

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

A Survey of Service-provider Perspectives

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

REPORT NO. 1

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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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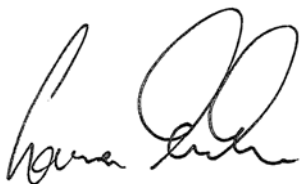
FOREWORD

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

INTRODUCTION

by the Head of the HSE Crisis Pregnancy Programme

The *Sexual Health and Sexual Education Needs Assessment of Young People in Care (SENYPIC)* programme of research was commissioned in late 2011 by the HSE Crisis Pregnancy Programme, in partnership with the Child and Family Agency (Tusla).¹ 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 first report from the programme of research, '*Report No. 1: A Survey of Service-provider Perspectives*' presents findings gathered by way of electronic survey (e-survey), which was circulated to those working with young people in care. The purpose of this approach was to gather information with as broad a range of service providers as possible to get a clear picture of needs from their particular perspective.

The findings point to the broader psychosocial issues linked to the lives of many young people in care and how these are inextricably linked to sexual health and sex education needs. The results also identify a number of barriers faced by service providers in providing sexual health education and information and those working with young people in care.

The results from the e-survey were used to inform the design of the subsequent qualitative stages of the research programme. Many of the findings in this Report No. 1 are explored in greater depth in Report numbers 3, 4 and 5 to follow. Report number 6 provides a summary of the findings from the standalone reports and provides key findings and a statement of actions to be followed up by the Crisis Pregnancy Programme and the Child and Family Agency. Both organisations have committed to delivering on these actions over the coming years.

I would like to thank the 182 social workers and service providers working with young people in care who took the time from their busy schedules to complete the e-survey.

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 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 Mugan, 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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Acknowledgements:

The authors wish to convey their sincere gratitude to the service-providers who attended an initial workshop associated with the SENYPIC study in 2012, and to all those who responded to the online survey presented in this report. They also acknowledge the help of Catherine Carty, National University of Ireland, Galway, for sharing her work in relation to child protection policies and procedures. During the course of the research, the SENYPIC study 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, for reviewing components of the 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
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
HSE CPP	Health Service Executive Crisis Pregnancy Programme
RSE	Relationships and Sexuality Education
SENYPIC	Sexual Health and Sexuality Education Needs Assessment of Young People in Care
YPIC	Young People in Care

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 Centre*, 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.

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.

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

International evidence indicates that young people in care (YPIC) have a higher risk of early sexual initiation, teenage pregnancy, sexually transmitted infections (Jones *et al.* 2011, Boonstra 2011, Ahrens *et al.* 2013) and socio-economic disadvantage (Viner and Taylor 2005) compared to young people in the general population. In spite of the challenges they face in relation to sexual health, very little research at an international level has been reported that specifically focuses on identifying the relationships and sexuality education (RSE) and sexual health needs of this cohort. Although the latest figures indicate that there are almost 6,500 children in state care in Ireland (Child & Family Agency 2014), no research to date has been published that has investigated these needs among YPIC in an Irish context. The SENYPIC¹ programme of research addresses this deficit by detailing, from a diversity of vantage points, perspectives on what these needs are deemed to be and what sexual health services are currently being provided in Ireland to YPIC. Presented over a suite of six² reports, an in-depth understanding of the complexity of the RSE and sexual health needs of this group unfolds and provides the first ever body of empirical evidence in Ireland to guide policy and practice on the topic. The SENYPIC programme constitutes the largest study to date on the sexual health needs of YPIC either in Ireland or Britain.

This report - an e-survey of service-provider perspectives on the RSE and sexual health needs of YPIC - constitutes the first part of the SENYPIC research programme. Because it is the first of a series of reports, a brief account of the SENYPIC programme is given in Part 1 before detailing the specifics of the e-survey in Part 2.

1 The acronym 'SENYPIC' stands for 'Sexual Health and Sexuality Education Needs Assessment of Young People in Care in Ireland'.

2 This figure includes a composite report (Hyde *et al.* 2015d) where the overall findings of the study are synthesised.

PART 1:

Overview of the SENYPIC programme of research

Aims and objectives (overall SENYPIC research programme)

Aim

The overall aim of the SENYPIC programme of research was to identify the sexual health and sexuality education needs of young people in care in Ireland. The scope of the study was to include young people in foster care and in residential care centres. Those in special-care units, high support units or residential services for young people with disabilities were not included. This was due to the small number of young people involved and the potential for identification, and also due to the very specific needs associated with young people in these types of care.

Objectives

The objectives of the SENYPIC research programme were to:

1. Reliably describe the sexual education and sexual health needs of young people in care.
2. Describe the approaches used and services delivered by professionals engaged in RSE and sexual healthcare to young people in care.
3. Analyse and describe protective and risk behaviours among this group and factors associated with these behaviours, from the psychological to the relational, situational, familial, community and social level.
4. Assess attitudes, knowledge and risk-perception levels among young people in care in relation to 'crisis' pregnancy, STIs and awareness of services and supports.
5. Estimate the teenage pregnancy rate among young people in care.
6. Compare and contrast findings from published qualitative Irish research on young people in general, including early school-leavers, and this cohort of young people; provide evidence of the degree to which issues generated by young people in care are similar and/or dissimilar to those issues raised by their peers.
7. Analyse results and triangulate findings across different research groups (young people, parents, carers) so as to provide meaningful insights that can be translated into practice and policy recommendations.
8. Present a thorough, reliable, and objective analysis of the sexual health needs of young people in care that the HSE Crisis Pregnancy Programme and Child & Family Agency (TUSLA) (formerly the HSE Children and Family Services) can use to promote evidence-informed practice and policy development.

Existing knowledge in the field (overall SENYPIC research programme)

Each component report of the SENYPIC research programme includes a literature review illuminating what is known already about the topic of that report. Since the present report (Report No. 1) and Report No. 3 (qualitative study on data from a sample of service-providers) focus on the perspectives of service-providers, albeit using different methods and analytical techniques, the literature review is, for the most part, identical in these two monographs.

Methodology (overall SENYPIC research programme)

The thrust of the methodology for the SENYPIC research programme was inductive and incremental, involving a variety of stages, each designed to contribute to a broad picture of the sexual health and RSE needs of YPIC. Both quantitative and qualitative research strategies were employed to achieve both scope and depth. In order to meet the range of objectives of the SENYPIC programme of research, a methodology was required that allowed a variety of vantage points to be captured on the sexual health and RSE needs of YPIC. It was decided that data sources would include those whose professional role or personal experiences positioned them to provide insights on the topic. Those considered best placed to participate were service-providers, foster carers, birth parents of YPIC, and young care leavers. The initial design proposed the participation of young people currently in care (those under the age of 18 years), in keeping with the contemporary discourse of children's right to inclusion; however, consent from birth parents was required and limited resources in terms of service-providers to facilitate this resulted in no minors being recruited. The inductive approach of the methodology allowed a degree of flexibility and a higher proportion of young care leavers (over 18 years) were recruited to offset the absence of participants aged under 18 years.

Informed by previous work indicating that collaboration and engagement with key stakeholders and gatekeepers in the design and implementation of the research is imperative to the success of research on children in care (Dale *et al.* 2011), the SENYPIC research programme commenced with an initial half-day workshop (in early 2012) with service-providers in the area. The workshop, held at the HSE Crisis Pregnancy Programme offices in Dublin, was attended by 30 key stakeholders representing different organisations and agencies working directly and indirectly with YPIC. Attendees from social work settings (including foster care, residential care, and aftercare) as well as other relevant voluntary and statutory organisations (such as homeless organisations, specialist sexual health services, youth organisations and teen parent support organisations) were represented. Individuals were selected for their knowledge of the subject and/or their experience in working with YPIC, delivering sexual healthcare³ or providing support/training to staff or carers. During the workshop, participants were provided with an outline of the research design, including recruitment and informed consent procedures, as well as the research approach for dealing with child protection issues and concerns.

3 The term 'sexual healthcare' used throughout the report refers to the broad spectrum of sexual health provision and relationships and sexuality education, where not otherwise specified.

Stakeholder engagement enabled the research team to gain insights into issues relating to the research topic that had not been documented previously and that were culturally and legally specific to an Irish context. Although the objectives of the SENYPIC research programme had been developed prior to the stakeholder meeting, the contributions of these professionals added considerable value in a field with very little previous research. It allowed the research instruments that would later be used (the e-survey questionnaire and topic guides) to be refined and further developed. It also helped to identify services and approaches currently in place to support the sexual health of YPIC in Ireland. During the meeting, stakeholders also discussed the needs of both young people using their services and the support needs of staff providing and delivering services. Specific needs of YPIC and those leaving care were highlighted and the research team were alerted to the relevant policies and procedures supportive of sexual health work. Stakeholder engagement was also important in bridging connections between potential research participants and the researchers throughout the various subsequent stages of the research.

From that first stakeholder meeting, the SENYPIC research programme rolled out over a series of overlapping stages throughout 2012 and 2013. While the objectives and broad thrust of the research design had been determined from the outset, each stage informed and shaped the next to some extent.

The first stage of the research proper was an e-survey (the substance of this first report) designed to capture service-providers' perspectives on the sexual health and RSE needs of YPIC. The e-survey also had the purpose of gleaning initial data, which informed the substance and focus of subsequent stages. Building on insights from the e-survey results, a qualitative study of 22 of these service-providers (a sub-sample of the e-survey respondents) was conducted based on in-depth interviewing. A separate qualitative study of 19 foster carers and 5 birth parents was subsequently conducted, also using the technique of in-depth interviewing. The final component of the study was a qualitative analysis of the interview accounts of 19 young care leavers. Parallel to capturing data on the sexual health and RSE needs of YPIC, a descriptive mapping of services in Ireland was conducted. The purpose of this component of the study was to get a sense of existing services with a role in delivering sexual healthcare to YPIC. Data for the descriptive mapping component of the study (Fullerton *et al.* 2015) came from a section of the e-survey as well as telephone interviews with a sample of service-providers.

Findings from the SENYPIC programme are reported in a suite of five related studies, with the specific focus of each as follows:

- Report No. 1 (this report) presents the results of an e-survey with service-providers
- Report No. 2 comprises a descriptive mapping of services and approaches that promote sexual healthcare among YPIC in Ireland (Fullerton *et al.* 2015)
- Report No. 3 presents a qualitative analysis of service-provider perspectives on the sexual health and RSE need of YPIC (Hyde *et al.* 2015a)

- Report No. 4 presents a qualitative analysis of foster carer and birth parent perspectives on the sexual health and RSE needs of YPIC (Hyde *et al.* 2015b)
- Report No. 5 presents a qualitative analysis of young care leaver perspectives on the sexual health and RSE needs of YPIC (Hyde *et al.* 2015c)

The whole SENYPIC programme of research is summarised and synthesised in Report No. 6 (Hyde *et al.* 2015d), which takes the form of a composite report.

Ethical considerations

The SENYPIC programme of research gained ethical approval from the Human Research Ethics Committee at University College Dublin. All components of the research were conducted according to normative ethical standards for research of this type, including protecting the privacy of participants and obtaining informed consent from them in advance of their participation. Since some service providers were sensitive that their professional role might identify them, the presentation of direct quotations of the open-ended responses in the e-survey makes no reference to the role of the respondent. In the case of all participants across the reports, any information that might disclose their identities was withheld or framed in a general way.

