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

The Perspectives of Care Leavers: A Qualitative Analysis

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

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

crisispregnancyprogramme

TUSLA
An Ghníomhaireacht um
Leanaí agus an Teaghlach
Child and Family Agency

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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.
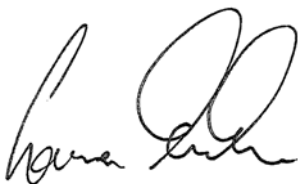
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FOREWORD

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 give 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 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).[1] This is the fifth report in the programme, '*The Perspectives of Care Leavers; A Qualitative Analysis*'. The report presents findings gathered by way of in-depth interviews with nineteen young people who were previously in State care.

This report clearly identifies the particular vulnerabilities associated with young people in care (YPIC). Although YPIC are not a homogenous group and arrive in State care for a multiplicity of reasons, engaging in risky behaviours, including drugs, alcohol and early sexual behaviour when in care, was commonly reported by the participants. Almost all of the participants reported having had first sex before the age of 17. What is particularly concerning is that virtually none of the descriptions of early sexual experiences involved sexual competence on their part – that is, use of contraception; autonomy in decision-making; being equally willing as partner at the time of sex; and absence of regret following sex.

With regard to relationships and sexuality education (RSE), care-leavers reported that different people played different roles in their lives and the level and quality of RSE delivery varied considerably.

This report, and the broader programme of research, makes it clear that while there is some very good work happening with RSE and sexual healthcare for young people in care, there is a greater need to respond in a more coordinated way to the contraceptive, sexual healthcare and crisis pregnancy needs of sexually active young people in a supportive way. Evidence-based messages about safer sex and access to sexual health advice and consultation need to be targeted towards YPIC, many of whom may be dealing with a range of negative social and psychological risk factors.

Those working with young people also need to be supported. It is key that those working with YPIC receive adequate training and resources to support the delivery of RSE and know how to address the sexual healthcare needs of these young people. The HSE Crisis Pregnancy Programme and the Child and Family Agency are committed to working with key stakeholders to meet needs identified in this programme of research over the coming years.

I would like to thank all of the young people who took the time to talk to the research team about their lives. 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.

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1   Formerly HSE Child and Family Social Services

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.

Deirdre Fullerton is Director of Insights Health and Social Research, an independent research consultancy specialising in sexual health improvement research. She qualified as a psychologist, specialising in developmental psychology. Before establishing Insights Health and Social Research, Deirdre had academic posts as research lecturer at the University of Ulster and as research fellow with the University of London Institute of Education SSRU and the University of York NHS Centre for Reviews and Dissemination.

Professor Maria Lohan is a Professor at the School of Nursing and Midwifery at Queen's University Belfast and is a Visiting Professor at School of Nursing University of British Columbia, Kelowna. Professor Lohan's research on men's health and in particular on men's (and young men's) sexual and reproductive health is internationally recognized through publications in leading journals including *Social Science and Medicine*, the *Journal of Adolescent Health* and *Culture Health and Sexuality* and *Sociology of Health and Illness.*

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.

Professor Geraldine Macdonald is Professor of Social Work at the University of Bristol having previously held a Professor of Social Work position at Queen's University Belfast. Her substantive areas of interest are vulnerable children and adolescents, particularly those experiencing maltreatment, and professional decision-making, and she has published in each of these areas. She is a long-standing advocate of evidence-based policy and practice within social care, and much of her research has focused on the evaluation of social interventions, including primary research, and systematic reviews. She is Coordinating Editor of the Cochrane Developmental, Psychosocial and Learning Problems Review Group. She is Trustee of CORAM, England's oldest children's charity which had its origins in the Foundling Hospital established by Thomas Coram.

Abbreviations used in this report

CIC	Children in Care
CPP	Crisis Pregnancy Programme
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.*

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* 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 theses 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

This report focuses on a qualitative analysis of the sexual health and sexuality education needs of young people in care (YPIC) from the perspectives of young care leavers, that is, people aged between 18 and 22 years who were formerly in the care of the state in Ireland. It is the fifth in a series of reports (Hyde *et al.* 2015a, 2015b; Fullerton *et al.* 2015a, 2015b), each of which presents a discrete component of a programme of research into the sexual health and sexuality education needs of YPIC in Ireland (the SENYPIC programme of research). The findings of all five reports are amalgamated in a composite summary report, which outlines each phase of the study and synthesises the overall results (Hyde *et al.* 2015c).

'Sexuality education' and 'sexual health': A note on terminology

One of the challenges in undertaking a needs assessment of sexual health and sexuality education for any group is in defining what is meant by the terms 'sexuality education' and 'sexual health'. Before moving on to Section 1, a brief note to clarify these terms is required. Sexuality has been variously defined in the literature. In this report – invoking the definition given by Jackson and Scott (1996) – sexuality is considered to 'encompass erotic desires, practices and identities' and includes 'aspects of personal and social life that have erotic significance' (p. 2). Sexuality education encompasses relationships education and is used interchangeably with the term 'relationships and sexuality education' (RSE), the latter being used by the Irish Department of Education and Skills as part of its Social, Personal and Health Education (SPHE) programme in secondary schools. Defining exactly what 'relationships' education' constitutes is difficult because the characteristics associated with contemporary notions of positive ways of relating (for example, through mutuality, emotional sensitivity, respect and dignity) spill over to non-sexual relations and the ability to engage competently in everyday life. Thus, the skills that RSE is designed to impart are not bounded strictly to sexual relationships; the teaching and learning of emotional literacy and the social learning associated with non-sexual relations may be invoked in negotiating sexual relationships.

Turning to sexual health, an important indicator of sexual health in adolescence is the extent to which young people develop what is referred to as *sexual competence* or *sexual readiness* (Hawes *et al.* 2010). This concept of sexual competence, which was used previously in the UK National Survey of Sexual Attitudes and Lifestyle (NATSAL study) (Wellings *et al.* 2001),

is operationalised by four indicators designed to get a measure of how ready a young person is at first sex. (Although usually used in the literature to gauge competence at sexual debut, it may also be used in relation to any sexual encounter). The four indicators are as follows: contraceptive protection; autonomy in decision-making (not influenced by alcohol or peer pressure); consensuality (both partners equally willing); and absence of regret (the timing being viewed as appropriate for the person) (Hawes *et al.* 2010). A growing body of evidence indicates that young people's ability to develop sexual competence rests in wider social and emotional experiences in childhood beyond RSE in its narrow sense (Wight & Fullerton 2013; Gordon Simons *et al.* 2013).

Given that the aim of this study was to identify the sexual health and RSE needs of YPIC through the retrospective accounts of recent care leavers, it was deemed important to illuminate participants' experiences of the environments in which they grew up in order to identify what this tells us about the extent to which the building blocks for sexual competence, including their sense of self and of family connectedness, were experienced. It is in appreciating the complex basis of sexual health that we justify devoting a considerable proportion of the analysis that follows to exploring social and emotional experiences of participants during their childhoods.

Structure of the report

This report is structured around ten sections.

In Section 1, the focus is on background issues and the current status of knowledge in relation to the following:

- The context of care in Ireland.

- Research into the sexual health of YPIC.

- Research on the sexual health needs of young people from their own perspectives.

- Evidence of the influence of family on sexual health.

The background and literature review culminate in a summary of what is known already about the topic under consideration. Also in Section 1, the objectives of this part of the SENYPIC programme of research are set out and the methodology employed is described.

In Section 2, participants' diminished sense of connectedness is considered, with reference to their relations with their birth family, the transience they experienced in the care system and their sense of difference from young people not in care. Reports of resilience are also considered here. In Section 3, we move on to explore participants' accounts of engaging in drug and alcohol use, given the established association between risky behaviours in general and risky sexual behaviour. Here, the influence of peer networks on alcohol and illicit drug use are

explored, as well as participants' experiences of transitioning out of these practices. Section 4 is concerned with accounts from those participants who experienced residential care that reveal the structure and process of life at this type of setting. The focus is particularly on the monitoring of behaviour, since existing literature links the monitoring of teenage behaviour to their sexual risk-taking. In Section 5, the emphasis is on the narratives of those who had been in long-term foster care, and in particular, the extent to which participants experienced a sense of family connectedness mediating (foster) parental monitoring while there. Section 6 concerns relationships with service-providers, particularly for those in residential care whose reliance on these as stable components in their lives was greatest. Here we consider participants' accounts of the impact that transience in service-provider relationships had on their sense of trust and emotional connectedness.

In Section 7, the emphasis shifts to more direct issues around sexual health, specifically sex education and access to sexual health services. Here, we consider the role that foster carers played in RSE for participants who had been fostered, as well as the input from health professionals, social workers and social care staff, school, friends, the media and after-care services. The section closes with some suggestions that participants made as to how to improve sexual health and RSE for YPIC. Staying with a direct focus on sexual health, in Section 8, participants' accounts of their sexual experiences are analysed using the framework of sexual competence referred to in the Introduction. The main focus here is exploring the extent to which indicators of sexual competence were evident in their sexual experiences to date. In the final data section, Section 9, participants' accounts of romantic relationships are explored, particularly in light of how they believed that their childhood experiences (and diminished sense of connectedness) impacted on these.

The report closes with an overall summary and conclusion (Section 10).

Section 1
Background, literature review and methodology

Background and literature review

In this section we review what is known already about the sexual health of YPIC and about their sexual health and RSE needs. The review begins by considering the context of the state care of children in Ireland, and the formal regulations governing care settings. Attention then turns to empirical studies of the sexual health of YPIC; since there are no studies that focus directly on this topic within an Irish context, scholarship reviewed here is predominantly international. We then consider a small number of studies from Britain that are closest to the study reported here insofar as they invoke the voices of young people themselves in identifying their sexual health needs.

Finally, because the sexual health and RSE needs of the young people who participated in this study were embedded in their experiences of everyday life in care and were mediated by their need for connectedness and belonging, we consider literature on the extent to which family connectedness (or lack of it) has been found to impact on the sexual health of young people in general. Research on the influence of parental monitoring and parental sex-focused communication on sexual outcomes for young people is also reviewed since, as will become clear when this report unfolds, monitoring by and education from those in *loco parentis* emerged in the accounts of participants.

The context of care in Ireland

In 2014, 6490 children were recorded as being in the care of the state under the provisions of The *Child Care Act 1991* (Child and 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)). The *Child Care Act 1991* makes provisions for taking children into care either on a voluntary basis (referred to as 'voluntary care') or through a court order known as a 'care order'. In the case of voluntary care, the parents have requested or agreed to have the child cared for by the state where they are not in a position to provide adequate care themselves. In the case of care orders, these occur where 'the child requires care or protection which he is unlikely to receive unless the court makes an order . . . in respect of the child'. The care order bestows upon the HSE 'control over the child as if it were his parent'.

Three broad categories have been identified as to why children and young people come into care, namely, abuse (physical abuse, sexual abuse, emotional abuse, and neglect), child-centred problems (stemming from the child's own behaviour or situation) and family-centred problems (arising from the family's circumstances or family members' behaviour) (Department of Children and Youth Affairs 2013). Irrespective of the reasons why children are admitted to care, they are placed at one of three broad types of care settings at any particular time – foster care, relative care or residential care. Of the 6,490 children in care, most (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 and Family Agency 2014). Of those in foster care, the majority (69%) were in general foster care, while a sizeable minority (31%) were in foster care with relatives. The type of residential care varies according to the level of supervision required, with most young people being in open residential centres; a small number are placed in open high-support units or Special Care Units if they have more challenging difficulties.

Each broad type of care is mapped to a statutory instrument embodying formal regulations, namely, 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.* Based on these pieces of legislation, consultation with stakeholders and best-practice in the field, two documents were subsequently published by the (then entitled) Department of Health and Children designed to enhance quality of care, namely, the *National Standards for Children's Residential Centres* (Department of Health and Children 2001) and the *National Standards for Foster Care* (Department of Health and Children 2003). Rippling through both National Standards' documents is the discourse of children's rights, which advocates dignity, respect and choice regarding the care of children and YPIC. This is especially prominent in Chapter 4 of the National Standards relating to residential care and Chapter 3 of those relating to foster care, both of which are devoted entirely to the issue of children's rights. Here, conditions are set out to facilitate the child's empowerment, including his/her right to exercise choice in relation to age-appropriate decisions and to be informed about the complaints' procedure. With regard to the specific issue of sexual health, The *National Standards for Children's Residential Centres* briefly refers to sexual health in directing that 'The care plan names a staff member responsible for giving appropriate guidance dependent on age and developmental stage on subjects such as . . . physical and sexual development; sexual health and sexually transmitted diseases; and the use of illegal substances' (Department of Health and Children 2001: 30). In the National Standards for Foster Care, while references are made to respecting the sexual identity of the young person, sexual health is referred to only in relation to the requirement that 'Care plans designate the person responsible for giving age appropriate advice and guidance on issues of physical, emotional and sexual health and development' (p.26), as well as identifying the responsibilities of link workers. Each young person in care is required to have an allocated social worker responsible for coordinating his or her care plan and for ensuring that decisions are implemented (Department of Health and Children 2003).

Research into the sexual health of YPIC

The only data sourced in Ireland that gives some insight into the sexual vulnerability of YPIC in Ireland comes from a preliminary analysis of data from the Health Behaviour of School-aged Children Ireland questionnaire, in which data from a sample of 46 15-17 years olds living in care were analysed (Burke *et al.* 2013). Data from these 46 young people revealed considerable differences between their age at first sex compared to those of a similar age sampled from the Mid-West region. Overall, 59% of 15-17 year olds in care in Ireland reported they had experienced sexual intercourse compared to 29.2% of 15-17 year olds in the Mid-West region. While caution must be exercised in any kind of statistical analysis with such a small sample size, and the fact that one sample was drawn from a national sample and the other from a regional one, the disparity between the two groups is significant.

Although no other research was located on the sexual health of YPIC in Ireland, it appears to be the case that YPIC in Ireland are at higher risk of teenage pregnancy than are young people who are not in care (Keilthy & Morris 2011). There is, however, consistent evidence internationally that this group suffers from poor sexual health compared to their counterparts in the wider population (MacDonald 2006). A number of studies have found YPIC to be at greater risk of early sexual initiation (Croker & Carlin 2002; Jones *et al.* 2011) than those not in care, with young people in residential care particularly at risk (Carpenter *et al.* 2001). YPIC in both Britain and the US are frequently associated with higher rates of adolescent pregnancies and sexually transmitted infections and diseases (MacDonald 2006; Douglas & Plugge 2006; Dale 2009; Twill *et al.* 2010; Schelble *et al.* 2010; Boonstra 2011; Dworsky & Courtney 2010).

Threats to the sexual health of YPIC arise because their lives are more likely to be mediated by drug and alcohol abuse, economic disadvantage and mental health problems (Kelleher *et al.* 2000; Pearce 2009; Department for Education and Skills 2006; Billings *et al.* 2007a; Dale 2009; Dale *et al.* 2011; Meltzer *et al.* 2003; Jones *et al.* 2011). Young people who are engaging in one form of risk-taking behaviour are more likely to engage in other forms of risk-taking behaviour (Baker *et al.* 2009). Factors influencing decisions around risk behaviours among YPIC include low self-esteem, loneliness, mistrust of others, lack of assertiveness, and lack of perceived choices or options in life (Haydon 2006; Berrington *et al.* 2005). This makes for a complex web of problems and exposes these young people to a higher risk of becoming sexually exploited. Although it is difficult to assess the proportion of YPIC being sexually exploited, owing to sophisticated techniques often adopted by abusers (Stredder *et al.* 2009), there is evidence from the UK that young women who have been in care are more likely to become involved in sex work (Ubido *et al.* 2009).

Research has also found that YPIC report gaps in their knowledge about safer sex and lack information needed to access sexual health or contraceptive services (Chase *et al.* 2006; Knight *et al.* 2006; Scott & Hill 2006; Dale 2009; Dale *et al.* 2011). Reasons for these gaps include poor relationships with parents and missed education and high exclusion rates from school, which causes them to miss out on the relationship and sexuality education (RSE) provided in schools. Aside from missing RSE at school, education in its own right has been strongly linked to sexual health outcomes. Success in school is associated with a lower

likelihood of teen parenthood, through its relationship with an older age at first sex and more effective contraceptive use; young people who do well academically tend to delay sex until later ages (Furstenberg *et al.* 1987; Lammers *et al.* 2000; Schvaneveldt *et al.* 2001; Parkes *et al.* 2010) and to be more effective in their use of contraception when they become sexually active (Herceg-Baron *et al.* 1990). Academic achievement has also been found to impact on the chances of becoming a teen parent because poor achievement is linked to early withdrawal from school (Manlove 1998). In a review of Irish and international literature Gilligan (2000) found evidence that young people in foster and residential care have a heightened risk of educational failure and later social disadvantage. A higher proportion of YPIC have been found to encounter difficulties with reading, spelling and mathematics (Meltzer *et al.* 2004).

Recent research published by Empowering People in Care (EPIC) conducted with 65 young care leavers in North Dublin revealed that half (51%) had not reached Leaving Certificate level in their education, and 39% suffered from poor mental health (EPIC 2011). Parental aspirations for their child have been found to play an important role in enhancing educational outcomes. International research has found that parental interest in and engagement in their daughters' education was associated with a lower risk of teenage motherhood (Manlove 1997, 1998). In an Irish study of early school leavers drawn from the wider population, Mayock and Byrne (2004) identified particular sexual health vulnerabilities.

In addition to educational disadvantage and its associated poverty and deprivation, YPIC are widely recognized as being more socially excluded and vulnerable to poor health and social outcomes than the most disadvantaged young people outside the care system (Dale *et al.* 2011; Meltzer *et al.* 2003; Biehal *et al.* 1995). Prior to entering care young people tend to experience family trauma, poor adult role modelling and domestic, physical and sexual abuse. During their time in care young people may experience frequent placement moves, discord within their own family, disruption of school placement and limited access to adequate support. Evidence from the UK notes that when they leave care, young care leavers often make the transition to independent living at an earlier age and with less support than peers not in care (Scottish Government 2011). Such experiences increase a young person in care's risk of social exclusion and disadvantage.

Research on the sexual health needs of young people from their own perspectives

A small body of research is emerging that attempts to capture the sexual health needs of YPIC from their own perspectives using qualitative methodologies (Bundle 2002; Chase *et al.* 2006; Knight *et al.* 2006; Billings *et al.* 2007b; Dale 2009; Dale *et al.*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. While sex education and information about sexually transmitted infections (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.

A (UK) Department of Health funded study explored factors contributing to early pregnancy and parenthood among young people in and leaving care, as well as the available supports and the degree to which services were believed to be accessible. The research was reported in two articles, one by Chase *et al.* (2006) and the other by Knight *et al.* (2006). Participants included 63 young people currently or previously in care, all of whom were either pregnant or currently parenting (service-providers were also interviewed). The study's findings as far as the young people were concerned were a perceived lack of preparation for adult life and limited exposure to information about sex and sexuality among almost all. Other issues to emerge in findings were peer pressure to be sexually active among those in residential care as a means of gaining acceptance. School sex education came in for criticism and was found by some to be overly biological in focus and introduced too late. However, Chase *et al.* (2006) describe as 'most striking' the 'factors associated with rejection, abandonment and the need to form strong attachments and to "be loved"' (pp. 446-447). Knight *et al.*'s (2006) article focused on the young people's experiences of foster care and found that some participants reported difficulties in talking to foster carers about sex.

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 those of the overall SENYPIC programme of research are by Billings *et al.* (2007b), based in an English context, and Dale (2009, 2011), conducted in Scotland.

Billings *et al.* (2007b), based on six focus groups with twenty 15-20 year-old YPIC currently or previously, found that participants reported diverse experiences and a range of views on sexual health provision. Billings *et al.* (2007b) study revealed that feeling different by virtue of being in care reduced participants' exposure to RSE and sustained gaps in their knowledge. Delivering RSE in large mixed-sex classes at school was also problematic for participants whose care status had the potential to make them more sensitive and embarrassed; instead they had a preference for one-to-one RSE over group approaches. There was also a sense from participants that school-based sex education did not take into account the impact of their previous transience and so regular school RSE was not experienced as supportive. In relation to approaching the sexual health services, although there were both positive and negative experiences reported, feelings of being judged negatively mediated the experience for some participants. One of the issues to emerge was that many of these participants had transient relationships with service-providers, which compromised their RSE and access to sexual health services. The researchers found that 'friendly, supportive and approachable members of staff' (p. 22) appeared to have considerable influence over service-use. Of particular importance to participants in Billings *et al.* (2007b) study was the issue of trust and confidentiality in sexual healthcare encounters. As well as in-school nurse services, preferences were expressed for out-of-school services, indicating the importance of making available 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 British study (specifically in the Fife region of Scotland) that sought to capture the sexual health needs of YPIC (Dale 2009; Dale *et al.* 2011), participation was confined to ten looked-after young people. Dale (2009) found that school was the most commonly reported source of sexual health knowledge. The young people comprising the sample called for greater attention to be given to sex and relationships and proposed a greater input from schools in the form of written material and a sensitive approach when dealing with sexual health with young people. Participants reported that sexual activity was generally unplanned and influenced by alcohol or drug-use. Dale *et al.* noted that while these young participants reported having knowledge about sex, there was a clear gap between this and their reported behaviour, prompting the researchers to recommend greater attention to developing skills to facilitate the practice of healthier sexual behaviours. Additionally, Dale noted that those who acquired information from parents or a parental figure held this input in high regard, and she concluded that:

> *Receiving sexual health knowledge from a range of sources appeared to be extremely valued by the respondents, stressing the importance for all people who work with, and care for, LAYP [looked-after young people] to discuss these issues with them. Since LAYP maybe more likely to miss out on schooling, and therefore sex and relationships education, this further emphasises the need for input to come from other people around them (Dale 2009, p. 31).*

She surmises that for young people who experience frequent shifts between placements, discussions about sensitive sexual health matters with their service-provider may be compromised in view of the disruptions to the relationship (Dale 2009).

