

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

## Composite Report of Findings

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

REPORT NO. 6

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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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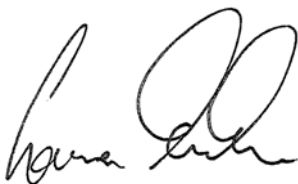
## FOREWORD

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**

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# INTRODUCTION

## by the Head of the HSE Crisis Pregnancy Programme

The *Sexual Health and Sexual Education Needs Assessment of Young People in Care in Ireland (SENYPIC)* programme of research was commissioned in late 2011 by the HSE Crisis Pregnancy Programme, in partnership with the Child and Family Agency (Tusla).<sup>1</sup> This is the sixth and final report in the programme, '*Composite Report of the Findings*'. The aim of this report is to bring together the findings from the five standalone reports comprising the SENYPIC programme of research in one succinct report.

A number of key themes emerged in these reports on the sexual health education and the provision of sexual health services to young people in care. Relationships and Sexuality Education (RSE) while important, is not considered sufficient to meet the needs of young people in care, who may have missed out on consistent, loving relationships in childhood. There is a strong shared sense from participants that when engaging in sexual health education with young people in care, additional attention should be given to the development of self-esteem and the social and personal skills required to safely negotiate relationships and sexual encounters.

Another major theme across the service providers' reports was the uncertainty about a perceived lack of clear guidelines nationally and locally about how to approach both sexuality education and the delivery of sexual healthcare, such as providing contraception. The Programme will be working with TUSLA to provide guidance on the law and ethics associated with working with minors on the area of sexual health in response to this finding.

I would like to thank all of the young people, foster parents, birth parents, social workers and service providers, who took the time to talk to the research team about their experiences. Their interviews provided really rich data to support decisions around resourcing and service planning which will make improvements to the lives of YPIC now and in future.

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 to Marzena Sekular for her hard work and support throughout the process.

**Helen Deely**

**Head of the HSE Crisis Pregnancy Programme**

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## About the Authors

Professor Abbey Hyde is an Associate Professor at the School of Nursing, Midwifery and Health Systems, University College Dublin. She has an established record in leading research on adolescent sexuality, having won a number of nationally competitive awards. Her research has been published extensively in leading international journals. She also has over 20 years' experience in teaching sociology of health and illness with particular emphasis on gender and sexuality.

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Caroline McKeown is a Research Assistant at the Educational Research Centre, Dublin and is engaged in an analysis of educational outcomes for children with special educational needs using data from Growing Up in Ireland (GUI) on behalf of the National Council for Special Education (NCSE). Caroline has previously worked on a number of different studies in relation to young people's health and well-being in the UK and Ireland, including the KIDS Study (KCL), investigating the relationship between paternal Post-Traumatic Stress Disorder and emotional and behavioural difficulties in children.

Dr Laura Dunne works between School of Education, Queen's University Belfast and the Centre of Excellence for Public Health Research, Northern Ireland. She currently works on the Wellbeing in Schools (WiSe) project, a large scale survey which explores health and wellbeing in Northern Ireland post-primary schools. She has extensive experience conducting both quantitative and qualitative research. Over the last fourteen years, she has managed a number of major evaluation and research projects such as the evaluation of Barnardo's Ready to Learn After-school Literacy Programme, the Lifestart Parenting Programme and the Brook NI Sexual Health Clinic.

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### **Acknowledgements:**

The authors wish to convey their sincere gratitude to those who participated in the SENYPIC programme of research, including service-providers, foster carers, birth parents and care-leavers, whose contribution enriched our understanding of the sexual health needs of YPIC. During the course of the research, individuals and organisations supported the study by providing information and facilitating access to participants. The research was also supported by a Steering Group and an Advisory Group who provided invaluable expertise throughout. The authors express their sincere thanks to these individuals and groups, and to the HSE Crisis Pregnancy Programme in conjunction with the Child and Family Agency (Tusla) (previously the HSE Children and Family Social Services) for funding the research. In addition, we are grateful to Jenny Bulbulia, Barrister-at-Law, and to Suzanne Phelan, Child Welfare Consultant, for reviewing components of individual reports.

*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
HSE	Health Service Executive
RSE	Relationships and Sexuality Education
SENYPIC	Sexual Health and Sexuality Education Needs Assessment of Young People in Care in Ireland
STI	Sexually Transmitted Infection
YPIC	Young People in Care (used in the Republic of Ireland)

## Terminology used in the report\*

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

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

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

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

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

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

**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)*

\* 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.

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**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.

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**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.



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# Introduction

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The aim of this report is to bring together the findings from the five standalone reports comprising the SENYPIC programme of research in one succinct report. This report contains a summary of the overall research programme, including aim, objectives and methodological approach (Section 1), followed by a summary of the component-specific objectives, methodologies and findings of each constituent report (Sections 2 – 6). Towards the end of this report, a synthesis of the findings across individual reports is presented. In integrating the overall findings, particular attention is given to shared perspectives on the sexual healthcare and RSE needs of YPIC that emerged in data across the participant groups sampled. In addition, those areas where there was less congruence in terms of needs' identification or where the emphasis from one group to the other varies is highlighted. The report closes with key findings from the SENYPIC programme of research and a set of actions for delivery agreed by the HSE Crisis Pregnancy Programme and the Child & Family Agency (Tusla).

# Section 1

## SENYPIC Programme of Research

### Introduction

A pattern found in Western countries, where such data are available, is that young people who have experienced state care are particularly vulnerable to early sexual experiences and teenage pregnancy. Small-scale research available from Ireland indicates that the pattern here is no different and suggests that YPIC have specific sexual health and education needs over and above young people who are not in care. The SENYPIC programme of research was designed to attempt to identify the specific sexual health and sexuality education needs of YPIC. Different groups and individuals are likely to hold different and sometimes conflicting views on the sexual health and sexuality education needs of YPIC. For this reason, a range of sources were used, including service-providers, foster carers and young care-leavers. The SENYPIC programme of research represents the most extensive research project to date in Ireland and internationally on the RSE and sexual health needs of YPIC.

The overall aim was to identify the sexual health and sexuality education needs of YPIC 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.