The limits to guarantees of confidentiality were written into study information sheets and consent forms. To this end, participants were informed that disclosures suggesting that a young person or another vulnerable person may be at risk of serious harm might require confidentiality to be breached so that help may be sought for that person. In some interviews with service-providers, foster carers and the young care leavers themselves, references were made to underage sex happening among young people in care, some of which suggested a level of coercion or age disparity between partners. The principal investigator, also the designated person (DP) responsible for reporting child protection concerns, considered these cases under both the *Children First 2011* document detailed in the ethical application, and in terms of legal obligations under the *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012* that commenced on 1st August 2012 as the research was in train.

As far as service provider accounts of underage sex among YPIC whom they had encountered were concerned (Report No. 3), the DP 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.

In the case of foster carer participants (Report No. 4), there were also revelations of underage sexual activity among YPIC but the DP was satisfied that there were no specific incidences that required follow-up. As indicated in Report No. 4, foster carers reported feeling obliged to interface with the HSE where they suspected that a foster child was sexually active.

With regard to interview data with young people themselves, since these data were more specific to individual cases, in order to ensure absolute compliance with all ethical, legal and best practice principles in relation to the safeguarding of children, each of the 19 interviews with the young adult participants was carefully reviewed. A template was developed to capture incidents/disclosures considered in relation to *Children First 2011* and also with reference to the *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012* (see Appendix 1). Data were carefully and seriously reviewed and reflected upon for each case in which underage sex featured. With regard to reporting under the obligations of *Children First 2011*, a limited number of cases were forwarded to the nominated Tusla staff member to whom the DP was to liaise for consideration and if appropriate, further action.

With regard to legal obligation to report, full consideration was given to any reporting requirements under the *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act, 2012* and *An Garda Síochána Policy on the Investigation of Sexual Crime Crimes Against Children Child Welfare 2nd Edition 2013*. It was considered that no reporting obligations arose.

It should be noted that the laws on child protection have changed rapidly in recent years in Ireland and there are currently no established guidelines for researchers or practitioners available on how to interpret the 2012 Act and how and what disclosures to report in practice.

PART 2:

An e-survey of service-provider perspectives on the sexual health and sexuality education needs of young people in care

Section 1

Background and literature review (e-survey)

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.³ 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 complex social and legal⁴ 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 overlooked. In addition, the importance of consistency in the sexual health messages 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

3 To recapitulate, since Report No. 3 of the SENYPIC study (Hyde *et al.* 2015a) focuses on in-depth interviews with a sub-group of service-provider respondents from the e-survey reported here, the main thrust of this background and literature review also appears in Report No. 3.

4 It should be noted that data collection for the SENYPIC study preceded the enactment of the Children First Act, 2015. The majority of the provisions of this Act await commencement.

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 that 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 programme of research 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, she 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 carers and social care staff, 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 as children 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 health 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*)⁵ 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-cut 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).

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 states 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:

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

- 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 Guidance 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 Law Reform Commission's 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 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 17-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 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 his or her view that he or she does 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 the remainder of this report 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.

Section 2

Design of the e-survey

Aims (e-survey)

The aims of the e-survey are:

- (1) To obtain service-provider perspectives on the RSE and sexual health needs of YPIC that would inform, refine and focus subsequent stages of the SENYPIC research.
- (2) To provide data capable of standing alone in addressing, to some degree, the objectives of the SENYPIC programme outlined in Part 1.

E-survey development

The questionnaire was developed from existing literature in the field (Dale 2009, Billings *et al.* 2007) (of which there was very little) and from knowledge acquired through engagement with key stakeholders, described earlier, who provided important feedback on the instrument's content. The questionnaire sought to gather initial data – to be supplemented with data from later stages of the whole SENYPIC research programme – as to whom service-providers viewed as important sources of RSE for YPIC. It also sought their views on the extent (if any) that they considered YPIC to have additional needs over and above those of young people in general. Furthermore, it was designed to capture some preliminary data on respondents' perspectives on RSE and sexual health delivery to YPIC, as well as to identify their views on the main challenges to and supports in engaging in RSE and/or sexual healthcare provision. A final section of the questionnaire sought to capture information on any RSE approaches or interventions that involved YPIC of which respondents had experience (these data were centrally important to the descriptive mapping exercise contained in SENYPIC Report No. 2).

The data that the questionnaire sought to capture, as described above, were structured around four sections:

Section 1

You and your organisation (from which a description of the sample was derived).

Section 2

Perspectives on (i) sources of information about sex and relationships (ii) RSE needs of YPIC relative to young people in general.

Section 3

Perspectives on (i) the importance of various aspects of the provision of RSE and sexual healthcare (ii) challenges and barriers to such provision.

Section 4

Experiences and descriptions of any RSE approaches or interventions that reach young people in care.

The survey was hosted through Survey Monkey, an online survey tool, and comprised both closed and open-ended questions (open-ended questions allowed respondents to respond in free text to the questions posed). The survey was open for a 6-week period from March 1st 2012.

Survey population

In order to reach the intended population (a diversity of professionals providing health and social care services to YPIC), the e-survey link was emailed to relevant individuals and organisations interfacing with YPIC via the contact details provided by the stakeholder group at the initial workshop. These stakeholders agreed to support the survey by forwarding the survey link to frontline staff. Additional requests were also issued beyond the stakeholders who attended the initial workshop through the internal HSE broadcast network as well as to a range of public and private organisations working with young people in different care settings. The intention was to capture a cross-section of views and experiences. To this end, all contacts were asked to cascade the survey to others working either directly or indirectly (such as in the provision of training/workforce development) with YPIC. Desk research was carried out simultaneously to identify other relevant organisations/individuals well positioned to participate in the survey. A description of those who ultimately constituted the sample is given in Section 3. The number of respondents was 182 (N=182).

Survey respondents were asked to indicate if they were willing to participate in interviews at a subsequent stage of the research, during which their anonymity would be protected if requested. Half (n=92) volunteered for a follow-up in-depth interview. Twenty-two of these were subsequently interviewed in-depth for the qualitative service-providers' report (Hyde

et al. 2015a) and an additional 12 were interviewed in brief for the descriptive mapping of services and approaches that promote sexual healthcare (Fullerton *et al.* 2015).

Data analysis

The quantitative data from the survey were analysed using descriptive statistics. Responses from the closed-ended questions are presented in percentages. Responses to the open-ended questions were analysed using thematic analysis, whereby key themes are categorised.

Section 3

E-survey results: quantitative analysis.

Section 1 of the e-survey focused on a description of the sample and the context of respondents' work, which is presented below. This is followed by the results structured around the key components of the questionnaire (reflecting the objectives of the e-survey). These results present the perspectives of respondents in relation to the following areas:

1. The relative importance of various sources of information on relationships and sex for young people in general and YPIC.
2. RSE and sexual health needs of YPIC compared to young people in general.
3. The provision of RSE and sexual healthcare to YPIC.
4. Challenges to and supports in delivering RSE and sexual health services to YPIC.

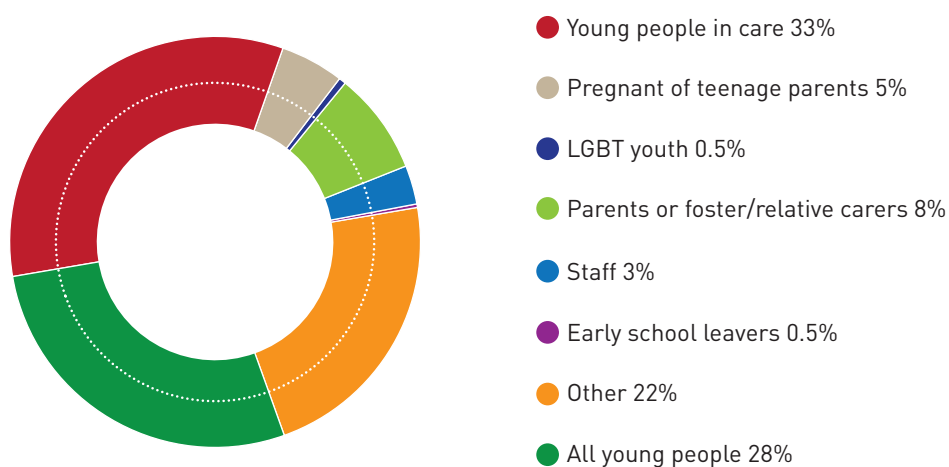
Description of the sample and the context of respondents' service provision

Of the 182 respondents, 79% were female and 21% were male. The survey received responses from statutory organisations (63.3%), voluntary organisations (25.5%) and other types of organisation (e.g. private organisations) (11.2%). Just over half (50.6%) of the respondents had daily contact with YPIC, 17.3% had weekly contact and 20.4% had monthly contact (11.7% reported that they did not have direct contact but provided training and support to social care workers). The sample comprised of those working in a diverse range of services including foster care, residential care, after-care, teen-parent support projects (general and specialised), youth work organisations, sexual health organisations, health promotion, professional development and clinical sexual health services (see Appendix 2).

Respondents' years of experience in working directly with young people or indirectly (by training or providing services to staff or social care workers involved with young people) were fairly evenly distributed: 24% had 0-5 years' experience, 28% had 6-10 years' experience, 26% had 11-15 years' experience and 22% had greater than 15 years' experience.

A third (33%) of respondents reported that YPIC were the main target population for their service, followed by 'all young people' (28%), 'parents/foster carers' (8%), and 'pregnant or parenting teenagers' (5%). Over a fifth (22%) described the main client group of the services they provided as 'other'. Care leavers, homeless people, people with mental health or addiction issues, separated young people, children in the community and staff were included in the category of 'other'. (See Chart 1)⁶

Chart 1: 'Who are the main target population of your service?' (n=182)



1. The importance of sources of information on relationships and sex for young people

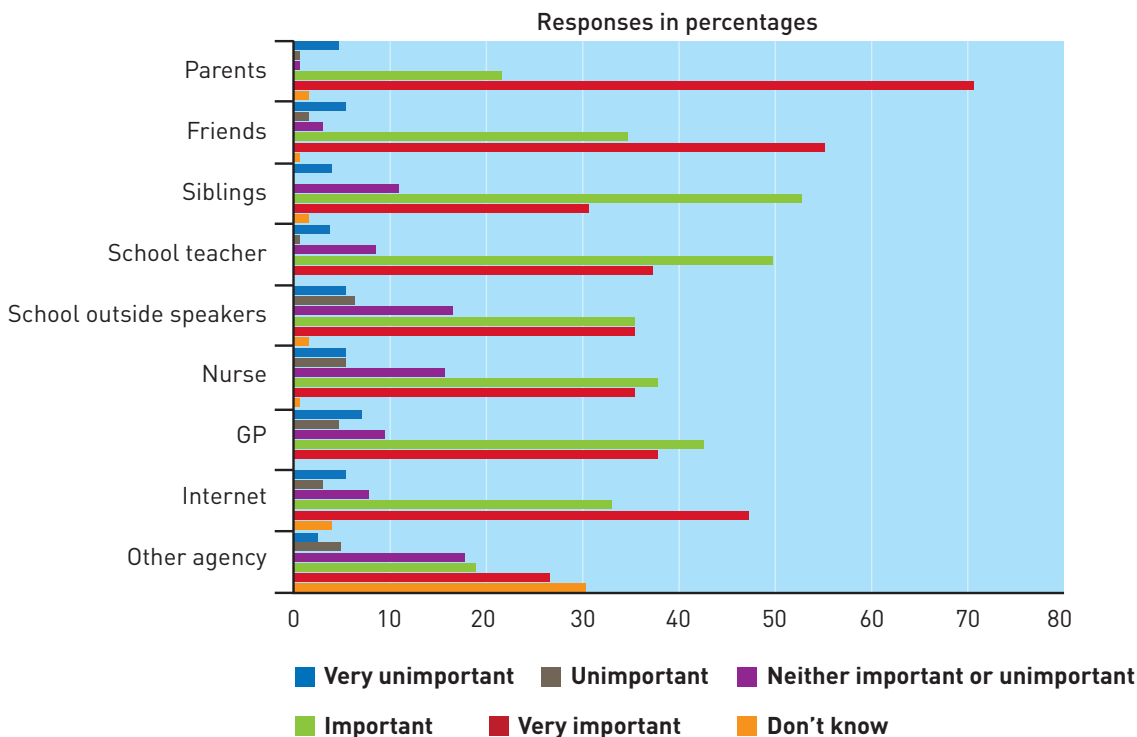
Three closed-ended questions sought respondents' views on the importance of different sources of RSE for (i) young people in general, (ii) young people in foster or relative care and (iii) young people in residential care.