Evidence of the influence of family on sexual health

While many of the difficulties encountered by YPIC are associated with socio-economic disadvantage and poor education, there is one critical factor that distinguishes young people living with their families in circumstances of socio-economic deprivation from YPIC, namely, the tendency for (birth) family connectedness to be compromised to a greater degree in the case of the latter. This may arise because of circumstances that led to the young person to be admitted to care, along with varying degrees of estrangement from family while in care. Family connectedness concerns the 'softer' aspects of family life, to do with interpersonal relationships, a sense of belonging and emotional attachments. Family connectedness is not an absolute concept, and can vary in quality and quantity regardless of with whom one lives. The extent to which family connectedness is known to impact on sexual health is explored here, and, in view of its importance, it will be revisited throughout this report.

In a recent review of reviews by Wight and Fullerton (2013) on family influence on the sexual health of young people, family connectedness emerged as one important factor, along with

parental monitoring and parents' attitudes and values about sex. (In other literature, each of these components is classified as an aspect of family 'connectedness', with parents' values, attitudes and regulating practices viewed as dimensions of connectedness (see Barber and Mikles Schluterman 2008 for an account of the diversity of ways in which connectedness has been conceptualised)). Before moving on, it should be noted that studies of the influence of family structure, that is, whether one lives with one or both parents, have consistently found that living with both parents has a protective effect on young people's sexual health (Wight & Fullerton 2013). However, connectedness may be experienced even in the context of separated parents.

Family connectedness

Family connectedness is manifested in parental support, closeness and warmth (Miller 2002) and in parents' attitude to their child in terms of quality and closeness (Manlove *et al.* 2012). Indicators that have been used to capture levels of supportive parenting include measures of the extent to which respondents deemed that when they were growing up, their parents really trusted them, really cared about them, frequently found fault with them undeservedly, and were unhappy with many of the things they did (Gordon-Simons *et al.* 2013). In a US study of over 2000 college students designed to identify mediators of the influence of family factors on risky sexual behaviour, Gordon-Simons *et al.* (2013) found that respondents who rated their parents as more highly supportive also rated commitment-related partner attributes more highly than those who reported less supportive parents. Higher scores on the importance of commitment-related partner attributes were also found to be inversely related to unrestricted socio-sexuality (casual sex). This lends support to family connectedness as having a protective impact on sexual health of young people. It is now established in literature that close and good-quality relationships between parents and teens are associated with later age of sexual debut (Browing *et al.* 2005; Pearson *et al.* 2006; Regnerus & Luchies 2006). Indeed, an earlier review of studies on family influences on teenage sexual and contraceptive behaviour found that parent-child connectedness was the most consistent protector against adolescent pregnancy, mainly by delaying sexual debut (Miller 2002).

The reasons why supportive parenting is believed to have an effect on adolescent sexual behaviour and relationship choices has been related to a number of factors. One of these is that the parenting style influences the characteristics that a person pursues in a potential partner. Berlin *et al.* (2006) found that young people who experienced intimate trusting relationships with their parents appreciated friendships and romantic relationships characterised by self-disclosure and emotionality. Those with harsh and rejecting parents were more likely to form volatile and more fleeting relationships. Simons *et al.* (2012) similarly found that harsh parenting and family instability led to distrustful and problematic relationships in young adults.

Another explanation for the association between parental connectedness and adolescent sexual behaviour is through attachment theory. Notwithstanding that attachment is a highly contested and complex theory (Law 2000), it has been argued that the insecurity of poor attachment propels individuals to early and casual sex to feel accepted (Bogaert & Sadava

2002). Miller (2002) noted that the success of child-parent connectedness as a protective factor was because a close child-parent relationship enabled family values to be communicated more effectively.

Parental monitoring

Another indicator of parental engagement and family connectedness is parental monitoring. Studies indicate that for both males and females, parental supervision is associated with later age of first intercourse (DiClemente *et al.* 2001; Dishion & McMahon 1998; Miller *et al.* 2001; Wight *et al.* 2006). One explanation for this is that greater parental monitoring is believed to curtail young people's opportunities to have sex (Miller *et al.* 2001). Parkes *et al.* (2011) used a range of indicators to measure parental monitoring, namely, the extent to which teenagers were required to: (1) seek permission to go out, (2) return home at a designated time and (3) inform parents of a change in plan by text or telephone. An additional measure was whether parents stayed up until the young person returned home. Results showed that higher levels of that parental monitoring were associated with delayed intercourse and with condom use (Parkes *et al.* 2011), and, concurring with previous results from a Scottish study (Wight *et al.* 2006), the impact of monitoring on females was greater for some outcomes. It should be noted, though, that there is also some evidence that excessively controlling or coercive parental supervision was found to be negatively associated with positive sexual health outcomes (Miller 2002), suggesting that a balance has to be achieved between levels of trust and supervision.

Parental sex-focused communication and RSE

There are less consistent findings regarding the impact of parental sex-focused education and direct communication about sex (Miller 2002). Some studies have found that parental input in direct sex education brings positive results (Wellings 2001; Hutchinson *et al.* 2003), while others have reported no clear link between parental sex education and sexual health outcomes for adolescents (Huebner & Howell 2003; Wight *et al.* 2006). There are also studies that challenge the view that parental sex education is singularly protective, at least in relation to some outcomes such as age at first sex. One of the UK studies that problematises the 'more is best' perspective on sex-focused communication between parents and their young people is the study by Parkes *et al.* (2001). This Scottish study found that teenagers who had not experienced sexual debut actually reported lower levels of parental communication about sex and lower parental endorsement of contraceptive-use compared to their sexually experienced counterparts. However, in that study, sexually inexperienced teenagers who had not yet had first intercourse reported a more supportive parental relationship and greater levels of parental monitoring than their sexually experienced peers. This and other studies (Wight *et al.* 2006) indicate the important role and influence of parents in the sexual health of adolescents beyond direct communication with their children about sex. Also, the impact of parental sex education in promoting positive sexual health outcomes for adolescents should not be dismissed, but rather acknowledged as a complex area.

Summary of what is known already about the topic

Most children in state care in Ireland are in foster care, with a smaller number in residential care. The standards and practices of this care are governed by a number of statutory instruments and official documents. The obligation of service-providers to provide sexual health guidance to YPIC is referred to (briefly) in this documentation. To date, apart from just one quantitative study with a very small sample size, no research based in an Irish context was located that investigated the sexual health of YPIC. There is, however, substantial evidence from Western countries that YPIC have poorer sexual health outcomes compared to those not in care measured by established indicators such as age at sexual debut and rates of teenage pregnancy and STIs. The relatively poor sexual health of YPIC is also known to be compounded by economic disadvantage, poor education, drug and alcohol abuse, mental health problems and psychological insecurity. A small number of studies from Britain have focused on identifying the sexual health and RSE needs of YPIC from their own perspectives and have found that transience, having multiple service-providers, and deficits in knowledge about negotiating romantic relationships presented difficulties for these young people These studies also found that being able to trust service-providers was important to the young people involved.

Existing literature also tells us that family connectedness – especially supportive parenting, closeness and warmth – are strongly linked to the good sexual health of young people. An aspect of connectedness, parental monitoring, has been found to have a positive impact on young people's sexual health. Family connectedness is important to consider in a study of the sexual health and RSE needs of YPIC because it tends to be compromised to varying degrees for this group by virtue of factors that underpinned them coming into care and their estrangement from their birth families while in care. There is some inconsistency around the evidence for direct communication between parents and young people about sexual relationships acting as a protective factor for young people – especially in delaying young people's sexual debut.

We have no knowledge already about what YPIC themselves, in an Irish context, perceive to be their sexual health and RSE needs.

Objectives of Report No. 5[2]

This report aims to give a voice to young people previously in care and to address the following 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 YPIC 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

The methodology for this study focusing on care leavers was influenced by previous and parallel studies that form part of the wider SENYPIC programme of research, the collective aim of which was to generate knowledge from various sources about the sexual health and RSE needs of YPIC in Ireland. The original proposal was to recruit young people under the age of 18 years currently in care, but recruitment problems were encountered because the consent of a birth parent would have been required in all cases, irrespective of the type of care order. (Recruitment difficulties are a well-documented problem with samples of this kind (Billings *et al*. 2007b; Dale & Watson 2010)). Young care leavers were deemed to be particularly useful informants for the study by virtue of the recency of their experiences in care, minimising the threat of recall difficulties, as well as the harnessing the benefits of retrospective reflection on one's situation.

Eligibility and recruitment

A limitation on the number of years since being in care was applied so that the memories of participants would be relatively fresh; to this end an age limit of 22 years was set for participants. Participants were recruited through key service-providers identified at earlier stages of the SENYPIC programme of research. These stakeholders were involved in organisations dealing with YPIC and in providing after-care services. The service-providers were provided with an information sheet about the study, supplemented with verbal information from a member of the research team. They acted as conduits of information initially and identified potential participants who were willing to meet a member of the research team with a view to participation.

Description of the sample

The sample consisted of 19 care leavers aged 18-22 years, 16 young women and three young men, who had experience of being in Child & Family Agency run residential centres, voluntary residential centres, private residential centres and/or foster care. Many had experienced initial short-term care arrangements or emergency care prior to longer term placements, and several had experienced multiple moves. Ten participants had experienced residential care of at least a year's duration, with one having spent 12 years in residential care. The remaining nine experienced foster placements of at least two years' duration. Two participants experienced both foster care and residential care, each on a long-term basis. Of those who had experienced long-term foster care, two of these were with family members (this is usually

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

referred to as 'relative care'). Among those previously in residential care, diverse types of residential settings were experienced, ranging from regular young people's residential care homes, accommodation for homeless people, a hostel and a high-support unit. At the time of the interview, some participants were availing themselves of after-care facilities while others were living independently. All but one participant identified themselves as heterosexual. Of the 19 participants, nine had become teen parents at the time of the interview. There was a good geographical spread achieved across Ireland, with interviews held in Donegal, Louth, Meath, Limerick, Dublin and Kildare.

Data collection

Data were gathered using individual in-depth interviews, apart from two instances where participants were friends and were more comfortable being interviewed in pairs. This amounted to 17 interviews in total. Data collection occurred at a private space on the premises of various organisations from where participants were recruited; these organisations included after-care/homeless organisations, an advocacy organisation centre, training centres and colleges, family support services, HSE after-care services and parenting support services. Each interview was loosely structured around a topic guide derived from existing literature as well as from earlier phases of the SENYPIC programme of research. Interviews lasted from between 40 minutes and 1 hour 20 minutes. Interviews were audio-recorded and later transcribed.

Data analysis

The thrust of data analysis resembled a strategy developed by Bogdan and Biklen (2007) referred to as modified analytical induction (MAI). It involved comparing whole narratives with each other, rather than slicing data into segments from the outset, as occurs in some types of qualitative data analysis. In this study, it involved taking the first whole transcript, paraphrasing the voice of the participant (raw data) and processing that through the researcher's repertoire of scholarly discourses (derived from literature) in order to make sense of it. From this first layer of analysis, particularly telling segments of data that most represented important points were retained. From this very first account, tentative hypotheses began to be developed about what was happening on the ground in relation to the topic under investigation. The substance of each subsequent transcript was folded into the emerging picture so that the whole account was filled out, accommodating both similar and new insights. The analysis continued until all transcripts had been analysed and incorporated into the overall account, with pertinent quotations included in order to provide direct empirical evidence to support points where appropriate. In practice, later interviews tended to add little to the emerging account, or only altered particular components of the whole picture as the analysis became saturated. This type of strategy ensured that aspects of data that contradicted the broad pattern were accommodated, but with their scope and strength acknowledged in the text.

Ethical considerations

Prior to commencing any field work, a submission to the Research Ethics Committee at University College Dublin (UCD) for ethical clearance for the study was approved. Information about the study was provided to participants in advance of the interviews by way of an information sheet, supplemented with additional information from a research team member if required. The limits to guarantees of confidentiality were written into the 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.

Participants were guaranteed that they would not be identified in any written reports of the study and informed consent was obtained from each participant. Audio recording of interviews occurred only where a participant was explicitly in agreement with this, which happened in all cases with care leavers. All audio recordings were destroyed following the submission of the report to the funding body. Data are held according to UCD's data protection policy.

In some interviews with the young care leavers whose accounts form the basis of this report, 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.

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 legal reporting obligations arose. It should be noted that none of the participants appeared distressed when referring to past experiences and all appeared enthusiastic about having their voices heard. This is likely to reflect the fact that it was a volunteer sample.

It should also 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.

Section 2
Disconnectedness, transience and stigma

Introduction

Given the significance of family connectedness as a basis for developing sexual competence, as outlined in Section 1, it is important to give some consideration to the extent to which this was compromised in the case of participants in view of their care status. Family connectedness is about parenting style and being positively regarded, secure and having a sense of belonging. In this section, we attempt to capture how participants perceived themselves in light of connectedness and security by first considering their relations with their birth families and their emotional connection to birth family members. We then explore the impact of transience and placement mobility on their sense of security before turning to their experiences of feeling different from young people who were not in care. Finally, accounts of resilience evident in the narratives of some participants are explored in order to highlight that YPIC may shape their lives positively, even in the face of adverse childhood experiences. The section closes by identifying what participants' experiences of disconnectedness, transience and stigma tell us about their sexual health needs.

Birth family relations

While close relations with the birth parents were occasionally reported it was far more common for participants to report contentious relations with their birth family, with inconsistent degrees of contact over time. Several participants described high levels of overt conflict and parental disengagement. One described her monthly encounters with her mother as 'horrible' and the mother's disposition as indifferent.

> We got to visit our [birth] mother – I got to see my mother for one day a year, it was two hours a month, so that's 24 hours a year. It was horrible! And half the time she wouldn't even talk.

Another participant similarly described conflict and volatility during her weekly visits to her birth mother, recounting that their visiting time together was dominated by 'roaring at her, shouting at her'.

Others described disturbing dialogues between themselves and the birth mother, where outright rejection was experienced, and the young person made to feel worthless. One of

these, a male participant, at the time of the interview had resumed relations with his birth father (with whom he reported 'a really good relationship'), but he captured the trauma of relations with his birth mother as follows:

> *My mother is heavy on drink and the stuff that she does. She is not our mother – she'd be telling us to kill ourselves and do this and do that. I have given my mother thousands of chances to be our mother and stop being the way she is but she hasn't, so I haven't talked to my mother in 8 or 9 months now.*

Another male participant, described having become accustomed to his birth mother not honouring promises to visit him while he was growing up in residential care. He indicated that since leaving care, relations between them had ceased. His mother now lived in Britain and although he had made attempts to maintain communication with her, these proved futile.

> *I always tried to contact her and stuff, but then she loses her phone and you can't contact her and the years go by without contact so you just kind of get on with it.*

Another participant reported having no contact with her birth parents and revealed that their manner of dealing with the issues that led to the dysfunctional behaviour of their children was by 'sweeping it under the carpet and not dealing with it at all'. Her own preference, she indicated, would be to discuss these openly and 'deal with it'. Relations had always been problematic, she recalled, particularly in relation to her father, who was an alcoholic. Her relationship with her siblings was also strained, she imparted, by virtue of their reluctance to confront the past.

Disconnectedness from their families – and from their birth mother in particular – was found to have left some participants with a persistent sense of abandonment and rejection. One participant rooted her lack of trust in people with this sense of early rejection by her birth mother.

> *It is like my mum giving me up, so I thought, 'You can't even trust your own mum so who are you going to trust?' So I just said I didn't. I always had that issue – I still do.*

Alongside these examples of highly dysfunctional relations were less obviously traumatic ones; however, in most cases for the young care leavers interviewed for this report relationships between participants and their birth families tended to be distant, strained and/or poor. In terms of sexual health needs, this data tells us that family connectedness – one of the most basic elements that builds sexual competence in teenagers – tended to be lacking for these young people.

Transience as a feature of being in care

Regular moves between placements added to the difficulty in attaining a level of connectedness to others in their living environment for participants in this study. Recent research from the USA has found that the strongest predictor of sexual and risky behaviour at the age of 23 was an unpredictable rather than a harsh early childhood environment (Simpson *et al*. 2012). While a small number of participants in the sample experienced the bulk of their childhood years with the same foster family or at the same residential home (as detailed in Sections 4 and 5), for most, to varying degrees, transience was a feature of their childhood and/or adolescence. This was something of which one participant was critical in light of her own experiences while in care.

> *Like, I was only in care for two years and I was moved around to so many places it was unreal. I think they should leave me in a place for longer. I mean when they put you in somewhere they should put you in somewhere that is going to be stable and not being moved constantly.*

Another participant described her sense of instability and lack of belonging as feeling 'in between' during a critical time of her development (from the age of 11 to 15 years).

> *I thought my [birth] mam was kind of better [recovered from addiction] so I went back to my mam myself when I was 15, so I left my grandparents' house because I felt so much in between, it wasn't good at the time.*

The reasons given for placement moves varied. Many started care in a setting designed to accommodate them temporarily, and moving on was inevitable. Several participants proffered 'running away' – that is, not returning to the home of the foster carer or the residential home – as the reason behind their being moved from one care setting to another. (Not observing curfews was very widely reported, and did not always result in being relocated – a number reported having been given a few chances). Another explained that absconding and drug and alcohol use underpinned her frequent moves between residential placements, including a high-support unit. However, one participant was critical of being relocated for what she believed to be a fairly minor transgression.

> *But they moved me out of there without a big reason. I think I went off for a night and I didn't come back and they panicked and the social worker was like, 'Oh move her'.*

In other cases, placement changes were instigated when health issues manifested themselves, one of which appeared to be a major mental health disorder that required specialist institutional care.

Whatever the reason for placement changes, the young people experienced these moves as difficult and distressing. The insecurity generated from the fear of being moved was described by a few participants. One, who had been placed with a foster family from the aged of 12 and with whom she formed a warm and enduring relationship (and who continued to live with them along with her baby at the time of the interview), spoke of the constant anxiety about the possibility of placement breakdown. She also drew attention to the professional discourse around the need for stability that contradicted the practice of multiple moves.

> *I was always worrying about moving placement- that is my biggest worry. I am happy, I am still there now, but it was just that I was delighted being there, I was happy, I finally found someone who loved me [foster carers] and would be there for me and things like that and I didn't want to be moving . . . They say you are not supposed to have broken families and they move you constantly. It is not right; I don't think it is right to move a child the whole time.*

At another point in the interview, she (whose narrative about transition anxiety was reported above) described an additional consequence of placement upheaval, namely, the experience of having to get to know new people at each new location, and then, having invested in making new acquaintances, face the prospect of yet another move.

> *It is really tough having to move because they take you into care and then you have to get to know new people and then once you get to know the new people they move you again and it all starts all over again, you need to get to know new people and things like that. It was really tough moving.*

Another participant recounted her experience of the intricacies of getting to know others on first arriving at a residential home. Her narrative suggested that this created a degree of stress and required a level of alertness not usually experienced in situations where individuals are comfortable and familiar with one another. The process involved having to read others, and being conscious of how to best conduct oneself in the presence of unfamiliar people. Learning to manage interpersonal relationships in the face of diverse personalities was part of the process for her.

> *I kind of just sussed people out and what way to be around different people … But you learn to step, like the different personalities work with different personalities.*

It was also evident further in her narrative that she was mistrustful and suspicious as she first navigated the care environment, a disposition that appeared to be exacerbated by the fact that the care setting that she described was emergency accommodation, in which she resided for just eight weeks before being moved again.

You kind of have to watch people. There would be all different sorts would be in and out... Different people come and go because it is only emergency accommodation ... People would come from all different walks of life. Some people would be shy and some people a bit more mouthy than others.

A component of negotiating the care environment for that participant was to curtail emotional expression and sensitivity through utilising defence mechanisms for self-protection.

You kind of have to put on a tough skin as well when you are in there.

While familiarising oneself with individuals encountered at new environments was one challenge, another was being a stranger in a new community. One participant moved to a new area when she came into foster care at the age of ten. She recalled that on entering post-primary education at the age of 12, while several other young people were encountering the new experience of secondary school, she had the added challenge of adjusting to life as an outsider in a town without the established networks that others enjoyed.

I was starting secondary school from 1st year so there were a lot of kids who didn't really know anybody anyway, which was kind of ok. But it was kind of hard because the town that I live in now, everybody knows each other because it is such a small town. So a lot of people did have cousins, they knew I was new, they knew I wasn't from the town that they were from, so that was kind of hard.

The view of another participant was that in his opinion placement moves were imposed where house rules had been breached, and he felt that this was not neccessary.[3] He proposed that foster carers should be permitted to deal with behavioural issues of foster children in the same way as do birth parents, that is, manage the deviance without threatening the security of the young person.

Because if you move into a house every time you do something wrong - if it was anyone else, if it was any other parents they can't send their children away to a different house when they want to. They just deal with it. So I don't understand why foster parents don't deal with it when it is happening instead of moving you on somewhere else or whatever.

As well as being distressing, that participant also believed that placement changes impact on a young person's sense of identity insofar as they heighten the feeling of difference that a foster child tends to experience relative to other children.

But it just feels like you are different because you get moved around.

There were additional reasons other than transience that served to make some participants feel different from young people who were not in care. It is to these that we now turn.

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3   The Child and Family Agency has indicated that it does not endorse this practice. and tries to ensure that placements are maintained before moving a young person.