The objectives of the SENYPIC programme of research were to:

1. Reliably describe the sexual education and sexual health needs of YPIC.
2. Describe the approaches used and services delivered by professionals engaged in RSE and sexual healthcare to YPIC.
3. Analyse and describe protective and risk behaviours among this group and factors associated with these, from the psychological to the relational, situational, familial, community and social levels.
4. Assess attitudes, knowledge and risk-perception levels among YPIC in relation to 'crisis' pregnancy, STIs and awareness of services and supports.

5. Estimate the teenage pregnancy rate among YPIC.
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 YPIC 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 YPIC that the HSE Crisis Pregnancy Programme and the Child and Family Agency can use to promote evidence-informed practice and policy development.

### Existing knowledge in the field

In spite of strong international evidence that YPIC are at higher risk of early sexual initiation, risky sexual behaviours, and early pregnancy, only a small number of studies have been conducted that specifically focus on the sexual health and RSE needs of this cohort. These are mainly British studies based on data from young people themselves. No research was located from Ireland that directly addressed the key aim of the SENYPIC programme of research. Each component report of the SENYPIC research programme includes a literature review illuminating what is known already about the topic of that report.

### Methodology

In order to meet the range of objectives of the SENYPIC programme of research, a methodology was developed that allowed a variety of vantage points to be captured on the sexual health and RSE needs of YPIC. To recapitulate, because what is believed to constitute a 'need' may not necessarily be shared by all, but tends to be shaped by an individual's experience or situation, multiple sources of data were sought. Data sources included 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 rights 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 proposed sample size of young care-leavers was increased to compensate for this deficit.

The thrust of the methodology 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. The research started in early 2012 with an initial workshop with key service-providers, from which an e-survey was developed. The e-survey was a self-report online questionnaire, designed to capture this

group's perspectives on the sexual health and RSE needs of YPIC. 182 service-providers from a diverse range of services, including foster care, residential care, after-care, teen-parent support projects, youth work organisations, sexual health organisations, health promotion, and clinical sexual health services, responded to the questionnaire. The e-survey also had the purpose of gleaning initial information that informed the substance and focus of subsequent stages. Building on insights from the e-survey findings, a qualitative study of a sub-set of 22 of these service-providers was conducted based on in-depth interviewing. A separate qualitative study of foster carers (n=19) and birth parents (n=5) 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 carried out, to get a sense of the type and scope of existing services with a role in RSE and sexual healthcare delivery to YPIC. This descriptive mapping is based on data gathered from the e-survey, the 22 in-depth interviews with service-providers, as well as an additional 12 short structured interviews with service-providers.

The SENYPIC programme of research gained ethical approval from the Human Research Ethics Committee at University College Dublin.

## Reports

Findings from the SENYPIC programme of research are reported in a suite of five related reports. The specific focus of each is as follows:

- Report No. 1 (Fullerton et al. 2015a) presents the results of an E-survey with service-providers
- Report No. 2 (Fullerton et al. 2015b) comprises a descriptive mapping of services promoting sexual health among YPIC
- Report No. 3 (Hyde et al. 2015a) presents a qualitative analysis of service-provider perspectives on the sexual health and RSE needs of YPIC
- Report No. 4 (Hyde et al. 2015b) presents a qualitative analysis of foster carer and birth parent perspectives on the sexual health and RSE needs of YPIC
- Report No. 5 (Hyde et al. 2015c) presents a qualitative analysis of young care-leaver perspectives on the sexual health and RSE needs of YPIC

In this composite report – Report No. 6 – a summary of the component-specific objectives, methodology and findings of each constituent report will be presented in numerical order, followed (towards the end of this report) by a synthesis of the findings across individual reports. In integrating the overall findings, particular attention will be given to shared perspectives on the sexual healthcare and RSE needs of YPIC that emerged in data across

the participant groups sampled. In addition, those areas where there was less congruence in terms of needs' identification or where the emphasis from one group to the other varied will also be highlighted. The report closes with key findings from the SENYPIC programme of research and a set of actions for delivery agreed by the HSE Crisis Pregnancy Programme and the Child & Family Agency (Tusla).

## Study Limitations

The SENYPIC programme of research, like all studies, has limitations. The fact that participation for each component of the study was voluntary may have resulted in attracting those who had a particular motivation to participate; the extent to which participants were similar to or different from the wider population of service-providers, foster carers, birth parents and care-leavers is not known. However, the fact that the participants' perspectives were diverse and their experiences heterogeneous suggests that the study was inclusive.

Another limitation of the study was that the initial plan to recruit young people under the age of 18 years remained unrealised, resulting in the voices of this group being absent from the research. This arose largely because of the challenges in obtaining consent from birth parents. In addition, resources were limited in relation to the service-providers who were the key gatekeepers for this group. The procedures proposed for the recruitment of minors were complex and demanding of the time of social workers and social care workers in a climate of staff shortages and human resource issues.

A separate limitation of the research was that the objective of estimating the teenage pregnancy rate among YPIC remained unrealised because accurate records of the number of young women who became pregnant while in care were not consistently available. Attempts were made over the course of the research to address this gap in knowledge. However, by the end of the study, an accurate picture of the pregnancy rate among YPIC in Ireland was still not available.

The rapidly shifting legal and policy context of child protection that occurred from the inception of the study in 2012 to this final report in 2015 also presented challenges for the research. Data were collected at a time when new policies and legal instruments were being created, making it necessary to consider data in a context that had been overtaken by changes nationally. However, these changes have been taken on board in developing the recommendations of the SENYPIC programme of research.



## Section 2

# A Survey of Service-provider Perspectives. Report No. 1

### Objectives

- 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.
- To provide data capable of standing alone in addressing, to some degree, the objectives of the SENYPIC programme outlined above.

### Methodology

An e-survey, comprising both fixed-choice and open-ended questions, was employed to capture respondents' perspectives on:

1. The importance of various sources of information on relationships and sex for young people in general and YPIC.
2. The 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.

The number of respondents who completed the questionnaire was 182. Respondents were drawn from a diverse range of professions and locations in Ireland. These respondents had a professional role, either directly or indirectly, associated with YPIC and/or in the realm of sexual healthcare accessed by YPIC.

### Findings

#### *Sources of information about sex and relationships*

Results 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.

### **RSE and sexual health needs of YPIC**

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 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 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. In the absence of a stable family life, this included a need for consistency in relationships with carers to support the development of sexual competence; the need to learn wider aspects of personal and social development that impact on relationships and sexuality and the need for factual RSE, which many had missed out on when growing up. 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.