(i) Sources of information on relationships and sex for young people in general

For young people in general, the most important source of RSE reported by respondents was parents, with 92.2% viewing parents as either important (21.7%) or very important (70.5%). Other sources of information considered to be important for young people in general were friends (89.7%), school teachers (86.8%), siblings (83.4%) and the internet (80%). (See Graph 1)

⁶ The 'n' given in charts and graphs refers to the number of respondents who answered the question (out of a total sample size of 182 [N=182])

Graph 1: 'How important are the following sources of information about relationships and sex for ALL young people?' (n=131)

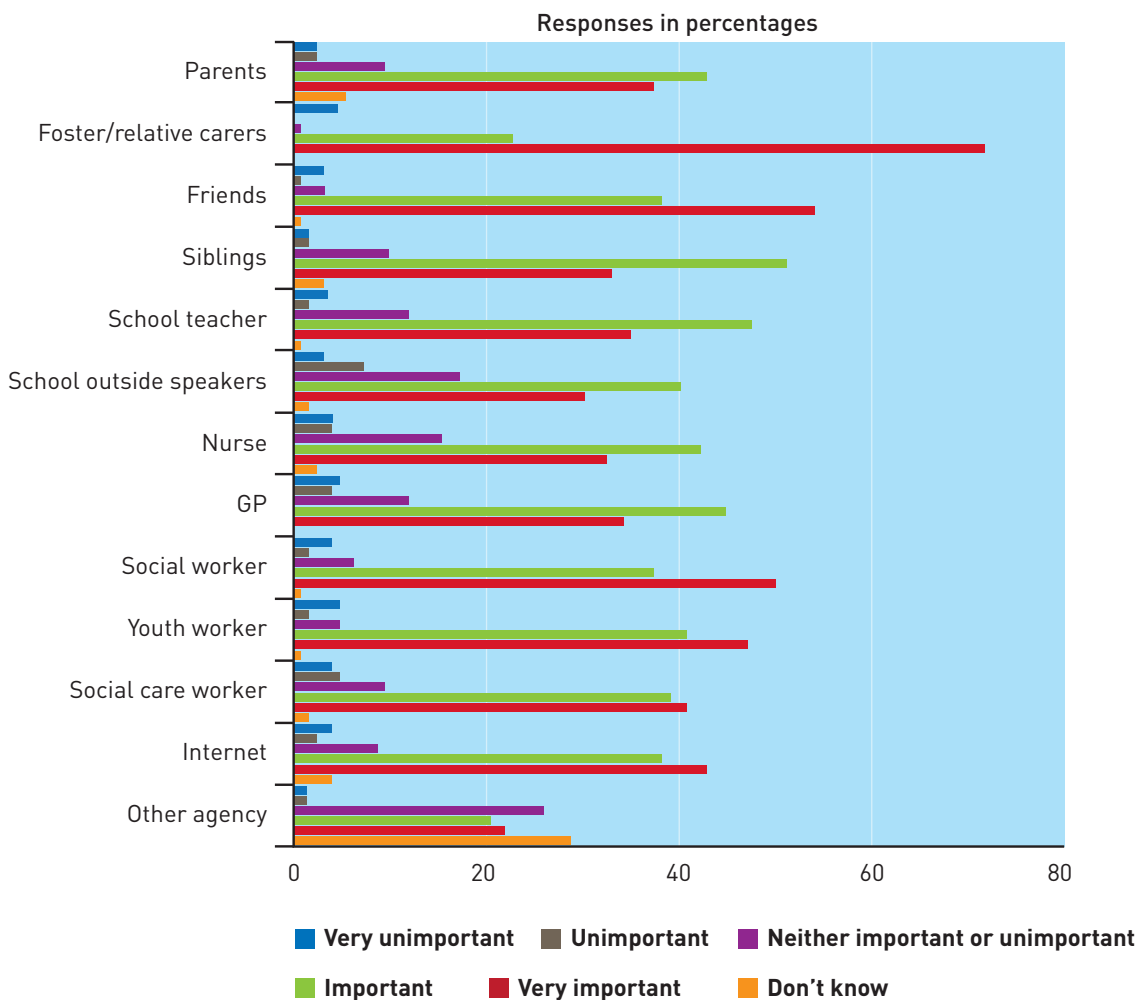


(ii) Sources of information on relationships and sex for young people in relative and foster care

With reference to the relative importance of sources of information on relationships and sex for young people in relative and foster care, relative carer/foster carers were more important to this group than parents (the most important source for young people in general); 94.4% of respondents reported relative carers/foster carers as the most important source of RSE for young people in foster care. While parents were still considered to be an important source by 42.8% of respondents, and very important by 30.7%, compared to the clear primacy of parents' role with reference to young people in general, others, particularly service-providers were broadly viewed as comparable in terms of their importance, and in some cases considered to be a more important source. Among the service-providers whom respondents reported as either an important or very important source of RSE for young people in relative/foster care were (in order of importance rated by respondents): youth workers (88%), social workers (87.3%), school teachers (82.5%), social care workers (80%), GPs (79.2%), nurses (77.4%) and professionals delivering RSE out-sourced by schools (71.4%).

Friends were also considered to be an important RSE source for young people in relative/foster care (92%), almost on a par with relative/foster carers when the categories 'important' and 'very important' are collapsed, though relative/foster carers were rated comparatively stronger in terms of being a very important source of RSE. Siblings were also rated highly as either 'important' or 'very important' by 84.2% of respondents. The importance of the internet was similar to that of service providers, with 80.9% of respondents reporting it as either 'important' or 'very important'. (See Graph 2)

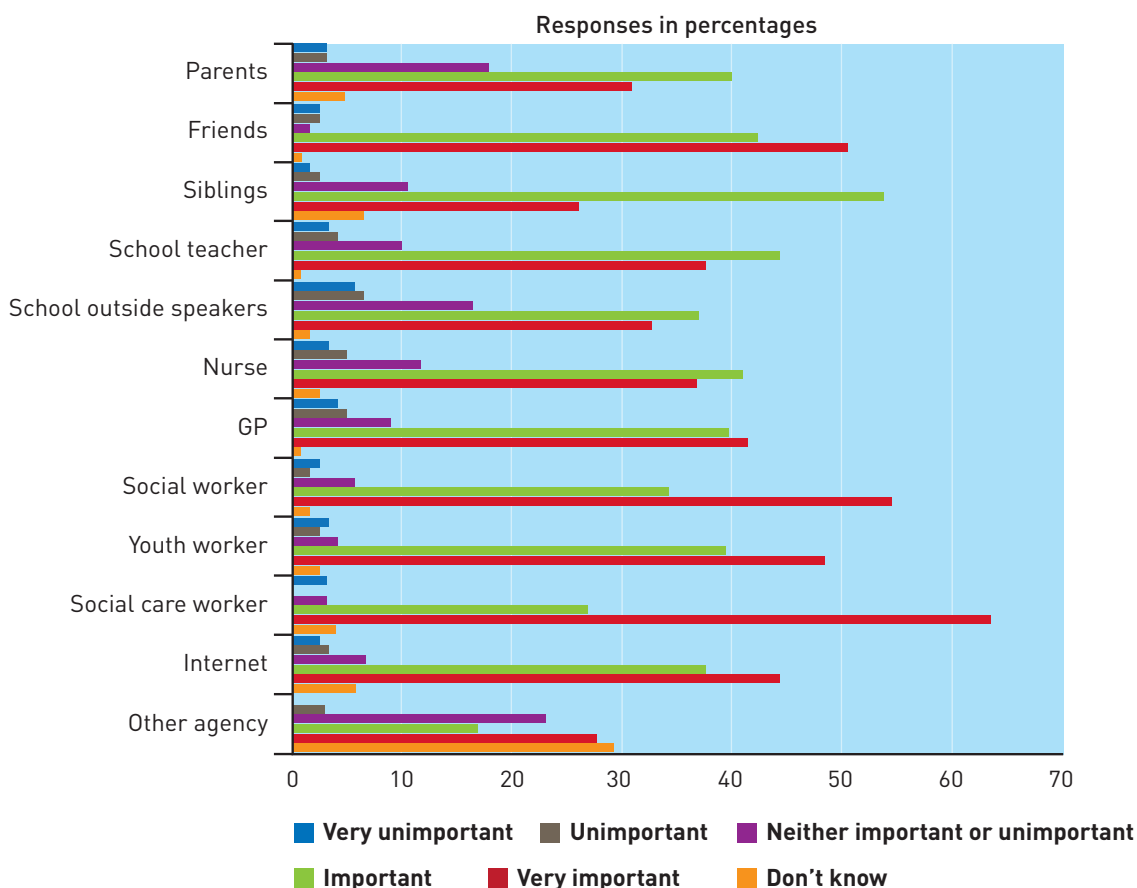
Graph 2: 'How important are the following sources of information about relationships and sex for young people in RELATIVE and FOSTER CARE?' (n=127)



(iii) Sources of information on relationships and sex for young people in residential care

Turning to young people in residential care, results indicated that the perceived importance of parents as a source of RSE was even lower than was the case for young people in foster/relative care: fewer than a third of respondents (30.8%) reported parents as a ‘very important’ source of RSE and fewer than half (39.4%) considered their role to be ‘important’. What comes to the fore in the case of young people in residential care is the perceived centrality of the role of social care workers as a source of RSE: Almost two-thirds of respondents (63.4%) regarded the social care worker as a ‘very important’ source of RSE. Moreover, when the category ‘important’ is factored in, 92% of respondents rated social care workers as being an ‘important’ or ‘very important’ source. Social workers also featured strongly as ‘important’ or ‘very important’ (88.5% on aggregate) sources for young people in residential care, though considerably fewer respondents viewed their input as ‘very important’ (54.4%) compared to the input of social care workers. Other service providers regarded as ‘important’ or ‘very important’ sources of RSE for young people in residential care (with the rated responses of respondents indicated) were: youth workers (87.6%), school teachers (81.6%), GPs (80.9%), nurses (77.4%) and outsourced school RSE professionals (69.5%). Friends were considered ‘very important’ sources of RSE for young people in residential care by just over half of respondents (50.4%), a proportion that rises to 92% when scores for ‘important’ and ‘very important’ are combined. Siblings were considered either ‘important’ or ‘very important’ sources of RSE for this group by almost 80% of respondents. (See Graph 3.)