Feeling different as a child in care

Research in a variety of fields has found that young people tend to want to fit in with peers and not become conspicuously different from the group (Furlong 2011). A Scottish study (Happer *et al.* 2006) found that not being treated differently from other young people was important to YPIC. In the SENYPIC study, some participants alluded to how their status as YPIC shaped their sense of identity as 'other' or different. Here we consider instances that arose in which the care status of the young person was reinforced, setting him or her apart from young people not in care. One such instance to which a participant referred related to routine vaccinations and immunisations that are administered through the school system. That participant was unable to receive these at the same time as her peers. In another case, the sense of difference from others in view of his care status was such that the participant felt that he was being judged negatively by others in the school environment. He revealed that in retrospect, the stigma and self-image that he experienced at school about being in care was unfounded and his situation was not unique.

> *I thought they were judging me, but at the end of it all, when I finally finished, I knew that they weren't judging me and I wasn't the only foster person in that school . . . I would love to go back now because at the end of the day no one did judge me because I was in foster care.*

Another participant reported feeling that she 'never had parents', recalling her embarrassment at going to school and the pain of witnessing other parents accompanying their children to the school. With regard to friendship networks, two participants indicated that being in care did not impact on these, although one described the difficulty that she encountered in disclosing to others that she was in care. She explained how information about her care status was kept guarded until such time as she was ready to reveal it.

> *No, when I first meet somebody I wouldn't just come out with it the first time that I am in foster care or I was in foster care or anything, that is not the first thing that comes up in conversation. That doesn't come up until I feel like talking about it.*

She recalled how some people who she had encountered had difficulty in understanding the concept of being in care, which she found to be irritating. She went on to explain that her identity as a child in care sometimes engendered the sympathy of others, something that she did not welcome because it set her apart from others. Another participant had similar experiences, and found herself regularly having to explain her circumstances in new social situations. Several participants referred to the requirement of having Garda clearance for adult members of their friends' families if they stayed overnight. (This requirement has since been revised). They felt that this immediately stigmatised them as YPIC.

Another participant indicated that simply on the basis of being a young man in residential care, he felt obliged to prove his worth to those in his community. This was to circumvent

any disapproval that tended to be associated with those in the residential setting within that local community; being in care was stigmatised and automatically gave one a questionable reputation. Elsewhere in the interview he reported how embedded and accepted he was by members of his local community and how much he enjoyed a sense of belonging there, but life had not always been like this for him.

> Then when I got my work other people in the community seen that he is not like other people in the house, which was typical: A lot of people had judged the house before they knew the people in the house [residential setting]. It was really bad sometimes … Very hard to become a part of the community when you first move there. The home itself had a bad name so automatically the people around the [place name] area would have been like, 'Oh there is new people from the home, they are obviously so and so, difficult and stuff like that'. So a tough time getting to know people, but once I knew them it was grand. I made great friends around the area.

For another young man, so complex and difficult to express were feelings of being in care that he believed that only those who had similar experiences would really understand that sense of differentness. It should be noted that this participant reported a traumatic experience while at a foster placement in early childhood and a positive one later in his time in care. (Foster care experiences are considered in Section 5). He proposed that those who had experienced foster care should be provided with a space and an opportunity to articulate their feelings with one another.

> There is no point someone in foster care sitting down with someone that doesn't know what it is like. They should get like a group of foster children and sit down and they can all talk amongst each other with a social worker or whoever and they can all talk among each other. And I guarantee that would be a lot better for everyone. I would feel a lot more comfortable talking to someone that knows what I have been through than someone that doesn't know what I have been through.

Similarly, the uniqueness of the experience of being homeless was believed to be something that others who had not experienced this would not understand.

> Nobody knows what it is like for a homeless child.

To summarise, for many participants, being a child in care made them feel different from 'normal' children, and experiences of stigma were reported.

Resilience

While there were a relatively high number of reports suggesting the damaging effect of adverse childhood experiences, a remarkable feature of data was the resilience of some

participants in the face of traumatic experiences. Before closing this section, some examples of this resilience are presented. One of these was in the narrative of participant, who was philosophical about her past experiences (which included child sexual abuse) and chose to focus on the positives. The end of the quotation conveyed a feeling of having survived in the face of adversity.

> But then I know it is horrible and people are like, 'Oh my God, God love you', but when it comes down to it, I am not happy with what happened - obviously I am not because it ruined my life, it did - but I wouldn't be here today if it didn't happen. So I am grateful in that sense. And I always think there is someone less fortunate than me . . . It could have been worse . . . With me I have always thought positively about everything. A lot of people, they let it drag them down, but as for me I think everything in life happens for a reason and I think this was the reason for me: for me to have a better life. I am grateful, not that I am grateful for what I have been through, but I am grateful for what I got at the end of it.

Another participant also reported being philosophical about her past experiences and reported having valued the friends and acquaintances who she encountered during her time in care. Although she believed that she ought to have been placed in foster rather than residential care, she nonetheless harnessed the experiences that residential care and adverse circumstances had given her and redefined them favourably. She appeared to possess a positive self-concept and resilience in spite of life's challenges.

> And I actually think that they shouldn't have put me into residential care, they should have put me, when I was 11, into a foster family. But if they did maybe things now might be different, I might not be as independent. I am very happy the way, I have learned lots from the experience I have been through in care . . . and moving different places to where I am now. I am grand.

The fact that the sample for this study was self-selected may have made for a disproportional number of participants who at the time of the interview were in a positive place in their lives and who felt in a position to contribute to this study. Virtually all had moved on to further education and training and had ambitions for employment and/or further training or travelling. Some suggested that they had turned a corner in life in after-care. Notwithstanding that the sample was not representative of all care leavers, it is still notable that several participants expressed a contentment with life and hope for the future.

In spite of accounts of resilience, data presented in this section indicate that many participants experienced poor parenting from birth parents, transience during their childhood, insecurity and stigma, collectively making for a very compromised degree of family connectedness that has been found to be so important to developing sexual competence.

Key points: Section 2

- While there were exceptions, participants tended to have conflictual and/or estranged relationships with birth family members and feelings of rejection or abandonment were common.

- Mobility between placements was widely experienced, making a sense of connectedness to a stable living environment difficult. While the young person's challenging behaviour and/or breaching of rules were frequently acknowledged as the reason behind placement transitions, this mobility nonetheless enhanced the insecurity of participants, and new environments tended to be experienced as distressing.

- Many participants described how being in care made them feel different to other children in a stigmatising way that impacted negatively on their sense of self.

- In spite of high levels of adversity as YPIC, some participants displayed a strong sense of resilience and attempted to harness their experiences in order to positively shape their lives.

- A strong theme in the data was that participants experienced disconnectedness, transience and stigma associated with being a child in care; we know from existing studies that this exposes them to sexual health problems and therefore a key sexual health need for YPIC is for enhanced stability and family connectedness.

Section 3
Risky behaviours: alcohol and drugs

Introduction

As indicated in Section 1, there is evidence that young people who engage in one form of risk-taking behaviour are more likely to engage in other forms of risk-taking behaviour, including sexual risk-taking (Baker *et al* 2009). While the impact of alcohol in particular in reducing sexual competence is considered in Section 8, here we provide a general account of participants' reported use of alcohol and drugs, including the transition to their use. In particular, we draw attention to narratives indicating that psychological processes associated with the need to belong permeate alcohol and drug use. Alcohol and drug use at mid adolescence was heavily mediated by peer group activities, and participants' accounts of the influence of the group are explored in this section. Finally, we consider narratives of transitioning away from drug use and the influence of friendship networks on this.

Alcohol and drug use

Risky practices such as underage alcohol consumption and smoking cannabis had reportedly been practised by participants across the sample during the early teenage years, almost without exception. (Smoking nicotine was also a widespread practice among participants). Most drug-use involved the use of 'soft' drugs, with a small proportion reportedly having used 'hard' drugs such as heroin. The usual pattern was to start smoking nicotine in the pre-teen years, and alcohol and cannabis from early teens, which continued into the mid-teen years (we consider this further on).

Most reports of the transition to alcohol and drug use involved peers, although there were reports of initiation via adult family members, as occurred for participant who reported having starting drinking alcohol at the age of 14 on the occasion of her father's 50th birthday, during which her uncle began buying her Bacardi Breezers at the party. Another participant revealed that her birth mother introduced her to cannabis at the age of 15, shortly before she entered residential care.

> *My mother introduced me to cannabis, so it kind of came from her a little bit as well, not just because I went into care. She smoked and she drank and it was around me most of my life, alcohol and weed, like cannabis was around me, so I did smoke a little bit, yes.*

For the most part, though, teenage alcohol and drug use were reported as peer group activities. References were made to 'hanging around' on 'mad weekends', which involved 'going on the gargle [drinking alcohol] all night' with a group. A female participant referred to having socialised with a group of boys (only) in which 'all they wanted to do was drink and smoke and stuff. That is all you ever done'. One participant recalled starting drinking at 13 because there were few other activities in which to engage. Another participant also recounted that she and her friends drank cider and smoked cannabis as part of a group from the age of 14, and, in common with virtually all other participants, never perceived cannabis as a drug. Alcohol was easily accessed she recalled, from a number of possible sources, including in the family home.

> Like you could older fellows that lived near you, you could get them to get it for you. You could have got the taxi man or something to bring it out to you. You would never have bother getting it. Even if you were desperate and there was drink in the house you would have took it with you.

One reported that she had been drinking alcohol from the age of 13 years, three years prior to entering care. Every weekend, she revealed, she and her peers purchased a flagon of cider from a large supermarket and would be 'twisted [drunk] and be puking everything up'. Another reported that she and her friends would access alcohol at an off-licence and drink it at the home of her mother, or alternatively in a public park. However, there was an issue, she indicated, when she was found to be drinking alcohol whilst babysitting.

Peer influence and the need to belong

A theme running through the accounts of a number of participants was a recognition that illicit group activities were rooted in a need to fit in and belong and/or dull the pain of rejection. One participant, who reported traumatic events as a small child, described her pathway into deviance through a peer group. Her account suggested that it was the need to belong that propelled her towards the group. Indeed, it appeared to have been the illicit activities of the group members that attracted her to it. Her sense of emotional disconnectedness is captured in the following narrative, in which she identified her need to belong 'somewhere' as a reason for engaging with the group.

> I started smoking very young, I was about nine when I started smoking cigarettes. Drinking, I wasn't very much of a big drinker because I seen the damage it done because my [step] father was an alcoholic. So I seen the damage it done. I don't think I really did it to forget, because when I was that age I didn't understand that drinking would make you forget . . . I think I was about 12 when I first started drinking and that would have been most weekends . . . But I think it was just a rebellious thing and I started hanging around with the wrong crowd. They were smoking hash and selling weed and stuff like that, and I hung around with that. But I think I hung around with it because it was the sense of I belonged somewhere.

Another participant directly linked her trajectory into risky practices with early life experiences – specifically, her sense of abandonment and rejection by her birth mother. She described a tenuous grip on life, a lack of emotional anchorage and a concomitant sense of isolation. She spent a period of time homeless during her teenage years and reported having engaged in criminal activity (theft) to access money to purchase alcohol and cigarettes.

> *I mean when you are 17 what are you supposed to do if you smoke or you drink? Obviously you are going to be inclined to rob stuff and rob off people and you don't give a shit because your ma is after disowning you, you are fucked out on your ear. You have nothing else to lose if you are after leaving school. I left school. And if you are after leaving school you just don't give a shit. Nobody cares about me so I will make my own way in life . . . Just being in care and being on the streets, you do awful things.*

The absence of emotional connectedness that positively regulates human behaviour is notable in her narrative. Elsewhere in the interview that participant recounted having socialised with teenagers who were a few years her senior. By the age of 12 years, she revealed, she was consuming alcohol and was embedded in a friendship network with those aged 15 and 16 years.

Engaging in risky peer practice out of a need to belong was also evident in the account of another participant. She described her pathway into drug use when she and a long-term friend became part of a peer group of which drug-use was a part. Both young women had recently moved from the same area to a new one (she was in a new foster placement), and it seemed that anxiety to develop new friendships and implicitly the need to belong underpinned their entry into the peer group. Although she acknowledged the experience of peer pressure to engage in drug use, her narrative suggested that she accepted responsibility for the pathway into drugs rather than perceiving herself to have been adversely influenced by the friend ('it was sort of a fifty-fifty thing').

> *I think it was my circle of friends to be honest. I always had a lovely group of friends and when I moved to [place name] I had this one friend who was my best friend for years and she got into it and I got into it with her. It was sort of a fifty-fifty thing, and we got into a bad circle of friends in that town because she had moved as well from [place name] to [place name]. So the two of us were like, 'Oh we have new friends now', and we got into the wrong crowd and it just developed . . . There was a lot of peer pressure as well.*

(As detailed in Section 5, that participant sought the help of her foster carers and was heavily supported by them during her drug rehabilitation).

One participant's pathway into drug-use started at 16 years, shortly after she entered the care system on moving to a residential setting in Dublin from a rural area, and was also associated with the need to 'fit in'. This experience of 'social coercion' (Finkelhor & Yllo 1983; Hyde *et al.*

2008), that is, pressure to follow a defined set of practices and the desire for cohesion with the group, led to a transition to using a range of drugs, which became more problematic over time.

> *And linking in with people that were in the units that were doing a lot of drug use. Then I ended up just to fit in to smoke with them . . . it got worse and worse and then just got completely off the radar.*

She listed the drugs she used as 'Weed, hash, coke, pills, the hemp shop stuff, crystal meth, everything, really, apart from heroin'. She was no longer taking illicit drugs at the time of the interview, though she admitted to a brief relapse two months' previously. Another described an environment of high drug and alcohol use in a hostel into which she was temporarily placed when she was 14 years, observing that 'there wasn't one person in there that was sober'.

Not all participants succumbed to peer influence around illicit activities. One described having resisted getting involved in these during his teenage years. His strategy was to socialise separately from those at the residential setting in which he was placed. His narrative suggested his sense that YPIC were different than those living with their birth parents, and more likely to engage in risky behaviour, and he thus deliberately disengaged from the former group.

> *[At 14 or 15 years] I didn't really hang around with the people in the house as such at all. Definitely one or two of the lads, you would definitely notice they were smoking and they were having a couple of drinks as well, but I didn't really hang around with the people in the care situation. I hung around with people that lived with their mums and dads so it was completely different.*

One participant reported being adamant that she would not repeat history, in light of her mother's self-destructive behaviours that brought misery and unhappiness; while she reported having experimented with cannabis at around 15 and 16 years when young people would congregate in the school yard 'and smoke weed', her involvement in this remained peripheral. Similarly, another reported having tried drugs, but conveyed that her birth siblings' addictions and the awareness of the negative impact of drugs this gave her, curtailed her use of them.

Transitioning in and out of peer groups

At the time of the interview, when all participants had reached 18 years at least, there was a tendency to reflect back on their days of peer alcohol and drug consumption with a recognition that the influences of the group had been negative. It seemed that drug use in particular was closely related to friendships, and a few participants described having straddled between friendship networks according to whether or not they were using drugs. For example, a participant, who moved from a rural area to a residential care setting in Dublin at the age of 15, described having shifted in and out of friendship groups according to whether or not

she and they were using drugs. At times during which she ceased drug-using, she avoided friendship networks where drug-use permeated group norms, and re-established relations with non-users.

> *I distanced myself from the rest of them because they were a bad influence. All they wanted to do was drink and go out, they didn't care about anything else and I didn't want to do that. And then I fell out with them and I met different people, well because I made friends with different people and I fell out with them I started to use drugs then in [townland of origin] when I was coming down. I just got into a lot of bother and constantly using them and I didn't talk to anyone. Then I stopped using and then I went back talking to [names].*

Another described having reached a point of being motivated to change her behaviour following introspection and self-reflection. Part of this process was to adopt a critical perspective on the behaviour of her friends. She recalled having come to a point of realising that she did have a choice and could chose an alternative path to those around her.

> *And I just got sick of that. Like, I was looking at other people; like, I have seen my best friends smoking gear and getting strung out and mad stuff. So you just stop and go, 'Do I want to do this or do I want to get away from this and do my own thing?' . . . I just looked at the rest of them and they were all going nowhere.*

Another, who reported that her foster carers were a key support in her successful disassociation from drug-use (see Section 5), also described having detached completely both from the friend with whom she first engaged with drug-use, and from the peer group. This severance, she explained, was sudden, abrupt and difficult, following the revelation of issues to her foster mother. Nonetheless, there is a sense of agency (control over destiny) mediating her narrative as she described the firm decision that she made to end relations with her best friend.

> *We [former best friend] don't speak; I haven't spoken to her since that day. It was hard for me. I had to leave that whole crowd . . . I ditched them that day that we all [foster carers] sat down and talked. I haven't talked to them since - not one of them.*

Reflecting on the time when she used illicit drugs, that participant expressed strong regret for past behaviour and conveyed how she had personally matured and now abhorred her previous conduct. She also looked back on her teenage years as 'wasted years'.

> *It is horrible - I hate looking back. I just hate looking back. It is like I wouldn't do it now and I wouldn't dream of it and I would hate to see anyone be like that . . . It took all my teenage years; it did, basically wasted when you look back . . . At least I got out of it young.*

Key points: Section 3

- Evidence suggests that young people who engage in one form of risk-taking behaviour are more likely to engage in other forms of risk-taking behaviour such as sexual risk-taking.

- In the sample, alcohol consumption and soft drug use were widespread, starting in early teens. Participants transitioned to these primarily though peer groups and friendship networks.

- A number of participants revealed that peer groups offered a sense of belonging that they needed in view of their sense of early life rejection and lack of connectedness.

- A few participants reported moderating their drug use in view of the insight that family members' addiction had given them.

- Transitioning out of drug use reportedly involved disassociating from drug-using friendship networks.

Section 4
Life in residential care

Introduction

As indicated in the literature review, good sexual health outcomes for teenagers require parental monitoring. For young people in residential care, the Child and Family Agency is the corporate parent and has responsibility for the welfare and safety of these young people. Just how those participants formerly in residential care (approximately half of those interviewed) experienced life in care is considered in this section, with a focus on the routines of care associated with monitoring their behaviour. Here we explore both the diverse and similar experiences of residential care from the perspectives of those who experienced it. It should be noted that an important component cross-cutting the rituals and routines in residential care is the quality of the interpersonal care delivered by staff. This is considered in Section 6.

Residential care is a group living environment that strives to provide a safe, caring environment for young people to live in. While these services strive to provide a home-like environment to young people they do so in the knowledge that residential care is very different to a family home. Finding a balance between giving freedom and defining boundaries as teenagers negotiate the passage into adulthood is a challenge for both parents and corporate parents. It should be noted that the latter are subjected to greater public scrutiny and criticism than are parents heading regular families. What is more, in the case of residential care, social care staff are charged with managing concentrated groups of teenagers, with all of the challenges that providing high-quality residential care brings in a climate of limited resources. The corporate parenting role is also rendered more demanding by virtue of the fact that YPIC tend to be grappling with more psychological, social and mental health issues arising from past difficulties compared to adolescents who are not in care.

Experiencing the routines and rituals of residential care

One of the issues that emerged in data was that routines and practices at different residential settings varied, giving rise to different experiences. A small number of participants had experiences with both public and private residential settings and in all cases found the private one more favourable. Two participants commented on how the round of life at the private residence reflected 'normal' life.

Just more organised, they were more together; it was more normality, definitely, I felt.

It was genuinely a home; it was just like a normal house in [names location].

One of them went on to make the point that creating a homely atmosphere was, from her experience of it, important to the staff working at the private residence.

And that was their thing - that they wanted it to be for people to come in and feel that they were in a home, not like they were in a residential house. It was really important to them.

That participant also imparted how the care at this residence was individualised by virtue of personal touches such as being allowed to decorate one's own room and request preferred toiletries. She also commented on the kindness and attentiveness of staff that permeated the day-to-day experiences while living there. After becoming pregnant at the age of 14, she moved into an alternative type of accommodation, and while she continued to be largely positive about her care experience overall, the social organisation at the second setting imposed greater limitations. She spoke of the strategies for monitoring the young people in residential care there, some of which were different from mechanisms normatively associated with parental surveillance in family homes.

It is a hostel house kind of thing, it is one of the best, but still you are in a place where they lock all the doors, they lock the kitchen at 8:00, you are not allowed have a TV in your room. You are not allowed have your lights on past 10:00.

Other surveillance strategies described by participants who also experienced residential care were the use of CCTV[4], the presence of night staff and security measures on internal doors.

There is no separation [of the sexes], but there was cameras. There was always 24-hour staff on in [name], like the staff didn't go asleep. And in the second one there was six residents, there was three girls and three boys and they were on different sides. You couldn't go through; there was alarmed doors and everything. And that staff went to sleep.

Because you would have staff on, you'd have two staff on during the day and then they'd swap and then you'd have the sleepover staff, what they called them, the ones that stayed in overnight with you. You couldn't walk to town. You are in the house the whole time, like even if you don't go to school you have to get up at 8:00 in the morning. If you are not at school you are not allowed the TV on until after 3:00. You can only eat at the times they give you to eat and then at the night time you have . . . to hand your phone up and you have to be in bed at 10:00. You are not allowed take your phone to bed, you have to hand

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4   The use of internal CCTV in mainstream residential care is against the Child and Family Agency policy.

everything up. And the kitchen downstairs is locked at 9:00, you are not allowed into it after 9:00 . . . There is no computer or no internet or anything.

One participant, who had initially experienced being in care at a private setting, described similar limitations and the social organisation at the location of her second residential placement that might be considered to be at variance with normative social practices in family homes. These included locks on cupboards and food stores[5] and, as was described by several others, alarmed doors.

> *There was locks on some of the presses and the doors and locks to the fridge, an actual lock into the pantry where the food was. Alarm systems on your door. Of course I was like, 'Jesus!' compared to this other place where it was so much more like normal life.*

Her reference to 'normal life' is suggestive of the distinction she felt between norms of living for those in residential care and those in regular homes.