### **Provision of RSE and sexual healthcare to YPIC**

In terms of issues around the provision of RSE and sexual healthcare to YPIC, there was very strong agreement from a large 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) with the idea 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. There was comparatively less strong agreement, however, for the statement that care plans<sup>2</sup> should be reviewed on a regular basis to ensure that RSE is provided.

### **Challenges to providing RSE and sexual healthcare to YPIC**

With regard to respondents' perspectives on challenges in providing RSE and delivering sexual healthcare to YPIC, a lack of skill and confidence on the part of service-providers, an 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 data generated from open-ended questions, and to this was added the need for practice guidance in keeping with national legislation. With regard to other challenges in providing RSE and sexual healthcare, the open-ended 'free text' responses (to specific questions) yielded considerably more information about these than did the fixed-choice options, which was a key strength of

<sup>2</sup> A written plan for the care of a young person is required under the *Child Care (Placement of Children in Foster Care) Regulations 1995*, the *Child Care (Placement of Children with Relatives) Regulations 1995*, and the *Child Care (Placement of Children in Residential Care) Regulations 1995*.

including open-ended questions on the questionnaire. Obstacles to providing RSE and sexual healthcare that emerged in the free text data with reference to young people in residential care included: inconsistency in the key carer over the course of their care trajectory, peer influences over young people's attitudes and the increased opportunity for sexual relations between peers in residential care. Also raised by respondents was the lack of continuity in carer relations at the point of moving out of care at the age of 18 years.

### *Supports to enable RSE and sexual healthcare delivery*

In terms of supports to enable RSE and sexual healthcare delivery, the strongest support identified was for clearer protocols to be in place to support YPIC who were sexually active to access sexual health services. Training and education needs of service-providers to support the delivery of RSE were also identified in the open-ended responses. Specific issues referred to in the free text responses related to the ad hoc nature of educational and training opportunities, complexities related to the RSE role and managing the attitudes and values of individual staff members that mediated RSE delivery.

### *Other issues*

A number of additional issues emerged in the free-text data that were not captured in the fixed-choice responses and this added value to the e-survey overall. Included among these was an emphasis in the free-text on the wider complexities that tend to be associated with the lives of YPIC and that were seen to impact on their sexual health. Three interrelated sets of needs in particular were identified, which impacted on good sexual health, namely: the need for consistency in relationships with carers, 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. Also raised in the open-ended responses was the issue of foster carers' needs in relation to providing RSE to their foster children. Specifically, reference was made to recognising the reluctance of some foster carers to engage in RSE owing to a 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 managing boundaries in sensitive issues pertaining to sexuality.

## Section 3

# A Descriptive Mapping of Services Promoting Sexual Health among Young People in Care. Report No.2

### Objective

- To describe current approaches and services that promote sexual healthcare and delivery of RSE to YPIC in 2012-2013.

### Methodology

Data for this descriptive mapping exercise were gleaned from:

- (1) A component of the e-survey questionnaire
- (2) Follow-up interviews with a sub-set of 34 e-survey respondents who indicated their willingness to be interviewed post-survey. Of the 34 participants interviewed following the e-survey, 12 were short structured interviews while 22 were longer, semi-structured interviews.

Data from both sources were gathered in 2012 and 2013.

### Findings

The data indicated that at the time of data collection (2012-13), a diverse range of services using a variety of approaches were being provided throughout Ireland that had the potential to impact directly or indirectly on the sexual health of YPIC. These included RSE and sexual healthcare training for service-providers and foster carers; RSE for young people in residential care and foster care; RSE and sexual healthcare and support for those in homeless organisations and in after-care; supports for young parents; sexual health clinics with youth friendly policies and youth services delivered in the community. It is also clear that a range of different educational resources were being used in the different settings.

While the data indicates that there are a number of approaches being delivered that address the sexual health and RSE needs of YPIC, the information provided suggests that service

provision across the country is not consistent. Furthermore, specific approaches to sexual healthcare vary both within and across settings.

### **Limitations**

It is important to consider that the information presented in Report No. 2 provides a picture of the range of services and approaches in place at the time of data collection but some of the services may only have had short-term funding, so the picture may have changed since 2013. Also, while every effort was made for the e-survey to be inclusive, it is possible that some services were not captured as an opportunistic sampling approach was used. Also while every effort has been made to reflect the information collected as accurately as possible, there may be some gaps in the descriptions provided by respondents. For example, some respondents described the approach used in their practice but did not provide the name of the organisation or contact details for further information. It is important to note that different forms of data collection resulted in detailed descriptions of some services and brief descriptions of others.

## Section 4

# The Perspectives of Key Service-providers: A Qualitative Analysis. Report No. 3

### Objectives

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

### Methodology

A qualitative methodology was employed. The sample comprised of 22 social and healthcare service-providers who interfaced with YPIC. The service-providers had completed the e-survey and indicated their willingness to take part in interviews. The sample was drawn from the following professional areas: social work, social care, counselling, project work, outreach services, health promotion, nursing, youth work, healthcare and education. Data were collected via in-depth telephone interviews, apart from one case, where a face-to-face interview was conducted. Data were analysed using an established technique for analysing qualitative data, known as modified analytical induction. Data for this component of the SENYPIC study were gathered in 2012.

### Findings

#### *Sexual health and sexuality education needs of YPIC*

The qualitative study of service-providers' perspectives on the sexual health and RSE needs of YPIC illuminated a range of issues that helps to build up a picture of the sexual health and RSE needs of YPIC. Across the sample of service-providers as a whole, YPIC were considered to have particular sexual health and RSE needs compared to young people who are not in care. In addition, participants' accounts suggested that current provision of sexual health and RSE to YPIC is patchy and uneven, varying both within and across care settings.

### *Specific sexual health and RSE needs of YPIC*

An analysis of what professionals in key roles described as important elements of sexual health provision facilitated the unpacking and identification of specific RSE and sexual health needs of YPIC, and revealed the complexity and skill required to deliver quality sexual healthcare to this group. Specific sexual health and RSE needs of YPIC identified by participants included the attainment of self-awareness, self-affirmation, emotional literacy, social skills and empowerment. These life skills were believed to cross-cut sexual competence and to facilitate the establishment of positive, mutually respectful intimate relationships, as well as ensuring sexual safety. Participants also referred to the need for YPIC to be taught factual sexuality education around biology and legal matters, but this educational need tended to be viewed as a lower priority compared to the emphasis placed on the need for social stability and emotional security as a basis for good sexual health.