Graph 3: ‘How important are the following sources of information about relationships and sex for young people in RESIDENTIAL care?’ (n=124)

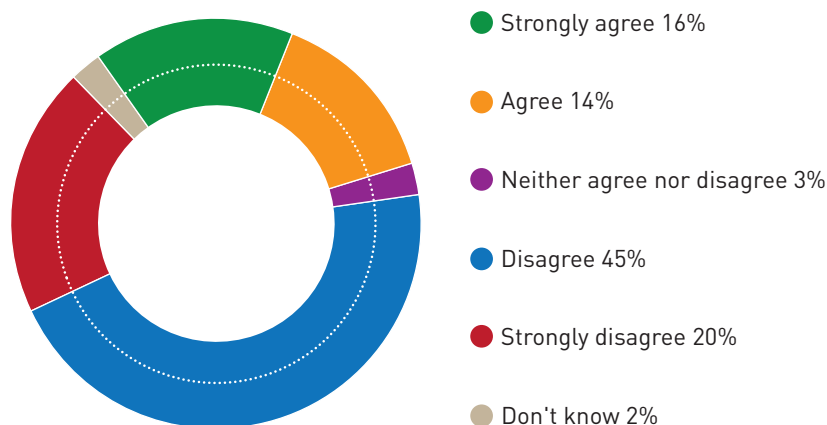


2. The RSE and sexual health needs of young people in care compared to young people in general

A series of closed-ended questions on the e-survey were designed to capture respondents' perspectives on the extent (if any) to which YPIC were deemed to have additional RSE and sexual healthcare needs compared to young people in general and whether these needs varied according to the care setting (foster/relative or residential).

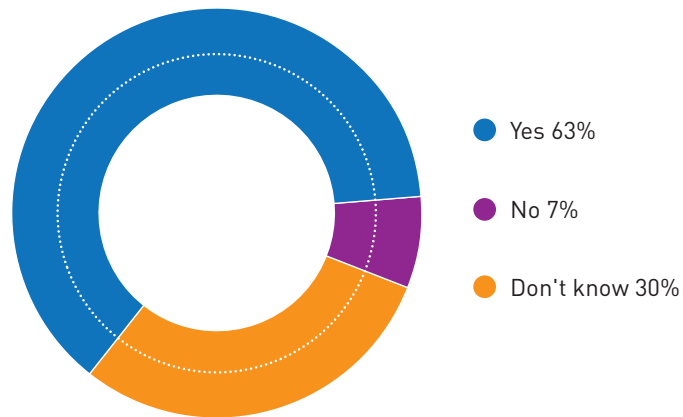
With regard to the extent to which the RSE needs of YPIC were held to be different from the general population of young people, the specific question related to the following statement: 'The relationships and sex education needs of YPIC are no different to the general population of young people.' Respondents were requested to indicate their level of agreement with the statement by opting for one of five choices – strongly agree, agree, neither agree nor disagree, disagree, strongly disagree. As indicated in Chart 2, a fifth of respondents (20%) strongly disagreed with this statement. Indeed, when scores for the percentage of respondents who either disagreed or strongly disagreed with this statement are combined, it emerges that nearly two-thirds (65%) of respondents were of the view that YPIC do indeed have different RSE needs compared to young people who are not in care.

Chart 2: 'The relationships and sex education needs of young people in care are no different to the general population of young people' (n=126)



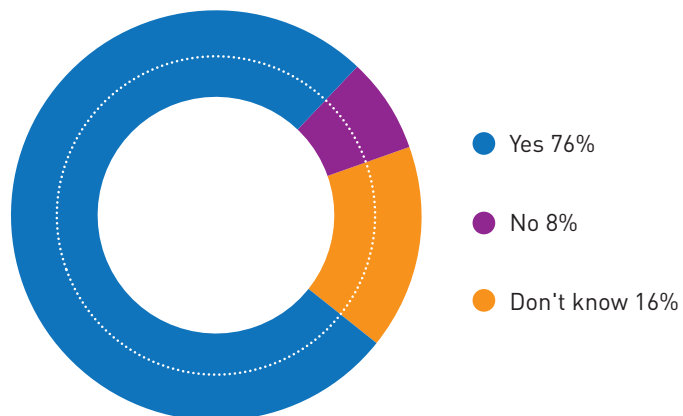
Turning to a more differentiated picture of the needs of young people in specific care settings – foster/relative care and residential care – the question posed here was as follows: 'Compared to young people in general, in your experience do young people in relative/foster care have any additional RSE and sexual health needs?'. An identical question relating to young people in residential care was also posed. In the case of this question, the response was a fixed choice 'yes' or 'no', with the option of 'don't know' (for those without an opinion on the matter, or with limited experience of the particular care setting). Results indicated that in the case of young people in relative/foster care, 63% of respondents believed that the RSE and sexual health needs of this group exceeded those of young people in general (See Chart 3).

Chart 3: 'Do young people in RELATIVE/FOSTER care have additional RSE and sexual health needs?' (n=122)



As far as young people in residential care were concerned, the view that these had additional needs over and above young people in general was even more marked, with over three-quarters of respondents (76%) affirming this (see Chart 4).

Chart 4: 'Based on your experience, do young people in RESIDENTIAL care have additional RSE and sexual health needs?' (n=119)



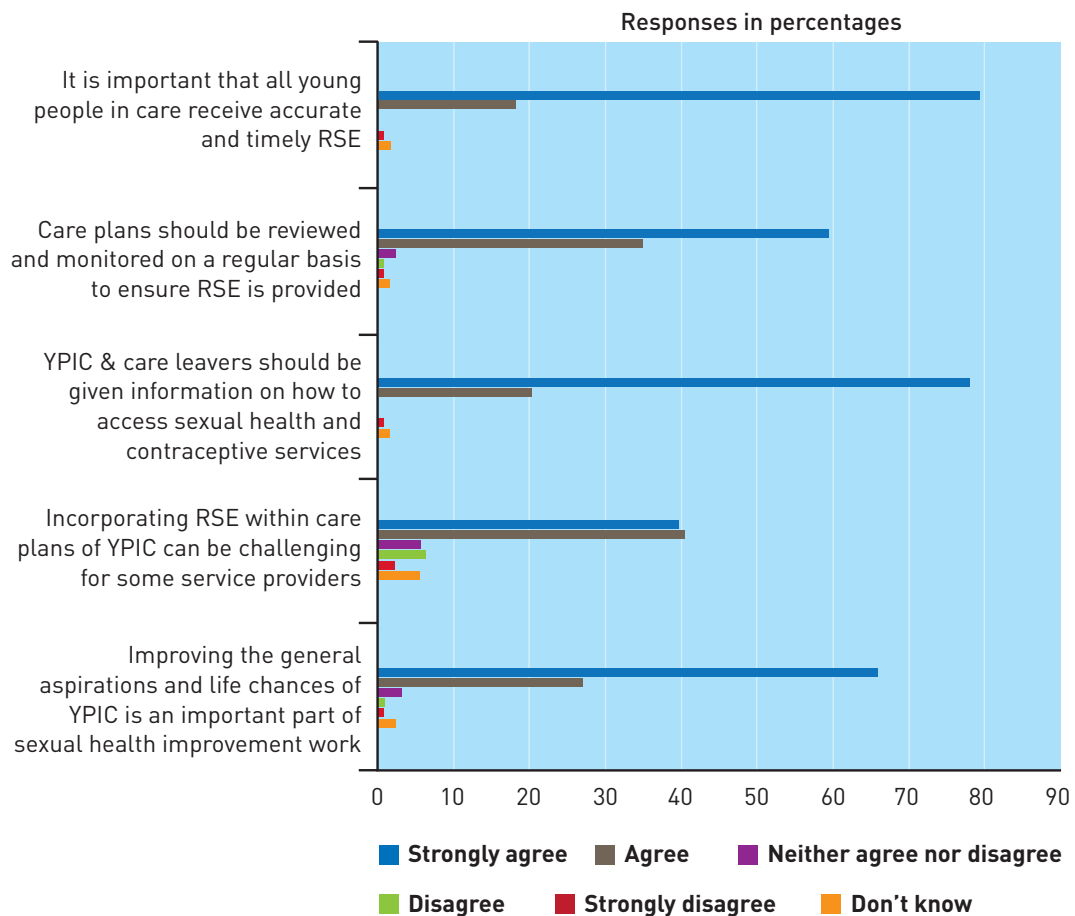
3. Perspectives on the provision of RSE and sexual healthcare to young people in care

A number of questions attempted to identify respondents' perspectives on the provision of RSE and sexual healthcare to YPIC.

These included questions on the importance of providing accurate and timely RSE to YPIC, regularly reviewing and monitoring care plans to ensure that RSE is included, providing information to YPIC and care leavers on how to access the sexual health services and contraception, and improving the general aspirations and life chances of YPIC as a component of sexual health work.

Responses to each of these questions are indicated on Graph 4.

Graph 4: 'Perspectives on the delivery of RSE to young people in care' (n=126)



With regard to RSE provision, respondents were asked to indicate their level of agreement (from five options as indicated earlier) with the statement that 'It is important that all young people in care should receive accurate and timely information on relationships and sex'. There was a unanimous agreement (97.5%) with this statement, with 79.3% opting for 'strongly agree' and 18.2% opting for 'agree'.

There was overwhelming agreement about the importance of reviewing and monitoring care plans to ensure that RSE is included (94.4% when scores for 'strongly agree' and 'agree' are combined (59.5% 'strongly agree'; 34.9% 'agree')). Overall, though, fewer respondents opted for 'strongly agree' than was the case with the previous item. It should be noted that a separate question sought information on the frequency with which RSE needs are currently included in care plans with reference to the various client groups (young people in relative care, foster care or residential care). A relatively high proportion of staff chose the option 'don't know', particularly with reference to young people in relative care (43.7%). It was not clear whether this was owing to their limited experience with a particular group or their lack of familiarity with the detail of care plans of their client group. Of those who chose one of the remaining options ('all of the time', 'most of the time', 'some of the time', 'rarely' or 'never'), the highest proportion of respondents - about a quarter - reported that RSE was included in care plans 'some of the time', signalling an inconsistent pattern of inclusion of RSE in formal care plans. For all three groups of YPIC (those in relative, foster or residential care), approximately a fifth of respondents reported that RSE was rarely or never included in care plans (22%, 22.2% and 19.9% respectively).

Respondents' perspectives on the importance of providing information to YPIC and care leavers on how to access the sexual health services also met with overwhelming assent. 77.7% of respondents strongly agreed that providing information on how to access sexual health services was important and another 19.8% indicated that they agreed.