Another participant was positive about the structure that residential care setting offered, allowing her to cook meals for other housemates. She acknowledged that she and her peers in care displayed challenging behaviour and 'ran amuck', making it difficult for staff to cope. The Gardaí were regularly involved in searching for her and her peers on occasions when they went missing.

If we consider other day-to-day experiences of life in residential care, one participant recalled the inflexibility around rules in residential care, using the example of young people's access to over 18s' films. In his experience of residential care, these were invariably restricted to residents until they had actually reached the age of 18 years, whereas in family homes, he contended, parents may intervene and make judgements as to the suitability of the film and sanction its viewing before the young person had quite reached 18 years. He referred to this as 'little stuff like that', which defined differences between young people in residential care and those in families. That participant also described the 'paperwork' associated with living in residential care, with reference to the requirement to have Garda clearance for his friends' parents in order to sleep over in their homes (referred to earlier in Section 2). (It should be noted that this requirement was raised by several of the previously-fostered participants also). He described having to get such clearance[6] as 'the worst thing ever I had to do', and explained that he would not have had an issue with the friends' parents being contacted by a residential staff member to verify the arrangements ('like every mother does').

> *But in a residential unit it is real paperwork . . . I turned around to the staff saying, 'What is the point in that?' I wasn't saying don't, I was like, 'Would you not ring the mother, hey is [name] staying there tonight, she'll go 'Yes, he'll be home at so and so the next day', like every mother does.*

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5 Locking cupboards and food stores is against the Child and Family Agency policy.

6 This is no longer Child and Family Agency policy and thus Garda clearance is no longer required in such situations.

Overall, from the perspective of the young person, the overwhelming sense from recollections of residential care was an experience of institutional living (with a small number of exceptions), where there was an excessive emphasis on monitoring, without this being mediated with a sense of family-home cohesiveness.

Key points: Section 4

- Routines and practices at different residential settings varied, giving rise to different experiences. 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.

- Aspects of residential care living such as alarmed doors, secure food cupboards and staff on night shifts that appeared distinct from normative family routines were highlighted by participants.

- Other governance aspects of residential living were recalled by participants where staff were obliged to observe official regulations without the flexibility and discretion that parents might normatively exercise.

Section 5
Experiences of foster care

Introduction

One means by which YPIC can achieve a sense of emotional connectedness resembling family connectedness is through the experience of being fostered long-term. Nine participants had experience of at least one foster placement of more than two years' duration. In this section, we consider the extent to which these participants experienced a sense of embeddedness and connectedness within the foster family. Two participants described unhappy and distressing long-term foster placements, although one of these went on to spend the last few years in care in a very stable foster placement. Another described an unhappy short-term foster placement; otherwise, though, very positive experiences of foster care were reported.

Identity within the foster family

The narratives on foster care largely tend to demonstrate a sense of belonging within the foster family, to varying degrees. In some interviews, where participants had spent all of their childhood with the same foster family, they tended to refer to the foster carers as 'mum' ('mam' or 'mammy' also) and 'dad' or 'daddy', signalling their identity as fully integrated family members. Even where participants arrived at a placement at a fairly advanced stage of childhood (early adolescence), this did not deter them from becoming embedded in a family and reportedly feeling part of it. Yet there were still references in the narratives that suggested an underlying uncertainty about their identity and how they positioned themselves relative to their birth parents and foster siblings who were birth children of the foster carers. For example, one participant referred to her foster carers as her 'mum and dad' and had been in the same foster family since she was a toddler, yet she used the term 'real family' when describing her birth family. When speaking about her birth siblings, another participant conveyed that they all remained with their 'proper ma and da'. When asked as to whether the other children in the foster family were also foster children, she described them as 'normal kids' to distinguish them from foster children.

Relations with foster carers

Virtually all of the participants who were fostered in long-term placements described a close and continuing relationship with their foster carers, speaking warmly about them. Yet a pattern was that these relations had not always been so harmonious. These participants relayed very similar descriptions of turmoil and conflict with the foster carers during the teenage years. In most of these accounts participants described rebelling against the rules and expectations set by the foster carers. In retrospect, they acknowledged that the root of the conflict was their own inappropriate behaviours, which they attributed to unresolved psychological issues. An appreciation that the foster carers remained steady and supportive during the difficult years permeates their accounts. Let us consider some of these experiences.

One contrasted an environment of no discipline with her birth mother to one of predictable structures and routine in the home of her foster carers, peppered with a positive regard for their parenting style.

> She [foster mother] is my number one. I was a bitch, I was so bold. To my foster parents I was so, so, so bold. And when I look back now I go, 'Oh my God! I was so evil', the things I did to them was just horrible . . . Like, I went in a bad way. Like, when I was 16 I kicked up murder because [foster mother] was so strict. Because I wanted to go over to my real mother because I knew she would let me drink and I was a teenager and I wanted what I wanted. Whereas [foster carers' home] you get up in the morning, you go downstairs, you get your breakfast, you go to school. You are off school at 3:30, you have a half hour to walk home, you'd be home at 4:00, you'd go in at 4:00, you'd study from 4:00 until 6:00. At 6:00 you get your dinner. It is still the same to this day, 6:00 is dinner. You go up and get changed and bed at 9:00. The same thing in and out the different days. And then at the weekend you are not allowed sleep past 12:00, you get a lie in but your lie in is 12:00, that is it. And then the one day you get to stay in your pyjamas is Sunday . . . We were spoiled! And then if they got bored they'd be like, 'Right come on we are going to [leisure event] or we will go to [names tourist attraction]'. We always did something, we were never bored.

It should be noted that the structure and regularity of family life described above are not vastly different from those described in relation to residential settings in Section 4, but the major difference is the consistent presence of emotionally engaged foster carers; this suggests that structure and routine are interpreted quite differently retrospectively if mediated by a sense of belonging and emotional engagement.

Another, a teen mother still living with her foster carers, similarly contrasted her previous unstructured environment in the care of a member of her birth family with the structured yet affectionate environment of her foster family.

I am very close to my foster parents. [Name's foster mother] is a great help and [names foster father] is just fabulous as well. They help me with everything, they help me with my baby and they are just a great help. They are the only people I talk to if I need any help or anything. I will just ask them and they are right there for me all the time. I think my foster parents, they always taught me what was wrong and what was right . . . Like, 'You are not allowed do this' or 'Don't do that'. When you are brought up with no rules . . . My [birth family] never taught me anything like that, I was allowed do what I wanted . . . I used to stay out at night time, I was just bold.

One, whose account follows, was the participant who reported a very traumatic foster placement earlier in his childhood yet described a very positive one later in his time in care. By way of context, this participant reported having been in care since the age of three, having been 'in 22 different foster homes, about four or five residential units'[7] until shortly before his twelfth birthday he finally settled down with a foster family. What comes across strongly in the narrative about his positive experience is that the rules set within that foster family were not associated with his status as a foster child, but were normative family rules for all family members, which made them more acceptable. His foster mother's positive regard and warmth for him was also identified as being important. Although he did not remain living there after the age of 18 years, as he no longer wanted to observe the rules, the relationship endured and remained harmonious.

Participant: I loved it [foster family]. I still have good contacts. They are only five or ten minutes over the road from me, so I go over to her [foster mother] about twice a week if I can - once a week, anyway.

Interviewer: What was good about that placement?

Participant: Everything. She treated us as if we were one of her own children; she didn't set all these rules just because you were in foster care. She didn't treat you any differently . . . But she has always been good to me, always been nice to me and always treated me like I was her own son and not any different just because I was in foster care.

Interviewer: So that placement was fairly steady.

Participant: That was the best placement I had, but she couldn't, obviously she didn't want me going and hanging out with the wrong crowd and going drinking and stuff. It was for my own safety really that she had to let me go. So I had to get my own place then because she couldn't give me the freedom that I wanted because there were so many rules...So I moved out by myself.

Interviewer: But you still have a very good relationship with her.

Participant: I do, yes.

7   Tusla has indicated that this number of reported moves is unusual. There is a national policy incorporating guidelines in place ensuring that the number of moves are limited.

The narrative of another participant suggested that her foster carers were central to her confronting a drug habit that she had acquired during her teenage years. She explained how she had started to use drugs during her teenage years while she was in foster care, but reached a point of a sudden recognition that her drug-use was destructive, both for herself and for her foster family. Part of this realisation was a self-awareness of her own anger and the need to take responsibility for the impact of her displaced emotions on others, including her foster carers.

> *Just one day I woke up and it was like, 'What are you doing to yourself? Why are you making yourself feel like this and everyone else around you? You are angry with everyone. No one deserves this; you need to just change your life'. And I did, from that day on.*

She described the start of her journey to change the direction of her life when, after a particularly bad week, she divulged her difficulties to her foster mother. The foster mother was reportedly very receptive and supportive, and while she apparently had sensed that the participant was dealing with difficult issues, she remained unaware as to what these were until the participant opened up to her.

> *I broke down. I think it was after being a bad week and I broke down and I said, 'I am on drugs, I just need help, I don't know what to do anymore'. And my foster mum I told first and she was very good. And she said, 'We need to tell [social worker]; we need to sit down and talk'. She said, 'I always knew there was something'. Because I never told them, I was never there, I was always out with the wrong people so it was hard for them to know what I was up to.*

She imparted that the support from her foster carers, who reportedly felt guilty for not having recognised her suffering during the time of her drug use, was a key factor in her taking control of her life. She reported having experienced guilt for having visited trauma upon the foster carers, but her stronger emotion was one of relief at having shared with them her difficulties. She also reported a transformation in her relationship with them in the year after confronting her drug addiction, and an appreciation for the support they had given her.

> *After a year, like that year was just perfect with them, the year of being off everything and our relationship was perfect and they understood and helped me in every aspect. They were so good.*

(It should be noted that that participant commenced the placement with the foster carers at the age of 14, indicating that benefits can ensue from placements that happen well into adolescence).

Another participant's account was somewhat similar, insofar as she recalled her anger and behavioural difficulties and how challenging this had been for her foster carers.

It has been positive in the sense of a family and the environment I am in, but I wasn't very positive myself. I went down a very bad patch with my attitude and I got in with the wrong crowd and I was smoking and drinking and just being stupid and bold and doing things. I was negative in that sense. Because of everything I went through, in my head, I didn't know how to deal with it. But my [foster carers] were really good, they were really supportive, they made sure that I got the help that I needed in terms of psychologists and anger management and stuff like that. So yes they have been great . . .
I think my foster mam suffered the most because I would fight. I was very aggressive. I would just - the littlest thing would set me off so my [foster] parents, they got the brunt of it because I was very angry.

That participant related how the only negative relationship she had experienced in life was with her step-father (birth mother's partner), who was currently serving a long prison sentence for sexual abuse. However, her warm relationship with her foster father appeared to mitigate to some extent the pain of the trauma reportedly inflicted by her step-father. In the narrative that follows, she referred to her foster father as 'my dad' and her sense of security is captured in the language she used: 'I have my dad now'.

I had a lot of hatred for him [step-father]. Mainly the reason why I am in care was because of the things he did, so I wouldn't really have any feelings towards him . . . I do feel that I have my dad [foster father] now, that is the way I look at it.

To summarise, although two participants described negative experiences while in foster care, with one of these being traumatic, participants who had experienced long-term foster care were overwhelmingly positive about the experience. Yet, in all cases, relationships with foster carers during the teenage years tended to be contentious and difficult, and at that stage, structure and routine as a feature of home life were not appreciated. Yet on more mature reflection, they viewed parental monitoring and restrictions in a much more positive light and expressed a strong sense of connectedness to their foster carers.

Key points: Section 5

- Almost all of participants who were fostered in long-term placements described a strong sense of connectedness to their foster carers, yet there were still isolated references in the narratives suggesting an underlying uncertainty about their identity and status in the foster family.

- Participants who had emotionally embedded themselves with their long-term foster family indicated that relations with foster carers were not always harmonious; a strong pattern was that high levels of turmoil and conflict were experienced with the foster carers during the teenage years.

- In retrospect, participants acknowledged that the root of the conflict was their own inappropriate behaviours, linked to unresolved psychological issues.

- It was easier for young people in foster care to accept house rules where these were seen to be applicable to all family members of a similar age and where they believed that they were not being treated differently by virtue of being in care.

- The sense of connectedness (warmth, love and appreciation) that participants expressed towards the foster carers enabled them to view (foster) parental monitoring and restrictions in a different and much more positive light in retrospect.

Section 6
Relationships with service-providers

Introduction

A key foundation for sexual health, which we emphasise throughout this report, is feeling connected emotionally. Previous sections have indicated that YPIC tend to have emotionally distant relations with birth parents and tend to drift between friendship networks. This makes the need for emotional anchorage to service-providers all the more important, particularly for those in residential care. Although young people in long-term foster care tended to report a continuous relationship with foster carers, in this section, we consider participants' relationships with service-providers across both foster care and residential care over the course of their care trajectory, as there are some overlaps in service-provider relations between both groups. We begin by presenting accounts of the diverse relations with social work and social care professionals that participants described and follow this with accounts of participants' relations with mental health professionals, of which several participants had experience. The focus then shifts to a widespread difficulty reported by participants, namely, transience in and temporality of relationships with professionals; the implications of instability in care relationships for trust and connectedness is also considered. Finally, the matter of multiple staff having jurisdiction over a young person's care - and how this affected their privacy - is explored.

Experiences of relationships with service-provider

Relationships with service-providers were found to vary considerably, and the same participant sometimes recalled both positive and negative experiences with different staff he or she had encountered during their time in care. There were warm recollections of specific staff peppered throughout the data, particularly where staff had helped the participant with a particular challenge, such as addiction. One participant recounted how, on being taken into care for the first time at the age of 15, which necessitated a move from her rural home to an urban area, it occurred to her that life in residential care might be more positive than her life before care because of the presence of staff who were in a position to care for her.

> Then it kind of dawned on me that it was a better life for me up here than it would be down in [place name]. And there are people who will actually look after me than what there would be down here [home].

Another participant, a non-Irish national who at the time of the interview was a 19-year-old second year student at university, reflected back with gratitude and warmth at the standard of care she had received.

> *They did so much for me and I really understood that. And I think a lot of social care workers do. Young people are in their own little bubble if they don't realise actually how lucky they are, but I actually saw how much stuff they did for me. They are my family.*

There were also reports of contentious relationships with service-providers. The same participant, (who spoke very highly of social care staff whom she had encountered during her time in care as indicated above), recalled having had a positive relationship with her very first social worker, but was scathing of social workers in general. Her cynicism about social workers appeared to stem from her belief that they privileged professional discourse over genuine human engagement.

> *My first social worker ever, I still talk to her. She doesn't even work there anymore but I still talk to her. I loved her, she was so nice. And she was always an advocate. Everybody [social workers] after that I hated . . . Social workers bring out the worst in me. Like you see how I am having a normal conversation, if this was a social worker I'd be like down the stairs raging, I couldn't even speak to them. They just bring out the worst in me because . . . I just feel like when they are talking to you they are regurgitating stuff they have learned from the book as opposed to actually trying to understand how you are feeling and where you are coming from. It is just really frustrating for me and I can't deal with people like that, even at this age, even at 19 years of age they bring out the worst in me.*

Other narratives suggested a fleeting relationship with social workers and a more continuous one with residential staff, although continuous relationships were not necessarily positive. For example, one participant reflected on the difficulty she encountered with a social care worker who she did not hold in high regard, and with whom she did not wish to engage in a therapeutic relationship. Her response was to become passive and to disengage.

Another participant had spent four years in care (from the age of 14). Her full interview transcript described a very chaotic experience while in care, including a spell at a high-support unit and she reflected insightfully on her relationships with social workers and social care workers. With the benefit of maturity she looked back with an understanding of the limits placed on service-provider roles, and how professional requirements curtailed staff in fully engaging emotionally with young people in their care. She also expressed regret at having projected her difficulties onto social workers.

> *I know we would be giving the staff a hard time and all and everything else . . . but at the same time I have to kind of stand back and take a look at it. They are kind of put*

on boundaries and rules as well, they can't form a relationship with a child too much because it is not in their job description, they can't do that; they can't form a real strong feeling for the child so they have to cut off links . . . But the social workers, I regret ever going mad at social workers saying, 'This is your fault, this is your fault'. Because at the end of the day they are really only kind of doing their job.

Relationships with mental health service-providers

Several participants reported mental health problems such as self-harm, depression, anxiety or addiction that brought them into contact with mental health service-providers. Relationships with these professionals also varied considerably. Positive reports included the experiences of one participant, who found that consultations with her psychologist to deal with her drug use were very effective. She commented, 'I wouldn't be where I am today if I didn't have my psychologist'. That participant believed that a third party such as a psychologist is preferable to a primary carer such as a foster carer because the latter might have a view on a particular course of action for a young person that is at variance with his or her own preference. By contrast, she proposed, an independent professional does not give opinions but rather enables the individual to consider options and take ownership of his or her choices.

Another participant, who had a mild intellectual disability, conveyed a sense of apathy about engaging with a counsellor to whom she was referred for depression, following a drug overdose attempt the previous year. That others had prescribed what was good for her appeared to be the basis for her indifference. She reported having found the psychology sessions to be of no therapeutic benefit, and described them as 'boring'. Although not specifying details of the encounters, she indicated that the psychologist was interested in exploring her relationship with a family member about which she was reticent. Her account suggests that she was passively complying with service-providers' perspectives of her needs.

Another described a deep-rooted suspicion of the mental health services, to such an extent that it prevented her from seeking help. She explained that when she was 16 years' old, she was admitted to an adult psychiatric hospital, an experience she described as 'horrible'. Asked if she would consult her GP (with whom she had a good relationship) if her mental health deteriorated, she replied: 'No, because the last time I talked to my GP they put me in hospital as well. So I don't really trust anyone'. She also reported having withdrawn from a relapse prevention group in her local area because another group member was a friend of her brother and she did not trust that her business would remain confidential. Asked if she would be prepared to consult with someone from EPIC [support group for people previously or currently in care] if she were feeling particularly low, she indicated her reluctance to do so out of a fear of being referred to the mental health services. She was prepared, however, to engage with the private services of the organisation One in Four, an organisation for survivors of sexual abuse. Consistency in the services that they provide appealed to her, although she was required to pay for the service.

That is private [One in Four service] but I don't mind paying for it because at least I know they will probably be there and I asked is there someone going to be there long term and they said yes. So it wasn't too bad.

It was not just continuity in mental health services that were important to participants; the need for continuity in service-provider relations was also a dominant feature of data, as was the threat to connectedness that transience in service-provider relations created, an issue to which we now turn.

Transience in relationships with service-provider

A strong and consistent finding in this study was that many relationships between young people and service-providers were ephemeral, and the transience of these relationships impacted negatively on participants. Before considering the threat to trust and stability arising from severed professional relations, an example of the appreciation of continuity in care is given:

The manager when I moved in, he was the only one that stayed the whole time that I had known from when I moved in . . . it was amazing, it was really great to find somebody like that in care.

There were, however, far more references in data to broken relationships with service-providers. A participant, who was in foster rather than residential care, reported having had multiple social workers and described as 'starting all over' each time a social worker came and went.

Yes I had social workers for my whole life. They always used to change, like the weather ...and sometimes it would be hard because you would only be really getting to know them and trust them and they are gone. You are starting all over again.

A number of participants were complementary about the social skills of individual residential staff, but did comment on the transiency of staff – 'There was different faces every day'. Another participant explained the effect on young people in residential care of the departure of trusted long-term staff. The particular scenario he outlined related to his brother, who was also in the care setting, and who had apparently shared private and personal information with the key worker and developed a bond of attachment with her. This bond was suddenly severed on her leaving the care setting, and the negative repercussions of this on the young person in question seem to have been exacerbated further by her failure to keep in contact with him, which she had promised to do.

You get to know the key worker and then she leaves, or he leaves. And you have trusted or told her so much and then she goes after a while. Even my younger brother grew very attached to one of the staff, her name was [name] and she was like, 'Oh I will keep in contact'. And then you just don't hear from them again.

Returning to his own experiences, that participant recalled how one social care worker had spent three months in the unit in which he resided and then without warning, 'never showed up again'. In his experience, the young people were never informed of details as to why staff left, and there may have been reason (such as illness) that might have made their departure more acceptable. Another participant reported a similar experience: When she was 15 years old she had a poor relationship with her social worker. She then was assigned a different social worker with whom she enjoyed a good relationship; however, that social worker was in the role for just three months, after which their contact ended.

One made the explicit link between the transience of these social care worker relations and both his own and others' subsequent difficulties in forming emotional attachments.

> And then you hear about people who come from care and find attachment very hard and I would, I would find attachment real hard, I find relationships real hard. I block myself off from that kind of trust area.

Another similarly reported experiencing difficulties with trust after a social worker with whom she had a reasonably positive relationship departed.

> I knew her [social worker] and trusted her so I could actually talk to her . . . And then she left, so I didn't trust anybody.

For one participant, the hurt caused by the fluid relationship to individual counsellors with whom he had shared the most private and painful experiences of his life is captured in the following quotation. Of note is his lack of faith that the therapeutic relationship with the counsellor who he was seeing at the time of the interview would endure, indicating that he had come to expect broken relationships in life as a matter of course.

> I have been in counselling since I was about seven years of age and they keep getting different counsellors for you every few months and that just hurts a lot more because you have to go back and tell someone your whole life story over and over again. Instead of having that one person you can rely on and you can talk to for a few years. The counselling that I am in now, she is probably going to get changed to a different person in another few months until I get onto someone else. So if you had that one person you could trust. And the same with social workers all the time, just as soon as you get close to one social worker another social worker comes in and takes over that place. So you have to start all over again and meet new people every single day.

