awareness in the training of social care workers was raised by others.

*Well I would love if it was a part of the initial training for care workers; I would love if it started with supporting the care workers themselves around looking at their own attitudes and values and how they impact in a supportive way.*

*I don't know how much is woven into social care training or their general care training but a big obstacle to their development is some kind of staff attitudes and anxieties around the whole thing.*

The real need, according to one service-provider (a specialist nurse) was to acquire skills to deliver sexuality education rather than more 'theoretical' material. Another, a social care worker, reflected back on her embarrassment when she first engaged with sexual health education with YPIC compared to her comfort with the topic following training and experience. It was reported by a sexual health trainer that even professionals like nurses who are very knowledgeable about reproductive biology, contraception and so forth are often uneasy with

other aspects of sexuality education. Similarly, a participant with graduate education in social care noted that the emphasis in the educational programmes that she had completed was in relation to task-orientation rather than relationship based. Linked to this is some professionals' lack of confidence in a sexuality education role because they view themselves as being at too much of a distance from the contemporary normative practices of teenagers to have enough expertise and knowledge on the topic (this was raised in Section 4).

### Staff willingness and suitability to engage with sexual health teaching and RSE

Another issue related to the need to address staff attitudes through educational programmes was the perceived apathy on the part of some service-providers to engage with sexuality education. It was observed by a trainer that reluctant staff were sometimes put forward for sexual health training because of their position, even when she deemed them to be neither suited to nor enthusiastic about the role.

*Because sometimes members of staff are sent to training, because, 'Listen you take care of that'. But they are maybe not the best person for it; they are best placed, maybe, but not necessarily the best person . . . they may not have a natural interest or passion.*

Another referred to her experience of managers avoiding enlisting for sexuality education social care staff whom they believed held homophobic views that might mediate the values and attitudes conveyed during a teaching session.

Finally, the need for educating and supporting foster carers in sexuality education was raised, as was the need to educate birth parents, as their input may conflict with that of others involved in the young person's life.

### Key points: Section 6

- The emerging picture from participants' accounts was that training opportunities in sexual health were *ad hoc* and facilitated predominantly in situations of 'committed' managers.
- Participants highlighted a lack of emphasis on sexuality education and self-awareness in their education (undergraduate and post-graduate degree programmes) and in the continuing professional development training of social care workers.
- It was noted that staff who specifically indicated a willingness and suitability to engage with sexual health teaching and RSE should be chosen for training purposes.

## Section 7

# Summary and conclusion to Report no. 3

This study, based on the accounts of 22 social and healthcare service-providers who interface with YPIC, has illuminated a range of issues that helps to build up a picture of the sexual health and RSE needs of YPIC. Across the sample as a whole, YPIC were considered to have particular sexual health and RSE needs compared to young people who were not in care. In addition, participants' accounts suggested that current provision of sexual health and RSE to YPIC is patchy and uneven, varying both within and across care settings. Most participants favoured those individuals with the closest and most continuous relationship with the young person for the role of providing RSE to him or her. This was deemed to be the foster carer for those in foster care, and the key social care worker for those in residential care. However, a willingness to engage in RSE on the part of the individual foster carer or social care worker was also held to be important, as it was acknowledged that not everyone is suitable for the role. A small number of participants were of the view that RSE for young people in residential care ought to be delivered by specialist professionals external to the organisation. Related to this was the issue of the extent to which information about a young person's sexual health ought to be communicated between external professionals and social care staff; the need for regular staff to be kept informed about such issues was deemed by some to conflict with the need to maintain discretion and confidentiality about the young person's sexual health.

A number of issues relating to bureaucracy, policies and guidelines emerged that reportedly cross-cut the work of professionals in addressing the sexual health needs of YPIC. At local level, participants tended to favour documenting issues relating to sexual health in the young person's care plan in order to ensure consistency in RSE delivery. There were mixed views on the extent to which the national guidance *Children First* (2011) facilitated meeting the sexual health and RSE needs of YPIC; how to interpret 'risk' and make judgements about what sensitive information to report formally was deemed to be problematic by some participants. This was particularly the case in relation to non-abusive sexual activity. (As indicated elsewhere in this report, the Children First Act, 2015 had not been enacted at the time of the interviews for this study). Indeed, the most central finding of the study was the uncertainty created by the perceived lack of clear guidance nationally and locally for practitioners about how to approach both sexuality education and the delivery of sexual healthcare (such as providing contraception). What this study clearly does is substantiate with

empirical evidence the concerns of those working on the ground about what they perceived to be the nebulous legal and policy situation in which they worked. While legacy issues in some organisations were reported to impede sexuality education for YPIC, for others, a fear culture emanating from official legal and political discourses and a lack of clear workable and pragmatic guidelines were perceived to be barriers to providing sexual healthcare. In addition, the uncertain legal situation was found to problematise trust and confidentiality believed to be central to therapeutic relations. The extent to which the recently enacted Children First Act, 2015 and the Criminal Law (Sexual Offences) Bill, 2015 may provide clarity to the role of service-providers with a remit in sexual healthcare remains to be seen.