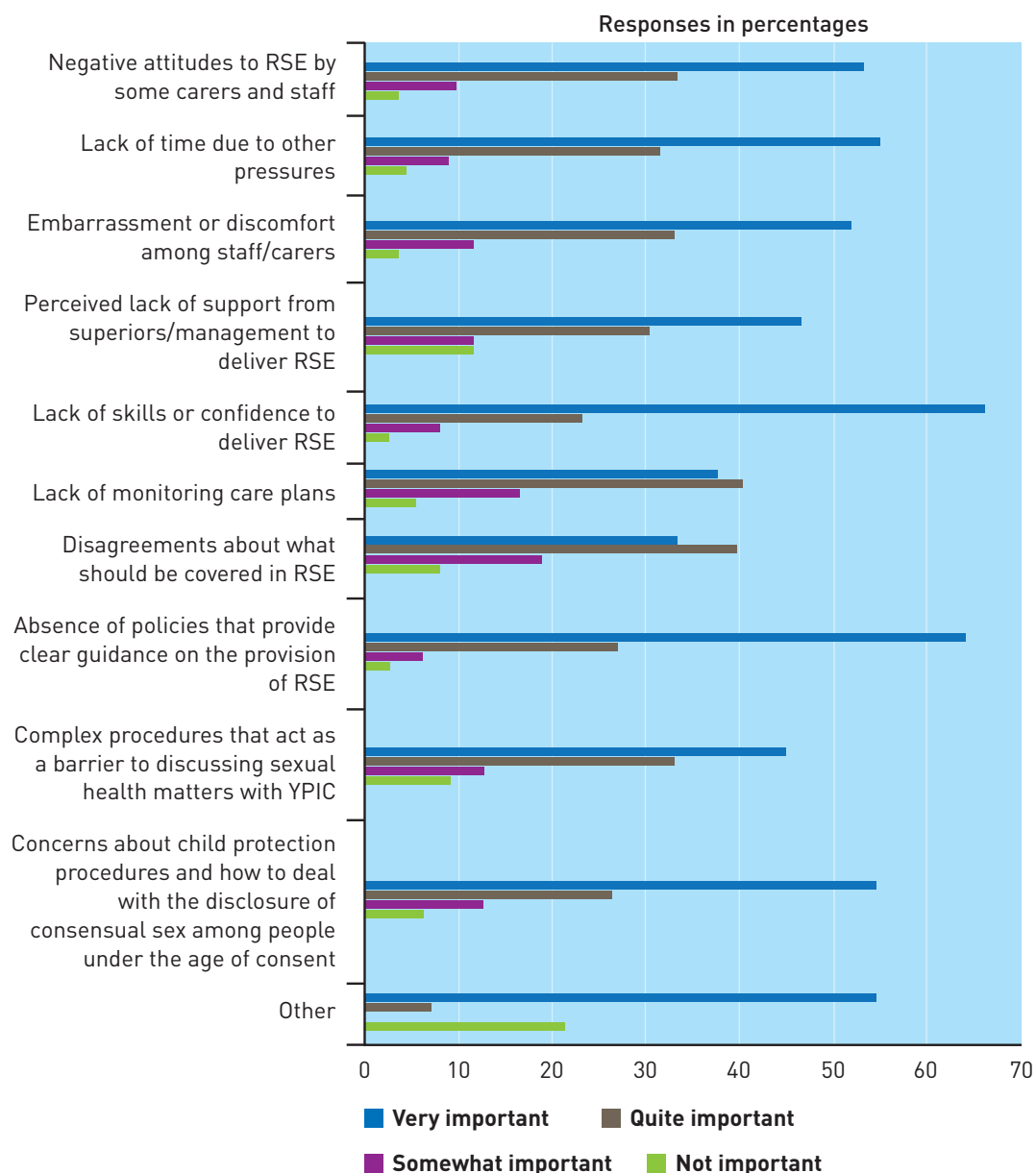
As far as 'improving the general aspirations and life chances' of YPIC was viewed as an important part of sexual health work, results indicated that almost two-thirds of respondents (65.8%) 'strongly agreed' that this was the case. The figure rose to 92.7% when the percentage of those who agreed was included.

4. Perspectives on challenges to and supports in delivering RSE and sexual health services to young people in care

In order to capture respondents' perspectives on challenges to and supports in delivering RSE and sexual health services to YPIC, two broad questions were posed, for which respondents were offered a variety of closed-ended responses. The first question focused on factors and conditions that potentially compromised the provision of RSE and sexual healthcare (the challenges), while the second sought to determine what was considered important to enable RSE and sexual health work for YPIC (the supports).

With reference to the challenges to RSE and sexual healthcare delivery, the options proffered to respondents were: negative attitudes by some staff, time constraints, embarrassment and discomfort among service-providers, perceived lack of support from managers, skills' and confidence deficits, lack of care plan monitoring, disagreements over RSE content, absence of policies and guidance, complex procedures that inhibited openness and concerns about child protection procedures and the management of information about underage non-abusive sex. As indicated in Graph 5, the main factors reported as most challenging in delivering RSE and in facilitating sexual health were as follows (the proportion who opted for 'very important' is given in brackets): a lack of skills and confidence on the part of service-providers (66%), the absence of policies to provide clear guidance on RSE practice (63.9%) and time pressures owing to competing commitments (54.9%). While all options presented were reported to inhibit RSE at least to some degree, those rated by relatively fewer respondents as 'very important' were 'disagreements about what should be covered in RSE' (at 33.3%) and 'lack of monitoring of care plans' (at 37.6%).

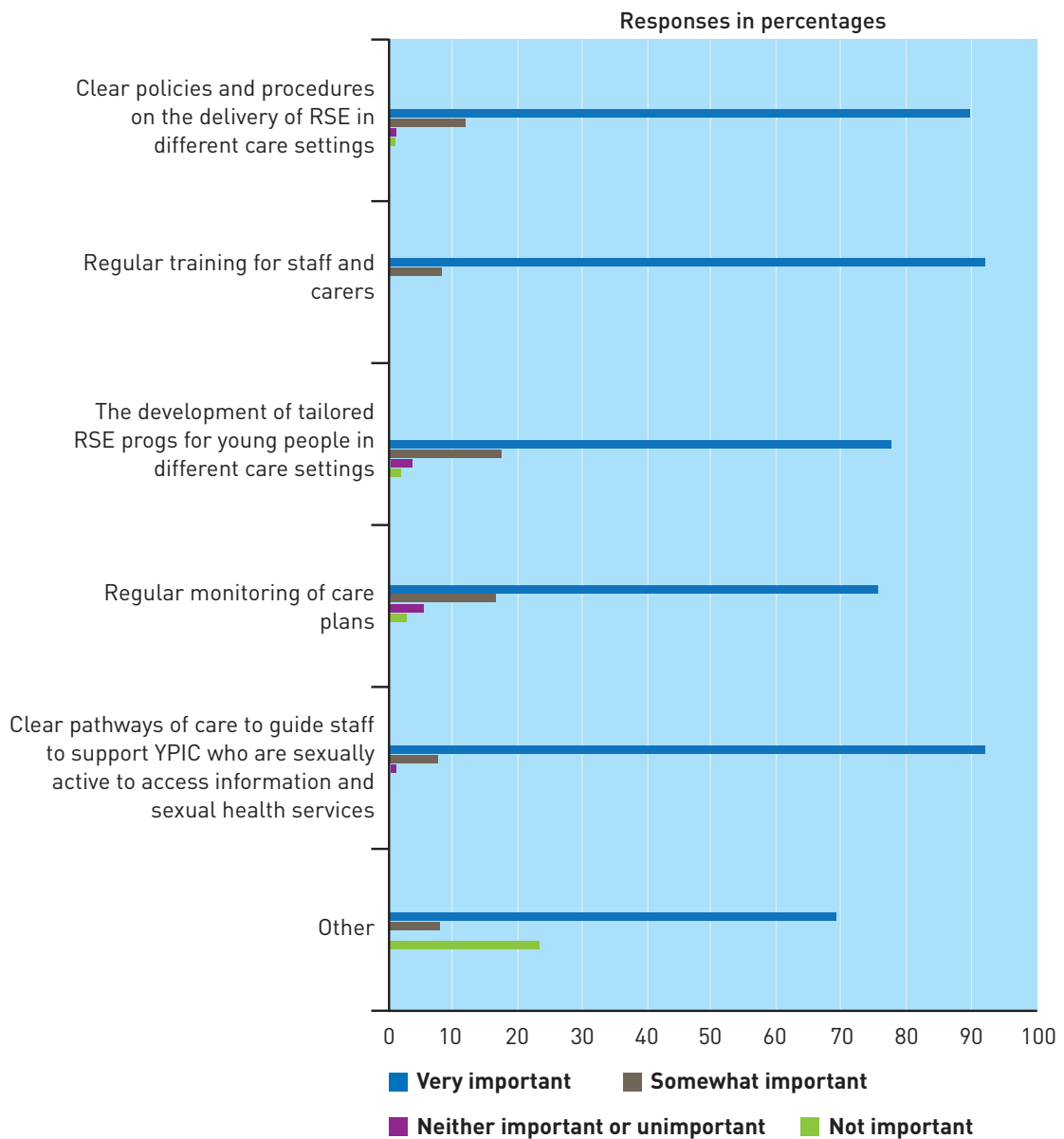
Graph 5: 'Of the possible conditions/factors that make it difficult to provide RSE to young people in care, how important are the following?' (n=112)



Turning to the participants' perspectives on supports to facilitate the delivery of RSE and sexual health services to YPIC, respondents were presented with a range of organisational arrangements and practices and asked to assess them in terms of their importance in meeting the RSE and sexual health needs of YPIC. Among the possibilities were: clear policies on RSE delivery, regular training of staff, tailored RSE programmes for YPIC, regular monitoring

of care plans and protocols for managing sexually active minors. As Graph 6 indicates, all options were strongly endorsed as being 'very important' by the majority of participants, with a relatively higher proportion of respondents (91.8%) identifying 'clear pathways of care to guide staff to support young people in care who are sexually active to access information and sexual health services' and 'regular training for staff and carers' as the most important.

Graph 6: 'How important are the following as a way of meeting the RSE and sexual health needs of young people in care?' (n=111)



The above quantitative findings of the e-survey are combined with the open-ended responses in a discussion of results in Section 5.

Section 4

E-survey findings: analysis of open-ended responses (qualitative analysis)

In this section, the focus is on analysing the open-ended responses to a range of specific open-ended questions posed at various junctures of the e-survey questionnaire. These questions were designed to allow respondents to elaborate on the following issues:

- The extent to which young people in care were believed to have additional RSE and sexual health needs compared to those not in care.
- The extent to which these needs were deemed to vary according to the type of care, that is, relative, foster or residential care.
- Challenges to the delivery of RSE and sexual healthcare arising from organisational factors.
- Service-provider training and education in relation to RSE and sexual health.
- The training of foster carers in relation to RSE and sexual health.

There was considerable fluidity in what respondents included in the open-ended responses, often with answers to individual questions encompassing a host of issues and overlapping with those of other questions. For this reason, the presentation of data generated from the open-ended questions is structured around themes that emerged rather than with reference to specific questions. These themes are:

1. Diversity across the broad category of young people in care.
2. Contextual and background issues frequently associated with young people in care.
3. Specific RSE and sexual health needs of young people in care.
4. Difficulties in providing care exacerbated with residential settings and influences in residential care.
5. Lack of clarity in policies and in relation to legal issues to guide practice.
6. Training and education needs of service-providers in relation to RSE and sexual health delivery.
7. The needs of foster carers in relation to RSE and sexual health provision to their foster children.

It should be noted that responses to the open end-ended questions are reproduced exactly as they were written, and in some cases include abbreviations, typographical and grammatical errors.

1. Diversity across the broad category of young people in care

While there was overwhelming consistency in the view that young people in both relative/ foster and residential care do indeed have additional RSE and sexual health needs compared to young people in general, young people in residential care were considered to have more complex needs than those in relative and foster care. The additional needs of those in residential care tended to be associated with residential settings and influences, which are considered in a later sub-section.

One participant singled out young people in relative care as being less vulnerable than others because of greater stability in the duration of the placement and the reduced likelihood of displacement once they reach 18 years:

In my experience young people leaving relative care are slightly less vulnerable than young people leaving foster care. Young people in relative care do not feel the same pressure to leave a placement at 18 as children in foster care. They have kinship relationships which are more helpful in terms of providing support around sexual health etc. (Re foster care?)