Indeed, the sense of rejection experienced at the inconsistency of staff over time for one participant (referred to earlier in this sub-section), was viewed as a continuation of the rejection he had experienced with his birth mother and his lack of confidence in her reliability as a stable presence. In a poignant extract from his interview, he recollected that as a child

he would always 'wait at the window' when she committed to visit him, only to be let down by her failure to appear, and he directly linked this disappointment to similar feelings when staff presence was inconsistent.

> *I would look at my own experience and go, my ma didn't come out and see me that much and I would always wait at the window waiting for her to come and that kind of trust thing broke up. And I think that is the main trust thing that I would have, waiting for people. She'd say, 'I will definitely be out this time'. And then she doesn't show up. That is a major trust issue. So when you see staff not showing up it kind of shows you that they don't care. Like my mother didn't care, so you over-think trust issues as well.*

That participant went on to recount an occasion in which he been informed that he was to have a new key worker, yet was never introduced to her, and 'she hadn't been on the floor once'. Sometime later, she approached him and informed him that she was indeed his key worker, yet he reported having had no previous relationship with her. He described this situation as being 'unfair' on the young person and something that ought to be addressed. Moreover, he recounted the difficulty he experienced in trusting a new key worker and engaging with him/her in matters relating to his personal life.

> *Usually you get two key workers, but the first one you get you have a bond with so you trust them. But I can't trust people, that is just myself. I find it very hard to trust someone, so you give me someone I have never talked to before, I am not going to talk to them or I am not going to do the key working as planned.*

Another participant attended an addiction service for her drug-use during her time in residential care and reported having had a good relationship with the counsellor there when she was a regular attendee. However, inconsistency in staffing, as well as having reached the maximum age for availing herself of the services prompted her to stop attending, and also appeared to generate in her a sense of mistrust of the service.

> *I don't go to counselling any more because every time I went to counselling the counsellors either got sick or she is not working or she had to move on or I was too old to work with her. So I just gave up on it. I don't really trust anyone to do it with.*

That young woman also indicated that while she had enjoyed good relations with social care workers and social workers whilst in care, her previous experience of fleeting connectedness with some professionals impacted on the effort and the investment she was prepared to make to engage in new relationships with staff.

> *There were two staff that came in at the end of it when I was leaving and I didn't want to make a relationship with them because I knew I was leaving and that was it and I hate making relationships and then having to move on. I just don't get it.*

Furthermore, around the time in which she was leaving care, she experienced the loss of the social worker who had consistently managed her care for the duration of her care period, and with whom she had no further contact thereafter.

And then my social worker - I had her since I went into care until I left- and she . . . went on maternity leave at that point [at the time of leaving care] so I had no contact whatsoever.

Privacy and personal information

The fact that social care is organised around teams also had implications for the young people insofar as there was a perception that a high number of professionals are privy to information.

But when you are in care you have to see a counsellor at least once a week. So I agreed to see one guy and he wasn't too bad because the woman [other psychologist] was very, like, I'd tell her something and she'd go straight outside and tell.

An associated issue was the sheer volume of staff to whom the young person's actions were transparent, which increased the number of people with authority over the young person's behaviour. This meant that any transgressions of rules could result in being corrected by several staff, as opposed to one or two parents if the deviance had arisen in the context of a family. One participant contrasted the situation in residential care with that in foster care (although his information about the latter was obtained indirectly from others in his social circle, since he had no direct experience of this) by referring to how young people in residential care were reprimanded.

I think a foster home is completely different than residential, completely. Foster home is like a family put together kind of service. Residential, you are getting used to 26 staff. If you get into trouble you have to hear all this crap from 20 different staff. So you get into trouble on Monday, for the whole week you are going to hear from different staff - what you did and why you did it and how come you didn't do it? And that is really annoying. In foster care you are used to having two people, a mum and a dad. You usually have your mum going mad at you and your dad going mad at you and then it is over.

Another, who had been cared for by the same foster family since she was a toddler, described the impact of having professionals outside the family having oversight of her behaviour, including her sexual behaviour. She described how this layer of surveillance relegated to her a status other than 'normal' (the sense of being different, that participants had by virtue of their care status, is considered in Section 2). In the narrative that follows, she also proposed that monitoring as occurs for those in care controlled what information she imparted to her foster carers, and made her cautious about sharing certain information with them.

But I think what I hated about being in care, if you done anything the social worker was on top of you. And that is not what you want - You want to grow up and you want to live a normal life and who you class as your family now. And it is like if you do anything wrong your family can't discipline you, it has to be a social worker to come in and do it. And you'd be scared of that too because if you done something and you wanted to tell your foster family that you slept with somebody or whatever, you are not going to do that because the social worker is going to come in and talk to you and you are going to get a whole eating for it. Like you are not going to go and tell them what you done.

The intermediary invigilating role of social care professionals also had implications for levels of trust with foster carers, as suggested by another participant.

You can trust them [foster carers], you can and you can't. Like you can trust them to a certain extent, but you can't because you know whatever you tell them is going to be passed onto the social worker.

One believed that the reverse was also an issue – disclosing information to a social worker ran the risk of foster carers being informed of issues that the young person may wish to conceal from them.

Keeping personal information to oneself was one strategy used by a participant to retain control over her actions. She reported that once she reached 16 years she maintained her privacy by withholding information from social care staff about her physician appointments. Once staff became aware that an appointment was pending or had occurred, she indicated that they were eager to investigate the basis of the consultation. Whether or not she chose to disclose to staff the rationale for the visit depended on her own preference. It seems that that participant did retain a good deal of control over access to her own healthcare.

Participant: Oh yes! They were very nosey. 'Oh I am going to the doctor'. 'What is that prescription for?' They were very nosey - They liked to know what was going on.

Interviewer: And did you tell them?

Participant: Depending, well I would have said, 'I am on a contraceptive now, I am taking something'.

Key points: Section 6

- Relationships with service-providers during the period of care varied considerably, with both good and poor relationships reported.

- Relationships with mental health providers also varied, with some reports of disengagement with or suspicion of mental health professionals.

- A strong feature of data was that participants experienced high levels of transience in relationships with a range of service-providers in view of the defined time over which professionals occupied a role. This sense of transience hindered the development of a deep sense of connectedness to any particular professional and contributed to the young person's insecurity.

- Transience in service-provider relationships was experienced as distressing and stressful for participants and was sometimes viewed as a continuation of early rejection by the birth parents.

- Having multiple staff involved in care had negative implications for the young person's privacy and the containment of information about them. Those in residential care tended to feel that a team of professionals were privy to information about them. Those in foster care 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.

Section 7

Sex education and access to sexual health services

Introduction

In this section the focus shifts to a direct emphasis on RSE and sexual health service provision for YPIC. As indicated in the literature review, research has consistently found that YPIC report gaps in their knowledge about safer sex and lack information needed to access sexual health or contraceptive services (Scott & Hill 2006; Dale 2009; Dale *et al.* 2011). In order to uncover the needs of YPIC with regard to RSE, we first consider what participants in foster care conveyed about their foster carers' engagement with RSE and the extent to which they facilitated access to the sexual health services. We then explore how participants experienced health professionals' role in RSE. Turning to social care service-providers, it was noted in Section 1 that these are charged with having a formal role in RSE provision, and we consider what participants, particularly those in residential care, conveyed about their experiences of this. Attention then shifts to participants' accounts of RSE at school, from friends, and via the media. As most participants had some experience in an after-care setting, we also examine RSE and sexual healthcare provision for young people who have left residential care. Finally we outline what participants identified as the RSE needs of YPIC when they were asked directly about this.

Foster carers' role in RSE and in facilitating access to sexual health services

The amount of sex education reportedly received from foster carers varied considerably, with some participants indicating that foster carers did not engage in any sex education at all with them, while others described attempts by foster carers to provide RSE. These attempts in a few cases appeared to be stymied by the young people because the subject was embarrassing for them. For example, in one participant's description of efforts by her foster mother to engage in sex education, it appeared to be the young person (the participant) who controlled the dialogue.

> Mum [foster mother] tried to talk, like say when you were younger and you took your period or something, she would try to explain that to you, and then as you got older then she tried to explain about sex and stuff but I didn't want to talk to her. I used to walk out of the room, I didn't want to hear it. Because it was embarrassing because she always went back to, 'I remember when me and your daddy...' And I was like, 'Oh shut up'.

A similar use of blocking techniques was reported by other participant when her foster mother attempted to open a discussion about sex. The foster mother was reportedly prompted to raise the issue when she chanced upon the young woman's contraceptive supply about which she had been previously unaware.

> She [foster mother] started talking to me about sex. But like it is very embarrassing when your mother is talking to you about sex and I was like, 'Mam I don't want to hear about it, go away!'

Another strategy described by a participant was to claim that she already had a sound knowledge of sex, so additional sex education was unnecessary.

> She [foster mother] would obviously explain sex to me and stuff. But I used to tell her, 'I know, there is no use in telling me, I know what sex is. If you have sex you will get pregnant'.

The mechanisms described above of the young person effectively blocking the communication about sex with the foster mothers closely mirrored findings from a previous Irish study of parents in general (Hyde *et al.* 2009) in which participants reported that young people verbally silenced them, physically removed themselves and/or claimed to know it all already to avoid engaging in a dialogue about sex.

One reported that her foster carers (birth grandparents) never discussed sex with her because, she surmised, of a failure to acknowledge that she was sexually active.

> Mummy and daddy [foster carers] are old fashioned . . . But they wouldn't chat to me. If my daddy knew I was even looking [at having sex] he would kill me. I am 18 and he would still kill me.

Another issue to emerge that was deemed to impact on dialogue about sexuality between foster carers and young people was the perceived clash in values between the two parties. The impact of a generational gap where foster carers were in late middle-age was also raised. That participant went on to explain that normative practices had shifted dramatically since her foster carers' (her birth grandparents) youth and pushed them out of touch with understanding contemporary norms around adolescent sexuality. Lack of knowledge by foster carers of contemporary sexual health issues, she believed, also compromised their capacity to engage in RSE.

> Some parents . . . wouldn't even know about half the things you could catch. Whenever they were growing up it was like you got married and then you had wee ones . . . There was no such thing as contraception. Like my mum and dad [birth grandparents], they got married and they had never slept with anyone else, it was only each other and back in

them days there was no contraception - you just slept with them and if you got pregnant, you got pregnant and that was it. They don't know about that either. They couldn't pass it on to us if they didn't know themselves.

Another who experienced long-term foster care, also commented on the generation gap, noting that her foster carers were in their late fifties. She remarked that her younger foster sister, who was 14, was set to receive no parental RSE because the generation gap would be even more marked than was the case for her.

Another participant reported that her grandparents, with whom she was fostered, had never discussed sexual issues with her; although when she was 15 (shortly before the placement broke down) her grandmother suggested that, because she had a steady boyfriend, she might have to be prescribed the contraceptive pill in the future. She explained that although she had never had penetrative sex with that boyfriend, from the grandmother's perspective, the length of the relationship signalled the need to raise the issue. Other than that reference to accessing sexual health, the participant reported that sexual health was never broached by the grandmother.

In a separate case, the foster mother accompanied the participant to the GP to access the contraceptive pill when the latter was 16 years, the consultation being instigated by the young woman. According to the participant, although she had already been sexually active at this stage she concealed this information from her foster mother, instead presenting her motives as being pro-active and precautionary in advance of sexual debut.

Well obviously I told her [foster mother] I wasn't doing anything, I told her I wanted to go on it in case. She didn't know that I was doing anything but I just told her I wanted it just in case anything happened.

Apparently the foster mother accepted the situation and, in the words of the participant, 'just thought I was being smart looking after myself'. (The participant was prescribed the contraceptive pill, but revealed that she had not taken it consistently and became pregnant soon after this).

In another similar case, a participant who experienced menstrual-cycle difficulties, secured the co-operation of her foster mother in accessing hormonal contraception by emphasising the need to manage period problems. In this case, the young woman was primarily seeking contraception, but did not admit to this, because, she explained, 'Back then it was a big secret. When you get older, like, sex is a normal thing when you are older: you can talk about it openly'. She also conveyed her belief that sexual activity among young people should be accepted by adults: 'I think young people should be told that it is okay if you have sex. I think they should be made feel comfortable'. While other participants implicitly seemed to convey a sense that sex was a topic that was just too sensitive and awkward for young people and those

in the parenting role to discuss openly, this participant elaborated on the importance of foster carers actively engaging with the role in order to empower the young person. In the following quotation she asserts that the particular difficulties experienced by YPIC make RSE from foster carers all the more important.

> Interviewer: And in another context, generally with young people in foster care, should there be … Do you think foster carers have a role to play, or...?

> Participant: Well that is their parents. I definitely think they have a role to play, that is their parents, they are rearing that child so they need to . . . If they don't want the child to take a path that they don't want them to take then they are going to have to educate them. And the only way to educate them is to talk to them, bring them to workshops. Children in care are very vulnerable, the same as any other child, but when they have gone through trauma it makes them even more vulnerable and they will look for anything that they are craving. They will look for it in drugs and drink and sex. They need to know their foster child, they need to know when they are in need and they need to educate them.

Before leaving this section, it should be noted that birth parents were generally presented as having very little input into the young person's RSE, largely because of their peripheral engagement in the young person's life. There was one exception – a participant whose mother was in prison reported that she found it easy to communicate with her, as she was more like a sister than a mother to her during her early childhood. She indicated that she would talk to her about sexual matters but would be selective about what she might reveal.

Healthcare professionals' role in RSE

Many participants reported having come into contact with health professionals from whom they received some level of sex education. Relationships with health professionals, unlike those with social care staff, tended to be fleeting and intermittent and confined to healthcare consultations. A number of participants reported having received information about contraception in the course of medical consultations, particularly if the primary reason for the consultation was related to sexual health. (At least one participant presented as the basis for her consultation menstrual irregularities when she was primarily seeking contraception; she reportedly denied being sexually active when asked about this by the GP). A few others spoke positively about the service at well-woman clinics.

One participant expressed her belief that it would be intimidating for younger teens to attend sexual health services independently in light of the fear of being judged negatively for being sexually active.

> Because when you are in the health service you have your key worker, your social worker, you don't really know anything about sexual health services . . . But I think when you are younger you wouldn't really use them [sexual health services] anyway because there is

this sense of children would get scared and they would feel like they are doing wrong. I think young people should be told that it is ok if you have sex. I think they should be made feel comfortable.

The role of pharmacists in delivering sexual health services was also raised. One participant reported having accessed emergency contraception on two occasions in the previous year through a pharmacy. She described having felt too embarrassed to present herself to the pharmacist and thus arranged for her boyfriend to attend while she waited outside; however, as a requirement of the medicine being dispensed, she was required to have a consultation. During this consultation, possible side effects of the medication and bodily changes to expect were reportedly explained to her. (She was critical of the fact that she was required to pay a fee of €25 at the pharmacy, because she needed the medication on a weekend when the GP clinic was closed). Another participant indicated that while he was in residential care, social care staff regularly made residents aware of the location of the nearest pharmacy and encouraged them to use it should they require anything. The staff endorsement of using the pharmacy was sometimes relayed in a jocose way when residents were embarking on a night out.

Another criticism raised by a participant was that STI testing was not available through her regular GP, who she had reason to visit for the treatment of a minor medical condition. That she was required to attend a special clinic for this deterred her from attending, as the clinic hours clashed with those of her further education course.

Social workers' and social care workers' role in RSE and in facilitating access to sexual health services

The reported input into sex education from both social workers and social care staff varied considerably. Some participants indicated that they had received no RSE at all from social care providers; however, in the majority of narratives participants appeared to have been exposed to at least some minimal RSE. The need to use contraception if sexually active, or advice about the availability of sexual health services was generally reported to have been offered by either a social worker or social care staff, although such advice tended to be at a superficial level in many instances. In two cases, participants (both female) relayed that they did not receive any sex education because their social worker was a man, indicating an expectation that because of gender sensitivities, sex education would not be expected from a male professional.

Several participants reported having been advised by social workers of the need to use contraception where the latter became aware that the young person had started a relationship and/or where he or she had moved into mid teens. Social workers were also reported to have put young people in contact with sexual health services such as Well Woman Clinics. However, the fact that social worker contact was fleeting appeared to compromise the quality of the RSE they provided.

> *So I didn't really communicate well with the social workers; they came, they asked me a few questions and that was it. The staff in the house would be the best to do their own, maybe, programmes.*

However, the only RSE that one participant recalled having received during her time in care was when she was being transported in the car of her social worker. She described this as being 'hit' with issues, although elsewhere in the interview she indicated that her relationship with this particular social worker was trusting and positive. From the following account, it appeared that these sessions with the social worker were relatively detailed, with the social worker engaging in a sexual health assessment.

> *She was talking about contraception and the bar. She told me to get the bar in my arm or go on the pill. So I got the bar in my arm because it lasted longer, so then I done that. And then she talked to me about condoms and relationships with people. Was I in a relationship or anything like that? Basically nearly everything she talked about. She would literally drag it out of you!*

RSE within residential care appeared to vary considerably. For example, one reported that RSE was never conducted while she was in residential care, and she would not have felt comfortable raising sexual health issues with staff. Another participant referred to a 'closed' atmosphere around sex education during her time in residential care. She attributed this to her own reluctance to open up to the staff until the end of her care period. She did, nonetheless, recall brief references to condom use by social care staff. In light of her more mature stage of adolescence (18 years) in the after-care she reported being less guarded about sexual health discussions. The only information about sexuality that another recollected having received was via the 'Real Deal' programme[8] at a hospital she attended, apart from intermittent RSE from the social worker. Several others also reported that RSE was covered in residential care at a superficial level or not at all.

However, another participant relayed a somewhat different experience, as she and her peers at a high-support residential unit were reportedly open to RSE and requested an RSE input at the school that was associated with the unit (and located on the same grounds). She reported that school staff indicated that they were not in a position to provide RSE owing to a lack of facilities, suggesting that this be provided instead by staff in the unit. She explained that staff at the unit similarly passed the responsibility of RSE back to school personnel, and so RSE fell between two stools. That participant believed that the young people's voices were not being heard and described this as 'a lack of respect, really, for the young people because we were looking to be educated and we never were'. She went on to explain that when subsequently some aspects of RSE were covered, this was confined to the skill of how to use a condom and did not extend to the science of ovulation or the side-effects of hormonal treatments.

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8   The REAL DEAL - 'Live life b4 you give life' is a training programme comprised of six sessions facilitated by those who experienced teenage parenting. It is funded by the HSE Crisis Pregnancy Programme.

There were also a small number of accounts in which sex education and sexual health awareness were portrayed as a clear feature of residential care. At a setting that accommodated homeless people, one participant recalled an openness to discussing sexuality, and pamphlets on contraception and a supply of condoms were available. She also recounted that at that same location, there were 'group nights', which involved outside speakers delivering sexual health talks to groups of service-users. That participant was at a loss to recall from where these outside speakers came, but remembered a range of issues to do with relationships, sexuality and risk behaviours being discussed. In a subsequent residential setting, she reported having been furnished with a list of telephone numbers, including that of a sexual health clinic.

Another participant also had positive reports of RSE at residential care. He recalled that the key worker made herself available to undertake sexuality education, and the social worker indicated an openness to discussing sexual health if required. That participant reported having felt confident about which staff member to approach about RSE matters. He also noted that sex education had been covered 'in the house about five or six times'. He described as follows one particular programme designed to raise consciousness about different types of physical contact.

> *One way of doing it was group – everyone in the house. When we first moved into residential care they did this practice thing about red flag and green flag and what is the right type of hug and the wrong type of hug and what is the right touch and what is the wrong touch. So they did all that with us.*

In the house where he resided, the young man also recalled that information on safer sex was conveyed in special sessions.

> *We did five different sex education [sessions]. One was just dedicated to contraception and different types of contraception. And then they went through them one after the other. For a girl if anything happens and their pills as well and what they should be taking if you are with a girl and stuff like that.*

Indeed, that young man noted that when he compared what he had covered in the course of residential care with what friends had said they covered with parents, his sex education was far more extensive.

> *I turned around to them, and these didn't live here, I turned around to those and said, 'Who taught you about your own sex education, was it your mother or school or...?' First of all they said, their parents, no way. Most of them said school and the internet.*

School-based RSE

During their time in care, school (along with friends) was the most frequently cited source of RSE (after friends), although several participants had very sketchy recollections of what RSE had actually been covered there. While the number of YPIC in full-time education in Ireland is extremely high[9] a recurring finding across the sample was that missing school (mainly through truancy) and changing school were commonplace, making school-based RSE very patchy for many participants. Truancy was related to a disinterest and dislike of school; it should be noted that an unfavourable disposition towards school in itself appears to be an important risk factor for teenage pregnancy (Bonell *et al.* 2005; Harden *et al.* 2009; Hosie *et al.* 2007).

By far the most heavily cited aspect of school-based sex education was 'the talk' – an account of the anatomy and physiology of sex – that pupils in Ireland receive in fifth or sixth class of primary school. The dominance of 'the talk' as a remembered feature of school-based RSE reflects the findings from a sample of adolescents drawn from the general school population in Ireland a decade ago (Hyde *et al.* 2004). This demonstrates similarities in the experiences of YPIC and those not in care. The primary-school talk was described as 'basic' by one participant and the sex education book used in primary school as 'rubbish' by another. The latter recalled that the book in question referred to 'sperm', but did not explain the meaning of this, prompting her to ask for clarification and suffer the consequent mortification. Another recalled that in view of the age of the children in fifth class (approximately 10 or 11 years), there was a good deal of 'tiptoeing' around the issues. She remembered that a classmate asked a question about what a condom was, but the question went unanswered because of a belief that the children were too young for this information. Because queries had been left unaddressed, she believed the session to be futile. If the memories of participants are accurate (and memory is not always reliable) it would appear that RSE practices varied across schools: a participant in another part of Ireland recalled that in the fifth-class talk reference was made to the need to use condoms and another indicated (also during the fifth-class talk) that a banana was used to demonstrate how to use a condom.