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

### *Modes of RSE delivery*

In terms of the most favoured mode of delivery for RSE to YPIC, individual teaching sessions tended to be preferred over group sessions by the majority of participants. Addressing the sexual health and RSE needs of young people in residential care was deemed to be more challenging than for those in foster care in view of residential living practices that varied across sites and personnel, as well as the more complex needs generally of those in residential care.

### *Providers of RSE to YPIC*

Most participants favoured those individuals with the closest and most continuous relationship with the young person for the role of providing RSE to him or her. This was deemed to be the foster carer for those in foster care, and the key social care worker for those in residential care. However, a willingness to engage in RSE on the part of the individual foster carer or social care worker and a non-judgemental approach were also held to be important, as it was acknowledged that not everyone was suitable for the role. A small number of participants were of the view that RSE for young people in residential care ought to be delivered by specialist professionals external to the organisation.

### *Bureaucracy, policies and guidelines in RSE delivery*

A number of issues relating to bureaucracy, policies and guidelines emerged that reportedly cross-cut the work of service-providers in addressing the sexual health needs of YPIC. At local level, participants tended to favour documenting issues relating to sexual health in the young person's care plan in order to ensure consistency in RSE delivery. In the context of national guidance, some participants reported difficulties in how to interpret 'risk' and make judgements about what sensitive information to report formally. This was particularly the case in relation to non-abusive sexual activity. Indeed, the most central finding of the service-providers' study was the uncertainty participants expressed about what they perceived to be a lack of clear guidelines nationally and locally about how to approach both sexuality education and the delivery of sexual healthcare (such as providing contraception). While legacy issues in some organisations were reported to impede sexuality education for YPIC, for others, a fear emanating from their uncertainty about official legal and political discourses and a perceived lack of clear workable and pragmatic guidelines were considered to be barriers to sexual healthcare provision. In addition, the uncertainty about the legal situation that participants' reportedly experienced was perceived by some to problematize the trust and confidentiality believed to be central to therapeutic relations. Another issue raised in relation to trust and confidentiality was the extent to which information about a young person's sexual health ought to be communicated between external professionals and social care staff; the need for social care staff to be kept informed about such issues was deemed by some to conflict with the need to maintain discretion and confidentiality about the young person's sexual health.

### *Support needs of staff with a role in the provision of sexual health and sexuality education to YPIC*

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

In relation to the qualitative data from service-providers, since these are new in a barren empirical field, there is little work nationally or internationally with which they may be compared to either support or problematise.



## Section 5

# The Perspectives of Foster Carers and Birth Parents: A Qualitative Analysis. Report No. 4

### Objectives

- To reliably describe the sexual health and sexuality education needs of YPIC from the perspective of foster carers and birth parents.
- To describe the degree to which these needs are currently being met by foster carers and birth parents.
- To analyse and describe protective and risk behaviours among YPIC from the perspectives of foster carers and birth parents.
- To assess attitudes, knowledge and risk-perception levels among children in care in relation to 'crisis' pregnancy, STIs and awareness of services and supports from the perspective of foster carers and birth parents.
- To compare and contrast findings from published qualitative Irish research and provide evidence of the degree to which issues generated relating to foster carers are similar and/or dissimilar to those issues raised by parents in general.

### Methodology

A qualitative methodology was employed. The sample was comprised of 19 foster carers and five birth parents. Data were gathered from foster-carer participants by in-depth individual interviews in the case of 15 participants, along with two sets of paired interviews where a fostering couple were interviewed together. (Paired interviews arose because the couples in question expressed a preference to be interviewed jointly.) Data from the five birth parents were gathered by telephone interviews. Data were analysed using an established qualitative analysis strategy.

## Findings

### *Experience of fostering*

As a context to identifying the sexual health and RSE needs of YPIC, foster carers' overall experiences of fostering were captured. Their experiences were found to vary considerably, both across the sample and for the same participant according to the demands of an individual young person. Overall, fostering was reported to be a positive experience.

### *Foster carers' views on their role in RSE*

In terms of the extent to which foster carers perceived themselves as having a role in delivering RSE to their foster children, the majority did indeed view RSE as part of their role. Some foster mothers indicated that they insisted on undertaking RSE with foster children, even when the young people were reticent about engaging with it. A minority, though, were of the view that RSE was the responsibility of the HSE and schools. Where participants expressed the view that RSE with foster children was not part of their role, they nonetheless described scenarios and situations involving foster children where the development of social skills and emotional literacy – fundamental building blocks for sexual health – were facilitated.

### *Birth parents' views on their role in RSE*

The birth parents interviewed indicated that they did not engage in RSE with their birth child who was in foster care. Social work involvement in the sexual health of foster children reportedly varied from a high level of engagement to very little. Several participants contended that RSE was implicitly relegated to foster carers and they accepted this. A strong and consistent theme was that schools were viewed as having a major role in RSE delivery.

### *Foster carers' perspectives on the sexual attitudes and behaviour of YPIC*

With reference to foster carers' perspectives on the sexual attitudes and behaviour of YPIC, there was a shared recognition that, notwithstanding individual differences among YPIC, fostered teens tended to present more challenges than did their own teenage children in terms of sexual health. Adolescent girls who were fostered were believed to be more sexualised than those not in care. In contrast to findings from previous research in Ireland that sampled parents more widely, foster carers in the present study readily acknowledged that their foster teen was or might well be sexually active, even by mid-adolescence. Participants expressed greater concerns about the sexual behaviour of teenage fostered girls compared to boys; risky behaviours such as alcohol and illicit drug use were found to be dominant concerns with fostered boys. Awareness that a foster teen was sexually active emerged in a variety of ways, ranging from implicit acknowledgement of a foster carer's suspicion by a foster teen, to uninhibited open admission by the young person.