In addition to the type of care experienced, the variation in young people's past experiences also contributed to the view that YPIC as a broad category were highly diverse. Some of the direct quotations that capture a recognition of this diversity are as follows:

It depends on the individual young person and whether they have particular issues/needs that affect this, e.g. previous school attendance, whether they perceive their carer a safe, supportive figure to approach, whether they have had a history of sexual/emotional abuse or of difficulties in relationships with parents. (Re foster care)

This would depend on their life experience so far in relation to RSE and sexual health needs, it is not a case of one cap fits all. Each young person's needs are different. (Re residential care)

The above quotations indicate a tendency among these respondents to avoid the blanket categorising of YPIC as an inherently or invariably problematic group; instead an individualised approach is suggested, based on a thorough assessment, invoking contextual factors to identify specific needs. This is in keeping with contemporary good practice in social care (Hayes and Llewellyn 2010).

7 'Re residential care' indicates that the question to which the service-provider was responding asked specifically about residential care and 'Re foster care' indicates that the question specified foster care. What emerged was that respondents filled in far greater details in responding to questions relating to residential care, and frequently cited 'same as above' in the case of foster care-specific questions. Where no reference is made to either residential or foster care after a quotation, this signifies that the question to which the respondent was answering was non-specific.

2. Contextual and background issues frequently associated with YPIC

Notwithstanding references to diversity and (implicitly) the need for individual assessments, the specific RSE needs of YPIC were frequently embedded in accounts of contextual and background issues as to why the young people entered care in the first place. Indeed, the vast majority of respondents who completed these open-ended questions elaborated on biographical or life experiences that tend to be associated with YPIC such as abuse or a history of emotional trauma. These are believed to impact on sexual competence, that is, an ability to choose sexual relationships without feeling under duress, and with autonomy of decision-making (Wellings et al. 2001).

A few respondents noted that some young people are placed in care as a result of sexual abuse or domestic violence, which may impact on the young person's capacity to choose healthy relationships. Overall, the most dominant theme cross-cutting the open responses in relation to both foster and residential care was the likelihood of attachment difficulties arising from a history of emotional trauma, which many YPIC bring to the care situation. These contextual issues were believed to impact on the young person's ability to form healthy sexual relationships and generate difficulties for them in achieving sexual competence.

Not having the security of a family support system puts them more at risk of seeking the need for love/security from a sexual relationship (Re residential care)

Given the risk of much fractured attachments . . . (Re foster care)

Given possible histories of sexual abuse, exposure to inappropriate sexual behaviour, insecure attachments (Re foster care)

[They] use sex as a painkiller/coping strategy as a result of said trauma (Re residential care)

Respondents referred to other background difficulties, specific to YPIC compared to those not in care, that give rise to additional RSE and sexual health needs. These were: a higher likelihood of inconsistent schooling (the placement location may require a move between schools); inconsistent peer-groups; learning difficulties and disabilities such as impaired speech and language; compromised capacity to process information/advice related to attention deficits; and a history of poor supervision and guidance. Exposure to a greater level of age-inappropriate sexual content - both directly and via the media, neglect, abandonment or family dysfunction, substance and alcohol abuse and malnutrition and hygiene problems were also identified as contributing to increased RSE and sexual health needs for YPIC. The concept of risk was noted in several responses; higher-risk behaviours and increased risk-taking in general were associated with YPIC, compared to those in the general population. As a consequence of dysfunctional attachments, insecurity and a lack of stable role models in their immediate kin and social networks, a number of discrete difficulties were identified

that respondents associated with sexual health problems. These included: a poorly developed sense of self-worth and empathy, a limited ability to make autonomous decisions, and a lack of ability to discriminate between healthy and unhealthy friendships and relationships.

May have less well developed empathy or social skills than average young person. (Re foster care)

Young people in care can experience difficulty in being autonomous, this can lead to poor decision making around friendships/relationships in order to gain acceptance & approval. (Re residential care)

In view of these vulnerabilities, in the reported experience of many respondents, a reduced sexual competence, earlier sexual debut and less self-defined sexual boundaries were associated with YPIC compared to young people in general. The higher risk of teenage pregnancy -especially after leaving care -and of STIs was mentioned in this regard.

3. Specific RSE and sexual health needs of young people in care

In view of the difficulties arising from an unstable background, a range of RSE and sexual health needs of young people were identified. These were: (1) The need for consistency in relationships with carers; (2) The need to learn wider aspects of personal and social development that impact on relationships and sexuality; and (3) The need for factual/scientific sexuality education. These three areas of need are interlinked but in order to tease them out, they are presented separately.

Need 1: The need for consistency in relationships with carers

As indicated earlier, a considerable amount of space in the open-ended responses was given to the difficulties of YPIC in relation to stability and security in relationships and consistency in their supervision and education. The need for consistency in relationships permeated the majority of open-ended responses. This is distinguished from other RSE and sexual health needs because it is set apart from formal 'teaching' or targeted interventions in a narrow sense. Rather, it constitutes part of the fabric of the socialisation of the young person, which academics consistently agree, has an indirect but powerful influence on the young person's sense of self (see Lam et al. 2011). Consistency in relationships was frequently identified as the foundation for building up more focused RSE education, whether this constitutes the wider dimensions of sexuality or the narrower biological and factual aspects that are considered further on.

Thus, in the absence of a stable family life that mediates the development of sexual competence, referred to in an earlier section, the security of a strong relationship with a social worker or social care worker was a key dimension in attempting to address the complex biographical disadvantages. This applied whether the care location was foster or residential care:

From my role in outreach after-care it is incredible to look at the amount of young people leaving care or still in care that become pregnant. In my opinion this is a statement of need for a relationship where they will be loved unconditionally. We need to work with young people in care to show them that they are cared for, are not at fault for being in care at a young age and are important members of our society. That they can have good relationships with people in general. (Re foster care)

Associated with this need was the notion of role-modelling by those who indirectly convey messages about respectful relationships through their own everyday behaviour. This does not tend to involve 'direct' teaching but rather provides a repertoire of behaviours to which the young person could aspire and emulate (see Bandura 1988).

Also modelling positive and respectful relationships within the care setting as most of our young people have come from homes where relationships were fractured and often abusive. (Re residential care)

It is important to model positive and respectful relationships as far as possible and this needs to be ongoing. (Re foster care)

The RSE and sexual health needs of those in residential care in this regard were generally deemed to be greater than those in foster care. The absence of a single dedicated carer or 'parent figure', inconsistency in relation to the key worker and a higher probability of multiple placements were identified as sources of difficulty for this group.

Mostly they need to feel loved and to be treated as an individual which is difficult to achieve in a residential care setting. Good RSE and advice on sexual health works best in the context of a good relationship and without this it is hard to get young people to engage in a way that works. (Re residential care)

Young people in residential care may have missed out on sexual health education in school or at home and while in residential care may not have developed relationships with adults who can provide the education and who are comfortable to do so. (Re residential care)

Thus, this lack of a strong guiding relationship in young people's lives was redefined as an RSE need as follows:

[They] need staff whom they recognise as caring and sensitive and who can relate to where the young people are at in terms of their sexual development and sexual experimentation. (Re residential care)

It should be noted that for social workers and social care workers to engage in the lives of those in their care at a level akin to that of parents is by no means straightforward, since the former are paid service-providers and are restricted by the need to maintain professional boundaries (O'Leary et al. 2013) in a way that parents are not.

Need 2: The need to learn wider aspects of personal and social development that impact on relationships and sexuality

The second type of need that respondents identified in their open-ended responses was the need for YPIC to learn wider aspects of personal and social development that impact on relationships and sexuality. In contrast to the first need identified above – the need for stability in a key carer relationship – meeting this need requires some level of tangible teaching and learning, albeit of a more exploratory and participatory type of learning than might occur in the case of delivering ‘factual’ scientific information (that we consider further on).

Based on my experience of working with young people in care I would be of the opinion that there is a need for further development of sexual health & relationships programmes that incorporates self-esteem issues, positive self-image & confidence building tools. (Re residential care)

Often, young people in res care have lower self-esteem and may need guidance around safe and positive relationships and also around keeping themselves safe in sexual relationships. (Re residential care)

Due to the lack of family support and in my experience negative peer relationships YP in care are vulnerable and in need of strong education in sexual health and particularly in appropriate relationships. This should happen from a young age and [be] carried through to adulthood. (Re residential care)

Due to the complex life many young people in residential care have experienced their sexual health is magnified within the many others facets of their being and challenges they face, the programme they receive may not be hugely different as the facts are the facts re sexual health but it is the placing it in the context of their view of themselves that is so important. (Re residential care)

One participant intimated taking this type of RSE education a step further by proposing that it should include an exploration of the young person’s own past experiences that may have led to unhealthy sexual relationships.

They are often seeking intimacy and comfort through sexualised relationships, or if they have been sexually abused or mistreated they can have distorted cognitions about what healthy sexuality and sexual behaviour consists of and this should be explored. (Re foster care)

A personalised biographical approach was advocated by another respondent, as suggested in the following quotation:

Staff undertaking this work need to have an understanding of the individual young person’s life story and take this into account when deciding best way of delivering RSE.

What was striking about the open-ended responses was that respondents were far more likely to refer to the need to address the wider social and emotional difficulties of young people in residential care that impacted on sexual competence than to young people's need for biomedical and scientific knowledge to help protect them against unintended pregnancy and STIs. This is summed up in the following quotation:

Although RSE should always be integrated into the wider development of the person, those working with these young people may need to pay even more attention to the fact that information alone will not lead to the adoption of healthy behaviours in a situation where other behaviours have status and attraction. (Re foster care)

Need 3: The need for factual/scientific sexuality education

While needs arising from emotional deprivation dominated responses, the need for 'factual', biological sexual health information (including information about safer sex) and information about the age of consent also featured in responses, though to a lesser degree.

Also in an attempt to make them "safe" purely medical (contraception, STI treatment) may be delivered rather than a more holistic approach. (Re residential care)

They need to be provided with the right information at the appropriate time for them. They need to be kept safe in society as they can be very vulnerable. (Re residential care)

Where the need for factual sex education was referred to by respondents it was almost always linked with the need to educate about wider aspects of sexuality in tandem.

As I mentioned above most of our young people need help with self-esteem, self image, self acceptance as well as the factual information about sexual health. (Re residential care)

Areas such as consent (age of and general) relationships, emotions are very important along with the general basic sex education needs. (Re residential care)

Many of the open-ended responses referred to the need for sexual health information, with little detail about what this might constitute; however, in other responses, among the areas mentioned were the following: consent, legal issues around sexual activity, safer sex and the consequences of unprotected sex. The issue of sexuality education being overlooked in situations of multiple placements was also raised.

4. Perceived difficulties exacerbated with residential settings and influences in residential care

A number of issues were singled out as additional factors that mediated the RSE and sexual health needs of young people in residential care, namely: (1) Inconsistency in the key carer in the residential setting, (2) Peer group influences in terms of attitudes to sexuality, (3) Increased opportunities for engaging in sexual activities with residential house mates, and (4) Lack of continuity in care relations and location after reaching the age of 18 years.

Issue 1: Inconsistency in the key carer and the delivery of sexuality education

For YPIC, the issues related to the need identified by respondents for a consistent and trusting relationship with key carers/social care workers were considered earlier and were viewed as more acute than for those in family settings.

The environment itself, being cared for by a high number of adults makes it more difficult for young people to form significant attachments. (Re residential care)

Residential settings were deemed to contribute to the lack of consistency in relationships with social care workers due to staff rostering, as expressed below.