An analysis of what elements of sexual health provision were described as important by professionals in key roles facilitated the unpacking and identification of specific RSE and sexual health needs of YPIC and revealed the complexity and skill required to deliver quality sexual healthcare to this group. Characteristics of the educator (e.g. having a non-judgemental approach and a willingness to undertake the role) were deemed to be central. Specific sexual health and RSE needs of YPIC identified by participants included the learning of self-awareness, self-affirmation, emotional literacy, social skills and empowerment. These life skills were believed to cross-cut sexual competency and to facilitate the establishment of positive, mutually respectful intimate relationships, as well as ensuring sexual safety. Participants also referred to the need for YPIC to be taught factual sexuality education around biology and legal matters, but this educational need tended to be viewed as a lower priority compared to the need for social stability and emotional security as a basis for good sexual health. In terms of the most favoured mode of delivery for RSE, individual teaching sessions tended to be preferred over group sessions by the majority of participants. Addressing the sexual health and RSE needs of young people in residential care was deemed to be more challenging than for those in foster care in view of residential living practices that varied across sites and personnel, as well as the more complex needs generally of those in residential care.

The study also found that service-providers routinely encounter YPIC who have particular sexual healthcare needs associated with issues such as an LGBT identity, or having a disability. Very few service-providers had experience with young people from ethnic minority groups so gaps in knowledge about these young people continue to exist. The particular sexual health and RSE needs of young men in care were also identified, especially in relation to difficulties they may experience in engaging in respectful relations with women.

The final area that the study explored was participants' accounts of training opportunities for service-providers engaged in sexual health. Findings here pointed to the lack of such opportunities, as well as these being contingent upon ad hoc decisions by individual managers rather than being available on a systematic basis. In addition, the lack of attention to RSE and self-awareness in the training of social care workers was highlighted. It was noted that staff who specifically expressed a willingness and suitability to engage with sexual health

teaching and RSE should be identified for training purposes. Our data lend empirical support to the observation (referred to in the literature review in Section 1) that service-providers were working in a context without standardisation of sexual health training programmes (Eastern Region Health Board 2005).

To conclude, in keeping with the first objective identified at the outset, a rich description of the sexual health and sexuality needs of YPIC from the perspective of key stakeholder and service-providers has been captured. In addition, the second objective of identifying the support needs of key staff with a central role in the provision of sexual health education to young people in care has been met through a detailed account of practical and legislative impediments that service-providers encounter in their daily work, and the identification of training and education deficits that they conveyed. These data are new in a barren empirical field, and there is little work with which they may be compared to either support or problematise. As indicated at the outset, the findings of this report are integrated with those of the other related reports in a composite report entitled *SENYPIC Composite Report of the Findings (Report No. 6)*. In the composite report, an overall conclusion and recommendations relating to the whole study are proffered.

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# Appendix 1:

## Topic Guide for Interviews with Professionals/Service-providers

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Note: Not all themes were relevant for all professionals working in a range of roles and providing different services to young people in care and to those who have left care.

The themes for the interviews are:

- Respondent background and experience of working with young people in care  
Sector (Social work, voluntary sector, education, health) and (residential, foster, after care, community)  
Role within organisation – type of contact with young people in care.  
Years of experience
- General needs of young people in care  
Education  
Social/emotional development  
Risk behaviours
- Specific needs of young people in care in terms of sex education and sexual health services  
Information needs  
Skills development  
Access to services
- How are sex education needs of young people in care currently met?  
Whose responsibility?  
Timing and content?  
Value of RSE from different sources (e.g. social worker, social care worker, foster parent, school, peers, GP/nurse media,etc)?
- Ways of engaging young people  
Approach (one to one or group)

- Are there any aspects of the care experience that impact on young people's health and social outcomes (and sexual health outcomes)?  
Placement history (e.g. foster care, multiple care experiences, residential care,etc)  
Education/training
- Specific needs of sub-groups with care settings – e.g. by ethnicity, learning disability, religion, asylum seekers,etc
- Barriers and facilitators to delivery of RSE or sexual health services for young people in care  
National guidelines, organisational policies,etc  
Skills,etc
- Staff training and support needs  
What is currently in place?  
What is required?
- What are the support needs of pregnant or parenting young people in care?  
What services are in place?  
What is required?
- Any other comments?
- Thank interviewee and close interview

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