### *Perspectives on the sexual health and RSE needs of young people in foster care*

In relation to the central issue of the SENYPIC programme of research – perspectives on the sexual health and RSE needs of YPIC – it was reported that while factual information about sexuality was an essential part of a young person’s RSE, this was already being delivered through schools and was not viewed as a priority. There was overwhelming agreement that, against a background of instability and inconsistency in parenting, young people in foster care have a strong need for emotional security and stability as a prerequisite to good intimate relationships. Building confidence and strengthening self-esteem and self-worth were deemed to be key needs in terms of providing the building blocks for good sexual health. There was also widespread agreement that YPIC need to learn social skills as a basis for good sexual health. None of the participants interviewed reported having encountered issues relating to LGBT with foster teenagers, and thus did not identify any particular needs for YPIC around sexual or gender orientation.

### *Modes of delivery and content of RSE for young people in foster care*

Participants reported that they tried to impart social and emotional skills to the young people in their care using everyday interactions and routines. While not strictly RSE, this emotional and social-skills’ learning was considered to be a prerequisite to learning about romantic relationships and sexuality. A key opportunity for psycho-social learning was through interactions during family meals. In addition, social skills were sometimes taught in more concrete ways such as in clarifying the house rules for the young person. A few participants alluded to the skills of contract-making and honouring and respecting agreements, which are important to facilitating mutuality in relationships. Various techniques were reported by participants in order to increase their foster child’s confidence and social competence, including role modelling of appropriate behaviour and advocating on their behalf.

As well as facilitating an environment for social and emotional skills’ learning, most participants also reported that they engaged in ‘direct’ sexuality education with foster children. During the preteen years, this direct RSE tended to be more science-orientated, but became more behaviour-orientated as the teenage years evolved. Messages related to sexual behaviour were heavily focused on the consequences of sex, particularly that of early pregnancy; these were more strongly emphasised with young women. However, values-orientated RSE with foster children that emphasised the morality of actions that pervade intimate relationships was also reported. Participants tended to prioritise pregnancy prevention over other sexual health concerns (e.g. STIs, sexual competence/readiness in relation to age of sexual consent) and to focus this concern towards foster daughters rather than foster sons (for example, by ensuring that the girls had knowledge of, and access to, contraception if they were sexually active). Identifying specific challenges in relation to the sexual health needs of boys were, relatively speaking, absent from participants’ narratives.

Participants referred to a variety of strategies that they employed to deliver RSE, including embedding safer sex communications in sex positive messages, making covert references to

sexual behaviour, invoking humour and by using opportunities that arose from everyday life. A diversity of responses from the young people to direct RSE were described by foster carers including embarrassment and disengagement; these mirror the responses that young people in general were reported to employ in a previous Irish study of parents' approaches to RSE.<sup>3</sup>

### *Differences and similarities between the RSE needs of young people in foster care and young people generally*

Among the objectives of the study was to identify what was similar and what was different in terms of sexual health and RSE needs when fostered young people are compared to young people in general. The extent to which foster children were deemed to have different RSE needs to birth children tended to depend on the age at which a foster child arrived at a placement. Generally, the earlier in childhood that a foster child had been placed, the more the RSE approach of the foster carers resembled that employed with their birth children. In some cases, even in long-term placements, a recognition of specific needs of a foster child first emerged during the teenage years. In addition, foster daughters were deemed to be in greater need of RSE than their own daughters because they were often believed to be more sexually precocious.

Although continuities were also reported in how foster carers delivered RSE to foster children and their own birth children, a consistent theme across data was the challenge for foster carers in understanding aspects of a young person's past of which the foster carers sometimes had limited knowledge. Other challenges lay in differences in everyday ways of interacting and behaving between the birth family and the foster family and the clashing expectations of each around issues that mediate sexual health. Several participants reported challenges in their foster carer role associated with the children's rights' discourse. While there was support for the notion of a societal shift towards recognising and meeting the needs of children at a macro level, there was also a recognition that, at a micro level, young people were still maturing and inclined to express wants rather than needs that were not always in their best interests. A few participants referred to threats to their role as foster carers arising from their weaker authority over parenting compared to the relative autonomy over parenting enjoyed by birth parents. This arose because others (birth parents and social workers especially) had a level of influence over their parenting role.

Findings also provide insights into how participants dealt with the sexual activity and sexual behaviour of foster teenagers. In situations where a foster teen was suspected of or had indicated being sexually active, the focus was predominantly on pregnancy prevention. Foster carers' knowledge of penetrative sexual activity (and sometimes also non-penetrative activity) of young people in foster care was reportedly imparted to service-providers. That foster carers reported feeling obliged to report underage consensual sex in the case of foster teens which meant that the underage sex of YPIC was managed beyond the foster family, whereas they believed that this could be dealt with by family members in the case of birth children.

3 Hyde, A., Carney M., Drennan J., Butler, M., Lohan M., & Howlett, E. (2009). *Parents' Approaches to Educating their Pre-adolescent and Adolescent Children about Sexuality*. Dublin: Crisis Pregnancy Agency.

Several foster carers had experiences of interacting with health and social care professionals in order to maintain the sexual health of the young person. Most of this interaction was related to accessing hormonally-based contraception for foster daughters. Some foster carers expressed the view that they believed that service-providers were restricted by the law in exercising their professional judgement and participants generally found them to be supportive within the limits of their role.

### *The role of foster fathers*

With regard to foster fathers, a dominant finding was for foster fathers to report fear and anxiety about false allegations of sexual abuse of a foster child, in particular of a foster daughter. There was a tendency for foster fathers to accept that while efforts to minimise the risk of an allegation was an ongoing personal challenge, rigorous child protection measures were necessary in order to protect children in society.

Foster fathers' concerns about allegations of sexual misconduct had implications for their relations with their foster daughters, for levels of trust in the relationship, and restricted them in undertaking RSE with foster teens, particularly with young women. Platonic physical contact that is normatively associated with father-child relations to express closeness and affection was also reportedly curtailed by foster fathers in relation to their foster children, again with foster daughters in particular. Foster fathers reported utilising a number of practical measures recommended by social work professionals designed to minimise an allegation of abuse. They also described a heightened vigilance in implementing house rules for the same purpose. These men indicated that they would welcome a forum such as a workshop for foster fathers to share their concerns and views in relation to the challenges of implementing child protection measures.