In relation to RSE at secondary school, a few participants remembered this being delivered as part of *Civic, Social and Political Education* and *Social, Personal and Health Education* (mandatory courses in citizenship and personal education for Junior Cycle students (12-15 years)). Another participant reported that in the Applied Leaving Certificate examination, RSE permeated several subjects. A few others recalled having covered RSE throughout the secondary school years. Active learning seems to have been remembered more easily than passive instruction – one participant remembered that in fourth year, a presentation was made by guest speakers about HIV, and the class learned a song designed to convey a safer sex message, the words of which she could not recall. Another also remembered some of the details of this specific HIV-awareness day, including 'the song about AIDS'.

9   Child and Family Agency (2014) *Children in Care in Education Metrics: National.*

One participant was of the opinion that RSE was taught too late, and with insufficient emphasis placed on 'proper' sex education in first and second year of second-level school (aged 12-13 approximately). That participant also believed that the emotional aspects of relationships were largely overlooked. She described the way in which the emphasis on pregnancy and STIs did not prepare vulnerable young women for the potential sexual exploitation that lay ahead or help them to understand gender dynamics in heterosexual relationships.

> *Like it is important for young people to know about pregnancy and STIs and stuff, but I think young people do know that already. They do know if you have sex and you are not careful you are going to get pregnant . . . You know the way when you are in sex ed. and they talk about pregnancy and STIs and stuff like that, but they don't actually talk about the emotional part of it. When you are with a boy, they don't teach you boys will be boys and boys will say anything to you and do whatever to get what they want out of you . . . If girls are vulnerable they are going to do anything so they can keep him happy. Like I only know this now because I am older. When you crave emotion from someone like that you are going to give them what they want, so they should teach you if you really want him you shouldn't give him what he wants. I think the emotional aspect isn't . . . I think they just worry about pregnancy and STIs. And I am not saying they are not important, they are, obviously, but the emotional part is important too . . . I think there should be terms that are focused on emotions and trusting someone and knowing when the right time is to do something.*

One of the other issues raised by participants was the difficulties that teachers experienced in teaching RSE to a disruptive class, particularly with young men.

> *The teacher just didn't teach us - She got upset with everything because the lads would give her a lot of trouble and she would run out of the classroom crying, so you couldn't learn anything apart from your book.*

The disruptive effect of young people in a group and the negative effect that this had on learning in a classroom were also raised by a male participant. His recollection was that the very fact that the topic under discussion was sex was enough to impact on the learning environment and to create chaos in the classroom.

> *But I think that is wrong this sex education in schools because it doesn't help. You have a load of little bastards who are all roaring and screaming, 'Look at that!' None of them are actually paying heed to anything that is going on. It is just the fact that they are all sex things and they are talking about sex. It is not going into their heads . . . And if you ask any one of them can they remember what happened in those sex education classes they will tell you, 'I can't really - only the fact that wasn't he laughing over there about something?'*

The role of friends in RSE

Several participants identified friends as a main source of information about sex. The present study offers some insights on the nature of friendship exchanges about sex and the possible impact of this within friendship networks.

As indicated elsewhere in this report, several participants indicated that they had difficulty in trusting others that made them cautious about friendships. In addition, even in established friendship networks, knowledge about sex was not indiscriminately exchanged among friends. Talking about sex with friends was not just a means of increasing knowledge about 'scientific' aspects of sex, but was also a way to discuss relationship difficulties and share emotional turmoil. A narrative of one participant indicated that there was a balancing act in how much to disclose to friends about problems with her boyfriend while also attempting to protect him from criticism and from friends' censure. In the following extract, she described the delicacy in balancing loyalty with sharing pain. The expected responses of friends regulated the amount and type of information the participant divulged.

> Interviewer: You said you would talk about the relationships. Would you talk about the emotional aspects to your friends?
>
> Participant: Oh yes! I'd be pretty hurt or . . . But then sometimes when you really like someone you don't want to . . . I would be a pretty private person - I don't really like expressing how I feel - so that aspect would be really hard. It would have to really hurt me to talk to my friends about it. But I think, because when you are with someone, too, you don't want anyone thinking that they are a bad person either. That is the way I look at it. I had a lot of trouble with my ex, we used to fight all the time. But I would never say to my friends, 'Oh he is this, that or the other', because I wouldn't want them to think negative of him . . . I would have been quite protective of him, very.

Her account suggests that certain aspects of a relationship may remain hidden out of a sense of loyalty to a partner or even shame.

The accounts of participants also suggested that friends have a regulating role in judging the sexual behaviour of each other and gave a measure of the extent to which a sexual practice was deemed to be acceptable or not. This reinforced norms within the peer groups and gave an individual a sense of what behaviours were permissible and what might meet with distain.

> I wouldn't really like people knowing that I had unprotected sex when I was this age with somebody that I wasn't in a relationship with. I would be insecure about that a little bit. I think I talked to one of my friends and I think she gave out to me: 'You eejit - no condom?' That is what she said to me.

One reflected back on having reprimanded friends who she believed to be sexually promiscuous about their indiscriminate sexual behaviour. Her narrative suggested that she privileged one particular discourse (that for women, sexual propriety was required) over another (that women should enjoy sexual liberty).

> *Participant: I had friends that I said it out straight about it [being promiscuous]. And you'd be honest with them and say, 'Calm yourself down there'. Because it is not on, getting yourself a name, and I don't want to be walking around with somebody who is dropping their knickers for it any time they got horny. You know what I mean?*
>
> *Interviewer: And would they have listened to you?*
>
> *Participant: They would and then they wouldn't. You would think they are but then they would just go back to their old ways, they do. I am not mammying them so just leave them if they are not going to take the advice.*

Discussing sex with friends also had the impact of normalising particular behaviours. In the context of a discussion about interpersonal coercion, where one individual coerces another, usually verbally, into an action (Finkelhor & Yllo 1983; Hyde *et al.* 2008) and social coercion (group norm influences) to engage in sexual activities, one participant was of the view that peers imitate each others' behaviours.

> *They are just listening to other people and thinking, 'Well if they are doing it I am going to do it'. They don't know what can happen you.*

Reflecting back on her first sexual encounter, one recalled sharing this information with friends about whose sexual escapades she was already aware. Sharing information in friendship networks allowed one to gauge one's behaviour in relation to peers and to have a sense as to what might be deemed acceptable according to group norms.

> *Interviewer: Did you talk to anybody at the time [after first sex]?*
>
> *Participant: Just my friends, just to say, 'Oh my God I had sex last night'. But they wouldn't be like, 'Oh my God what did you do?' It was just because they all did it before, I was the last one out of our group to lose my virginity. . .*

Another similarly learnt what sexual practices were normative in the group.

> *That is where you learned it, from people talking and your friends talking or one of your friends coming and saying, 'Me and such and such done whatever'. That is where you learned it, from listening to other people.*

Some also spoke about the insularity of the peer group, which allowed young people to completely exclude those in the adult world.

We never really talked to anyone - It was just ourselves that we used to talk to. Because when you are that age, grown-ups is a no-go. You don't talk to grown-ups about stuff like that. Like I wouldn't come home and tell my mam because I know I would be killed. So you don't.

Discussing sex with friends was not merely about learning about sex (receiving sex education) but also about making judgements and creating and reproducing norms.

Before leaving this section, it is worth noting that one participant who had experienced residential care asserted that young people would be more responsive to peer-led sex education than alternatives modes. Her view was that YPIC would be responsive and attentive to her message in view of her experience of having been in care.

If I was to go and speak to someone now that is in care they would have a better time, they would listen to me better than they would anyone that wouldn't have a clue what they are talking about if they just read it out of a book.

The media as a source of information about sex

A few participants reported using the internet to access information about sex, including verifying information relayed by friends, while others indicated that they did not use the internet for information about sex and contraception. Print media were also a source of information, including tabloid newspapers (sensational stories) and leaflets at the premises of health clinics. Most participants used the internet as a general source of information.

Sex education provided at after-care facilities

At the time of the interview, a strong feature of data were reports that after-care services provided good levels of RSE, and some supplied condoms. In one case, leaflets and condoms were delivered (unsolicited) to the letter boxes of service-users. A few participants described having availed themselves of the services of the Youthreach youth club at which RSE was delivered by youth workers. There was also reference made to a Women's Health Centre where good information about STIs was conveyed at a course to which service-users were invited.

As far as relationships were concerned, the impact of these on substance and drug abuse and vice versa were a feature of counselling at an after-care drug recovery centre that one participant attended. Since advancing to after-care, another participant felt a greater readiness to discuss relationships and sexuality with her key worker. She attributed this to her more mature years. Her account also indicated a sense of awareness of choice around whether to share or remain private about sexual health matters.

With my key worker, yes. I think it is because I am older and I am more able to open up when I want to. I can be private about some things and then when I want to open up or talk about things I will.

One reported that her counsellor (in after-care) would 'chat a little bit about' sexuality, but she qualified this by adding, 'But obviously I know now - I am 18', suggesting that there was an expectation that by the age of 18 sufficient RSE would have been acquired. While after-care services appeared to offer more RSE and facilitate access to sexual health services compared to (pre-18) care settings, there was some variation in data, with a few reports of sexual health never having been alluded to by after-care providers.

Sex education: what would young people like?

Participants were invited to propose recommendations about sex education for YPIC, and a disparate range of issues emerged. The first four identified below were mentioned by more than one participant; each of the others was proposed by an individual participant. Participants recommended that:

- A greater amount of RSE be provided by social care staff.

- Scare tactics be employed to drive home the message regarding STIs and greater emphasis be placed on the negative consequences of unprotected sex.

- Young people and/or care leavers be involved in RSE delivery.

- Greater attention should be given to the emotional dimensions of relationships and sex, particularly around the additional vulnerabilities of YPIC.

- RSE be delivered once a week at secondary school rather than irregularly.

- In situations of 'personality clashes' or other interaction difficulties between staff and residents, social care staff should be substituted with those found to be more compatible in delivering RSE.

- Foster carers should have a greater role in RSE.

- A sexual health advisor in the HSE be appointed to undertake RSE.

- The sexes be segregated in RSE classes to avoid embarrassment.

- An anonymous telephone service should be made available so that sexual health issues may be discussed confidentially without a fear of a foster carer or social care worker being privy to the consultation.

- Programmes such as the Real Deal should be made available at youth centres and leaflets made available within residential settings.

- The services of organisations such as EPIC should be engaged in delivering RSE.

- RSE should be weaved into the structure of existing key-working meetings between young people and social care staff/social workers.

- STI screening should be made available as a standard component of general practitioner services.

- Career guidance should be available via the HSE to advise on higher education.

Key points: Section 7

- Participants' accounts suggested that for those previously in foster care, 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.

- Some foster mothers accompanied their foster daughters to the GP to access sexual health services.

- Health professionals reportedly did deliver basic RSE in the course of defined consultations.

- The frequency and content of RSE provided by social workers and social care workers varied considerably. Some reports suggested that little or no RSE was delivered by these service-providers while other accounts suggested that they provided relatively in-depth and regular RSE. Some residential settings appeared to provide a good level of RSE while others did not.

- One of the main sources of information about sex reported by participants was school; however, exposure to RSE at school seemed to vary. A strong theme was an inconsistent pattern of school attendance, which may have resulted in participants having less exposure to school-based RSE. A criticism of school sex education was that there was insufficient attention given to the emotional aspects of relationships.

- Friends were frequently cited as sources of information about sex, but the kind of sexual knowledge shared among friends appeared to be focused on sexual behaviour that reproduced peer group norms and expectations.

- The internet was used by some for seeking and checking out knowledge about sex, but not used for this purpose by others.

- Some after-care providers appeared to offer good levels of RSE, but 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, mainly focusing on direct sex education.

Section 8
Sexual experiences and sexual competence

Introduction

How participants came to be sexually active and their approach to sexual relationships since the experience of first sex may be understood with reference to the concept of sexual competence referred to in the Introduction to this report. To recapitulate, sexual competence or readiness is gauged according to four criteria (Wellings *et al.* 2001; Hawes *et al.* 2010):

1. Contraceptive protection
2. Autonomy in decision-making (not influenced by alcohol or peer pressure)
3. Consensuality (both partners equally willing)
4. Absence of regret (the timing being viewed as appropriate for the person).

In order to examine participants' experiences of sexual relationships and their physical and emotional preparedness for such experiences, we consider their accounts of their first and subsequent sexual experiences in light of each of the above components of sexual competence. First, however, a brief overview is given of participants' reported age at first sex.

Age at first sex

Of the nineteen care leavers interviewed, all apart from one indicated that they had experienced penetrative heterosex[10] (sometimes referred to as 'sexual debut' in social science literature), the first experience of which occurred between the ages of 12 and 17 years, with the vast majority occurring before the age 17 years. Numbers were roughly equally divided between those who reported first sex at 14, 15 and 16 years, with smaller numbers at ages 12, 13 and 17 years. These figures for the early age at first sex are in keeping with those found among YPIC in the HBSC survey (Burke *et al.* 2013), but the fact that ours was not a representative sample means that numerical evidence is speculative.

Sexual competence criterion 1: Contraceptive protection

With regard to contraceptive protection, a strong theme across the sample was the inconsistent use of contraception both on the occasion of first sex and/or in sexual encounters subsequent to this. Indeed, virtually no participant reported the consistent use of dual

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10 It is acknowledged that the focus on heterosex as a marker of sexual transition is problematised in some bodies of scholarship, particularly feminist literature, where penetration is seen as a manifestation of male power. In addition, privileging intercourse over non-penetrative activities is constructed as undermining the value of other forms of sex from which women may derive more satisfaction (see Jackson 1999). However, in view of its significance in relation to pregnancy, we retain a focus on penetrative heterosex here.

methods (condoms and an additional contraceptive, usually hormonal), which is considered to be good practice and promoted by sexual health educators.

Condom-use

The reasons given as to why condoms were not used consistently often crossed over to the second component of sexual competence, namely, impediments to autonomy in decision-making owing to intoxication with alcohol or peer influence (both of which are dealt with in a general way in Section 3). There were other reasons also for non-use of condoms, one of which might be described as a general apathy and passivity about safer sex. This is captured by a male participant who was at a loss to explain why he did not practise safer sex.

> But I never used contraception at all. I never would have paid heed to anything like that ... I don't know what it is.

In the following quotation, another male participant, who reported that he experienced first sex at 15 years and had had sex with approximately 40 women since, described his indifference about using condoms. It is notable in the extract how he demonstrates some knowledge of the consequences of unprotected sex and revealed that he had sought testing for STIs; nonetheless he conveyed a generally nonchalant disposition about the potential risks of unsafe sex. He described his consistent risk-taking with a tone predominantly of indifference rather than self-criticism.

> Like some of the stuff, you can see what happens if you don't use condoms – STDs and stuff, that is kind of scary all right. And if you are young and you are out drinking and going to discos and stuff, you are not exactly going to use a condom and not many girls are going to be on the pill or whatever . . . I have had unprotected sex before I got with my girlfriend. I had sex with 40 women . . . I never did use condoms or any safety . . . It was just me being me, I got paranoid then and I went and got checked but there was nothing ever wrong . . . To this day I don't use condoms with my girlfriend.

(That participant's reference to intoxication with alcohol as a contributory factor in his non-use of condoms will be considered further on).

When the young women were asked about condom-use, their accounts suggest that they relied on the male sex partner to supply and use the condoms. However, references to the use of hormonal contraception were a dominant feature of their narratives.

Hormonal contraception

With regard to the use of hormonal products as contraceptive protection, a fairly high proportion of the young women reported having used a method of hormonal contraception at some stage, in almost all cases after experiencing first sex. In a number of cases the move to hormonal contraception was prompted by either the foster mother for those in foster care, or

the social worker for those in residential care after the young person's sexual activity came to the fore or was suspected. With regard to hormonal contraception, high levels of adverse effects were reported; these often resulted in the contraception being abandoned, thus exposing the young woman to pregnancy. When talking about the side-effects of hormonal contraception it was very common for the young women to describe psychological difficulties such as anger management, depression, self-harm and severe mood swings. For example, one participant described having used the contraceptive pill during her second relationship (condoms were used for first sex at 13 years), yet she revealed that she stopped using this because of unpleasant side-effects (mood swings and alopecia). Her current method of contraception was condoms, which, she revealed, were being used inconsistently.

> Participant: I went off the pill then because it set my hormones all over the place and I can't cope with crying and hormones and breaking down and all. So I came off that and just started using condoms again and sometimes you wouldn't even use them.
>
> Interviewer: You take risks?
>
> Participant: Yes.

One participant, who was 18 and in a sexual relationship of less than a year, had abandoned using contraception altogether. She reported disliking the soreness associated with placing hormonal implants ('the bar') under her skin, along with the itching sensation that she had heard about from others, which, she believed, would prompt her to 'reef it out'. (It should be noted that this participant had a history of self-harm). Another participant, who became pregnant at the age of 17, rooted the cause of her pregnancy in her reluctance to take hormonal contraception as advocated by her foster mother because of her (the participant's) nervous disposition.

> Well my foster parents were constantly trying to get me on the pill and things like that, but the problem is I wouldn't take it. I am a very nervous person, I would be afraid of the symptoms of medication . . . I don't like trying new things out. That is how I got pregnant because I wouldn't take any pill.

By contrast, another explained that her foster carers were opposed to her using hormonal contraception because of their belief that it exacerbated her depression. She too became pregnant at the age of 17. During the interview, she initially indicated that the contraceptive pill had failed; however, later in the interviewed she described her pregnancy as arising out of having 'taken a risk' by not taking the pill as prescribed. There were other examples of user-efficacy factors in the accounts of participants that resulted in pregnancy.

> I was on the pill but it was actually January of that year, it was actually [names family event], so I had gone to [the event] and I didn't plan to stay up that night. So I stayed up but I had no pill with me for the next morning. So my boyfriend was along with me and I didn't have my pill with me and we didn't use anything and then a few weeks after that I was being sick.

Based on information that she had acquired through friendship networks, another participant believed that the reason why so many young women at her school became pregnant was because of user-errors associated with hormonal contraception.

Reasons for non-use of contraceptive protection

Lack of knowledge

While several factors (particularly associated with lack of autonomy in decision-making and apathy towards consequences) often combined to explain risky sexual behaviour, lack of information about safer sex and fertility as a basis for non-use of contraception was cited by a few. Three of the teenage mothers identified a lack of knowledge as the key reason why they became pregnant. Two of these were young non-Irish national women, each of whom described a closed culture around discussing sexuality within their own ethnic group, particularly with parents. One of these, who came to Ireland when she was 13 years old, reported that she did not have any knowledge of contraception, although aspects of sex education were covered in her transition year at school.

> If I had known about contraception before I wouldn't be in this position now. I don't really know much and my parents don't even tell me at this stage you should be doing this. I don't know much at the time.

Similarly, another participant, also a teenage mother, who came to Ireland when she was ten years old described her lack of knowledge, which extended to not understanding the basic physiology of sex when she had intercourse at the age of 12 (in the context of a level of duress, which we consider in the next section).

> It is just so absurd. You would never have the sex ed. talk . . . I had lost it [virginity] anyways but I still didn't know really what had happened or where anything was supposed to go or anything about sex ed. or anything.

Another participant, an Irish national, attributed her pregnancy directly to a lack of knowledge.

> And I just kept looking back and saying to myself, 'How did I get pregnant?' I was so safe over the years, how did I ever get pregnant? Because we were never told that there is a gap in the month where a woman will fall pregnant . . . We didn't know nothing about that. I didn't know fully about the whole sex education until I actually fell pregnant and it was the nurses and midwives in the hospital that filled in the gaps for me . . . And they had to sit down and explain everything to me and they explained that between 12 and 15 days in a women's menstrual cycle, that is the most time that they had to get pregnant and this and that. And I never understood or I never knew what that was.

Notwithstanding the contribution that a lack of knowledge played in that participant becoming pregnant, it appeared from other parts of her interview that a number of factors were also at play in how she approached contraception. Her narrative indicates that a complex myriad of factors may work together to increase vulnerability to a pregnancy, of which knowledge gaps are but one. The participant's response to the pregnancy (conveyed in the quotation that follows) was one of positive acceptance in the context of chaos and uncertainty in her life (drug use and the threat of homelessness).

> And then after that I turned 18 and just soon after I turned 18, three months after turning 18, I was clean off heroin. I would say about twelve months and a couple of months after turning 18 I fell pregnant on my son. And with that, it wasn't a shock to me because it was something that I wanted and something that would keep me safe and sane.

While these three teenage mothers attributed their pregnancies primarily to a lack of knowledge about sex, there were others among the non-parenting participants who reflected back on their earlier sexual experiences in which they described gaps in their understanding as contributory factors in having unsafe sex. One described her first sexual experience, at the age of 14 as, 'Just one of those things that happened very fast'. No contraception was used, and it never occurred to that participant to access post-coital contraception, as she had no knowledge of it at that stage since 'nobody talked about it'.

However, overall it appeared that a lack of information was not the sole or even primary reason for engaging in unsafe sexual practices. Some accounts suggested that participants continued to take risks even where they appeared to have at a least basic knowledge of sex. This concurs with findings from a recent qualitative study of 24 young women in England who had recently had an abortion, which found that lack of knowledge was rarely cited as a reason for them not using contraception (Brown & Guthrie 2010).

Lack of agency (pro-activity) in using contraception

Access to and use of all forms of contraception require at least some level of effort and agency on the part of the user, and this may have explained non-use of contraception in some cases. However, even when condoms were easily at the disposal of the user, as was the case for one of the male participants, this did not ensure that they would be used. The participant described how his foster mother supplied condoms, yet he reportedly never used them because of competing influences on his sexual behaviour, namely, peer pressure (this will be dealt with under Criteria 2 of sexual competence).