Where child does not have a primary carer who they can approach to answer questions etc due to rota of residential care staff. (Re residential care)

The lack of standardisation in approaching sexuality education was also reported in some responses. In the first quotation below, the respondent identified the delivery of RSE as contingent upon the commitment of individual social care workers to the task. In the second quotation, a similar point is made about 'hit and miss' exposure to school-based sexuality education, but with the observation that social care staff may not be at ease with delivering RSE.

There is also no standardised approach to the provision of RSE support to complement whatever the young person might be accessing at school, so it can be the luck of the draw whether or not sex ed support is provided and often can be down to the personal interest of a member of staff [social care staff]. (Re residential care)

Young people in residential care may have missed out on sexual health education in school or at home and while in residential care may not have developed relationships with adults who can provide the education and who are comfortable to do so. (Re residential care)

Among the consequences of a lack of strong emotional bonds with a parent/carer for those in residential care was reduced physical closeness between the social care worker and young person.

Y/P leaving care may have received less tactile care in terms of being held and hugged than Y/P in other settings. (Re residential care)

Issue 2: Peer influences over attitudes

A few open responses made reference to the impact of negative peer influence in residential care settings, describing a sub-culture of damaging, risky behaviours and the development of destructive group norms.

In addition, in a situation where a young person is living in community with other young people who also have had traumatic life experiences, they may develop a culture where sexually unhealthy behaviours have status. (Re residential care)

Within residential care, there is generally a group of approximately 4-5 young people placed in residential centre together. These young people can have a wide range of family experiences, behavioural difficulties etc. Their experiences, including sexual experiences can be shared amongst the residents and this can include the young people placing themselves in at risk situations such as engaging in sex with older men, prostitution etc. (Re residential care)

As above plus young people in residential care are exposed to other young people's negative views and practices . . . (Re residential care)

Issue 3: Sexual relations between peers within the institution

A few open responses raised the issue of unrelated youths of a similar age living in close quarters, increasing the opportunities for sexual relationships between them.

Increased opportunities and pressure to be sexually [active] (Re residential care)

It stems from mixing youths of mixed gender in residential units where issues arise... (Re residential care)

Young people in residential care have access to teenagers their own age and management of their sexual behaviours pose additional problems for themselves and for staff caring for them. (Re residential care)

The last quotation above identifies the challenge to the social regulation of adolescent sexuality that group living arrangements create. There is strong agreement in scholarly literature that within normative family situations, growing up in close proximity to kin peers over an extended period from infancy and early childhood mitigates against sexual attraction between peers living together (Rantala and Marcinkowska 2011), even if the reasons for this (whether biological or socially-produced) continue to be debated. However, in the case of young people in residential care, coming together for the first time in adolescence means that the protective effect of growing up together is absent meaning that sexual attraction may feature between young people.

Issue 4: Lack of continuity in care relations and location after reaching the age of 18 years

An additional difficulty posed by the social organisation of residential care raised in the open-ended responses was that young people were obliged to leave the care setting when they reached the age of 18, something that was deemed to put them at a distinct disadvantage compared to their counterparts living with birth families. For young people who were fostered the situation was also true once they turned 18.

The increased expectation on them to develop independent living skills as they turn 18, due to the social policies which dictate the type of care provided to young people in the care system. These young people have less time to experiment and grow in the relative safety of the family home compared to other young people. As a result of this a greater amount of support may be needed before they turn 18. (Re residential care)

Sociological accounts of childhood note that in the contemporary period of late modernity, the childhood dependency years have extended and the boundary between childhood and adulthood is blurred (Valentine 2003). Yet for young people in residential care in particular, as the respondent above notes, turning 18 years is a sudden marker that signals the abrupt transition to adulthood and makes demands on them to have acquired life skills that those not in care have greater time latitude to develop. Indeed, the respondent's perspective is echoed in literature that has highlighted the view that age-defined social policy indicators 'lack resonance in the lived experiences of young people' (Jones 2005, p.7).

One factor affecting YPIC to a greater degree than those not in care was the risk of pregnancy. This was particularly believed to be the case for those leaving residential care.

It has been my experience that young people, particularly young girls leaving residential care can be vulnerable in terms of feeling needed and wanted. It has been my experience that teenage girls approaching 18 (leaving care age) turn to male relationships to address these needs. It has also been my experience that these girls get pregnant soon after leaving care and it has been described to me by one young person that she got pregnant because she did not want to be on her own. (Re residential care)

The respondent's concern (shared by several others) is substantiated by research evidence: a study of outcomes for young people leaving care in England found that a quarter of those leaving care were either pregnant or had become parents within a year of leaving care (Dixon 2008).

5. Lack of clarity and policies in relation to legal issues to guide practice

A clear policy from the HSE on the provision of RSE to young people in care was felt to be an important priority for staff to feel supported in delivering sexual health improvement work within social care settings. A strong theme in data was that national and local policies were largely absent from care areas. The need for a clear policy was voiced with a sense that this would ensure that staff had a clear steer and understanding of what was expected from them, and how the sexual health work could become integrated within the organisation in a way which met the individual needs of YPIC.

A related area of staff concern – particularly for those in senior decision-making roles – was a lack of clarity about legal issues associated with seeking and providing sexual healthcare for a young person in care. This reportedly manifested itself in a lack of confidence about what constituted good practice and uncertainty in the day-to-day decisions with which service-providers were faced.

I think social work staff [such] as case managers would benefit from specific information in relation to legal/ethical issues such as whether social worker can actively support young person to seeking the contraceptive pill etc. This repeatedly presents difficulties for social workers due to concerns whether we are acting appropriately in supporting, for example, an “underage” young person in getting the pill (including morning after pill).

Legal issues i.e. can a social worker for a child in care encourage a young person to seek the contraception pill if social worker knows they are sexually active (this issue presents itself regularly and to my knowledge there isn't a policy decision on this.

This lack of clarity was viewed as resulting in individuals (and possibly organisations) adopting a more cautious, 'conservative' approach to RSE.

May be over protective resulting in not enabling young people make decisions around sex and sexuality. May be fear driven and as a result over restrictive of young people. May have very conservative values frameworks which they impose on young people.

6. Training and education needs of service-providers in relation to RSE and sexual health delivery

While some accounts indicated that service-providers often had some level of knowledge and preparation to undertake RSE, there was overwhelming support for the notion that they required additional education in order to develop their skills and competence in this regard with reference to YPIC. There was also a suggestion in other accounts that the initial training of social care workers did not prepare them sufficiently for a role in RSE delivery.

When I was in college there was no module on sexual health and this should be an important part of social care work training as YP in care are more vulnerable and open to abusive situations due to the lack of supports available to them.

Additional training in RSE was seen to be particularly important for residential care staff to enable them to engage in RSE delivery within the residential setting.

Residential staff should be trained in sex ed curriculum so they can run info sessions with young people in residential care.

It was also reported that budgetary cuts in the context of Ireland's economic recession had impacted negatively on opportunities for staff training in RSE.

Training has been provided in the past, but with the current climate limited budgets are available to provide additional training or refresh training for staff.

Some accounts suggested that staff training in RSE was inconsistent and insufficient rather than absent.

Nothing beyond the occasional workshop once a year or what they learned in college there needs to be a lot more training.

Such training was viewed to be important to provide staff with the confidence to deliver sexual health improvement work, individually and as a team.

I think some staff can find delivering information on sexual health issues difficult. Staff cannot always be as informed as they need to be. Training and information would help.

Among the comments on the need for additional staff training was a recognition that RSE with young people in residential care is complex, in part owing to the realities and restrictions of the professional role of social workers and social care workers, but that an educational intervention would nonetheless bring positive benefits.

I think staff need to be supported to find a balance between child protection concerns (age of consent etc) and enabling young people to open up. They may need more professional support themselves so that they feel supported when speaking in confidence to young people. In a residential setting there is no way of getting away from the fact that staff (no matter how committed) are professionals who work shifts and may not be there when a young person is ready to open up or listen to an adult. . . . I think training in active listening, counselling-type skills might help.

While training and education were singled out as being particularly important in preparing service-providers for their RSE role, there was also a suggestion in a few accounts that obstacles to good RSE provision to YPIC lay less in a lack of staff training and more in deeply embedded attitudes and values of staff that were difficult to alter.

Their [staff] ability to meet their needs are usually based on their own life experiences and sometimes religious beliefs. In my opinion the majority prefer not to discuss these issues, rather than them not having access to resources.

7. The needs of foster carers in relation to RSE and sexual health provision to their foster children

The open-ended responses to the e-survey captured a number of issues related to the needs of foster carers in providing RSE and sexual healthcare to their foster children. One theme was that some foster carers tended to be reticent to engage with RSE.

Can be difficult if foster parents do not agree to openness around sexual health promotion. In my experience, some (foster carers) are not comfortable addressing the subject.

There were several references to the additional needs of relative carers (compared to non-relative foster carers) around providing RSE to the young people in their care. One factor raised was the generation gap, whereupon the relative carer (often a grandparent) may be considered by the young person to be out of touch with contemporary issues, resulting in the young person disengaging from discussions around RSE. The relative carers themselves, by virtue of being remote from engaging with sexual health services may lack knowledge of these services.

Relatives are frequently older than the parents and generation gap can cause young person to totally disregard advice from this relative as irrelevant "out of date". For the same reason the relative may well be unaware of sexual health services and treatments available.

In particular relatives such as a grandparent may not be comfortable or competent dealing with RSE/sex health in relation to young people and they are often trying to 'hold things together' and manage.

Whether relative carers or foster carers, an age gap between foster carers and young people was considered to be an impediment to their confidence and knowledge in delivering RSE.

Confidence of foster carers especially older carers to discuss and dialogue with young people.

Accurate information on sexual health and appropriate methodologies to engage the young person around building their knowledge and life skills necessary to develop

healthy relationships. Access or knowledge of appropriate support services to assist them. (Re foster carers)

In light of the perceived support needs of foster carers (in general) there were calls to provide additional educational resources to facilitate them in their role. One issue raised was the need to increase awareness among foster carers of the additional needs that YPIC may have over and above those of birth children.

Developing programmes on RSE & SHN [sexual health needs] for foster carers. Helping foster carers understand that the needs of foster children may be different from the needs of their birth children and the issues that this can cause within the family.

Foster carers with teenage foster children were considered to have specific needs for focused programmes designed to enable them to complement the RSE delivered by schools.

Carers with teenage children placed with them could benefit from a concentrated module on sexual education so that this is not 'left to the school' to complete.

The role of service providers – social and youth workers, for example – was raised in terms of the input from these professionals in supporting educational endeavours for foster carers or indeed in providing the educational programmes themselves.

For foster carers I think training is key and having back up support through their social worker. I think youth workers can play a key role with young people in relative/foster care regarding RSE as they are non-formal education in a non threatening environment and can tailor a programme with is based on the individuals needs.

Issues around training required to maintain boundaries in handling the sensitive topic of sexuality were also raised in the free text responses. The need for foster carers to keep themselves safe (implicitly from any accusations of inappropriate dialogues or actions) and simultaneously to protect the young people featured in respondents' open answers.

Helping any carer keep themselves safe and ensure appropriate boundaries when discussing sexual health needs. Carers require training in recognition of the sexual health needs both for the child's and their own safety.