## Section 6

# The Perspectives of Care-leavers: A Qualitative Analysis. Report No. 5

### Objectives

- To reliably describe the sexual health and sexuality education needs of YPIC from the perspective of young care-leavers.
- To describe the degree to which care-leavers believe that these needs are currently being met.
- To analyse and describe protective and risk behaviours among YPIC from the perspectives of care-leavers.
- To assess attitudes, knowledge and risk-perception levels among children in care in relation to 'crisis' pregnancy, STIs and awareness of services and supports from the perspective of care-leavers.
- To compare and contrast findings from published qualitative Irish research and provide evidence of the degree to which sexual health issues associated with YPIC are similar and/or dissimilar to those issues raised by young people in general.

### Methodology

A qualitative research methodology was employed. The sample consisted of 19 care-leavers (people who had formerly experienced state care) aged 18-22 years: 16 young women and three young men. Of the 19 participants, 9 had already become teen parents at the time of the interview. Data were gathered using individual in-depth interviews, apart from in two instances where participants were friends and were more comfortable being interviewed in pairs. An established qualitative strategy was used to analyse data.

### Findings

#### *Disconnectedness, transience and stigma*

The analysis of data from care-leavers illuminated the extent to which family connectedness – a key basis for good sexual health – was potentially compromised for YPIC. Findings indicated that participants tended to have conflictual and/or estranged relationships with

birth family members and harboured feelings of rejection or abandonment. Transience between placements added to their insecurity, making a sense of connectedness to a stable living environment problematic. It also generated stress in the face of negotiating new relationships and routines in a new environment. Participants conveyed that their sense of identity as YPIC made them feel different from other young people in a stigmatising way. Yet despite high levels of adversity, some participants manifested a strong sense of resilience and attempted to harness their experiences in order to positively shape their lives. Nonetheless, existing research suggests that this early insecurity and instability makes YPIC more vulnerable to sexual health problems and suggests the need for enhanced stability and family connectedness.

### *Risky behaviours: alcohol and drugs*

Risky behaviours, particularly drug and alcohol use, to which participants reported being exposed were analysed because existing studies report that risky behaviours tend to cluster and sexual risk often goes hand in hand with other types of risk. Data indicated that alcohol consumption and soft drug use were widespread, starting in the early teen years. Participants transitioned to these primarily through peer groups and friendship networks. A number of participants revealed that peer groups offered a sense of belonging that attracted them in the face of their perceived early life rejection and lack of connectedness. Transitioning out of drug use reportedly involved disengaging from drug-using friendship networks.

### *Life in residential care*

While residential care services strive to provide a home-like environment to young people in care, they do so in the knowledge that residential care is very different to family life. Care-leaver data captured how life was experienced in residential care, particularly in relation to monitoring practices that are known to be important in protecting sexual health, when they are practised by parents at least. Residential care did not tend to be experienced as a family-type home, and many of the participants' recollections were of limitations and rules being instrumentally applied. A small number of participants who had experienced both private and public residential settings found the former to be more homely and personal than the latter. Another governance aspect of residential living recalled by participants was the requirement for staff to observe official regulations without the flexibility and discretion that parents might normatively exercise.

### *Life in foster care*

The analysis in this report also considered the accounts of those participants who had experienced long-term foster care, to get a sense of the extent to which they felt a degree of connectedness within the foster family. Almost all of those participants who had been fostered described a strong sense of connectedness with their foster carers, yet there were still isolated references in the narratives indicative of an underlying uncertainty about their identity and status in the foster family. A strong pattern emerged of high degrees of conflict with the foster carers during adolescence being reported, predominantly over boundaries

and (foster) parental monitoring; however, from their current vantage point as care-leavers and with the maturity of age, participants came to appreciate the structures that the foster carers had imposed on them. In retrospect, participants acknowledged that the root of the conflict was their own inappropriate behaviours linked to unresolved psychological issues. House rules imposed by foster carers were not interpreted retrospectively with contempt, as were house rules in residential care. What made the difference seemed to be that house rules and monitoring in foster care tended to be underpinned by the consistency and emotional engagement (warmth, love and care) of the foster carers. As far as sexual health is concerned, findings indicated that YPIC may have achieved some measure of protection by virtue of being fostered.

### *Relationships with service-providers*

Staying with issues of stability and connectedness, participants' perspectives of their relationships with service-providers during their time in care were considered. These were found to vary within and across the range of service-providers involved including social care workers, social workers, health professionals and mental healthcare providers. There were several references to very positive relationships with individual professionals, but the main problem recalled by participants was the high level of transience in relationships with service-providers, which exacerbated participants' feelings of insecurity. This prevented a deep sense of connectedness to any particular service-provider. This absence of connection and continuity was experienced as distressing and stressful for participants, and was sometimes viewed as a continuation of early rejection by their birth parents. A further consequence of service-provider transience was the impact of staff mobility on a young person's privacy and the containment of information about them. (Aside from staff transience, team-working in itself was also a problem in this regard.) Those in residential care were particularly affected by the number of professionals who were privy to information about them. Those in foster care, though less affected, reported that information-sharing between foster carers and social workers had implications for trust with each party; foster carers could not be trusted to keep information from social workers and social workers could not be trusted to keep information from foster carers.

### *Sex education and access to sexual health services*

Care-leavers also provided insights into RSE and access to the sexual health services and their experiences of the role that foster carers and various stakeholders played in these. With regard to foster carers, participants' accounts suggested that foster carers' attempts to deliver RSE tended to be impeded by various strategies used by the young people who did not want to engage with it. These findings are very similar to those found in an earlier Irish study in which parents in general identified barriers to undertaking RSE with their adolescent children. This suggests that there are continuities between YPIC and those not in care in this regard. Another finding concerning foster carers was that some foster mothers accompanied their foster daughters to the GP to avail of sexual health services. When the role of service-providers in providing RSE is considered, findings indicated that health professionals reportedly did



deliver basic RSE in the course of defined consultations. The role of social workers and social care workers in RSE appeared to vary considerably, with some reports of little or no RSE being delivered by these service-providers and other accounts suggesting that they provided relatively in-depth and regular RSE. Furthermore, some residential settings appeared to provide a good level of RSE while others did not.

One of the main sources of information about sexual health reported by participants in the present study was school. This is in line with the findings of other studies on sources of RSE for young people. However, exposure to RSE at school seemed to vary. While the number of YPIC in full-time education in Ireland is almost at 100%, a strong theme was an inconsistent pattern of school attendance which may have resulted in participants having reduced exposure to school-based RSE. A criticism of school-led RSE was that there was insufficient attention given to the emotional aspects of relationships.