> Interviewer: And had your foster carer talked to you about...?
>
> Participant: She did, yes. She used to buy me condoms and stuff but I never really used it ... The information was there, you just don't listen, you are cool when you are that age ... It is just more peer pressure than anything else.

While there is no legal age requirement on accessing condoms, this example highlights the dilemma faced by foster carers between their requirements to report suspected sexual behaviour and their duty of care to the young person in their care.

That participant's observation that information is available yet not acted upon is an important one, and points to an issue that has been under-developed in sexual health research to date, namely motivation and receptiveness of the individual to prevent pregnancy and STIs. This suggests that the heavy focus on transmitting knowledge – a feature of conventional sex education – underpinned by a view that more teacher input and information brings better results, may be misguided. Let us consider a few more examples where apathy towards safer sex was in evidence.

Another participant admitted to taking sexual risks 'all the time', in spite of having received sex education, reportedly with a heavy emphasis on STIs, delivered at a Women's Health Centre through Youthreach. During the interview, she conveyed her understanding of the need for contraception and the morning-after-pill, having previously explained that she had engaged in risky sexual behaviours in her early teens.

> Interviewer: Did you use condoms at the time [first sex]?
>
> Participant: No.
>
> Interviewer: What did you do then? What about the morning-after pill?
>
> Participant: No I didn't even know what that was then. Nobody talked about it. I just waited, well I am here so I am all right.
>
> Interviewer: Did you take any risks since then?
>
> Participant: Yes, I do all the time.

A level of anxiety about becoming pregnant or contracting an STI is arguably necessary in order to be pro-active and ensure consistent access to and use of contraception. This requires effort and awareness of risk, as was evident in the account of one young care leaver. She described having been promiscuous in her teens, and having unprotected sex after her first sex at the age of 16 years, because, 'The fear of pregnancy wasn't there when I was 16'. However, she reportedly used the three-monthly hormonal injection and later a hormonal implant (that protects for three years) once the realisation of risk registered. One participant described having become 'scared and panicked' after having unprotected first sex, and others had availed themselves of emergency contraception, demonstrating a strong level of fertility awareness. However, several narratives indicated that no fear and anxiety whatsoever was experienced after having unprotected sex.

Heightened consciousness of the possibility of a pregnancy, which underpins pro-active contraceptive use, is also lacking in the account of another young care leaver. That participant,

a teenage mother, recalled the contraceptive practices that led to her pregnancy by explaining that on a night away from home with her boyfriend, she had forgotten to pack her contraceptive pill. The couple had sex, and once back in her home the following day, she resumed taking the contraceptive. Yet, it never occurred to her that she might have exposed herself to pregnancy, and missing a pill did not worry her. Even weeks later when her period did not arrive, the fact that she might be pregnant had not occurred to her. It was the increasing size of her breasts that caused her to consider that she might be pregnant.

> *I was due my period and I never got it, and my mother was always saying to mark it on the calendar when you get it. So then when I didn't get it I thought . . . And I just never took any notice about why I wasn't getting them. Then I got these pair of boobs . . . I thought Jesus, something is there. That wasn't too bad. And then I kind of knew then after a few weeks. So I found out when I was about eight weeks, so it was kind of funny . . . So it didn't even click.*

That participant was pregnant for the second time at the time of the interview because of circumstances not dissimilar to those that brought about her first pregnancy. She explained that she had been using a contraceptive 'patch' (a transdermal adhesive that releases synthetic oestrogen and progestin hormones via the skin to stop ovulation), which was to be applied to the skin continuously for three weeks and removed for a week before re-applying a fresh one (this is how the appliance is intended to be used). However, on one occasion, following the week without it, she was two days late in re-applying it, during which time she became pregnant. However, it was only when her period was late that she realised that she might be pregnant.

A lack of anxiety about becoming pregnant in the immediate aftermath of having had unprotected sex (during which time emergency contraception could be accessed) was evident in other accounts. Reflecting back on when she first started having sex at 15 years, one had difficulty recalling how she felt after unprotected sex and whether she was concerned about having left herself exposed to pregnancy. It seemed that it was some time later before an awareness of having exposed herself to risk began to set in.

> *I don't know, I was 15. I have never talked about this before, really. It is mad, it is crazy. At the time I don't know if I was worried or not. I was fine. And then everything started dawning on me soon after and you start thinking to yourself: that was very silly.*

Another described a similar response to unprotected sex, except that she admitted to continuing to take risks. When asked how such sexual risk-taking might affect her future plans to attend college, her response suggested a sense of denial that pregnancy would occur, interspersed with an intermittent realisation that it might.

> *Interviewer: How does that fit in with your plans [for college]?*
>
> *Participant: Taking risks? You don't even think of it and then you are like, 'Ahhhhhh!!!'*

However, that participant did report having used emergency contraception on two occasions in the previous year, suggesting that she did experience an awareness of her fertility on those occasions.

The denial of fertility here mirrors the sense of invincibility to pregnancy reported in a previous Irish study of women who became pregnant (Hyde 1996), indicating that sexual risk-taking is not confined to YPIC.

There was also a participant whose apathy to safer sex was associated with an indifference to becoming pregnant. This did not amount to actively planning a pregnancy but rather to being passive about taking the necessary measures to prevent it. That participant, who had reportedly dispensed with using contraception in view of the side-effects of hormonal contraception, when asked at interview how she would feel about becoming pregnant, revealed that it would upset her (birth) parents but she herself would not respond adversely. She also revealed that her boyfriend (of less than a year) would be happy to become a father. It should be noted that this participant had a mild intellectual disability and her responses to almost all of the interview questions tended to be brief and her demeanour largely passive about a host of issues.

Self-determination around contraceptive protection

Not all participants reported being currently remiss when it came to contraceptive protection, although virtually all had been at one stage or another. What tended to distinguish the small number of current consistent users of contraception from inconsistent or non-users were factors associated with the individual, such as the motivation to seek out information and be receptive to it when it was offered, and a willingness to act on it. An extract from the narrative of one young care leaver suggests that the knowledge provided by her GP contributed to her good contraceptive practices.

> And then when I was 16 I went out with this person who was a lot older than me and in that sense I wore protection or whatever and was heavily advised from my doctor and stuff.

Another participant reported that she had attended her GP 'constantly' since she was about 17 and had been using a hormonal implant. She described being very anxious to avoid a pregnancy, revealing that she had 'a big phobia about getting pregnant. I still don't want to have kids to this day. That is just personal reasons, I don't think I would be able to cope with it'. A small number of others who were anxious to prevent pregnancy indicated that of their own volition, they sought out further, more-refined knowledge around contraceptive protection.

In these narratives – small in number – the determination to use contraception consistently was largely self-directed. For example, one young person's recollection was that nobody had advised her to use contraception; rather, the impetus for this came from her own resolve to

avoid a pregnancy and a heightened consciousness of fertility arising from the high number of girls becoming pregnant at her school. Also evident in the narrative is an explicitly expressed desire that she did not want to become pregnant.

> But in the school I went to when I moved to [place name] so many girls were getting pregnant, there was all bumps, it was just ridiculous. Nobody had a clue. Nobody particularly said to me, 'Go on the pill, make sure you don't get pregnant'. I just knew, I got into a relationship and it was a five-year relationship and I knew it is a thing that I am going to need for the next while – I don't want any babies.

Another participant also revealed that her use of contraception was intrinsically motivated, during which she became an active learner in taking control over her fertility. This involved her actively seeking out information, including knowledge of reproductive physiology around ovulation.

> Interviewer: That is the thing we are trying to get at a lot: Did you have the information? Did you have a good doctor? Could you get contraception?

> Participant: You see I researched myself, and I still do to this day, I would research everything myself and I know what contraceptives to be on and when I have to take it and how it affects me and what days you can be pregnant and the likes of that. It is kind of my own research, really . . . No one advised me, my foster parents wouldn't have advised me. I think my social worker went over it with me at the start of care but I can't really remember, but it wasn't brought up again.

There was also an indication from another participant's account that where the type of contraception was determined by others rather than the young person him/herself, the motivation to consistently engage in using that method became problematic. That participant described the pitfalls of failing to take responsibility for contraception, which in her case appeared to be determined and driven by service-providers. She described her own concerns as being having been discounted by staff and she discontinued using the contraceptive.

> And it was the staff that made the decision of what contraception you were going on. I was on the pill. I kept forgetting to take the pill. Then I was put on the injection and the injection just completely disagreed with my body and I was trying to explain it to the staff and the staff were like, 'Don't be ridiculous, just because you don't want to be on any contraception, it is better than getting pregnant'. So I took myself off it because I was getting awful migraines from it.

(That participant subsequently became pregnant).

In this section, we have identified learner-focused factors, such as learner motivation and attaining skills for further inquiry as important in understanding why some young people

display higher levels of competence around contraceptive protection than others. Much literature on RSE proposes the provision of greater levels of teacher-focused RSE, with the emphasis on the content and frequency of delivery of RSE. Yet, in education more widely there has been a shift from the focus on teaching to a focus on learning (Barr & Tagg 1995), that is, a shift from merely transmitting knowledge to considering strategies that promote active engagement of the learner in learning. The focus on learning includes enabling in the learner to develop techniques for seeking information in a world of rapidly changing information. This clearly requires a motivation on the part of the learner, something that may be developed through educational techniques that foster active learning. Clearly, wider issues such as socialisation and socio-economic grouping have a pervasive effect on motivation and self-determination, and these may present greater challenges for YPIC than those not in care.

As indicated earlier in this subsection, contraceptive protection as an indicator of sexual competence is often cross-cut by aspects of the second criterion to which we now turn: autonomy in decision-making.

Sexual competence criterion 2: Autonomy in decision-making (not influenced by alcohol or peer pressure)

With regard to the second indicator of sexual competence, autonomy in decision-making, a strong feature of data was that autonomy tended to be undermined by alcohol intoxication and/ or the influence of peers. There were strong links between this aspect of sexual competence and the previous one insofar as the use of alcohol reportedly was associated with unplanned sex and the non-use of contraception.

Alcohol diminishing autonomy to engage in sex

If we first consider the influence of alcohol, it was reported by a few participants that first sex was unplanned and happened after alcohol had been consumed. In one such case, a participant's first sexual experience was with man with whom she had only been relatively recently acquainted and alcohol intoxication appeared to impact on her thinking about contraception.

> Interviewer: And had you used contraception?
>
> Participant: No because I never even thought about it, the drink came into it, the drink and I never thought about it . . . I had a few drinks before I left. And then I went off and I met my friend and then I met my boyfriend, and . . . the drink . . . I was meeting him on and off for maybe a month or two, so it was very soon. I barely even knew him.

Another reported a very similar experience.

> Participant: My first time I wasn't sober, I had been drinking vodka.
>
> Interviewer: And do you think you wouldn't have taken the risk if you had been sober?

Participant: I probably wouldn't have, I don't think it would have happened there and then like it did if I hadn't been drinking all night.

Interviewer: And did you know him well?

Participant: Not particularly well, no . . . We weren't in a relationship with each other, we just knew each other and we went off one night together to [place name] when it happened.

Before moving on it should be noted that the influence of alcohol may be more marked in a context of general apathy about contraceptive use.

Influence of peers

Autonomy in choosing to enter into sexual relationships was also reportedly compromised by a sense of influence from peers to engage in sexual activity. Peer influence suggests that an individual may not actually be explicitly coerced into a particular activity but merely feel under pressure to passively conform to group norms to avoid exclusion. However, what some participants described was closer to the concept of pressure than influence, insofar as explicit and overt derogatory labels were reportedly applied to those who revealed that they had not yet experienced penetrative sex.

Some young girls were different to the others, some of them were very young [sexually active], some of them weren't. And it was kind of like, say if you were in school there was a lot of pressure on you. If you went into school at 17 or 18 and said that you had never slept with anyone, that was terrible . . . you were called all the names under the sun.

An example of having experienced peer pressure came from a participant, whose narrative (below) indicates that her sexual debut was strongly influenced by peers in an effort to avoid being bullied. In her account she implicitly links the non-use of contraception at first sex to her overriding concern to lose her virginity, to avoid censure from her peers.

Participant It was just a friend, he was a friend and that was it.

Interviewer: And had you used any protection or had you thought about it?

Participant: No, didn't even think about it. Because everybody is sitting there and they are like, 'Oh yeah you are a virgin'. And I was like, 'No I am not'. But I was and I ended up having sex.

What both these young care leavers described in the quotations above is a strong sense of social coercion mediating peer networks. While just a couple of participants reported that their first sex occurred predominantly because of social coercion, several spoke at a more general level of the pressures that young people are under from peers to become sexually active. This suggests that social coercion is one of a number of factors influencing first sex.

Sexual competence criterion 3: Consensuality (both partners equally willing)

The third indicator of sexual competence is consensuality, which means that the intimacy occurs without a sense of pressure from either party. Consensuality was also compromised in several cases described in the current study. A striking feature of data were reports of first sex between young women and men who were considerably older in a number of cases, as in the case of a 14-year-old girl having sex with an 18-year-old man. In legal terms, under the *Criminal Law (Sexual Offences) Act 2006* it is an offence to engage in a sexual act with a child under the age of 17 years. However, the law does offer limited concession in that where the victim is aged between 15 and 17 years and the age gap between the victim and the person convicted of the offence is no more than 24, months, the offender may not be subject to the provisions of the Sex Offenders Act 2001.[11] While drawing definitive limits around age gaps between sex partners may well be seen as far from flawless, in cases where the gap in adolescence is greater than two years, there is a higher potential for exploitation in view of normative maturity of adolescents to make decisions and to be influenced adversely by those older, perhaps without even being conscious of this. Thus consensuality becomes questionable in the many cases reported by participants in this study where an age gap of more than two years was reported, irrespective of how willing the young woman appeared to be.

Another issue to consider in relation to data here is that consent to sex is not clear cut, in part because of an embedded expectation in Western culture that in encounters with a new partner, women are not expected to be equally willing to engage in sex as are men (Crown & Roberts 2007). In order to protect her reputation, the woman is expected to show some level of resistance and the man to lead and push the boundaries of the intimacy. Because it is culturally applauded that women should show a level of reticence in a first sexual encounter, they may offer token resistance, which men come to recognise and attempt to get past. This has been referred to as a 'heterosexual script' and has been defined as follows:

> *The TSS [traditional sexual script] maintains that women should appear at least somewhat sexually willing, while refusing higher levels of sexual intimacy to avoid being viewed as sexually promiscuous. Men, guided by TSS, may believe that women engage in token resistance and may persist in their attempts at sexual coercion*
> (Livingston et al. 2004, p. 294.)

The subtleties in intimate encounters have been found to give rise to interpersonal coercion, that is, where one person in an interpersonal encounter pressurises (usually verbally) another (Finkelhor & Yllo 1983). In this type of coercion, physical force may not manifest itself at all, rather verbal pushiness may impact on a young woman's capacity to freely reject a sexual advance. This type of coercion was described by one participant as follows.

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11 Further, please note that the Criminal Law (Sexual Offences) Bill, 2015 does not propose a change to the law on the age of consent but does provide for a defence to underage sexual activity where the person accused of an offence against a child who is 15 or 16 years old consented to the activity and there is less than a 2 year age difference between them, the person is not in a position of trust or authority, it is not a relationship of dependency and the relationship is not intimidatory or exploitative. It is similar to the proximity clause in the Children First Act 2015.

> *And then they [males] are putting pressure on the girl to do it. And the girls think they are going to finish with me if I don't do it so I am going to have to do it.*

Another participant described how she and her peers accepted submissiveness in heterosexual relationships, and passively accepted coercion as a normative aspect of these relationships. It was only following exposure to alternative ways of thinking after leaving care that she came to understand that her previous understanding of sexual relationships was problematic, and that assertiveness in sexual encounters was an option. A consciousness that she could negotiate safer sex by insisting on condom-use was also not part of her frame of reference during her time in care.

> *As far as we [YPIC] were concerned, the men controlled relationships, the men told us what we were to do in a relationship and if we didn't listen to the man, the relationship it would break down. That is the way we all thought in care. That we would listen to the fellow and the fellow was always right, not that we, as a woman, had rights to stand up to the man and say, 'No I don't want to do that today'. Or know about the communication factor in a relationship. We all just thought it was always the man. So we thought the man, if he would come over to us and say, 'I would love a bit of sex now', or whatever, that is the way it went. We would listen to the fellow. And if we turned around and said, 'Well do you want to put a condom on?' and he said, 'No', we had to go with it because we weren't educated in that way that us girls can actually stand up and say, 'No I am not doing it today without you having protection', or anything like that.*

Given the power differential between older teenage or adult men and younger teenage girls, the confidence and capacity to resist verbal coercion may be compromised. In all cases where male sex partners were older by at least two years than the participant – and several such cases were reported in this study – consensuality and therefore the young woman's level of sexual competence in that particular sexual encounter were questionable. It should be noted that in Mayock and Byrne's (2004) study of early school-leavers, sexual coercion was also reported where young women had sexual relations with men several years their senior.

It is notable that the transition to becoming sexually active for many of the woman was with males several years older than themselves, even though a few reported having had romantic peer relations prior to this that did not develop into sexual relationships. For example, in the years before to coming into care, one participant reported having been in a romantic relationship (at the age of 14) with a peer that did not develop into a sexual relationship. It was within two months of that relationship ending that first sex occurred, when at the age of 15 years, shortly after arriving at residential care, she encountered a man who was a number of years older than her. She was not in a romantic relationship with him, and indicated that she did 'not know him particularly well'. She reported not having been prepared insofar as intercourse was not planned, 'and it wasn't lovely and romantic for your first time or anything like that. It just happened'.

There were also disturbing reports of obvious exploitation, where both parties were clearly not equally willing participants in the sex act. In one case, a participant who had first sex at the age of 14 years came to recognise that she had not in fact consented to sex at the time of her first experience. The realisation came after she experienced mental health problems and divulged her recollections of first sex to a psychiatrist who she had been seeing for depression.

> *At 14 it was a very vulnerable age for me. I was sexually assaulted and at that age, because I wasn't educated or anything, I didn't know. I kept blaming me and saying that is my fault. Because as I said before, I thought if the man wanted it you had to give it. And I was sexually assaulted when I was 14 and that was taking a weight on me and from there on, like, no one ever told me it wasn't your fault, it wasn't anything to do with you. It wasn't until I broke the news to my psychiatrist at the time and she sent me to [sexual assault therapy unit]. I went to them and they were very helpful and they talked things through and educated me in the way of it was not consensual sex, you didn't give yourself to him, it was not your fault, blah-de-blah.*

An additional poignant case was that of a participant who described having had her first sexual experience while in residential care at the age of 12 with a young man of 18 years, who was due to leave the care setting. The girl had arrived in Ireland from a developing country at the age of 10, and reported having had no knowledge or understanding of sex. The relationship began when he came to her assistance in dealing with conflict from other residents who had demonstrated hostility, aggression and racism towards her. Her narrative of how sex happened tells of the man befriending her and ostensibly protecting her before demanding sex. It also tells of her lack of understanding of basic anatomy about how sex occurs.

Less severe levels of coercion were reported, sometimes in relations with a peer. One participant described agreeing to have sex, even when she did not appear to be ready ('I was too afraid') because of her belief that this might enhance the man's feelings for her. The relationship ended shortly afterwards.

> *And when I had sex, I was going out with him, but when you are going out with someone you are not really going out with them. And he was asking me [to have sex] and I was like, 'No!' I was too afraid. But then I was like, 'Well if I do it maybe he will love me more'. So I did it. But I felt no different afterwards . . . it was probably a month afterwards, the relationship was gone then.*

Overall, as far as consensuality as an indicator of sexual competence is concerned, this component of readiness was problematic in many of the sexual encounters described by participants in this study.

Sexual competence criterion 4: Absence of regret (the timing being viewed as appropriate for the person)

The fourth indicator of sexual competence, absence of regret, (the timing of first sex being viewed as appropriate for the person), was also compromised for a number of participants. For example, one participant revealed how, in retrospect, she regretted her early sexual experiences at 15 years and while at the time she did have some feelings for the young man, she noted 'I think looking back on it you regret it . . . looking back now I wouldn't even speak to him if I met him on the street'.

Another participant, whose first sexual experience was at 16 years, indicated that she would have preferred to have waited for the right person but did not. Another one, who experienced first sex at the age of 14, similarly regretted the timing, putting it down to her challenging behaviour and reluctance to listen to advice.

> *Interviewer: So looking back, how do you feel about the timing? Do you think was it right for your first sex?*
>
> *Participant: No definitely not. I was too young and I suppose I was just wild and didn't listen to anyone.*

Another care leaver described her devastation when, shortly after her sexual debut, the relationship ended. She had a high emotional investment in the relationship and realised that this was not the case for her sex partner. Her misreading of the partner's emotions and believing that his desire for sex was based on a desire to consolidate their emotional attachment had painful consequences for her.

> *Because I remember when I had sex, I was devastated because I did really like the person. When you are that age you think it is love, even though you know it is not love, you don't think that is the only thing he wants you for. You think he loves you and he wants to make love to you. But it is not. I think that is why a lot of girls do, because they don't understand that and they aren't taught that.*

Another also reported feelings of being used for sex, having been under the false impression that men's sexual interest was rooted in genuine relational emotions.

> *I have been strung along by fellows. Like in between those relationships and things I have had one-night stands and everything and you think they are into you and all but they are not. They are after one thing.*

Whether YPIC actually experience greater levels of regret over the timing of their first sexual encounter compared to young people not in care is difficult to establish and could not be determined in a qualitative study of this type. However, given that YPIC are more likely to have

an earlier sexual debut, and for young women in care, to have sex with partners significantly older than themselves, it is plausible that regrets about timing of sex are more widely experienced by this group.

Key points: Section 8

- Almost all participants reported having had first sex before the age of 17 years.