Section 5

Discussion of e-survey results

There is little extant literature that captures the views of service-providers on the sexual health needs of young people with which to compare the results of this e-survey. Instead this discussion attempts to draw together findings from both the quantitative and qualitative components of the e-survey and to highlight what they tell us about service-providers' perspectives on the RSE and sexual health needs of YPIC

Results of the quantitative component of the e-survey indicated that parents are viewed as the most important source of information about sex and relationships for young people in general, but less so for YPIC. For young people in foster care, foster carers had overtaken parents as the most important source, and for those in residential care, the most important source was deemed to be the social care worker. This broadly reflects the level of exposure that young people have to those occupying parental roles in various circumstances. These results suggest that those with the most continuous and consistent contact with a young person are thought to be best placed to provide him/her with RSE.

Turning to respondents' perspectives on the RSE and sexual health needs of YPIC compared to young people in general, results indicated that a strong majority were of the view that YPIC do indeed have additional needs in this regard. Although a sizeable minority (approximately a third) indicated that the needs of YPIC were no different to young people in general, that proportion reduced to a quarter once the needs of young people in residential care were singled out. Indeed over three-quarters of respondents reported that young people in residential care do have additional RSE needs over and above those of young people in general, making them the group deemed to be most in need of greater support. The open-ended responses corroborated the quantitative data in terms of perceived additional needs and strongly emphasised the view that young people in residential care were deemed to be at the greatest risk and thus had more complex needs. That the needs of YPIC were perceived to vary according to their care type (whether kin, foster or residential care) has some empirical support in the literature. Although there is very little research internationally comparing the levels of risk across the broad category of YPIC, children in residential care have been found to have greater difficulties with attachment, relationship insecurity and sexual behaviour

than those in foster care, and in turn, those in foster care have greater difficulties than those in relative care (Tarren Sweeney (2008)). Carpenter *et al.* (2001) found that young people in residential care were likely to experience sexual initiation earlier than other YPIC, also lending some support to respondents' assessment of their needs.

In terms of issues around the provision of RSE and sexual healthcare to YPIC, there was very strong agreement from a heavy majority that YPIC should receive accurate and timely RSE as well as information on access to sexual health services and contraception. There was also strong support (with almost two-thirds strongly agreeing) that improving the general aspirations and life chances of YPIC is an important part of sexual health work, perhaps reflecting an understanding on the part of respondents of the links between socio-economic disadvantage and poorer sexual health (Viner and Taylor 2005). There was comparatively less strong agreement, however, for the statement that care plans should be reviewed on a regular basis to ensure that RSE is provided. Thus, respondents placed far more importance on making sure comprehensive RSE was delivered than on the monitoring of efforts to provide it, through care plan reviews.

With regard to respondents' perspectives on challenges in providing RSE and delivering sexual healthcare to YPIC, in the quantitative data, a lack of skill and confidence on the part of service providers, absence of policies to guide practice in RSE delivery and time pressures featured most strongly, in that order. A lack of policies as an impediment to sexual health work was also raised in the qualitative data, and to this was added the need for clarity in relation to legal issues to guide practice. With regard to other challenges in providing RSE and sexual healthcare, the open-ended responses yielded considerably more information about these than did the fixed-choice options, which was a key strength of including open-ended questions on the questionnaire. Obstacles to sexual healthcare provision to young people in residential care that emerged in the qualitative data included: inconsistency in the key carer relationships; peer influences over young people's attitudes; the increased opportunity for sexual relations between peers in residential care; and the lack of continuity in the care relations and location after reaching the age of 18 years.

In terms of supports to enable RSE and sexual healthcare delivery, the strongest support identified in the quantitative data was for clearer protocols to be in place to support YPIC who were sexually active to access the sexual health services, as well as regular training for staff and social care workers. Training and education needs of service-providers were also identified in the open-ended responses. Specific issues that were referred to in the free text responses were the ad hoc nature of educational opportunities, complexities of the RSE role, and attitudes and values of individual staff that mediated RSE delivery. The importance respondents placed on the need for clearer protocols in dealing with sexually active YPIC reflects the very complex social and legal situation in terms of underage non-abusive sex that was explored in Section 1 (Part 2).

A number of additional issues emerged in the qualitative data that were not captured in the fixed-choice responses, which added value to the e-survey overall. Included among these was an emphasis in the open-ended responses on the wider complexities that tend to be associated with the lives of YPIC that were seen to impact on their sexual health. Three interrelated sets of needs in particular that cross-cut sexual health were identified: the need for consistency in relationships with carer, the need to learn wider aspects of personal and social development that impact on relationships and sexuality and the need for factual/scientific sexuality education.

In the open-ended responses, the needs of foster carers in relation to the RSE and sexual health provision to their foster children were raised. Reference was made to recognising the reluctance of some foster carers to engage in RSE owing to the generation gap, their lack of confidence in delivering RSE, the additional needs of YPIC over and above those of birth children, the challenge of providing RSE to teenagers and the difficulty in managing boundaries in sensitive issues pertaining to sexuality.

Limitations

The approach used to recruit participants to the survey relied on the invitations being cascaded to relevant individuals and organisations. Although this cascade approach ensured a wide reach, as the description of the sample (presented in Section 3) indicated, it has a number of limitations. It cannot be viewed to be a statistically representative sample since participants were not randomly selected but rather self-selected; as with all self-selected samples, there may be a tendency for those most committed or favourably disposed to the topic to respond, with the potential for associated biases. Nonetheless, the cascade approach adopted for this survey ensured the invitation to participate reached a wide range of organisations/individuals known to play an important role in the provision of sexual health improvement work to YPIC (including direct and indirect approaches such as training and support).

Another limitation of the e-survey is that responses to the open-ended questions were bounded; the nature of surveys is that useful and interesting issues to emerge are not followed through with further probing as might happen with, for example, flexible interviewing techniques. However, the follow-up phases of the overall SENYPIC research programme involved in-depth interviewing with those best positioned to contribute to the overall picture (including service-providers). This offered the opportunity to probe the issues further and the rich and in-depth accounts that were captured at subsequent stages of the study off-set the limitations here to some extent.

Section 6

Conclusion

This e-survey, the first study in a related series that collectively comprise the SENYPIC programme of research, provided useful data in its own right and fulfilled its objectives of identifying themes and issues to follow up at later phases. Responses to the open-ended questions were particularly insightful in this regard, and pointed to the complexity that cross-cuts the RSE and sexual health needs of YPIC and the provision of sexual healthcare to this group. This complexity arises partly because of the wider context of the lives of YPIC that mediates their sexual health needs – their background, biographies and often difficult early life experiences. In the subsequent qualitative components of the SENYPIC study, the topic guides for the in-depth interviews were developed to include triggers for discussion around the wider social and emotional components of being in care that emerged in the e-survey open-ended responses as important underpinnings of sexual health. Indeed, attention to the needs associated with the wider influences on sexual health went on to form a substantial part of the qualitative studies of the perspectives of service-providers (Hyde *et al.* 2015a), foster carers and birth parents (Hyde *et al.* 2015b) and of care leavers (Hyde *et al.* 2015c). In addition, information coming through in the e-survey concerning the legal and social environment in which service-providers work also influenced the topic guide for in-depth interviews with service-providers (Hyde *et al.* 2015a).

Building on results of the e-survey, subsequent reports in the series (Fullerton *et al.* 2015b, Hyde *et al.* 2015a, 2015b, 2015c) provide a greater level of insight and depth into these complex issues from a range of vantage points. Collectively, the SENYPIC programme of research (Hyde *et al.* 2015d) builds a comprehensive and detailed picture of the RSE and sexual health needs of YPIC in Ireland.

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Appendix 1

SENYPIC CHILD PROTECTION: Internal Incident Reporting Form

[To be completed with regard to of the Specific Obligations in the Reporting of Child Protection Concerns Guidance Note for SENYPIC]

Section A Participant Details
Details of Participant:
Anonymous code:
Residence Type:

Section B Reporting Considerations under Children First, 2011
1. Was there any incident/disclosure of physical, sexual or emotional abuse and/or neglect? Please refer to the SENYPIC Child Protection Policy for definitions of physical, sexual or emotional abuse and neglect. Yes: _____ No: _____
1.1 If yes, brief description of the incident.
2. If "YES", are there reasonable grounds for concern or suspicion that a child or children (even if specific children cannot be identified) might currently be at risk of physical, sexual or emotional abuse and/or neglect? Yes: _____ No: _____
2.1 Yes there are reasonable grounds. Please state reasons: Date disclosed: Date of incident (if known): Name of alleged perpetrator: Gender: Age: Relationship to the Participant:
2.2 No, there are not reasonable grounds. Please state reasons: Brief outline of incident or disclosure:
IF THERE ARE REASONABLE GROUNDS, CONTACT MUST BE MADE WITH THE CHILD AND FAMILY AGENCY – SEE REPORTING PROCEDURES OF THE SENYPIC CHILD PROTECTION POLICY

<p>Section C Reporting Considerations under The Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 (“the Act”)</p>
<p>1. Is there knowledge or belief that a serious offence (as listed in Schedule 1 to the Act) has been committed? Yes: _____ No: _____</p>
<p>If “Yes” please give details:</p>
<p>2. Is there information that might be of material assistance in securing the apprehension, prosecution or conviction of the offender? Yes: _____ No: _____</p>
<p>If “Yes” please give details:</p>
<p>3. If the answer to 1 and 2 above is “Yes”, is there any reasonable excuse for non-disclosure of this information to An Garda Síochána? Yes: _____ No: _____</p>
<p>If “Yes” please give details:</p>
<p>IF THE ANSWER TO QUESTION 1 AND 2 ABOVE IS “YES” AND THE ANSWER TO QUESTION 3 IS “NO”, A REPORT SHOULD BE MADE. PLEASE NOTE THAT A REPORT MAY BE MADE TO AN GARDA SÍOCHANA AT ANY STAGE IF THE SITUATION WARRANTS IT, REGARDLESS OF THE REQUIREMENTS OF THE ACT.</p>

<p>Section D Reporting Considerations under general Ethical Obligations</p>
<p>Notwithstanding the specific reporting considerations outlined at Sections B and C above, are there any additional child protection concerns that should be reported to the HSE liaison person and/or to An Garda Síochána in the best interest of a child or children? Yes: _____ No: _____</p>
<p>If “Yes” please give details:</p>

Section E Record of who has been contacted in relation to this incident (if no report has been made this section should be marked "N/A" (Not Applicable).
Name(s):
Profession(s):
Time(s):
Report was made verbally in person Yes: _____ No: _____
Report was made verbally by telephone Yes: _____ No: _____
Report was made written Yes: _____ No: _____

Section F Follow Up
Where any child protection concern arose, was the Participant signposted to an agency or agencies that could provide appropriate advice and support? Yes: _____ No: _____ Not recorded: _____
If "No" please give details:
If "Yes" please give details:
If "No" or "Not recorded" should consideration be given to providing such information now? Yes: _____ No: _____

Section G Details of the person completing this form
Name:
Role within SENYPIC:
Date:
Signature:

Appendix 2: Profile of E-Survey Respondents

Answer choices	Responses (% and no.)
Advocacy	33.52% 61
Service planning / monitoring	14.29% 26
After-care support	28.02% 51
General education	15.38% 28
Teenage parent support	24.73% 45
Youth work	25.82% 47
Research	4.95% 9
Foster carer/relative care support	28.02% 51
Residential care	26.92% 49
Support homeless young people	18.13% 33
Workforce development (training for social work or health professionals)	8.79% 16
Specialist sexual health	11.54% 21
General youth health	23.08% 42
Other (please specify)	31.87% 58
Total number of respondents: 182	

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