Another source of information about relationships and sex was friends. However, the kind of knowledge shared among friends appeared to be focused on sexual behaviour that reproduced peer group norms and expectations. The internet was also used by some for sourcing knowledge about sex, but used for accessing general information (rather than information about sex) by others. Some aftercare providers appeared to offer good levels of RSE, but here too delivery was reportedly inconsistent. When asked directly about what YPIC needed when it came to sexual health and RSE, a diverse range of needs were proffered. These included:

- A greater amount of RSE provided by care staff.
- Scare tactics employed to drive home the message regarding STIs and greater emphasis placed on the negative consequences of unprotected sex.
- Young people and/or care leavers involved in RSE delivery.
- Greater attention given to the emotional dimensions of relationships and sex, particularly around the additional vulnerabilities of YPIC.
- RSE delivered once a week at secondary school rather than irregularly.
- In situations of 'personality clashes' or other interaction difficulties between staff and residents, care staff substituted with those found to be more compatible in delivering RSE.
- Foster carers having a greater role in RSE.
- A sexual health advisor in the HSE appointed to undertake RSE.
- The sexes segregated in RSE classes to avoid embarrassment.
- An anonymous telephone service made available so that sexual health issues may be discussed confidentially without a fear of a foster carer or care worker being privy to the consultation.

- Programmes such as the Real Deal made available at youth centres and leaflets made available within residential settings.
- The services of organisations such as EPIC engaged in delivering RSE.
- RSE weaved into the structure of existing key-working meetings between young people and care staff /social workers.
- STI screening made available as a standard component of general practitioner services.
- The availability of career guidance on higher education via the HSE.

### *Sexual experiences and sexual competence*

The important issue of participants' sexual experiences and what these revealed about their degrees of sexual competence was also considered in Report No. 5. Almost all participants reported having had first sex before the age of 17 years, and among these, there were virtually no participants who described sexual experiences that were characterised by a high level of sexual competence. (Sexual competence is characterised by the consistent use of contraception, autonomy in decision-making, both partners being equally willing and the absence of regret.) Among the two male participants who had experienced first sex at an early age, apathy about condom-use was in evidence. Young women implied that they relied on their sex partners to use condoms, and several had themselves used hormonal contraception at some stage. In many instances, hormonal products were believed to exacerbate underlying mental health and mood disorders, and there was a high level of reported user-efficacy problems. The reasons underlying the failure to use contraception, or to use it effectively, were a lack of knowledge and a lack of agency to take full control of fertility. The lack of agency was related to a casual approach to risk-taking, which resulted in pregnancy for some participants. There were, however, a small number of participants who expressed a strong determination to avoid pregnancy, and these appeared to have a level of anxiety about becoming pregnant that motivated them to engage with knowledge about contraception and its use.

The dimension of sexual competence relating to autonomy in decision-making was reportedly affected either by alcohol consumption or social coercion, that is, peer influence to have sex. Non-use of contraception appeared to be related to diminished autonomy in decision-making, particularly due to alcohol intoxication. Sexual competence was also reportedly undermined by exploitation and the fact that consent to sex was not always clear cut between sex partners. A strong theme was that young women, sometimes in their early teens, reported having had first sex with male sex partners several years older than themselves. It was clear from their accounts that these young women's capacity to consent without reservation was compromised and that they were not ready for sex with that partner. There were also reports of regret at the timing or circumstances of first sex. While it is difficult to determine whether such regret is experienced to a greater degree by YPIC compared to those not in care, the wider evidence that YPIC experience an earlier age of sexual debut suggests that they may be more vulnerable to regrets about the timing of first sex.

### *Intimate relationships*

Care-leaver data also included accounts of their intimate relationships. Findings here indicated that insecurities, instability and a sense of abandonment were believed by several participants to impact on romantic partner choices. Indeed, several participants linked their lack of trust in romantic relationships and their tendency to seek love indiscriminately to a sense of early rejection. Some reported having had dysfunctional relationships with controlling partners, where they did not recognise the destructive nature of the relationship at the time. Where the ending of a relationship for reasons of deception or infidelity was reported by participants, this reinforced their insecurity and lack of trust in others. However, two participants reported having experienced satisfying and respectful romantic relationships, which is important to acknowledge because it signals that YPIC are not automatically destined for destructive relations but can come to recognise and engage in good relationships.

## Section 7

# Synthesising the findings of the SENYPIC programme of research

When the analyses of all sources of data – service-providers, foster carers, birth parents and care-leavers – are brought together, it becomes clear that there was a high level of consistency across the groups as to what the sexual health and sexuality education needs of YPIC in Ireland are deemed to be. In particular, there was a very strong shared sense that good sexual health and RSE needed to be underpinned with emotional security, stability and self-esteem, along with social competence to safely negotiate sexual encounters. While direct RSE was considered to be important, it was not deemed to be sufficient. Another theme that emerged as being important from the range of perspectives was that YPIC need to have their privacy respected and matters about their intimate lives managed in a sensitive manner. The negative repercussions of the uncertainty about reporting of non-abusive underage sex and/or access to contraception in such cases was an issue raised by participants across the wider study.

While there was within-group diversity in opinion expressed about a host of issues, taken as a whole there was actually very little dissent across the groups in terms of their perceptions of the sexual health and RSE needs of YPIC. Rather, where differences arose across categories of participants – service-providers, young people, etc. – it tended to be largely in terms of emphasis arising from the vantage point of that group. For example, service-providers made much of the need for clarification about the perceived nebulous legal situation and lack of guidelines around delivering sex education and dealing with knowledge of non-abusive sex, while care-leavers tended not to express overt concerns about legal sanctions they themselves or their sex partners might have faced for underage intercourse. Instead, their focus tended to be on how professionals' knowledge of their sexual activity affected their privacy. Some service-providers gave rich accounts of challenges in delivering RSE, while care-leavers focused on the extent to which they received RSE. Service-providers spoke of challenges in maintaining the sexual safety of young people in residential care while young people largely reflected on these as overly restrictive rules. Foster carers registered strong concerns about foster daughters becoming pregnant, while several care-leaver participants manifested much less concern about this.