- Among participants who were sexually active, there were virtually no participants who described their sexual experiences of which sexual competence, that is, consistent use of contraception, autonomy in decision-making, consensuality and absence of regret, was consistently a feature.

- For the two male participants who had experienced first sex, sexual competence was undermined by an apathy about condom-use.

- Young women relied on their sex partners to use condoms, and several had themselves used hormonal contraception at some stage. In many instances, the side-effects of hormonal products were believed to exacerbate underlying mental health difficulties, and there was a high level of reported user-efficacy problems.

- The reasons underlying the failure to use contraceptives or to use them properly were a combination of a lack of knowledge and a lack of agency to take full control of fertility. The lack of agency was often related to a blasé approach to risk-taking, which resulted in pregnancy for some participants.

- A small number of participants 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.

- Sexual competence was also compromised by either alcohol consumption or social coercion, that is, peer influence to have sex.

- Sexual competence was also undermined by exploitation and a lack of consensuality between sex partners; a dominant finding was that young women, sometimes in early teens, had first sex with male sex partners several years older than themselves. It was obvious from some of their accounts that the young women's capacity to consent without reservation was compromised and they were not ready for sex with that partner.

- There were 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 have an earlier age at sexual debut suggests that they may be more vulnerable to misgivings in this regard.

Section 9
Intimate relationships

Introduction

Existing research indicates that harsh and rejecting parenting is associated with difficulties in intimate relations experienced in due course by their children (Berlin *et al.* 2006; Simons *et al.* 2012). Given the sense of parental rejection that many participants described (as detailed in Section 2) and the absence of a consistent parent (to varying degrees) showing them unconditional love throughout childhood, their vulnerability to seeking love indiscriminately in intimate relationships is considered here. The section begins by analysing participants' accounts of entering romantic relationships and, for some at least, destructive relationships. Following through on the difficulties that participants raised in relation to trust, the impact of a lack of trust in intimate relations is also explored. Finally, it is important to acknowledge that YPIC have agency and, against the odds, may recognise democratic and mutually fulfilling relationships. We close this section by considering positive relations that were reportedly experienced by participants.

Entering relationships and insecurity

Several participants spoke of the impact of early rejection on their later romantic relationships. For example, one linked her sexual promiscuity with a need for love and security.

> *I kind of have been a bit promiscuous but I think it is because I have missed out on love. That is the way I feel. I didn't grow up with it so I am kind of looking for it now.*

Another was explicit - with the benefit of hindsight - about the reasons why she, and others in a similar position, became involved in destructive relationships.

> *You are looking to fill a void or get love from somewhere that you are not getting it somewhere else in your life. And if you are fighting your ma and your da and whatever is going on you are looking for love off someone. So I would say everybody is a bit vulnerable and they get stuck with people and have babies and all that.*

That participant also described having started an intimate relationship at a time of high vulnerability after she had been expelled from home by her mother at the age of 15 and was living casually with different friends. The man in question was 19 years old, also living casually with no regular abode. Like a number of others, her ability to read and recognise problematic relationships appeared to be compromised. She described how the relationship diminished her confidence, and the lack of consistency in how this boyfriend engaged with her, including apparently failing to acknowledge the relationship, had a damaging impact.

> *And I was real taken advantage of. The relationship came to be an abusive relationship where he manipulated and I lost confidence and all. I probably didn't even know what confidence was. I didn't even realise I had looks or anything, he just put me down and everything . . . But he was making it out as if we weren't in a relationship, he was telling me not to say we were together and things like that . . . So me feeding into it, I was only a little young one, I didn't know any better. So I would say I was real vulnerable and taken advantage of and that kind of thing.*

Another participant had what she described as 'a very bad relationship' two years' previously during the time when she was 'very messed up'. She associated being in the relationship with challenging contextual factors at the time. She reflected on her lack of awareness at the time that she was being controlled by the man involved, and when she did come to a realisation, she ended the relationship.

> *I wasn't meant to be in that place in my life, I shouldn't have went near that guy. He was very manipulative and put me down and I accepted that and went on because my head was so distraught. I didn't think it was wrong and then after a while I realised. I thought, 'What am I doing?' And I got out of the whole thing.*

Another participant similarly revealed that her knowledge of relationships was such that she did not recognise that the relationship she was in at 15 years was a dysfunctional one. She became pregnant at 15 years to the man in question, and at the time of the interview described the relationship with the baby's father as 'horrible'.

> *It is horrible: We hate each other. He is horrendous. And the fact that I thought that was a functioning relationship just goes to show that I didn't know what a relationship was.*

That participant described a previous relationship she experienced with a man with whom she had first sex at the age of 12, while both of them were in residential care. The chaos and instability of her life and her despondent state of mind, it seems, blurred her ability to reflect critically on the nature of the relationship. In the following account she described how the man became violent after their sexual relationship began.

Because I was in just so a troubled place in my life that I was just like, 'Whatever . . . it doesn't matter'. It was just so horrendous. Then after it happened [sexual activity] he started getting really violent with me, because he was in the house all the time with the girls [housemates], so he would come over. And one of the days he came over, right in my face, I was just watching TV, like punched the sofa right beside my face, threw a fire extinguisher at me, he just became really violent.

Another participant had experienced one serious relationship that lasted two years, ending in the year prior to the interview. In a candid manifestation of self-awareness, she explained her feelings of 'craving love'. She associated her (dysfunctional) need for romantic love and her dependency on her former partner with an insecurity arising from unmet needs in the relationship with her birth mother.

And I relied on him an awful lot because I crave love, that is one thing I do crave is love – I always want to feel that I am loved. And I found that with my ex boyfriend - I depended on him an awful lot because he loved me. And I craved that . . . Because of the stuff we went through, my mam could never show me the love that I wanted from her so I was always looking for something in a fellow that I couldn't get from my mam . . . I never received anything like love, yeah I did receive love but not in the way normal children would receive love, so when you are not used to something.

Elsewhere in the interview, she described her insecurity in the relationship and the lingering fear that the relationship would end because someone better would replace her. While acknowledging that 'most girls think like that', she nonetheless felt that emotional neglect exacerbated her vulnerability within the relationship.

One of my earliest relationships, like it feels good and you know, 'Oh he really likes me'. But you know it is going to end. So you don't get your hopes up, that is the thing, and you think very negatively. I remember when I was with my ex, my longest relationship, and he was my first love, I was always thinking something is going to happen. So you are very negative . . . You always feel like there is going to be something bigger and better than you. I think most girls think like that but I think more so when you experience neglect and starvation of love and stuff, you are going to be negative about it anyway.

She went on to recount the trauma experienced when the relationship subsequently ended, including a negative impact on relations with her birth mother.

I think since I broke up with my ex, that is when I went down a really bad patch because I was looking for something in people that I couldn't get . . . At that stage I fell out with my birth mam, which I am really close to.

The ending of a relationship did not, however, always signal a sense of dejection and failure. For one participant, for example, it signalled a turning point, where after 18 months of an abusive relationship, she came to a decision to take control of her life. She described how the motivation to change things occurred as she was making the transition to a college course, and how the decision to end the destructive relationship marked the beginning of a new, positive phase in her life.

> *After a year and a half of being in a really abusive relationship and all, just enough is enough. And I was in Youthreach and all at this point and everything. It was coming to the end of my Youthreach year and I was going on my summer holidays and going into college and all and I just had enough and just clearing my head and I am worth more than this shit and got out of that relationship. Just from then on everything just shot up.*

The basis of her new found confidence, she explained, was the encouragement from those around her and the positive affirmation of her worth that emanated from the experience of educating herself. The impact, she revealed, was to motivate her to continue to achieve.

> *Interviewer: Was it the course itself or was it just the course built your confidence?*
>
> *Participant: People around me . . . Going into college as well. When I started college was when I really got my confidence back, a new environment . . . College was all you are adult now, new friends, everybody was really nice. It was just a completely different atmosphere. I just got confidence back and just copped on and when you realise your self-worth and everything, everything just gets better and you start to cop on . . . All my peers just encouraging me telling me I can go far and all. It does make you put your head down.*

Caution about relationships

There were also participants who were cautious about engaging in sexual relationships. For example, one participant reported that it took her a long time to trust potential romantic partners. Her account suggested that steps towards intimate relations were paced (in keeping with discourses about appropriate ways of advancing a relationship). At the time of the interview she was engaged in a lesbian relationship.

> *But it just takes me a while to trust somebody, to get intimate with them. I just couldn't go off with anybody, I would have to know them and trust them. That is just the way that I am.*

Another participant indicated that she avoided romantic relationships and disapproved of the promiscuous behaviour of her friends. She revealed that she would rather confine sexual activity to an individual relationship, and put her sense of caution about relationships down to her 'history' (sexual abuse and mental illness). In addition, her previous experience of a two-

year relationship (at around the age of 15/16 years) in which she discovered that her boyfriend had been unfaithful dented her confidence.

> *Since then I haven't really had a proper relationship because I can't deal with the trust or confidence in myself to actually have it.*

Another young care leaver reported having had her first sexual relationship at 17 years, which ended badly when deception and sexual infidelity on the part of the boyfriend came to the fore. Shortly after that (a year prior to the interview), she began a relationship with a young man of 22 and became engaged within three months. The couple were still in the relationship at the time of the interview and interacted on a daily basis, although she reported conflict in the relationship that prompted her to 'go off the rails'.

While teenage relationships (in general) tend to be unstable and often distressing for those involved in break-ups, teenagers in stable families tend to have more resources at their disposal, specifically the unconditional love of parents, to enable them to move forward and recover emotionally. It is likely that this enduring sense of worth buttresses feeling demolished in the face of break-ups. It is also likely that for those without this emotional anchor, the ending of a relationship may be interpreted as a personal failure, a sense of not deserving love, and a lack of confidence that one is capable of having an enduring relationship.

Positive intimate relationships

The findings of this study indicate that while there were several reports of destructive relationships, good romantic relationships were also experienced, indicating that YPIC are not invariably destined for problematic partnerships.

One reported experiencing a positive two-year romantic relationship after having previously been in a destructive one.

> *He is such a lovely person - you couldn't ask for a nicer person, and I would love for him to be a really good friend and support what I want to do in life. And he does. So I think he is ok with that.*

Because of her ambition to travel and study abroad, she reported having recently ended the relationship, which, she noted, was difficult for both of them. However, she reported that she was now more attracted to 'the nicer type' (of man), having learnt from her own experience.

Another one described having had a positive relationship that lasted five years, from the age of 15 to 21 years. She reported that in spite of having strong feelings for each other from the outset, it was six months before the couple had penetrative sex. Prior to this, she had experienced fleeting sexual encounters with other men who she did not know particularly well.

She described the rational process involved in choosing to delay sex with the man who became a stable partner, because allowing the relationship to develop took priority, a course of action that she planned to repeat in the future.

> *But the funny thing is I met him one week before Christmas five years ago and I really like him, really, really liked him, he was lovely and we didn't have sex for six months. Because I knew what I was after doing before, I was after having sex with two people I didn't want relationships with really and it was very silly of me. And then I knew that I liked him and I eventually would want a relationship with him but it took six months then before anything happened. Myself, I decided this is what I am going to do and in the future I am going to do this - It is not going to happen the way it has before.*

She also revealed that while it would have been preferable to have had her first sexual experience with a man she loved, she nonetheless had learned from the two casual sexual encounters. The steady relationship that she developed endured over the course of her two residential placements and after-care and had only recently ended because she no longer felt in love with him. She described the difficulty in leaving a stable relationship with her 'best friend' after the romance had run its course.

> *It is tough, but life goes on. I didn't want to lead him on any more if I didn't feel . . .*
> *It is very hard to walk away from somebody you know will never ever walk away from you. He just adores me and wants me back and I love him as well but I don't feel in love anymore.*

She relayed how she had enjoyed positive experiences while in this relationship and that partner was a stable influence in view of his own steadiness.

> *But with him it was good because he was brilliant, didn't smoke, didn't drink, had a nice family and I was always part of that as well . . . I would say he kept me out of a bit of trouble.*

Recalling his caring gestures (such as cooking meals for her), she pondered as to why she found that she did not feel that she 'had anything left for the relationship' and surmised that it may be because she was just 15 and he 17 when they got together.

Although the healthy romantic relationships described here did not last, this seemed to be primarily because of the youthful age of those involved (adolescent relationships tend not to endure as the parties involved are still maturing and sexual passion is considered important, rather than commitment and pragmatic concerns that characterise adult relationships (Connolly & McIsaac 2011; Furman & Winkles 2011). Yet, given that there appears to be some evidence that early romantic experiences influence a person's approach to later adult

relationships (Crissey 2005), these positive relationships are important to acknowledge insofar as participants appeared to recognise signals of mutuality, respect and affection that they may invoke in future partner selection.

Key points: Section 9

- Several participants linked their sense of early rejection to a lack of trust in romantic relationships, and also to being vulnerable to seeking love indiscriminately.

- Some participants reported having had dysfunctional relationships with controlling partners, and 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.

- Two participants reported having had long and positive relationships based on mutuality and love, indicating that enduring successful relationships are possible for YPIC.

Section 10
Summary and conclusion to Report No. 5

In analysing the rich raw data that young care leaver participants contributed to this study, it was important not to lose sight of the specific purpose of the SENYPIC programme of research, which was a needs analysis of RSE and sexual health for this group of young people. A major strength of qualitative work of this type is that it allows more embedded needs to be identified, which participants may not have articulated had the interviews focused directly and solely on listing sexual health and RSE needs that could readily have been captured by using a questionnaire. It was also important to be guided by what is known from scholarship about what underpins good sexual health, so that more complex dimensions of life for YPIC (that mediate sexual health) were included in the analysis. It was actually through participants' accounts giving voice to their biographies and wider care experiences that more refined sexual health and RSE needs came to the surface. Thus, while at first glance, detailed narratives of self-concept, care experiences, family connectedness, service-provider relationships and monitoring may seem somewhat remote from the real focus of the study, as the analysis progressed it became clear that nested within these narratives were challenges and impediments to good sexual health which revealed a sexual health and/or RSE need.

The analysis of data for this study began in Section 2 with an exploration of 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 harbour 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 through the need to negotiate new relationships and routines in a new environment. 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.

In Section 3 we considered risky behaviours, particularly drug and alcohol use to which participants reported being exposed, because existing studies tell us that risk 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.

In Section 4 the analysis moved on to consider 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. However, residential care did not tend to be experienced as a family-type home, and many of the participants' recollections were of institutional living with institutional rules, 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. Additional governance aspects of residential living recalled by participants were the requirements for staff to observe official regulations without the flexibility and discretion that parents might normatively exercise.

In Section 5, we 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 family connectedness within the foster family. Almost all of the 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 tended to acknowledge that the root of the conflict was their own inappropriate behaviours linked to unresolved psychological issues. House rules imposed by foster carers tended to be interpreted retrospectively with less contempt than were house rules in residential care (detailed in Section 4). What made the difference seemed to be that house rules and monitoring in foster care tended to be underpinned by the 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 insofar as a sense of family connectedness was often reported. However, population studies have not yet established whether foster care actually brings better sexual health outcomes in the longer term over and above residential care for YPIC (Viner & Taylor 2005). Variations in the quality, number and length of placements make such comparative outcome measurements very complex.

Staying with issues of stability and connectedness, in Section 6 participants' perspectives on 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, which exacerbated participants' feelings of insecurity. This prevented a deep sense of connectedness to any particular service-provider, was experienced as distressing and stressful for participants, and was sometimes viewed as a continuation of early rejection by the 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.

Section 7 saw the emphasis shift to RSE and access to the sexual health services, as well as the role that foster carers and various stakeholders play 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 (Hyde *et al.* 2010) 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 GPs 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 carers 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 sex 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 among participants seemed to vary. 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 sex education was that there was insufficient attention given to the emotional aspects of relationships.

Another source of information about 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 after-care 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, mainly focusing on direct sex education.

The important issue of participants' sexual experiences and what these revealed about their degrees of sexual competence was considered in Section 8. 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 consistently characterised by high levels of sexual competence. (To recapitulate, 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 young men who had experienced first sex, an 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 also 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 undermined by exploitation and a lack of consensuality between sex partners. A strong theme was that young women, sometimes in their early teens, 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 this.

The final data section, Section 9, dealt with participants' accounts of their intimate relationships and brought the findings of the study full circle – the insecurities, instability and sense of abandonment identified in the first data section were believed by several participants to impact on romantic partner choices. Indeed, several participants linked their lack of trust in romantic relationships, and 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. When 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 had 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.

As indicated at the outset, the findings of this report are integrated with those of the other related reports in a composite report entitled *Sexual Health and Sexuality Education Needs Assessment of Young People in Care in Ireland (SENYPIC): Composite Report of Findings. Report No. 6*. In the composite report, an overall conclusion and recommendations relating to the whole study are proffered. We close this report by highlighting the main sexual health and RSE needs for YPIC nested in the narratives of the care leaver participants.

These are the need for:

- Awareness of the negative impact that social work and social care staff changes can have on the lives of YPIC.

- Awareness of the importance of encouraging development in the following areas and providing continued support where work is already taking place:
    - o Teaching self-development and confidence building skills
    - o Developing an understanding of emotional connectedness and social learning
    - o Teaching skills to allow for self-directed learning
    - o Developing skills around routine and structure.

- Continuing support for attending school.

- Having a better understanding of the type of information that requires recording about the young people.

- Having a better understanding about how to balance young people's need for privacy while maintaining their safety.

- Facilitating access to clinical sexual health services when required.

- Facilitating consistent delivery of RSE that can meets the particular needs of individual young people.

- Facilitating access to RSE that explores emotions and readiness for sex.

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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

Section C   Reporting Considerations under The Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 ("the Act")
1. Is there knowledge or belief that a serious offence (as listed in Schedule 1 to the Act) has been committed? Yes: No:
If "Yes" please give details:
2. Is there information that might be of material assistance in securing the apprehension, prosecution or conviction of the offender? Yes: No:
If "Yes" please give details:
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 Siochana? Yes: No:
If "Yes" please give details:
IF THE ANSER 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 SIOCHANA AT ANY STAGE IF THE SITUATION WARRANTS IT, REGARDLESS OF THE REQUIREMENTS OF THE ACT.

Section D   Reporting Considerations under general Ethical Obligations
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 Siochana in the best interest of a child or children? Yes: No:
If "Yes" please give details:

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:
Topic Guide (Triggers for discussion to structure the interview)

NON-PARENTING CARE LEAVERS 18-22 YEARS

School/education/training – current situation

- Are you at college/working/training?

- School experience: awards/achievements/truancy/suspensions/exclusions

- Educational or work aspirations

Care history /placement experience & family background

- Placement type/care history – when first in care/placements etc

- Relationship with birth family/foster family (if applicable)

- Positive or negative experience/transition since leaving care?

Social Relationships and Lifestyle

- During your teenage years did you have many close friends/confidants?

- Making new friends?

- What did you do at evenings/weekends?

  o Going out and socialising, cinema, pubs, clubs?

Alcohol/illicit drug use

- During your teenage years – did you or your peers use of alcohol/drugs? – What age? Any examples?

General Health; physical, mental, well-being and self-care

- How are you about looking after your health?

  o Use/knowledge of general health services? (GP, nurse, youth health services etc.)

- When you were younger did you look after your health? What about your sexual health? Any examples?

- What about other types of support services? E.g. drop-in cafes, young people's services, advocacy organisations etc.

- What are your views of such services? Experiences of using such services

Romantic relationships

- During your teenage years were boyfriends/girlfriends important to you or your friends?

- Were they casual or serious relationships? How frequently did they change?

- What age did you or your friends become interested in romantic relationships?

Knowledge about sex and relationships, sources of information, sex education

- Sources of information – media, friends/peers

- Sex education in school/social worker/parent & carers

- Where did you learn what you know?

- Would you like to have more information? From whom?

- Have you ever used the internet to find out more about something you didn't know?

- Has anyone spoken to you about contraception or risk of pregnancy?

- What about infections or diseases people can get from having sex?

Depending on the young person's level of knowledge and experience:

- When was your first sexual experience? Did you think about STIs or pregnancy? Did you use contraception/protection? Did you get any advice or attend any healthcare services before or after? Looking back how do you feel about the timing?

Finishing interview

- Advice to other young people

- Advice/recommendations to the foster/residential care system

ADDITIONAL TRIGGER QUESTIONS FOR PARENTING CARE LEAVERS 18-22 YEARS

Pregnancy

- Tell me a little about your experience of getting pregnant. Prompt: What age, what was the reaction to the pregnancy, who did you tell, how was your relationship with child's father, reaction of parent/foster parent/social worker?

- What circumstances led to the pregnancy? (E.g. planned/accident etc.)

- Where did you go for the test? Self-test, GP, specialist service

- Did you get any advice or support from outside agencies? E.g. crisis pregnancy service?

- Did you get any help from anyone during the pregnancy? (Friends, social care worker, parent/foster parent, social worker etc.)

- Are you attending or did you attend any services during the pregnancy? (Antenatal care, Teen mums service, GP/Nurse etc.)

Parenting

- Tell me a little bit about your son/daughter?

- What is it like having a young child?

- Have you changed? Has your life changed?

  o You as a person,

  o Your education/work,

  o Your relationship with parents/carers,

  o Your relationship with father etc.

  o Your social life/friendships?

- Is there anything from your experiences with your family/or life in care that influenced your views about becoming pregnant or fathering a child or the timing of the pregnancy?

Help seeking behaviour/Coping strategies/Service use

- Are you or did you attend any support services? (Teen parents projects, mother toddler group, talking to public health nurse etc.)

- Have these services made a difference?

- Is there anything else that would help you as a parent?

Finishing interview

- What would you like to do in the future?

- What advice would you give to someone who was in your position?

- Advice to other young people?

- Advice/recommendations for foster/residential care system?

THANK YOU