### **Key needs of service-providers in relation to the sexual health and RSE needs of YPIC**

- Clearer guidelines in relation to dealing with the provision of RSE and contraception to those under the age of 17 years.
- Clearer guidelines in relation to the reporting of non-abusive sex under the age of 17 years.
- More consistent training opportunities to equip staff in meeting RSE needs.

### **Key needs of foster carers in relation to the sexual health needs of foster children**

- An understanding that fostered teenagers are still maturing and resistance to authority is a normative aspect of adolescence.
- Training and support to equip foster carers to deliver RSE in the foster care environment, including an emphasis on the broader benefits and protective impacts of discussing age appropriate relationships and sexuality information with young people in their care; confidence-building to support them in delivering RSE messages; and clarity regarding legislative situation around reporting requirements and access to sexual health services.
- A forum for foster fathers to explore their concerns around sexual health of their foster children.

### **Key needs of YPIC in relation to sexual health and RSE**

- Greater acknowledgement from social workers and social care workers of the importance of a consistent adult in the lives of YPIC and the negative impact that social work and social care staff changes can have on the lives of YPIC.
- Development of new approaches and continued support where work is already taking place in the following areas:
  - Self-development and confidence building skills.
  - Developing an understanding of emotional connectedness and social learning.
  - Skills to allow for self-directed learning.
  - Developing skills around routine and structure.
- Support for attending school.
- Provision for privacy while maintaining safety.
- Access to non judgemental clinical sexual health services when required.

- Consistent access to RSE that meets individual needs. Key areas identified included:
  - exploring emotions and readiness for sex.
  - an understanding about readiness for sex, consent to sex and, particularly for young women, including the skills to refuse sex.
  - the potential long-term impact of STIs.
  - attention to the sexual health and RSE needs of boys and young men.
- To be made aware that, as with teenagers in general, they are still developing socially and emotionally and may view their best interests differently as they mature.

## Section 8

# Response from HSE Crisis Pregnancy Programme and the Child & Family Agency

Informed by the SENYPIC programme of research, the following actions agreed by the HSE Crisis Pregnancy Programme and the Child & Family Agency are framed within a strong Government commitment to improve the health and wellbeing of the population and to improve outcomes for children and young people including the needs of the most vulnerable in our society.<sup>4,5</sup>

### Implementation

1. An implementation group comprising HSE Crisis Pregnancy Programme and Child & Family Agency staff will be established. The group will be responsible for overseeing the delivery of the actions outlined below. The first task the group will be responsible for completing is the development of an implementation plan. The group will ensure that relevant actions are included in the annual operational planning for both organisations and reporting on progress will be a requirement of annual performance reporting.

### Knowledge Transfer and Data Collection

2. The HSE Crisis Pregnancy Programme and the Child & Family Agency will develop and implement a targeted knowledge transfer and dissemination plan to communicate findings from the SENYPIC programme of research to key stakeholders. This will involve implementing different approaches to ensure that key messages are communicated effectively to the particular groups, with a view to informing policy, practice and service delivery.
3. The Child & Family Agency will establish internal processes to collect national data on teenage pregnancies and parenting among young people in care under the age of 18. The data will be collected annually and centrally reported.

<sup>4</sup> *Healthy Ireland, a Framework for Improved Health & Wellbeing, 2013 – 2025* provides a set of overarching goals and actions to support the population to stay healthy and well, reduce health inequalities and protect people from threats to their health and wellbeing.

<sup>5</sup> *Better Outcomes Brighter Futures 2014 – 2020* is a national, whole-of Government policy framework, which sets out the Government's agenda and priorities relating to children and young people and how Ireland can best achieve optimum outcomes and bright futures for all children and their families

### **Supporting Young People in Care**

4. The HSE Crisis Pregnancy Programme and the Child & Family Agency will work together to ensure that foster carers, social care workers, social workers and other professionals working with young people in care have the skills and knowledge required to meet the RSE needs of young people in care and will be able to direct young people to relationships and sexuality information as appropriate to their needs.
5. The HSE Crisis Pregnancy Programme will continue its work with key stakeholders, including colleagues in the Department of Education and Skills and the youth work sector, to ensure that Relationships and Sexuality Education is implemented in schools, centres delivering the Youthreach programme and youth work settings. Increasing the quality and availability of RSE means that young people in care attending school and youth work settings will benefit from RSE programmes in mainstream settings alongside their peers.

### **Supporting Professionals, Service Providers and Foster Carers liaising with Young People in Care**

6. From 2015, the Foundation Programme in Sexual Health Promotion provided by HSE Health Promotion & Improvement will be rolled out nationally. The ten-day Programme offers professional development to a range of professionals, including social workers and social care professionals.
7. The HSE Crisis Pregnancy Programme and the Child & Family Agency will work with key stakeholders to develop accessible and user-friendly guidance on the law and ethics associated with working with minors in the area of sexual health. The guidance will be supported by workshops to create a learning environment to support professional development in this area. The guidance will provide support decision-making for service-providers, foster carers and health professionals who come into contact with young people in care in need of sexual healthcare.
8. The HSE Crisis Pregnancy Programme and the Child & Family Agency will undertake an assessment of RSE training currently provided in undergraduate courses in social work and social care work.
9. The HSE Crisis Pregnancy Programme and the Child & Family Agency will work with foster carers to ensure that training and resources on RSE are available to foster carers nationally, to support them to deal with the sexual health and education needs of young people in care.



### **Parents of Young People in Care**

10. The HSE Crisis Pregnancy Programme has developed evidence-informed resources to help parents talk to their school-aged children about relationships, sexuality and growing up. These resources include information on the broader benefits and protective impacts of discussing age appropriate relationships and sexuality information with children. The HSE Crisis Pregnancy Programme and the Child & Family Agency will work with key stakeholders providing parenting supports through Children's Services Committees to ensure that resources and information are available to parents who wish to talk to their children about relationships and sex.

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## SENYPIC Reports

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Fullerton, D., Hyde, A., McKeown, C., Lohan, M., Dunne, L., & Macdonald, G. (2015a). *Sexual Health and Sexuality Education Needs Assessment of Young People in Care in Ireland (SENYPIC): A Survey of Service-provider Perspectives. Report No. 1*. Dublin: HSE Crisis Pregnancy Programme and Child & Family Agency (Tusla).

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